INSTRUCTION MANUAL PART 2B - INSTRUCTIONS FOR CLASSIFYING MULTIPLE CAUSES OF DEATH, 2016

SECTION I – INTRODUCTION

A. Introduction

This manual provides instructions to mortality medical coders and nosologists for coding multiple causes of death from death certificates filed in the states. These mortality coding instructions are used by both the State vital statistics programs and the National Center for Health Statistics (NCHS), which is the Federal agency responsible for the compilation of U.S. statistics on causes of death. NCHS is part of the Centers for Disease Control and Prevention.

In coding causes of death, NCHS adheres to the World Health Organization Nomenclature Regulations specified in the most recent revision of the International Statistical Classification of Diseases and Related Health Problems (ICD). NCHS also uses the ICD international rules for selecting the underlying cause of death for primary mortality tabulation in accordance with the international rules.

Beginning with deaths occurring in 1999, the Tenth Revision of the ICD (ICD-10) is being used for coding and classifying causes of death. This revision of the Classification is published by the World Health Organization (WHO) and consists of three volumes.

Volume 1 contains a list of three-character categories, the tabular list of inclusions, and the four-character subcategories. The supplementary Z code appears in Volume 1 but is not used for classifying mortality data. Optional fifth characters are provided for certain categories and an optional independent four-character coding system is provided to classify histological varieties of neoplasm, prefixed by the letter M (for morphology) and followed by a fifth character indicating behavior. These optional codes, except those for place of occurrence of external cause and activity code related to external cause codes, are not used in NCHS. The place code and activity code are used as supplementary codes rather than as additional characters. Volume 2 includes the international rules and notes for use in classifying and tabulating underlying cause-of-death data. Volume 3 is an alphabetical index containing a comprehensive list of terms for use in coding. Copies of these volumes may be purchased in hard-copy or on diskette from the following address:

WHO Publications Center
49 Sheridan Avenue
Albany, New York 12210
Tel. 518-436-9686

NCHS has prepared an updated version of Volume 1 and Volume 3 to be used for both underlying and multiple cause-of-death coding. The major purpose of the updated version is to provide a single published source of code assignments including terms not indexed in Volume 3 of ICD-10. NCHS has included all nonindexed terms encountered in the coding of deaths during 1979-1994, under the Ninth Revision of the International Classification of Diseases (ICD-9). With the availability of the updated Volumes 1 and 3, NCHS will discontinue publishing the Part 2e manual, Nonindexed Terms, Standard Abbreviations, and State Geographic Codes Used in Mortality Data Classification, which was first published in 1983. Due to copyright considerations, the updated Volumes 1 and 3 may not be reproduced for distribution outside of NCHS and State vital statistics agencies.

The basic purpose of this manual is to document concepts and instructions for coding multiple causes of death, which were developed by NCHS for use with the Eighth Revision of the ICD adapted for use in the United States (ICDA-8), and which were updated to ICD-9, and subsequently to ICD-10. The coding concepts are generally consistent with provisions of ICD-10. Thus, this manual should be used with ICD-10, Volumes 1 and 3 as updated by NCHS. The list of

abbreviations used in medical terminology (Appendix A), the list of synonymous sites (Appendix B), and the list of geographic codes (Appendix C) are included in this publication.

NCHS does not use the "dagger and asterisk" system which WHO introduced in ICD-9 and continued in ICD-10. For some medical conditions, this system provides two codes, which distinguish between the etiology or underlying disease process and the manifestation or complication for selected conditions. The etiology or underlying disease codes is denoted with a dagger (†) and the manifestation or complication code by an asterisk (*) following the code. For example, Coxsackie myocarditis has a code (B33.2†) marked with a dagger in the chapter for infectious and parasitic diseases and a different code (I41.1*) marked with an asterisk in the chapter for diseases of the circulatory system. Similarly, diabetic nephropathy has a dagger code (E14.2 †) in the chapter relating to endocrine disease and an asterisk code (N08.3*) in the genitourinary system chapter. Under ICD-9, limited use was made of the asterisk codes in classifying mortality data for data years 1979-1982. Effective July 1982 the use of asterisk codes in mortality coding was discontinued and will not be used in the 10th revision for mortality coding. NCHS assigns only the dagger code to such conditions.

The multiple cause-of-death codes are used as inputs to the ACME program (Automated Classification of Medical Entities) developed by NCHS to automatically select the underlying cause of death, and the TRANSAX program (Translation of Axes) used to produce multiple cause-of-death statistics, beginning with deaths occurring in 1968. As inputs, the computer programs require codes for each condition reported on the death certificate, usually in the order in which the information is recorded.

The outputs of the ACME program are the traditional underlying cause-of-death codes selected according to the selection and modification rules of the Classification, the same cause that would be selected using manual underlying cause-of-death coding instructions specified in Instruction Manual Part 2a. Thus, a single cause is associated with each decedent.

Using the same input codes, the TRANSAX program generates two sets of outputs: "entity-axis" codes that reflect the placement of each condition on the certificate for each decedent; and "record-axis" codes that, where appropriate, link two or more diagnostic conditions to form composite codes that are classifiable to a single code, according to the provisions of the Classification. Record axis codes are preferred for multiple cause tabulation to better convey the intent of the certifier, and to eliminate redundant cause-of-death information (see Instruction Manual Part 2f).

Major revisions from previous manuals

1. Corrections have been made to clarify instructions, spelling, and format throughout the manual. These changes are not specifically noted.
2. Section II, Part B, 4, added missing code Q899 on line (b) of example
3. Section III, #19, updated tobacco instructions and added new example
4. Section IV, Part C, 2.b.(2), changed code in instruction to reflect the only applicable code O969.
5. Section IV, Part C, 2.b.(3), changed code in instruction to reflect the only applicable code O979.
6. Section IV, Part F, added 'by history' and 'history' to sequela instructions.
7. Section V, 4, reformatted and modified the statements that mean stationary.
8. Section V, Part K, added new information to clarify how to code falls with other external events.
9. Section V, Part P, edited the title at Table 3, Instruction 2 to indicate on the record with.
10. Section V, Part S, added 'by history' and 'history' to sequela instructions for external causes.
11. Appendix H, added new drug examples for polypharmacy #38-40.

Other manuals relating to coding causes of death are:

Part 2a, NCHS Instructions for Classifying the Underlying Cause of Death, 2016

Part 2c, ICD-10 ACME Decision Tables for Classifying the Underlying Causes of Death, 2016

Part 2k, Instructions for the Automated Classification of the Initiating and Multiple Causes of Fetal Death, 2016

Part 2s, SuperMICAR Data Entry Instruction, 2011

B. Medical Certification

The U. S. Standard Certificate of Death provides spaces for the certifying physician, coroner, or medical examiner to record pertinent information concerning the diseases, morbid conditions, and injuries which either resulted in or contributed to death as well as the circumstances of the accident or violence which produced any such injuries. The medical certification portion of the death certificate includes items 32-44. It is designed to obtain the opinion of the certifier as to the relationship and relative significance of the causes, which he reports.

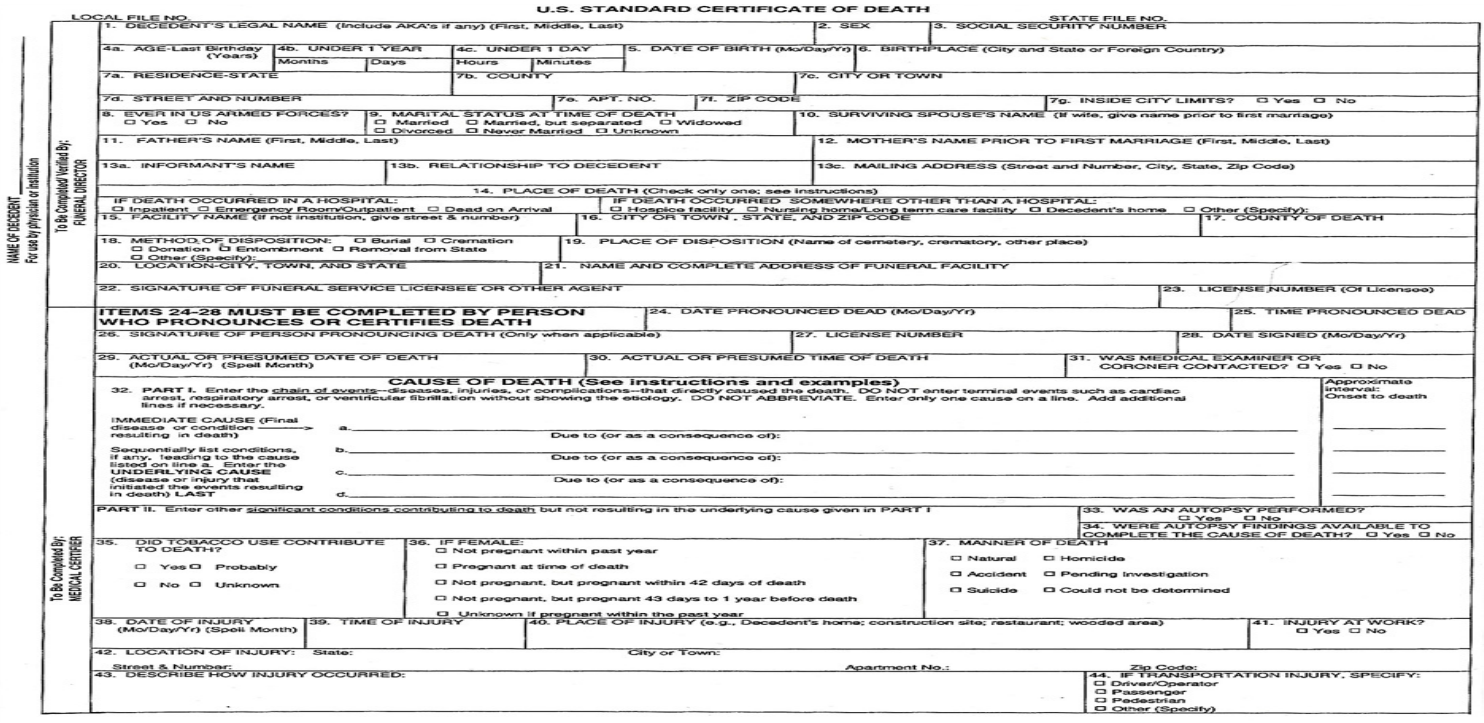
A cause of death is the morbid condition or disease process, abnormality, injury, or poisoning leading directly or indirectly to death. The underlying cause of death is the disease or injury, which initiated the train of morbid events leading directly or indirectly to death or the circumstances of the accident or violence, which produced the fatal injury. A death often results from the combined effect of two or more conditions. These conditions may be completely unrelated, arising independently of each other or they may be causally related to each other; that is, one cause may lead to another which in turn leads to a third cause, etc.

The order in which the certifier is requested to arrange the causes of death upon the certification form facilitates the selection of the **underlying cause** when two or more causes are reported. He is requested to report in Part I on line (a) the immediate cause of death and the antecedent conditions on lines (b), (c), and (d) which gave rise to the cause reported on

I (a), **the underlying cause** being stated lowest in the sequence of events. However, no entry is necessary on I(b), I(c), or I(d) if the immediate cause of death, stated on I(a) describes completely the sequence of events. If the decedent had more than four causally related conditions relating to death, the certifier is requested to add lines (e), (f), etc., so all conditions related to the immediate cause of death are entered in Part I with only one condition to a line.

Any other significant condition which unfavorably influenced the course of the morbid process and thus contributed to the fatal outcome but not resulting in the underlying cause given in Part I is entered in Part II.

EXCERPT FROM U.S. STANDARD CERTIFICATE OF DEATH (Rev.11/2003)



U.S. STANDARD CERTIFICATE OF DEATH

LOCAL FILE NO. STATE FILE NO.

NAME OF DECEDENT — For use by physician or institution

To Be Completed/Verified By: FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last) | 2. SEX | 3. SOCIAL SECURITY NUMBER

4a. AGE-Last Birthday (Years) | 4b. UNDER 1 YEAR: Months, Days | 4c. UNDER 1 DAY: Hours, Minutes | 5. DATE OF BIRTH (Mo/Day/Yr) | 6. BIRTHPLACE (City and State or Foreign Country)

7a. RESIDENCE-STATE | 7b. COUNTY | 7c. CITY OR TOWN

7d. STREET AND NUMBER | 7e. APT. NO. | 7f. ZIP CODE | 7g. INSIDE CITY LIMITS? ☐ Yes ☐ No

8. EVER IN US ARMED FORCES? ☐ Yes ☐ No | 9. MARITAL STATUS AT TIME OF DEATH ☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown | 10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)

11. FATHER'S NAME (First, Middle, Last) | 12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

13a. INFORMANT'S NAME | 13b. RELATIONSHIP TO DECEDENT | 13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)

14. PLACE OF DEATH (Check only one; see instructions)

IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival | IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify):

15. FACILITY NAME (If not institution, give street & number) | 16. CITY OR TOWN, STATE, AND ZIP CODE | 17. COUNTY OF DEATH

18. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify): | 19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)

20. LOCATION-CITY, TOWN, AND STATE | 21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY

22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT | 23. LICENSE NUMBER (Of Licensee)

To Be Completed By: MEDICAL CERTIFIER

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

24. DATE PRONOUNCED DEAD (Mo/Day/Yr) | 25. TIME PRONOUNCED DEAD

26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable) | 27. LICENSE NUMBER | 28. DATE SIGNED (Mo/Day/Yr)

29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month) | 30. ACTUAL OR PRESUMED TIME OF DEATH | 31. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☐ No

CAUSE OF DEATH (See instructions and examples)

32. PART I. Enter the chain of events--diseases, injuries, or complications--that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

Approximate interval: Onset to death

IMMEDIATE CAUSE (Final disease or condition resulting in death) ——> a. _____ Due to (or as a consequence of):

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST

b. _____ Due to (or as a consequence of):

c. _____ Due to (or as a consequence of):

d. _____

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I | 33. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No | 34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown

36. IF FEMALE: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year

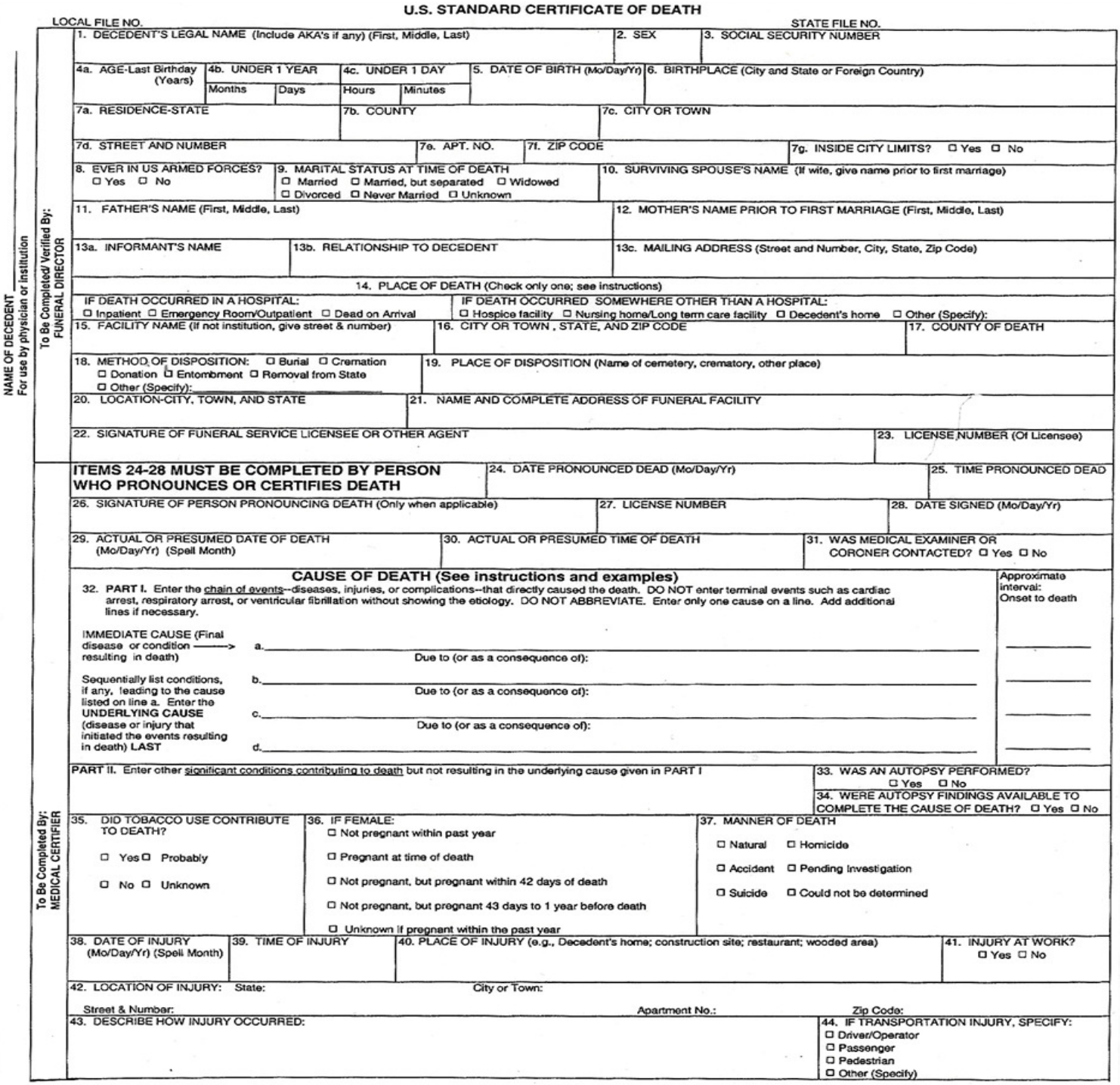
37. MANNER OF DEATH ☐ Natural ☐ Homicide ☐ Accident ☐ Pending investigation ☐ Suicide ☐ Could not be determined

38. DATE OF INJURY (Mo/Day/Yr) (Spell Month) | 39. TIME OF INJURY | 40. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area) | 41. INJURY AT WORK? ☐ Yes ☐ No

42. LOCATION OF INJURY: State: | City or Town: | Street & Number: | Apartment No.: | Zip Code:

43. DESCRIBE HOW INJURY OCCURRED:

44. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)



U.S. STANDARD CERTIFICATE OF DEATH

LOCAL FILE NO. STATE FILE NO.

