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RESCISSIONS

The following material is rescinded:

COMPLETE RESCISSIONS

a. **Manuals**

M-1, Part I, Chapter 7 and Appendix 7D, dated May 18, 1989.

b. **Interim Issues**

10-83-5
10-83-20
10-85-1
II 10-84-29
II 10-85-3 and Supplement No. 1
II 10-85-11
II 10-85-20
II 10-86-7
II 10-87-2
II 10-87-9
II 10-88-4

c. **Circulars**

10-83-141
10-87-9
10-90-021

CHAPTER 7. PATIENT DATA AND QUALITY CONTROL

SECTION I. ICD-9-CM CODING GUIDELINES

7.01 INTRODUCTION

a. The ICD-9-CM (International Classification of Diseases-Ninth Revision-Clinical Modification) will be used to report diagnostic, procedural, and operative information into the PTF (Patient Treatment File) system on all releases from inpatient care occurring on and after October 1, 1980.

b. Diagnostic, procedural, and operative information which is reported using ICD-9-CM codes is used for epidemiological and clinical research, health care planning, quality assurance and utilization management, medical legal purposes, and the resource allocation program.

c. The resource allocation program used by VHS&RA (Veterans Health Services and Research Administration) is based, in part, upon DRGs (Diagnosis Related Groups). DRGs represent a classification system of patients which is defined clinically by a patient's primary diagnosis, and in some, but not all cases, a qualifying secondary diagnosis, an operation/procedure, and the age and discharge status of the patient. Each DRG is intended to be medically meaningful. Thus, patients in the same DRG are expected to evoke a set of clinical responses which results in a similar pattern of resource use.

d. Qualifying secondary diagnoses are known as ccs (complications/comorbidities). A complication is a condition that arises during an episode of care and is thought to increase a patient's length of stay by at least 1 day for approximately 75 per cent of the patients. A comorbid condition is one that existed at the time of the patient's admission and is also thought to increase the length of stay by at least 1 day for approximately 75 per cent of the patients.

e. A valid primary diagnosis generates an established value known as a weighted work unit. Additional weighted work units may be assigned each patient with one qualifying cc. When a patient has more than one qualifying cc, there is no additional increase in weighted work units. As a result, patients with multiple ccs are assigned to the same DRG as those with only one cc. A listing of cc's which impact upon DRG assignment will be found in appendix A to this chapter.

f. An operation/procedure can also increase the weighted work units of a patient's episode of care. However, it is not unusual to find that the same DRG is assigned when a patient has both a qualifying cc as well as a qualifying operation/procedure. As a general rule, the operation/procedure must be one that is recognized as a treatment modality for the primary diagnosis. A listing of operations/procedures which impact upon DRG assignment will be found in appendix B to this chapter.

g. A listing of DRGs for any medical center provides an index to the type and volume of inpatients treated by a medical center. This index is called the "case mix." Resources are allocated to each medical center based upon it's case mix.

h. Coding personnel are advised to become familiar with the codes which appear in appendices A and B and to assign appropriate codes to diagnostic and operative/ statements when provided on medical records by medical staff members.

i. The instructions as provided in this section are applicable upon receipt of this issue.

7.02 GENERAL

a. Coding questions which cannot be resolved locally will be directed to Medical Administration Service (161B), VA Central Office, by the Chief, Medical Information or designee. Assigned Central Office personnel will serve as liaison with Central Office on ICD-9-CM of the AHA (American Hospital Association). Medical center personnel are not authorized to contact the AHA regarding coding or classification problems.

b. To meet the information demands of medical care facilities and Central Office, some of the diagnostic, operative, and procedural codes listed in the ICD-9-CM have been expanded to provide the specificity needed for required reports. These codes will be found in appendix 7C. Where required, the phrase "DO NOT USE" has been added to the English text translation of the diagnosis, operation, or procedure.

c. Additions, deletions or other changes to the diagnostic, operative, and procedural codes will be published by VA directive and referenced to appendix 7D of this chapter.

d. The content of this section does not represent a comprehensive treatise on coding each of the diagnostic or operative/procedures described in the ICD-9-CM code books. As a result, in addition to the basic 3 volume set of ICD-9-CM, coders should have ready access to English and medical dictionaries, and the most recent editions of CMIT (Current Medical Information Terminology) and CPT (Current Procedural Terminology), and DSM-III-R (Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised). CMIT and CPT are published by the AMA (American Medical Association). DSM-III-R is published by the APA (American Psychiatric Association). These references may be used by clinicians as a resource in establishing diagnostic and operative statements. Unless otherwise specified by VA directive, the following publications will be used for training and reference purposes:

(1) AHA, ICD-9-CM Coding Handbook With Answers, Revised Edition, 1989, published by the American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611.

(2) AHA, Coding Clinic.

e. The PTF system is programmed to detect most invalid, incomplete, and inconsistent diagnostic, operative, and procedural codes. This program is based upon the coding instructions which are provided in the ICD-9-CM and upon specialized VA requirements .

f. Diagnostic, operative, and procedural indices which contain data reported into the PTF system are produced on microfiche at monthly and/or semiannual intervals. Each of these indices has been assigned a PTF report number. The monthly diagnostic index (PTF Report Number 001) and the monthly operative index (PTF Report Number 003) are produced and distributed to medical care facilities on the fourth Saturday following the end of the report period. The semiannual diagnostic index (PTF Report number 601), operative index (PTF Report Number 603), and procedure index (PTF Number 604) are produced and distributed to medical care facilities 6 weeks following the end of the report period. Diagnostic and operative data representing non-VA care are printed as trailer reports to the monthly and semiannual reports.

Questions concerning microfiche which has not been received following the end of the report periods will be directed to Medical Administration Service (161B), VA Central Office. Facility personnel are not authorized to contact the DPC for these outputs.

g. Diagnostic, operative, and procedural indices containing discharges which are both prior to and after October 1, 1980, will reflect releases reported with ICDA-8 codes at the beginning of the listing. The ICD-9-CM codes will be listed after the last ICDA-8 entry.

7.03 DOCUMENTATION OF DIAGNOSES, OPERATIONS, AND PROCEDURES

a. Diagnoses

(1) The primary diagnosis and other diagnoses, conditions, and situations which were treated during an episode of care, observed for possible medical intervention, or known to have impacted the patient's length of stay will be documented on the discharge summary. The primary diagnosis is defined as the diagnosis, condition, or situation responsible for the major part of a patient's length of stay (DXLS). Other diagnoses will include those diagnoses, conditions, and situations which exist at the time of admission or develop subsequently which affect the treatment received and/or the length of stay.

(2) The DXLS will appear on the discharge summary as the first diagnosis listed. All other diagnoses, conditions, and situations which are treated during an episode of care, observed for possible medical intervention, or known to have impacted the patient's length of stay should appear on the discharge summary following the DXLS in descending order of clinical importance. Autopsy diagnoses, and other clinical conditions noted but not treated and/or which did not impact the length of stay or affect the treatment received may appear on the discharge summary, in the section specified as "Pertinent Clinical Diagnoses Noted, But Not Treated."

(3) The medical staff member who prepares the discharge summary will identify the DXLS by prefixing that diagnosis with an alpha character "X." The diagnostic code representing the DXLS will be used for planning and resource allocation purposes.

(4) When two or more diagnoses contribute equally to a patient's length of stay, the medical staff member will provide one, which is judged to be the most significant in relation to the total length of stay.

(5) The primary diagnosis and other diagnoses, conditions, and situations which were treated on a bed section during an episode of care, observed for possible medical intervention, or known to have impacted the patient's length of stay will be documented on each transfer and discharge note. For the purpose of this subparagraph, the primary diagnosis is defined as the diagnosis, condition, or situation responsible for the major part of a patient's length of stay (DXLS) on the releasing (losing) bed section. Other diagnoses will include those diagnoses, conditions and situations which exist at the time of admission or develop subsequently which affect the treatment received and/or the length of stay.

(6) The DXLS will appear on each transfer/discharge note as the first diagnosis listed. All other diagnoses, conditions, and situations which are treated on the releasing bed section, observed for possible medical intervention, or known to have impacted the

patient's length of stay should appear on the transfer/discharge note following the DXLS in descending order of clinical importance. Other clinical conditions noted but not treated and/or which did not impact the length of stay or affect the treatment received on the releasing (losing) bed section will not be documented on the transfer/ discharge note.

(7) The medical staff member who prepares the transfer/discharge note will identify the DXLS by prefixing that diagnosis with an alpha "X." The diagnostic code representing the DXLS will be used for resource allocation purposes.

(8) When two or more diagnoses contribute equally to a patient's length of stay on a bed section, the medical staff member must provide one, which is judged to be most significant in relation to the total length of stay on the releasing bed section.

b. Operations/Procedures

(1) All significant procedures will be documented on the discharge summary. A significant procedure is one that:

(a) **Is surgical in nature.** Surgery includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulation.

(b) **Carries a procedural risk.** Procedural risk refers to a professionally recognized risk that a given procedure may induce some functional impairment, injury, morbidity, or even death. This risk may arise from direct trauma, physiologic disturbances, interference with natural defense mechanisms, or exposure of the body to infection or other harmful agents.

1. Traumatic procedures are those that are invasive, including Non-surgical procedures that utilize cut-downs, that cause tissue damage, e.g., irradiation, or introduce some toxic or noxious substance, e.g., caustic test reagents.

2. Physiologic risk is associated with the use of virtually any pharmacological or physical agent that can affect homeostasis, e.g., those that alter fluid distribution, electrolyte balance, blood pressure levels, and stress or tolerance tests.

3. Any procedure in which it is usual to utilize pre- or post-medications that are associated with physiologic or pharmacological risk should be considered as having a "procedural risk." For example, those that require heavy sedation or drugs selected for their systemic effects such as alteration of metabolism, blood pressure or cardiac function.

4. Some of the procedures that include harmful exposures are those that can introduce bacteria into the bloodstream, e.g., cardiac catheterization, those capable of suppressing the immune system, those that can precipitate idiosyncratic reactions such as anaphylaxis after the use of contrast materials, and those involving substances with known systemic toxicity. Long-life radioisotopes pose a special kind of exposure risk to other persons as well as to the patient. Thus, these substances require special precautionary measures and the procedures using them carry procedural risk, or

(c) **Carries an anesthetic risk.** Any procedure that either requires or is regularly performed under general anesthesia carries an anesthetic risk, as do procedures

performed under local, regional, or other forms of anesthesia that induce sufficient impairment necessitating special precautions to protect the patient from harm, or

(d) **Requires specialized training.** This criterion is important for procedures that are exclusively or appropriately performed by specialized professionals, qualified technicians, or clinical teams that are either specifically trained for this purpose or whose services are principally dedicated to carrying them out. Whenever specially trained staff resources are necessary or are customarily employed in the performance of a procedure, it is considered significant.

(2) A significant procedure may consist of a therapeutic component as well as a diagnostic component; it may consist of a therapeutic component only; or it may consist of a diagnostic component only. A therapeutic procedure is defined as one performed for definitive treatment. Conversely, a diagnostic procedure is performed to identify either the cause of a patient's problem, or the site of the patient's problem. For example, an appendectomy, performed for acute appendicitis, is considered a therapeutic procedure because it is performed to remove the inflamed appendix. Thus, the procedure is performed for definitive treatment. A coronary by-pass procedure may be performed immediately following cardiac catheterization for a diagnosis of coronary artery insufficiency. In this example, the cardiac catheterization represents the diagnostic component of the procedure because the catheter dye will identify the site(s) of the coronary artery narrowing or occlusion while the by-pass represents the therapeutic component of the procedure because blood circulation to the affected site is being restored. A cystoscopic procedure may precede both a bronchoscopy and a gastroscopy. In this last example, all procedures are considered diagnostic: they are performed to identify either the cause of the patient's problem or the site of the patient's problem.

(3) Significant procedures may be performed in a main operating room or in a designated specialized operating treatment room. Specialized operating rooms include those where endoscopies, fracture reductions and/or with cast applications, ophthalmologic procedures, etc., are performed. Procedures performed in a main operating room or in a specialized operating room by a member of the surgical staff will be reported as a surgical episode into the PTF system (TT401). Significant procedures may also be performed in Radiology Service, e.g., intravenous cholangiogram; Cardiac Laboratory, e.g., cardiac catheterization; Nuclear Medicine Service, e.g., CAT (computerized axial tomography) scans and NMR (nuclear magnetic resonance), and at the patient's bedside or ward treatment room, e.g., thoracentesis, bone marrow aspiration. These procedures will be reported as a non-OR episode into the PTF system (TT601).

(4) Procedures performed by surgeons in a main OR (operating room) or in a specialized OR will be documented on SF 516, Operation Report. Procedures performed in Radiology or Nuclear Medicine Services will be documented on SF 519A or SF 519B, Radiologic Consultation Request/Report. Some non-OR procedures performed at the patient's bedside or ward treatment room will be documented in the progress notes or on an approved local form. All procedures performed will be documented on the discharge summary and on the transfer and discharge notes.

7.04 REPORTING DIAGNOSES, OPERATIONS, AND PROCEDURES

a. The PTF system contains provisions for reporting up to 10 different diagnostic codes which represent diagnoses appearing on VA Form 10-1000, Discharge Summary, or on

VA Form 10-1000a, Abbreviated Medical Record; provisions for reporting up to 5 different diagnostic codes which represent diagnoses appearing on each transfer note; and up to 5 different diagnoses appearing on the discharge note. In addition, the PTF system contains provisions to report 10 operative episodes performed in a main OR in a specialized OR. Up to 5 different ICD-9-CM operative codes can be reported for each episode of surgery. Provisions are also available in the PTF system to report non-OR ICD-9-CM procedural codes.

b. The first ten diagnosis on the discharge summary will be assigned codes. These diagnoses should represent those conditions which were treated, observed, or known to have impacted the patient's length of stay. Diagnoses representing a history of past conditions, now resolved and not relevant to the current episode of care should not be coded. When, as required by ICD-9-CM coding instructions, one diagnosis requires the assignment of 2 or more codes, the number of diagnoses to be coded on the discharge summary will be decreased accordingly. In addition, since these diagnoses have been sequenced in descending order of clinical importance by the medical staff member, the codes will be assigned following ICD-9-CM coding instructions and this directive, and in the order as documented by the medical staff member. There will be no exception to this principle. The coder will not assign codes to diagnoses, conditions, or situations which are not provided by the medical staff member on the discharge summary, or transfer/discharge notes. Cases which show the need for additional information as well as omitted diagnosis, conditions, or situations will be referred to the responsible medical staff member for clarification and possible amendment of the source document.

c. Only 5 diagnoses per transfer and/or discharge note will be coded. Diagnoses representing a history of past conditions now resolved and not relevant to the current episode of care should not be coded. When as required by ICD-9-CM coding instructions, one diagnosis requires the assignment of 2 or more codes, the number of diagnoses to be coded on the transfer and/or discharge note will be decreased accordingly. In addition, since these diagnoses have been sequenced in descending order of clinical importance by the medical staff member, the codes will be assigned following ICD-9-CM coding instructions and this directive, and in the order as documented by the medical staff member. There will be no exception to this principle.

d. Non-OR procedures performed by members of the surgical staff will be coded and reported in date order only if they impact upon resource allocation or are requested by members of the medical staff. These procedures will be documented on the discharge summary and transfer/discharge notes. Report non-OR procedures only once per bed section.

e. Each operation performed by a member of the surgical staff in an OR will require identification of the principal therapeutic, ancillary procedures, and diagnostic procedure(s) performed. The principal therapeutic procedure will be coded and reported first. The principal therapeutic procedure is defined as that procedure most related to the operative diagnosis; one which is performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. It is usually more significant in terms of the degree of risk and/or resource consumption. Ancillary procedures will be reported following the principal procedures. Diagnostic procedures will be reported last. When two or more operative codes are required to describe the procedure performed, the number of operations which can be reported will be decreased accordingly. If, however, an operative episode consists of more diagnostic procedures than therapeutic procedures, the therapeutic procedures

will be reported first. When an operative episode involves only diagnostic procedures, these procedures will be coded and reported according to the time sequence in which they were performed. These operative episodes include endoscopies.

- f. A listing of OR and non-OR procedures which impact upon DRG assignment will be found in appendix B.
- g. Diagnoses and other clinical conditions noted, but not treated and/or which did not impact the length of stay or affect the treatment received will not be coded or reported into the PTF system.
- h. Autopsy diagnoses will not be coded or reported into the PTF system.
- i. Organs and tissues obtained by harvesting (for future transplant operation) after the death of a patient will not be coded or reported into the PTF system.

7.05 STRUCTURE OF THE ICD-9-CM CODE BOOKS

a. The basic ICD-9-CM code consists of three digits. All three digit codes appear in bold type face. Fourth and/or fifth digits are, in some instances, added to the basic code in order to provide added clinical detail and to isolate terms for clinical accuracy. Many fourth and fifth positions of a basic code appear subordinate to the printed three digit code. For example, see diagnostic code category 836.5. In other instances, reference to a required fifth position code is provided following the basic three position code. (See the instructional notation following diagnostic codes 835, and in the introductory statement to the classification of tuberculosis on page 7 of volume 1. Also see subparagraph b(3)(b) below.) Code books will be highlighted to indicate where fifth digits are required.

b. Multiple abbreviations, punctuation's, symbols, and other instructional notations are used in the tabular listings of the ICD-9-CM.

(1) Abbreviations

(a) NEC (Not Elsewhere Classifiable) is used for 2 purposes:

1. To describe ill-defined terms. The codes provided for ill-defined terms should be used only if more precise information is not available.

2. To describe terms for which a more specific category is not provided in the listings and no amount of additional information will alter the selection of the code.

(b) NOS (Not Otherwise Specified) is the equivalent of "unspecified."

(2) Punctuation

(a) [] Brackets are used to enclose synonyms, alternative wordings, or explanatory phrases. For example, see diagnostic code 682.2, other cellulitis and abscess of trunk. The brackets used following the site of the back explain that any part of the back except the buttocks is included in the classification of 682.2.

(b) () Parentheses are used to enclose supplementary words which may be present or

absent in the statement of a disease or procedure without affecting the code number to which it is assigned.

(c) : Colons are used after an incomplete term which needs one or more of the modifiers which follow in order to make it assignable to a given category. For example, diagnostic code 472.1, Chronic pharyngitis, is appropriate only if the diagnostic statement includes the terms atrophic, granular (chronic), or hypertrophic.

(d) { } Braces are used to enclose a series of terms, each of which is modified by the statement appearing at the right of the brace.

(3) **Symbols**

(a) [] The lozenge symbol printed in the left margin preceding the disease code denotes a four-digit rubric unique to the ICD-9-CM: the code does not appear in the parent ICD-9. This symbol appears only in volume 1.

(b) § The section mark symbol preceding a code denotes the placement of a footnote at the top of the page which is applicable to all subdivisions in that code.

(4) **Instructional Notes**

(a) Include: This note appears to further define or give examples of, the contents of a chapter, section, or category which is subdivided in volume 1, and following the two and three position codes in volume 3. Thus, an inclusion term which appears under a chapter title indicates that the inclusion term applies to all subdivisions in the chapter (see volume 1, page 1). An inclusion term which appears in a section applies to all subdivisions in the section (see volume 1, page 460). An inclusion term which appears in a category applies only to that category.

(b) Exclude: Terms following the word "excludes" are to be coded elsewhere as indicated in each case. Thus, diagnoses and operations which appear in an excludes note are not included in the specific classification. For example, throughout the operative tabular listing, notes appear which exclude the reporting of biopsies. These notes will be interpreted to mean that the biopsy will be coded elsewhere as specified. Biopsies performed during any type of examination or episode of surgery will be assigned a code unless the English text interpretation of the code includes biopsy. Some excludes notes are considered prohibitive. For example, category 496 includes chronic obstructive pulmonary disease, but the content of the note further states that with bronchitis, chronic obstructive pulmonary disease is coded 491.2, a more specific code. The remaining exclusion notes which appear in the tabular listings of volumes 1 and 3 of ICD-9-CM do not necessarily imply inconsistency between diagnostic or operative entities. The coder is advised to refer to the code provided in the exclusion note in order to assign a code to the diagnostic or operative statement.

(c) **Note:** *The word "note" appears in all 3 volumes of ICD-9-CM. Its purpose is to serve as a guide in classification assignments; to define the content of a category and the use of subdivision codes.*

(d) See, See Category, and See Also: Any one of these terms may appear in the ICD-9-CM volumes to direct the coder to another entry, another category, or to look elsewhere if the terms provided are not sufficient for coding.

(e) Omit Code: This term alerts the coder when not to assign a code. This instruction appears primarily in volume 3.

(f) Use additional code if desired: This phrase appears in those instances where additional codes will probably provide a more complete description of the diagnosis or procedure. The words "if desired" will be deleted wherever they appear and the words "if known" will be inserted. For example, the instructional notation for diagnostic code 510, empyema states "use additional code, if known, to identify infectious organism (041.0-041.9)." If the laboratory report confirms the presence of streptococcus in the culture and physician documents this finding on the discharge summary transfer and/or discharge note, an additional (secondary) code of 041.0 will be assigned. Conversely, if a laboratory report is not present in the record and the physician does not document the organism, an additional code representing the organism will not be coded.

(g) Code also underlying disease: This instruction is used in those categories not intended for primary tabulation of disease. In such cases, the code, its title, and instructions appear in italics. The note requires that the underlying disease (etiology) be coded first and the particular manifestation be coded secondarily. For the purpose of clarity, the word "also" will be deleted wherever it appears and the words "first the" will be inserted. Thus, the phrase will read "code first the underlying disease." The recognizable feature of this instructional notation is that the code and title are in italics. Codes which appear in italics will be highlighted since they cannot be used to report the DXLS. A listing of all codes which cannot be used to report the DXLS, including italicized codes, appears in appendix E of this chapter.

(h) And: The word "and" in the text of diagnosis or operation title will be interpreted as "and/or."

(i) With: The terms "with," "with mention of," and "associated with" in the text of a diagnosis or operation title indicate a requirement that both parts of the statement be present in the description of the diagnosis or procedure. For example, a diagnostic statement of diabetes mellitus in ketoacidosis with dehydration and malnutrition; ulcers of left leg is coded 250.10, 276.5, 263.9, 707.1.

(j) Synchronous: The word synchronous appears in volume 3 and will be interpreted as "performed or occurring at the same time" as another operation/ procedure.

7.06 CODING GUIDELINES

a. The terms "use additional code if known" and "code first the underlying disease" as discussed in paragraph 7.05 represent instructions referable to the principle of multiple coding. Multiple coding is defined as the use of more than one code number to fully identify all components of a diagnostic or operative statement. While these instructional notations appear in the tabular listings of the ICD-9-CM, there are still other conditions where it is important to code both the etiology and the manifestation of a disease. For example, two codes are required to identify the components of the diagnosis diabetic retinitis: 250.5, which describes the eye complication resulting from diabetes, and 362.01 which describes the specific complication, retinitis. The alphabetical index provides the instruction that both conditions will be coded and the sequence in which they will be reported. This instruction appears through the use of italicized brackets. These brackets are slanted and indicate that 2 codes are required. The code within the slanted/italicized

bracket will be reported following the code which does not appear within the bracket. Note that the code for the retinitis appears in italicized brackets. Thus, the code for the diabetes will be documented before the code for the retinitis. To verify the information appearing in volume 2, the coder will reference volume 1. Conversely, when connecting words or phrases are used in a diagnostic or operative statement, such as "due to," "secondary to," "associated with," "incidental to," these words/phrases reflect a cause-and-effect relationship between two or more conditions. There is no hard and fast rule for sequencing such conditions except for secondary hypertension and a few other diagnostic entities which are described in this issue. For example, a diagnosis of aortic insufficiency due to arteriosclerotic heart disease will be assigned a code for the aortic insufficiency first followed by the code for the arteriosclerotic heart disease. Arteriosclerotic heart disease is seldom justification for admission to inpatient services. However, the condition may produce anatomical and/or physiological impairments, in this example, aortic insufficiency. Secondary hypertension means that the hypertension rates second to another condition. The other condition will be reported before that of the secondary hypertension. Multiple codes will always be assigned when more than one code number is needed to fully classify a disease or operation. Multiple codes are not required when the English text interpretation of a code includes all components of a diagnostic or operative statement. When the English text interpretation of a code includes all components of a diagnostic or operative statement, it is known as a combination code. For example, only one code is required for acute appendicitis with perforation and peritonitis. (See diagnostic code 540.0) A code of 58.39, Urethrectomy, would not be reported with a code of 57.71, Radical cystectomy, because the cystectomy includes urethrectomy. Indiscriminate coding should be avoided unless there is a demonstrated need for more detail. Ordinarily, laboratory test results, social factors, symptoms, or signs mentioned in the discharge summary or transfer/discharge note, but characteristic of the diagnosis will not be coded unless there is a local need for the information.

b. A diagnosis stated to be both acute and chronic will be assigned two codes when the alphabetical index provides codes for both. The code for the acute (or subacute) condition will always be assigned before the code for the chronic condition. For example, two codes will be assigned for a diagnosis of chronic and acute cholecystitis: 575.0 will be assigned first because it represents the acute phase of the disease process; and 575.1 will be assigned as a secondary code because it represents a chronic condition. When the alphabetical index does not provide for the reporting of acute, subacute, or chronic, the code provided for the stated condition will be assigned.

c. Suspected conditions will be coded as if the condition exists. A suspected diagnosis may be stated as "rule out," "probable," "questionable," "possible." For example, a diagnosis of "rule out blind loop syndrome" will be assigned a code of 579.2. The term "rule out" should not be confused with the term "ruled out." This latter term usually appears at the end of a diagnostic statement such as "suspected gastritis, ruled out." This statement indicates that the gastritis does not exist and the code will be assigned from the V71 category when there are no signs or symptoms. (See V71.8.) When there are signs or symptoms associated with the condition, i.e., abdominal pain, a code should be assigned the symptom, e.g., 789.0.

d. A code representing an "unspecified condition" of a site should not be used. Unspecified conditions appear throughout the diagnostic tabular listing, usually as the last entity in a range of codes. These conditions can be identified because of the absence of

an etiologic component of the disease process. (See 568.9 Unspecified disease of the peritoneum). When an incomplete diagnosis is provided of, for example, "liver disease" which does not contain the etiology of the disease process, the medical record will be referred to the medical staff member for a more definitive diagnosis. Only when a more definitive diagnosis cannot be established will the unspecified condition be coded. Unless guided by the alphabetic index, a code representing the classification "other" should not be used as a dumpster for unfamiliar terminology. Medical staff members in various geographic locations often use different terminology to describe well-established clinical conditions. If a discussion with the medical staff member is not fruitful for classification purposes, the case should be referred to VA Central Office for resolution.

e. Certain chapters in volume 1 of ICD-9-CM provide classifications or subclassifications which accommodate reporting of "unspecified sites." (See diagnostic code 730.00.) These unspecified sites will not be coded. When the medical record does not provide identification of the anatomical part(s) involved in the disease process, the responsible medical staff member will be requested to provide the required information. This principle also applies to the coding of certain operations and procedures. For example, volume 3 of ICD-9-CM provides for coding a replacement of an "unspecified" heart valve (see 35.20), endarterectomy of an "unspecified" vessel (see 38.10), and bone graft of an "unspecified" bone. These unspecified sites are not acceptable and will not be coded. Nor will unspecified surgical approaches be coded. When a site or surgical approach is required to adequately identify an operation or procedure, but is not provided, the medical record will be referred to the physician or dentist for amendment of the source document.

f. Care will be exercised before assigning a code from the category of 780-799. These codes represent symptoms, signs, and ill-defined conditions. Most of the codes listed in this category could well be classified as "of unknown etiology." Generally, a code from this category may be used without substantiation. For example, if the presence of a myocardial infarction is not confirmed by study, the diagnosis which was treated may be that of pericardial pain (786.51). Conversely, a code for pericardial pain should not be coded when there is a diagnosis of myocardial infarction unless there is a local need to identify this symptom as a problem in the delivery of medical care. If this need exists, the code for the sign or symptom may be reported as a secondary code. The coder should also be aware that symptoms appear throughout Chapters 1-15 of volume 1. Like those symptoms assigned in the range of 780-799, many of these codes may be fully acceptable as a DXLS depending on the individual case, however, they should not be used as the DXLS when a related definitive diagnostic code is available. When a symptom is not confirmed by study or treated, the diagnosis will be assigned a code from the V71 category. A code for a symptom or sign (manifestation) will always be reported prior to reporting a code representing an adverse effect of properly administered substance. If the diagnosis specifies "no diagnosis," "undiagnosed" or similar terms at the time of patient discharge/transfer, assign a code of 799.99. However, if a sign or symptom is also provided in the diagnostic statement, assign a code to the symptom/sign, but do not assign a code of 799.99.

g. Inconclusive diagnoses may be documented in terms of differential conditions. These diagnoses will be coded and sequenced as follows:

(1) Two or more contrasting or comparative diagnoses documented as "either/or" will be coded as if the conditions were confirmed. For example, acute pancreatitis vs. acute

cholecystitis will be assigned codes 577.0 (first) and 575.0 (second). The first listed diagnoses may be assumed as the DXLS unless otherwise specified.

(2) Two or more conditions due to contrasting/comparative etiologies will be coded to the disease or condition, cause not otherwise specified. For example, acute peritonitis, bile or generalized will be assigned one code, 567.9.

(3) A symptom followed by a contrasting/comparative diagnosis will be coded with the symptom as the DXLS. The contrasting diagnoses should be coded as suspected conditions. For example, fatigue due to either depressive reaction or hypothyroidism will be assigned codes 780.7, 300.4, and 244.9.

h. In cases involving multiple injuries, a separate code will be assigned each injury unless the tabular and/or alphabetical indicates instructions to the contrary. The medical staff member should document the most severe injury first.

i. Threatened or impending conditions will only be coded following a thorough qualitative analysis of the medical record. If the analysis shows that the condition actually occurred, the condition will be coded as a confirmed diagnosis. If the analysis shows that the condition did not occur, the alphabetic index will be reviewed for a subentry term of "impending" or "threatened." The tabular listing of the code for one of the latter terms will be assigned as appropriate. If the terms are not listed in the alphabetic index, code only the condition that exists and not the threatened or impending condition so stated by the medical staff member, or refer the case to the medical staff member for clarification.

j. Diagnostic statements expressed as an operative procedure will not be coded. For example, a diagnosis of "resection, right colon" is not acceptable because it does not identify the condition for which the resection was performed. Medical record documents containing a diagnostic statement expressed as an operative procedure will be referred to the responsible medical staff member for corrective action.

k. In volume 2, a subterm identifying an infectious organism takes precedence in code selection over a subterm at the same indentation level that identifies a site or other descriptive term. (See par. 7.08a.)

l. With the exception of codes in the range of E878-E879, E930-E949, E950.0-E959, and E997.1 the use of "E" codes is optional. The E878-E879 codes will be used to describe current and late effects of surgical and medical complications. The E930-E949 classification will be used to identify the drug causing an adverse reaction when a correct substance was properly administered. The E950.0-E959 classification will be used to identify actual and attempted suicides. The E997.1 code will be used to identify Agent Orange Exposure. An "E" code will not be used to report the DXLS.

m. "M" (morphology) codes will not be used in the PTF system.

n. The surgical approach and closure are part of an operation. Additional codes are not assigned to identify the approach or closure to an operation unless they are unusual or if the Alphabetic or Tabular List instructs otherwise. For example, in order to excise a meningioma, an incision must be made into the cranium. Following the instructions under "craniotomy," when performed as an operative approach, the incision is not reported.

o. If a surgical procedure is stated as an eponym and the eponym is not listed in the Alphabetical Index, refer to the main term and subterms(s) that describe the procedure. For example, a Roux-en Y can be a cholecystojejunostomy, esophagoenterostomy, pancreaticojejunostomy, or a choledochoenterostomy.

p. If a surgical procedure is stated as an excision of abnormal tissue or a lesion of a certain type that is not listed in the Alphabetical Index under the words specified in the statement of procedure, refer to the main term and subterm "Excision, lesion" to determine if the code assignment can be located. For example, excision of fat necrosis of abdominal wall wound is coded 54.3.

q. If the surgical procedure is stated as removal of an inert (synthetic) implant, graft, or prosthesis and the procedure is not listed in the Alphabetical Index, refer to the main term and subterm Removal, foreign body. For example, incision with removal of painful subcutaneous silicone chin implant is coded 86.05.

r. Always use the principle of multiple coding as discussed in subparagraph a. when coding surgical procedures.

s. If a procedure is started, but not completed, code it as far as the procedure went, such as

(1) If an incision was made, use the incision code of a given site.

(2) If a cavity or space was entered, used the exploratory procedure of the given site.

7.07 STEPS IN THE CODING PROCESS

a. The coding process will begin only after a thorough review, and quantitative and qualitative analysis of the medical record has been performed. The purpose of this analysis is to assure that the diagnostic and operative statements are complete; that the content of the medical record is internally consistent and substantiates the diagnoses and operations/procedures performed; and that the content of the medical record justifies patient outcome. For example, a diagnosis of benign prostatic hypertrophy cannot be supported when the tissue report, following transurethral prostatic resection, shows a diagnosis of adenocarcinoma of the prostate. A diagnosis of fracture of the medial malleolus of the left ankle cannot be supported without the presence of a radiology report which confirms the fracture diagnosis and site. Conversely, the diagnoses should include that of a knee laceration when the progress notes show this condition to have occurred as the result of inpatient injury. The progress notes of patient's who expire should reflect whether resuscitation efforts were employed and the specific resuscitation technique employed should be documented as a procedure on the discharge summary. A diagnosis of acute cystitis should be accompanied by identification of the organism causing the infection, e.g., E. coli. A culture report should be present in the record which provides confirming evidence of the presence of the organism. VHS&RA policy for performance of a qualitative and quantitative analysis are contained in the provisions of paragraph 5.07 and guidelines for this process are contained in appendices 5E, F and G of M-1, part I, chapter 5. Medical records which indicate the need for additional reports, e.g., X-ray, EKG, operative, laboratory, tissue reports, etc., should not be coded until the required

report(s) are obtained, authenticated, and filed in the patient's medical record. Discharge summaries, transfer/discharge notes which show the need for additional information as well as omitted diagnoses, conditions or situations will be referred to the responsible medical staff member for clarification and possible amendment of the document. The medical record review process thus provides the coder with additional information which permits a more accurate classification, and therefore minimizes the use of the not otherwise specified categories. The coder will not assign codes to diagnoses, conditions, or situations which are not provided by the medical staff member on the discharge summary, transfer note(s), or discharge note unless required by the instructions provided in the tabular listings of the ICD-9-CM or this directive.

