Highlights of the Revised Official ICD-9-CM Guidelines for Coding and Reporting Effective October 1, 2008

Please refer to the complete ICD-9-CM Official Guidelines for Coding and Reporting posted on this web site for full details.

I. Revised General Coding Guidelines

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

Admissions/Encounters for Rehabilitation
When the purpose for the admission/encounter is rehabilitation, sequence the appropriate V code from category V57, Care involving use of rehabilitation procedures, as the principal/first-listed diagnosis. The code for the condition for which the service is being performed should be reported as an additional diagnosis. Only one code from category V57 is required. Code V57.89, Other specified rehabilitation procedures, should be assigned if more than one type of rehabilitation is performed during a single encounter. A procedure code should be reported to identify each type of rehabilitation therapy actually performed.

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

II. Chapter Specific coding Guidelines

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

Methicillin Resistant Staphylococcus aureus (MRSA) Conditions — Selection and sequencing of MRSA codes

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

(b) Other codes for MRSA infection
When there is documentation of a current infection (e.g., wound infection,
stitch abscess, urinary tract infection) due to MRSA, and that infection does
not have a combination code that includes the causal organism, select the
appropriate code to identify the condition along with code 041.12, Methicillin
resistant Staphylococcus aureus, for the MRSA infection. Do not assign a
code from subcategory V09.0, Infection with microorganisms resistant to
penicillins.

(c) Methicillin susceptible Staphylococcus aureus (MSSA) and MRSA
colonization
The condition or state of being colonized or carrying MSSA or MRSA is
called colonization or carriage, while an individual person is described as
being colonized or being a carrier. Colonization means that MSSA or MSRA
is present on or in the body without necessarily causing illness. A positive
MRSA colonization test might be documented by the provider as “MRSA
screen positive” or “MRSA nasal swab positive”. Assign code V02.54, Carrier
or suspected carrier, Methicillin resistant Staphylococcus aureus, for patients
documented as having MRSA colonization. Assign code V02.53, Carrier or
suspected carrier, Methicillin susceptible Staphylococcus aureus, for patient
documented as having MSSA colonization. Colonization is not necessarily
indicative of a disease process or as the cause of a specific condition the
patient may have unless documented as such by the provider. Code V02.59,
Other specified bacterial diseases, should be assigned for other types of
staphylococcal colonization (e.g., S. epidermidis, S. saprophyticus). Code
V02.59 should not be assigned for colonization with any type of
Staphylococcus aureus (MRSA, MSSA).

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

B. Chapter 2: Neoplasms (140-239)
Malignant neoplasm associated with transplanted organ
A malignant neoplasm of a transplanted organ should be coded as a transplant
complication. Assign first the appropriate code from subcategory 996.8,
Complications of transplanted organ, followed by code 199.2, Malignant
neoplasm associated with transplanted organ. Use an additional code for the
specific malignancy.

C. Chapter 3 Endocrine, Nutritional, and Metabolic Diseases and Immunity
Disorders (240-279)
Diabetes mellitus
Secondary Diabetes Mellitus
Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).

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

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

(c) Assigning and sequencing secondary diabetes codes and associated conditions — When assigning codes for secondary diabetes and its associated conditions (e.g. renal manifestations), the code(s) from category 249 must be sequenced before the codes for the associated conditions. Assign as many codes from category 249 as needed to identify all of the associated conditions that the patient has. The corresponding codes for the associated conditions are listed under each of the secondary diabetes codes.

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

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

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

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

Pressure ulcer stage codes

1) Pressure ulcer stages — Two codes are needed to completely describe a pressure ulcer: A code from subcategory 707.0, Pressure ulcer, to identify the site of the pressure ulcer and a code from subcategory 707.2, Pressure ulcer stages. The codes in subcategory 707.2, Pressure ulcer stages, are to be used as an additional diagnosis with a code(s) from subcategory 707.0, Pressure Ulcer. Codes from 707.2, Pressure ulcer stages, may not be assigned as a principal or first-listed diagnosis. The pressure ulcer stage codes should only be used with pressure ulcers and not with other types of ulcers (e.g., stasis ulcer).
2) **Unstageable pressure ulcers** — Assignment of code 707.25, Pressure ulcer, unstageable, should be based on the clinical documentation. Code 707.25 is used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma. This code should not be confused with code 707.20, Pressure ulcer, stage unspecified. Code 707.20 should be assigned when there is no documentation regarding the stage of the pressure ulcer.

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

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

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

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

7) **Patients admitted with pressure ulcers documented as healed** — No code is assigned if the documentation states that the pressure ulcer is completely healed.

8) **Patients admitted with pressure ulcers documented as healing** — Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign code 707.20, Pressure ulcer stage, unspecified. If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.

9) **Patient admitted with pressure ulcer evolving into another stage during the admission** — If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, assign the code for highest stage reported for that site.

**E. Chapter 17 Injury and Poisoning (800-999)**

**Documentation of complications of care**

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

1. Chronic kidney disease and kidney transplant complications — Patients who have undergone kidney transplant may still have some form of chronic kidney disease (CKD) because the kidney transplant may not fully restore kidney function. Code 996.81 should be assigned for documented complications of a kidney transplant, such as transplant failure or rejection or other transplant complication.