NAME OF DECEDENT
For use by physician or institution

To Be Completed/ Verified By: FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last)
2. SEX
3. SOCIAL SECURITY NUMBER
4a. AGE-Last Birthday (Years)
4b. UNDER 1 YEAR Months Days
4c. UNDER 1 DAY Hours Minutes
5. DATE OF BIRTH (Mo/Day/Yr)
6. BIRTHPLACE (City and State or Foreign Country)
7a. RESIDENCE-STATE
7b. COUNTY
7c. CITY OR TOWN
7d. STREET AND NUMBER
7e. APT. NO.
7f. ZIP CODE
7g. INSIDE CITY LIMITS? ☐ Yes ☐ No
8. EVER IN US ARMED FORCES? ☐ Yes ☐ No
9. MARITAL STATUS AT TIME OF DEATH ☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown
10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)
11. FATHER'S NAME (First, Middle, Last)
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)
13a. INFORMANT'S NAME
13b. RELATIONSHIP TO DECEDENT
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)
14. PLACE OF DEATH (Check only one; see instructions)
IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival
IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify):
15. FACILITY NAME (If not institution, give street & number)
16. CITY OR TOWN , STATE, AND ZIP CODE
17. COUNTY OF DEATH
18. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify):
19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)
20. LOCATION-CITY, TOWN, AND STATE
21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT
23. LICENSE NUMBER (Of Licensee)

To Be Completed By: MEDICAL CERTIFIER

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

24. DATE PRONOUNCED DEAD (Mo/Day/Yr)
25. TIME PRONOUNCED DEAD
26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)
27. LICENSE NUMBER
28. DATE SIGNED (Mo/Day/Yr)
29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month)
30. ACTUAL OR PRESUMED TIME OF DEATH
31. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☐ No

CAUSE OF DEATH (See instructions and examples)

32. PART I. Enter the chain of events--diseases, injuries, or complications--that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

Approximate interval: Onset to death

IMMEDIATE CAUSE (Final disease or condition ——> resulting in death) a. _____ Due to (or as a consequence of):

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I

33. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown
36. IF FEMALE: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year
37. MANNER OF DEATH ☐ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined
38. DATE OF INJURY (Mo/Day/Yr) (Spell Month)
39. TIME OF INJURY
40. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area)
41. INJURY AT WORK? ☐ Yes ☐ No
42. LOCATION OF INJURY: State: City or Town: Street & Number: Apartment No.: Zip Code:
43. DESCRIBE HOW INJURY OCCURRED:
44. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

US STANDARD CERTIFICATE OF DEATH (Rev. 11/2003)

In the following example, there are three causes reported. On line I(c) the underlying cause is entered-congenital heart disease. Congenital heart disease gave rise to congestive heart failure (line I(b)) which in turn led to a myocardial infarction (line I(a)) -- the immediate cause of death.

I (a) Myocardial infarction
(b) Congestive heart failure

(c) Congenital heart disease
(d)

II

As demonstrated by the following example, the certifier may not always list one cause per line:

I (a) Myocardial infarction and pulmonary embolism with congestive heart failure
(b)
(c)
(d)

II

Likewise, the causes may not be reported in an acceptable sequence. In the following example, cancer is reported as due to diabetes.

I (a) Cancer
(b) Diabetes
(c)
(d)

II

To date, the causes of the majority of cancers are still unknown so the causal relationship tables stored in the NCHS computers preclude the assumption that diabetes caused the cancer. Cancer is selected as the underlying cause of death from this certification for statistical purposes. However, the selection of the underlying cause of death is not relevant for this manual. For coding purposes, the order and position of each cause of death reported on the death certificate must be interpreted accurately so the computer software can then determine the correct underlying cause of death.

There is an average of three causes listed per certificate. Approximately 20 percent have only one cause of death and 45 percent have three or more causes. Frequently, a cause will be reported on I(a) in Part I and a cause in Part II with no other reported causes. For other records, several causes may all be reported on a single line of the certificate or they may be entered on several lines in Part I. Rarely, the only cause(s) reported may be in Part II. Representative examples follow.

I (a) Pneumonia
(b)
(c)
(d)

II Diabetes

I (a) Cancer
(b)
(c)
(d)

II

I (a)
(b)
(c)
(d)

II Diabetes

I (a)
(b) Acute myocardial infarction
(c)
II Renal disease

I (a) AMI, renal disease, pulmonary embolism

SECTION II – GENERAL INSTRUCTIONS

A. Introduction

Code all information reported in the medical certification section of the death certificate and any other information pertaining to the medical certification, when reported elsewhere on the certificate. In Volumes 1 and 3 of ICD-10, the fourth-character subcategories of three-character categories are preceded by a decimal point. For coding purposes, omit the decimal point.

Enter codes in the same order and location as the entries they represent appear on the death certificate, proceeding from the entry reported uppermost in Part II downward and from the left to right. If the uppermost line in Part II is an obvious continuation of a line below, enter the codes accordingly.

For instructions on placement of codes when the certifier states or implies a "due to" relationship between conditions not reported in sequential order, refer to Section II, Part C, Format. For instructions on placement of nature of injury (N-code) and external cause codes (E-codes), refer to Section V, Part B, Placement of Nature of Injury and External Cause Codes.

When an identical code applies to more than one condition reported on the same line, enter the code for the first-mentioned of these conditions only. When conditions classifiable to the same code are reported on different lines of the certificate, enter the code for each of the reported conditions. (This does not apply to external cause of morbidity and mortality (E-codes)).

1. Excessive Codes

a. When a single line in Part I or Part II requires more than eight codes, delete the excessive codes (any over eight) for the line using the following criteria in the order listed:

(1) Delete ill-defined conditions (I469, I959, I99, J960, J969, P285, R00-R94, R96, R98) except when this code is the first code on a line, proceeding right to left.

(2) Delete nature of injury codes (S000-T983) except for the first one entered on a line, proceeding right to left.

(3) If, after applying the preceding criteria, any single line still has more than eight codes, delete beginning with the last code on the line until only 8 remain.

I (a) I460
(b) I219 I739
(c)
(d)
II &E109 I739 T811 &Y835 R18 R33 N19 C475 N359 I490 I493 J181

After deleting excessive codes:

I (a) I460
(b) I219 I739
(c)
(d)
II &E109 I739 T811 &Y835 N19 C475 N359 I490

Delete (1) R33, (2) R18, (3) J181 and (4) I493

b. When a single record requires more than 14 codes, delete the excessive codes using the following criteria in the order listed:

(1) Delete ill-defined conditions (I461, I469, I959, I99, J960, J969, P285, R00 - R94, R96, R98) except when this code is the first code on a line, beginning with the last code in Part II, proceeding right to left then upward right to left on each line (Part II, line e, line d, line c, line b, line a).

(2) Delete nature of injury codes (S000-T983) except for the first one entered on a line beginning with the last code in Part II, proceeding right to left then upward right to left on each line (Part II, line e, line d, line c, line b, line a).

(3) Delete repetitive codes except when it is the first code on a line beginning with the last code in Part II, proceeding right to left then upward right to left on each line (Part II, line e, line d, line c, line b, line a).

(4) If after applying the preceding criteria, any record still has more than 14 codes, delete beginning with the last code in Part II, proceeding upward right to left on each line (Part II, line e, line d, line c, line b, line a).

I (a) C80 I460 R570
(b) R098 R53
(c) R54 F09 F03
(d) I709 I635
II I119 C473 R200 I258 I251 D539 R798 I635

After deleting excessive codes:

I (a) C80 I460
(b) R098
(c) R54 F09 F03
(d) I709 I635
II I119 C473 I258 I251 D539 I635

Delete (1) R798, (2) R200, (3) R53 and (4) R570

2. Created Codes

To facilitate automated data processing, the following ICD-10 codes have been amended for use in coding and processing the multiple cause data. Special five character subcategories are for use in coding and processing the multiple

cause data; however, they will not appear in official tabulations.

A169 Respiratory tuberculosis, unspecified

Excludes: Any term indexed to A169 not qualified as respiratory or pulmonary (A1690)
*A1690 Tuberculosis NOS
Includes: Any term indexed to A169 not qualified as respiratory or pulmonary

E039 Hypothyroidism, unspecified
Excludes: Any term indexed to E039 qualified as advanced, grave, severe, or with a similar qualifier (E0390)
*E0390 Advanced hypothyroidism
Grave hypothyroidism
Severe hypothyroidism
Includes: Any term indexed to E039 qualified as advanced, grave, severe, or with a similar qualifier

G122 Motor neuron disease
Excludes: Any term indexed to G122 qualified as advanced, grave, severe, or with a similar qualifier (G1220)
*G1220 Advanced motor neuron disease
Grave motor neuron disease
Severe motor neuron disease
Includes: Any term indexed to G122 qualified as advanced, grave, severe, or with a similar qualifier

G20 Parkinson's disease
Excludes: Any term indexed to G20 qualified as advanced, grave, severe, or with a similar qualifier (G2000)
*G2000 Advanced Parkinson's disease
Grave Parkinson's disease
Severe Parkinson's disease
Includes: Any term indexed to G20 qualified as advanced, grave, severe, or with a similar qualifier

I219 Acute myocardial infarction, unspecified
Excludes: Embolism of any site classified to I219
*I2190 Embolism cardiac, heart, myocardium or a synonymous site
Includes: Embolism of any site classified to I219

I420 Dilated cardiomyopathy
Excludes: Any term indexed to I420 qualified as familial, idiopathic, or primary (I4200)
*I4200 Familial dilated cardiomyopathy
Idiopathic dilated cardiomyopathy
Primary dilated cardiomyopathy
Includes: Any term indexed to I420 qualified as familial, idiopathic, or primary

I421 Obstructive hypertrophic cardiomyopathy
Excludes: Any term indexed to I421 qualified as familial, idiopathic, or primary (I4210)

*I4210 Familial obstructive hypertrophic cardiomyopathy
Idiopathic obstructive hypertrophic cardiomyopathy
Primary obstructive hypertrophic cardiomyopathy
Includes: Any term indexed to I421 qualified as familial, idiopathic, or primary

I422 Other hypertrophic cardiomyopathy
Excludes: Any term indexed to I422 qualified as familial, idiopathic, or primary (I4220)
*I4220 Familial other hypertrophic cardiomyopathy
Idiopathic other hypertrophic cardiomyopathy
Primary other hypertrophic cardiomyopathy
Includes: Any term indexed to I422 qualified as familial, idiopathic, or primary

I425 Other restrictive cardiomyopathy
Excludes: Any term indexed to I425 qualified as familial, idiopathic, or primary (I4250)
*I4250 Familial other restrictive cardiomyopathy
Idiopathic other restrictive cardiomyopathy
Primary other restrictive cardiomyopathy
Includes: Any term indexed to I425 qualified as familial, idiopathic, or primary

I428 Other cardiomyopathies
Excludes: Any term indexed to I428 qualified as familial, idiopathic, or primary (I4280)
*I4280 Familial other cardiomyopathies
Idiopathic other cardiomyopathies
Primary other cardiomyopathies
Includes: Any term indexed to I428 qualified as familial, idiopathic, or primary

I429 Cardiomyopathy, unspecified
Excludes: Any term indexed to I429 qualified as familial, idiopathic, or primary (I4290)
*I4290 Familial cardiomyopathy
Idiopathic cardiomyopathy
Primary cardiomyopathy
Includes: Any term indexed to I429 qualified as familial, idiopathic, or primary

I500 Congestive heart failure
Excludes: Any term indexed to I500 qualified as advanced, grave, severe, or with a similar qualifier (I5000)
*I5000 Advanced congestive heart failure
Grave congestive heart failure
Severe congestive heart failure
Includes: Any term indexed to I500 qualified as advanced, grave, severe, or with a similar qualifier

I514 Myocarditis, unspecified
Excludes: Any term indexed to I514

qualified as arteriosclerotic (I5140)

*I5140 Arteriosclerotic myocarditis
Includes: Any term indexed to I514 qualified as arteriosclerotic

I515 Myocardial degeneration
Excludes: Any term indexed to I515
qualified as arteriosclerotic (I5150)

*I5150 Arteriosclerotic myocardial degeneration
Includes: Any term indexed to I515 qualified as arteriosclerotic

I600 Subarachnoid hemorrhage from carotid siphon and bifurcation
Excludes: Ruptured carotid aneurysm (into brain) (I6000)

*I6000 Ruptured carotid aneurysm (into brain)

I606 Subarachnoid hemorrhage from other intracranial arteries
Excludes: Ruptured aneurysm (congenital) circle of Willis (I6060)

*I6060 Ruptured aneurysm (congenital) circle of Willis

I607 Subarachnoid hemorrhage from intracranial artery, unspecified
Excludes: Ruptured berry aneurysm (congenital) brain (I6070)
Ruptured miliary aneurysm (I6070)

*I6070 Ruptured berry aneurysm (congenital) brain
Ruptured miliary aneurysm

I608 Other subarachnoid hemorrhage
Excludes: Ruptured aneurysm brain meninges (I6080)
Ruptured arteriovenous aneurysm (congenital) brain (I6080)
Ruptured (congenital) arteriovenous aneurysm cavernous sinus (I6080)

*I6080 Ruptured aneurysm brain meninges
Ruptured arteriovenous aneurysm (congenital) brain
Ruptured (congenital) arteriovenous aneurysm cavernous sinus

I609 Subarachnoid hemorrhage, unspecified
Excludes: Ruptured arteriosclerotic cerebral aneurysm (I6090)
Ruptured (congenital) cerebral aneurysm NOS (I6090)
Ruptured mycotic aneurysm brain (I6090)

*I6090 Ruptured arteriosclerotic cerebral aneurysm
Ruptured (congenital) cerebral aneurysm NOS
Ruptured mycotic aneurysm brain

I610 Intracerebral hemorrhage in hemisphere, subcortical
Excludes: Any term indexed to I610 qualified as bilateral, multiple, or similar term(1) (I6100)

*I6100 Bilateral, multiple [or similar term(2)] intracerebral hemorrhages in hemisphere, subcortical
Includes: Any term indexed to I610 qualified as bilateral, multiple, or similar term(3)

I611 Intracerebral hemorrhage in hemisphere, cortical
Excludes: Any term indexed to I611 qualified as bilateral, multiple, or similar term(4)