- b. Identify all main terms or procedures included in the diagnostic or operative/procedural statement.
- c. Locate each main term or procedure in the alphabetical index. Complications of medical and/or surgical care are located under "Complications," and the cause of residual illnesses or injuries under "Late Effects." Factors influencing health status and contact with health services (V codes) are found under references such as "Admission," "Examination," "History of," "Problem," "Observation," "Status," "Aftercare," etc.
- d. Refer to any subterms indented under the main term. These subterms form individual line entries and describe essential differences by site, etiology, or clinical type.
- e. Never assign a code from the alphabetical index. Reference and verify the code selected from the alphabetical index to the Tabular List.
- f. Read and be guided by any instructional terms in the Tabular List. (Instructional terms are discussed in par. 7.04.)
- g. Follow cross reference instructions if the needed code is not located under the first main entity consulted. (Cross reference refers to the terms "see," "see also," and "see category" also discussed in par. 7.04.)
- h. As much specificity as possible should be used in coding with ICD-9-CM. Where there is subdivision of a code, the most detailed subdivided code will be used. For example, four-digit subcategory codes are to be used only if no fifth digit subdivisions are provided. Fifth digit subdivisions will be used unless amended by the instructions of this directive. When a category does not have a required fourth digit, but does require a fifth digit, a filler numeric character "0" will be used in the fourth digit space.
- i. Continue coding diagnostic and operative/procedural statements until all of the component elements are fully identified. When coding operations, always ensure that a diagnosis(es) is present and coded which supports the operative/procedural intervention.

7.08 INSTRUCTIONS FOR SPECIAL DIAGNOSES/CONDITIONS

a. Infectious and Parasitic Diseases

(1) Chapter 1, in volume 1, contains provisions for reporting infectious and parasitic diseases as well as the late effect codes for infectious and parasitic diseases. In this chapter, the principle of multiple coding is frequently employed to show the infectious

disease process as well as the manifestation of the disease. Multiple coding is also required for infectious organisms causing diseases which are classified elsewhere. For example, a diagnosis of Arthropathy with Reiter's Disease requires coding an infectious disease with manifestations to another chapter.

Arthropathy with Reiter's Disease	099.3
	711.1

NOTE: *The code from the chapter on infectious and parasitic diseases is sequenced first. Periurethral abscess due to E. Coli is an example of coding an infectious organism causing a disease classified elsewhere. Example:*

Periurethral abscess due to E. coli	597.0
	041.4

In this example, the code for the organism is sequenced second.

(2) To determine the sequencing of infectious organisms, refer to volume 2. In volume 2, a subterm identifying an infectious organism takes precedence in code selection over a subterm at the same indentation level that identifies a site or other descriptive term. For example, a diagnosis of chronic monilial cystitis is coded 112.1. A diagnostic code of 595.2, chronic cystitis, is not assigned because the organism of *Monilia* takes precedence over the descriptive term of chronic.

(3) When the medical staff member does not identify a required organism in an infectious disease process, the coder should review laboratory reports for evidence of an appropriate culture; and when indicated, refer the case to the medical staff member for amendment of the source document.

(4) Pseudomembranous Colitis

(a) Pseudomembranous colitis is a diarrheal illness, usually febrile and with abdominal cramping. It affects debilitated patients and some patients taking antibiotics. In some instances, it may occur postoperatively or in patients with uremia.

(b) In most cases the cause of pseudomembranous colitis is a toxin of the bacterium *Clostridium difficile*. It is coded 008.49, Intestinal infections due to other bacteria. The code assignment of 564.1, Irritable colon, will not be assigned when the cause of the colitis is identified or presumed as due to bacterial infection.

(5) Late Effects of Infections

(a) A late effect is the presence of a residual condition produced as a result of an acute phase of illness or injury. The residuals of infections usually occur early in the disease process and usually represent long term conditions which may not be amenable to cure, such as in brain damage due to viral encephalitis.

(b) Chapter 1 provides 3 categories which indicate late effects of infectious diseases:

1. 137 Late effects of tuberculosis
2. 138 Late effects of acute poliomyelitis

3. 139 Late effects of other infectious and parasitic diseases

(c) The coding of late effects of infections require 2 codes and these codes will be sequenced to show first, the residual condition, and secondly, the late effect. For example,

Brain damage due to old viral encephalitis	348.9
	139.0

b. Neoplasms

(1) Neoplasms will be classified according to the behavior and anatomical site of the neoplasm involved. Morphology codes will not be used.

(2) ICD-9-CM classifies neoplasms according to malignant behavior, benign behavior, carcinoma in situ behavior, uncertain behavior, and unspecified behavior.

(a) Malignant neoplasms (140-199) are tumor cells that have the potential for invading or attaching to adjacent structures and/or, for spread to distant sites.

1. The primary site of a malignant neoplasm (140-195) identifies the presumed site or origin of the neoplasm. For example, Carcinoma of sigmoid colon, 153.3.

2. The secondary site of malignancy (196-198) identifies site(s) to which the primary site has spread or metastasized. Direct extension is the ability of the malignant cells of the primary site to infiltrate and invade adjacent or nearby structures. Metastasis is the ability of the malignant cells to move from a primary site to a distant site and establish new centers of malignant growth. This dissemination can be accomplished as follows: by lymphatic spread as when tumor cells infiltrate local lymph vessels; hematogenous dissemination as when tumor cells invade the bloodstream (referred to as circulating cancer cells); and implants as when tumor cells shed into body cavities.

3. Metastasis(es) often is used interchangeably with direct extension in documenting secondary malignancies. ICD-9-CM classifies both as secondary malignant neoplasms. Some examples of direct extension:

150.0	Carcinoma of the cervical esophagus with erosion into the trachea
197.3	
153.0	Carcinoma, hepatic flexure with direct extension to the liver
197.7	
185	Carcinoma, prostate with direct extension to the bladder
198.1	

Some examples of metastasis:

174.4	Carcinoma, upper-outer quadrant of left breast with metastasis to
196.3	axillary lymph nodes
162.5	Carcinoma, lower lobe lung with metastasis (hematogenous) to liver
197.7	

157.9 Cancer of the pancreas with peritoneal seeding
197.6

(b) Lymphatic and hematopoietic system neoplasms (200-208) identify neoplasms arising in the reticuloendothelial and lymphatic systems and neoplastic disorders of the blood-forming tissues presumed to be primary malignancies. Lymphohematopoietic system malignancies differ from other malignancies in that the tumor cells often circulate in large numbers in the bloodstream.

1. The diagnosis for a condition classifiable to categories 200-202 with a stated primary and/or "metastatic" site(s) requires the use of the fifth-digit subclassification listed on page 121 in volume 1.

2. If there is any mention of "sarcoma" in the documented diagnosis, refer to the sublistings under Sarcoma on page 639 in the Alphabetic Index for coding directions. Osteogenic sarcoma (osteosarcoma), chondrosarcoma, and fibrosarcoma are not classified in the 200-202 code series, while reticulosarcoma and mast cell sarcoma are classified in the 200-202 code series. Also refer to the sublistings under Myeloma and Histiocytoma for coding directions. The excludes note on page 121 in the Tabular List directs the coder not to use categories 200-208 for secondary sites (metastatic) of adenocarcinoma, sarcoma, and other types of malignancies not classifiable to categories 200-208. Malignant neoplasms classifiable to categories 200-208 stated as secondary or metastatic site(s) remain within the 200-208 categories and are not coded to categories 196.0-196.9. The following are examples of conditions coded to 200-208:

200.13 Gastric lymphoma, lymphosarcoma type

203.0 Multiple myeloma, spine

204.1 Chronic lymphocytic leukemia

Some examples of conditions which are not coded to 200-208:

211.1 Gastric lymphoma, nonmalignant (pseudolymphoma)

288.8 Lymphocytopenia

170.7 Ewing's sarcoma of femur

(c) Benign neoplasms (210-229) are tumor cells that do not invade adjacent structures, do not spread to distant sites, and may be the cause of local effects, such as displacement of or pressure on adjacent structure, impingement on a nerve, or compression of a vessel. Most benign tumors can be cured by total excision. For example, Uterine myomas, 218.9, may cause pressure on the urinary bladder, resulting in urinary symptoms.

(d) Carcinoma in situ (230-234) are tumor cells that are undergoing malignant changes but are still confined to the point of origin without invasion of surrounding normal tissue. Adjectives used to describe carcinoma in situ include intraepithelial, noninfiltrating, noninvasive, or preinvasive carcinoma. For example, Carcinoma in situ of cervix, 233.1.

(e) Neoplasms of uncertain behavior (235-238) are tumor cells of nondetermined behavior. Distinction between malignant and benign tumor cells is not always possible,

since intermediate stages exist and further diagnostic studies may be necessary. In some instances, it may be necessary to follow a needle biopsy with an incisional biopsy for a better sample of tissue. Also, certain benign tumors may undergo malignant transformation and require continued study for a conclusive diagnosis. For example, Transitional cell papilloma of bladder, 236.7.

(f) Neoplasms of unspecified nature (239) is a category code used when neither the behavior of the tumor cells nor the morphology is specified in the diagnostic statement. It may be the working diagnosis pending further diagnostic studies. For example, Kidney tumor, 239.5. If an unspecified neoplasm appears on the discharge summary, refer to the content of the episode of care to ascertain whether further studies revealed a more specific type. When this type of information is present in the record, refer the case to the clinician for amendment of the discharge summary.

(3) Within each of the subsections for behavior of neoplasms, the categories are arranged by the anatomical site involved, except for the lymphatic and hematopoietic system (200-208). ICD-9-CM differentiates malignant neoplasms of the primary sites (140-195) from those of the secondary sites (196-198), with anatomical breakdowns for each.

(4) Morphology of neoplasms (M codes) refers to the study of the form and structure of the tumor cells and tissue with classification of the tissue by its origin. The type of cells that make up the malignant neoplasm often determines the expected rate of growth, degree of severity, and type of treatment to be pursued. Examples of tumor cells by tissue origin are as follows:

Tissue origin	Tumor cells
<u>mesenchyme</u>	
muscle, tendon, bone	sarcoma, fibroma,
cartilage, fat, lymphoid,	fibrosarcoma, leiomyoma
blood vessels, connective	
<u>nervous system</u>	meningioma, glioma
<u>common source</u> , but with	
several neoplastic cells	mixed tumors
<u>epithelial</u> adenoma, papilloma,	
carcinoma	

Carcinomas may be further specified as to histological appearance, such as adenocarcinoma (glandular), squamous (epidermoid), transitional, or undifferentiated.

A tabular listing of morphology codes is located in the appendix of Volume 1. The morphology code consists of four digits to identify the histological type, with a fifth digit to identify its behavior. The behavior (fifth) digit is subject to change if the reported information indicates a behavior different from that assigned in the listing of histologic types. For example, Oat cell carcinoma of lung (primary site) M8042/3; Oat cell carcinoma of bone marrow (implantation or metastatic site) M8042/6. The Alphabetic Index of ICD-9-CM lists the morphological names of many of the tumors with the M codes in parentheses, and appropriate primary site codes or instructions for

coding are given where possible. For example, a diagnosis of "metastatic renal cell carcinoma of liver and lungs" can be coded by referencing Carcinoma, renal cell, which identifies the primary site as kidney, 189.0; therefore, the liver and lungs are secondary sites. The listing of Adenoma, bronchial, carcinoid type directs the coding of "bronchial adenoma, carcinoid type" to malignant neoplasm of the lung, 162.9. Morphology codes will not be used in the PTF system, but they may be used in the maintenance of tumor registries, pathology department indexes, and other cancer studies.

(5) Diagnostic Procedures

(a) Clinical evaluation for evidence and support of a neoplasm diagnosis can be carried out by one or more diagnostic procedures, such as scans and other diagnostic radiology (see categories 87-88); endoscopic examinations with or without brush or tissue biopsy; exploratory procedures, such as laparotomy, 54.11, or thoracotomy, 34.02; staging laparotomy (includes placement of markers), 54.11.

(b) Procedures for obtaining tissue or cells for pathological examination include cytology which may be obtained by scraping, such as in a D&C, 69.09; by fine-needle aspiration, such as in lungs, 33.26; by brush, such as in stomach, 44.14; and by washing during endoscopy. In a needle biopsy, a core of tissue is obtained. In an incisional biopsy, a representative sample of a tumor mass is removed for pathological examination. An excisional biopsy is the total removal of local small masses or growths.

(6) Therapy

(a) The treatment goal is to cure the patient of the neoplasm. However, the curative goal may be limited by the extent of the neoplasm and the physical condition of the patient. More than one measure may be taken in the treatment of a neoplasm. The following are examples of courses that may be taken in carrying out therapeutic measures: total or partial excision of a neoplasm with or without total or partial removal of an organ or anatomical structure; radiation therapy prior to surgical resection of neoplasm (preoperative radiation therapy); surgical resection (total or partial of neoplasm) with subsequent radiation therapy or chemotherapy; radiation therapy only; chemotherapy only; chemotherapy with subsequent surgical resection or removal of an organ or other anatomical structure.

(b) Patients may also be treated with BCG (Bacille Calmette Guerin). BCG is a nonspecific immunotherapy agent (99.25) used in the treatment of melanoma, cancer of the lung, soft tissue sarcoma, colon carcinoma, and breast carcinoma. Interferon is another nonspecific immunotherapy agent (99.25). Adjunctive therapy refers to the procedures used following the first measures used in the treatment, such as radiation therapy, chemotherapy, or endocrine therapy employed after surgical resection.

(c) Surgical procedure terms commonly used in treatment include en bloc resection. This is a surgical resection that permits dissection of normal tissue in the area of the malignant neoplasm so that the tumor itself is never exposed or entered. An en bloc resection is done to minimize the possibility for implantation (seeding or shedding) of the malignant tumor cells in the operative site. Debulking is a type of resection to reduce the tumor mass as much as possible before starting adjunctive therapy, such as chemotherapy. Local excision involves entire removal of smaller lesion or removal of a smaller portion of the neoplasm with the remainder of the neoplasm to be treated by an adjunctive therapy.

(7) Coding Rules and Guidelines

(a) A contiguous site is defined as a primary malignant neoplasm that overlaps the boundaries of two or more subcategories within a three-digit category and whose point of origin cannot be determined. A contiguous site is classified to the fourth-digit subcategory ".8." For contiguous sites between three-digit categories, ICD-9-CM provides the following four-digit codes for certain malignant neoplasms whose point of origin cannot be assigned (not established) and whose stated sites overlap two or more three-digit category sites:

149.8 Neoplasms of lip, oral cavity, and pharynx whose point of origin cannot be assigned to any one of the categories 140-148

159.8 Neoplasms of digestive organs and peritoneum whose point of origin cannot be assigned to any one of the categories 150-158

165.8 Neoplasms of respiratory and intrathoracic organs whose point of origin cannot be assigned to any one of the categories 160-164

(b) A vague site is defined as a malignant neoplasm of a contiguous site (overlapping boundaries), not elsewhere classified, whose point or origin cannot be determined. These sites are assigned to 195, Malignant neoplasm of other and ill-defined sites. Inclusion terms under category 195 at the fourth digit level are as follows:

195.0 Head, face, and neck, such as cheek, jaw, nose, cervical region, supraclavicular region.

195.1 Thorax, such as axilla, chest, chest wall, intrathoracic site, thoracic wall, infraclavicular region, scapular region.

195.2 Abdomen, such as abdominal wall, intra-abdominal nonspecific site.

195.3 Pelvis, such as buttock, groin, ischiorectal fossa, pelvic wall, perineum, rectovaginal septum, rectovesical septum, gluteal region, inguinal region, perirectal region, presacral region, sacrococcygeal region.

195.4 Upper limb, such as antecubital space, arm, elbow, finger, forearms, hand, shoulder, thumb, wrist.

195.5 Lower limb, such as ankle, calf, foot, heel, hip, knee, leg, popliteal space, thigh, toe.

195.8 Other and ill-defined sites, such as back, flank, trunk.

(c) Malignant neoplasms of lymph nodes or glands are presumed to be secondary neoplasms (196.0-196.9) unless the diagnosis states or indicates a malignancy classifiable to categories 200-202. Lymphoma(s) may be benign or malignant. If the physician's diagnostic statement does not match any subentries under Lymphoma in the Alphabetic Index, refer to the pathology report for correlation with entries in the Alphabetic Index. Otherwise, ask the responsible physician if the lymphoma is benign or malignant.

(d) If unspecified in the diagnosis, malignant neoplasms of the liver are not presumed to be either primary or secondary in nature. In such cases, a separate code, 155.2, has been provided for malignancy of liver not specified as primary or secondary.

(e) If there is recurrence of the primary malignant neoplasm which was previously excised or eradicated, code it as primary malignancy of the stated site, using the appropriate code in the 140-195 series. Code also any mention of secondary site(s). Recurrence of previously excised anterior wall bladder carcinoma, now identified as lateral wall, 188.2, is an example. Another example is recurrence of carcinoma of the ascending colon at the site of previous anastomosis with rectum, 154.0.

(f) If the primary site of the malignancy was previously excised or eradicated by treatment and the original primary site has not recurred and is no longer under treatment, code the previous primary site as "personal (past) history of malignant neoplasm" using the appropriate sub-category code under V10. Code any mention of current secondary sites. With the exception of the V10.6 category, a code from the category of V10 cannot be used to report the DXLS.

(g) If the patient receives initial treatment for malignancy of the primary site, either radiation or chemotherapy, retain the code for malignancy of primary site.

(h) Periodic follow-up examinations (V67) are carried out to determine if there is any recurrence of primary malignant neoplasm site or any occurrence of secondary malignant neoplasm site(s). If there is evidence of recurrence at the primary site, code it as primary of the stated site. If there is evidence of a secondary (metastasis) site, code it to the stated secondary malignancy site. If there is no evidence of any recurrence or metastatic site, use the appropriate code from the V67.0-V67.2 series as the malignancy. Select from the V67.0-V67.2 series the last previously carried out therapy for the DXLS. Select the appropriate code from the V10 category, personal history of malignant neoplasm, as the secondary code. Code also the procedures carried out in the follow-up examination, such as an endoscopy, biopsy, etc.

(i) If only one site is stated in the diagnosis and that site is qualified as "metastatic," and the body of the medical record provides no further information to assist in coding the diagnosis, the following steps must be taken:

1. Code to the category for "primary of unspecified site" for the morphology type stated in the diagnosis, such as: Metastatic infiltrating duct carcinoma, 174.9; Metastatic islet cell adenocarcinoma, 157.4; Metastatic malignant histiocytoma, 171.9. However, if the code thus obtained is 199.0 or 199.1 (such as metastatic carcinoma, colon, 199.1), follow the instructions in subparagraph 2.

2. If the morphology is not stated or the code obtained in step 1 is 199.0 or 199.1, assign the site qualified as "metastatic" to the primary malignant code for that stated site (such as, metastatic carcinoma of colon, 153.9) except for the following sites, which should be coded as secondary neoplasm of the stated site: Bone; brain; diaphragm; heart; liver; lymph nodes; mediastinum; meninges; peritoneum; pleura; retroperitoneum; spinal cord; sites classifiable to 195.0-195.8.

3. The content of subparagraphs 1. and 2. should result in code assignments for both primary and secondary sites of specified sites, or one site specified and one site unspecified. For example, when following subparagraph 1., a diagnosis of Metastatic renal cell carcinoma of lung is coded 189.0 and 197.0. When following 2., a diagnosis of Metastatic carcinoma of lung is coded 162.9 and 199.1.

(j) Cancer described as "metastatic from ___ (site)" should be interpreted as primary of that site. For example, Metastatic carcinoma from breast is coded 174.9, and code 199.1 is used to indicate metastatic site unspecified.

(k) Cancer described as "metastatic to ___(site)" should be interpreted as secondary neoplasm of the stated site. For example, Metastatic carcinoma to lung is coded 197.0 with code 199.1 to indicate primary site not specified.

(l) If two or more sites are stated in the diagnosis and all are qualified as "metastatic sites," code the primary site as "unknown" (199.0) or where appropriate "ill-defined site" (195.0-195.8), and code the stated sites as secondary neoplasms of those sites. Example:

1. Metastatic carcinoma of stomach and left lower lung is coded first (DXLS) as secondary malignancy of stomach, 197.8; secondary malignancy of lung, 197.0; and primary malignancy of unknown site, 199.1.

2. Metastatic carcinoma of colon and liver with pelvic malignancy is coded first (DXLS) as secondary neoplasm of the colon, 197.5; secondary neoplasm of the liver, 197.7; with mention of pelvic malignancy, 195.3.

(m) On occasion, a patient may be admitted to the hospital following an outpatient encounter during which a biopsy identifies a malignant neoplasm. Surgery is performed during the episode of inpatient care to remove further tissue or to partially or totally remove an organ, however the inpatient pathology report is negative for any further evidence of malignancy. If physician documents the diagnosis as a malignancy in accordance with the findings on the original biopsy report, code the malignancy as recorded by the physician and make sure the biopsy report from the outpatient procedure documenting the malignancy is filed in the current medical record.

(8) Coding with sequencing rules

(a) If the treatment is directed at the primary site of the malignancy, designate the primary site as the DXLS, except when the encounter or hospital admission is for radiotherapy session(s), V58.0, or for chemotherapy session(s), V58.1, in which instance the malignancy is coded and sequenced second. The following examples apply:

1. Carcinoma of the sigmoid colon with small metastatic nodules located on liver. Sigmoid resection of colon is carried out. The DXLS would probably be Carcinoma of the colon, 153.3.

2. Patient admitted for chemotherapy involving placement of a Hickman catheter into subclavian vein for infusion of anticancer agent in the treatment of metastatic carcinoma to lung. The DXLS would probably be Admission for chemotherapy, V58.1.

3. Patient admitted with cervical lymphadenopathy and probable diagnosis of Hodgkin's disease. Lymph node biopsy confirmed diagnosis of Hodgkin's disease and the extent of the disease was established by X-rays, CT scans, liver function tests, and bone marrow biopsy. Wide-field megavoltage radiotherapy was started. The established DXLS is probably Hodgkin's disease, multiple sites, 201.98, since the admission was not for radiotherapy.

(b) When an episode of inpatient care involves surgical removal of a primary or secondary site malignancy followed by adjunct chemotherapy or radiotherapy, code the malignancy as the DXLS, using codes in the 140-198 series or where appropriate in the 200-203 series. When codes V58.0 or V58.1 are to be used as the DXLS, the malignancy code is listed second to designate the condition being treated.

(c) When the primary malignancy has been previously excised or eradicated from its site and there is no adjunct treatment directed to that site and no evidence of any remaining malignancy at the primary site, use the appropriate code from the V10 series to indicate the former site of the primary malignancy. Any mention of extension, invasion, or metastasis to a nearby structure or organ or to a distant site is coded as a secondary malignant neoplasm to that site and may be the DXLS in the absence of the primary site.

(d) 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 the (DXLS), regardless of the number of admissions or encounters for treatment and care of the malignant neoplasm.

(e) Coding and sequencing of complications associated with the malignant neoplasm or with the therapy thereof are subject to the following guidelines:

1. When admission is for management of an anemia associated with the malignancy and the treatment is only for anemia, the anemia code will be designated as the DXLS and will be followed by the appropriate code(s) for the malignancy. This type of anemia may be iron deficiency due to blood loss (280.0), acute nonautoimmune hemolytic anemia (283.1), or myelophthitic anemia (285.8).

2. When the admission is for management of an anemia associated with chemotherapy or radiation therapy and the only treatment is for the anemia, the anemia code will be designated as the DXLS and followed by the appropriate code(s) for the malignancy. These anemias include secondary thrombocytopenia (287.4), agranulocytosis or neutropenia (288.0), and aplastic anemia (284.8).

3. When the admission is for management of dehydration due to malignancy or the therapy, or a combination of both and only the dehydration is being treated (intravenous rehydration), the dehydration will be designated as the DXLS, followed by the code(s) for the malignancy.

4. When the admission is for treatment of a complication resulting from a surgical procedure, designate the complication as the DXLS if treatment is directed at resolving the complication. Post-surgical nonabsorption syndrome (579.3), malfunction of a colostomy or other stoma, and complications of implants are examples of conditions that would be designated as DXLS and followed by code(s) for the existing malignancy.

5. When the admission is for control of intractable pain due to the malignancy, designate the malignancy, primary or secondary site, as the DXLS. Code also any treatment, such as infusion of morphine via a catheter inserted into subarachnoid space, 03.99 + 03.91. There is no code in ICD-9-CM that specifically identifies intractable pain; therefore, intractable pain is classified to its cause.

(9) Chemotherapy

(a) A code of V58.1, Chemotherapy will be used to describe a course of treatment following initial treatment of a malignancy. A code of V58.1 will thus be used to describe an admission for chemotherapy. For example, a code of V58.1 will be used for an episode of care other than that during which the initial diagnosis/treatment was made or initiated. This treatment by chemotherapy during a subsequent episode of care is known as adjunctive therapy.

(b) The patient's length of stay may be considered but is not a good indicator of whether to use a code of V58.1 when the diagnostic statement is not specific or is suspect. This is because some types of chemotherapy involve a course of treatment of 1-2 days, while other types may involve treatment of from 6-8 days.

(c) The selection of V58.1 as a DXLS requires at least one secondary code from the range of codes 140-208 or from V10.0-V10.9. A procedure code for the chemotherapy should also be reported.

(d) A patient who receives initial treatment of the malignancy on one service, e.g., Surgery, and is then transferred to Medicine for implementation of chemotherapy, will be assigned a DXLS code for the malignancy on both bed sections.

(10) A discharge summary may show that the patient was hospitalized because of symptoms suggestive of a malignancy. When the results of examination and tests do not reveal that a malignancy is present, a code of V71.1 will be assigned. A V10 code will not be used.

(11) The codes appearing in category V76 do not apply to inpatients and will not be used.

c. Endocrine, Nutritional, Metabolic, and Immunity Disorders

(1) Diabetes/Glucose Intolerance

(a) The VA supports the clinically oriented classification system for diabetes and other types of glucose intolerance developed by the National Diabetes Data Group of the National Institute of Health. Accordingly, this classification will be used to report diabetes mellitus, impaired glucose tolerance, and gestational diabetes.

(b) Diabetes mellitus is divided into three subclasses: insulin-dependent, noninsulin-dependent, and other types which include diabetes mellitus associated with certain conditions and syndromes.

1. IDDM (insulin-dependent diabetes mellitus) requires insulin to sustain life. Juveniles with diabetes were formerly assigned to this category, however, since dependence upon insulin can occur at any age, it is no longer appropriate to classify this condition to juveniles only. It should be noted that patients in this category are also prone to ketosis. The fifth digit "1" used in the ICD-9-CM code 250 will therefore be amended to read "1-juvenile/insulin dependent." As a general rule, the IDDM patient will more than likely be admitted because the diabetic condition is out of control (250.91) or because the condition is complicated (see 250.11 through 250.81). Diabetes which is out of control is usually evidenced by blood sugars in excess of 250 mg/dl. When the IDDM condition is complicated, an additional code is required.

a. The requirement for an additional code is a principle of multiple coding, and diabetes mellitus is one of a number of disease categories in which the basic disease category serves as a primary code to classify both the disease and its major manifestations. Paragraph 7.06 references multiple code assignments when a diagnosis of diabetic retinitis is encountered. Other diabetic conditions which indicate the need for multiple coding are those with renal, neurological, and peripheral circulatory disorders. Example:

Diabetic gangrene, right foot	250.71 785.4
Gangrene, right foot due to diabetes	250.71 785.4
Diabetic gastroparesis	250.61 337.1 536.8

b. One of the newer therapeutic approaches used in the control of diabetes is the insulin pump. The pump provides a continuous source of insulin release. In order to report the application of an insulin pump, 2 codes are required. These codes are 86.06 and 99.17. A code of 99.17 will not be used as a solo code to describe the therapeutic regimen employed to control diabetes or other pancreatic diseases.

c. When a known diabetic patient is admitted for some other condition, e.g., fracture of the femur, and the patient is given insulin in order to maintain control of the diabetic condition, a secondary diagnosis of IDDM should be provided by the medical staff member. A diagnostic code of 250.01 will be assigned to this secondary condition.

d. A discharge summary, or transfer/discharge note showing a DXLS of diabetes mellitus or IDDM which is neither out of control nor complicated will be referred to the responsible medical staff member for clarification.

2. NIDDM (Noninsulin-dependent diabetes) is generally controlled by using oral medications and dietary restrictions, however, this condition may also require insulin to bring the condition under control. Although ketosis can occur in the patient with NIDDM, it is not a common finding. To classify patients with NIDDM, the fifth digit "0" used in the ICD-9-CM code 250 will be amended to read "0-adult onset or unspecified as to type/noninsulin-dependent." As a general rule, the NIDDM patient will more than likely be admitted because the diabetic condition is out of control (250.90) or because the condition is complicated (see 250.10 through 250.80). When the NIDDM condition is complicated, an additional code is required. A discharge summary or transfer/discharge note showing a DXLS of diabetes mellitus or NIDDM which is neither out of control nor complicated will be referred to the responsible medical staff member for clarification. When the NIDDM patient is admitted for some other condition e.g. bronchitis, and the patient is provided a diabetic diet and/or Orinase to maintain control of the diabetic condition, a secondary diagnosis of NIDDM should be provided by the medical staff member. A diagnostic code of 250.00 should be assigned to this secondary condition.

3. Other types of diabetes mellitus, known as secondary diabetes, are generally contingent upon a presumed cause and effect situation between some other condition and

the development of diabetes. Some of the causes include adverse effects of properly administered medications, and, pancreatic and hormonal conditions. Both the cause and the effect will be specified by the physician. The code representing the cause will be reported prior to reporting the diabetes. As appropriate, a code of 251.8 will be used to report diabetes mellitus clinically induced in the treatment of leukemia, and clinically induced with steroid therapy. The appropriate "E" code will also be used to describe the adverse effect of a properly administered medication.

4. Impaired glucose tolerance, often termed borderline diabetes, chemical diabetes, latent diabetes, or asymptomatic diabetes, is a condition characterized by a glucose laboratory finding ranging between a normal level and a diabetic level. This condition may be present in pancreatic diseases, and induced by drugs and chemicals. To classify patients with impaired glucose tolerance, an ICD-9-CM code of 790.2, Abnormal glucose tolerance test, will be assigned.

5. Gestational diabetes arises during pregnancy and usually disappears following delivery. The gestational diabetic will not have a previous history of diabetes. An ICD-9-CM code of 648.83 will be assigned to those patients when the condition is diagnosed during pregnancy. Diabetics who become pregnant will be assigned a code of 648.03.

6. When medications are increased or changed for the diabetic patient, the possibility exists that hypoglycemia occurred. In such cases, a code of 251.2 will be assigned, providing that the patient was not comatose on admission.

7. Patients admitted for diabetic teaching will be assigned a DXLS code of V65.4.

8. The accurate classification of diabetes mellitus and other types of glucose intolerance will require documentation, consistent with the fore mentioned provisions, by members of the medical staff. This issue will therefore be discussed in the Medical Record Committee, and as needed, with individual members of the medical staff.

(2) Dehydration

(a) Dehydration, 276.5, refers to water depletion. Symptoms and signs of dehydration, such as dryness of mucous membranes, loss of skin turgor, and anorexia, may be due to inadequate fluid intake, vomiting, diarrhea, sweating, or polyuria. With more severe degrees of volume depletion, the patient is often lethargic, weak, and obtunded and shock or coma may occur. The treatment goal is total replacement of fluid deficit within 48-72 hours where possible.

(b) Conditions such as burns, gastrointestinal disease, peritonitis, ascites, diabetic glycosuria, Addison's disease, hypoaldosteronism, renal failure, and urinary tract infections and other infections are often accompanied by dehydration. Profuse sweating with inadequate fluid intake or loss of thirst on the part of an individual may result in dehydration. Depending on the severity of the dehydration and severity of any underlying cause, dehydration may be treated by oral replenishment of fluids or by intravenous administration of fluids.

(c) Dehydration can be reported as the DXLS or as a secondary diagnosis.

d. Psychiatric/Mental Diagnoses**(1) DSM-III-R**

(a) The DSM-III-R will be used by clinicians to establish psychiatric diagnoses. This manual (the DSM-III-R) requires the use of a multiaxial approach to psychiatric evaluation. Axes I and II include all of the mental disorders. Two classes of mental disorders, Developmental Disorders and Personality Disorders, are assigned to Axis II, whereas all of the other mental disorders are assigned to Axis I. Axis III permits the clinician to indicate any current physical disorder or condition that is potentially relevant to the understanding and management of the individual. Axis IV points out the severity of psychosocial stressors which relate to the disorder. Axis V identifies the global assessment of functioning of the patient. Axes IV and V therefore provide additional information to Axes I, II and III which is of value for planning treatment, predicting outcome, followup, and after care.

(b) Documentation of psychiatric disorders on the discharge summary will require at least one diagnosis for Axis I and at least one diagnosis for Axis II. In some instances, there may be no disorder on Axis I, the reason for seeking treatment being limited to a condition noted on Axis II. In this case, the clinician will write: "(Axis I) No Diagnosis on Axis I." If a disorder is noted on Axis I but there is no evidence of an Axis II disorder, the clinician will write "(Axis II) No Diagnosis on Axis II." or another appropriate term. In other instances, there may be more than one disorder on each axes. In these instances, the clinician will provide the multiple diagnoses and apply the appropriate axes number to each diagnosis. Where clinical information is insufficient to confirm a suspected condition, the physician may specify diagnostic uncertainty by writing "(Provisional)" following the suspected diagnosis.

(c) Diagnoses on Axes I, II, and III will be recorded in the "Diagnoses" section of the Discharge Summary and will be assigned ICD-9-CM codes for PTF input. There is no requirement for the documentation of Axes IV and V information on the discharge summary. When documented, however, Axes IV and V information will not be coded. A code of V71.09 will not be assigned in the presence of a confirmed or deferred diagnosis on Axis I or on Axis II. Nor will a code of V71.09 be assigned to indicate no diagnosis on an axis.

(d) The provisions of paragraph 7.03 apply to the identification of the DXLS. When, however, the DXLS is other than psychiatric, the medical staff member responsible for preparation of the discharge summary should note the principal psychiatric diagnosis by adding the clarifying term "Principal Psychiatric Diagnosis" following the appropriate Axis I or Axis II diagnosis.

(e) When a patient, primarily under medical or surgical care, is referred for psychiatric consultation, the recording of the mental disorder will be documented on SF 513, Consultation Sheet, or on SF 509, Progress Notes. The recording will include AXIS I through Axis V, and where information is lacking concerning an Axis, the reader will assume "none." The medical staff member responsible for the preparation of the discharge summary will include, if appropriate, the consultant's diagnosis(es) in the listing of established clinical diagnoses. If the consultant's recording of the mental disorder does not include any Axis information, then the diagnosis(es) will be listed as stated on the summary. The Medical Record Administrator will accept for coding a medical record containing a mental disorder with no Axes information. It is

recommended that the incidence of these records be brought to the attention of the Chief, Psychiatry Service.