2. Ventilator associated pneumonia
   (a) Documentation of Ventilator associated Pneumonia — As with all procedural or postprocedural complications, code assignment is based on the provider’s documentation of the relationship between the condition and the procedure. Code 997.31, Ventilator associated pneumonia, should be assigned only when the provider has documented ventilator associated pneumonia (VAP). An additional code to identify the organism (e.g., Pseudomonas aeruginosa, code 041.7) should also be assigned. Do not assign an additional code from categories 480-484 to identify the type of pneumonia. Code 997.31 should not be assigned for cases where the patient has pneumonia and is on a mechanical ventilator but the provider has not specifically stated that the pneumonia is ventilator-associated pneumonia. If the documentation is unclear as to whether the patient has a pneumonia that is a complication attributable to the mechanical ventilator, query the provider.
   (b) Patient admitted with pneumonia and develops VAP — A patient may be admitted with one type of pneumonia (e.g., code 481, Pneumococcal pneumonia) and subsequently develop VAP. In this instance, the principal diagnosis would be the appropriate code from categories 480-484 for the pneumonia diagnosed at the time of admission. Code 997.31, Ventilator associated pneumonia, would be assigned as an additional diagnosis when the provider has also documented the presence of ventilator associated pneumonia.

III V Code Update and Table Changes

Status Codes

Other postsurgical states (V45)
   a. Transplant organ removal status — Assign code V45.87, Transplant organ removal status, to indicate that a transplanted organ has been previously removed. This code should not be assigned for the encounter in which the transplanted organ is removed. The complication necessitating removal of the transplant organ should be assigned for that encounter.
   b. Status post administration of tPA — Assign code V45.88, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to the current facility, as a secondary diagnosis when a patient is received by transfer into a facility and documentation indicates they were administered tissue plasminogen activator (tPA) within the last 24 hours prior to admission to the current facility. This guideline applies even if the patient is still receiving the tPA at the time they are received into the
current facility. The appropriate code for the condition for which the tPA was administered (such as cerebrovascular disease or myocardial infarction) should be assigned first. Code V45.88 is only applicable to the receiving facility record and not to the transferring facility record.

c. Long-term (current) drug use(V58.6x) — This subcategory is not for use of medications for detoxification or maintenance programs to prevent withdrawal symptoms in patients with drug dependence (e.g., methadone maintenance for opiate dependence). Assign the appropriate code for the drug dependence instead.

Observation

Suspected maternal and fetal conditions not found — Codes from subcategory V89.0, Suspected maternal and fetal conditions not found, may either be used as a first listed or as an additional code assignment depending on the case. They are for use in very limited circumstances on a maternal record when an encounter is for a suspected maternal or fetal condition that is ruled out during that encounter (for example, a maternal or fetal condition may be suspected due to an abnormal test result). These codes should not be used when the condition is confirmed. In those cases, the confirmed condition should be coded. In addition, these codes are not for use if an illness or any signs or symptoms related to the suspected condition or problem are present. In such cases the diagnosis/symptom code is used. Additional codes may be used in addition to the code from subcategory V89.0, but only if they are unrelated to the suspected condition being evaluated. Codes from subcategory V89.0 may not be used for encounters for antenatal screening of mother. For encounters for suspected fetal condition that are inconclusive following testing and evaluation, assign the appropriate code from category 655, 656, 657 or 658.

Aftercare

Aftercare codes should be used in conjunction with any other aftercare codes or other diagnosis codes to provide better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. The sequencing of multiple aftercare codes is discretionary.

V Code Table Changes

Newly designated as First Listed Only

V51.0  Encounter for breast reconstruction following mastectomy

Newly designated as Additional Only

V07.4  Hormone replacement therapy (postmenopausal)
V07.5X  Prophylactic use of agents affecting estrogen receptors and estrogen levels
V46.3  Wheelchair dependence
V87.4x  Personal history of drug therapy
V88.0x  Acquired absence of cervix and uterus
IV Present on Admission Reporting Guidelines

Timeframe for POA Identification and Documentation

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

Same Diagnosis Code for Two or More Conditions

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

Categories and Codes Exempt from Diagnosis Present on Admission Requirement

Newly added to the POA Exempt List:
V15.01-V15.09, Other personal history, Allergy, other than to medicinal agents
V15.1, Other personal history, Surgery to heart and great vessels
V15.2, Other personal history, Surgery to other major organs
V15.3, Other personal history, Irradiation
V15.4, Other personal history, Psychological trauma
V15.5, Other personal history, Injury
V15.6, Other personal history, Poisoning
V15.7, Other personal history, Contraception
V15.81, Other personal history, Noncompliance with medical treatment
V15.82, Other personal history, History of tobacco use
V15.88, Other personal history, History of fall
V15.89, Other personal history, Other
V15.9, Unspecified personal history presenting hazards to health
V87.4, Personal history of drug therapy
V88, Acquired absence of cervix and uterus
V89, Suspected maternal and fetal conditions not found

POA Example

Four new scenarios have been added to this section.