(I6110)

*I6110 Bilateral, multiple [or similar term(5)] intracerebral hemorrhages in hemisphere, cortical
Includes: Any term indexed to I611 qualified as bilateral, multiple, or similar term(6)

I612 Intracerebral hemorrhage in hemisphere, unspecified
Excludes: Any term indexed to I612 qualified as bilateral, multiple, or similar term(7) (I6120)

*I6120 Bilateral, multiple [or similar term(8)] intracerebral hemorrhages, unspecified
Includes: Any term indexed to I612 qualified as bilateral, multiple, or similar term(9)

I613 Intracerebral hemorrhage in brain stem
Excludes: Any term indexed to I613 qualified as bilateral, multiple, or similar term(10) (I6130)

*I6130 Bilateral, multiple [or similar term(11)] intracerebral hemorrhages in brain stem
Includes: Any term indexed to I613 qualified as bilateral, multiple, or similar term(12)

I614 Intracerebral hemorrhage in cerebellum
Excludes: Any term indexed to I614 qualified as bilateral, multiple, or similar term(13) (I6140)

*I6140 Bilateral, multiple [or similar term(14)] intracerebral hemorrhages in cerebellum
Includes: Any term indexed to I614 qualified as bilateral, multiple, or similar term(15)

I615 Intracerebral hemorrhage, intraventricular
Excludes: Any term indexed to I615 qualified as bilateral, multiple, or similar term(16) (I6150)

*I6150 Bilateral, multiple [or similar term(17)] intracerebral hemorrhages, intraventricular
Includes: Any term indexed to I615 qualified as bilateral, multiple, or similar term(18)

I618 Other intracerebral hemorrhage
Excludes: Any term indexed to I618 qualified as bilateral, multiple, or similar term(19) (I6180)

*I6180 Bilateral, multiple [or similar term(20)] other intracerebral hemorrhages
Includes: Any term indexed to I618 qualified as bilateral, multiple, or similar term(21)

I619 Intracerebral hemorrhage, unspecified
Excludes: Any term indexed to I619 qualified as bilateral, multiple, or similar term(22) (I6190)

*I6190 Bilateral, multiple [or similar term(23)] intracerebral hemorrhages, unspecified
Includes: Any term indexed to I619 qualified bilateral, multiple, or similar term(24)

I630 Cerebral infarction due to thrombosis of precerebral arteries

Excludes: Any term indexed to I630 qualified as bilateral, multiple, or similar term(25) (I6300)

*I6300 Cerebral infarction due to bilateral, multiple [or similar term(26)] thrombi of precerebral arteries

Includes: Any term indexed to I630 qualified as bilateral, multiple, or similar term(27)

I631 Cerebral infarction due to embolism of precerebral arteries

Excludes: Any term indexed to I631 qualified as bilateral, multiple, or similar term(28) (I6310)

*I6310 Cerebral infarction due to bilateral, multiple [or similar term(29)] emboli of precerebral arteries

Includes: Any term indexed to I631 qualified as bilateral, multiple, or similar term(30)

I632 Cerebral infarction due to unspecified occlusion or stenosis of precerebral arteries

Excludes: Any term indexed to I632 qualified as bilateral, multiple, or similar term(31) (I6320)

*I6320 Cerebral infarction due to bilateral, multiple [or similar term(32)]unspecified occlusions or stenosis of precerebral arteries

Includes: Any term indexed to I632 qualified as bilateral, multiple, or similar term(33)

I633 Cerebral infarction due to thrombosis of cerebral arteries

Excludes: Any term indexed to I633 qualified as bilateral, multiple, or similar term(34) (I6330)

*I6330 Cerebral infarction due to bilateral, multiple [or similar term(35)] thrombi of cerebral arteries

Includes: Any term indexed to I633 qualified as bilateral, multiple, or similar term(36)

I634 Cerebral infarction due to embolism of cerebral arteries

Excludes: Any term indexed to I634 qualified as bilateral, multiple, or similar term(37) (I6340)

*I6340 Cerebral infarction due to bilateral, multiple [or similar term(38)] emboli of cerebral arteries

Includes: Any term indexed to I634 qualified as bilateral, multiple, or similar term(39)

I635 Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries

Excludes: Any term indexed to I635 qualified as bilateral, multiple, or similar term(40)(I6350)

*I6350 Cerebral infarction due to bilateral, multiple [or similar term(41)]unspecified occlusions or stenosis of cerebral arteries

Includes: Any term indexed to I635 qualified as bilateral, multiple, or similar term(42)

I636 Cerebral infarction due to cerebral venous thrombosis, nonpyogenic

Excludes: Any term indexed to I636 qualified as bilateral, multiple, or similar term(43) (I6360)

*I6360 Cerebral infarction due to bilateral, multiple [or similar term(44)] cerebral venous thrombi, nonpyogenic

Includes: Any term indexed to I636 qualified as bilateral, multiple, or similar term(45)

I638 Other cerebral infarction

Excludes: Any term indexed to I638 qualified as bilateral, multiple, or similar term(46) (I6380)

*I6380 Bilateral, multiple [or similar term(47)] other cerebral infarctions

Includes: Any term indexed to I638 qualified bilateral, multiple, or similar term(48)

I639 Cerebral infarction, unspecified

Excludes: Any term indexed to I639 qualified as bilateral, multiple, or similar term(49) (I6390)

*I6390 Bilateral, multiple [or similar term(50)] cerebral infarctions, unspecified

Includes: Any term indexed to I639 qualified as bilateral, multiple, or similar term(51)

I64 Stroke, not specified as hemorrhage or infarction

Excludes: Any term indexed to I64 qualified as bilateral, multiple, or similar term(52)(I6400)

*I6400 Bilateral, multiple [or similar term(53)] strokes, not specified as hemorrhage or infarction

Includes: Any term indexed to I64 qualified as bilateral, multiple, or similar term(54)

I691 Sequelae of intracerebral hemorrhage

Excludes: Any term indexed to I691 qualified as bilateral, multiple, or similar term(55) (I6910)

*I6910 Sequela of bilateral, multiple [or similar term(56)] intracerebral hemorrhages

Includes: Any term indexed to I691 qualified as bilateral, multiple, or similar term(57)

I693 Sequelae of cerebral infarction

Excludes: Any term indexed to I693 qualified as bilateral, multiple, or similar term(58) (I6930)

*I6930 Sequela of bilateral, multiple [or similar term(59)] cerebral infarctions

Includes: Any term indexed to I693 qualified as bilateral, multiple, or similar term(60)

I694 Sequelae of stroke, not specified as hemorrhage or infarction

Excludes: Any term indexed to I694 qualified as bilateral, multiple, or similar term(61) (I6940)

*I6940 Sequela of bilateral, multiple [or similar term(62)] strokes, not specified as

hemorrhage or infarction
Includes: Any term indexed to I694 qualified as bilateral, multiple, or similar term(63)

J101 Influenza with other respiratory manifestations, influenza virus identified
Excludes: Influenza, flu, grippe (viral), influenza virus identified (without specified manifestations) (J1010)
*J1010 Influenza, flu, grippe (viral), influenza virus identified (without specified manifestations)

J111 Influenza with other respiratory manifestations, virus not identified
Excludes: Influenza, flu, grippe (viral), influenza virus not identified (without specified manifestations) (J1110)
*J1110 Influenza, flu, grippe (viral), influenza virus not identified (without specified manifestations)

J849 Interstitial pulmonary disease, unspecified
Excludes: Interstitial pneumonia, not elsewhere classified (J8490)
*J8490 Interstitial pneumonia, not elsewhere classified

J984 Other disorders of lung
Excludes: Lung disease (acute) (chronic) NOS (J9840)
*J9840 Lung disease (acute) (chronic) NOS

K319 Disease of stomach and duodenum, unspecified
Excludes: Disease, stomach NOS (K3190)
Lesion, stomach NOS (K3190)
*K3190 Disease, stomach NOS
Lesion, stomach NOS

K550 Acute vascular disorders of intestine
Excludes: Any term indexed to K550 qualified as embolic (K5500)
*K5500 Acute embolic vascular disorders of intestine
Includes: Any term indexed to K550 qualified as embolic

K631 Perforation of intestine (nontraumatic)
Excludes: Intestinal penetration, unspecified part (K6310)
Intestinal perforation, unspecified part (K6310)
Intestinal rupture, unspecified part (K6310)
*K6310 Intestinal penetration, unspecified part
Intestinal perforation, unspecified part
Intestinal rupture, unspecified part

K720 Acute and subacute hepatic failure
Excludes: Acute hepatic failure (K7200)
*K7200 Acute hepatic failure

K721 Chronic hepatic failure
Excludes: Chronic hepatic failure (K7210)
*K7210 Chronic hepatic failure

K729 Hepatic failure, unspecified
Excludes: Hepatic failure (K7290)
*K7290 Hepatic failure

M199 Arthrosis, unspecified
Excludes: Any term indexed to M199 qualified as advanced, grave, severe, or with a similar qualifier (M1990)
*M1990 Advanced arthrosis
Grave arthrosis
Severe arthrosis
Includes: Any term indexed to M199 qualified as advanced, grave, severe, or with a similar qualifier

Q278 Other specified congenital malformations of peripheral vascular system
Excludes: Congenital aneurysm (peripheral) (Q2780)
*Q2780 Congenital aneurysm (peripheral)

Q282 Arteriovenous malformation of cerebral vessels
Excludes: Congenital arteriovenous cerebral aneurysm (nonruptured) (Q2820)
*Q2820 Congenital arteriovenous cerebral aneurysm (nonruptured)

Q283 Other malformations of cerebral vessels
Excludes: Congenital cerebral aneurysm (nonruptured) (Q2830)
*Q2830 Congenital cerebral aneurysm (nonruptured)

R58 Hemorrhage, not elsewhere classified
Excludes: Hemorrhage of unspecified site (R5800)
*R5800 Hemorrhage of unspecified site

R99 Other ill-defined and unspecified causes of mortality
Excludes: Cause unknown (R97)
*R97 Cause unknown

3."Dagger and asterisk" codes

ICD-10 provides for the classification of certain diagnostic statements according to two different axes-etiology or underlying disease process and manifestation or complication. Thus, there are two codes for diagnostic statements subject to dual classification. The etiology or underlying disease codes are marked with a dagger (†) and the manifestations or complication codes are marked with an asterisk (*) following the code. The terms classified to codes with an asterisk are to be coded to the dagger code for the term only. These codes will not appear in official tabulations on multiple cause data.

I (a) Salmonella meningitis A022

Use only the dagger code for multiple cause-of-death coding.

Do not use the following ICD-10 codes for multiple cause coding:

D63*	H03*	I68*	M36*
D77*	H06*	I79*	M49*
E35*	H13*	I98*	M63*

E90*	H19*	J17*	M68*
F00*	H22*	J91*	M73*
F02*	H28*	J99*	M82*
G01*	H32*	K23*	M90*
G02*	H36*	K67*	N08*
G05*	H42*	K77*	N16*
G07*	H45*	K87*	N22*
G13*	H48*	K93*	N29*
G22*	H58*	L14*	N33*
G26*	H62*	L45*	N37*
G32*	H67*	L54*	N51*
G46*	H75*	L62*	N74*
G53*	H82*	L86*	P75*
G55*	H94*	L99*	
G59*	I32*	M01*	
G63*	I39*	M03*	
G73*	I41*	M07*	
G94*	I43*	M09*	
G99*	I52*	M14*	

B. General coding concept

The coding of cause-of-death information for the ACME system consists of the assignment of the most appropriate ICD-10 code(s) for each diagnostic entity that is reported on the death certificate. In order to arrive at the appropriate code for a diagnostic entity, code each entity separately. Do not apply provisions in ICD-10 for linking two or more diagnostic terms to form a composite diagnosis classifiable to a single ICD-10 code.

	I (a) Cholecystitis with cholelithiasis		K819	K802

Code each entity separately even though the Index has provided for a combination code for cholecystitis with cholelithiasis.

	I (a) Malignant neoplasm of colon with rectum		C189	C20

Code malignant neoplasm of colon and malignant neoplasm of rectum separately even though the Index has provided for a combination code for malignant neoplasm of colon with rectum.

Place	I (a) Injury of intra-abdominal and intrathoracic organs		S369	S279
9	II &X599			

Code injury of each site separately even though the Index has provided for a combination code for intra-abdominal and intrathoracic injury.

1. Definitions and types of diagnostic entities

A diagnostic entity is a single term or a composite term, comprised of one word or of two or more adjoining words, that is used to describe a disease, nature of injury, or other morbid condition. In this manual diagnostic entity and diagnostic

term are used interchangeably. A diagnostic entity may indicate the existence of a condition classifiable to a single ICD-10 category or it may contain elements of information that are classifiable to different ICD-10 categories. For coding purposes, it is necessary to distinguish between two different kinds of diagnostic entities – a "one-term entity," and a "multiple one-term entity."

a. One-term entity

(1) A one-term entity is a diagnostic entity that is classifiable to a single ICD-10.

I	(a) Pneumonia	J189
	(b) Arteriosclerosis	I709
	(c) Emphysema	J439

These terms are codable one-term entities.

I	(a) Allergic vasculitis	D690

This condition is indexed as one-term entity under "vasculitis."

I	(a) Cerebral arteriosclerosis	I672

This condition is indexed as one-term entity.

(2) A diagnostic term that contains one of the following adjectival modifiers indicates the condition modified has undergone certain changes and is considered to be a one-term entity.

adenomatous	hypoxemic
anoxic	hypoxic
congestive	inflammatory
cystic	ischemic
embolic	necrotic
erosive	obstructed, obstructive
gangrenous	ruptured
hemorrhagic	

(These instructions apply to these adjectival modifiers **only**).

For code assignment, apply the following criteria in the order stated.

(a) If the modifier and lead term are indexed together, code as indexed.

I	(a) Embolic nephritis	N058

Code Nephritis, embolic. The adjectival modifier "embolic" is indexed under nephritis.

(b) If the modifier is not indexed under the lead term, but "specified" is, use the code for specified (usually .8).

I	(a) Obstructive cystitis	N308

Code Cystitis, specified NEC. The adjectival modifier "obstructive" is not indexed

under cystitis.

(c) If neither the modifier nor "specified" is indexed under the lead term, refer to Volume 1 under the NOS code for the lead term and look for a specified 4th character subcategory.

I (a) Hemorrhagic cardiomyopathy I428

Code hemorrhagic cardiomyopathy to I428, Other cardiomyopathies. "Hemorrhagic" is not indexed under cardiomyopathy, neither is Cardiomyopathy, specified NEC indexed. The Classification does provide a code, I428, for "Other cardiomyopathies" in Volume 1.

(d) If neither (a), (b), or (c) apply, code the lead term without the modifier.

I (a) Adenomatous bronchiectasis J47

"Adenomatous" is not an index term qualifying bronchiectasis. Code bronchiectasis only, since there is no provision in the Classification for coding "other bronchiectasis."

b. Multiple one-term entity

A multiple one-term entity is a diagnostic entity consisting of two or more contiguous words on a line for which the Classification does not provide a single code for the entire entity but does provide a single code for each of the components of the diagnostic entity. Consider as a multiple one-term entity if each of the components can be considered as separate one-term entities, i.e., they can stand alone as separate diagnosis. Code each component of the multiple one-term entity as indexed and on the same line where reported.

I	(a)	Myocardial infarction	I219
	(b)	Uremic acidosis	N19 E872
	(c)	Chronic nephritis	N039

"Uremic acidosis" is not indexed as a one-term entity. Code "uremia" and "acidosis" as separate one-term entities, each of which can stand alone as a diagnosis.

I	(a)	Uremia	N19
	(b)	Diabetic heart disease	E149 I519
	(c)		

"Diabetic heart disease" is not indexed as a one-term entity. Code "diabetic" and "heart disease" as separate one-term entities, each of which can stand alone as a diagnosis.

I	(a)	Senile cardiovascular disease, MI	R54 I516 I219
	(b)		
	(c)		

"Senile cardiovascular disease." is not indexed as a one-term entity. Code "senile" and "cardiovascular disease"

as separate one-term entities each of which can stand alone as a diagnosis.

Exception:

When any condition classifiable to I20-I25, except I250, or I60-I69 is qualified as "hypertensive," code to I20-I25 or I60-I69 **only**.