(f) There is no requirement that the Axis information be recorded with mental diagnoses on VA Forms 10-1000 or other types of discharge summaries prepared by non-VA sources for care rendered under VA auspices.

(g) The use of the multiaxial system for evaluation is to ensure that certain information which may be of value in planning treatment and predicting outcome for each individual is recorded on each of the five Axes, the first three of which constitute an official diagnostic evaluation.

(2) Metabolic Encephalopathy

(a) Metabolic encephalopathy refers to an altered state of consciousness, usually denoting delirium. The delirium is either hypoactive or hyperactive in form, is transient in nature, and is essentially a reversible dysfunction in cerebral metabolism. The term "acute confusional state" may be used by some physicians to describe metabolic encephalopathy. The code assignments in the Alphabetic Index of ICD-9-CM for delirium and acute confusional state are compatible.

(b) A variety of conditions may cause metabolic encephalopathy (delirium) such as brain tumors, malignant metastasis to brain, cerebral infarction or hemorrhage, subdural or epidural hematoma, hypoxia, cerebral ischemia, uremia, nutritional deficiency, poisoning, systemic infection, meningitis, postoperative or post-traumatic states, postictal state, hypoglycemia, severe burns, and drug or alcohol withdrawal.

(c) Metabolic encephalopathy refers to any of the following conditions: acute delirium or acute brain syndrome with transient delirium or acute delirium associated with systemic infection (293.0); Acute alcohol withdrawal with delirium tremens or alcoholic delirium (291.0); drug induced delirium (prescribed or nonprescribed drug)(cumulative effect of drug) (various combinations of drugs) (292.81); and uremic delirium (586).

(3) PTSD (Post-traumatic Stress Disorder)

(a) The medical records of patients treated for PTSD should reveal that the veteran:

1. Experienced an event (stressor) that is outside the range of usual human experience and that would be markedly disturbing to almost anyone. Examples of such a stressor include: a life-threatening experience during combat, or a natural disaster or an accident, serious threat or harm to friends, rape or assault, or seeing other persons who have recently been or are being seriously injured, or killed by accident or physical violence. Duty on a burn ward or combat medical MASH (mobile Army surgical hospital) unit or on a graves registration unit may constitute such an experience. POW status is considered conclusive evidence of an inservice stressor.

2. Reexperienced the traumatic event either by recurrent intrusive, distressing recollections or dreams, suddenly acting or feeling as if the event were recurring (including hallucinations, illusions, dissociative "flashback episodes") or psychological distress when exposed to events of situations that symbolize or resemble an aspect of the trauma (e.g., anniversaries).

3. Shows persistent avoidance of stimuli associated with the trauma or a numbing of general responsiveness. This may include avoidance of thoughts, feelings, activities or situations that arouse recollections of the trauma; inability to recall aspects of the trauma, diminished interest in activities, feeling of detachment or restricted range of affect or a sense of foreshortened future.

4. Displays symptoms of increased arousal which were not present before the trauma such as difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, exaggerated startle response, and physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event

5. Has experienced the disturbance for at least 1 month.

(b) Patients released following care and treatment (including rehabilitation) of PTSD will not be assigned a DXLS from the V57 category. When a patient is released from any ward, service, or specialized unit following care and treatment (including rehabilitation) for PTSD, the DXLS will be coded as 308.3, acute post-traumatic stress disorder, or as 309.81, chronic post-traumatic stress disorder, as indicated by the physician responsible for the care of the patient. Example:

Rehabilitation for Chronic PTSD	309.81
Group Therapy	94.44

(4) Alcohol and Drug Conditions

(a) Patients admitted to any service/ward for the care and treatment of alcohol and/or drug abuse/dependence will not be assigned a diagnostic code from the V57 category. The DXLS for these cases will always be selected from diagnostic categories 303, 304, or 305.

(b) When the alcohol or drug abuse/dependence patient is admitted to a rehabilitation program, transferred into a rehabilitation program, or receives rehabilitation services as part of the therapeutic regimen for alcohol/drug abuse/dependence, a diagnostic code from the V57 category will not be assigned.

(c) When the alcohol or drug abuse/dependence patient receives only detoxification therapy on any one bed section, a non-OR procedure code of 94.62 or 94.65 will be assigned.

(d) When the alcohol or drug abuse/dependence patient receives only rehabilitation therapy on any one bed section, a non-OR procedure code of 94.61 or 94.64 will be assigned.

(e) When the alcohol or drug abuse/dependence patient receives both detoxification and rehabilitation on any one bed section, a non-OR procedure code of 94.63 or 94.66 will be assigned.

(f) When the patient receives combined alcohol/drug rehabilitation/detoxification on any one bed section, a non-OR procedure code of 94.67, 94.68, or 94.69 will be assigned.

(e) When a diagnostic statement representing rehabilitation services is provided as the DXLS on the discharge summary, transfer note(s), or discharge note of an

alcohol/drug patient, the medical record will be coded as described in previous subparagraphs.

(f) Physical complications arising from the use of alcohol will be coded when documented on the discharge summary or transfer/discharge note(s). These complications may include delirium tremens, alcohol withdrawal and other conditions resulting from alcohol use. Example:

Alcoholic cirrhosis with chronic, continuous	571.2
alcoholism and alcoholic psychosis	303.91
	291.8

(g) If a patient is dependent on more than one drug and the types are known, each should be coded. If the types of drugs are not identified, use a code from either 304.7, 304.8, or 304.9. Example:

Marijuana abuse under partial control	305.200
Withdrawal from Valium	292.0
	304.106

e. **Nervous System and Sense Organs**

(1) **Meniere's Disease**

(a) Meniere's disease (ICD-9-CM category 386.0) is a noninflammatory disease of the inner ear or labyrinth involving the cochlea, the vestibular apparatus, and their nerves. The origin of the disease is not known, but it does affect the fluid function in the inner ear.

(b) The disease usually has its onset in the third or fourth decades, and it affects both sexes equally. It is characterized by active periods of variable length interspersed by long periods of remission of variable length. Over time, degeneration of the sensory elements takes place, with hearing disturbances. The symptoms during active periods include intra-ear pressure followed by sudden onset of vertigo, and loud roaring tinnitus. Symptoms peculiar to the cochlear function include fluctuating hearing loss, perception of the same sound having a different pitch in the involved ear than in the normal ear, and intolerance to loud sounds. Unless the physician specifies cochlear, vestibular, or cochleovestibular involvement, use code 386.00. Lermoyez's syndrome is Meniere's with hearing changes occurring before vertigo attacks occur.

(2) Other code assignments for diagnoses which affect the nervous system and sense organs are as follows:

Peripheral neuropathy	356.9
Polyneuropathy	357.9
Severe nerve hearing loss due to viral infection	389.12 079.9

f. **Circulatory**

(1) **Rheumatic Heart Disease**

(a) Rheumatic heart disease occurs as a result of infection with Group A hemolytic streptococci. This is the same organism which causes rheumatic fever (390).

(b) Acute rheumatic fever with heart involvement is classified in categories 391 and 392. Heart diseases due to previous exposure to rheumatic infections are classified in categories 393-398. These diseases most often involve the valves of the heart which are classified to categories 394-397.

(c) There are two primary manifestations of chronic endocarditis: stenosis and insufficiency. Stenosis occurs when adhesions of the cusps of the heart valve prevent the valve from opening properly to allow an adequate blood flow. Insufficiency occurs when a valve cannot close properly because of retraction of the valve cusps. When this happens, the blood escapes back to the heart chamber from which it originated.

(d) The mitral valve is the structure most frequently affected in chronic rheumatic heart disease. Both mitral stenosis and mitral endocarditis are assigned to chronic rheumatic heart disease whether or not "rheumatic" is stated in the diagnosis. This is because rheumatic heart disease is the most common cause of these conditions. Note that mitral stenosis (394.0) and mitral valve disease (394.9) are assigned to category 394 for rheumatic disease even if "rheumatic" is not mentioned, but in order for mitral valve insufficiency to be assigned to 394.1, it must be specified as rheumatic. When both stenosis and insufficiency of the mitral valve are mentioned, the etiology is presumed to be rheumatic even though it may not be specified. These latter conditions are coded 394.2.

(e) Diseases of the aortic valve must be specified as rheumatic in order to use codes in category 395.

(f) In rheumatic heart disease, very often both the mitral and aortic valves are affected. For convenience, ICD-9-CM provides a combination category to describe involvement of both valves. The "includes" note under the category title 396 provides the instruction that the category includes involvement of both mitral and aortic valves whether specified as rheumatic or not.

(g) Examples of heart diseases with valve involvement:

Aortic stenosis due to old rheumatic fever	395.0
Rheumatic fever with endocarditis	391.1
Possible mitral valve stenosis	394.0

(2) **Atherosclerosis**

(a) Arteriosclerotic heart disease and atherosclerosis of the coronary artery are terms used interchangeably. Both are terms classifiable to 414.0. Atherosclerosis or atheroma is a thickening or hardening (arteriosclerosis) of the muscular arteries such as the aortic, coronary, femoral, iliac, internal carotid, and cerebral arteries. Conversely, ischemic heart disease is a deficiency in the blood supply to the heart muscle due to obstruction or constriction of the coronary artery. In describing this latter condition, clinicians will often state "coronary artery disease" (414.9) or "coronary heart disease" (414.9). Both are usually attributable to atherosclerotic changes (414.0). However, other causes of coronary artery disease include syphilis (093.89), systemic lupus erythematosus (710.0), and congenital aneurysm or arteriovenous fistula (746.85).

(b) As a general rule, patients with ASHD or coronary heart disease are admitted because of a manifestation of the disease such as angina, aortic insufficiency, etc. To complicate the situation, many physicians classify heart patients according to the axes recommended by the American Heart Association. For example, a diagnosis may be stated as follows:

Etiology: Arteriosclerotic Heart Disease
Anatomical: Hypertrophy of Heart
Physiological: Aortic insufficiency
Functional: Class II

In the example, the aortic insufficiency should be reported as the DXLS since it represents the manifestation of the ASHD and is probably the condition that prompted the admission of the patient. The following represents other examples of how ASHD in the presence of manifestations should be coded:

Stable angina with ASHD	413.9
	414.0
Chronic coronary insufficiency with ASHD	411.89
	414.0

(c) A DXLS code of 414.0 (ASHD) in the presence of manifestations is inappropriate. Thus, in a diagnosis of ASHD with aortic insufficiency, the code for the ASHD will be reported as a secondary code. Example:

ASHD with stable angina	413.9
	414.0
ASHD with aortic insufficiency	424.1
	414.0

(d) When there are 2 or more manifestations on either the physiological axis or the anatomical axis, the medical staff member will be requested to designate the DXLS.

(e) A DXLS of ASHD is appropriate when the patient is admitted for diagnostic study or surgical intervention on the heart or the vessels of the heart, and there are no manifestations. Such studies include cardiac catheterization. Surgical intervention includes coronary angioplasty (36.0) and aorto-coronary bypass grafts (36.1).

(3) **Asymptomatic or Presymptomatic Atherosclerotic Coronary Disease**

(a) As indicated above, a diagnosis of asymptomatic or presymptomatic atherosclerotic coronary artery disease (414.0) may be based upon the findings resulting from diagnostic study, such as exercise stress tests, electrocardiographs, etc. In some instances, the signs of an old "silent" myocardial infarct may be present in the findings of asymptomatic coronary heart disease (414.0 plus 412). An old silent myocardial infarct usually implies that the patient was not aware of having had an infarction. In other instances, there may be evidence of a healing or healed myocardial infarction. Depending on the severity of the infarction, the healing process may take 6 to 12 weeks. Physicians use the term "healed" or "old" to describe the condition classifiable to code 412.

(b) A DXLS of ASHD is acceptable only if the patient is admitted expressly for

diagnostic tests and/or therapeutic intervention, e.g., aortocoronary bypass, percutaneous transluminal angioplasty, etc., and there are no manifestations of the arteriosclerosis.

(4) **Angina Pectoris**

(a) Angina pectoris (413.9) is a specific type of chest pain usually associated with myocardial ischemia and due to arteriosclerotic heart disease. Angina pectoris may be caused by exertion or may occur when the patient is resting and seemingly without stimulation, such as during the night. This is referred to as nocturnal or decubitus angina (413.0). Prinzmetal's angina (413.1) is a variant type, occurring at rest, with the S-T segment elevated rather than depressed during the attack. Angina described as "angiospastic" or "with coronary spasm" at rest is coded 413.1. When coronary atherosclerosis coexists with any of the types of angina, code the specific type of angina and 414.0. Example:

Prinzmetal's angina with extensive coronary atherosclerosis	413.1 414.0
Coronary arteriosclerosis with nocturnal angina	413.0 414.0
Prinzmetal's angina with normal appearing coronary arteries and Raynaud's phenomenon	413.1 443.0

(b) On occasion, angina pectoris can occur in the absence of coronary atherosclerosis as the result of calcific aortic stenosis, aortic and mitral insufficiency, syphilitic aortitis, hypertrophic subaortic stenosis, etc. In these cases, a code is assigned for the causative condition first and 413.9 is assigned to the angina. Example:

Mitral insufficiency with angina pectoris	424.0 413.9
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(c) Unstable angina is the intermediate stage between stable angina and myocardial infarction. It is sometimes referred to as crescendo angina (411.1). This angina occurs with less exertion than previously experienced; the pain is often different in duration or radiation, and it is not relieved promptly by nitroglycerin. Myocardial infarction may develop within hours, days, or weeks after unstable angina starts to occur.

(d) There will be times when the presenting complaint will vary from that of the diagnosis established after study. For example, complaints of chest pain, precordial pain, heart pain, and angina-like pain may mimic angina pectoris, but after study, the underlying condition causing the pain may be something other than any co-existing coronary atherosclerosis. It could be one of the following:

1. Chest pain radiating to the neck and arm due to sprain or inflammation of the chondrocostal junctions and diagnosed as anterior chest wall syndrome (786.52)
2. Tietze's syndrome (733.6)
3. Intercostal neuritis (353.8) due to herpes zoster (053.10) or diabetic neuritis (250.6)

4. Dorsal nerve root pain causing sudden sharp, severe chest pain with radiation resulting from degenerative thoracic spine (722.51) or cervical spine disease (722.4) or due to postural strain (729.9)

5. Angina-type pain associated with secondary pulmonary hypertension (416.8) or precordial pain of constrictive pericarditis (423.2)

6. Substernal pain due to cardiospasm (530.0)

7. Radiating chest pain of a peptic ulcer (533.9), chronic cholecystitis (575.1), hiatal hernia (553.3) or spontaneous pneumothorax (512.8)

8. Psychogenic heart pain (307.89)

9. Dull aching chest pains diagnosed as psychophysiologic reaction (307.89)

(e) In all of the examples, the chest pains are symptoms of the illness and are not coded. In instances where no underlying condition can be established for the patient's chest pain, a fifth-digit code from the 786.5 category is used where the physician records only "chest pain."

(6) **Postmyocardial Infarction, Eight Weeks or Less From Date of Infarction**

A patient may be admitted six to eight weeks after a myocardial infarction to determine the extent of coronary atherosclerosis or presence of any sequelae following the myocardial infarction and there may be mild or no symptoms of angina. The extent of the arteriosclerosis may be discovered through studies such as cardiac catheterization (37.21-37.23), coronary angiogram, and/or ventriculography (88.52-88.54), and may result in a diagnosis of coronary atherosclerosis or arteriosclerosis (414.0); vessel disease described as 1, 2, or 3 (414.0); chronic coronary insufficiency (414.8); mitral valve insufficiency with coronary atherosclerosis (424.0 plus 414.0); ventricular aneurysm (414.10); or rupture of papillary muscle (429.6). The results of such examinations may indicate the need for operative intervention, such as a coronary bypass, and the number of coronary vessels to be considered in the bypass procedure. If the postmyocardial diagnosis is pericarditis with friction rub, pericardial effusion, pleurisy or pleural effusion, and joint pains, the diagnosis should be coded as 411.0, Postmyocardial infarction syndrome. If a myocardial infarction occurs during the course of the diagnostic study, the appropriate code in the 410.0-410.8 series is used with a numeric "1" in the fifth position. To show the "post" infarction, assign a code from the 410 category with a fifth position numeric "2."

(7) **Acute Myocardial Infarction**

(a) Members of the medical staff should include the site of the myocardial infarction when documenting this diagnosis. However, coders are authorized to identify specific sites of myocardial infarctions by reviewing reports of EKG for this information. The fifth position "0" should rarely, if ever, be used.

(b) A myocardial infarction described as "transmural" involves a full thickness of myocardium from endocardium to epicardium and is coded to any site specified in the codes which appear in the range of 410.0-410.6. A myocardial infarction described as "minor" is coded 410.71. The coder should be aware that congestive heart failure (428.0) and shock (785.51) may be present at the onset of myocardial infarction or may

develop later. When myocardial infarction is documented as the DXLS, secondary diagnoses of congestive heart failure, cardiogenic shock, ventricular arrhythmia, or fibrillation should be coded and reported as complications/comorbidities as appropriate.

(c) Any mitral insufficiency (424.0) resulting from a papillary muscle infarction (410.8) should be coded. Although the diagnosis may be stated as "complete atrioventricular (heart) block in acute myocardial infarction, anterior site," the diagnoses are sequenced, coded and reported, first as 410.11 and then as 426.0.

(d) A Swan-Ganz catheter is a flow-directed catheter frequently employed in monitoring patients with myocardial infarcts. The code assignment for insertion or placement of a Swan-Ganz catheter depends upon the purpose for which it is used. The three most frequent uses of the Swan-Ganz catheter are in pulmonary artery pressure monitoring (89.63); pulmonary arterial wedge pressure monitoring (89.64); and catheterizations on the right side of the heart (37.21).

1. Codes 89.63 and 89.64 involve introduction of a catheter (such as a Swan-Ganz) with passage to the pulmonary artery via the heart ventricle, the purpose being to measure and monitor arterial pressure. The measurement and monitoring function may include determination of cardiac output, evaluation of therapy, and infusion of drugs. Pulmonary artery lines may be placed in patients with anticipated complications, such as respiratory failure, respiratory distress syndrome following surgery or trauma, hypotension resistant to therapy, or organ failure.

2. Intraoperative arterial monitoring of pressure and obtaining blood gases (both during and after surgery) may require the use of a Swan-Ganz catheter. Central venous pressure monitoring (89.62) is performed in the assessment of circulation during some surgical procedures and a Swan Ganz catheter is not used.

(8) Elevated Blood Pressure

(a) Blood pressure changes from time to time depending upon the time of day the measurement is taken, the patient's age, or emotional factors. Because of these variables, the diagnosis of hypertension is made on a series of blood pressure readings rather than on an isolated reading. The World Health Organization places the upper limits of normal blood pressure at 160/95.

(b) An elevated blood pressure reading without a diagnosis of hypertension (796.2) may be due to emotional factors causing stress or may be characteristic of older age groups. However, elevated blood pressure in a patient diagnosed as having hypertension may refer to poor toleration of a stressful situation which in turn affects therapy given to maintain an acceptable blood pressure level.

(c) "Transient" hypertension may refer to an established hypertension or to an elevated blood pressure without the diagnosis of hypertension. As a result, the physician should be queried for a more definitive diagnostic statement. An excessive rise in blood pressure during general anesthesia is sometimes referred to as "hypertension under anesthesia." This condition may be caused by carbon dioxide retention, insufficient depth of anesthesia, increased intracranial pressure, or presence of pheochromocytoma. Hypertension under anesthesia is coded 796.2 and E938.4. If carbon dioxide retention or

acidosis is mentioned as cause of elevated blood pressure under anesthesia, the codes assigned would be 276.2, 796.2, and E938.4. If pheochromocytoma is present, the case would be coded as secondary hypertension.

(9) **Benign and Malignant Hypertension**

(a) ICD-9-CM provides subcategories for systemic hypertension to designate the benign, malignant, or unspecified nature of hypertension. Malignant hypertension is characterized by rapidly rising blood pressure, usually in excess of 140 mm HG diastolic with findings of visual impairment and symptoms or signs of progressive cardiac failure. Without effective antihypertensive treatment, severe visual loss with hemorrhage, exudates, and papilledema, may appear and death may occur due to uremia, cardiac failure, or cerebral hemorrhage.

(b) Primary and secondary hypertension not specified as either benign or malignant is assigned to the unspecified status (fourth digit .9). It is highly unusual for patients to be admitted with a diagnosis of benign hypertension. As a result, members of the medical staff should be informed of the need for qualifying hypertension for purposes of subsequent review of actual data for UR and/or QA purposes.

(c) Uncontrolled hypertension does not necessarily refer to malignant hypertension. Failure of diuretics to control hypertension often indicates a need for antihypertensive drugs, such as beta-blockers. ICD-9-CM does not have a code to specify "uncontrolled," and as a result, the hypertension will be classified according to its type and nature, e.g., Hypertensive cardiovascular disease.

(10) **Hypertensive Disease**

(a) Hypertension due to an unknown cause is coded to a classification in the range of 401-404. Hypertension due to an underlying cause is coded to category 405. Diagnostic statements of hypertensive disease often refer to the degree of vascular deterioration and any involvement of the heart, brain, kidney, eyes, and peripheral organs affected by the hypertension.

(b) Essential hypertension (401.0-401.9) is also known as hypertensive vascular disease. Essential hypertension (sometimes described as labile) is more common in younger patients. With this condition, the blood pressure rises in excess of 140/90, returns to normal after a few days, and then rises again later. A diagnosis of high blood pressure is classified to this category (401). Hypertension may also accelerate atherosclerosis and, when both are mentioned in the diagnostic statement, both conditions will be coded. Example:

Atherosclerotic aorta with benign	440.0
essential hypertension	401.1

(c) Systolic hypertension (401.0-401.9) usually refers to a systolic pressure above 160mm Hg but with a diastolic pressure of less than 95mm Hg. Systolic hypertension with normal diastolic pressure is more common in the elderly, and usually reflects loss of elasticity of the major vessels and atherosclerosis of the central aorta and its branches. Example:

Atherosclerosis of the aorta with systolic	440.0
hypertension and generalized arteriosclerosis	401.1
	440.9.

In a younger patient, systolic hypertension may be associated with an arteriovenous fistula or thyrotoxicosis and the systolic hypertension would thus be classified as a secondary hypertension.

(d) Hypertensive heart disease (402.00-402.91) refers to an elevated systemic vascular resistance that increases the workload of the left ventricle of the heart. As a result of this workload, the heart may show hypertrophy or combined hypertrophy and dilation leading to the diagnosis of hypertensive heart disease. Left ventricular failure and congestive heart failure may occur if the hypertension goes untreated or if the medication therapy fails to control the hypertension. Category 402 has a fifth-digit subclassification to identify those cases in which congestive heart failure has occurred. Hypertensive heart disease in ICD-9-CM includes that with mention of interstitial, chronic, or fibroid myocarditis; with mention of degenerative myocardium; and with mention of hyperkinetic heart or cardiomegaly. The following examples apply:

Hypertensive heart disease with left ventricular failure	402.11
Hypertensive heart disease with right and left heart failure and passive congestion of the liver	402.11 573.0
Acute anterior myocardial infarction with benign hypertensive cardiovascular disease and coronary arteriosclerosis	410.11 402.10 414.0
Hypertensive cardiovascular disease benign with angina pectoris	402.10 413.9
Congestive heart failure and hypertensive cardiovascular disease with papilledema findings (by definition, malignant hypertension is always associated with papilledema. Papilledema is thus not coded.)	402.01

Heart conditions listed in 428, 429.0-429.3, 429.8, and 429.9 described as due to hypertension or hypertensive are coded to the 402 category.

(e) Hypertensive renal disease (403.0-403.9) or progressive renal nephrosclerosis may develop in long-standing hypertension. Arteriosclerosis of the kidney, nephrosclerosis, and renal sclerosis associated with hypertension refer to structural changes in the arterioles and not in the renal artery. Renal failure is not common in hypertensive renal disease until the hypertension becomes malignant, 403.01. Thus, a diagnosis of hypertension and renal failure is incomplete without a qualifying term of benign or malignant hypertension. Example:

Hypertensive nephropathy, benign	403.10
Hypertensive nephroangiosclerosis	403.00
Accelerated hypertension with renal failure	403.01

Renal conditions classified to 585, 586, or 587 with any condition classified to category 401 or described as hypertensive renal disease are coded to category 403.

(f) Hypertensive heart and renal disease (404.0-404.9) is also referred to as cardiorenal disease or hypertensive heart disease with nephrosclerosis. A record with a diagnosis of hypertensive cardiovascular and renal disease, or hypertensive cardiovascular renal disease should be referred to the medical staff member for additional diagnoses of coronary arteriosclerosis, angina pectoris, or chronic coronary insufficiency when these conditions are not documented on the discharge/transfer note. These latter diagnoses require additional coding. Cardiovascular hypertension may imply the presence of a coronary artery disease.

(g) Hypertension and the brain (437.2) (430-438), in which an abrupt rise in blood pressure causes cerebral symptoms such as headaches, confusion, stupor, and convulsions, is known as cerebral encephalopathy (437.2). Intracerebral hemorrhage may result from rupture of an arteriosclerotic vessel due to arterial benign hypertension (431 plus 401.1). Malignant hypertension may cause a cerebral infarction (434.0 plus 401.0).

(h) Acute postoperative hypertension may reflect patient agitation or inadequate control of pain, and the physician should be queried to determine if this is hypertension, as opposed to elevated blood pressure without a diagnosis of hypertension. Postoperative hypertension is often of nonspecific origin and of short duration. When treated with antihypertensive drugs, it may resolve spontaneously as the patient convalesces (401.1).

(i) A diagnosis of controlled hypertension should be coded to the type of hypertension (401-405) for which the patient received treatment. The rationale is that while being treated primarily for some other condition, the patient is still receiving treatment for hypertension. In addition, even though the hypertension is controlled, the possibility of congestive heart failure developing is always present. The coder should also be aware that physicians sometime document a diagnosis of controlled hypertension for patients who were uncontrolled when admitted, but after treatment, were controlled. In such cases, the medical record should be referred to the responsible medical staff member for amendment of the source document. The type of hypertension treated will be documented.

(j) Secondary hypertension (405.0-405.9) will not be reported as a DXLS. Secondary hypertension can be due to a variety of underlying causes. Code first the underlying cause, and then the hypertension. When the underlying cause can be cured or brought under reasonable control, the hypertension may disappear or become stabilized at a reasonable level. The table on hypertension in the Alphabetic Index provides a listing of the different types of secondary hypertension.

(11) **Cardiac Arrest**

(a) Cardiac arrest is defined as an immediate cessation of the pumping action of the heart due to conditions such as ventricular fibrillation. Ventricular fibrillation or other critical arrhythmia can be confirmed by electrocardiogram, but on occasion, the finding is established by the physician upon auscultation of the patient's heart.

(b) Resuscitation measures are usually instituted when there is timely identification of the cardiac arrest or impending cardiac arrest. These measures include open and/or closed heart massage; mouth-to-mouth resuscitation; defibrillation; endotracheal intubation via a laryngoscope; intravenous medications via peripheral venous catheter, cutdown, or percutaneous central venous line; and intracardiac injections. And, of

course, some of these measures may be implemented anywhere in the health care facility: at the patient's bedside; in special treatment rooms; in the OR; in a hallway; or even in an elevator. Successful resuscitation terminates the arrest, however, the patient may thereafter be treated for the ventricular fibrillation. The fibrillation need not be the DXLS, especially when the patient is admitted for some other condition, e.g., a malignancy, peritonitis, renal failure, etc. The fibrillation could be a secondary diagnosis.

(c) Since cardiac arrest is an immediate cessation of the pumping action of the heart, it is unlikely that this diagnosis would represent the DXLS except during a patient's stay of 24 hours or less which terminated in death and another diagnosis had not been established or suspected. Thus, a DXLS of cardiac arrest is highly questionable for any patient who expires and whose length of stay exceeds 24 hours. In addition, a DXLS of cardiac arrest is not appropriate for any patient who is discharged alive.

(12) **Heart Failure**

(a) Heart failure occurs when the heart is no longer able to pump an adequate supply of blood to meet the metabolic needs of the tissues of the body. It is clinically identified according to the ventricle (left or right) primarily impaired. Left-sided heart failure refers to symptoms and signs of elevated pressure and congestion in the pulmonary veins and capillaries. Example:

Acute pulmonary edema with heart failure 428.1

Acute pulmonary edema (518.4) is never coded when heart failure is mentioned in the diagnostic statement.

(b) Right ventricular or right-sided heart failure is most commonly due to failure of the left ventricle. This condition is characterized by elevated pressure and congestion in the systemic veins and capillaries. Another term for right heart failure is congestive heart failure. Since congestive heart failure is a statement of both left and right ventricular failure, code 428.0 includes conditions mentioned under code 428.1.

(c) Heart failure which occurs as a postoperative complication is not included in category 428. All heart failure occurring in the immediate postoperative period, no matter what causes it, is coded 997.1. The immediate postoperative period is defined as the period following surgery during the same episode of care in which the surgery was performed.

(d) Long-term effects of cardiac surgery (not occurring in the immediate postoperative period) are classified using code 429.4. Postcardiotomy syndrome and postvalvulotomy syndrome are conditions which develop weeks or months after open heart surgery, and would be assigned to 429.4 because they represent long-term effects.

(13) **CVA (Cerebrovascular Accident)**

(a) CVA is an "umbrella" term used to describe anatomical and/or physiological changes which occur in and affect the vessels of the brain. As a general rule, these changes are due to thrombosis arising from cerebral arteriosclerosis (atherosclerosis), or hemorrhage resulting from a rupture of a cerebral vessel due to hypertension, or cerebral embolism due to another disease. Also known as "stroke," the residuals of a CVA often include hemiplegia, brain originated paraplegia, and aphasia.

(b) A review of the ICD-9-CM diagnostic code 436 will show that CVA is an acceptable diagnostic entity, but further review will show that the term CVA actually represents an ill-defined cerebrovascular disease. As a result, when this term is used on a source document, the physician will be queried to provide a more definitive diagnosis. The diagnosis may actually be that of a cerebral thrombosis due to arteriosclerosis, or cerebral hemorrhage due to hypertension, or cerebral embolism. The codes for cerebral arteriosclerosis or hypertension will be reported secondary to the thrombosis or hemorrhage. The following are examples of coding the aforementioned occurrences:

Cerebral thrombosis due to cerebral	434.0
arteriosclerosis with aphasia	437.0
	784.3
CVA with hemiplegia 436	
	342.9

(c) Categories 430-432 classify cerebrovascular accidents which are characterized by hemorrhage. Category 433 classifies CVA caused by occlusion and/or stenosis of precerebral arteries. Category 434 classifies CVA caused by occlusion of the cerebral arteries.

(d) Diagnoses of aphasia and hemiplegia are common residual conditions resulting from damage to the motor nerves due to hemorrhage or vascular occlusion. These conditions are also known as neurological deficits. As shown above, the deficits will be coded if present upon discharge of the patient from inpatient services.

(e) When patients with a residual condition/deficit are readmitted, show the cause-and-effect relationship between the residuals, e.g., hemiplegia, and the condition which caused the original illness (CVA). The code for the residual will be reported first; and a code of 438 will be used as a secondary entry. Category 438 is used to identify the cause of the late effect only when residual conditions are present. It will not be used to denote a history of previous cerebrovascular disease if no residuals or sequelae are present. A code of 438 cannot be used to report the DXLS.

(14) RIND (Reversible Ischemic Neurologic Deficit)

(a) A reversible ischemic neurological deficit is one of brief duration or with gradual recovery occurring within 6 months or more. Neurological deficits may occur with cerebrovascular diseases (see 430-435) and include one or more of the following: numbness, weakness, clumsiness, paralysis in one or both limbs, inability to eat or talk, vertigo, loss of vision.

(b) If a diagnosis of RIND is associated with a TIA (transient ischemic attack), assign an appropriate code from the 435 category. The patient's deficit(s) should have practically resolved by the time of hospital release.

(c) If the RIND is associated with an occlusion, assign an appropriate code from categories 433-434. A small thrombus or embolism may result in a RIND if the blood supply is restored promptly.

(d) When documented, all reversible neurological deficits should be coded.

h. Respiratory Diseases

(1) COPD (Chronic Obstructive Pulmonary Disease)

(a) COPD, sometimes referred to as irreversible airway obstruction, is assigned a diagnostic code of 496. This term is often loosely used by physicians without regard to the underlying condition. COPD may be due to:

1. Chronic bronchitis with or without centrilobular emphysema, 491.2;
2. Predominant panacinar emphysema, 492.8; or
3. Overlapping chronic bronchitis and predominant panacinar emphysema, 496.

(b) The COPD patient with chronic bronchitis usually presents for care because of an acute exacerbation of the bronchitis. Example:

COPD with acute and chronic bronchitis	466.0
	491.2

(c) If the diagnosis is stated as COPD and there is evidence of chronic bronchitis (with or without centrilobular emphysema) in the patients medical record but no evidence of an exacerbation of the bronchitis, assign a code of 491.2.

(d) If the diagnosis is stated as COPD and there is evidence of panacinar emphysema in the patient's medical record, assign a code of 492.8. A diagnosis stated as COPD with asthmatic bronchitis will also be assigned a code of 492.8.

(e) If the diagnosis is stated as COPD and there is no evidence of acute or chronic bronchitis, or panacinar emphysema, assign a code of 496.

(f) If during an episode of inpatient care, the COPD patient develops respiratory failure, a code of 518.81 should be assigned as a secondary diagnosis unless the physician documents the condition as the DXLS. Although the primary objective in these cases is to correct hypoxemia present in the respiratory failure, the patient also receives concurrent treatment for the underlying condition, e.g., bronchitis and/or emphysema. Example:

Respiratory failure due to COPD with chronic bronchitis 491.2	518.81
COPD with respiratory failure with mechanical ventilation	496 518.81 93.92

(2) Asthma and Status Asthmaticus

(a) Asthma (493.0-493.9) is referred to as a reversible airway obstruction: it can be treated by removing the obstruction with bronchodilators, epinephrine, aminophylline, or adrenal corticosteroids. Therefore, when both asthma (reversible airway obstruction) and COPD (an irreversible airway obstruction) appear in the same diagnostic statement, a code of 493.2 will be assigned.

(b) Status asthmaticus is defined as an acute asthmatic attack in which the degree

of bronchial obstruction is not relieved by the usual treatment, such as by epinephrine or aminophylline. To identify cases of status asthmaticus, the fifth digit "1" is assigned to the basic code of 493.91. Other terms used to describe status asthmaticus include intractable asthmatic attack, refractory asthma, severe, prolonged asthmatic attack, airway obstruction (mucous plug) not relieved by bronchodilators, or severe intractable wheezing.

(3) **Bronchospasm**

(a) A code of 519.9 will not be assigned for bronchospasm associated with asthma or with chronic obstructive lung disease.

(b) Bronchospasm is a component of an acute asthmatic attack and as such, is included in the code assignments under category 493, Asthma. Bronchospasm mentioned in conjunction with acute exacerbation of COPD is assigned to code 496, Chronic airway obstruction, NEC.

(4) **Respiratory Failure**

(a) Respiratory failure (518.81) is defined as a partial pressure of oxygen in the arterial blood of 50 mmHg or less and/or a partial pressure of carbon dioxide greater than 50 mmHg. A diagnosis of respiratory failure is usually made by obtaining arterial blood gas determinations while the patient is breathing room air.

(b) The causes of respiratory failure fall into 2 main categories: Non-pulmonary and pulmonary.

1. The non-pulmonary causes include central nervous system depression such as that caused by drugs, intracranial hemorrhage/infarction, intracranial masses, or head injury; neuromuscular diseases such as those caused by muscular dystrophy, multiple sclerosis, Guillain-Barre Syndrome, or spinal cord injuries; and cardiovascular diseases caused by conditions such as left ventricular failure or cardiogenic pulmonary edema.

2. The pulmonary causes of respiratory failure include such conditions as chronic bronchitis, emphysema, interstitial pulmonary fibrosis, asthma, pneumonia, and non-cardiogenic pulmonary edema (ARDS/adult respiratory distress syndrome).

(c) The treatment of respiratory failure is usually directed to the underlying cause of the disease. For example, a patient with respiratory failure resulting from chronic obstructive pulmonary disease (496) would probably be treated initially with oxygen supplementation, bronchodilators, corticosteroids, and antibiotics. Should this regimen fail, mechanical ventilation (93.92) may be required.

(d) Thus, in all cases where respiratory failure is mentioned, the underlying cause of the condition should also be documented. For example, a COPD patient admitted in respiratory failure and respiratory failure is documented as:

Chronic respiratory failure due to COPD	518.81
	496

(e) When the underlying cause of the respiratory failure cannot be determined, a code of 518.81 may stand alone.

(f) When appropriate, also code the mechanical ventilation (93.92). This code should be reported on TT 601.

(5) **Aspiration Pneumonia**

(a) Aspiration pneumonia results from aspiration of gastric contents or aspiration of the secretions of the upper respiratory flora. This condition is caused by some type of esophageal disease which impairs swallowing; an inadequate cough reflex following anesthesia or the inhalation of injection of drugs (abuse/dependence); or impaired gastric emptying as in a semicomatose patient. Suctioning may be attempted but seldom are aspirates completely removed. As a result, the patient may develop an inflammatory reaction to the secretions remaining in the respiratory tract.

(b) When there is no evidence of a bacterial flora, a code from the 507 category will be assigned. (See 507.0, 507.1, 507.8.)

(c) When there is evidence of bacteria, as revealed in physician documentation or laboratory report(s), an appropriate code will be selected from the 480, 482, or 483 category. The code for the gram negative or gram positive organism will take precedence over the code for the substance aspirated.

(6) **ARDS (Adult Respiratory Distress Syndrome)**

(a) ARDS is a descriptive term that applies to an acute clinical-pathological state characterized by diffuse infiltrative lung lesions, severe dyspnea, and hypoxemia occurring in certain clinical situations. Another description of ARDS is respiratory failure due to shock and trauma occurring in the presence of previously normal lungs. The predominant symptoms are those of hypoxemia (anxiety, dyspnea, and altered sensorium). Physical examination shows tachypnea and tachycardia, and auscultation of the chest may reveal few or no rales. Cyanosis may be present. Diffuse alveolar and interstitial infiltrates show on chest x-ray (which may progress to consolidation). Treatment is usually directed at the underlying condition, plus maintaining fluid balance, and providing respiratory supportive measures such as oxygen and possibly mechanical ventilation.

(b) ARDS following shock, surgery, or trauma is assigned to code 518.5; ARDS not otherwise specified is assigned to 518.5; and ARDS associated with conditions not classifiable to code 518.5 is assigned to code 518.82

(7) Some examples of other codes affecting the respiratory system:

Pneumonia, left upper lobe	486
Acute lobar pneumonia, right middle lobe, Klebsiella	482.0
Chronic bronchial asthma with acute bronchitis due to pseudomonas	466.0 493.90 041.7
Acute and chronic bronchitis	466.0 491.9
Acute chemical bronchitis due to inhalation of chlorine fumes	506.0

i. **Digestive System Conditions**

(1) **Intestinal Pseudo-Obstruction**

(a) Intestinal pseudo-obstruction is a motility disorder characterized by distention or dilatation of the small and/or large intestine. The underlying cause is not a mechanical obstruction of the intestine but rather a severe dysmotility of the intestine.

(b) There are three major types of pseudo-obstruction:

1. Acute intestinal pseudo-obstruction, 560.89, involves primarily the colon and sometimes the small intestines. It is also referred to as Ogilvie's syndrome. This pseudo-obstruction is usually characterized by massive dilatation of the colon and, at times, of the small intestine. Acute pseudo-obstruction occurs most often in patients who have undergone major surgery, suffered a myocardial infarction, have a severe infection or septicemia, or are experiencing respiratory failure and are on a respirator. Contributing factors to this condition may be ventilation therapy, sedatives or narcotics, and metabolic and electrolyte disturbances. Treatment may include intubation of the stomach or small intestines for decompression (96.07 or 96.08) or decompressive colonoscopy, 46.85.

2. Chronic or intermittent secondary pseudo-obstruction, 564.8, is chronic dilatation of the large and small bowel due to a variety of medical conditions, such as scleroderma, dermatomyositis, amyloidosis, muscular dystrophy, myxedema, diabetes mellitus, and chronic neurologic diseases including Parkinson's and the after effect of stroke. Code also any mention of gastric distention of steatorrhea secondary to bacterial overgrowth. Code the underlying condition, such as scleroderma, 710.1, with pseudo-obstruction of the intestine and stomach, 564.8 and 536.8, and steatorrhea, 579.8.

3. Idiopathic or primary pseudo-obstruction of the intestine, 564.8, indicates that no systemic disease can be identified and that the motility disorder, involving primarily the small intestine, may be attributed to abnormalities of sympathetic innervation or of the muscle layers of the intestine. Steatorrhea secondary to bacterial overgrowth, 579.8, may be associated with the idiopathic pseudo-obstruction, 564.8.

4. The treatment for idiopathic, primary, chronic, or intermittent pseudo-obstruction may involve changes in medication, relief of any fecal impaction, and nutritional support through diet and possibly parenteral hyperalimentation.

(2) **Cholecystitis and Cholelithiasis**

(a) Acute cholecystitis (575.0) is usually characterized by pain in the right upper quadrant and/or epigastrium, nausea and vomiting, fever and leukocytosis, and sometimes jaundice. Strongly associated with gallstones, cholecystitis may occur when a calculus becomes lodged in the cystic duct.

(b) Cholecystitis may be treated conservatively with analgesics and antibiotics, or by surgical intervention, e.g., cholecystectomy (51.22). Surgical intervention may be planned as in the case of a patient with chronic cholecystitis (575.1) who has not responded well on a conservative regimen; or it may be unplanned as in the case of a patient never treated before, or treated before and presenting with an exacerbation of symptoms, e.g., pain, jaundice, etc.

(c) Cholangiography (87.53) is frequently performed at the time of cholecystectomy (51.22) especially when the patient is jaundiced or has provided a history of jaundice, to determine the need for exploration of the common duct following the cholecystectomy. When an exploration of the common duct is performed (51.41), the primary goal is to remove one or more stones discovered by cholangiography or to resolve some other obstruction (51.42) e.g., stricture of the common duct. An operative code of 51.51 is assigned a common duct exploration performed in the absence of obstruction of the bile duct. A code of 51.61 should not be assigned when the cystic duct remnant is excised during the cholecystectomy procedure. When a patient is too debilitated to tolerate a cholecystectomy, trocar decompression may be performed, stones removed, and a drain inserted without removing the gallbladder. In such cases, a code of 51.02, Trocar cholecystostomy is assigned. If only the common bile duct is decompressed during an OR procedure (without removing the gallbladder), a code of 51.43, Insertion of choledochohepatic tube, is assigned. If the common bile duct is decompressed percutaneously, a code of 51.98 is assigned.

(d) Not all cholangiograms need be performed intraoperatively. Some are performed in Radiology Service one or more days prior to a planned cholecystectomy. When the cholangiogram is performed in Radiology Service, a code of 87.51 or 87.52 will be assigned and the procedure will be reported on the non-OR PTF transaction.

(e) Cholecystitis and/or cholelithiasis are not the only biliary diseases which indicate the need for intraoperative cholangiogram. Other conditions include malignancies of the liver, gallbladder, or pancreas as well as some other non-malignant hepatobiliary conditions. When an intraoperative cholangiogram is performed during the course of an operative episode involving one or more therapeutic procedures, the code for the intraoperative cholangiogram (87.53) will be the last code assigned. If the intraoperative cholangiogram is the only procedure performed, the operative code of 87.53 will be assigned.

(f) The sequencing and reporting of codes for the patient who undergoes intraoperative cholangiography, cholecystectomy, and exploration of the common duct is as follows:

Cholecystectomy	51.22
Exploration, common duct for removal of stones/calculus	51.41
Intraoperative cholangiogram	87.53

(3) Other common digestive traction conditions

Acute hemorrhagic gastritis (or acute gastritis with hemorrhage) 578.9	535.0
A-V malformation, colon	557.1
Asymptomatic cholelithiasis	574.20
Sump syndrome	997.4

j. Genitourinary

(1) End-Stage Renal Disease

(a) End-stage renal disease is a complex syndrome characterized by a variable and inconsistent group of biochemical and clinical changes affecting volume regulation, acid-base balance, electrolyte balance, excretion of waste products, and several endocrine functions. It is a progression of chronic renal failure and is defined by clinicians as the point at which chronic maintenance dialysis or kidney transplantation is required to maintain the patient's life.

(b) Chronic renal failure and end-stage renal disease are caused by many diseases, among which are diabetes mellitus, primary hypertension, glomerulonephritis, renal disease with edema (nephrosis), interstitial nephritis, systemic lupus erythematosus (SLE), obstructive uropathy, polycystic kidney disease, and a number of other congenital disorders. All of these conditions are progressive diseases with which the patient usually lives for many years and for which treatment varies substantially according to the specific disorder. However, once kidney involvement becomes so extensive that kidney function no longer keeps up the body's needs, uremia sets in and dialysis may be required.

(c) The diagnoses of diabetic renal failure, diabetic uremia, diabetic intercapillary glomerulosclerosis and chronic renal, diabetic nephropathy with chronic renal failure, or diabetic nephrosis with chronic renal failure provide a cause-and-effect relationship, which requires that code 250.4 (with fifth digit) be listed as the primary code, followed by 581.81 as the secondary code. Example:

Chronic renal failure due to insulin dependent	250.41
diabetic nephropathy	581.81
	585

(d) Hypertensive renal disease with chronic renal failure (or chronic renal failure due to hypertensive renal disease) is coded to the 403 category when it involves primary hypertension with progression to renal involvement. There is an exclusion note under 585, Chronic renal failure, which references primary hypertension with renal involvement to the 403 category.

(e) Chronic renal failure in cases where secondary hypertension is due to renovascular (renal artery) disease or a kidney disease may be coded to 585. Code 585, chronic renal failure, does not exclude secondary hypertension classifiable to category 405. Example:

Chronic renal failure with secondary hypertension	585
due to polycystic kidney disease	753.12
	405.99
Chronic renal failure with secondary hypertension	585
due to nephrotic syndrome with membranous	581.1
glomerulonephritis	405.99

Secondary hypertension may be present in acute and chronic glomerulonephritis, pyelonephritis, scleroderma, Goodpasture's syndrome, acute vasculitis with lupus erythematosus, and polyarteritis. Secondary hypertension is listed in the Table on Hypertension the volume 2.

(2) **Bladder Neck Obstruction or Obstructive Uropathy**

(a) Bladder neck obstruction or obstructive uropathy may be caused by a number of conditions, e.g., BPH (Benign prostatic hypertrophy), carcinoma of the prostate, urethral

stricture.

(b) For reporting purposes, the cause of the obstruction will be reported first. Example:

Bladder neck obstruction due to benign prostatic hypertrophy	600 596.0
Urinary retention due to BPH	600 788.2

(3) **Infections of the Urinary Tract**

(a) Multiple coding should be used when coding infections affecting the urinary tract. Many of the organisms can be identified by a review of laboratory reports, however if the organism is not documented, the coder will refer the case to the responsible medical staff member for amendment of the source document.

(b) Some common examples of infections affecting the urinary tract:

Urinary tract infection due to E. coli	599.0 041.4
Prostatitis due to staphylococcus	601.0 041.1
Monilial cystitis	112.1

k. **Musculoskeletal System and Connective Tissue**

(1) **Lupus Erythematosus**

A systemic lupus erythematosus patient admitted for chemotherapy to treat the lupus will be assigned a DXLS of 710.0. Treatment may consist of steroid therapy and/or immunosuppressive agents.

(2) **Pathological Fractures**

(a) A pathological or spontaneous fracture is one that occurs without external injury. Thus, a pathological fracture will not be assigned from the 800 category. As a general rule, these fractures can be caused by osteoporosis, malignancies, nutritional problems, osteomyelitis, and Paget's disease.

(b) A code of 733.1 will be assigned to a pathological fracture, however the DXLS should represent the condition which caused the fracture. Example:

Pathological fracture of the femur due to osteoporosis (senile)	733.01 733.1
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(c) A diagnosis of "compression fracture" due to osteoporosis will also be assigned a secondary code of 733.1.

(d) Only if the cause of the fracture is unknown, should a code of 733.1 be assigned as the DXLS.

1. **Symptoms, Signs, and Ill-Defined Conditions**

(1) Manifestations are characteristic signs or symptoms of an illness. Signs and symptoms that point to a given diagnosis are assigned to the appropriate chapter of ICD-9-CM. For example, hematuria (599.7) is assigned to the Genitourinary System chapter. However, Chapter 16 (780-799) includes ill-defined conditions and symptoms that may suggest two or more diseases or may point to two or more systems of the body. These ill-defined conditions and symptoms are usually used in cases lacking the necessary study to make a final diagnosis.

(2) In ICD-9-CM, categories 780-799 include;

(a) Cases for which no more specific diagnosis can be made even after all facts bearing on the case have been investigated, such as 784.0 Headache;

(b) Provisional diagnosis in a patient who failed to remain in the hospital for further investigation, such as 782.4 Jaundice;

(c) Signs or symptoms existing at the time of admission that proved to be transient and whose cause could not be determined, such as 780.2 Syncope;

(d) Cases transferred elsewhere for investigation or treatment before the diagnosis was made, such as 782.5 Cyanosis;

(e) Cases in which a more precise diagnosis was not available for any other reason, such as 780.7 Malaise and fatigue; and

(f) Certain symptoms which represent important problems in medical care and which might be desirable to classify in addition to the known cause, such as 780.0 Coma in a patient with a subdural hematoma. In such cases, the sign (coma) will be sequenced following the known cause (subdural hematoma).

(3) **Azotemia**

(a) Unless specified by the medical staff member as acute or chronic renal failure, a diagnosis of azotemia will be assigned a code of 790.6. This condition is produced by renal disease and can result in acute or chronic renal failure.

(b) Azotemia refers to an alteration in urinary function. It involves an elevated serum concentration of nonprotein nitrogenous compounds, primarily urea nitrogen, but also creatinine, amino acids, uric acids, creatine, and ammonia. It is produced by diminished glomerular filtration of these compounds by the kidney.

(c) The terms prerenal azotemia and postrenal azotemia, both coded 788.9, are sometimes used by physicians. Prerenal azotemia is the normal kidney's response to an extrarenal condition that produces a reduced glomerular filtration rate. It may be due to severe dehydration, congestive heart failure, or any edema forming condition, systemic hypotension or any cause of vascular pooling. Postrenal azotemia is due to diminished glomerular filtration rate and is due to urinary tract obstruction, such as incomplete obstruction of the ureter, bladder outlet obstruction, or prostatic enlargement.

(d) A code of 790.6 should not be assigned if the cause of the azotemia is known. For example, insulin dependent diabetes and nephropathies.

(4) **Respiratory Arrest**

- (a) Respiratory arrest denotes an immediate shut-down of the cardiorespiratory systems.
- (b) Respiratory arrest (799.1) is not expected to represent the DXLS except during a patient's stay of 24 hours or less which terminated in death and another diagnosis had not been established or suspected.

m. **Injury and Poisoning**(1) **Injuries**

(a) Injuries (categories 800-959) include fractures, dislocations, sprains, open and closed wounds, and other types of injuries. They are classified first according to the general type of injury. Within each type of injury, there is a further breakdown by anatomical site.

(b) Injuries classifiable to more than one sub-category should be coded separately whenever possible. The exceptions to the multiple coding principle for injuries are:

1. For primary tabulation purposes (when there is only space for reporting one code);
2. When combination codes are provided, and
3. When the diagnostic statement does not provide sufficient information. If only one code may be used to identify multiple injuries, use the code identifying multiple injuries of the type and sites specified.

(c) If the Alphabetic Index or the Tabular List provides instructions to use a combination code to identify a combination of injuries or injuries of more than one site, use the combination code rather than assign separate codes. Example:

Fracture of the ulna and radius 813.83

(d) If the diagnostic statement does not provide sufficient information to code the injuries separately, assign the code for multiple injuries of the type and sites identified. For example,

Multiple contusions 924.8

Note that the English text interpretation for this code includes multiple sites not elsewhere classified.

(e) Where multiple sites of injury are specified in the titles of volume 1, the word "with" indicates involvement of both sites, and the word "and" indicates involvement of either or both sites. The word "finger" includes thumb.

(f) Gunshot wound is coded to "wound, open, by site." If there is an injury to a blood vessel due to an open wound or any other injury, assign an additional code from categories 900-904 to indicate the blood vessel(s).

(g) Codes 806.01, 806.06, 806.11, 806.16, 952.01, and 952.06 require an additional code of 344.0. Codes 806.21, 806.26, 806.31, 806.36, 952.12, and 952.16 require an additional code of 344.1.

(h) A fracture or a fracture-dislocation not specified as closed or open should be classified as a closed fracture.

1. The following terms describe closed fractures with or without delayed healing:

comminuted	impacted
depressed	linear
elevated	march
fissured	simple
fracture, NOS	slipped epiphysis
greenstick	spiral

2. The following terms describe open fractures with or without delayed healing:

compound	puncture
infected	with foreign body
missile	

(i) When a fracture is described as having both open and closed features, assign the code representing open which is the more severe of the two types. Example: Depressed fracture, patella, with foreign body 822.1. Multiple fractures should be documented in order of severity of each fracture site. Assign a code to each. Insofar as possible, avoid using combination codes for multiple fractures.

(j) A dislocation not specified as open or closed will be coded as "closed." The following terms describe "open" and "closed" dislocations:

<u>Closed</u>	<u>Open</u>
complete	compound
dislocation NOS	infected
partial	with foreign body
simple	
uncomplicated	

(k) Note that there is a difference between an open or closed fracture and an open or closed reduction procedure.

(l) Examples of traction devices include skin traction (such as tapes); skeletal traction into or through the bone (such as with Kirschner wire or Steinmann pin); cervical spine traction (such as Barton's tongs, Crutchfield tongs and Halo skull traction). Examples of external fixation devices include: cast and splint; Steinmann pin and Kirschner wire. Examples of internal fixation devices include: screw, nail, pin, rod, metal band, plate and screws.

(m) Late effects of fractures are classified to the condition identifying the residuals, such as malunion, deformity, or paralysis, with the use of an additional code to identify the cause of the late effect. The code for the residual will be sequenced before the late effect. Example:

Status post reduction of tibia and fibula	733.81
with malunion	905.4

(n) Injuries classifiable to categories 872-897 are considered to be complicated if the diagnostic statement mentions delayed healing, delayed treatment, foreign body, or major infection. Example:

Infected lacerations of the face	873.50
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(o) Pathological/spontaneous fractures are classified to the condition specified by the clinician that has caused the fracture, such as neoplasm, nutritional disturbances, hyperparathyroidism, bone cysts, or osteoporosis, with the use of an additional code of 733.1 to identify the fracture. If the clinician specifies that the cause of the pathological or spontaneous fracture is unknown, a code of 733.1 may be assigned without an associated code.

(p) When coding late effects of any injury, assign and sequence the code identifying the residuals first using the appropriate code from categories 001-799, followed by the code identifying the cause of the late effect using the appropriate code from categories 905-909. Example:

Traumatic neuroma due to old laceration,	354.8
right arm	906.1

(Always assign the late effect code to the original injury rather than to the late effect of the nerve injury).

(q) "E" codes will be used to describe injuries incurred in actual and attempted suicides (E950.0-E950.5).

(2) Spinal Cord Impairments (SCI)

(a) A spinal cord patient may be defined as a person who has incurred trauma to or disease of the spinal cord or cauda equina which has resulted in a paraplegia or quadriplegia. Diagnostic statements representing complete lesions of the cord will thus require an additional diagnostic statement representing paraplegia or quadriplegia. Complete lesions are readily discernible in the following codes: 806.01, 806.06, 806.11, 806.16, 806.21, 806.26, 806.31, 806.36, 952.01, 952.06, 952.11, and 952.16. As will be discussed in the subparagraphs that follow, a complete lesion of the cervical region of the cord will result in quadriplegia; a complete lesion of the thoracic region of the cord will result in paraplegia. Concussions of the cord are usually evidenced by a history of temporary paresis experienced at the time of injury, but without permanent disability. Incomplete lesions of the cord will result in some, but not total, sensory and/or motor deficits below the level of the injury. Patients who sustain incomplete lesions may recover some functions. Paraplegia or quadriplegia will always be coded when identified by the physician in a diagnostic statement.

(b) A spinal cord patient is usually admitted because of one of the following conditions:

1. The patient has sustained a "recent" injury of the spinal cord;
2. The patient has involvement of the spinal cord due to a disease process;
3. The patient has experienced a condition or sequela common to spinal cord patients;
4. The patient has experienced an unexpected and unrelated condition to the spinal cord problem; or

5. The spinal cord patient has been determined to need a general examination with additional tests that can only be provided on inpatient services.

(c) Recent Injuries

1. A "recent" spinal cord injury may be defined as one which prompts the admission of a patient to inpatient services within a few hours to a few weeks after the spinal cord injury, or causes the transfer of the spinal cord patient from one facility to another for the implementation and/or continued treatment of the spinal cord injury.

2. As a general rule, when the spinal cord is injured in the cervical region, quadriplegia will result. Probably the most common traumatic spinal cord diagnoses which will result in quadriplegia are the "recently incurred" open and closed fractures of the cervical vertebrae with spinal cord injury, and the "recently incurred" cervical spinal cord injuries without evidence of spinal bone injury. (See ICD-9-CM diagnostic categories of 806.0, 806.1, and 952.0.) The episode of hospitalization for the "recently" injured patient is usually characterized by a long length of stay, during which time a number of other conditions or complications may occur. The final diagnoses, however, should be ranked, coded, and reported first by the DXLS and then in order of clinical importance as documented by the medical staff member who prepared the discharge summary, or transfer/discharge notes. For example, the final diagnoses could be documented, ranked, and coded as follows:

Result	X Quadriplegia	344.0
Recent Injury	Closed fracture C-7 with cord lesion	806.06
Other condition	Acute cystitis, E. Coli	595.0 041.4

3. As a general rule, when the spinal cord is injured in the thoracic region, paraplegia will result. Probably the most common traumatic spinal cord diagnoses which will result in paraplegia are the "recently incurred" open and closed fractures of the thoracic vertebrae with spinal cord injury, and, the "recently incurred" thoracic spinal cord injuries without evidence of spinal bone injury. (See ICD-9-CM diagnostic categories of 806.2, 806.3 and 952.1.) The episode of hospitalization for this "recently" injured patient is also characterized by a long length of stay during which time, complications may occur. The final diagnoses should be ranked, coded, and reported by the DXLS and then in order of clinical importance as documented by the medical staff member who prepared the discharge summary, or transfer/discharge notes. For example, the final diagnoses could be documented, ranked, and coded as follows:

Result		X Paraplegia
344.1		
Recent Injury	Penetrating gunshot wound	876.1 back (with) T-9 perforation of cord952.16
Other Condition	Neurogenic bladder	344.61

4. Since the cord ends at the level of the first lumbar vertebrae, an injury to the lumbar area of the spine may result in paraplegia or paraparesis due to trauma of the cauda equina. Therefore, the most common condition which will evolve from an injury to

or below the lumbar area is a cauda equina syndrome. Again, the diagnoses should be ranked, coded, and reported first by the code representing the DXLS and then in order of clinical importance as documented by the medical staff member. For example, diagnoses could be ranked and coded as follows:

Recent Injury	Fracture, lumbar spine (with)	805.4
Other Condition	X Cauda equina syndrome	344.61
Result	Paraplegia	344.1

NOTE: *It is highly unlikely that the DXLS for a long term spinal cord injury would be assigned a code of a recent injury. For long term spinal cord patients, the DXLS should be reported as paraplegia or quadriplegia.*

(d) **Nontraumatic Diseases.** There are multiple (nontraumatic) diseases of the spinal cord and cauda equina which may result in paraplegia or quadriplegia. Among the most common of these are spinal cord abscess, spinal cord cyst, and intraspinal neoplasms. Following the rationale discussed, when the disease affects the spinal cord in the cervical area, quadriplegia will most likely result; when the disease affects the spinal cord in the thoracic region or the cauda equina, paraplegia or paraparesis will most likely result. Again, however, the final diagnoses should be ranked, coded and reported first by the DXLS and then in order of clinical importance as documented by the medical staff member. For example, the diagnoses could be ranked and coded as follows:

Result	X Paraplegia	344.1
Disease	Spinal cord thrombosis	336.1

OR

Disease	X Inoperative carcinoma lung with metastasis to the thoracic spine and brain	162.8 198.5 198.3
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(e) **Conditions Common to Spinal Cord Patients**

1. Among the sequelae common to traumatic or disease-originated spinal cord patients are urinary tract infections; neurogenic bladder; fracture of a bone due to a fall from a wheelchair, litter, bed, etc.; and decubitus ulcer which results from prolonged pressure of the skin overlying a prominence of bone.

2. As a general rule, when the sequela is the reason for readmission to any medical center, that condition will also be responsible for the greater portion of the hospital stay. Being responsible for the hospital admission, the condition will be coded and reported as the DXLS. In addition, however, further information must be coded and reported which describes the status of the spinal cord trauma or disease, and its result.

a. The status of a readmitted traumatic spinal cord patient will not be coded and reported as a "recent" injury. ("Recent" injuries are described.) The status of a readmitted traumatic spinal cord patient will, however, be coded and reported as a "Late Effect of Spinal Cord Injury." (See ICD-9-CM diagnostic code 907.2) For example, the diagnoses for a readmitted traumatic paraplegic who sustained a fracture as a result of a fall from a wheelchair should be ranked and coded as follows:

DXLS	X Intertrochanteric fracture, closed left	820.21
Old condition	Paraplegia	344.1
Late effect	Old spinal cord injury	907.2

b. The status of a readmitted (non-traumatic) diseased spinal cord patient can be coded and reported in one of two ways: as a "late effect" or as an exacerbation of an existing disease. The following are examples which show the correct ranking of diagnoses in each of these two ways:

DXLS	X Decubitus ulcer, buttocks	707.0
Old condition	Paraplegia	344.1
Old condition	Old (spinal cord) epidural abscess	326

OR

Exacerbated condition	X Metastatic carcinoma thoracic spine with compression	198.5 V10.11
Result	myelopathy	336.3
	Paraplegia	344.1

(f) Unexpected and Unrelated Conditions. Unexpected and unrelated conditions experienced by the spinal cord patient follow the full gamut of diseases to which any other person is subject. As a general rule, the unexpected conditions are also usually the reason for readmission to inpatient care. Furthermore, the condition is most likely to be responsible for the greater portion of a patient's hospital stay. Again, the spinal cord status and result must also be noted. For example, the final diagnoses should be ranked and coded as follows:

Unexpected condition	X Myocardial infarction anterolateral wall	410.01
Old condition	Paraplegia	344.1
Late effect	Old spinal cord injury	907.2

(g) General Examinations and Tests

1. The spinal cord patient may be admitted for a general examination and/or additional tests that can only be provided on inpatient services. On occasion, the result of the examination and/or tests may provide a diagnosis indicative of a condition common to spinal cord patients or a diagnosis unrelated to the spinal cord patient. On still other occasions, the patient is simply followed; a new or additional diagnosis is not made.

2. As a general rule, the diagnosis uncovered as the consequence of the examination and/or tests should be the same as the DXLS.

3. When a new diagnosis is not made, the DXLS should be one representing a follow-up examination or observation and evaluation for a suspected condition. (See ICD-9-CM diagnostic categories of V67 and V71.) The status of the spinal cord disease or injury and its result should also be stated, but only following that of the applicable follow-up or observation diagnosis. For example, the final diagnoses should be ranked and coded as follows:

DXLS	X Observation for suspected kidney malignancy, none found	V71.1
Old condition	Paraplegia	344.1
Old condition	Old spinal cord injury	907.2

OR

DXLS	X Follow-up examination for	V67.59
Old condition	Quadriplegia	344.0
Old condition	Old spinal cord injury	907.2

(h) It should be noted that paraplegia and quadriplegia may also result from trauma to or disease originating in the brain. A diagnostic code of 437.80, Cerebral/brain quadriplegia, or 437.81, Cerebral/brain paraplegia, will be assigned to describe these cases. Brain originated paraplegia or quadriplegia may be reported as the DXLS. Probably, the most common brain originated conditions which can result in quadriplegia or paraplegia are cerebral thrombosis, brain stem infarction, and brain tumors. Again, the emphasis will be placed on the ranking or sequencing of diagnoses, which is primarily the responsibility of the medical staff member.

(i) For PTF reporting purposes, all cases of spinal quadriplegia (344.0) and spinal paraplegia (344.1) will be substantiated by the use of a numeric code in the block designated as Spinal Cord Indicator. The code used will further specify whether the paraplegia or quadriplegia is due to a traumatic or non-traumatic (disease) process. The codes which follow are the only appropriate entries for this block:

- 1-(Spinal) Paraplegia, traumatic
- 2-(Spinal) Quadriplegia, traumatic
- 3-(Spinal) Paraplegia, non-traumatic (disease)
- 4-(Spinal) Quadriplegia, non-traumatic (disease)

(i) All other discharges including those cases diagnosed as brain originated quadriplegia and paraplegia will be substantiated by the use of an alpha code of "X" in the block designated as Spinal Cord Indicator. The numeric codes of 1, 2, 3, or 4 are not applicable to cerebral/brain originated paraplegia or quadriplegia.

(3) Burns

(a) With the exception of sunburn (692.71) and friction burns, codes appearing in categories 940-949 will be used for coding burns due to chemicals and other causes

(b) Burns are classified according the degree of burn except for

1. Burns of the eye and adnexa (940) which are classified according to the agent causing the burn; and
2. Burns of internal organs (947) which are classified according to the site of the burn.
3. Degrees of burns:
 - a. First degree burns indicate erythema

b. Second degree burns indicate blisters and skin loss

c. Third degree burns indicate full thickness skin loss

(d) Burns of the same site but of different degrees should be classified to the highest degree in the subcategory listed. For example;

First and second degree burns of leg.	945.20
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(e) If a burn becomes infected, assign a code first for the burn, but also assign an additional code of 958.3 to identify the infection. For example;

Second and third degree burns of abdominal wall, infected	942.33 958.3
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(f) Category 948 may be used

1. As a solo code when the site of the burn is not specified, but the percent of the body burned is mentioned; or

2. As an additional code when the site of the burn is specified.

3. Category 948 is used to indicate the percent of body surface involved with third degree burns. Coders will always assign the appropriate fifth digit when using this category. If the total percent of body surface is specified and there is no percentage for third-degree burn or the percent for third-degree burn is less than 10 percent, use the fifth digit "0". Example:

Third degree burns, back, 15 per cent	942.34 948.11
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(g) Category 949 should not be used. When neither the site nor the percentage of body surface of the burn is specified in the diagnosis, refer the case to the responsible medical staff member.

(h) Internal and external chemical burns are classified to categories 940-949. Example:

Lye burns of the esophagus (accidental ingestion)	947.2
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(4) Complications of Care

(a) For the purpose of this subparagraph, a complication is a condition which

1. Arises during an episode of inpatient care and which modifies the course of a patient's illness;

2. Arises following an episode of inpatient care and necessitates another period of inpatient care; or

3. Arises during an outpatient encounter requiring and necessitating an episode of inpatient care.

(b) Many of the postoperative complications are classified in the categories 996-999. The excludes note in volume 1, page 867, should be carefully reviewed before assigning

a complication code. Of particular significance are the last three lines of the exclusion note which state: "any condition classified elsewhere in the Alphabetic Index when described as due to a procedure." Thus postoperative complications may also appear in categories 001-799. A code identifying a postoperative complication will be sequenced as the DXLS if no further qualifying primary diagnosis arises during the episode of care.

(c) A condition which is specified as a "complication" or "postoperative," and which does not have a specific subentry in the Alphabetic Index will be coded to the appropriate code in categories 996-999. An additional code, when possible, will be used to identify the anatomical site or the manifestation of the complication. When multiple coding is used, the sequencing of these codes is important. Thus, the codes from categories 996-999 take precedence in sequencing when an additional code is used for specificity.

(d) Before assigning an additional code for use with codes 996-999, refer to volume 1 to be sure the title of the code does not alter the diagnostic statement.

(e) Subcategories/subclassifications codes 996.0-996.5 are for mechanical complications resulting from various prosthetic devices or implants. A code of 996.01 will be used for pacemaker malfunction and for those cases recalled at the request of the manufacturer. The remaining codes in category 996 are for physiological complications. For example, complications or rejections following organ or tissue transplants (See category 996.8). As a general rule, when an admission occurs because of a complication and/or rejection of a previously transplanted organ/tissue, the DXLS code will be assigned from the 996 category and a secondary code from the V42 category will be assigned showing the presence of a transplanted organ (if the organ is not removed during the current episode of care).

(f) In ICD-9-CM, differentiation is made between long-term postoperative cardiac complications and those that occur in the immediate postoperative period. In reference to codes 997.1 and 429.4 only, ICD-9-CM defines the immediate postoperative period as "the period between surgery and the time of discharge from the hospital." Subcategory 997.1 classifies immediate cardiac complications resulting from any type of procedure; whereas subcategory 429.4 classifies long-term cardiac complications resulting from cardiac surgery.