I (a) Hypertensive arteriosclerotic cerebrovascular disease — I672
I (a) Hypertensive myocardial ischemia — I259

(1) Code an adjective reported at the end of a diagnostic entity as if it preceded the entity. This applies whether reported in Part I or II.

I (a) Arteriosclerosis, hypertensive — I10 I709
(b)
(c)

The complete term is not indexed as a one-term entity. "Hypertensive" is an adjectival modifier; code as if it preceded the arteriosclerosis.

I (a) MI — I219
(b)
(c)
II Coronary occlusion, arteriosclerotic — I709 I219

"Coronary occlusion, arteriosclerotic" is not indexed as a one-term entity. Arteriosclerotic is an adjectival modifier; code as if it preceded the coronary occlusion.

(2) (a) When a multiple one-term entity indicates a condition involving different sites or systems for which the Classification provides different codes, code the condition of each site or system separately.

I (a) Cardiac, respiratory, hepatic, renal failure — I509 J969 K7290

Code each site separately since the Classification provides a different code for each site.

(b) Where there is provision for coding the condition of one or more but not all of the sites or systems, code the conditions of the site(s) or system(s) that are indexed. Disregard the site(s) or system(s) for which the Classification does not provide a code.

I (a) Cerebro-hepatic failure — K7290

"Hepatic failure" is the only term indexed. Do not enter a code for "cerebral failure."

(c) When a site is not indexed and the Classification provides an NOS code for the condition, assign this code.

I (a) Ischemia colon, liver and spleen — K559 I99
(b)

"Ischemia colon" is the only term indexed. Since liver and spleen are not indexed and the condition has an NOS code, assign the NOS code for these terms.

c. Adjectival modifier reported with multiple conditions

(1) If an adjectival modifier is reported with more than one condition, modify only the first condition.

I	(a) Arteriosclerotic cardiomyopathy and nephritis		I251	N059
I	(a) Diabetic coma and gangrene		E140	R02

(2) If an adjectival modifier is reported with one condition and more than one site is reported, modify all sites.

I	(a) Diabetic gangrene of hands and feet		E145	
I	(a) Arteriosclerotic cardiovascular and cerebrovascular disease		I250	I672

(3) When an adjectival modifier precedes two different diseases that are reported with a connecting term, modify only the first disease.

I	(a) Arteriosclerotic cardiovascular disease and cerebrovascular disease		I250	I679

2. Parenthetical entries

a. When one medical entity is reported, followed by another complete medical entity enclosed in parenthesis, disregard the parenthesis and enter as separate terms.

I	(a) Heart dropsy		I500	
	(b) Renal failure (CVRD)		N19	I139

Code each medical entity as indexed.

Place 9	I	(a) Pneumonia (aspiration)	J189	T179	&W80

Code each medical entity as indexed.

b. When the adjectival form of words or qualifiers are reported in parenthesis, use these adjectives to modify the term preceding it.

I	(a) Collapse of heart		I509
	(b) Heart disease (rheumatic)		I099
	(c)		

Use the adjective to modify the term and code rheumatic heart disease.

c. If the term in parenthesis is not a complete term and is not a modifier, consider as part of the preceding term.

I	(a) Metastatic carcinoma (ovarian)		C56

Consider the site as part of the preceding term and code metastatic ovarian

carcinoma.

I	(a) Drug dependence (heroin) (cocaine)	F112	F142

Consider the specified drugs as part of the preceding term and code heroin and cocaine dependence.

3. Special diagnostic entities

a. When a condition is qualified as "HIV-related," "HIV," disregard the indexing of these conditions and code as separate one-term entities.

I	(a) HIV-related encephalopathy	B24	G934
I	(a) AIDS-related tuberculosis	B24	A1690
I	(a) AIDS encephalopathy	B24	G934
I	(a) HIV encephalopathy	B24	G934

b. Alzheimer's dementia: Consider the following terms as one term entities and code as indicated:

When reported as:	Code
Endstage Alzheimer's, senile dementia	G301
Senile dementia, Alzheimer's	
Senile dementia, Alzheimer's type	
Senile dementia of the Alzheimer's	

When reported as:	
Alzheimer's, dementia	G309
Alzheimer's; dementia	
Alzheimer's disease (dementia)	
Dementia Alzheimer's	
Dementia, Alzheimer's	
Dementia-Alzheimer's	
Dementia, Alzheimer's type	
Dementia of Alzheimer's	
Dementia-Alzheimer's type	
Dementia; Alzheimer's type	
Dementia, probable Alzheimer's (disease)	
Dementia syndrome, Alzheimer's type	
Endstage dementia (Alzheimer's)	

4. Plural form of disease

Do not use the plural form of a disease or the plural form of a site to indicate multiple.

I	(a)	Cardiac arrest	I469
	(b)	Congenital defects	Q899

Code I(b) Q899 (congenital defect); do not code as multiple (Q897).

5. Implied "disease"

When an adjective or noun form of a site is entered as a separate diagnosis, i.e., it is not part of an entry immediately preceding or following it, assume the word "disease" after the site and code accordingly.

I	(a)	Congestive heart failure	I500
	(b)	Myocardial	I515

Code I(b) to I515, myocardial disease. The site "myocardial" is not indexed with congestive heart failure.

I	(a)	Coronary	I251
	(b)	Hypertension	I10

Code I(a) to I251, coronary disease. Coronary hypertension is not indexed.

I	(a)	Renal	I129
	(b)	Hypertension	

Code I(a) to I129, renal hypertension. Consider the site, renal, to be a part of the condition that immediately follows it on line b, since Hypertension, renal is indexed.

6. Non-traumatic conditions

Consider conditions that are usually but not always traumatic in origin to be qualified as non-traumatic when reported due to or on the same line with disease.

I	(a)	Fat embolism	I749
	(b)	Pathological fracture	M844

Code line (a) as non-traumatic since reported due to disease.

7. Drug dependent, drug dependency

When drug dependent or drug dependency modifies a condition, consider as a non-codable modifier unless indexed.

I	(a) Perforated gastric ulcer	K255
	(b) Steroid-dependent COPD	J449

Code I(a) as indexed. Code I(b) to J449, chronic obstructive pulmonary disease NOS. Consider the "steroid dependent" to be a non-codable modifier.

C. Format

1. "Due to" relationships involving more than four causally related conditions

Four lines, (a), (b), (c), **and (d)** have been provided in Part I of the death certificate for reporting conditions involved in the sequence of events leading directly to death and for indicating the causal relationship of the reported conditions. In cases where the decedent had more than four causally related conditions leading to death, certifiers have been instructed to report all of these conditions and to add line, (e), to indicate the relationship of the conditions. In the ACME system, provision has been made for identifying conditions reported on the additional "due to" line in Part I. Code conditions reported on line (e) or in equivalent "due to" positions as having been reported on separate lines. (Refer to Section II, Part I, 2, Reject code 9 - More than four "due to" statements, for instructions for coding certificates with conditions reported on more than **five** "due to" lines.)

I	(a) Shock due to pneumonia	R579
	(b) Rupture of esophageal varices	J189
	(c) Cirrhosis of liver due to alcoholism	I859
	(d)	K746
	(e)	F102

2. Connecting terms

a. "Due to" written in or implied

When the certifier has stated that one condition was due to another or has between conditions in Part I, enter the codes as though the conditions had been reported, one due to the other, on separate lines. Code the conditions on each of the remaining lines in Part I, if there are any, as though they had been reported on the succeeding line. (Refer to Section II, Part I, 2, Reject code 9 - More than four "due to" statements, for instructions for coding certificates with more than four "due to" statements).

I	(a) Myocardial infarction as a result of	I219
	(b) ASHD	I251

Interpret "as a result of" as "due to" and code the ASHD on I(b).

I	(a) Stomach hemorrhage from gastric ulcer	K922
	(b) Cholecystitis	K259
	(c)	K819

Because of the implied "due to," code the gastric ulcer on I(b) and the cholecystitis on I(c).

(1) The following connecting terms should be interpreted as meaning "due to" or "as a consequence of" when the entity immediately preceding and following these terms is a

disease condition, nature of injury, or an external cause.

after	incident to	received in
arising in or during	incurred after	resulting from
as (a) complication of	incurred during	resulting when
as a result of	incurred in	secondary to (2°)
because of	incurred when	subsequent to
caused by	induced by	sustained as
complication(s) of	occurred after	sustained by
during	occurred during	sustained during
etiology	occurred in	sustained in
following	occurred when	sustained when
for	occurred while	sustained while
from	origin	
in	received from	

I	(a)	Myocardial infarction	I219
	(b)	Nephritis due to arteriosclerosis	N059
	(c)	Hypertension from toxic goiter	I709
	(d)		I10
	(e)		E050

Both "due to" and "from" indicate the conditions following these terms are moved to the next due to position.

I	(a)	Neurological devastation due to stroke	
	(b)		I64

Neurological devastation is a disease condition. Move stroke down to the next due to position.

I	(a)	Death from heart attack	I219
	(b)		

Death is not a disease condition, nature of injury, or external cause. Do not reformat heart attack.

I	(a)	Complication from diabetes	E149

Complication is not a disease condition, nature of injury, or external cause. Do not reformat diabetes.

(2) When one of the previous terms is the first entry in Part II, indicating that the following entry is a continuation of Part I, code in Part I in next due to position.

I	(a)	Respiratory failure	J969
	(b)	Cardiac arrest	I469
	(c)	Coronary occlusion	I219

	(d)	I251
II	due to ASHD	

Since Part II is indicated to be a continuation of Part I, code the ASHD on I(d).

(3) Certain connecting terms imply that the condition following the connecting term was "due to" the condition preceding it. In such cases, enter the code for the condition following the connecting term on the line above that for the condition that preceded it.

Interpret the following connecting terms as meaning that the condition following the term was due to the condition that preceded it:

as a cause of	manifested by
cause of	producing
caused	resulted in
causing	resulting in
followed by	underlying
induced	with resultant
leading to	with resulting
led to	

I	(a) Myocardial infarction followed by	I469
	(b) Cardiac arrest	I219
	(c)	

Code the cardiac arrest on I(a) since "followed by" indicates it was due to the myocardial infarction.

I	(a) Respiratory arrest	R092	
	(b) Pulmonary edema	J81	
	(c) Bronchitis with resulting pneumonia	J189	I469
	(d) and cardiac arrest	J40	

Code the pneumonia and cardiac arrest on I(c) since "with resulting" indicates they were due to the bronchitis.

b. Not indicating a "due to" relationship

When conditions are separated by "and" or by another connecting term that does not imply a "due to" relationship, enter the codes for these conditions on the same line in the order that the conditions are reported on the certificate.

The following terms imply that conditions are meant to remain on the same line

and	consistent with
accompanied by	with (c)
also	precipitated by
associated with	predisposing (to)
complicated by	superimposed on

li i

complicating

I	(a) Acute bronchitis superimposed on	J209	J439
	(b) Emphysema		
	(c) Tobacco abuse (smokes 3 packs a day)	F171	F179

Interpret "superimposed on" as "and." Enter the code for the condition on I(b) as the second code on I(a). Do not enter a code on I(b).

I	(a) MI	I219	
	(b) ASHD	I251	
	(c) Hypertension	I10	
	(d) Diabetes	E149	E142
II	also diabetic nephropathy		

Consider "also" as a connecting word that does not imply "due to" and code Part II as a continuation of I(d).

3. Condition entered above line I(a)

When a condition is reported on the certificate above line I(a), enter the code for this condition on I(a). Code the condition(s) entered on line I(a) on line I(b); then code the conditions entered on each of the remaining line(s) in Part I as though they had been reported on the succeeding lines.

Myocardial infarction

I	(a) Pulmonary embolism	I219
	(b) Congestive heart failure	I269
	(c) Congenital heart disease	I500
	(d)	Q249

Code the condition entered above I(a) on I(a), then code the condition entered on I(a) on I(b); then code the conditions entered on each of the remaining line(s) in Part I as though they had been reported on the succeeding lines.

4. Condition reported between lines in Part I

When a condition is reported between I(a) and I(b) or I(b) and I(c) or I(c) and I(d), without a connecting term, enter the code for this condition on the following "due to" line. Code the conditions entered on each of the remaining line(s) in Part I as though they had been reported on the succeeding line.

I	(a) Pneumonia	J189
	Bronchitis	
	(b) Emphysema	J40
	(c) Cancer of lung	J439
	(d)	C349

Code the condition reported between lines I(a) and I(b) in the next "due to"

position, and move the codes for conditions reported on lines I(b) and I(c) downward.

When a condition is reported between I(a) and I(b) or I(b) and I(c) or I(c) and I (d) with a connecting word, consider as a continuation of the line above and code accordingly unless there is a definite indication that it is a continuation of the line below.

I (a)	Cerebral hemorrhage	I619 I64
	c̄ CVA	
(b)	Cerebral arteriosclerosis	I672

Code the condition entered between I(a) and I(b) as a continuation of I(a).

I (a)	Cerebral hemorrhage	I619
(b)	Cerebral arteriosclerosis	I672 I64

Since the certifier indicated by an arrow that the condition entered between I(a) and I(b) was a continuation of I(b), code the CVA on I(b).

I (a)	Cerebrovascular accident due to cerebral hemorrhage	I64
(b)	Cerebral arteriosclerosis	I619
(c)		I672

Consider the condition entered between I(a) and I(b) as a continuation of I(a) and code accordingly.

5. Condition reported as due to I(a), I(b), or I(c)

When a condition(s) in Part I is reported with a specific statement interpreted or stated as "due to" another on lines I(a), I(b), I(c), or I(d), rearrange the codes according to the certifier's statement. **Do not apply** this instruction to such statements reported in Part II.

I (a)	Myocardial failure		I249
(b)	Pneumonia		I509
(c)	Myocardial ischemia due to (a)	3wks	J189

Accept the certifier's statement that the condition reported on I(c) is "due to" the condition on I(a). Move the codes for conditions reported on I(a) and I(b) downward. (Apply the duration on I(c) to the myocardial ischemia).

I (a)	Heart failure	I509	N19
(b)	Pneumonia	J189	
(c)	Uremia due to (b)		

Take into account the certifier's statement on I(c) and code the condition reported on

I(c) as the second entry on I(a).

I	(a) Carcinomatosis	I469
	(b) Cancer of lung	C80
	(c) Cardiorespiratory arrest due to above	C349

Take into account the certifier's statement and code the cardiorespiratory arrest on I(a), then move the codes for the remaining conditions downward.

I	(a) Coronary thrombosis	I219
	(b) Chronic nephritis	N039
	(c) Arteriosclerosis	I709
II	Uremia caused by above	N19

Disregard the certifier's statement, "caused by above," reported in Part II.

6. Conditions reported in Part II

Enter the codes for entries in Part II in the order the entries are reported, proceeding from the entry reported uppermost in Part II downward and from left to right, if there is more than one entry on the same line. If the conditions are numbered, code in numerical order.

I	(a) MI	I219		
	(b) ASHD	I251		
	(c)			
II	Pneumonia			
	Heart murmur, arteriosclerosis	J189	R011	I709

7. Deletion of "due to" on the death certificate

When the certifier has indicated that conditions in Part I were not causally related by marking through items I(a), I(b), I(c), and /or I(d), or through the printed "due to, or as a consequence of" which appears below items I(a) – I(c) on the death certificate, proceed as follows:

a. If the deletion(s) indicates that none of the conditions in Part I were causally related, consider as though all of the conditions had been reported on the uppermost used line. In determining the order of the codes, proceed from I(a) downward and from left to right if more than one condition is reported on a line.

I	~~(a)~~ Heart disease	I519	I10	N039
	~~(b)~~ Malignant hypertension			
	~~(c)~~ Chronic nephritis			
II	Cancer of kidney	C64		

I	(a) Cardiac failure	I509	I251	J439
	~~(b)~~ Arteriosclerotic heart disease			
	~~(c)~~ Emphysema and bronchitis			
	(d)			

b. If only item I(b), I(c), or I(d) or the printed "due to, or as a consequence of" which appears below lines I(a), I(b), or I(c) is marked through, consider the condition(s) reported on the crossed out line as though reported as the last entry (or entries) on the preceding line.