(g) Sub-category codes 999.0 through 999.9 will be used when the diagnostic statement specifies that condition as a complication resulting from medical care. Carefully read the inclusion and exclusion terms.

(h) Sub-category code 999.9 will not be used alone to indicate a complication of medical care when the specific condition is not mentioned by the responsible physician.

(i) Coding personnel should thoroughly review the record to ascertain whether the condition requiring hospitalization was in fact a complication or aftercare. An admission for aftercare is usually scheduled, whereas an admission for complication of surgical or medical care occurs at the time the complication develops. Example:

Admitted for removal of pins from femur (Aftercare)	V54.0
Admitted following by-pass graft (at non-VA hospital)(Aftercare)	V58.4 V45.81

History of coronary heart bypass with infection(Complication) 998.5

(j) Occlusion of Coronary Bypass Grafts

1. Coronary artery bypass grafts (usually using the patient's own saphenous leg vein or internal mammary artery) may become totally or partially occluded after CABG (coronary artery bypass graft) surgery because of one or more of the following reasons:

- a. Thrombus (clot) formation which may occur within 1 month of surgery to 1 year following surgery (996.72);
- b. Atherosclerotic plaques which usually occur from one to 5 years after surgery 996.03 (414.0);
- c. Fibrointimal proliferation (hyperplasia) which usually occurs 10 years postoperatively (996.03); or
- d. Failure of the graft to maintain patency (996.03).

2. **Note:** *Occlusion of coronary bypass grafts are assigned to complications peculiar to certain specified procedures.*

(k) The DXLS for patients admitted to inpatient services due to complications of ambulatory surgery should reflect the medical or surgical complication which necessitated the admission. The secondary diagnosis should reflect the condition/diagnosis for which the procedure was performed. The procedure performed in ambulatory surgery will be reported using Transaction Type 401. Thus, a hernia patient who experienced atrial fibrillation while undergoing repair will be assigned the following codes:

Atrial fibrillation	427.31
Indirect inguinal hernia, left	550.90
Repair, indirect inguinal hernia, left	53.02

(l) Other examples of complications:

Postmastectomy lymphedema syndrome	457.0
Postgastric surgery syndromes	564.2
Colostomy and enterostomy malfunction	569.6
Functional disturbances following cardiac surgery	429.4
Complications following mastoidectomy	383.32
Postoperative cerebral embolism	998.8 and 434.1
Postoperative pulmonary embolism	998.8 and 415.1
Postoperative acidosis	998.8 and 276.2
(See page 867, excludes electrolyte imbalances)	
Postoperative respiratory insufficiency	518.5
(See page 872, excludes note under code 997.3)	
Site of persistent postoperative fistula	998.6
Failure of small bowel postoperative fistula to resolve	998.6 and 569.81
Talc (talcum powder) peritonitis	998.7
is an inclusion term.	

Postoperative thrombophlebitis, deep veins of calves following hysterectomy would be coded 997.2 with an additional code to identify site, such as femoral 451.11.

(5) Poisonings and Adverse Effects

(a) A poisoning may result when foods, drugs, and other substances are given or taken in error. For example, a drug may be given in error during a diagnostic or therapeutic procedure. A drug may also be given in error by one person to another; or it may be taken in error by the patient. Medications taken in combination with alcohol can also produce a poisoning. These latter poisonings are known as accidental poisonings.

(b) A poisoning may also result when a drug is consumed in suicide or homicide attempts. This type of poisoning is known as a purposeful poisoning.

(c) Both types of poisonings are classified to Category 960-989.

(d) To code poisoning by drugs or chemicals:

1. Determine by a review of the record if the substance was given or consumed in error; or if the substance was given or consumed in a homicide/suicide attempt. A poisoning can be identified by the use of such terms as intoxication, overdose, toxic effect, poisoning, wrong drug or wrong dose given or taken in error.

2. Reference the Alphabetical Index to Poisoning and External Causes of Adverse Effects of Drugs and Other Chemical Substances for the drug/chemical identified in the diagnostic statement.

3. Assign codes showing

a. First, the code for the poisoning (960-989). If the drug which caused the poisoning is not listed in the Table of Drugs and Chemicals, refer to the Index of the AHFS (American Hospital Formulary Service). If the drug is not listed in the Formulary, assign a code of 977.8, Other Specified Drugs and Medicinal Substances.

b. Secondly, assign one or more codes for the effect the poison had on the patient, e.g., coma, vertigo, etc.

c. Lastly, assign the "E" code, but only if the substance was given or consumed in a suicide or homicide attempt. Therapeutic Use "E" codes do not apply to poisonings and will not be used.

4. Example:

Coma due to accidental overdose of Librium	969.4 780.0
Coma due to suicide attempt (Librium)	969.4 780.0 E950.31

(e) Poisonings may also cause late effects. A late effect is defined as the presence of a residual condition which was caused by a previous illness or injury. The code identifying poisoning as the cause of a late effect is 909.0. An "E" code will be used when the late effect is designated as caused by an attempted suicide.

(f) To code a late effect of a poisoning:

1. Identify and assign a code(s) to the condition resulting from the poisoning by reviewing the diagnostic statement and record content.

2. Secondly, assign a code of 909.0; and

3. If appropriate, assign the "E" code which identifies the late effect of the suicide.

4. Example:

Anoxic brain damage due to suicide attempt with sleeping pills 2 years ago	348.1 909.0 E959
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(g) An adverse effect can occur even if a substance is properly administered. The reaction results because of the interactions between medications, or because of a patient's age, sex, disease, or genetic factors. Many adverse effects produce allergic reactions or drug intoxications. An adverse effect of a medicine taken in combination with alcohol is coded as a poisoning. An adverse effect resulting from a prescribed drug in combination with a medication a patient took on their own initiative such as aspirin, antihistamines, etc., is also coded as a poisoning.

(h) To code an adverse effect of a substance properly administered:

1. Review the diagnostic statement and record content for identification of key words which are sometimes used to describe adverse effects, e.g., allergic reaction, accumulative effect, idiosyncratic reaction, hypersensitivity, side effects, toxicity, intoxication. Also identify the presenting manifestation(s) of the adverse effect.

2. Reference the alphabetical index to Poisoning and External Causes of Adverse Effects of Drugs and Other Chemical Substances for the drug identified in the diagnostic statement.

3. Assign codes showing:

a. First the code for the effect the drug had on the patient (coma, vertigo, etc); and

b. Secondly, the "E" code from the "Therapeutic Use" column in the table previously referenced.

4. Example:

<u>Vertigo</u> due to (prescribed) Valium	780.4 E939.4
Allergic <u>rash</u> due to penicillin (injection)	693.0 E930.0
Coumadin intoxication with <u>hematuria</u>	599.7 E934.2
Urticaria due to allergic reaction to tetracycline	708.0 E930.0

(i) ICD-9-CM provides a code to identify an adverse drug reaction in which the manifestation or nature of the adverse reaction is not specified, 995.2.

(j) Adverse reactions may also cause late effects. Before coding a late effect of an adverse reaction, determine whether a manifestation(s) from the previous adverse reaction is mentioned in the diagnostic statement.

1. When there is mention of a previous manifestation(s):

a. First, assign a code for the residual of the late effect; and

b. Secondly, assign the "E" code which represents the late effect. (See E930-E949.)

c. Do not assign a code for the previous manifestation. Example:

Brain damage due to old cerebral anoxia	348.9
due to previous allergic reaction to penicillin	E930.0

2. When there is no mention of a previous manifestation(s):

a. First, assign a code for the residual of the late effect; and

b. Assign a code from the 909 category. A code of 909.9 is used to identify the cause of the late effect when the manifestation of previous allergic reaction is not specified.

c. Assign the "E" code which represents the late effect. (See E930-E949)

d. Example:

Brain damage due to previous allergic	348.9
reaction to penicillin	909.9
	E930.0

3. Although codes are available to report unspecified manifestations, if the residual condition is not specified in the diagnostic statement, refer the case to the medical staff member for clarification.

(k) Long term chronic effects of drugs taken over a period of time and still being taken at the time chronic effects arise, are coded as an adverse reaction to the correct substance properly administered. For example;

Cardiac arrhythmia due to digitalis intoxication	427.9
	E942.1

(l) Delayed chronic effects of drugs that occur or are present a long time after the use of the drug has been discontinued are coded as late effects of either poisoning or adverse reaction to a correct substance properly administered, depending on the circumstances. Example:

Anoxic brain damage due to accidental	348.1
barbiturate overdose, 1 year ago.	909.0
	E929.2

(m) Dermatitis due to allergic reaction to drugs assigned a code from the 692 category if the medication was applied to the skin. If the medication was taken internally and dermatitis presents as an allergic reaction, assign a code from the 693.0 category.

(n) Aluminum Overloading

1. Excessive aluminum in the body may be associated with dementia and/or progressive bone disease. Increased aluminum content appears to have a direct effect on the brain, while in the bone, it blocks normal deposition. The usual source of aluminum is parenteral and may be found in the water used with renal dialysis and with long-term total parenteral alimentation. Though aluminum is poorly absorbed in the intestinal tract, small amounts may collect in the body with use of aluminum continuing antacids. With the recognition of aluminum intoxication, care in the selection of water source and in the use of aluminum containing antacids should decrease the frequency of problems caused by increased aluminum content in the body.

2. Excessive concentration of aluminum in the body is classified first to the poisoning; then to the manifestation; and finally the comorbid condition. For example:

985.8	Toxic effect of other metals (due to water, renal dialysis therapy, or total parenteral nutrition)
294.8	Dialysis dementia (manifestation of aluminum intoxication)
585	Chronic renal failure (comorbid condition)

o. "V" codes

(1) "V" codes are used to identify encounters with health care facilities for reasons other than an illness or injury classified to categories 001-999. Some key words often used in diagnostic statements which may be applicable to the use of a "V" code are: admission; attention to; examination; fitting; follow-up; history of; observation; problem with; status; and screening.

(2) Persons with potential health hazards related to communicable disease (V01-V08) are generally treated in outpatient settings. The patient who is hospitalized for a suspected communicable or infectious disease will not be assigned a code from this category. Rather, the code for the actual infectious or communicable disease will be used or an appropriate code from the V71 category will be selected. Codes in the V01-V08 category may be used to report secondary diagnoses.

(3) Codes for persons with potential health hazards related to personal and family history (V10.0-V10.5 and V10.71 through V19) will be reported as supplementary information when appropriate. They will not be reported as the DXLS.

(a) It is necessary to report codes in the V10 category in order to provide a complete picture of the patient's diagnosis or episode of care. For example, a code of V10.05 will be assigned to describe a diagnosis of "carcinoma, ascending colon, no evidence of recurrence." Although the V10.05 cannot be reported as the DXLS, it can explain the reason for patient follow-up, V67.1. For example:

Follow-up for carcinoma, ascending colon, no evidence of recurrence	V67.1 V10.05
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A secondary code of V10.60 will be assigned the leukemia patient who is in remission, but primarily treated for another condition. Example:

Acute and chronic tonsillitis	463
Leukemia, in remission	474.0 V10.60

A DXLS code of V10.60 will be assigned the leukemia patient in remission when the patient is admitted for a bone marrow transplant.

(b) Codes in the range of V11.0-V19.8 should not be used unless they relate to the current episode of care; when a medical staff member is interested in tracking patients who have a family history of neoplasm; or as required by this chapter. For example, a code of V15.5 will only be used to report patients identified as TBI (traumatic brain injury) patients. A TBI is defined as an insult to the brain not of a degenerative or congenital nature but caused by an external physical force that may produce a diminished or altered state of consciousness which results in impairment of cognitive abilities or physical functions. It can also result in the disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustment. Some of the more common diagnoses which may indicate a current or old TBI are fractures of the skull (800-804); cerebral concussions, contusions, and lacerations (850-851); intracranial hemorrhages due to injuries (852-854); epilepsy (345); and some non-psychotic mental disorders due to organic brain damage (see (310)). Conditions believed to represent a late effect of a skull fracture, intracranial injury, or cranial nerve injury (905 and 907) may also indicate an old TBI. For example:

851.04	Cerebral contusion
V15.5	Traumatic brain injury

(4) Codes for persons with a condition influencing their health status (V40-V41) are more applicable for recording reasons for ambulatory care encounters. For inpatient releases, the actual condition, the suspected condition, or condition ruled out should be reported.

(5) Codes appearing the range of V42-V46 will always be used when applicable, to describe postsurgical states which impact upon the care rendered the patient during the episode of hospitalization. A review of codes in Appendix A will show that some of the codes in the range of V42-V46 impact upon resource allocation: Organ or tissue transplants and other replacements, other postsurgical states, and dependence on respirator. For example, a 73 year old pacemaker recipient may be hospitalized for acute hemorrhagic glomerulonephritis. The pacemaker status will be coded because its presence always presents a problem in the delivery of care:

Acute hemorrhagic glomerulonephritis	580.9
Pacemaker-in-situ	V45.0

When the postsurgical state represents the reason for admission and requires treatment, however, a code will be selected from the V51-V55, V57-V58 or 996-999 categories. If a complication is the reason for admission, the complication should be coded rather than

the V code for the postsurgical state. In the example that follows, note that a code of V44.3 is not assigned:

Colostomy status with colostomy malfunction	569.6
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Codes appearing in the range of V42-V46 will not be used for reporting the DXLS. Codes V47-V49 may be used to report impairments noted while the patient is treated for some other condition; however, the medical staff member should be queried to provide a more definitive diagnostic entity which describes the problem.

(6) Categories V51-V55 and V57-V58 may be used to classify the reason for care in patients who have been previously treated for a disease or injury. Included in these categories are aftercare, fitting of devices, rehabilitation, and maintenance chemotherapy. As a general rule "aftercare" cases are scheduled for admission.

(a) When patients are released from organized rehabilitation services, bed section 20, a diagnostic code from the ICD-9-CM category V57 may be assigned as the DXLS. In such cases, a secondary code should be assigned which describes the condition for which rehabilitation services were provided. For example, a patient may be admitted to medicine, bed section 15, because of a stroke which resulted in hemiplegia. The patient may subsequently be transferred to rehabilitation medicine, bed section 20, for physical therapy prior to being discharged. Bed section 15 may carry a DXLS of 436 and a secondary diagnosis of 342.9. However, bed section 20 may carry a DXLS of V57.1 with a secondary diagnosis of 342.9. Depending on the length of stay on rehabilitation medicine, the DXLS as reported on the 701 could well be V57.1. The secondary diagnoses reported on the 702 could be reported as 342.9 and 436 respectively. Patients who have received care in an alcohol/drug or PTSD rehabilitation program will not be assigned a DXLS from the V57 category.

(b) Patients admitted for health instruction, such as in diabetic teaching will be assigned a code of V65.4. A code from the V57 category will not be used.

(c) If a malignancy patient is admitted for chemotherapy or radiation therapy, a V code (see V58) will be assigned as the DXLS. A secondary code representing the active malignancy (140-208) or the malignancy in remission/by history (V10.0-V10.9) will be assigned. Example:

Admitted for chemotherapy	V58.1
Hodgkin's disease, in remission	V10.72

(d) Category V58.4, Other aftercare following surgery, will be used for patients returning to a VA medical center following surgery/care under contract or sharing in a non-VA facility. For example, a patient with a diagnosis of coronary artery arteriosclerosis may be transferred from a VAMC to a non-VAH for a 4 vessel aortocoronary artery bypass procedure. Codes of 414.0 plus 36.14 will be assigned the episode of non-VA care. When the heart-lung machine is used, a code of 39.61 will also be reported. It is not unusual for this patient to be scheduled for readmission to the VAMC following a stay of 1 or more days in the non-VA hospital. In such instances, the primary diagnosis for the episode of VA care will be that for aftercare following Surgery, V58.4. As a general rule, when the condition has been abated or resolved by therapeutic intervention in a non-VA hospital, a code representing the aftercare status

will be assigned as the DXLS. Conversely, when the patient is readmitted to the VA medical center and the condition has not been abated by therapeutic intervention, the condition should be representative of a condition for which diagnostic intervention was initiated. For example, a VA medical center patient may be transferred to the non-VA hospital for a diagnostic procedure, videosigmoidoscopy (45.23), to determine the presence of a colorectal neoplasm (RO sigmoid malignancy). The results of the exam may reveal only colon redness and spasm, which did not support the working diagnosis of the primary care provider. There was no surgical intervention, e.g., incision, excision, drainage, resection, etc. Thus, the post referral diagnosis of acute and chronic colitis, 558.9, would probably be reported as the DXLS for both the VA medical center and the non-VA episodes of care. The non-VA procedure, videosigmoidoscopy, will also be reported.

(e) A code of V58.8 will be used to show the care provided a patient admitted to have medication(s) regulated or changed. When medications are regulated, the dosage may be increased or decreased. Caution will be exercised, however, before assigning the code of V58.8 because the need to change the medication may be due to an adverse effect of a previously prescribed drug. Instructions for coding adverse effects appear in subparagraph n(5). As a general rule, the code of V58.8 will not be assigned diabetics. When medications are increased or changed for these patients, the possibility exists that the diabetes is complicated by hypoglycemia (251.2) or out of control (see 250.9). These and other like cases should be evaluated with the responsible medical staff member.

(7) One-Day Stay Dialysis Treatment

(a) The maintenance dialysis program is a service provided only to outpatients. Thus, patients receiving maintenance dialysis treatment (V56) will not be reported into the PTF system.

(b) Maintenance dialysis can be defined as the treatment rendered the patient with chronic renal failure who will require repeated dialysis treatments in order to maintain life (unless the patient receives a successful kidney transplant). Some examples of diseases which may result in chronic renal failure are chronic glomerulonephritis, polycystic kidneys, nephrosclerosis, chronic pyelonephritis, and hypertensive nephrosclerosis. Generally, patients receiving maintenance dialysis treatment will have been initially diagnosed and treated during a prior episode of hospitalization in a VA medical center and referred to the dialysis program for maintenance dialysis treatment.

(c) Occasionally, a dialysis patient may be admitted to an inpatient service for a 1-day stay and/or for some purpose other than for dialysis treatment. During the 1-day stay, however, the patient may be found to be in need of and receive dialysis treatment. In a situation of this type, the diagnosis responsible for the admission of the patient will be reported and a secondary code of V45.1 will be reported. The code of V45.1 will not be used to report the DXLS. The dialysis treatment procedure code will not be reported.

(d) The dialysis patient who is transferred to a bed unit from the Dialysis Unit for 2 or more days will be reported into the PTF system. The clinical complication responsible for the extended stay or death of the patient will be reported; a code for the chronic renal failure will be reported; and a code of V45.1 will be reported. As a general rule, the diagnosis representing the complication and/or other clinical condition

for which treatment was rendered will be reported as the DXLS. A diagnostic code of V56.0 or V56.8 will not be reported. The procedure transaction will be used to report the dialysis treatment in addition to other non-surgical therapy rendered.

(e) Selected codes within the range of V60-V68 may be used to identify a DXLS as specified by the medical staff member. For example, a code a V63.2 may be used to identify patients awaiting transfer to another facility. A code of V66 may be used to identify patients released from nursing homes if the care was primarily devoted to convalescence. Many patients may be admitted for follow-up of previously treated conditions (V67). Although most frequently incurred, follow-up is not limited to those patient with previously treated malignancies. Always assign a secondary code which represents the reason for follow-up. The following code assignment will be made depending upon the individual record:

Follow-up examination	V67.0
Status post 4-vessel aortocoronary bypass	V45.81
Follow-up examination	V67.59
Post CVA (no residuals)	V12.5
Follow-up examination	V67.2
Status post prostatectomy with chemotherapy and radiation therapy, no evidence of recurrence	V10.46

Other codes in the range of V60-V68 will only be used to report secondary or supplementary information. For example, category V64 addresses procedures which are cancelled. Procedures which are cancelled are discussed in subparagraph (9). Frequently used, but primarily an inaccurate diagnostic statement for follow-up is that of "Status Post." When this term is used, the coder is advised to review the content of the summary and the entire record to determine if the physician actually means that the patient was admitted for follow-up, or for one or more symptoms, the etiology of which could not be determined by examination and/or tests. For example, a diagnosis of "status post suture of gastric ulcer" may be made in the case of a patient admitted for abdominal pain (of undetermined etiology). In this case, a code of 789.0 should be assigned the abdominal pain. "Status post suture, gastric ulcer" may also appear on the record of a patient in abdominal pain but whose pain resolved following ingestion of milk of magnesia. In this case, the clinician should be queried as to whether the patient had constipation. Finally, a diagnosis of "status post suture, gastric ulcer" could actually reference a patient admitted for follow-up. A code of V67.9 should not be used as it indicates that the medical record is devoid of any reference to the condition for which the patient was followed.

(8) Respite Care

(a) Most chronically ill persons who do not need hospital services can be more effectively cared for at home. At the same time, there is also recognition that such arrangements for care of a patient at home place severe physical and emotional burdens on the caregiver and the household generally. The clinical objective of providing institutionally based respite care is to support the caregiver's role in caring for the chronically ill veteran at home. The critical element of respite arrangements is that the respite is planned in advance for the benefit of the caregiver, rather than being incidental to the provision of necessary medical care of the patient.

(b) Until October 1, 1990, the bed section code assigned each Respite patient will reflect the bed service on which the patient was housed, e.g., Medicine, Surgery, Neurology, Psychiatry, Nursing Home Care Unit. A bed section code of 83 will not be assigned. The ICD-9-CM code representing the clinical condition for which the patient was receiving Respite Care will be reported as the DXLS, and a secondary code of V60.5, Holiday Relief Care will be assigned. For example, a patient with Alzheimer's Disease requiring Respite Care may be admitted to Neurology Service, bed section 10. A DXLS code of 331.0 will be assigned for the Alzheimer's Disease; and a secondary code of V60.5 will be assigned.

(c) On and after October 1, 1990, the bed section code assigned will be consistent with the provisions of MP-6, Part XVI.

(9) **Cancelled Procedures**

(a) Surgical procedures which are cancelled or aborted will be coded as far as the procedure progressed:

1. If the patient changes their mind and refuses to have the procedure performed, a code will be assigned to the condition which justified the planned procedure, and a code of V64.2 will be assigned. A procedure code will not be assigned.

2. If the patient develops a complication, such as atrial fibrillation prior to the incision and the surgery was cancelled, a code will be assigned to the condition which justified the planned procedure; a code for the complication will be assigned; and a code of V64.1 will be assigned. An operative/procedure code will not be assigned.

3. If the patient develops a complication after the incision was made but before the site or cavity was entered and the surgery was cancelled, a code will be assigned to the condition which justified the planned surgical procedure; a code will be assigned to the complication; a code of V64.1 will be assigned; and a code for the incision will be assigned.

4. If the patient develops a complication after the site or cavity was entered but before the therapeutic procedure commenced and the surgery was cancelled, a code will be assigned which justified the planned surgical episode; a code will be assigned the complication; a code of V64.1 will be assigned; and a code for the exploratory procedure (i.e., exploratory laparotomy) will be assigned.

5. If during a procedure such as a cystotomy to extract a ureteral calculus, the calculus could not be removed, assign a code of 57.19, Cystotomy, only. Do not assign a code from the V64 category. The same principle applies to an unsuccessful attempt to pass an endoscope to the site of a stone in the ureter. If the endoscope was passed into the ureter, assign a code of 56.31, Ureteroscopy. If the endoscope could not be passed into the ureter, assign a code of 57.32, Cystoscopy. A code from the V64 category will not be assigned. Often, a surgeon may plan extensive abdominal surgery only to find, after entering the abdominal cavity, widespread metastatic lesions involving practically all visible organs. The surgeon may decide to terminate the procedure, and close the abdomen. In such cases, a procedure code of 54.11 exploratory laparotomy will be assigned. A code from the V64 category will not be assigned.

6. A code of V64.1 will be assigned when a reduction of closed fracture is attempted but not accomplished. A procedure code will not be assigned since there is no code for failed closed reduction of a fracture.

(b) A code of V64.3 will be assigned only when administrative problems are incurred, such as when an operating room has been closed due to unforeseen circumstances and the patient must be discharged and readmitted at a later date for the planned procedure.

(c) A code in the V64 category cannot be reported as the DXLS.

(10) O & E (Observation and Examination) Cases and Other Examinations

(a) CFR (Code of Federal Regulations) 17.45 authorizes hospitalization for observation and physical examination of both veteran and non-veteran patients. Most frequently, however, the patient is a veteran who has filed a claim for compensation at a VA regional office. When appropriate, the regional office will refer the claimant to inpatient services at a medical center for observation and examination of the condition(s) for which the veteran claims to be service connected.

(b) The medical staff is responsible for observation and examination and will document findings in the patient's medical record adequate for both professional and adjudication purposes. The diagnoses appearing on the discharge summary will reflect the conditions for which the claimant was observed. Each diagnosis provided will give evidence of one of the following:

1. The existence of a disease process. If a disease condition exists, the medical staff member should state, for example, observation and examination for multiple sclerosis;

2. No evidence of the suspected disease process. If the examination indicated no evidence of the suspected condition, the medical staff member should state, for example, Observation and examination for suspected diverticulosis, none found; or

3. The presence of a sign or symptom. If the examination indicates some evidence of the suspected condition, but it is not conclusive to support a statement of an established diagnosis, the medical staff member should state, for example, Observation and examination for trigeminal neuralgia manifested by headache.

(c) For coding purposes, all patients admitted and discharged under the authority of CFR 17.45 will be assigned a DXLS code of V70.3 (other medical examination for administrative purposes). The secondary codes will show evidence of the findings resulting from the observation and examination. The following examples apply:

1. A code of V70.3 will be assigned the DXLS; and a secondary code of 340 will be assigned for the multiple sclerosis.

2. A code of V70.3 will be assigned the DXLS; and a secondary code of V71.8 will be assigned the diverticulosis.

3. A code of V70.3 will be assigned to the DXLS; and a secondary code of 784.0 will be assigned the headaches.

4. The patient admitted and discharge under the authority of CFR 17.45 will not be reported as a release to OPT-SC or OPT-NSC.

5. On occasion, the O & E patient may be converted, while still a bed occupant, to that of a patient in treatment status (CFR 17.47). In this situation, the medical staff member should provide the diagnosis(es) for which treatment was rendered. For coding purposes, DXLS code should reflect that diagnosis, established after study, which was found to have occasioned the conversion of the patient to treatment status. Also code the V70.3.

6. Documentation requirements for O & E cases will be discussed in the Medical Record Committee and, as appropriate, with individual members of the medical staff.

(11) Other specified General Medical Examinations

(a) Code V70.8 has been expanded to provide classifications for the following:

Examination of potential organ donors	V70.81
Examination of former POW	V70.82
Other specified examinations	V70.83

(b) The specific code assignment provided will be designated each case as indicated. The conditions noted while in examination status should be coded and reported as secondary diagnoses. If the patient incurs an acute problem while undergoing examination and is converted to treatment status, the medical staff member should provide the diagnoses for which treatment was rendered. For coding purposes, the DXLS should reflect that diagnosis, established after study, which was found to have occasioned the conversion of the patient to treatment status.

(12) Patients admitted for annual physical exams will be assigned a code of V70.0.

(13) Organ and Tissue Transplants

(a) Patients are sometimes admitted for examination to determine tissue compatibility prior to organ/tissue donation. These patients are potential organ/tissue donors and will be assigned a DXLS code of V70.81, Examination of potential donor. This code indicates that patient is not serving as a donor during the current episode of hospitalization, and therefore, a procedure code for organ/tissue removal will not be assigned.

(b) Category V59 will be used for patients who serve as an organ/tissue donor during an episode of inpatient care. When a code from the V59 category is used, an operative code will be assigned which indicates organ/tissue removal.

(c) A code of V70.81 (Examination of potential donor) code will not be used on the same record as a code of V59 (Donor). When the examination and the donation takes place during the same episode of care, the donor "activity" takes precedence over the examination and only a code from the V59 category will be assigned.

(d) The medical records of patients admitted for an initial organ/tissue transplant will contain a DXLS which justifies the transplant. For example, a few of the more common diagnoses which may justify a kidney transplant are chronic glomerulonephritis (582.9), nephrosclerosis (403.01), polycystic kidneys (753.12), or chronic renal failure (585). When patients with leukemia are stated to be in remission, they are better able to

tolerate bone marrow transplants (category 41.03). However, since they are receiving "active" treatment during the remission stage, the DXLS should represent a specific type of leukemia and the appropriate code from the 204-208 series will be assigned. The recipient's surgical procedure indicating the organ/tissue transplanted will be documented on the operative report, and will be coded as the principal therapeutic procedure. A code from the V42 category will not be assigned during the episode of care in which the initial transplant was performed.

(e) When an admission occurs due to a complication e.g., rejection of a previously transplanted organ/tissue, the DXLS should be representative of a condition in the 996.8 subcategory. An additional code from category V42 (Organ or tissue replaced by transplant) is required to denote the specific organ involved if the rejected organ/tissue is still present at the time of discharge.

(f) At specified intervals, transplant patients are readmitted for follow-up examination, testing and evaluation purposes. When the results of follow-up reveal no complications, a code of V67.0 will be assigned as the DXLS. A code from the V42 category will be assigned as a secondary code to indicate the organ or tissue replaced by transplant.

(g) All subcategory codes in the V42 category are status codes which indicate the presence of a transplanted organ/tissue.

(h) The following examples apply to coding organ and tissue transplants:

Examination potential kidney donor V70.81

Kidney donor V59.4

Total nephrectomy, right 55.501

Rejection of cadaver kidney transplant 996.81
V42.0

Hemodialysis x 14 39.951

Follow-up for renal transplant V67.0
V42.0

p. Status post, Post, History Of

(1) Status post, history of, and post are terms sometimes used by clinicians to describe:

- (a) personal history of given injuries or diseases with or without mention of residual effects;
- (b) history of previous surgery with or without mention of any postoperative complications;
- (c) follow-up examination performed with no evidence of any recurrence of a condition or complications;
- (d) surgical aftercare or recuperation episode; or

(e) the actual condition of the patient at the time of discharge from the medical center.

(2) When a term of status post or post is used to describe a previous illness, injury or surgery, read the discharge summary, admission notes and/or progress notes to obtain a better understanding on how the terms are being used. After referencing the discharge summary and/or other physician entries in the medical record, such as procedures performed, the coder may find information which indicates the postsurgical condition (status) is a complication of a procedure performed, or that the listed "post" diagnosis documented is to reflect follow-up.

(3) The following are examples of some of the ways "status post" and "post" are used:

(a) Postcerebral vascular accident with hemiplegia (one year ago). If the patient was admitted to an authorized Rehabilitation Medicine bed section, assign the DXLS from the V57 category. Then assign a code for the hemiplegia, 342.0 if specified as flaccid, and finally a code for the late effect, 438. This sequencing would also be applicable for a Rehabilitation Medicine bed section if the primary diagnosis is stated as "History of Cerebral Vascular Accident" or "Old Cerebral Vascular Accident." The procedures provided by the Rehabilitation Medicine staff will be reported.

(b) Postcerebral vascular accident, 6 months ago (no mention of residuals). If this is the DXLS, review the record to determine why the patient was admitted. For example, was the patient admitted for follow-up? If so, assign the DXLS from the V67 category followed by a code of 438. Was the patient admitted for observation and examination and nothing was found? Assign the DXLS from the V71 category. If the diagnosis is secondary and has no bearing on the current episode of care, omit coding unless there is a local need for the information. Return the case to the clinician if signs and symptoms were confirmed by study for amendment of the source document.

(c) Basal cell carcinoma of the nose; post myocardial infarction; status post right below knee amputation. Assign a code for the old MI. Any type of care provided is usually impacted by an old MI. Omit coding the old amputation unless there is a local need for the information. A history of past conditions, now resolved and not relevant to the current episode of care may be omitted.

(d) Tonsillitis and adenoiditis; status post hemorrhoidectomy 5 years ago. Do not assign a code for the posthemorrhoidectomy. A history of past conditions, now resolved and not relevant to the current episode of care may be omitted.

(e) History of gastric ulcer. If this is the DXLS, review the record to determine why the patient was admitted. For example, was the patient admitted in abdominal pain which resolved after ingestion of an antifatulent? Or did the results of gastric study show a recurrence of the ulcer? In both cases, refer the record to the physician for amendment of the discharge summary.

(f) Status post open reduction of fracture, left ankle. Refer to the content of the record. If the current admission was for fracture of ankle and open reduction was performed, refer the case to the physician for proper documentation. As a general rule, diagnoses which relate to an earlier episode of care which have no bearing on the current hospital stay should not be coded.

(g) Limit the use of the V71 category to the classification of patients without a diagnosis, sign, or symptom. For example, a patient admitted for evaluation of cardiovascular disease prior to renal transplant would be assigned codes of V71.7 and 585, if of course, no cardiovascular disease was found.

q. Late Effects

(1) A late effect is defined as the presence of a residual condition which was caused by a previous illness or injury. The previous illness or injury is often described by the medical staff member as "old," however description of the residual is usually more definitive. Examples of residuals include such conditions as malunion of a fracture, hemiplegia, quadriplegia, scarring due to third degree burns, and aphasia.

(2) Certain codes in ICD-9-CM which represent late effects (see 326) reference conditions which are present one year or more after the cause of the original illness or injury. The one year or more requirement is not a hard and fast rule. If a residual develops during any time period after the acute phase of the illness or injury, the one year rule will be disregarded.

(3) Residuals of previous injuries and illness are listed throughout the diagnostic tabular listing and may be used to report the DXLS. Whenever a code representing a residual condition is reported, an additional code which identifies the late effect will also be reported. Thus, the correct sequencing of late effects is as follows:

- (a) Report the code representing the residual first;
- (b) Then, report the code representing the late effect.

(4) A solo or single code representing a late effect, e.g., "old" fracture (905), will not be reported. The medical staff member will be requested to provide the residual condition. When a residual condition does not exist, the coder may assume that the "old" condition is actually a "history of ..." previous illness or trauma. Such conditions will not be coded unless there is a local need for the information.

(5) A late effect code will not be used to report the DXLS. All late effect codes are listed in appendix 7E of this chapter.

(6) Some examples of residuals and late effect conditions are listed below. Note the sequencing of the residual, the late effect and the required "E" codes resulting from suicide attempts.

<u>Paralysis</u> of wrist due to suicide attempt by laceration, right radial nerve, 1 year ago	354.9 907.4 E959
Posttraumatic <u>scars</u> of face	709.2 908.9
Esophageal stricture due to old lye burn of esophagus (attempted suicide)	530.3 906.8 E959
Malunion of fracture, right femur	733.81 905.4

r. **"E" Codes**

(1) "E" codes provide a classification of external causes such as how an accident occurred, whether a drug overdose was accidental or purposeful, and other circumstances that caused an injury or the condition being coded.