I	(a) Diabetes	E149	N40
	(b)		
	~~(c)~~ BPH		
I	(a) Cardiac arrest	I469	K746
	~~(b)~~ Cirrhosis of liver		
	(c) Alcoholism	F102	
I	(a) Congestive failure	I500	I251
	~~(b)~~ ASHD		
	(c)		
II	Pneumonia	J189	
I	(a) Heart block	I459	
	(b) Degenerative myocarditis	I514	I619
	~~(c)~~ Cerebral hemorrhage		
II	Bronchopneumonia	J180	

c. If only one part of the printed "due to, or as a consequence of" which appears below I(a), I(b), and I(c) is marked through, consider the condition(s) reported on that line as though reported as the last entry (or entries) on the preceding line.

I	(a) Cardiorespiratory failure	R092	
	Due to, or as a consequence of		
	(b) Infarction of brain	I639	I259
	~~Due to,~~ or as a consequence of		
	(c) Ischemic heart disease		
	Due to, or as a consequence of		

<u>Code</u> ischemic heart disease as though reported as second entry on I(b).

8. Deletion of "Part II" on death certificate

When the certifier has marked through the printed Part II, code the condition(s) reported in Part II as the last entry on the lowest used line in Part I.

I	(a) Apoplectic coma	I64	
	(b) Ruptured aneurysm, brain	I6090	
	(c) Arteriosclerosis	I709	
	(d) ESRD	N185	I10
~~II~~	and hypertension		

Since Part II is indicated to be a continuation of I(d), code hypertension as last entry on I(d).

I	(a) Myocarditis	I514	I219	I500
	~~(b)~~ M.I.			
	~~(c)~~ CHF			
	~~(d)~~ Cardiovascular arteriosclerosis			
~~II~~	Diabetes			

I	(a) M.I.	I219	
	(b) Uremia	N19	
	(c) Arteriosclerosis	I709	
	(d) Hypertension	I10	N059
~~II~~	Nephritis		

9. Numbering of causes reported in Part I

a. When the certifier has numbered all causes or lines in Part I, that is 1, 2, 3, etc., code these entries as if reported on the same line. This instruction applies whether or not the numbering extends into Part II, and it also applies whether or not the "due to" below lines I(a) and/or I(b) and/or I(c) are marked through.

I	(a) 1. Coronary thrombosis	I219 I250 I10 I709 N289
	(b) 2. ASCVD	
	(c) 3. Hypertension and arteriosclerosis	
	(d) 4. Renal disease	
II	5. Influenza	

Code all the entries on I(a).

b. When part of the causes in Part I are numbered, make the interpretation for coding such entries on an individual basis.

I	(a) 1. Bronchopneumonia	J180	C169
	(b) 2. Cancer of stomach		
	(c) Chronic nephritis	N039	

Enter the codes for the conditions numbered "1" and "2" on I(a) in the order indicated by the certifier. Do not enter a code on I(b); however, enter the code for the condition on I(c) on that line.

I	(a) Bronchopneumonia	J180	
	(b) 1. Cancer of stomach	C169	N039
	(c) 2. Chronic nephritis		

Enter the codes for conditions numbered "1" and "2" on I(b) in the order indicated by the certifier. Do not enter a code on I(c).

I	(a) Congestive heart failure	I500

	(b) Influenza	J1110		
	(c) 1. Pulmonary emphysema	J439	J449	C349
	(d) 2. COPD			
II	3. Cancer of lung			

Enter the codes for the conditions numbered 1, 2, and 3 on I(c) in the order indicated by the certifier. Do not enter a code on I(d) or in Part II.

c. When the causes in Part I are numbered, and an entry is stated or implied as "due to" another, enter the code(s) connected by the stated or implied "due to" in the next "due to" position, followed by the codes for the **remaining numbered** causes.

I	(a) 1. Bronchopneumonia due to	J180		
	(b) influenza	J1110	J841	J40
	(c) 2. Pulmonary fibrosis 3. Bronchitis			

Enter the code for the condition followed by the stated "due to" on I(b), followed by codes for the conditions numbered "2" and "3." Do not enter a code on I(c).

I	(a) 1. Pneumonia	J189	
	(b) MI	I219	I251
	(c) 2. ASHD		

Code the condition numbered "2" as a continuation of I(b). Leave I(c) blank.

10. Punctuation marks

a. Disregard punctuation marks such as a period, comma, question mark, or exclamation mark when placed at the end of a line in Part I. Do not apply this instruction to a hyphen (-), which indicates a word is incomplete.

I	(a) Myocardial infarct?	I219	
	(b) Meningitis, mastoiditis	G039	H709
	(c) Otitis media	H669	

Disregard the punctuation marks and code the conditions reported on I(a), I(b), and I(c) as indicated by the certifier.

I	(a) Chronic rheumatic heart disease,	I099	I958
	(b) chronic hypotension		
	(c) Cancer	C80	

Regard the conditions reported on I(b) as a continuation of I(a). Do not enter a code on I(b).

b. When conditions are separated by a slash (/), code each condition as indexed.

I	(a) Cardiac arrest/respiratory arrest/pneumonia	I469	R092	J189
	(b) ASHD	I251		

Disregard the slash and code conditions as indexed.

c. When a dash (-) or slash (/) is used to separate sites reported with one condition and the combination of the sites is indexed to a single ICD-10 code, disregard the punctuation and code as indexed. This does not apply to commas.

I	(a) Cardiac-respiratory arrest	I469	

Code as one code assignment since the 2 sites are indexed as Arrest, cardiorespiratory.

I	(a) Cardiac, respiratory arrest	I469	R092

Code each site separately since this instruction does not apply to commas.

I	(a) Cardiac respiratory arrest	I469	

Code as one code assignment since the 2 sites are indexed as Arrest, cardiorespiratory.

d. When conditions are indexed together yet separted by a comma, code conditions separately. If the term following the comma is an adjective, refer to Section II, Part B, 1, b (1).

I	(a) Cancer, cachexia	C80	R64
	(b) Anxiety, depression	F419	F329

Code each term separately even though indexed together.

11. Conditions in the duration box

When a condition is entered in the duration block, code the condition on the same line where it is reported.

			Duration		
I	(a)	Arteriosclerotic heart disease	CVA	I251	I64
	(b)				
	(c)				
II		Arteriosclerosis		I709	

Code the condition reported in the duration block as the last entry on I(a).

D. Doubtful diagnosis

1. Doubtful qualifying expression

a. When expressions such as "apparently," "presumably," "?," "perhaps," and "possibly,"

qualify any condition, disregard these expressions and code condition as indexed.

I	(a) ? hemorrhage of stomach	K922		
	(b) Possible ulcer of stomach	K259		

Disregard "?" and code hemorrhage of stomach on I(a) as reported.
Disregard "possible" and code ulcer of stomach on I(b) as reported.

I	(a) Heart disease, probable ASHD	I519	I251	

Disregard "probable" and code heart disease and ASHD on I(a).

Place 9	I	(a) Pneumonia, probably aspiration	J189	T179	&W80

Disregard the "probably" and code both pneumonia and aspiration as indexed.

b. When these expressions are reported at the end of a line in Part I, **do not consider to be a continuation of the next lower line.**

I	(a) Heart disease probably	I519
	(b) Acute myocardial infarction	I219

Disregard "probably" and code heart disease on I(a) and acute myocardial infarction on I(b).

I	(a) Cardiovascular disease presumably	I516
	(b) Cerebral thrombosis	I633

Disregard "presumably" and code each condition on the line where it is reported.

c. When these expressions are reported at the beginning of a line in Part I, **do not** consider to be a continuation of the line above it.

I	(a) Heart disease	I519
	(b) Possibly acute myocardial infarction	I219

Disregard "possibly" and code each condition on the line where it is reported.

d. When these expressions are reported at the beginning of Part II, **do not** consider to be a continuation of Part I.

I	(a) Heart disease probably	I519
	(b)	
	(c)	
II	Probably MI	I219

Disregard "probably" and code heart disease on I(a) and MI in Part II.

2. Interpretation of "either…or…"

Consider the following as a statement of "either or:"

- Two conditions reported on **one** line and **both** conditions qualified by expressions such as "apparently," "presumably," "?," "perhaps," and "possibly"
- Two or more conditions connected by "or" or "versus"

Code using the following instructions:

a. When a condition of more than one site is qualified by a statement of "either…or…" and both sites are classified to the **same system**, code the condition to the residual category for the **system**.

I	(a) Pneumonia	J189
	(b) Cancer of kidney or bladder	C689

Code I(b) C689, malignant neoplasm of other and unspecified urinary organs.

I	(a) Heart failure	I509
	(b) Coronary or pulmonary blood clot	I749

Code I(b) I749, blood clot.

b. When a condition of more than one site is qualified by a statement of "either…or…" and these sites are in different systems, code to the residual category for the disease or condition specified.

I	(a) Cardiac arrest	I469
	(b) Carcinoma of gallbladder or kidney	C80

Code I(b) C80, malignant neoplasm without specification of site.

I	(a) Respiratory failure	J969
	(b) Congenital anomaly of heart or lungs	Q899

Code I(b) Q899, anomaly, congenital, unspecified.

c. When conditions are qualified by a statement of "either…or…" and **only one site/system** is involved, code to the residual category for the site/system.

I	(a) Apparently stroke, perhaps heart attack	I99

Since both conditions are preceded by a doubtful qualifying expression, consider as a statement of "either…or…." Stroke and heart attack are classified to the circulatory system. Code to Disease, circulatory system, NEC.

I	(a) Pulmonary edema	J81

(b) Tuberculosis or cancer of lung J9840

Code I(b) J9840, lung disease NOS.

Note: When embolism and thrombosis are qualified by a statement of "either…or…," code to Clot (I749)

I (a) Cardiac thrombosis vs pulmonary embolism I749

Code I(a) I749, Clot (blood). Embolism and thrombosis are both blood clots, and Clot NOS is a more specific category than Disease, circulartory system.

d. When conditions are classified to the same three character category with different fourth characters, code to the three character category with fourth character "9."

I (a) ASCVD vs ASHD I259

Code to I259 the residual category. ASCVD and ASHD are both classified to 125.-, chronic ischemic heart disease.

e. When conditions are classified to different three character categories and Volume 1 provides a residual category for the diseases in general, code to that residual category.

I (a) MI vs coronary aneurysm I259

Code to I259 the residual category for ischemic heart disease. MI and coronary aneurysm are both classified as "ischemic heart diseases."

f. When conditions involving different systems are qualified by "either… or…," and cannot be classified to the residual category for the disease, code R688, other specified general symptoms and signs.

I (a) Coma R402
(b) ? gallbladder colic ? coronary thrombosis R688

Code I(b) R688, other ill-defined conditions. (Consider the two question marks on a single line as "either…or…").

g. When diseases and injuries are qualified by "either… or…," code R99, other unknown and unspecified cause, provided this is the only entry on the certificate. When other classifiable entries are reported, omit R99.

I (a) Head injury or CVA R99

Code I(a) R99, other unknown and unspecified cause.

h. For doubtful diagnosis in reference to "either… or…" **accidents**, **suicides**, and **homicides**, refer to Section V, Part A, External Cause Code Concept.

E. Conditions specified as "healed" or "history of"

The Classification provides sequela categories for certain conditions qualified as "healed" or "history of." Refer to Section IV, Part F, Sequela. When the Classification does not provide a code or a sequela category for a condition qualified as "healed" or "history of," code the condition as though not qualified by this term.

I	(a) Myocardial infarction	I219
	(b)	
	(c)	
II	Gastritis, healed	K297

Code K297, gastritis NOS in Part II.

F. Coding entries such as "same," " ditto (")," "as above"

When the certifier enters "same," "ditto mark (")," "as above," etc., in a "due to" position to a specified condition, do not enter a code for that line.

I	(a) Coronary occlusion	I219
	(b) Same	
	(c) Hypertension	I10

Do not enter a code on I(b) for the entry "same."

I	(a) Pneumonia	J189
	(b) "	
	(c) Emphysema	J439

Do not enter a code on I(b) for the " ditto mark (")."

G. Conditions qualified by "postmortem," "rule out," "ruled out," "r/o"

When a condition is qualified by "postmortem,"," or "r/o," etc., **do not** enter a code for the condition.

H. Nonindexed and illegible entries

1. Terms that are not indexed

When a term is reported that does not appear in the ICD-10 Index, refer the term to the supervisor.

2. Illegible entries

When an illegible entry is the **only** entry on the certificate, code R99. When an illegible entry is reported with other classifiable entries, disregard the illegible entry and code the remaining entries as indexed.

I. Coding one-character reject codes

When a death record qualifies for more than one reject code, code only one in this order: 1, 2, 3, 4, 5, 9.

1. Reject code 1-5–Inconsistent duration

When a duration of an entity in a "due to" position is shorter than that of an entity reported on a line above it and only **one** codable entity is reported on each of these lines, enter a reject code (1-5) in the appropriate data position. When more than one codable entity is reported on the same line, disregard the duration entered on that line. Use the appropriate reject code even though there are lines without a duration or with more than one codable entity between the entities with the inconsistent duration; in such cases, consider the inconsistency to be between the line immediately above and the line with the shorter duration.

If the inconsistent duration is between:

Lines	Enter Reject Code
I (a) and I (b)	1
I (b) and I (c)	2
I (c) and I (d)	3
I (d) and I (e)	4
Inconsistent durations between more than two lines in Part I, or any situation where reject codes 1-4 would not be applicable	5

Do not enter a reject code if the only inconsistency is between the durations of malignant neoplasms classifiable to C00-C96.

I	(a) ASHD	10 yrs.	I251
	(b) Chronic nephritis and hypertension	5 yrs.	N039 I10
	(c) Diabetes	5 yrs.	E149
			Reject 2

Disregard the duration on I(b), since more than one codable entity is reported on this line. Only **one** codable entity is reported on lines I(a) and I(c) and the duration of the diabetes was shorter than that of ASHD. For the purposes of assigning the reject code, consider the duration on I(b) to be at least as long as the duration on I(a). Therefore, enter reject code 2 denoting an inconsistency between I(b) and I(c).

I	(a) ASHD	5 yrs	I251
	(b) Chronic nephritis and hypertension	10 yrs	N039 I10
	(c) Diabetes	5 yrs	E149

Do not enter reject code 2. The duration on I(b) is disregarded. The duration of diabetes on I(c) was not shorter than that of ASHD on I(a).

I	(a) Cardiac arrest		I469
	(b) Congestive heart failure	1 week	I500

	(c) Cancer of stomach	1 year	C169
	(d) Metastatic cancer of lung	6 months	C780

Do not use reject code 3 since the inconsistent duration is between malignant neoplasms.

I	(a) Basilar artery thrombosis	7 weeks	I630
	(b) Renal failure	4 weeks	N19
	(c) Pneumonia	1 week	J189
			Reject 5

Enter reject code 5 since the inconsistent durations are between more than 2 lines.

Age 1 yr.

I	(a) Congenital nephrosis life		N049
	(b)		
	(c) Intestinal hemorrhage	1 day	K922
			Reject 5

Enter reject code 5 since reject codes 1-4 are not applicable.

2. Reject code 9 – More than four "due to" statements

When certifier's entries or reformatting result in more than **four** statements of "due to," continue the remaining codes horizontally on the **fifth** line and enter reject code 9 in the appropriate position.

I	(a) Terminal pneumonia	J189	
	(b) Congestive heart failure	I500	
	(c) Myocardial infarction	I219	
	(d) ASHD	I251	
	(e) Generalized arteriosclerosis	I709	E039
	(f) Myxedema		
		Reject 9	

Enter the code for the myxedema reported on the fifth "due to" line, I(f), following the code for the condition reported on this line (generalized arteriosclerosis). Enter reject code 9 in the appropriate data position.

If there are more than four "due to" statements in Part I and there is no codable condition reported on one or more lines, consider the condition(s) on each subsequent "due to" line as though reported on the preceding line. Enter reject code 9 only if, after reformatting, there are codable conditions on more than five lines.

I	(a) Pneumonia	J189
	(b) Extended illness	G839
	(c) Paralysis following CVA	I64
	(d) Hypertension due to	I10
	(e) adrenal adenoma	D350

Do not enter reject code 9. Since extended illness is not a codable condition, enter the code for paralysis on I(b), the code for CVA on I(c), etc. As a result of the rearrangement of the conditions, there are codable conditions on only five lines.

When a death record qualifies for more than one reject, prefer a reject code for inconsistent durations over reject code 9.

J. Inclusion of additional information \(AI\) to mortality source documents

Code supplemental information when it modifies or supplements data on the original mortality source document.

1. When additional information (AI) **states** the underlying cause of a **specified disease in Part I**, code the additional information (AI) in a "due to" position to the specified disease.

I	(a) Pulmonary edema	J81
	(b) Congestive heart failure	I500
	(c) Arteriosclerosis	I251
	(d) I709	
II		
	AI The underlying cause of the congestive heart failure was ASHD.	

   Since the certifier **states** the underlying cause of the congestive heart failure is ASHD, code I251 on I(c) and move the condition on I(c) to the next "due to" position.

2. When additional information (AI) **modifies** a disease condition, use the AI and code the disease modified by the AI in the position **first** indicated by the certifier.

I	(a) Pneumonia	J181
	(b)	
	(c)	
	AI Lobar pneumonia	

   Code lobar pneumonia as the **specified** type of pneumonia on I(a) only.

3. When there is a stated or implied complication of surgery and the additional information indicates the condition for which surgery was performed, code this condition in a "due to" position to the surgery when reported in Part I and following the surgery when reported in Part II. Precede this code with an ampersand (&).

I	(a) Coronary occlusion	T818
	(b) Gastrectomy	&Y836
	(c)	&K259
	AI Gastrectomy done for gastric ulcer.	

   Code the condition necessitating the surgery on I(c) and precede this code with an ampersand.

I	(a) Respiratory arrest	R092
	(b) Septicemia	T814

(c)
II Uremia, cholecystectomy N19 &Y836 &K802
AI Surgery for gallstones

Code the condition necessitating the surgery following the E-code for surgery in Part II.

4. When additional information (AI) **states** a certain condition is the **underlying cause** of death, **code** this condition in Part I in a "due to" position (on a separate line) to the conditions reported on the original death record.

I (a) Cardiac arrest I469
(b) MI I219
(c) ASHD I251
(d) E149
II
AI U.C. was diabetes

Accept the certifier's statement that the underlying cause of death was "diabetes," and code this condition on I(d) in a "due to" position to the conditions originally reported in Part I.

5. When any morphological type of neoplasm is reported in Part I with no mention of a "site" and additional information specifies a site, **code** the specified site **only** on the line where the morphological type is reported.

I (a) Cancer C349
(b)
(c)
II
AI Cancer of lung

Code only the specified cancer (lung) on I(a).

6. When additional information states the primary site of a malignant neoplasm, code this condition in a "due to" position to the other malignant neoplasms reported in Part I.

I (a) Metastatic neoplasm C80
(b) Metastasis to liver C787
(c) C189
II
AI Colon was primary site.

Code the stated primary site on I(c) in a "due to" position to the other neoplasms reported in Part I.

I (a) Carcinomatosis C80
(b) C61
(c)

II

AI Prostate was probably the primary site.

Code the presumptive primary site (prostate) on I(b) in a "due to" position to the stated neoplasm reported on the original death certificate.

7. When the additional information **does not modify** a condition on the certificate, or **does not state** that this condition is the underlying cause, code the AI as the last condition(s) in Part II. Code AI reported on the certificate beginning with the uppermost downward and from left to right.

I	(a) Coronary thrombosis	I219		
	(b) HASCVD	I119		
	(c)			
II	Hypertension	I10	I709	I64
	AI Arteriosclerosis, CVA, old MI			

The additional information does not modify conditions on the certificate. Code as the last entries in Part II.

Male, 30 minutes-Twin B

I	(a) Immature	P073		
600 gm	(b)			
	(c)			
II	Atelectasis	P281	P015	P070

Code the additional information in the order reported, uppermost downward and from left to right.

K. Amended certificates

When an "amended certificate" is submitted, code the conditions reported on the amended certificate only.

L. Effect of age of decedent on classification

Always note the **age of the decedent** at the time the causes of death are being coded. Certain groups of categories are provided for certain age groups. There are several conditions within certain categories which cannot be properly classified unless the **age** is taken into consideration. Use the following terms to identify certain age groups:

1. NEWBORN OR NEONATAL means **less than 28 days** of age at the time of death.

Code any index term with the indention of "newborn," "neonatal," "neonatorum," "perinatal," "perinatal period," "fetus or newborn," or "fetal" (in this priority order) to the newborn category if the decedent is less than 28 days of age or there is evidence the condition originated in the first 27 days of life, even though death may have occurred later.

Female, 4 hours

I	(a) Anoxia	P219
	(b) Cerebral hemorrhage	P524

Since the age of decedent is less than 28 days, code anoxia of newborn, and cerebral hemorrhage of newborn.

Male, 31 days		Duration
I	(a) Pulmonary hemorrhage	26 days P269
	(b)	

Since the condition originated in the first 27 days of life, code as a newborn.

2. INFANT or INFANTILE means less than 1 year of age at the time of death

Male, 9 months		
I	(a) Pneumonia	J189
	(b) Osteomalacia	E550

Since the decedent is less than 1 year of age at the time of death, code Osteomalacia, infantile.

3. CHILD or CHILDHOOD means less than 18 years of age at the time of death

Male, 11 years		
I	(a) Asthma	J450

Code as Asthma, childhood.

4.Congenital anomalies (Q00-Q99)

Regard the conditions listed below as congenital and code to the appropriate congenital category if death occurred within the age limitations stated, provided there is no indication that they were acquired after birth.

a. Less than 28 days:

heart disease NOS
hydrocephalus NOS

Male, 27 days		
I	(a) Renal failure	N19
	(b) Hydrocephalus	Q039

Code the hydrocephalus as congenital since the decedent was less than 28 days of age at the time of death.

b. Less than 1 year:

aneurysm (aorta) (aortic)
(brain) (cerebral) (circle of
cyst of brain
deformity

Willis) (coronary)	displacement of organ
(peripheral) (racemose)	ectopia of organ
(retina) (venous)	hypoplasia of organ
aortic stenosis	pulmonary stenosis
atresia	valvular heart disease (any valve)
atrophy of brain	

Female, 3 months

I	(a) Pneumonia	J189
	(b) Cyst of brain	Q046

Code cyst of brain as congenital since the age of the decedent is less than 1 year.

5. Congenital syphilis

Regard syphilis and conditions that are qualified as syphilitic as congenital and code to the appropriate congenital syphilis category if the decedent was less than two years of age.

Male, 16 mos

I	(a) Syphilitic pneumonia	A500
	(b)	
	(c)	

Code **congenital** syphilitic pneumonia since age is less than 2 years.

6. Age limitation

Some categories in ICD-10 are limited by provisions of the Classification to certain ages. Code the categories listed below only if the age at the time of death was as follows:

a. Age 28 days or over

A32	E14	J13	R00
A35	E162	J14	R01
A40	E561	J15	R048
A41	E63	J16	R090
A56	E834	J18	R092
A74	E835	J43	R11
B30	F10	J80	R17
B370	F11	J849	R230
B371	F12	J96	R233
B372	F13	J981	R290
B373	F14	J982	R40
B374	F15	J984	R50

B374	F15	J984	R50
B375	F16	J988	R53
B376	F17	K27	R56
B377	F18	K631	R58
B378	F19	K65	R60
B379	G473	K92	R633
D65	G700	L01	R680
D751	I48	L10	R681
E05	I49	L50	
E10	I50	L530	
E11	I61	M34	
E12	I62	N390	
E13	J12	N61	

Male, age 25 days
I (a) Urinary tract infection P393
(b)

Code urinary tract infection, newborn since age is less than 28 days.

Female, age 27 days
I (a) Respiratory failure P285
(b)
(c)

Code respiratory failure, newborn since age is less than 28 days.

Female, age 28 days
I (a) Atelectasis J981
(b)
(c)

Code atelectasis, J981 since age is reported as 28 days.

b. Age under 1 year:

R95

c. Age 1 year or over:

R960

Age 1 year
I (a) Sudden infant death syndrome R960

d. Age 5 years or over:

X60-X84

Age 4 years

Place 9	I	(a) GSW to head Suicide	S019	&W34

M. Sex limitations

Certain categories in ICD-10 are limited to one sex:

For Males Only	**For Females Only**	
B260	A34	M830
C60-C63	B373	N70-N98
D074-D076	C51-C58	N992-N993
D176	C796	O00-O99
D29.-	D06.-	P546
D40.-	D070-D073	Q50-Q52
E29.-	D25-D28	Q96
E895	D39.-	Q97
F524	E28.-	R87
I861	E894	S314
L291	F525	S374-S376
N40-N50	F53.-	T192-T193
Q53-Q55	I863	T833
Q98	L292	Y424
R86	L705	Y425
S312-S313	M800-M801	Y76.-
	M810-M811	

If the cause of death is inconsistent with the sex, code the cause of death to R99, other ill-defined and unspecified causes of mortality (R99).

Female, age 32

I	(a)	Cancer of prostate	R99
	(b)		
	(c)		

Code other ill-defined and unspecified causes of mortality (R99).

N. Effect of duration on assignment of codes

Before assigning codes, take into account any statements entered on the certificate in the spaces for duration since these statements may affect the code assignments for certain conditions.

1. Qualifying conditions as acute or chronic

a. Usually the duration should **not** be used to qualify the condition as "acute" or "chronic."

			Duration
I	(a)	Nephritis	2 years N059

Code nephritis as indexed. Do not use the duration to qualify the nephritis as chronic.

b. However, when assigning codes to certain conditions classified as "ischemic heart diseases" the Classification provides the following specific guidelines for classifying a condition with a **stated** duration as acute or chronic:

- acute or with a stated duration of 4 weeks or less
- chronic or with a stated duration of over 4 weeks

			Duration
I	(a)	Acute myocardial infarction 3 mos.	I258
	(b)		
	(c)		

Code Infarction, myocardium, chronic or with a stated duration of over 4 weeks, I258.

(1) For the purpose of interpreting these instructions:

Consider these terms:	To mean:
brief days hours immediate instant minutes recent short sudden weeks (few) (several)	4 weeks or less or acute
longstanding 1 month	over 4 weeks or chronic

			Duration
I	(a)	Aneurysm heart weeks	I219
	(b)		
	(c)		

Code Aneurysm, heart, acute or with a stated duration of 4 weeks or less, I219.

"Weeks" is interpreted to mean 4 weeks or less.

c. When the duration is stated to be "acute" or "chronic," consider the condition to be specified as acute or chronic.

			Duration
I	(a)	Heart failure 1 hour	I509
	(b)	Bronchitis acute	J209

Code "acute" bronchitis on I(b).

2. Subacute

In general, code a disease that is specified as subacute as though qualified as acute if there is provision in the Classification for coding the acute form of the disease but **not** for the subacute form.

I	(a)	Subacute pyelonephritis	N10

Code subacute pyelonephritis to N10, acute pyelonephritis since there is no code for subacute pyelonephritis.

3. Exacerbation

Interpret "exacerbation" as an acute phase of a disease. Code "exacerbation" of a chronic specified disease to the acute and chronic stage of the disease if the Classification provides separate codes for "acute" and "chronic."

I	(a)	Exacerbation of leukemia	C950	
	(b)	Chronic lymphocytic leukemia	C911	
I	(a)	Exacerbation of chronic	C910	C911
	(b)	lymphocytic leukemia		
I	(a)	Chronic leukemia with conversion to	C951	C950
	(b)	acute phase		
I	(a)	Exacerbation of chronic	N10	N119
	(b)	pyelonephritis		
I	(a)	Exacerbation of bronchitis	J209	
	(b)			
I	(a)	Acute exacerbation of chronic	J209	J42
	(b)	bronchitis		
I	(a)	Chronic obstructive lung disease exacerbation	J449	J441
	(b)			

Code the preceding examples to the acute and chronic stages of each specified disease since the Classification provides separate codes for the "acute" and "chronic."

4. Acute and chronic

Sometimes the terms acute and chronic are reported preceding two or more diseases. In these cases, use the term ("acute" or "chronic") with the condition it **immediately** precedes.

I	(a) Chronic renal and liver failure	N189	K7290

Code renal failure, chronic and liver failure NOS.

5. Qualifying conditions as congenital or acquired

Code conditions classified as congenital in the Classification as congenital, even when not specified as congenital if the interval between onset and death and the age of the decedent indicate that the condition existed from birth.

Female, age 2 years		Duration	
I	(a) Pneumonia	1 week	J189
	(b) Heart disease	2 years	Q249

Code the condition on I(b) as congenital since the age of the decedent and the duration of the condition indicate that the heart disease existed at birth.

Do not use the interval between onset and death to qualify conditions that are classified to categories Q00-Q99, congenital anomalies, as acquired.

Male, 62 years		Duration	
I	(a) Renal failure	3 months	N19
	(b) Pulmonary stenosis	5 years	Q256

Do not use the duration to qualify the pulmonary stenosis as acquired.

6. Two conditions with one duration

When two or more conditions are entered on the same line with one duration, disregard the duration and code the conditions as indexed.

		Duration		
I	(a) Myocardial ischemia and congestive heart failure	3 weeks	I259	I500
	(b) Hypertension	5 years	I10	

Disregard the duration on I(a) and code the myocardial ischemia as indexed.

		Duration
I	(a) MI due to nephritis 3 months	I219

(b) Arteriosclerosis		N059
(c)		I709

Disregard the duration on I(a) and code myocardial infarction as indexed.

7. Conflict in durations

When conflicting durations are entered for a condition, give preference to the duration entered in the space for interval between onset and death.

			Duration	
I	(a) Ischemic heart disease	2 weeks	years	I259

Use the duration in the block to qualify the ischemic heart disease.

8. Span of dates

Interpret dates that are entered in the spaces for interval between onset and death separated by a slash (/), dash (-), etc., as meaning from the first date to the second date. Disregard such dates if they extend from one line to another and there is a condition reported on both of these lines since the span of dates could apply to either condition.

Date of death 10-6-98		Duration	
I	(a) MI	10/1/98 -	I219
	(b) Ischemic heart disease	10/6/98	I259

Disregard duration and code each condition as indexed since the dates extend from I(a) to I(b).

Date of death 10-6-98		Duration	
I	(a) Aneurysm of heart	10/1/98 - 10/6/98	I219
	(b)		

Since there is only one condition reported, apply the duration to this condition.

Date of death 10-6-98		Duration	
I	(a) Ischemic heart disease	10/1/98 - 10/6/98	I249
	(b) Arteriosclerosis		I709

Apply the duration to I(a).

O. Relating and modifying conditions

1. Implied site of disease

Certain conditions are classified in the ICD-10 according to the site affected, e.g.:

atrophy	enlargement	obstruction
calcification	failure	perforation

calculus	fibrosis	rupture
congestion	gangrene	stenosis
degeneration	hypertrophy	stones
dilatation	insufficiency	stricture
embolism	necrosis	

(This list is not all inclusive)

Occasionally, these conditions are reported without specification of site. Relate conditions such as these for which the Classification does not provide a NOS code. Also relate conditions which are usually reported of a site. Generally, it may be assumed that such a condition was of the same site as another condition if the Classification provides for coding the condition of unspecified site to the site of the other condition. These coding principles apply whether or not there are other conditions reported on other lines in Part I. Apply the following instructions when relating a condition of unspecified site to the site of a specified condition:

a. General instructions for implied site of a disease

(1) Conditions of unspecified site reported on the same line:

(a) When conditions are reported on the same line, with or without a connecting term that implies a due to relationship, assume the condition of unspecified site was of the same site as the condition of specified site.

I	(a) Congestive heart failure		I500	
	(b) Infarction with myocardial		I219	I515
	(c) degeneration			
	(d) Coronary sclerosis		I251	

Code the infarction as myocardial, the site of the condition reported on the same line.

I	(a) Aspiration pneumonia	J690	
	(b) Cerebrovascular accident due to	I64	
	(c) thrombosis	I633	

Code the thrombosis as cerebral, the site of the condition reported on the same line.

I	(a) Duodenal ulcer with internal hemorrhage	K269	K922

Code Hemorrhage, duodenal (K922). Relate the internal hemorrhage to the site of the condition reported on the same line.

I	(a) CVA with hemorrhage	I64	I619
	(b) MI	I219	

Code Hemorrhage, cerebral (I619). Relate the hemorrhage to the site of the condition reported on the same line.

(b) When conditions of different sites are reported on the same line, assume the condition of unspecified site was of the same site as the condition immediately preceding it.