(2) For DM&S reporting purposes, "E" codes will be used to describe the cause of the following conditions:

(a) current and late effects of surgical and medical complications (E878-E879)

(b) medications causing adverse effects when the correct substance was properly administered (E930.0-E949.9);

(c) actual and attempted suicides (E950.0-E958.8); and

(d) Agent Orange exposure (E997.1).

(3) Codes in the range of E870-E876 will not be used. When one of the listed "E" codes is used, the "E" code representing the late effect will be assigned during subsequent admissions. The use of other "E" codes is optional.

(4) "E" codes are supplementary in nature and as a result, will not be used to report the DXLS. The actual condition/diagnosis which occurred because of the suicide, adverse effect, etc., will be coded and reported prior to the reporting of the "E" code.

s. **Actual and Attempted Suicides**

(1) Concerned personnel within VHS&RA continue to monitor and study cases of actual and attempted suicides which justify admission to or occur during an episode of inpatient care. The study of these unfortunate occurrences form the basis for employee education and training in the management of these and other patients who show evidence of suicidal tendencies.

(2) A suicide may be defined as an intentional or voluntary act or behavior towards oneself in which death occurs. An attempted suicide may be defined as an intentional or voluntary act to end one's life which does not result in death.

(3) A patient will be reported as a suicide (a) when the act is committed during an episode of inpatient care; and (b) when an attempted act is the reason for admission and the patient subsequently expires as a result of the attempt.

(4) A patient will be reported as an attempted suicide when the act is the reason for admission and when the attempt occurs during an episode of inpatient care.

(5) Actual and attempted suicides are classifiable to the range of codes which appear in E950 through E958. These codes (E950-E958) will not be assigned to accidental poisonings, self-inflicted accidental injuries, or assaults levied by other person.

(6) In order to provide information for monitoring and study purposes, each code within the diagnostic category of E950 through E958 has been expanded to require an

additional subclassification of "1" or "2". A numeric character of "1" in the additional position of the appropriate code will indicate an attempted suicide. A numeric character of "2" in the additional position of the appropriate code will indicate an actual suicide. The basic four or five position code will not be used.

(7) The listing of codes for attempted and actual suicides will be found in appendix 7C.

7.09 INSTRUCTIONS FOR SPECIAL OPERATIONS/PROCEDURES

a. Biopsies

(1) A biopsy performed via endoscopy or percutaneous aspiration is known as a closed biopsy. When a biopsy is performed during an endoscopic examination, the code for the endoscopy will be reported prior to the code for the biopsy, unless volume 3 provides a combination code. For example,

Cystoscopy with biopsy, bladder	57.33
Pharyngoscopy with biopsy, pharynx	29.11 29.12
Needle biopsy, liver	50.11
Percutaneous biopsy, kidney	55.23

(2) If an endoscopy is performed and a further procedure, such as local excision lesion, is performed, code both unless the index instructs otherwise. Sequence the excised tissue first. For example, cystoscopy with transurethral resection, prostate, is coded 60.2 plus 57.32.

(3) An incisional (operative) approach for the diagnostic removal of tissue is known as an open biopsy. When a biopsy is performed following exploratory laparotomy (incisional approach) and no further procedures are performed, code both the exploratory laparotomy and the biopsy. The code for the exploratory laparotomy will be sequenced before the code for the biopsy. Example:

Exploratory laparotomy with biopsy, liver	54.11 50.12
Exploratory thoracotomy with biopsy, mediastinum and left lower lobe, lung	34.02 34.26 33.28

(4) When a biopsy is performed during a procedure during which other operative procedures were performed, the principal therapeutic procedure will be reported first, followed by other therapeutic procedures or associated procedures. The code representing the open biopsy will be assigned last. In the example which follows, note that a code for the exploratory laparotomy is not assigned:

Exploratory laparotomy with biopsy stomach and gastrectomy with esophagoduodenostomy	43.99 44.15
Biopsy, left breast with radical mastectomy	85.45 85.12

(5) An operative statement of "excisional biopsy of ..." will require a review of the operative and tissue reports or contents of the medical record in order to determine whether the lesion or mass was biopsied or excised. For example, an operative statement of excisional biopsy, mass, left breast can be coded 3 different ways, depending on what was done. Refer to codes 85.11, 85.12, or 85.21.

b. **Cardiac Pacemaker Codes**

(1) A cardiac pacemaker is an internal or external electronic prosthesis used to regulate the action of the heart. An external cardiac pacemaker remains outside the body and its use is temporary until the patient's heart rhythm stabilizes, or until a permanent pacemaker is implanted. An internal cardiac pacemaker is one in which the pulse generator is implanted permanently under the skin and the electrical leads are guided to the epicardium, the myocardium, or the endocardium. Implantation of an internal cardiac pacemaker is one of a number of permanent approaches to resolution of a chronic arrhythmia.

(2) A cardiac pacemaker consists of two parts:

(a) The pulse generator, which contains the electronic circuitry which determines the firing rate and a power source for the electrical impulse.

(b) The lead, which serves as a conductor for the impulse, has at its tip an electrode.

(3) The impulse passes through the lead and electrode to the heart ventricle, or the atrium, or both ventricle and atrium and initiates heart muscle contraction. Many types of pacemakers are manufactured to cope with the wide ranges of rhythm abnormalities which are possible. Some cardiac pacemakers are designed to "retard" an excessively fast irregular heart rate, and others "trigger" faster action of the heart when there is extreme bradycardia.

(4) A number of significant malfunctions of cardiac pacemaker prostheses can occur. Examples are: "battery exhaustion," "short-out," and "disconnection of leads." Such malfunctions require surgical intervention. Potential malfunction necessitates close and continued surveillance of the patient. Practically all pacemaker manufacturers now project an anticipated battery life for the pulse generator ranging from 5 to 10 years. Depletion of the pacemaker battery prior to the 5 to 10 year period not only necessitates battery replacement, but may hint at possible failure of the other components.

(5) An initial insertion of a pacemaker system or a replacement of a pacemaker system will require 2 codes.

(a) One code will be used to identify the type of device:

1 Single chamber, or

2 Dual chamber, or

3 Rate responsive; and

(b) One code will be used to identify the type of lead(s) inserted:

- 1 Transvenous atrial, or
- 2 Transvenous ventricular, or
- 3 Epicardial

(6) Thus, the only combination of codes which are applicable for reporting the initial insertion or replacement of a pacemaker system appears as follows:

37.70 and 37.80	37.73 and 37.82
37.70 and 37.81	37.73 and 37.85
37.70 and 37.82	37.73 and 37.86
37.70 and 37.85	37.73 and 37.87
37.70 and 37.86	37.74 and 37.80
37.70 and 37.87	37.74 and 37.81
37.71 and 37.80	37.74 and 37.82
37.71 and 37.81	37.74 and 37.83
37.71 and 37.82	37.74 and 37.85
37.71 and 37.85	37.74 and 37.86
37.71 and 37.86	37.74 and 37.87
37.71 and 37.87	37.76 and 37.80
37.72 and 37.80	37.76 and 37.85
37.72 and 37.83	37.76 and 37.86
37.73 and 37.80	37.76 and 37.87
37.73 and 37.81	

(7) The replacement of a pacemaker pulse generator (single chamber, dual chamber, or unknown/unspecified pulse generator) is reflected only in the codes listed below. (**NOTE:** *These codes do not appear in combination with another pacemaker code.*)

37.80	37.86
37.85	37.87

(8) The replacement or revision of a cardiac lead is reflected in the codes listed below. (**NOTE:** *These codes do not appear in combination with another pacemaker code.*)

37.74	37.77
37.75	37.79
37.76	37.89

(9) The initial insertion of a permanent pacemaker is usually justified by a diagnosis of chronic arrhythmia (see category 427) or by a diagnosis of a conduction disorder (see category 426).

(10) As a general rule, when a patient is admitted to have the pulse generator replaced because the battery is nearing depletion or because of a manufacturer recall a DXLS code of 996.01 will be assigned. If the physician states that the patient's condition has reverted to the arrhythmia or conduction disorder which justified the initial insertion, a diagnosis code will also be assigned to describe this condition.

(11) When the patient is admitted to have the pulse generator replaced because of infection, a DXLS code from the 996.6 category will be assigned. A code from the 996.7 category will be assigned if the pacemaker pocket is too tight causing pain, or if there is

tissue breakdown of an uninfected pocket, or if there is erosion of the pacemaker device through the skin.

(12) A diagnostic code of V53.3 will be used as the DXLS when a patient is admitted expressly to have the pulse generator reprogrammed. Reprogramming may involve increasing or decreasing the rate, stimulus, strength, and/or duration of impulses produced by the pulse generator and/or changing the sensing ability. Ordinarily, reprogramming is an ambulatory care procedure but because of the age and condition of many pacemaker recipients, the patient may be admitted to inpatient services. A code of V53.3 may also be used as a secondary diagnosis when the pulse generator is reprogrammed during the episode of initial insertion or replacement, or during an episode of care for some other condition. There is no operative code to show the actual reprogramming procedure.

(13) A secondary code of V45.0 will not be reported during the episode of care of initial insertion, replacement, or reprogramming. A secondary code of V45.0 will be reported when the pacemaker recipient is hospitalized for some other condition, such as pneumonia, and the pacemaker is found to be functioning well.

(14) All pacemaker procedures will be reported using TT 401.

c. **Multiple Vessel Percutaneous Transluminal Coronary Angioplasty**

(1) PTCA (percutaneous transluminal coronary angioplasty) is an accepted alternative to CABG (coronary artery bypass graft) surgery in selected patients with significant coronary artery disease. The rationale for PTCA is based on the demonstration that stenotic arterial lesions can be dilated by exerting pressure from within the vessel lumen. This is currently done by introducing a balloon-tipped catheter through a peripheral artery into the coronary arteries. The goal is to split or compress the stenotic lesion, thereby increasing the luminal diameter, increasing blood flow and relieving symptoms and pathologic changes caused by ischemia.

(2) Advances in catheter designs and increasing experience with the procedure have enabled cardiologists to treat occlusions of more than one vessel during a given procedure. Multi-vessel PTCA is a more complex, resource intensive procedure than single vessel PTCA and requires the use of multiple catheters; takes more time; and requires greater skill and experience on the part of the cardiologist.

(3) A code of 36.05 will be used to describe multiple vessel percutaneous transluminal coronary angioplasty performed with or without thrombolytic agent.

d. **Swan-Ganz Catheterization**

(1) A Swan-Ganz catheter is a flow-directed catheter. The code assignment for "insertion or placement of a Swan-Ganz catheter" depends upon the purpose for which it is used. Example:

(a) 37.21 Diagnostic catheterization on the right side of the heart (placement of a Swan-Ganz catheter in the performance of a diagnostic cardiac catheterization). Diagnostic catheterizations are usually performed in a special laboratory equipped for this purpose. The written report usually includes measurements for intracardiac pressure, pressure pulse tracing, and blood-saturation gases, as well as calculation of

cardiac output and vascular resistance. The procedure may include measurement of capillary wedge pressure.

(b) 89.63, Pulmonary artery pressure monitoring or 89.64 Pulmonary arterial wedge pressure monitoring. Codes 89.63 and 89.64 involve introduction of a catheter (such as a Swan-Ganz) with passage to the pulmonary artery via the heart ventricle for purposes of measuring and monitoring arterial pressure, usually in acutely ill patients and often at the bedside. The measurement and monitoring function may also include determination of cardiac output, evaluation of therapy, and infusion of drugs. Pulmonary artery lines may be placed in patients with anticipated complications, such as respiratory failure, respiratory distress syndrome following surgery or trauma, hypotension resistant to therapy, or multiple organ failure.

(c) 89.63 plus 89.65, Intra-operative arterial monitoring of pressure and obtaining blood gases (both during and after surgery) may occasionally necessitate the use of Swan-Ganz catheter.

(d) 89.62, Central venous pressure monitoring is performed more often in the assessment of circulation during certain surgical procedures and a Swan-Ganz catheter is not used.

(2) **Do not use** code 37.21 with code 89.63 or 89.64 unless a diagnostic cardiac catheterization was performed during the non-OR episode and a report of the diagnostic catheterization is in the medical record.

e. Cardiac Support Codes

(1) Cardiac support pertains to the use of cardiopulmonary bypass. Other terms used in lieu of cardiopulmonary bypass are extracorporeal circulation, and, the heart lung machine. Cardiopulmonary bypass is used primarily with major operative interventions on the heart and for major operative interventions on the great vessels in the thorax, e.g., the vena cava, aorta.

(2) In order to identify those operations on the heart and great vessels which are performed using the heart lung machine, an additional code of 39.61 will be assigned. Operations on the heart and great vessels which are performed without cardiopulmonary bypass will not require an additional code. Some procedures which may require a code of 39.61 are as follows:

35.01	35.32	35.81	36.19	38.15
35.02	35.33	35.82	36.2	38.16
35.03	35.34	35.83	36.3	38.34
35.04	35.35	35.91	36.91	38.35
35.11	35.39	35.92	36.99	38.44
35.12	35.41	35.93	37.11	38.45
35.13	35.42	35.94	37.12	38.64
35.14	35.51	35.95	37.31	38.84
35.21	35.52	35.98	37.32	38.85
35.22	35.53	35.99	37.33	39.0
35.23	35.54	36.03	37.4	39.21
35.24	35.61	36.11	37.5	39.22
35.25	35.62	36.12	38.04	39.23
35.26	35.63	36.13	38.05	39.54
35.27	35.71	36.14	38.06	39.59
35.28	35.72	36.15	38.07	
35.31	35.73	36.16	38.14	37.34

(3) A code of 39.61 cannot appear as the first operation performed. A code 39.61 will not be reported as a solo code.

f. **Coronary Artery Bypass Grafts**

(1) Most aortocoronary bypass grafts use the saphenous vein with a segment removed from the leg, transposed to and sewn into the aorta, and then sewn into the coronary artery distal to the blockage. Occasionally, a segment of the internal mammary artery is used as the graft material. Most aortocoronary artery bypass grafts now involve multiple arteries.

(2) The axis for coding an aortocoronary artery bypass graft operation is the number of coronary arteries involved, rather than the number of grafts. The codes are the same whether a section of the saphenous vein or the internal mammary artery is used as the graft material.

(3) It is not unusual to see both aortocoronary artery bypass grafts and an internal mammary-coronary artery bypass in the same operation. In such cases, a code from the range of 36.11-36.14 is assigned and a code from the range of 36.15-36.16 is assigned. It is important to distinguish between the direct internal mammary-coronary artery graft and those aortocoronary grafts in which a segment of the internal mammary artery is used since a segment of the internal mammary artery may be used as graft material in lieu of a saphenous vein segment.

(4) Coronary artery bypass grafts may become totally or partially occluded and further surgery is required to restore blood flow to the myocardium. In nearly all cases, a new aortocoronary bypass must be performed. While this may be referred to as a graft "revision," it should be coded as a new procedure with the correct aortocoronary bypass code (36.11-36.14) since the old graft is left in place rather than "revised."

g. **Hemofiltration**

(1) Hemofiltration, like hemodialysis, is an extracorporeal treatment for End Stage Renal Disease. Hemofiltration uses a membrane which is more permeable than that used in hemodialysis through which water, electrolytes, and small- and middle-sized molecules, which have built up due to renal failure, are removed from the blood. In hemodialysis the middle-sized molecules are not removed because of the less permeable membrane. During hemofiltration, blood volume is restored through the administration of a substitution fluid similar to plasma. Through more efficient removal of middle-sized molecules and maintenance of blood volume, there has been a significant reduction in subjective symptoms and a decrease in hypotensive episodes in patients being treated in this manner. The high cost of the substitution fluid, however, has prevented the wide use of this technique in the United States.

(2) The process called hemodiafiltration has been confused with hemofiltration. It creates the same benefits for the patient as hemofiltration without the need for a large volume of substitution fluid. In addition hemodiafiltration reduces treatment time from 4 hours to approximately 2 hours. Hemodiafiltration is currently under development. It is anticipated to come into side use in the future. Until further notice hemofiltration will be coded to 39.951.

h. **Anastomosis with Pouch Reservoir**

(1) Patients with chronic ulcerative colitis or familial polyposis coli must often undergo total abdominal colectomy and proctectomy to treat their disease. An alternative to an ileostomy in these patients is a procedure known as endorectalileoanal anastomosis. The procedure offers patients the promise of preserving anorectal function while removing all disease. Functional results are improved by incorporating an ileal reservoir proximal to the ileoanal anastomosis. Several types of reservoirs or "pouches" have been proposed and used clinically. These include the "S" type, the "J" type and, more recently the "H" type (or lateral-lateral ileal) reservoirs.

(2) A code of 45.95 will be assigned to describe any intestinal anastomosis with pouch reservoir.

i. Extracorporeal Shock Wave Lithotripsy (ESWL) and Percutaneous Lithotripsy (of Renal Stones)

(1) ESWL (Extracorporeal shock wave lithotripsy) is a noninvasive method of fragmenting renal stones by passing sonic shock waves through the body while the patient is partially immersed in water. A code of 98.51, is used for coding this procedure.

(2) Percutaneous lithotripsy involves the surgical creation of a passage through the skin and tissues of the flank to the renal pelvis. A mechanical or ultrasonic probe is then inserted through the channel and the stone is crushed and removed by irrigation. This procedure is coded 55.04.

j. Bone Growth Stimulators

(1) A bone growth stimulator is a device which make use of electrical currents to stimulate new bone formation and healing of fractured bones. The device is approved for use after conventional methods of treating a fractured bone (i.e., reduction and immobilization) have failed to unite or heal the fracture, or after a bone graft has failed to fuse the fracture. Other possible, but not yet approved, uses of bone growth stimulators include application to a "fresh" (i.e., new) severe fracture; and use during the early post operative period in patients having total hip or knee replacement.

(2) Three basic types of bone growth stimulators are now on the market: Stimulators inserted directly into the fractured bone requiring an invasive surgical procedure usually under general anesthesia; stimulators inserted percutaneously into the bone, considered a semi-invasive procedure done under aseptic conditions using local anesthesia; and stimulators using pads or patches placed directly on the skin around the fracture site, requiring no anesthesia.

(3) In order to classify the insertion of a bone growth stimulator, a code will be assigned from category 78.9. A code of 78.90 will not be assigned.

(4) A code of 99.86 will be assigned to describe the application of non-invasive bone growth stimulator (transcutaneous placement of pads or patches.)

k. Interleukin-2 Cancer Therapy

(1) Interleukin-2 is the product T lymphocytes, a type of white blood cell which is part of the immune system and is important in defense against the intrusion of foreign substances into the body. It is needed to support the multiplication of other T cells which

actually attack foreign cells such as bacteria. When normal cells turn cancerous, they often acquire characteristics which make them appear foreign. As a result, the immune system responds and tries to destroy them. Clinical cancer is generally felt to result from a failure of immune surveillance.

(2) Immunotherapy of cancer falls into two general categories, specific and non-specific.

a. Specific immunotherapy consists of administration of antibodies and immune cells which attack cancer cells which they recognize with exquisite specificity. Thus, monoclonal antibodies have been made against specific cancers, indeed against the cancers of specific individuals, and then administered to them. The production of sufficient quantities of immune T cells programmed to destroy specific cancers depends on support of their multiplication by IL-2. The logistics of the production of specific antibodies and cells is forbidding.

b. In non-specific immunotherapy, agents are administered which are intended to boost the capacity of the patient's immune system to destroy his cancer. There were early attempts to do this by administering IL-2 intravenously. However, the doses that might have been effective, by extrapolation from doses given to mice, were lethal in man. An alternative approach, based on the observation that IL-2 stimulates the appearance and growth of cells that destroy cancer cells in general, involves taking lymphocytes from patients, treating them with IL-2 to cause the outgrowth of large numbers of these killer cells and reinfusing them into the patients, along with much more moderate doses of IL-2 to support the continued multiplication of these cells. This approach has resulted in the shrinkage of tumors in some patients and is currently under further evaluation. It is clearly highly experimental and is used in a very limited number of patients.

(3) The injection of IL-2 is very rarely performed, however, it should be coded as 99.25.

1. Apheresis/Plasmapheresis

(1) Apheresis is the generic term for procedures where plasma or some other blood component is selectively removed from the circulation of a patient or donor. Specific types of apheresis include plasmapheresis. These terms are correctly used to refer to the removal of blood components only. Any accompanying transfusion is a separate and distinct procedure.

(2) Within each apheresis procedure there is a distinction between it being performed on a donor or therapeutically on a patient. When performed on a donor it is for the purpose of removing a needed blood component from a healthy person to be transfused into a patient with a specific blood product deficiency. In fact, the primary use for apheresis has been to collect platelets, leukocytes, or plasma from normal donors for transfusion into patients. The donor is never transfused or given replacement fluid as a result of the procedure because the amount of component taken is not of sufficient volume that its loss is harmful to the donor. A small amount of saline and anticoagulant used during the procedure will enter the donor's system because of the way the apheresis machines function.

(3) Therapeutic apheresis is performed because a specific substance in the patient's blood can be associated with or is thought to be associated with the patient's illness. The patient may or may not be transfused with healthy blood products depending on

the specific procedure performed and/or the amount of the component removed. Often a replacement solution (e.g. 5 percent albumin) is given to the patient. This is not considered a transfusion. In erythrocytapheresis, an accompanying transfusion of red blood cells is always necessary for the patient to live.

(4) Types of apheresis

a. Therapeutic plasmapheresis is done to treat patients in approximately 100 diseases. The plasma is removed from the whole blood and discarded because it is thought or is known to be associated with some noxious substance. Another substance, like albumin, is put back into the patient to replace the plasma.

b. Leukopheresis may be performed therapeutically on leukemia patients to remove excess white blood cells. Donated white blood cells are often given to patients with leukemia and other cancer patients who need white blood cells to fight infection because of their disease or because of the side effects of chemotherapy. Platelets from donors are also given to patients such as these to protect against bleeding, another common side effect of chemotherapy.

c. Therapeutic erythrocytapheresis is occasionally used for patients with sickle cell anemia to remove their abnormal red blood cells and replace them with red blood cells containing normal hemoglobin. As noted, any patient that has therapeutic erythrocytapheresis must be transfused to replace the red blood cells. The combination of erythrocytapheresis plus transfusion is often referred to as red blood cell exchange.

d. Plateletpheresis is most often performed for donations to patients and would not be considered therapeutic. Therapeutic uses of plateletpheresis are currently being investigated but are considered experimental.

(5) The following code assignments will be used for describing different types of apheresis:

- 99.71 Therapeutic plasmapheresis
- 99.72 Therapeutic leukopheresis
- 99.73 Therapeutic erythrocytapheresis
- 99.74 Therapeutic plateletphersis

ICD-9-CM DIAGNOSIS CODES WHICH REPRESENT SUBSTANTIAL
COMPLICATIONS OR COMORBIDITIES WHEN PRESENT AS SECONDARY DIAGNOSES

V237	01152	01301	01380	01626	01725	01794	0388
V238	01153	01302	01381	01630	01726	01795	0389
V239	01154	01303	01382	01631	01730	01796	0400
V420	01155	01304	01383	01632	01731	01800	0420
V421	01156	01305	01384	01633	01732	01801	0421
V422	01160	01306	01385	01634	01733	01802	0422
V426	01161	01310	01386	01635	01734	01803	0429
V427	01162	01311	01390	01636	01735	01804	0430
V428	01163	01312	01391	01640	01736	01805	0431
V432	01164	01313	01392	01641	01740	01806	0432
V451	01165	01314	01393	01642	01741	01880	0433
V461	01166	01315	01394	01643	01742	01881	0439
01100	01170	01316	01395	01644	01743	01882	0440
01101	01171	01320	01396	01645	01744	01883	0449
01102	01172	01321	01400	01646	01745	01884	0462
01103	01173	01322	01401	01650	01746	01885	0520
01104	01174	01323	01402	01651	01750	01886	0521
01105	01175	01324	01403	01652	01751	01890	0527
01106	01176	01325	01404	01653	01752	01891	0528
01110	01180	01326	01405	01654	01753	01892	0529
01111	01181	01330	01406	01655	01754	01893	0530
01112	01182	01331	01480	01656	01755	01894	05310
01113	01183	01332	01481	01660	01756	01895	05311
01114	01184	01333	01482	01661	01760	01896	05312
01115	01185	01334	01483	01662	01761	0310	05313
01116	01186	01335	01484	01663	01762	0360	05319
01120	01190	01336	01485	01664	01763	0361	05379
01121	01191	01340	01486	01665	01764	0362	0538
01122	01192	01341	01600	01666	01765	0363	0543
01123	01193	01342	01601	01670	01766	03640	0545
01124	01194	01343	01602	01671	01770	03641	05471
01125	01195	01344	01603	01672	01771	03642	05472
01126	01196	01345	01604	01673	01772	03643	05479
01130	01200	01346	01605	01674	01773	03681	0548
01131	01201	01350	01606	01675	01774	03682	0550
01132	01202	01351	01610	01676	01775	03689	0551
01133	01203	01352	01611	01690	01776	0369	0552
01134	01204	01353	01612	01691	01780	037	05571
01135	01205	01354	01613	01692	01781	0380	05579
01136	01206	01355	01614	01693	01782	0381	0558
01140	01210	01356	01615	01694	01783	0382	05600
01141	01211	01360	01616	01695	01784	0383	05601
01142	01212	01361	01620	01696	01785	03840	05609
01143	01213	01362	01621	01720	01786	03841	05671
01144	01214	01363	01622	01721	01790	03842	05679
01145	01215	01364	01623	01722	01791	03843	0568
01146	01216	01365	01624	01723	01792	03844	0702
01150	01300	01366	01625	01724	01793	03849	0703
01151							

**M-1, Part I
Chapter 7
Change 4
APPENDIX 7A**

May 10, 1991

0704	1142	1509	1630	1987	20112	20190	20247
0705	1143	1510	1631	19881	20113	20191	20248
0706	1149	1511	1638	19882	20114	20192	20250
0709	11500	1512	1639	19889	20115	20193	20251
0720	11501	1513	1640	1990	20116	20194	20252
0721	11502	1514	1641	20000	20017	20195	20253
0722	11503	1515	1642	20001	20118	20196	20254
0723	11504	1516	1643	20002	20120	20197	20255
07271	11505	1518	1648	20003	20121	20198	20256
07272	11510	1519	1649	20004	20122	20200	20257
07279	11511	1520	1890	20005	20123	20201	20258
0728	11512	1521	1891	20006	20124	20202	20260
0860	11513	1522	1892	20007	20125	20203	20261
09040	11514	1523	1910	20008	20126	20204	20262
09041	11515	1528	1911	20010	20127	20205	20263
09042	11519	1529	1912	20011	20128	20206	20264
09049	11590	1530	1913	20012	20140	20207	20265
0930	11591	1531	1914	20013	20141	20208	20266
0931	11592	1532	1915	20014	20142	20210	20267
09320	11593	1533	1916	20015	20143	20211	20268
09321	11594	1534	1917	20016	20144	20212	20280
09322	11595	1535	1918	20017	20145	20213	20281
09323	11599	1536	1919	20018	20146	20214	20282
09324	1160	1537	1920	20020	20147	20215	20283
09381	1161	1538	1921	20021	20148	20216	20284
09382	1173	1539	1922	20022	20150	20217	20285
09389	1174	1540	1923	20023	20151	20218	20286
0939	1175	1541	1928	20024	20152	20220	20287
0940	1176	1542	1960	20025	20153	20221	20288
0941	1177	1543	1961	20026	20154	20222	20290
0942	118	1548	1962	20027	20155	20223	20291
0943	1300	1550	1963	20028	20156	20224	20292
09481	1301	1551	1965	20080	20157	20225	20293
09487	1302	1552	1966	20081	20158	20226	20294
09489	1303	1560	1968	20082	20160	20227	20295
0949	1304	1561	1969	20083	20161	20228	20296
0980	1305	1562	1970	20084	20162	20230	20297
09810	1307	1568	1971	20085	20163	20231	20298
09811	1308	1569	1972	20086	20164	20232	2030
09812	135	1570	1973	20087	20165	20233	2031
09813	1363	1571	1974	20088	20166	20234	2038
09814	1370	1572	1975	20100	20167	20235	2040
09815	1371	1573	1976	20101	20168	20236	2041
09816	1372	1574	1977	20102	20170	20237	2042
09817	138	1578	1978	20103	20171	20238	2048
09819	1500	1579	1980	20104	20172	20240	2049
1120	1501	1622	1981	20105	20173	20241	2050
1124	1502	1623	1982	20106	20174	20242	2051
1125	1503	1624	1983	20107	20175	20243	2052
11281	1504	1625	1984	20108	20176	20244	2053
11282	1505	1628	1985	20110	20177	20245	2058
11283	1508	1629	1986	20111	20178	20246	

2059	2535	2818	29500	2984	30562	34551	40411
2060	2541	2824	29501	29900	30570	34561	40412
2061	2550	28260	29502	29910	30571	34571	40413
2062	2553	28261	29503	29980	30572	34581	40491
2068	2554	28262	29504	29990	30590	34591	40492
2069	2555	28263	29510	30300	30591	3481	40493
2070	2556	28269	29511	30301	30592	3491	40501
2071	2580	2830	29512	30302	3071	34981	40509
2072	2581	2831	29513	30390	3182	34982	41001
2078	2588	2832	29514	30391	3200	3570	41011
2080	2589	2839	29521	30392	3201	3580	41021
2081	2592	2840	29522	30400	3202	3581	41031
2082	260	2848	29523	30401	3203	3590	41041
2088	261	2849	29524	30402	3207	3591	41051
2089	262	2850	29530	30410	3208	37700	41061
24200	2630	2851	29531	30411	3209	37701	41071
24201	2631	2860	29532	30412	3210	37702	41081
24210	2632	2861	29533	30420	3211	38301	41091
24211	2638	2862	29534	30421	3212	38330	4110
24220	2639	2863	29540	30422	3213	38381	4111
24221	2690	2864	29541	30440	3214	3940	41181
24230	2733	2865	29542	30441	3218	3941	41189
24231	2760	2866	29543	30442	3220	3942	
24240	2761	2867	29544	30450	3221	3949	4130
24241	2762	2869	29560	30451	3222	3950	4131
24280	2763	2870	29561	30452	3229	3951	4139
24281	2764	2871	29562	30460	3240	3952	4150
24290	2765	2872	29563	30461	3241	3959	4151
24291	2766	2873	29564	30462	3249	3960	4160
25001	2767	2874	29570	30470	325	3961	4200
25010	2768	2875	29571	34071	3314	3962	42090
25011	2769	2878	29572	30472	3350	3963	42091
25020	27700	2879	29573	30480	33510	3968	42099
25021	27701	2880	29574	30481	33511	3969	4210
25030	27902	2881	29580	30482	33519	3970	4211
25031	27903	2910	29581	30490	33520	3971	4219
25040	27904	2911	29582	30491	33521	3979	4220
25041	27905	2912	29583	30492	33522	3980	42290
25050	27906	2913	29584	30500	33523	39891	42291
25051	27909	2914	29590	30501	33524	4010	42292
25060	27910	2918	29591	30502	33529	40200	42293
25061	27911	2919	29592	30530	3358	40201	42299
25070	27912	2920	29593	30531	3359	40211	4230
25071	27913	29211	29594	30532	340	40291	4231
25080	27919	29212	29604	30540	3432	40300	4232
25081	2792	2922	29614	30541	3440	40301	4240
25090	2793	29281	29634	30542	34501	40311	4241
25091	2794	29282	29644	30550	34510	40391	4242
2510	2798	29283	29654	30551	34511	40400	4243
2513	2799	29284	29664	30552	3452	40401	42490
2521	2800	29289	2980	30560	3453	40402	42491
2532	2814	2929	2983	30561	34541	40403	42499

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4250	430	4510	4846
4251	431	45111	4847
4252	4320	45119	4848
4253	4321	4512	485
4254	4330	45181	486
4255	4331	452	4870
4257	4332	4530	4911
4258	4333	4531	4912
4259	4340	4532	4918
4260	4341	4533	4919
42612	4349	4560	4928
42613	436	45620	49301
42653	4372	4572	49311
42654	4374	4590	49320
4266	4375	46411	49321
4267	4376	46421	49391
42681	4410	46431	494
42689	4411	475	4950
4269	4413	47821	4951
4270	4415	47822	4952
4271	4440	47824	4953
4272	4441	47830	4954
42731	44421	47831	4955
42732	44422	47832	4956
42741	44481	47833	4957
42742	44489	47834	4958
4275	4449	481	4959
4280	4460	4820	496
4281	44620	4821	
4289	44621	4822	
4290	44629	4823	
4294	4463	4824	
4295	4464	4828	
4296	4465	4829	
42971	4466	483	
42979	4467	4841	
42981	4470	4843	
42982	4480	4845	

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APPENDIX 7A

500	5190	53400	5570		5967
501	5192	53401	5581		5970
502	5273	53410	5582	5761	5981
503	5274	53411	5600	5763	5982
504	5283	53420	5601	5764	5990
505	5304	53421	5602	5770	5994
5060	5307	53431	56030	5772	5996
5061	53100	53440	56031	5780	5997
5070	53101	53441	56039	5781	6010
5071	53110	53450	56081	5789	6012
5078	53111	53451	56089	5793	6013
5080	53120	53460	5609	5800	6021
5081	53121	53461	566	5804	6031
5100	53131	53471	5670	58081	6040
5109	53140	53491	5671	58089	6071
5111	53141	5350	5672	5809	6072
5118	53150	5361	5678	5810	6073
5119	53151	5370	5679	5811	61172
5120	53160	5373	56881	5812	6140
5128	53161	5374	5693	5813	6143
5130	53171	5400	5695	58181	6145
5131	53191	5401	5696	58189	6150
515	53200	5409	56983	5819	6163
5160	53201	55000	570	5834	6164
5161	53210	55001	5711	5845	6190
5162	53211	55002	5712	5846	6191
5163	53220	55003	57149	5847	6192
5168	53221	55010	5715	5848	6198
5169	53231	55011	5716	5849	6199
5171	53240	55012	5720	585	6207
5172	53241	55013	5721	59010	63400
5178	53250	55100	5722	59011	63401
5180	53251	55101	5724	5902	63402
5181	53260	55102	5731	5903	63410
5184	53261	55103	5732	59080	63411
5185	53271	5511	5733	59081	63412
51881	53291	55120	5734	5909	63420
51882	53300	55121	57400	591	63421
	53301	55129	57401	5921	63422
	53310	5513	57410	5935	63430
	53311	5518	57411	5950	63431
	53320	5519	57421	5951	63432
	53321	55200	57430	5952	63440
	53331	55201	57431	5954	63441
	53340	55202	57440	59581	63442
	53341	55203	57441	59582	63450
	53350	5521	57450	59589	63451
	53351	55220	57451	5959	63452
	53360	55221	5750	5960	63460
	53361	55229	5752	5961	63461
	53371	5523	5753	5962	63462
	53391	5528	5754	5964	63470
		5529	5755	5966	63471