I	(a) ASHD, infarction, CVA	I251	I219	I64

(b)
(c)

Code Infarction, heart (I219). Relate the infarction to the site of the condition immediately preceding it.

(2) Conditions of unspecified site reported on a separate line:

(a) If there is only one condition of a specified site reported either on the line above or below it, code to this site.

I	(a) Massive hemorrhage	K922
	(b) Gastric ulceration	K259

Code the hemorrhage as gastric. Relate hemorrhage to the site of the condition reported on I(b).

I	(a) Uremia	N19
	(b) Chronic prostatitis	N411
	(c) Benign hypertrophy	N40

Code the hypertrophy as prostatic. Relate hypertrophy to prostate, the site of the condition reported on I (b).

I	(a) Internal hemorrhage	K868
	(b) Pancreatitis	K859

Code Hemorrhage, pancreas (K868). Relate the internal hemorrhage to the site of the condition reported on I(b).

(b) If there are conditions of different specified sites on the lines above and below it **and** the Classification provides for coding the condition of unspecified site to only one of these sites, code to that site.

I	(a) Intestinal fistula	K632
	(b) Obstruction	K566
	(c) Carcinoma of peritoneum	C482

Code the obstruction as intestinal since the Classification does not provide for coding obstruction of the peritoneum.

(c) If there are conditions of different specified sites on the lines above and below it **and** the Classification provides for coding the condition of unspecified site to both of these sites, code the condition unspecified as to site.

I	(a) CVA	I64
	(b) Thrombosis	I829
	(c) ASHD	I251

Code Thrombosis NOS on I(b). Do not relate the thrombosis since the Classification

provides codes for both sites reported.

(3) Do not relate conditions which are not reported in the first position on a line to the line above. It is acceptable to relate conditions not reported as the first condition on a line to the line below.

I	(a) Kidney failure	N19	
	(b) Vascular insufficiency $\overline{c}$ thrombosis	I99	I219
	(c) ASHD	I251	

Code Thrombosis, cardiac (I219). Relate thrombosis to line below.

(4) When relating conditions to sites start at the top of the certificate and work down.

I	(a) Hemorrhage	R5800
	(b) Necrosis	K729
	(c) Hepatoma	C220

The hemorrhage cannot be related. Relate necrosis to liver (K729), the site of the hepatoma.

b. Relating specific categories

(1) When ulcer, site unspecified or peptic ulcer NOS is reported causing, due to, or on the same line with gastrointestinal hemorrhage, code peptic ulcer NOS (K279).

I	(a) Gastrointestinal hemorrhage	K922
	(b) Peptic ulcer	K279
	(c)	

Code peptic ulcer (K279). Do not relate to gastrointestinal.

I	(a) Ulcer causing gastrointestinal hemorrhage	K922
	(b)	K279

Code ulcer to peptic ulcer (K279).

(2) When ulcer NOS (L984) is reported causing, due to, or on the same line with diseases classifiable to K20-K22, K30-K31, and K65, code peptic ulcer NOS (K279).

I	(a) Peritonitis	K659
	(b) Ulcer	K279

Code Ulcer, peptic (K279).

(3) When hernia (K40-K46) is reported with disease(s) of unspecified site(s), relate the disease of unspecified site to the intestine.

I	(a) Hernia with hemorrhage	K469	K922

Code Hemorrhage, intestine.

(4) When calculus NOS or stones NOS is reported with pyelonephritis, code to N209 (urinary calculus).

I	(a)	Pyelonephritis with calculus	N12	N209

Code calculus (N209) since it is reported with pyelonephritis.

(5) When arthritis (any type) is reported with

- contracture – code contracture of the site
- deformity – code deformity acquired of the site

If no site is reported or if site is not indexed, code contracture or deformity, joint.

I	(a)	Phlebitis	I809
	(b)	Contractures	M245
	(c)	Osteoarthritis lower limbs	M199

Code Contracture, joint (M245) since contracture lower limb is not indexed.

I	(a)	Pulmonary embolism	I269
	(b)	Multiple deformities	M219
	(c)	Arthritis in both hips	M139

Code deformity (acquired) of hip.

(6) When embolism, infarction, occlusion, thrombosis NOS is reported

- from a specified site **-** code the condition of the site reported
- of a site, from a specified site **–** code the condition to both sites reported

I	(a)	Congestive heart failure	I500
	(b)	Embolism from heart	I2190
	(c)	Arteriosclerosis	I709

Code I(b) embolism of heart (I2190).

I	(a)	Pulmonary embolism from leg veins	I269
	(b)		I803
	(c)		

Code I(a) pulmonary embolism (I269) and I(b) leg veins embolism (I803).

(7) Relate a condition of unspecified site to the complete term of a multiple site entity. If it is not indexed together, relate the condition to the site of the complete indexed term.

I	(a)	Cardiorespiratory arrest c̄ failure	I469	R092

Code Failure, cardiorespiratory (R092). Relate failure to the complete term.

I	(a)	Cardiorespiratory arrest	I469	I509
	(b)	c insufficiency		

Code Insufficiency, heart (I509) since cardiorespiratory arrest is indexed to a heart condition. Relate insufficiency to the site of the complete term.

(8) When vasculitis NOS is reported, apply the general instructions for relating and modifying.

I	(a)	Renal failure	N19
	(b)	Vasculitis	I778

Code Vasculitis, kidney (I778). Relate vasculitis to the site reported on line I(a).

c. Exceptions to relating and modifying instructions

(1) Do not relate the following conditions:

Arteriosclerosis	Neoplasms
Congenital anomaly NOS	Paralysis
Hypertension	Vascular disease NOS
Infection NOS (refer to Section III, #6)	

I	(a)	Arteriosclerosis with CVA	I709	I64
	(b)			
	(c)			

Code Arteriosclerosis NOS (I709).

I	(a)	Cardiac arrest	I469
	(b)	Congenital anomaly	Q899
	(c)		

Code congenital anomaly NOS (Q899).

I	(a)	Pneumonia	J189
	(b)	Infection	
	(c)		

Code Pneumonia (J189) on I(a). Do not enter a code on I(b).

I	(a)	Perforation esophagus	K223
	(b)	Cancer	C80
	(c)		

Code cancer NOS (C80).

(2) Do not relate hemorrhage when causing a condition of a specified site. Relate hemorrhage to site of disease reported on **same** line or on line **below** only.

I	(a) Respiratory failure	J969	
	(b) Hemorrhage	R5800	

Code Hemorrhage NOS. Do not relate to respiratory.

I	(a) Respiratory failure	J969	
	(b) Hemorrhage	K922	
	(c) Gastric ulcer	K259	

Relate hemorrhage on I(b) to gastric on I(c) and code gastric hemorrhage.

(3) Do not relate conditions classified to R00-R99 except:

Gangrene and necrosis	R02
Hemorrhage	R5800
Regurgitation	R11
Stricture and stenosis	R688

I	(a) Myocardial infarction with anoxia	I219	R090

Code anoxia as indexed. Do not relate to heart since anoxia is classified to R090.

I	(a) Pneumonia with gangrene	J189	J850

Code the gangrene as pulmonary, the site of the disease reported on the same line since gangrene is one of the exceptions.

(4) Do not relate a disease condition that, by the name of the disease, implies a disease of a specified site unless it is obviously an erroneous code. If not certain, refer to supervisor.

I	(a) Cirrhosis, encephalopathy	K746	G934

Do not relate encephalopathy to liver since the name of the disease implies a disease of a specific site, brain.

I	(a) Pulmonary embolism	I269	
	(b) Thrombophlebitis	I809	

Code thrombophlebitis (I809) as indexed. Do not relate thrombophlebitis since it is not usually reported of any site other than extremities.

I	(a) Cerebral hemorrhagec herniation	I619	G935

Relate herniation to brain since hernia NOS is classified to a disease of the digestive system (K469) and it seems illogical to have a brain disease paired with a digestive system disease.

Refer to Section V, Part D, Implied site of injury for instructions on relating the site of injuries to another site.

2. Coding conditions classified to injuries as disease conditions

a. Some conditions (such as injury, hematoma or laceration) of a specified organ are indexed directly to a traumatic category but may not always be traumatic in origin. Consider these types of conditions to be qualified as nontraumatic when reported:

- due to or on the same line with a disease
- due to: drug poisoning
  drug therapy

If there is provision in the Classification for coding the condition that is considered to be qualified as nontraumatic as such, code accordingly. Otherwise, code to the category that has been provided for "Other" diseases of the organ (usually .8).

I	(a) Laceration heart	I518	
	(b) Myocardial infarction	I219	
	(c)		

Code to myocardial infarction (I219) selected by General Principle. Since laceration heart is reported due to myocardial infarction, consider the laceration to be nontraumatic.

I	(a) Subdural hematoma	I620	
	(b) CVA	I64	
	(c)		

Code Hematoma, subdural, nontraumatic (I620) as indexed.

I	(a) Acute kidney injury	N288	
	(b) Kidney disease	N289	
	(c)		

Code acute kidney injury as nontraumatic since reported due to a disease. Apply instruction to assign other diseases of kidney (N288), even though indexed as acute.

I	(a) Cardiorespiratory failure	R092	
	(b) Intracerebral hemorrhage	I619	
	(c) Meningioma, subdural hematoma	D329	I620

Code subdural hematoma as nontraumatic since it is reported on the same line with a disease.

I	(a) Liver failure	K7290	
	(b) Cirrhosis with injury to liver	K746	K768

(c)

Code injury to liver as nontraumatic since it is reported on the same line with a disease.

I	(a) Cerebral arteriosclerosis with		I672	I620
	(b) subdural hematoma			

Code subdural hematoma as nontraumatic since it is reported on the same line with a disease.

b. Some conditions are indexed directly to a traumatic category but the Classification also provides a nontraumatic code. When these conditions are reported due to or with a disease and an external cause is reported on the record or the Manner of Death box is checked as Accident, Homicide, Suicide, Pending Investigation or could not be determined, code the condition as traumatic.

Place	I	(a) Subdural hematoma	S065	
9		(b) CVA	I64	
		(c)		
MOD	II		&W18	
A				

Accident	Fell while walking

Code the subdural hematoma as traumatic since the manner of death is accidental.

Place	I	(a) Cardiorespiratory arrest	I469	
0		(b) Subdural hematoma	S065	
		(c) Arteriosclerosis	I709	
MOD	II	Advanced age	R54	&W18
A				

Accident	Home	Fell in her room striking head

Code the subdural hematoma as traumatic since the manner of death is accidental.

Place	I	(a) Cerebral hematoma with	S068	I672
9		(b) cerebral arteriosclerosis		
		(c)		
MOD	II		&X599	
A				

Accident

Code the cerebral hematoma as traumatic since the manner of death is accidental.

c. Some conditions are indexed directly to a traumatic category, but the Classification also

provides a nontraumatic code. When these conditions are reported and the Manner of Death is Natural, code condition as nontraumatic unless the condition is reported due to or on the same line with an injury or external cause. This instruction applies only to conditions with the term "nontraumatic" in the Index. It does not apply to conditions in Section III, Intent of Certifier.

	I	(a) Subdural hematoma	I620	
		(b)		
MOD	II			
N				

Natural

Code I(a) as nontraumatic since Manner of Death box states "Natural."

Place	I	(a) Subdural hematoma	I620	
2		(b)		
		(c)		
MOD	II	Hip fracture	S720	&W19
N				

Natural | Fell in hospital

Code I(a) as nontraumatic since Manner of Death box states "Natural."

Place	I	(a) Subdural hematoma	S065	
2		(b) Open wound of head	S019	
MOD	II	Fell in hospital	&W19	
N				

Natural

Code subdural hematoma as traumatic since it is reported due to an injury, disregarding Natural in the Manner of Death box.

SECTION III – INTENT OF CERTIFIER

In order to assign the most appropriate code for a given diagnostic entity, it may be necessary to take other recorded information and the order in which the information is reported into account. It is important to interpret this information properly so the meaning intended by the certifier is correctly conveyed. The objective is to code each diagnostic entity in accordance with the intent of the certifier without combining separate codable entities. The following instructions help to determine the intent of the certifier. Apply Intent of Certifier instructions to "See also" terms in the Index and to any synonymous sites or terms as well.

1. Other and unspecified gastroenteritis and colitis of unspecified origin (A099)

a. Code A090 (Gastroenteritis and colitis of infectious origin)

When reported due to:

A000-B99
R75
Y431-Y434
Y632
Y842

I	(a)	Enteritis	A090
	(b)	Listeriosis	A329

Code I(a) gastroenteritis and colitis of infectious origin, A090, since enteritis is reported due to a condition classified to A329.

EXCEPTION: When the enteritis is reported due to another infectious condition or an organism classified to A49 or B34, refer to Section III, 6. Organisms and Infections.

b. Code K529 (Noninfective gastroenteritis and colitis, unspecified)

When reported due to:

C000-K929
L272
M000-N999
P000-R749
R760-Y430
Y435-Y631
Y633-Y841
Y843-Y899

I	(a)	Enteritis	K529
	(b)	Abscess of intestine	K630

Code I(a) noninfective gastroenteritis and colitis, unspecified, K529, since enteritis is reported due to a condition classified to K630.

I	(a)	Colitis	A099

Code I(a) gastroenteritis and colitis of unspecified origin, A099, as indexed.

2. Spinal Abscess (A180)
Vertebral Abscess (A180)

Code M462 (Nontuberculous spinal abscess)

When reported due to:

A400-A419	H650-H669	M910-M939
A500	H950-H959	M960-M969
A509	J00-J399	N10-N12
A527	J950-J959	N136
A539	K650-K659	N151
B200-B24	K910-K919	N159
B89	L00-L089	N288
B99	M000-M1990	N340-N343
C412	M320-M351	N390
C760	M359	N700-N768
C795	M420-M429	N990-N999
C810-C969	M45-M519	R75
D160-D169	M600	S000-T983
D480	M860-M889	
D550-D589	M894	

I	(a) Spinal Abscess	M462
	(b) Staphylococcal septicemia	A412

Code I(a) nontuberculous spinal abscess, M462, since spinal abscess is reported due to a condition classified to A412.

3. Charcot's Arthropathy (A521)

Code G98 (Arthropathy, neurogenic, neuropathic (Charcot's), nonsyphilitic)

When reported due to:

A30	Leprosy	G608	Hereditary sensory neuropathy
E10-E14	Diabetes mellitus	G901	Familial dysautonomia
E538	Subacute combined degeneration (of spinal cord)	G950	Syringomyelia
F101	Alcohol abuse	Q059	Spina bifida, meningo-myelocele
F102	Alcoholism	Y453	Indomethacin
G600	Hypertrophic interstitial neuropathy	Y453	Phenylbutazone
G600	Peroneal muscular atrophy	Y427	Corticosteroids

I	(a) Charcot's arthropathy	G98
	(b) Diabetes	E149

4. General Paresis (A521)

a. Code G839 (Paralysis)

When reported due to or on the same line with:

A022	A988	B690	D180-D181	I159
A040	B003-B004	B719	D210	I600-I709
A051	B010-B011	B75	D233-D234	I748
A066	B020-B022	B832	D320-D339	J108
A078	B03-B04	B888	D352	J118
A170-A179	B050-B051	B89	D355	M000-M1990
A180	B060	B900	D360-D367	M420-M429
A190-A191	B200-B24	B901-B909	D420-D439	M45-M519
A203	B258	B91	D443	M860-M949
A228	B259	B92-B940	D446	N000-N399
A260-A289	B261-B262	B941	D448	O100-O16
A321-A329	B268	B948-B949	D45-D479	O740-O749
A368	B270-B279	C470	D487	O900-O909
A390-A394	B334-B338	C479	D489	O95
A398-A399	B375	C700-C729	E713	O994
A428	B384	C751	E750-E756	P000-Q079
A440-A539	B428	C754	F449	Q750-Q799
A544	B450-B459	C758	G000-G239	Q860-Q999
A548	B461	C760	G300-G379	R270-R278
A680-A689	B49-B64	C770	G450-G459	R75
A692	B673	C793-C794	G540-G729	
A800-A959	B676	C798-C97	G839-G98	
A981-A982	B679	D170	I10	

I	(a) CVA with general paresis		I64	G839
	(b)			
	(c)			

b. Code T144 (Paralysis, traumatic)

Refer to Section V, Part S, Sequela of injuries, poisonings, and other consequences of external causes, if a sequela is indicated.