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63472	64263	64864	67124	6808	72281	74560	7740
63480	64264	65930	67130	6809	72282	74569	7741
63481	64270	65931	67131	6820	72283	7457	7742
63482	64271	65933	67133	6821	7234	74601	77430
63490	64272	66500	67140	6822	7235	74602	77431
63491	64273	66501	67142	6823	7280	7461	77439
63492	64274	66503	67144		73000	7462	7744
6390	64400	66510	67300	6825	73001	7463	7745
6391	64403	66511	67301	6826	73002	7464	7747
6392	64410	66512	67302	6827	73003	7465	7751
6393	64413	66514	67303	6828	73004	7466	7752
6394	64660	66632	67304	6829	73005	7467	7753
6395	64661	66634	67310	683	73006	74681	7754
6396	64662	66800	67311	684	73007	74682	7755
6398	64663	66801	67312	6850	73008	74683	7756
6399	64664	66802	67313	6944	73009	74684	7757
64000	64670	66803	67314	6945	73080	74686	7760
64001	64671	66804	67320	6950	73081	74710	7761
64003	64673	66810	67321	7070	73082	74711	7762
64080	64730	66811	67322	7071	73083	74722	7763
64081	64731	66812	67323	7080	73084	7484	7771
64083	64732	66813	67324	7100	73085	7485	7772
64090	64733	66814	67330	7101	73086	74861	7775
64091	64734	66820	67331	7103	73087	76501	7776
64093	64740	66821	67332	7104	73088	76502	7780
64100	64741	66822	67333	7108	73089	76503	7790
64101	64742	66823	67334	71100	73090	76504	7791
64103	64743	66824	67380	71101	73091	76505	7793
64110	64744	66880	67381	71102	73092	76507	7794
64111	64800	66881	67382	71103	73093	76508	7800
64113	64801	66882	67383	71104	73094	7670	7801
64130	64802	66883	67384	71105	73095	7685	7803
64131	64803	66884	67400	71106	73096	769	7817
64133	64804	66890	67401	71107	73097	7700	7854
64180	64820	66891	67402	71108	73098	7701	78550
64181	64821	66892	67403	71109	73099	7702	78551
64183	64822	66893	67404	71160	7331	7703	78559
64190	64823	66894	67410	71161	74100	7704	7863
64191	64824	66910	67412	71162	74101	7705	7880
64193	64830	66911	67420	71163	74102	7707	7882
64240	64831	66912	67422	71164	74103	7710	7895
64241	64832	66913	67424	71165	74190	7711	7907
64242	64833	66914	67510	71166	74191	7713	7908
64243	64834	66930	67511	71167	74192	7718	7911
64244	64850	66932	67512	71168	74193	7721	7913
64250	64851	66934	6800	71169	7450	7722	7991
64251	64852	67000	6801	7141	74510	7724	7994
64252	64853	67002	6802	7142	74511	7725	80000
64253	64854	67004	6803	71430	74512	7730	80001
64254	64860	67120	6804	71431	74519	7731	80002
64260	64861	67121	6805	71432	7452	7732	80003
64261	64862	67122	6806	71433	7453	7733	80004
64262	64863	67123	6807	72280	7454	7734	80005

80006	80072	80136	80221	80333	80399	80463	8057
80009	80073	80139	80222	80334	80400	80464	8058
80010	80074	80140	80223	80335	80401	80465	8059
80011	80075	80141	80224	80336	80402	80466	80600
80012	80076	80142	80225	80339	80403	80469	80601
80013	80079	80143	80226	80340	80404	80470	80602
80014	80080	80144	80227	80341	80405	80471	80603
80015	80081	80145	80228	80342	80406	80472	80604
80016	80082	80146	80229	80343	80409	80473	80605
80019	80083	80149	80230	80344	84010	80474	80606
80020	80084	80150	80231	80345	80411	80475	80607
80021	80085	80151	80232	80346	80412	80476	80608
80022	80086	80152	80233	80349	80413	80479	80609
80023	80089	80153	80234	80350	80414	84080	80610
80024	80090	80154	80235	80351	80415	80481	80611
80025	80091	80155	80236	80352	80416	80482	80612
80026	80092	80156	80237	80353	80419	80483	80613
80029	80093	80159	80238	80354	80420	80484	80614
80030	80094	80160	80239	80355	80421	80485	80615
80031	80095	80161	8024	80356	80422	80486	80616
80032	80096	80162	8025	80359	80423	80489	80617
80033	80099	80163	8026	80360	80424	80490	80618
80034	80100	80164	8027	80361	80425	80491	80619
80035	80101	80165	8028	80362	80426	80492	80620
80036	80102	80166	8029	80363	80429	80493	80621
80039	80103	80169	80300	80364	80430	80494	80622
80040	80104	80170	80301	80365	80431	80495	80623
80041	80105	80171	80302	80366	80432	80496	80624
80042	80106	80172	80303	80369	80433	80499	80625
80043	80109	80173	80304	80370	80434	80500	80626
80044	80110	80174	80305	80371	80435	80501	80627
80045	80111	80175	80306	80372	80436	80502	80628
80046	80112	80176	80309	80373	80439	80503	80629
80049	80113	80179	80310	80374	80440	80504	80630
80050	80114	80180	80311	80375	80441	80505	80631
80051	80115	80181	80312	80376	80442	80506	80632
80052	80116	80182	80313	80379	80443	80507	80633
80053	80119	80183	80314	80380	80444	80508	80634
80054	80120	80184	80315	80381	80445	80510	80635
80055	80121	80185	80316	80382	80446	80511	80636
80056	80122	80186	80319	80383	80449	80512	80637
80059	80123	80189	80320	80384	80450	80513	80638
80060	80124	80190	80321	80385	80451	80514	80639
80061	80125	80191	80322	80386	80452	80515	8064
80062	80126	80192	80323	80389	80453	80516	8065
80063	80129	80193	80324	80390	80454	80517	80660
80064	80130	80194	80325	80391	80455	80518	80661
80065	80131	80195	80326	80392	80456	8052	80662
80066	80132	80196	80329	80393	80459	8053	80669
80069	80133	80199	80330	80394	80460	8054	80670
80070	80134	8021	80331	80395	80461	8055	80671
80071	80135	80220	80332	80396	80462	8056	80672

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80679	8209	85126	85193	85300	86231	86612	8872
8068	82100	85129	85194	85301	86232	86613	8873
8069	82101	85130	85195	85302	86239	8670	8874
80704	82110	85131	85196	85303	8629	8671	8875
80705	82111	85132	85199	85304	8631	8672	8876
80706	83819	95133	85200	85305	86330	8673	8877
80707	83900	85134	85201	85306	86331	8674	8960
80708	83901	85135	85202	85309	86339	8675	8961
80709	83902	85136	85203	85310	86350	8876	8962
80710	83903	85139	85204	85311	86351	8677	8963
80711	83904	85140	85205	85312	86352	8678	8970
80712	83905	85141	85206	85313	86353	8679	8971
80713	83906	85142	85209	85314	86354	86800	8972
80714	83907	85143	85210	85315	86355	86801	8973
80715	83908	85144	85211	85316	86356	86802	8974
80716	83910	85145	85212	85319	86359	86803	8975
80717	83911	85146	85213	85400	86390	86804	8976
80718	83912	85149	85214	85401	86391	86809	8977
80719	83913	85150	85215	85402	86392	86810	90000
8072	83914	85151	85216	85403	86393	86811	90001
8073	83915	85152	85219	85404	86394	86812	90002
8074	83916	85153	85220	85405	86395	86813	90003
8075	83917	85154	85221	85406	86399	86814	9001
8076	83918	85155	85222	85409	86400	86819	90081
8080	8500	85156	85223	85410	86401	8690	90082
8081	8501	85159	85224	85411	86402	8691	90089
8082	8502	85160	85225	85412	86403	8703	9009
8083	8503	85161	85226	85413	86404	8704	9010
80843	8504	85162	85229	85414	86409	8708	9011
80849	8505	85163	85230	85415	86410	8709	9012
80851	8509	85164	85231	85416	86411	8710	9013
80852	85100	85165	85232	85419	86412	8711	90141
80853	85101	85166	85233	8600	86413	8712	90142
80859	85102	85169	85234	8601	86414	8713	90183
8088	85103	85170	85235	8602	86419	8714	9020
8089	85104	85171	85236	8603	86500	8719	90210
82000	85105	85172	85239	8604	86501	87272	90211
82001	85106	85173	85240	8605	86502	87273	90219
82002	85109	85174	84241	86101	86503	87274	90220
82003	85110	85175	85242	86102	86504	87333	90222
82009	85111	85176	85243	86103	86509	8739	90223
82010	85112	85179	85244	86110	86510	87400	90224
82011	85113	85180	85245	86111	86511	87401	90225
82012	85114	85181	85246	86112	86512	87402	90226
82013	85115	85182	85249	86113	86513	87410	90227
82019	85116	85183	85250	86122	86514	87411	90229
82020	85119	85184	85251	86130	86519	87412	90231
82021	85120	85185	85252	86131	86600	8743	90232
82022	85121	85186	85253	86132	86601	8745	90233
82030	85122	85189	85254	8621	86602	8750	90234
82031	85123	85190	85255	86221	86603	8751	90239
82032	85124	85191	85256	86222	86610	8870	90240
8208	85125	85192	85259	86229	86611	8871	90241

90242	99600	99680	9994
90249	99601	99681	9995
90250	99602	99682	9996
90251	99603	99683	9997
90252	99609	99684	9998
90253	9962	99685	
90254	9961	99686	
90259	99630	99689	
90287	99639	99690	
9040	9964	99691	
925	99651	99692	
9290	99652	99693	
95200	99653	99694	
95201	99654	99695	
95202	99659	99696	
95203	99660	99699	
95204	99661	9970	
95205	99662	9971	
95206	99663	9972	
95207	99664	9973	
95208	99665	9974	
95209	99666	9975	
95210	99667	99762	
95211	99669	9979	
95212	99670	9980	
95213	99671	9981	
95214	99672	9982	
95215	99673	9983	
95216	99674	9984	
95217	99675	9985	
95218	99676	9986	
95219	99677	9987	
9522	99678	9988	
9523	99679	9989	
9524		9991	
9528		9992	
9529		9993	
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9587			
9954			

ICD-9-CM OPERATION/PROCEDURE CODES
WHICH AFFECT DRGS

01.12	03.21	05.21	07.45	08.62	10.1	12.02	12.97	14.71
01.14	03.29	05.22	07.49	08.63	10.21	12.11	12.98	14.72
01.15	03.32	05.23	07.51	08.64	10.29	12.12	12.99	
01.18	03.39	05.24	07.52	08.69	10.31	12.13	13.00	
01.19	03.4	05.29	07.53	08.70	10.32	12.14	13.01	
01.21	03.51	05.81	07.54	08.71	10.33	12.21	13.02	
01.22	03.52	05.89	07.59	08.72	10.41	12.22	13.11	
01.23	03.53	05.9	07.61	08.73	10.42	12.29	13.19	
01.24	03.59	06.02	07.62	08.74	10.43	12.31	13.2	
01.25	03.6	06.09	07.63	08.81	10.44	12.32	13.3	
01.31	03.71	06.12	07.64	08.82	10.49	12.33	13.41	
01.32	03.72	06.13	07.65	08.83	10.5	12.34	13.42	
01.39	03.79	06.19	07.68	08.84	10.6	12.35	13.43	
01.41	03.93	06.2	07.69	08.85	10.91	12.39	13.51	
01.42	03.94	06.31	07.71	08.86	10.99	12.40	13.59	
01.51	03.97	06.39	07.72	08.87	11.0	12.41	13.61	
01.52	03.98	06.4	07.79	08.89	11.1	12.42	13.62	
01.53	03.99	06.50	07.80	08.91	11.21	12.43	13.63	
01.59	04.01	06.51	07.81	08.92	11.22	12.44	13.64	
01.6	04.02	06.52	07.82	08.93	11.29	12.51	13.65	
02.01	04.03	06.6	07.91	08.99	11.31	12.52	13.66	
02.02	04.04	06.7	07.92	09.0	11.32	12.53	13.69	
02.03	04.05	06.81	07.93	09.11	11.39	12.54	13.70	
02.04	04.06	06.89	07.94	09.12	11.41	12.55	13.71	
02.05	04.07	06.91	07.99	09.19	11.42	12.59	13.72	
02.06	04.12	06.92	08.11	09.20	11.43	12.61	13.8	
02.07	04.19	06.93	08.20	09.21	11.49	12.62	13.9	
02.11	04.3	06.94	08.21	09.22	11.51	12.63	14.00	
02.12	04.41	06.95	08.22	09.23	11.52	12.64	14.01	
02.13	04.42	06.98	08.23	09.3	11.53	12.65	14.02	
02.14	04.43	06.99	08.24	09.41	11.59	12.66	14.11	
02.2	04.44	07.00	08.25	09.42	11.60	12.69	14.19	
02.31	04.49	07.01	08.31	09.43	11.61	12.71	14.21	
02.32	04.5	07.02	08.32	09.44	11.62	12.72	14.22	
02.33	04.6	07.12	08.33	09.49	11.63	12.73	14.26	
02.34	04.71	07.13	08.34	09.51	11.64	12.74	14.27	
02.35	04.72	07.14	08.35	09.52	11.69	12.79	14.29	
02.39	04.73	07.15	08.36	09.53	11.71	12.81	14.31	
02.42	04.74	07.16	08.37	09.59	11.72	12.82	14.32	
02.43	04.75	07.17	08.38	09.6	11.73	12.83	14.39	
02.91	04.76	07.19	08.41	09.71	11.74	12.84	14.41	
02.92	04.79	07.21	08.42	09.72	11.75	12.85	14.49	
02.93	04.91	07.22	08.43	09.73	11.76	12.86	14.51	
02.94	04.92	07.29	08.44	09.81	11.79	12.87	14.52	
02.99	04.93	07.3	08.49	09.82	11.91	12.88	14.53	
03.01	04.99	07.41	08.51	09.83	11.92	12.89	14.54	
03.02	05.0	07.42	08.52	09.91	11.99	12.91	14.55	
03.09	05.11	07.43	08.59	09.99	12.00	12.92	14.59	
03.1	05.19	07.44	08.61	10.0	12.01	12.93	14.6	

14.73	18.31	21.4	25.02	28.4	31.99	34.51	35.31	36.2
14.74	18.39	21.5	25.1	28.5	34.59	35.32	36.3	
14.75	18.5		25.2	28.6	32.01	35.33	36.91	
14.79	18.6	21.61	25.3	28.7	32.09		35.34	36.99
14.9	18.71	21.62	25.4	28.91	32.1	34.6	35.35	37.10
15.01	18.72	21.69	25.59	28.92	32.21		35.39	37.11
15.09	18.79	21.72	25.94	28.99	32.28			37.12
15.11	18.9	21.82	25.99		32.29		35.42	37.21
15.12	19.0	21.83	26.12	29.0	32.3	34.73		37.22
15.13	19.11	21.84	26.21	29.11	32.4	34.74	35.50	37.23
15.19	19.19	21.85	26.29	29.2	32.5	34.79	35.51	37.24
15.21	19.21	21.86	26.30	29.3	32.6		35.52	37.26
15.22	19.29	21.87	26.31	29.4	32.9	34.81	35.53	37.27
15.29	19.3	21.88	26.32	29.51		34.82	35.54	37.31
15.3	19.4	21.89	26.41	29.52		34.83	35.60	37.32
15.4	19.52	21.99	26.42	29.53		34.84	35.61	37.33
15.5	19.53	22.12	26.49	29.54		34.85	35.62	37.34
15.6	19.54	22.31	26.99	29.59	33.0	34.89	35.63	37.4
15.7	19.55	22.39		29.92	33.1		35.70	37.5
15.9	19.6	22.41	27.0	29.99	33.21		35.71	37.61
16.01	19.9	22.42	27.1	30.01	33.22		35.72	37.62
16.02	20.01	22.50	27.21	30.09	33.23	34.93	35.73	37.63
16.09	20.21	22.51	27.22	30.1	33.24	34.99		37.64
16.1	20.22	22.52	27.31	30.21	33.25			37.70
16.22	20.23	22.53	27.32	30.22	33.27	35.00		37.71
16.23	20.32	22.60	27.42	30.29	33.28	35.01		37.72
16.29	20.39	22.61	27.43	30.3	33.29	35.02	35.81	37.73
16.31	20.41	22.62	27.49	30.4	33.34	35.03	35.82	37.74
16.39	20.42	22.63	27.53	31.1	33.39	35.04	35.83	37.75
16.41	20.49	22.64	27.54	31.21	33.41		35.84	37.76
16.42	20.51	22.71	27.55	31.29	33.42		35.91	37.77
16.49	20.59	22.79	27.56	31.3	33.43		35.92	37.79
16.51	20.61	22.9	27.57	31.41	33.48		35.93	37.80
16.52	20.62	23.01	27.59	31.42	33.49		35.94	37.81
16.59	20.71	23.09	27.61	31.43	33.5		35.95	37.82
16.61	20.72	23.11	27.62	31.44	33.6	35.10	35.96	37.83
16.62	20.79	23.19	27.63	31.45	33.92	35.11	35.98	37.85
16.63	20.91	23.2	27.69	31.5	33.93	35.12	35.99	37.86
16.64	20.92	23.3	27.71	31.61	33.98	35.13	36.00	37.87
16.65	20.93	23.41	27.72	31.62	33.99	35.14	36.01	37.89
16.66	20.95	23.42	27.73	31.63	34.02	35.20	36.02	37.91
16.69	20.96	23.43	27.79	31.64	34.03	35.21	36.03	37.94
16.71	20.97	23.49	27.92	31.69	34.1	35.22	36.05	37.95
16.72	20.98	23.5	27.99	31.71	34.21	35.23	36.09	37.96
16.81	20.99	23.6		31.72	34.22	35.24	36.10	37.97
16.82	21.04	23.70	28.0	31.73	34.26	35.25	36.11	37.98
16.89	21.05	23.71	28.11	31.74	34.27	35.26	36.12	37.99
16.92	21.06	23.72	28.19	31.75	34.28	35.27	36.13	38.00
16.93	21.07	23.73	28.2	31.79	34.29	35.28	36.14	38.01
16.98	21.09	24.2	28.3	31.91	34.3		36.15	38.02
16.99	21.21	24.4		31.92	34.4		36.16	38.03
18.21		24.5		31.98			36.19	

38.04	38.69	40.22	42.51	44.40	45.79	47.0	49.51	51.39
38.05	38.7	40.23	42.52	44.41		47.1	49.52	
38.06	38.80	40.24	42.53	44.42	45.8	47.2	49.59	51.41
38.07	38.81	40.29	42.54			47.91	49.6	51.42
38.08	38.82	40.3	42.55	44.5		47.92	49.71	51.43
38.09	38.83	40.40	42.56	44.61	45.90	47.99	49.72	51.49
38.10	38.84	40.41	42.58	44.63	45.91		49.73	51.51
38.11	38.85	40.42	42.59	44.64	45.92		49.74	51.59
38.12	38.86	40.50	42.61	44.65	45.93		49.79	51.61
38.13	38.87	40.51	42.62	44.66	45.94		49.91	51.62
38.14	38.88	40.52	42.63	44.69	45.95	48.0	49.92	51.63
38.15	38.89	40.53	42.64	44.91	46.01	48.1	49.93	51.64
38.16	39.0	40.54	42.65	44.92	46.02	48.21	49.94	51.69
38.18	39.1	40.59	42.66	44.99	46.03	48.22	49.95	51.71
38.21	39.21	40.61	42.68	45.00	46.04	48.23	49.99	51.72
38.29	39.22	40.62	42.69	45.01		48.24		51.79
38.30	39.23	40.63	42.7	45.02	46.10	48.25		51.81
38.31	39.24	40.64	42.82	45.03	46.11	48.35		51.82
38.32	39.25	40.69	42.83	45.11	46.12	48.41		51.83
38.33	39.26	40.9	42.84	45.12	46.13	48.49		51.84
38.34	39.27	41.00	42.85	45.13	46.20	48.5		51.85
38.35	39.29	41.01	42.86	45.14	46.21	48.61	50.0	51.86
38.36	39.30	41.02	42.87	45.15	46.22	48.62	50.12	51.87
38.37	39.31	41.03	42.89	45.16	46.23	48.63	50.19	51.89
38.38	39.32	41.2	42.91	45.21	46.40	48.64	50.21	51.91
38.39	39.41	41.33	43.0	45.22	46.41	48.65	50.22	51.92
38.40	39.42	41.41	43.3	45.23	46.42	48.69	50.29	51.93
38.41	39.43	41.42	43.41	45.24	46.43	48.71		51.94
38.42	39.49	41.43	43.42	45.25	46.50	48.72	50.3	51.95
38.43	39.51	41.5	43.49	45.26	46.51	48.73	50.4	51.99
38.44	39.52	41.93	43.5	45.30	46.52	48.74	50.51	52.01
38.45	39.53	41.94	43.6	45.31	46.60	48.75	50.59	52.09
38.46	39.54	41.95	43.7	45.32	46.61	48.76	50.61	52.12
38.47	39.55	41.99	43.81	45.33	46.62	48.79	50.69	52.13
38.48	39.56	42.01	43.89	45.34	46.63	48.81		52.14
38.49	39.57	42.09	43.91	45.41	46.64	48.82	51.02	52.19
38.50	39.58	42.10	43.99	45.42	46.71	48.91	51.03	52.21
38.51	39.59	42.11	44.00	45.43	46.72	48.92	51.04	52.22
38.52		42.12	44.01	45.49	46.73	48.93	51.10	52.3
38.53		42.19	44.02	45.50	46.74	48.99	51.11	
38.55	39.7	42.21	44.03	45.51	46.75	49.01	51.13	
38.57	39.8	42.22	44.11	45.52	46.76	49.02	51.14	
38.59	39.91	42.23	44.12	45.61	46.79	49.04	51.19	
38.60	39.92	42.24	44.13	45.62	46.80	49.11	51.21	
38.61	39.93	42.25	44.14	45.63	46.81	49.12	51.22	
38.62	39.94	42.31	44.15	45.71	46.82	49.21	51.31	
38.63	39.98	42.32	44.21	45.72	46.91	49.31	51.32	
38.64	39.99	42.33	44.29	45.73	46.92	49.39	51.33	
38.65	40.0	42.39	44.31	45.74	46.93	49.44	51.34	
38.66	40.11	42.40	44.39	45.75	46.94	49.45	51.35	
38.67	40.19	42.41		45.76	46.99	49.46	51.36	
38.68	40.21	42.42				49.49	51.37	

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52.4	54.22	56.0	57.85	60.3	64.2	66.61	69.21	70.79
52.51	54.23	56.1	57.86	60.4	64.3	66.62	69.22	70.8
52.52	54.29	56.2	57.87	60.5	64.41	66.63	69.23	
52.53	54.3	56.31		60.61	64.42	66.69	69.29	70.91
52.59	54.4	56.34	57.88	60.62	64.43	66.71	69.3	70.92
52.6	54.5	56.39	57.89	60.69	64.44		69.41	
52.7	54.61	56.40	57.91	60.72	64.45	66.72	69.42	71.01
52.80	54.62	56.41	57.93	60.73	64.49	66.73		71.09
52.81	54.63	56.42	57.96	60.79	64.5	66.74		71.11
52.82	54.64	56.51	57.97	60.81	64.92	66.79		71.19
52.83	54.71	56.52	57.98	60.82	64.93	66.92		71.22
52.92	54.72	56.61	57.99	60.93	64.95	66.93		71.23
52.93	54.73	56.62	58.0	60.94	64.96	66.94		71.24
52.95	54.74	56.71	58.1	60.99	64.97	66.95	69.49	71.29
52.96	54.75	56.72	58.22	61.2	64.98	66.96	69.51	71.3
52.97	54.92	56.73	58.41	61.42	64.99	66.97	69.52	71.4
52.98	54.93	56.74	58.42	61.49	65.0	66.99	69.95	71.5
52.99	54.94	56.75	58.43	61.92	65.11	67.11	69.97	71.61
53.00	54.95	56.79	58.44	61.99	65.12	67.12	69.98	71.62
53.01	55.01	56.81	58.45	62.0	65.19	67.19	69.99	71.71
53.02	55.02	56.82	58.46	62.12	65.21	67.2		71.72
53.03	55.03	56.83	58.47	62.19	65.22	67.31		71.79
53.04	55.04	56.84	58.49	62.2	65.29	67.32		71.8
53.05	55.11	56.85	58.5	62.3	65.3	67.33		71.9
53.10	55.12	56.86	58.91	62.41	65.4	67.39		
53.11	55.21	56.89	58.92	62.42	65.51	67.4		
53.12	55.22	56.92	58.93	62.5	65.52	67.5		
53.13	55.24	56.93	58.99	62.61	65.61	67.61	70.12	
53.14	55.29	56.94	59.00	62.69	65.62	67.62	70.13	
53.15	55.31	56.95	59.01	62.7	65.71	67.69	70.14	
53.16	55.39	56.99	59.02	62.99	65.72	68.0		
53.17	55.4	57.12	59.09	63.09	65.73	68.12	70.21	
53.21	55.501	57.18	59.11	63.1	65.79	68.13	70.22	
53.29	55.51	57.19	59.19	63.2	65.8	68.14	70.23	
53.31	55.52	57.21	59.21	63.3	65.91	68.15	70.24	
53.39	55.53	57.22	59.29	63.4	65.92	68.16	70.29	
53.41	55.54	57.31	59.3	63.51	65.93	68.19	70.31	
53.49	55.61	57.32	59.4	63.53	65.94	68.21	70.32	
53.51	55.69	57.33	59.5	63.59	65.95	68.22	70.33	
53.59	55.7	57.34	59.6	63.81	65.99	68.29	70.4	
53.61	55.81	57.39	59.71	63.82	66.0	68.3	70.50	
53.69	55.82	57.41	59.79	63.83	66.11	68.4	70.51	
53.7	55.83	57.49	59.91	63.85	66.19	68.5	70.52	
53.80	55.84	57.51	59.92	63.89	66.21	68.6	70.61	
53.81	55.85	57.59		63.92	66.22	68.7	70.62	
53.82	55.86	57.6	60.0	63.93	66.29	68.8	70.71	
53.9	55.87	57.71	60.12	63.94	66.31	69.01	70.72	
54.0	55.89	57.79	60.14	63.95	66.32	69.02	70.73	
54.11	55.91	57.81	60.15	63.99	66.39	69.09	70.74	
54.12	55.97	57.82	60.18	64.0	66.4	69.11	70.75	
54.19	55.98	57.83	60.19	64.11	66.51	69.19	70.76	
54.21	55.99	57.84	60.2		66.52		70.77	

73.94	77.02	77.56	78.08	78.65	79.27	79.97	80.75
73.99	77.03	77.57	78.09	78.66	79.28	79.98	80.76
74.0	77.04	77.58	78.10	78.67	79.29	79.99	80.77
74.1	77.05	77.59	78.11	78.68	79.30	80.00	80.78
74.2	77.06	77.60	78.12	78.69	79.31	80.01	80.79
74.3	77.07	77.61	78.13	78.70	79.32	80.02	80.80
74.4	77.08	77.62	78.14	78.71	79.33	80.03	80.81
74.91	77.09	77.63	78.15	78.72	79.34	80.04	80.82
74.99	77.10	77.64	78.16	78.73	79.35	80.05	80.83
75.36	77.11	77.65	78.17	78.74	79.36	80.06	80.84
75.50	77.12	77.66	78.18	78.75	79.37	80.07	80.85
75.51	77.13	77.67	78.19	78.76	79.38	80.08	80.86
75.52	77.14	77.68	78.20	78.77	79.39	80.09	80.87
75.61	77.15	77.69	78.22	78.78	79.40	80.10	80.88
75.93	77.16	77.70	78.23	78.79	79.41	80.11	80.89
75.99	77.17	77.71	78.25	78.80	79.42	80.12	80.90
76.01	77.18	77.72	78.27	78.81	79.45	80.13	80.91
76.09	77.19	77.73	78.29	78.82	79.46	80.14	80.92
76.11	77.20	77.74	78.30	78.83	79.49	80.15	80.93
76.19	77.21	77.75	78.31	78.84	79.50	80.16	80.94
76.2	77.22	77.76	78.32	78.85	79.51	80.17	80.95
76.31	77.23	77.77	78.33	78.86	79.52	80.18	80.96
76.39	77.24	77.78	78.34	78.87	79.55	80.19	80.97
76.41	77.25	77.79	78.35	78.88	79.56	80.20	80.98
76.42	77.26	77.80	78.37	78.89	79.59	80.21	80.99
76.43	77.27	77.81	78.38	78.90	79.60	80.22	81.00
76.44	77.28	77.82	78.39	78.91	79.61	80.23	81.01
76.45	77.29	77.83	78.40	78.92	79.62	80.24	81.02
76.46	77.30	77.84	78.41	78.93	79.63	80.25	81.03
76.5	77.31	77.85	78.42	78.94	79.64	80.26	81.04
76.61	77.32	77.86	78.43	78.95	79.65	80.27	81.05
76.62	77.33	77.87	78.44	78.96	79.66	80.28	81.06
76.63	77.34	77.88	78.45	78.97	79.67	80.29	81.07
76.64	77.35	77.89	78.46	78.98	79.68	80.40	81.08
76.65	77.36	77.90	78.47	78.99	79.69	80.41	81.09
76.66	77.37	77.91	78.48	79.10	79.80	80.42	81.11
76.67	77.38	77.92	78.49	79.11	79.81	80.43	81.12
76.68	77.39	77.93	78.50	79.12	79.82	80.44	81.13
76.69	77.40	77.94	78.51	79.13	79.83	80.45	81.14
76.70	77.41	77.95	78.52	79.14	79.84	80.46	81.15
76.72	77.42	77.96	78.53	79.15	79.85	80.47	81.16
76.74	77.43	77.97	78.54	79.16	79.86	80.48	81.17
76.76	77.44	77.98	78.55	79.17	79.87	80.49	81.20
76.77	77.45	77.99	78.56	79.18	79.88	80.50	81.21
76.79	77.46	78.00	78.57	79.19	79.89	80.51	81.22
76.91	77.47	78.01	78.58	79.20	79.90	80.59	81.23
76.92	77.48	78.02	78.59	79.21	79.91	80.6	81.24
76.94	77.49	78.03	78.60	79.22	79.92	80.70	81.25
76.97	77.51	78.04	78.61	79.23	79.93	80.71	81.26
76.99	77.52	78.05	78.62	79.24	79.94	80.72	81.27
77.00	77.53	78.06	78.63	79.25	79.95	80.73	81.28
77.01	77.54	78.07	78.64	79.26	79.96	80.74	81.29

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81.40	82.01	83.01	84.00	85.12	86.06	87.53	92.27
81.42	82.02	83.02	84.01	85.20	86.07		
81.43	82.03	83.03	84.02	85.21	86.09		93.92
81.44	82.09	83.09	84.03	85.22	86.21	88.52	
81.45	82.11	83.11	84.04	85.23	86.22	88.53	94.61
81.46	82.12	83.12	84.05	85.24	86.25	88.54	94.63
81.47	82.19	83.13	84.06	85.25	86.3	88.55	94.64
81.49	82.21	83.14	84.07	85.31	86.4	88.56	94.66
81.51	82.22	83.19	84.08	85.32	86.60	88.57	94.67
81.52	82.29	83.21	84.09	85.33	86.61	88.58	94.69
81.53	82.31	83.29	84.10	85.34	86.62		
81.54	82.32	83.31	84.11	85.35	86.63		
81.55	82.33	83.32	84.12	85.36	86.65		
81.56	82.34	83.39	84.13	85.41	86.66		
81.57	82.35	83.41	84.14	85.42	86.69		
81.59	82.36	83.42	84.15	85.43	86.70		98.51
81.71	82.39	83.43	84.16	85.44	86.71		
81.72	82.41	83.44	84.17	85.45	86.72		
81.73	82.42	83.45	84.18	85.46	86.73		
81.74	82.43	83.49	84.19	85.47	86.74		
81.75	82.44	83.5	84.21	85.48	86.75		
81.79	82.45	83.61	84.22	85.50	86.81		
81.80	82.46	83.62	84.23	85.53	86.82		
81.81	82.51	83.63	84.24	85.54	86.83		
81.82	82.52	83.64	84.25	85.6	86.84		
81.83	82.53	83.65	84.26	85.7	86.85		
81.84	82.54	83.71	84.27	85.82	86.86		
81.85	82.55	83.72	84.28	85.83	86.89		
81.93	82.56	83.73	84.29	85.84	86.91		
81.94	82.57	83.74	84.3	85.85	86.93		
81.95	82.58	83.75	84.40	85.86			
81.96	82.59	83.76	84.44	85.87			
81.98	82.61	83.77	84.48	85.89			
81.99	82.69	83.79	84.91	85.93			
	82.71	83.81	84.92	85.94			
	82.72	83.82	84.93	85.95			
	82.79	83.83	84.99	85.96			
	82.81	83.84		85.99			
	82.82	83.85					
	82.83	83.86					
	82.84	83.87					
	82.85	83.88					
	82.86	83.89					
	82.89	83.91					
	82.91	83.92					
	82.99	83.93					
		83.99					

ICD-9-CM DIAGNOSTIC AND OPERATIVE EXPANSIONS

A. The following instructions and expansions will be referenced in volume 1, ICD-9-CM:

ICD-9-CM Code	Title/Instruction
291.2	Other alcoholic dementia--DO NOT USE
291.20	Dementia associated with alcoholism unspecified
291.21	Dementia associated with alcoholism, mild
291.22	Dementia associated with alcoholism, moderate
291.23	Dementia associated with alcoholism, severe
304.0	Opioid type dependence--DO NOT USE
304.000	Heroin dependence unspecified
304.010	Heroin dependence continuous
304.020	Heroin dependence episodic
304.030	Heroin dependence in remission
304.001	Methadone dependence unspecified
304.011	Methadone dependence continuous
304.021	Methadone dependence episodic
304.031	Methadone dependence in remission
304.002	Morphine dependence unspecified
304.012	Morphine dependence continuous
304.022	Morphine dependence episodic
304.032	Morphine dependence in remission
304.003	Opium dependence unspecified
304.013	Opium dependence continuous
304.023	Opium dependence episodic
304.033	Opium dependence in remission
304.009	Other opioid dependence unspecified
304.019	Other opioid dependence continuous
304.029	Other opioid dependence episodic
304.039	Other opioid dependence in remission
304.1	Barbiturate and similarly acting sedative or hypnotic dependence--DO NOT USE
304.100	Chloral hydrate dependence unspecified
304.110	Chloral hydrate dependence continuous
304.120	Chloral hydrate dependence episodic
304.130	Chloral hydrate dependence in remission
304.101	Librium dependence unspecified
304.111	Librium dependence continuous
304.121	Librium dependence episodic
304.131	Librium dependence in remission
304.102	Meprobamate dependence unspecified
304.112	Meprobamate dependence continuous
304.122	Meprobamate dependence episodic
304.132	Meprobamate dependence in remission
304.103	Noludar, methyprylome dependence unspecified
304.113	Noludar, methyprylome dependence continuous
304.123	Noludar, methyprylome dependence episodic
304.133	Noludar, methyprylome dependence in remission
304.104	Paraldehyde dependence unspecified
304.114	Paraldehyde dependence continuous
304.124	Paraldehyde dependence episodic

ICD-9-CM Code	Title/Instruction
304.134	Paraldehyde dependence in remission
304.105	Placidyl, ethchloruynol dependence unspecified
304.115	Placidyl, ethchloruynol dependence continuous
304.125	Placidyl, ethchloruynol dependence episodic
304.135	Placidyl, ethchloruynol dependence in remission
304.106	Valium, diazepam dependence unspecified
304.116	Valium, diazepam dependence continuous
304.126	Valium, diazepam dependence episodic
304.136	Valium, diazepam dependence in remission
304.107	Doriden, glutethimide dependence unspecified
304.117	Doriden, glutethimide dependence continuous
304.127	Doriden, glutethimide dependence episodic
304.137	Doriden, glutethimide dependence in remission
304.108	Barbiturates dependence unspecified
304.118	Barbiturates dependence continuous
304.128	Barbiturates dependence episodic
304.138	Barbiturates dependence in remission
304.109	Other sedative or hypnotic dependence unspecified
304.119	Other sedative or hypnotic dependence continuous
304.129	Other sedative or hypnotic dependence episodic
304.139	Other sedative or hypnotic dependence in remission
304.2	Cocaine dependence--DO NOT USE
304.20	Cocaine dependence unspecified
304.21	Cocaine dependence continuous
304.22	Cocaine dependence episodic
304.23	Cocaine dependence in remission
304.3	Cannabis dependence--DO NOT USE
304.300	Marijuana dependence unspecified
304.310	Marijuana dependence continuous
304.320	Marijuana dependence episodic
304.330	Marijuana dependence in remission
304.309	Other cannabis dependence unspecified
304.319	Other cannabis dependence continuous
304.329	Other cannabis dependence episodic
304.339	Other cannabis dependence in remission
304.4	Amphetamine and other psychostimulant dependence--DO NOT USE
304.400	Amphetamine dependence unspecified
304.410	Amphetamine dependence continuous
304.420	Amphetamine dependence episodic
304.430	Amphetamine dependence in remission
304.401	Preludin dependence unspecified
304.411	Preludin dependence continuous
304.421	Preludin dependence episodic
304.431	Preludin dependence in remission
304.409	Other psychostimulant dependence unspecified
304.419	Other psychostimulant dependence continuous
304.429	Other psychostimulant dependence episodic
304.439	Other psychostimulant dependence in remission
304.5	Hallucinogen dependence--DO NOT USE
304.500	LSD dependence unspecified
304.510	LSD dependence continuous
304.520	LSD dependence episodic

ICD-9-CM Code	Title/Instruction
304.530	LSD dependence in remission
304.509	Other hallucinogen dependence unspecified
304.519	Other hallucinogen dependence continuous
304.529	Other hallucinogen dependence episodic
304.539	Other hallucinogen dependence in remission
304.6	Other specified drug dependence--DO NOT USE
304.600	Phencyclidine (PCP) dependence, unspecified
304.610	Phencyclidine (PCP) dependence, continuous
304.620	Phencyclidine (PCP) dependence, episodic
304.630	Phencyclidine (PCP) dependence, in remission
304.609	Other specified drug dependence, unspecified
304.619	Other specified drug dependence, continuous
304.629	Other specified drug dependence, episodic
304.639	Other specified drug dependence, in remission
304.7	Combinations of opioid type drug with any other--DO NOT USE
304.70	Combinations of opioid type drug with any other unspecified
304.71	Combinations of opioid type drug with any other continuous
304.72	Combinations of opioid type drug with any other episodic
304.73	Combinations of opioid type drug with any other in remission
304.8	Combinations of drug dependence excluding opioid type drug--DO NOT USE
304.80	Combinations of drug dependence excluding opioid type drug unspecified
304.81	Combinations of drug dependence excluding opioid type drug continuous
304.82	Combinations of drug dependence excluding opioid type drug episodic
304.83	Combinations of drug dependence excluding opioid type drug in remission
304.9	Unspecified drug dependence--DO NOT USE
304.90	Unspecified drug dependence, NEC unspecified
304.91	Unspecified drug dependence, NEC continuous
304.92	Unspecified drug dependence, NEC episodic
304.93	Unspecified drug dependence, NEC in remission
305.0	Alcohol abuse--DO NOT USE
305.00	Alcohol abuse unspecified
305.01	Alcohol abuse continuous
305.02	Alcohol abuse episodic
305.03	Alcohol abuse in remission
305.1	Tobacco use disorder DO NOT USE
305.10	Tobacco use disorder unspecified
305.11	Tobacco use disorder continuous
305.12	Tobacco use disorder episodic
305.13	Tobacco use disorder in remission
305.2	Cannabis abuse--DO NOT USE
305.200	Marijuana abuse unspecified
305.210	Marijuana abuse continuous
305.220	Marijuana abuse episodic
305.230	Marijuana abuse in remission
305.209	Other cannabis abuse unspecified
305.219	Other cannabis abuse continuous
305.229	Other cannabis abuse episodic

ICD-9-CM Code	Title/Instruction
305.239	Other cannabis abuse in remission
305.3	Hallucinogen abuse--DO NOT USE
305.300	LSD abuse unspecified
305.310	LSD abuse continuous
305.320	LSD abuse episodic
305.330	LSD abuse in remission
305.309	Other hallucinogen abuse unspecified
305.319	Other hallucinogen abuse continuous
305.329	Other hallucinogen abuse episodic
305.339	Other hallucinogen abuse in remission
305.4	Barbiturate and similarly acting sedative of hypnotic abuse--DO NOT USE
305.400	Chloral hydrate abuse unspecified
305.410	Chloral hydrate abuse continuous
305.420	Chloral hydrate abuse episodic
305.430	Chloral hydrate abuse in remission
305.401	Librium abuse unspecified
305.411	Librium abuse continuous
305.421	Librium abuse episodic
305.431	Librium abuse in remission
305.402	Meprobamate abuse unspecified
305.412	Meprobamate abuse continuous
305.422	Meprobamate abuse episodic
305.432	Meprobamate abuse in remission
305.403	Noludar, methyprylome abuse unspecified
305.413	Noludar, methyprylome abuse continuous
305.423	Noludar, methyprylome abuse episodic
305.433	Noludar, methyprylome abuse in remission
305.404	Paraldehyde abuse unspecified
305.414	Paraldehyde abuse continuous
305.424	Paraldehyde abuse episodic
305.434	Paraldehyde abuse in remission
305.405	Placidyl, ethchloruynol abuse unspecified
305.415	Placidyl, ethchloruynol abuse continuous
305.425	Placidyl, ethchloruynol abuse episodic
305.435	Placidyl, ethchloruynol abuse in remission
305.406	Valium, diazepam abuse unspecified
305.416	Valium, diazepam abuse continuous
305.426	Valium, diazepam abuse episodic
305.436	Valium, diazepam abuse in remission
305.407	Doriden, glutethimide abuse unspecified
305.417	Doriden, glutethimide abuse continuous
305.427	Doriden, glutethimide abuse episodic
305.437	Doriden, glutethimide abuse in remission
305.408	Barbiturates abuse unspecified
305.418	Barbiturates abuse continuous
305.428	Barbiturates abuse episodic
305.438	Barbiturates abuse in remission
305.409	Other sedative or hypnotic abuse unspecified
305.419	Other sedative or hypnotic abuse continuous
305.429	Other sedative or hypnotic abuse episodic
305.439	Other sedative or hypnotic abuse in remission

ICD-9-CM Code	Title/Instruction
305.5	Opioid abuse--DO NOT USE
305.500	Heroin abuse unspecified
305.510	Heroin abuse continuous
305.520	Heroin abuse episodic
305.530	Heroin abuse in remission
305.501	Methadone abuse unspecified
305.511	Methadone abuse continuous
305.521	Methadone abuse episodic
305.531	Methadone abuse in remission
305.502	Morphine abuse unspecified
305.512	Morphine abuse continuous
305.522	Morphine abuse episodic
305.532	Morphine abuse in remission
305.503	Opium abuse unspecified
305.513	Opium abuse continuous
305.523	Opium abuse episodic
305.533	Opium abuse in remission
305.509	Other opioid abuse, NEC unspecified
305.519	Other opioid abuse, NEC continuous
305.529	Other opioid abuse, NEC episodic
305.539	Other opioid abuse, NEC in remission
305.6	Cocaine abuse--DO NOT USE
305.60	Cocaine abuse unspecified
305.61	Cocaine abuse continuous
305.62	Cocaine abuse episodic
305.63	Cocaine abuse in remission
305.7	Amphetamine or related acting sympathomimetic abuse--DO NOT USE
305.700	Amphetamine abuse unspecified
305.710	Amphetamine abuse continuous
305.720	Amphetamine abuse episodic
305.730	Amphetamine abuse in remission
305.701	Preludine abuse unspecified
305.711	Preludine abuse continuous
305.721	Preludine abuse episodic
305.731	Preludine abuse in remission
305.709	Other related acting sympathomimetic abuse, NEC unspecified
305.719	Other related acting sympathomimetic abuse, NEC continuous
305.729	Other related acting sympathomimetic abuse, NEC episodic
305.739	Other related acting sympathomimetic abuse, NEC in remission
305.8	Antidepressant type abuse--DO NOT USE
305.80	Antidepressant type abuse unspecified
305.81	Antidepressant type abuse continuous
305.82	Antidepressant type abuse episodic
305.83	Antidepressant type abuse in remission
305.9	Other, mixed, or unspecified drug abuse--DO NOT USE
305.900	Phencyclidine (PCP) abuse unspecified
305.910	Phencyclidine (PCP) abuse continuous
305.920	Phencyclidine (PCP) abuse episodic
305.930	Phencyclidine (PCP) abuse in remission
305.909	Other, mixed or unspecified drug abuse, NEC (includes caffeine) unspecified

ICD-9-CM Code	Title/Instruction
305.919	Other, mixed or unspecified drug abuse, NEC (includes caffeine) continuous
305.929	Other, mixed or unspecified drug abuse, NEC (includes caffeine) episodic
305.939	Other, mixed or unspecified drug abuse, NEC (includes caffeine) in remission
437.8	Other--DO NOT USE
437.80	Cerebral/brain quadriplegia
437.81	Cerebral/brain paraplegia
437.89	Other cerebrovascular disease, NEC
482.8	Pneumonia due to other specified bacteria--DO NOT USE
482.80	Legionnaire's Disease (Legionella Pneumophilia)
482.89	Pneumonia, due to other specified bacteria, NEC
706.1	Other acne--DO NOT USE
706.10	Chloracne
706.19	Other and unspecified acne NEC
799.9	Other unknown and unspecified cause--DO NOT USE
799.90	Mental disorder/diagnosis deferred on Axis 1 or Axis II
799.99	Other unknown or unspecified cause, NEC
989.2	Chlorinated hydrocarbons--DO NOT USE
989.20	Toxic effect of phenoxy acid herbicides 2,4-D and/or 2,4,5-T
989.21	Toxic effect of TCDD and other dioxins
989.29	Other chlorinated hydrocarbons, NEC
989.4	Other pesticides, not elsewhere classified--DO NOT USE
989.40	Toxic effect of dioxin (Agent Orange)
989.49	Toxic effect of other pesticides, NEC
E950.0	Analgesics, antipyretics, and antirheumatics--DO NOT USE
E950.01	Analgesics, antipyretics, and antirheumatics, attempted
E950.02	Analgesics, antipyretics, and antirheumatics, actual
E950.1	Barbiturates--DO NOT USE
E950.11	Barbiturates, attempted
E950.12	Barbiturates, actual
E950.2	Other sedatives and hypnotics--DO NOT USE
E950.21	Other sedatives and hypnotics, attempted
E950.22	Other sedatives and hypnotics, actual
E950.3	Tranquilizers and other psychotropic agents--DO NOT USE
E950.31	Tranquilizers and other psychotropic agents, attempted
E950.32	Tranquilizers and other psychotropic agents, actual
E950.4	Other specified drugs and medicinal substances--DO NOT USE
E950.41	Other specified drugs and medicinal substances, attempted
E950.42	Other specified drugs and medicinal substances, actual
E950.5	Unspecified drug or medicinal substance--DO NOT USE
E950.51	Unspecified drug or medicinal substance, attempted
E950.52	Unspecified drug or medicinal substance, actual
E950.6	Agricultural and horticultural chemical and pharmaceutical preparations other than plant foods and fertilizers--DO NOT USE
E950.61	Agricultural and horticultural chemical and pharmaceutical preparations other than plant foods and fertilizers, attempted
E950.62	Agricultural and horticultural chemical and pharmaceutical preparations other than plant foods and fertilizers, actual
E950.7	Corrosive and caustic substances--DO NOT USE
E950.71	Corrosive sand caustic substances, attempted

ICD-9-CM Code	Title/Instruction
E950.72	Corrosive and caustic substances, actual
E950.8	Arsenic and its compounds--DO NOT USE
E950.81	Arsenic and its compounds, attempted
E950.82	Arsenic and its compounds, actual
E950.9	Other and unspecified solid and liquid substances--DO NOT USE
E950.91	Other and unspecified solid and liquid substances, attempted
E950.92	Other and unspecified solid and liquid substances, actual
E951.0	Gas distributed by pipeline--DO NOT USE
E951.01	Gas distributed by pipeline, attempted
E951.02	Gas distributed by pipeline, actual
E951.1	Liquefied petroleum gas distributed in mobile containers--DO NOT USE
E951.11	Liquefied petroleum gas distributed in mobile containers, attempted
E951.12	Liquefied petroleum gas distributed in mobile containers, actual
E951.8	Other utility gas DO NOT USE
E951.81	Other utility gas, attempted
E951.82	Other utility gas, actual
E952.0	Motor vehicle exhaust gas--DO NOT USE
E952.01	Motor vehicle exhaust gas, attempted
E952.02	Motor vehicle exhaust gas, actual
E952.1	Other carbon monoxide--DO NOT USE
E952.11	Other carbon monoxide, attempted
E952.12	Other carbon monoxide, actual
E952.8	Other specified gases and vapors--DO NOT USE
E952.81	Other specified gases and vapors, attempted
E952.82	Other specified gases and vapors, actual
E952.9	Unspecified gases and vapors--DO NOT USE
E952.91	Unspecified gases and vapors, attempted
E952.92	Unspecified gases and vapors, actual
E953.0	Hanging--DO NOT USE
E953.01	Hanging, attempted
E953.02	Hanging, actual
E953.1	Suffocation by plastic bagir DO NOT USE
E953.11	Suffocation by plastic bag, attempted
E953.12	Suffocation by plastic bag, actual
E953.8	Other specified means--DO NOT USE
E953.81	Other specified means, attempted
E953.82	Other specified means, actual
E953.9	Unspecified means--DO NOT USE
E954	Suicide and self-inflicted injury by submersion--DO NOT USE
E954.1	Suicide and self-inflicted injury by submersion (drowning attempted)
E954.2	Suicide and self-inflicted injury by submersion drowning actual
E955.0	Handgun--DO NOT USE
E955.01	Handgun, attempted
E955.02	Handgun, actual
E955.1	Shotgun--DO NOT USE
E955.11	Shotgun, attempted
E955.12	Shotgun, actual
E955.2	Hunting rifle--DO NOT USE
E955.21	Hunting rifle, attempted
E955.22	Hunting rifle, actual
E955.3	Military firearms--DO NOT USE

ICD-9-CM Code	Title/Instruction
E955.31	Military firearms, attempted
E955.32	Military firearms, actual
E955.4	Other and unspecified firearm--DO NOT USE
E955.41	Other and unspecified firearm, attempted
E955.42	Other and unspecified firearm, actual
E955.5	Explosives--DO NOT USE
E955.51	Explosives, attempted
E955.52	Explosives, actual
E955.9	Unspecified--DO NOT USE
E956	Suicide and self-inflicted injury by cutting and piercing instrument--DO NOT USE
E956.1	Suicide and self-inflicted injury by cutting and piercing instrument, attempted
E956.2	Suicide and self-inflicted injury by cutting and piercing instrument, actual
E957.0	Jump from residential premises--DO NOT USE
E957.01	Jump from residential premises, attempted
E957.02	Jump from residential premises, actual
E957.1	Jump from other man-made structures--DO NOT USE
E957.11	Jump from other man-made structures, attempted
E957.12	Jump from other man-made structures, actual
E957.2	Jump from natural sites--DO NOT USE
E957.21	Jump from natural sites, attempted
E957.22	Jump from natural sites, actual
E957.9	Jump from unspecified high place--DO NOT USE
E957.91	Jump from unspecified high place, attempted
E957.92	Jump from unspecified high place, actual
E958.0	Jumping or lying before moving object--DO NOT USE
E958.01	Jumping or lying before moving object, attempted
E958.02	Jumping or lying before moving object, actual
E958.1	Burns, fire--DO NOT USE
E958.11	Burns, fire, attempted
E958.12	Burns, fire, actual
E958.2	Scald--DO NOT USE
E958.21	Scald, attempted
E958.22	Scald, actual
E958.3	Extremes of cold--DO NOT USE
E958.31	Extremes of cold, attempted
E958.32	Extremes of cold, actual
E958.4	Electrocution--DO NOT USE
E958.41	Electrocution, attempted
E958.42	Electrocution, actual
E958.5	Crashing of motor vehicle--DO NOT USE
E958.51	Crashing of motor vehicle, attempted
E958.52	Crashing of motor vehicle, actual
E958.6	Crashing of aircraft--DO NOT USE
E958.61	Crashing of aircraft, attempted
E958.62	Crashing of aircraft, actual
E958.7	Caustic substances, except poisonings--DO NOT USE
E958.71	Caustic substances, except poisonings, attempted
E958.72	Caustic substances, except poisonings, actual
E958.8	Other specified means--DO NOT USE

ICD-9-CM Code	Title/Instruction
E958.81	Other specified means, attempted
E958.82	Other specified means, actual
E958.9	Unspecified means--DO NOT USE
E978	Legal execution--DO NOT USE
V67.52	Follow-up examination of inactive pulmonary tuberculosis, inactive on admission
V67.53	Follow-up examination of other cases of inactive tuberculosis
V67.54	Follow-up examination of inactive infection of the longs, due to mycobacteria, excludes tuberculoosis
V70.8	Other specified general medical examination - DO NOT USE
V70.81	Examination of Potential donor or organ or tissue
V70.82	Examination of former Prisoner of War
V70.83	Other specified general examination
V72.8	DO NOT USE
V72.80	Examination for possible exposure to herbicides includes phenoxy acid herbicides, i.e., Agent Orange
V72.81	Examination for possible exposure to TCDD and other dioxins
V72.82	Examination for possible exposure to other chemical agents
V72.83	Examination for possible nuclear radiation exposure
V72.89	Other special examinations, NEC

B. The following expansions will be referenced in volume 3, ICD-9-CM:

39.95	Hemodialysis - DO NOT USE
39.951	Hemodialysis for chronic renal failure
39.952	Hemodialysis for acute renal failure
39.953	Hemodialysis for other conditions
54.98	Peritoneal dialysis - DO NOT USE
54.981	Peritoneal dialysis for chronic renal failure
54.982	Peritoneal dialysis for acute renal failure
54.983	Peritoneal dialysis for other conditions
55.501	Nephrectomy complete, donor
55.69	Other kidney transplantation - DO NOT USE
55.691	Kidney transplant recipiet - living donor
55.692	Kidney transplant recipient - cadaver donor
99.291	Infusion of streptokinase/urokinase (thrombolytic agents)
99.991	Other therapy in cancer treatment

ICD-9-CM ADDITIONS, DELETIONS, CHANGES

A. The following additions, deletions, and/or changes will be made in volume 1, ICD-9CM.

Page 530: After "0 unspecified" add "DO NOT USE".

Page 531: After "0 unspecified" add "DO NOT USE".

Page 532: After "0 unspecified" add "DO NOT USE".

Page 537: After "0 unspecified as to episode of care or not applicable" add "DO NOT USE".

Page 544: After "646.9" add "DO NOT USE".

Page 545: After "647.9" add "DO NOT USE".

Page 546: After "0 unspecified as to episode of care or not applicable" add "DO NOT USE".

Page 550: After "654.9" add "DO NOT USE".

Page 553: After "656.9" add "DO NOT USE".

Page 554: After "658.9" add "DO NOT USE".

Page 555: After "659.9" add "DO NOT USE".

Page 555: After "0 unspecified as to episode of care or not applicable" add "DO NOT USE".

Page 557: After "661.9" add "DO NOT USE".

Page 558: After "663.9" add "DO NOT USE".

Page 560: After "664.9" add "DO NOT USE".

Page 560: After "665.9" add "DO NOT USE".

Page 562: After "668.9" add "DO NOT USE".

Page 563: After "669.9" add "DO NOT USE".

Page 564: After "0 unspecified as to episode of care or not applicable" add "DO NOT USE"

Page 567: After "675.9" add "DO NOT USE".

Page 568: After "676.9" add "DO NOT USE".

Page 593: After "0 site unspecified" add "DO NOT USE".

Page 595: After "0 site unspecified" add "DO NOT USE".

- Page 598: After "0 site unspecified" add "DO NOT USE".
- Page 603: After "0 site unspecified" add "DO NOT USE".
- Page 604: After "0 site unspecified" add "DO NOT USE".
- Page 607: After "0 site unspecified" add "DO NOT USE".
- Page 608: After "0 site unspecified" add "DO NOT USE".
- Page 625: After "0 site unspecified" add "DO NOT USE".
- Page 639: After "740.0" add "DO NOT USE".
- Page 639: After "740.1" add "DO NOT USE".
- Page 639: After "740.2" add "DO NOT USE".
- Page 639: After "0 unspecified region" add "DO NOT USE".
- Page 641: After "743.00, 743.03, 743.06, 743.10, 743.11, and 743.12" add "DO NOT USE".
- Page 647: After "744.5" add "DO NOT USE".
- Page 665: After "753.5" add "DO NOT USE".
- Page 681: After "759.4" add "DO NOT USE".
- Page 682: After "759.7" add "DO NOT USE".
- Page 683: After "760 through 779.9" add "DO NOT USE".
- Page 732: After "798 through 798.9" add "DO NOT USE".
- Page 761: After "829.0 and 829.1" add "DO NOT USE".
- Page 868: After "996.00" add "DO NOT USE".
- Page 869: After "996.30" add "DO NOT USE".
- Page 870: After "996.80" add "DO NOT USE".
- Page 871: After "996.90" add "DO NOT USE".
- Page 873: After "997.60" add "DO NOT USE".
- Page 876: After "998.9" add "DO NOT USE".
- Page 894: After ":V20 through V20.2" add "DO NOT USE".
- Page 896: After "V25.2" add "DO NOT USE".

Page 897: After "V26.1" add "DO NOT USE".

Page 899: After "V30 through V39" add "DO NOT USE".

Page 907: After "V50 through V50.9" add "DO NOT USE".

Page 910: After "V56 through V56.8" add "DO NOT USE".

Page 919: After "V68.0 through V68.2" add "DO NOT USE".

Page 920: After "V68.9" add "DO NOT USE".

Page 922: After "V71.9" add "DO NOT USE".

Page 923: After "V72.0 through V72.7" add "DO NOT USE".

Page 923: After "V72.9 through V82.9" add "DO NOT USE".

Page 980: After "E870 through E76.9" add "DO NOT USE".

B. The following additions, deletions, and/or changes will be made in volume 3, ICD-9-CM, Tabular and Alphabetical Listings.

Page 16: After "06.50" add "DO NOT USE".

Page 18: After "07.00" add "DO NOT USE".

Page 20: After "07.63" add "DO NOT USE".

Page 20: After "07.69" add "DO NOT USE".

Page 21: After "07.80" add "DO NOT USE".

Page 63: After "26.30" add "DO NOT USE".

Page 83: After "35.00" add "DO NOT USE".

Page 83: After "35.10" add "DO NOT USE".

Page 84: After "35.20" add "DO NOT USE".

Page 86: After "35.50" add "DO NOT USE".

Page 87: After "35.60" add "DO NOT USE".

Page 89: After "35.70" add "DO NOT USE".

Page 92: After "36.10" add "DO NOT USE".

Page 99: After "0 unspecified" add "DO NOT USE".

Page 111: After "40.40" add "DO NOT USE".

- Page 111: After "40.50" add "DO NOT USE".
- Page 114: After "42.10" add "DO NOT USE".
- Page 115: After "42.40" add "DO NOT USE".
- Page 119: After "44.00" add "DO NOT USE".
- Page 120: After "44.40" add "DO NOT USE".
- Page 122: After "45.00" add "DO NOT USE".
- Page 126: After "45.90" add "DO NOT USE".
- Page 127: After "46.10" add "DO NOT USE".
- Page 128: After "46.20" add "DO NOT USE".
- Page 128: After "46.50" add "DO NOT USE".
- Page 129: After "46.60" add "DO NOT USE".
- Page 130: After "46.80" add "DO NOT USE".
- Page 146: After "52.80" add "DO NOT USE".
- Page 159: After "56.40" add "DO NOT USE".
- Page 178: After "63.70" add "DO NOT USE".
- Page 203: After "75.50" add "DO NOT USE".
- Page 207: After "76.70" add "DO NOT USE".
- Page 209: After "0 unspecified site" add "DO NOT USE".
- Page 212: After "0 unspecified site" add "DO NOT USE".
- Page 214: After "0 unspecified site" add "DO NOT USE".
- Page 215: After "79.70" add "DO NOT USE".
- Page 216: After "79.80" add "DO NOT USE".
- Page 216: After "79.9" add "DO NOT USE".
- Page 217: After "0 unspecified site" add "DO NOT USE".
- Page 218: After "81.00" add "DO NOT USE".
- Page 220: After "81.20" add "DO NOT USE".

- Page 234: After "84.00" add "DO NOT USE".
- Page 236: After "84.40" add "DO NOT USE".
- Page 237: After "84.91, 84.92, and 84.93" add "DO NOT USE".
- Page 248: After "87.11" add "DO NOT USE".
- Page 249: After "87.12" add "DO NOT USE".
- Page 249: After "87.16 and 87.17" add "DO NOT USE".
- Page 249: After "87.22 through 87.29" add "DO NOT USE".
- Page 251: After "87.43 through 87.49" add "DO NOT USE".
- Page 253: After "88.21 through 88.31" add "DO NOT USE".
- Page 254: After "88.33" add "DO NOT USE".
- Page 255: After "88.40" add "DO NOT USE".
- Page 258: After "88.60" add "DO NOT USE".
- Page 259: After "89.0 through 89.09" add "DO NOT USE".
- Page 260: After "89.16" add "DO NOT USE".
- Page 261: After "89.26" add "DO NOT USE".
- Page 261: After "89.31" add "DO NOT USE".
- Page 261: After "89.33 and 89.34" add ""DO NOT USE".
- Page 262: After "89.36" add "DO NOT USE".
- Page 264: After "89.7 and 89.8" add "DO NOT USE".
- Page 264: After "90.0 through 91.9" add "DO NOT USE".
- Page 288: After "98.20" add "DO NOT USE".
- Page 292: After "99.3 through 99.59", add "DO NOT USE".

ICD-9-CM DIAGNOSTIC CODES INVALID FOR REPORTING THE DXLS

1370	36644	61611	71157	71227	7740	V016	V079
1371	37044	61651	71158	71228	77431	V017	V1000
1372	37105	6281	71159	71229	7745	V018	V1001
1373	37215	71110	71160	71230	9050	V019	V1002
1374	37231	71111	71161	71231	9051	V020	V1003
138	37233	71112	71162	71232	9052	V021	V1004
1390	3734	71113	71163	71233	9053	V022	V1005
1391	3735	71114	71164	71234	9054	V023	V1006
1398	3736	71115	71165	71235	9055	V024	V1007
2681	37451	71116	71166	71236	9056	V025	V1009
3207	37613	71117	71167	71237	9057	V026	V1011
3210	37621	71118	71168	71238	9058	V027	V1012
3211	37622	71119	71169	71239	9059	V028	V1020
3212	38013	71120	71170	7130	9060	V029	V1021
3213	38015	71121	71171	7131	9061	V030	V1022
3214	38202	71122	71172	7132	9062	V031	V1029
3218	412	71123	71173	7133	9063	V032	V103
3230	4200	71124	71174	7134	9064	V033	V1040
3231	4211	71125	71175	7135	9065	V034	V1041
3232	4220	71126	71176	7136	9066	V035	V1042
3234	42491	71127	71177	7137	9067	V036	V1043
3236	4257	71128	71178	7138	9068	V037	V1044
3237	4258	71129	71179	72081	9069	V038	V1045
326	438	71130	71180	72701	9070	V039	V1046
3302	44381	71131	71181	73070	9071	V040	V1047
3303	45620	71132	71182	73071	9072	V041	V1049
3317	45621	71133	71183	73072	9073	V042	V1050
3344	4841	71134	71184	73073	9074	V043	V1051
3362	4843	71135	71185	73074	9075	V044	V1052
3363	4845	71136	71186	73075	9079	V045	V1059
3371	4846	71137	71187	73076	9080	V046	V1060
3571	4847	71138	71188	73077	9081	V047	V1061
3572	4848	71139	71189	73078	9082	V048	V1062
3573	5161	71140	71210	73079	9083	V050	V1063
3574	5171	71141	71211	73080	9084	V051	V1069
3581	5172	71142	71212	73081	9085	V052	V1071
3595	5178	71143	71213	73082	9086	V058	V1072
3596	5670	71144	71214	73083	9089	V059	V1079
36201	5731	71145	71215	73084	9090	V060	V1081
36202	5732	71146	71216	73085	9091	V061	V1082
36271	58081	71147	71217	73086	9092	V062	V1083
36272	58181	71148	71218	73087	9093	V063	V1084
36411	58281	71149	71219	73088	9094	V064	V1085
36541	58381	71150	71220	73089	9099	V068	V1086
36542	59081	71151	71221	7311	V010	V069	V1087
36543	5954	71152	71222	7318	V011	V070	V1088
36544	59801	71153	71223	73740	V012	V071	V1089
36641	6014	71154	71224	73741	V013	V072	V109
36642	60491	71155	71225	73742	V014	V073	V110
36643	60881	71156	71226	73743	V015	V078	V111

M-1, Part I
Chapter 7
APPENDIX 7E

May 18, 1989

V112	V170	V2542	V432	V498
V113	V171	V2549	V433	V499
V118	V172	V258	V434	V640
V119	V173	V259	V435	V641
V120	V174	V262	V436	V642
V121	V175	V263	V437	V643
V122	V176	V264	V438	V689
V123	V177	V268	V440	All "E" Code
V124	V178	V269	V441	
V125	V180	V270	V442	
V126	V181	V271	V443	
V127	V182	V272	V444	
V130	V183	V273	V445	
V131	V184	V274	V446	
V132	V185	V275	V447	
V133	V186	V276	V448	
V134	V187	V277	V449	
V135	V188	V279	V450	
V136	V190	V280	V451	
V137	V191	V281	V452	
V138	V192	V282	V453	
V139	V193	V283	V454	
V140	V194	V284	V455	
V141	V195	V285	V456	
V142	V196	V288	V4581	
V143	V197	V289	V4589	
V144	V198	V400	V460	
V145	V210	V401	V461	
V146	V211	V402	V468	
V147	V212	V403	V469	
V148	V218	V409	V470	
V149	V219	V410	V471	
V150	V220	V411	V472	
V151	V221	V412	V473	
V152	V222	V413	V474	
V153	V230	V414	V475	
V154	V231	V415	V479	
V155	V232	V416	V480	
V156	V233	V417	V481	
V157	V234	V418	V482	
V1581	V235	V419	V483	
V1589	V238	V420	V484	
V159	V239	V421	V485	
V160	V241	V422	V486	
V161	V242	V423	V487	
V162	V2501	V424	V488	
V163	V2502	V425	V489	
V164	V2509	V426	V490	
V165	V251	V427	V491	
V166	V252	V428	V492	
V167	V253	V429	V493	
V168	V2540	V430	V494	
V169	V2541	V431	V495	

1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Services and Research Administration Manual M-1, "Operations," Part I, "Medical Administration Activities," Chapter 7, "Patient Data and Quality Control." Brackets have not been used to indicate the changes.

2. Principal change is:

Update of CCs (Complications and Comorbidities) and ORs (Operating Room Procedures) which impact upon DRG (Diagnosis Related Group) assignment.

3. Filing Instructions

Removes pages

7A-1 through 7B-6

Insert pages

7A-1 through 7B-6

4. **RESCISSIONS:** M-1, part I, chapter 7, Appendixes 7A dated August 25, 1989, and 7B dated May 18, 1989.

Arthur J. Lewis, M.D.
Acting Chief Medical Director

Distribution: **RPC: 1131 (Is assigned)**
FD

Printing Date: 5/90

1. Transmitted is a change to Veterans Health Services and Research Administration Manual M-1, "Operations," Part I, "Medical Administration Activities," Chapter 7, "Patient Data and Quality Control." Because of the number of changes, brackets have not been used.

2. The purpose of this change is to provide **ICD-9-CM Coding Instructions**.

3. **Filing Instructions**

Remove pages

7-i through 7-78
7D-1 through 7D-35

Insert pages

7-i through 7-82
7D-1 through 7D-5

4. **RESCISSIONS:** M-1, part I, chapter 7, dated May 18, 1989, and Appendix 7D, dated May 18, 1989.

James W. Holsinger, Jr., M.D.
Chief Medical Director

Distribution: **RPC: 1016**
FD

Printing Date: 9/90

1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Administration Manual M-1, "Operations," Part I, "Medical Administration Activities," Chapter 7, "Patient Data and Quality Control." Brackets have not been used to indicate the changes.

2. Principal change is:

Update of CCs (Complications and Comorbidities) and ORs (Operating Room Procedures) which impact upon DRG (Diagnosis Related Group) assignment.

3. Filing Instructions

Removes pages

7A-1 through 7B-6

Insert pages

7A-1 through 7B-6

4. **RESCISSIONS:** M-1, part I, chapter 7, Appendixes 7A and 7B dated May 9, 1990.

James W. Holsinger, Jr., M.D.
Chief Medical Director

Distribution: **RPC: 1131**
FD

Printing Date: 6/91