When reported due to or on the same line with:

S000-T149	W81-X39
T20-T35	X50-X599
T66-T79	X70-X84
T90-T95	X91-Y09
T981-T982	Y20-Y369
V010-W43	Y850-Y872
W45-W77	Y890-Y899

I	(a) General paresis		T144
	(b) Brain injury		S069
	(c)		

II Auto accident &V499

5. Viral Hepatitis (B161, B169, B171-B179)

Code

For Viral Hepatitis in Categories	Code Chronic Viral Hepatitis
B161	B180
B169	B181
B171	B182
B172	B188
B178	B188
B179	B189

When reported as causing liver conditions in:

K721, K7210
K740-K742
K744-K746

I (a) Cirrhosis of liver K746
(b) Viral hepatitis B B181

Code I(b) B181, chronic viral hepatitis B, since reported as causing a condition classified to K746.

6. Organisms and Infections NOS (B99)

Organisms

Bacterial organisms classified to A49.-	Viral organisms classified to B34.-	Organisms classified to *other* than A49.- or B34.-
Escherichia coli Haemophilus influenzae Pneumococcal Staphylococcal Streptococcal	Adenovirus Coronavirus Coxsackie Enterovirus Parvovirus	Aspergillus Candida Cytomegalovirus Fungus Meningococcal

Infectious conditions

Abscess Bacteremia	Infection Pneumonia	Sepsis, Septicemia Septic Shock

Empyema	Pyemia	Words ending in "itis"

These lists are NOT all inclusive. Use them as a guide.

In order to determine which instruction to use, refer to the Index under the named organism or under Infection, named organism.

a. Bacterial organisms and infections classified to A49 and Viral organisms and infections classified to B34

(1) When an infectious or inflammatory condition is reported and

(a) Is preceded or followed by condition classified to A49 or B34 **or**

(b) A condition classifiable to A49 or B34 is reported as the only entry or first entry on the next lower line **or**

(c) Is followed by a condition classified to A49 or B34 separated by a connecting term not indicating a due to relationship

(i) If a single code is provided for the infectious or inflammatory condition modified by the condition classified to A49 or B34, use this code. Do not assign a separate code for the condition classifiable to A49 or B34. It may be necessary to use "due to" or "in" in the Index to assign the appropriate code.

I (a) E. coli diarrhea A044

Code as indexed under Diarrhea, due to, Escherichia coli.

I (a) Pneumonia J129
(b) Viral infection

Code as indexed under Pneumonia, viral.

I (a) Meningitis and sepsis G000 A413
(b) H. influenzae

Code as indexed under Meningitis, Haemophilus (influenzae) and Septicemia, Haemophilus influenzae.

I (a) Sepsis with staph A412

Code as staphylococcal sepsis as indexed under Septicemia, staphylococcal.

I (a) Pneumonia c̄ MRSA J152

Code as methicillin resistant staphylococcal aureus pneumonia as indexed under Pneumonia, MRSA.

(ii) If (i) does not apply, and the Index provides a code for the infectious or inflammatory condition qualified as "bacterial," "infectious," "infective," or "viral," assign the appropriate code based on the reported type of organism. Do not assign a separate

code for the condition classified to A49 or B34.

I (a) Coxsackie virus pneumonia J128

Coxsackie virus is a specified virus. Code as indexed under Pneumonia, viral, specified NEC.

I (a) Peritonitis K650
(b) Campylobacter

Campylobacter is a specified bacteria. Code as indexed under Peritonitis, bacterial.

I (a) Pneumonia with coxsackie virus J128

Code as coxsackie virus pneumonia. Since coxsackie virus is a specified virus, code as indexed under Pneumonia, viral, specified NEC.

(iii) If (i) and (ii) do not apply, assign the NOS code for the infectious or inflammatory condition. Do not assign a separate code for the condition classified to A49 or B34.

I (a) Klebsiella urinary tract infection N390

The Index does not provide a code for Infection, urinary tract specified as bacterial, infectious, infective, or Klebsiella. Therefore, code Infection, urinary tract.

I (a) Pyelonephritis N12
(b) Staphylococcus

The Index does not provide a code for pyelonephritis specified as bacterial, infectious, infective, or staphylococcal. Therefore, code Pyelonephritis as indexed.

I (a) Pyelonephritis and pseudomonas N12

The Index does not provide a code for pyelonephritis specified as bacterial, infectious, infective or pseudomonas. Therefore, code pyelonephritis as indexed.

b. Organisms and infections classified to categories other than A49 and B34

(1) When an infectious or inflammatory condition is reported and

(a) Is preceded by a condition classifiable to Chapter I other than A49 or B34

(i) Refer to the Index under the infectious or inflammatory condition. If a single code is provided for this condition, modified by the condition from Chapter I, use this code. It may be necessary to use "due to" or "in" in the Index to assign the appropriate code.

I (a) Cytomegaloviral pneumonia B250

Code as indexed under Pneumonia, cytomegaloviral.

(ii) If (i) does not apply, refer to Volume 1, Chapter I to determine if the Classification provides an appropriate fourth character for the organism.

Indications of appropriate fourth characters for sites would be "of other sites," "other specified organs," or "other organ involvement."

I (a) Candidiasis peritonitis B378

Since this term is not indexed together, refer to Volume I, Chapter I and select the fourth character, .8, candidiasis of other sites.

(iii) If (i) and (ii) do not apply, code as two separate conditions.

I (a) Mononucleosis pharyngitis B279 J029

Since this term is not indexed together and Volume I, Chapter I does not provide an appropriate fourth character under B27.-, code as two separate conditions.

(b) A condition from Chapter I other than A49 or B34 is reported as the only entry or the first entry on the next lower line

(i) Code each condition as indexed where reported.

I (a) Peritonitis K659
(b) Candidiasis B379

Since candidiasis is classified to a condition other than A49 or B34, code each condition as indexed.

(c) A condition from Chapter I other than A49 or B34 is reported separated by a connecting term not indicating a due to relationship

(i) Code each condition as indexed where reported.

I (a) Pneumonia with candidiasis J189 B379

Since candidiasis is classified to a condition other than A49 or B34, code each condition as indexed.

c. Do not use HIV or AIDS to modify an infectious or inflammatory condition. Code as two separate conditions.

I (a) HIV pneumonia B24 J189

d. When an infectious or inflammatory condition is reported and a specified organism or specified nonsystemic infection is not the only entry or the first entry on the next lower line.

- Code the infectious or inflammatory condition and the organism or infection separately.

I (a) Pneumonia J189
(b) Emphysema & viral infection J439 B349

I (a) Peritonitis K659
(b) Gastric ulcer and staphylococcal infection K259 A490

e. When an infectious or inflammatory condition is reported and

(1) Infection NOS is reported as the only entry or the first entry on the next lower line

- Code the infectious or inflammatory condition where it is entered on the certificate and do not enter a code for infection NOS, but take into account if it modifies the infectious condition.

I	(a) Cholecystitis & arthritis	K819	M009	
	(b) Infection			
I	(a) Meningitis	G039		
	(b) Infection & brain tumor	D432		

(2) Infection NOS is not the only entry or the first entry on the next lower line

- Code the infectious or inflammatory condition where it is entered on the certificate and code infection NOS separately.

I	(a) Septicemia	A419	
	(b) Diabetes & infection	E149	B99

f. When a noninfectious or noninflammatory condition is reported and infection NOS is reported on a lower line

- Code the noninfectious or noninflammatory condition as indexed and code infection NOS (B99) where entered on the certificate.

I	(a) ASHD	I251	
	(b) Infection	B99	

g. When an organism is reported preceding two or more infectious conditions reported consecutively on the same line

- Code each of the infectious conditions modified by the organism.

I	(a) Staphylococcal pneumonia and	J152	G003
	(b) meningitis		

h. When one infectious condition is modified by more than one organism, modify the condition by all organisms.

I	(a) Strep, Klebsiella and MRSA pneumonia	J154	J150	J152
I	(a) Strep pneumonia, MRSA	J154	J152	
I	(a) Sepsis enterococcus, MRSA	A402	A410	

i. When any condition is reported and a generalized infection such as bacteremia, fungemia, sepsis, septicemia, systemic infection, or viremia is reported on a lower line

- Code both the condition and the generalized infection where entered on certificate. Do not modify the condition by the infection.

I	(a) Bronchopneumonia	J180
	(b) Septicemia	A419

I	(a) Pneumonia	J189
	(b) Viremia	B349

7. Eaton-Lambert syndrome (C80)

Code G708 (Eaton-Lambert syndrome unassociated with neoplasm)

When reported on a record without a condition from the following categories also reported:

C000-D489

Male, 57 years old

I	(a) Aspiration pneumonia	J690
II	(b) Eaton-Lambert syndrome	G708

Code I(b) Eaton-Lambert syndrome unassociated with neoplasm (G708) since there is no condition from categories C000 - D489 reported anywhere on the record.

Female, 69 years old

I	(a) Eaton-Lambert syndrome	C80
I	(b) Small cell lung cancer	C349

Code I(a) Eaton-Lambert syndrome (C80) since there is a condition from categories C000 - D489 reported on the record.

8. Erythremia (C940)

Code D751 (Secondary erythremia):

When reported due to

A000-D489	F55	L710-L719	N700-N768	R730-R739
D510-D619	G000-G419	L930-L932	N980	R75
D751	G450-G459	L950-L959	N990-Q999	R780
D760-E149	G600-G979	M000-M1990	R030	R826
E240-E279	I00-J989	M300-M359	R040-R049	R893
E65-E678	K20-L00	M420-M549	R090-R098	S000-Y899
E890	L100-L139	M800-M949	R160-R162	
E896-E899	L230-L309	M960-M969	R31	
F100-F199	L500-L599	N000-N399	R58-R5800	

I	(a) Septicemia	A419
	(b) Erythremia	D751

(c) Polycythemia D45

9. Polycythemia (D45)

Excludes:

idiopathic
primary
rubra
vera

Code D751 (Secondary polycythemia)

When reported due to:

A000-D489	F55	L710-L719	N700-N768	R730-R739
D510-D619	G000-G419	L930-L932	N980	R75
D751	G450-G459	L950-L959	N990-Q999	R780
D760-E149	G600-G979	M000-M1990	R030	R826
E240-E279	I00-J989	M300-M359	R040-R049	R893
E65-E678	K20-L00	M420-M549	R090-R098	S000-Y899
E890	L100-L139	M800-M949	R160-R162	
E896-E899	L230-L309	M960-M969	R31	
F100-F199	L500-L599	N000-N399	R58-R5800	

I (a) Polycythemia D751
(b) Pneumonia J189

I (a) Polycythemia &D751
(b) Chloromycetin therapy Y408

I (a) Polycythemia vera D45
(b) Emphysema J439

10. Hemolytic Anemia (D589)

Code D594 (Secondary hemolytic anemia)

When reported due to:

A000-D489	F180-F199	Q200-Q289
D594	G000-G09	R75
D65-D699	I00-I519	R780
D760	I776	R823
D800-D899	J09-J22	R826
E201	K700-K769	R893
E280-E289	M000-M359	S000-Y899
E40-E46	N000-N399	
E700-E899	O000-O998	
F100-F169	P550-P579	

I	(a) Hemolytic anemia	D594
	(b) Hairy cell leukemia	C914
	(c)	

I	(a) Hemolytic anemia	D589
	(b)	
	(c)	

II	Hypogammaglobulinemia	D801
I	(a) Secondary hemolytic	D594
	(b) anemia	

11. Sideroblastic Anemia (D643)

a. Code D641 (Secondary sideroblastic anemia due to disease)

When reported due to:

A000-C97	E230	F180-F182	J069	M023
D45	E531	F190-F192	J65	M101
D461	E539	F55	K700-K703	M352
D471	E798	G030	K709	N143
D510-D599	E800-E802	G040	K721	N188-N19
D640-D643	E831	G361	K730-K746	N341
D648	E880	G933	K760	O980-O981
D731	E890	I330	K761	R162
D748	F100-F102	I423	K766	R75
D758	F109-F112	I729	K769	R780
D860-D869	F119-F122	I888	K908	R826
D892	F130-F132	J00	L081	R893
E018-E02	F140-F142	J020	L448	R897
E032-E0390	F150-F152	J030	L946	
E050-E059	F160-F162	J040-J042	M021	

I	(a) Pneumonia	J189
	(b) Sideroblastic anemia	D641
	(c) Alcoholic cirrhosis	K703

b. Code D642 (Secondary sideroblastic anemia due to drugs or toxins)

When reported due to:

D642	X60-X69
T510-T659	Y10-Y19
T97	Y400-Y599
X40-X49	Y86-Y880

I	(a) CHF	I500
	(b) Sideroblastic anemia	&D642
	(c) Chloramphenicol	Y402

12. Hemorrhagic Purpura NOS (D693)

Code D690 (Hemorrhagic purpura not due to thrombocytopenia)

When reported due to:

A000-C97	F119	I771-I779	N19	Q848
D45-D460	F120	I872	N200-N219	Q872-Q873
D462-D469	F121-F122	I878	N250-N311	Q878
D471	F130-F132	I879 -I889	N312-N319	R104
D510	F140	I898-I899	N320-N390	R162
D511-D581	F141-F142	I99-J00	N392	R233
D582	F150	J020	N398-N399	R238
D588-D618	F151-F152	J030	N719	R291
D619	F160-F162	J040-J042	N897	R31
D648	F180-F181	J069	N910-N939	R398
D65-D692	F182	J65	N948	R72
D698-D71	F190-F191	K658	N950-N959	R75
D720	F192	K660	N991	R780
D721	G000-G032	K700-K769	P070-P073	R826
D728	G038-G039	K908	P219	R893
D729-D759	G040	L081	P221-P289	R897
D860-D869	G042-G049	L272	P546	T360-T658
D892	G060	L448	P916	T659
E240	G061-G09	L573	Q458	T780-T784
E241	G312	L80-L819	Q680	T789
E242	G361	L946	Q740-Q741	T806
E243	G373-G374	L958	Q758	T818
E248	G540	L959	Q772	T881
E249	G92	M021-M023	Q775-Q776	T885
E301	G933	M050-M089	Q778	T886-T887
E54	G958	M101	Q779-Q783	T96-T97
E569	G961	M120	Q785	T981
E642	I00-I019	M138	Q788-Q789	X20-X29
E648	I10	M159	Q791	X40-X48
E703	I159	M300	Q794-Q795	X49
E798	I308	M301-M352	Q796	X60-X69
E850-E859	I330-I339	M358	Q798	Y10-Y19
E871	I400-I409	M359	Q808	Y400-Y599
E880	I423	M898	Q810-Q819	Y86
F100	I729	N000-N078	Q820	Y870
F101-F102	I749	N079	Q821-Q825	Y871
F110-F112	I770	N10-N189	Q828	Y872

I	(a) CVA	I64
	(b) Hemorrhagic purpura	D690
	(c) Leukemia	C959

13. Thrombocytopenia (D696)

Code D695 (Secondary thrombocytopenia)

When reported due to:

A000-D447	F110	J030	P350 -P399	T752
D448	F111-F112	J040-J042	P550 -P560	T780-T783
D449-D509	F119	J069	P570	T784
D510	F120	J09-J118	P610	T788-T789
D511-D691	F121-F122	J65	P614	T803-T804
D692	F130	K658	P916	T808-T809
D693-D699	F131-F132	K660-K661	Q204 -Q205	T818
D730-D752	F140	K700-K769	Q206	T881
D758	F141-F142	K908	Q208	T882 -T883
D759-D763	F150	K920-K921	Q209	T885
D814	F151-F152	K922	Q210	T886 -T888
D820	F160	L081	Q220 -Q246	T889
D821	F161-F162	L448	Q248	T950 -T97
D840	F180-F181	L590	Q249	T981
D841-D848	F182	L818	Q289	T983
D860-D892	F190-F191	L946	Q758	V010-V99
E000-E009	F192	M021	Q775-Q776	W00-W53
E018-E02	F55	M023	Q778	W54-W56
E031-E033	G000-G032	M050-M089	Q779-Q783	W57
E034	G038-G039	M101	Q788-Q789	W58-W87
E035-E0390	G040	M120	Q798	W88-W93
E055	G042-G048	M138	Q828	W94-X19
E059	G049-G060	M159	Q850	X20-X32
E071	G061-G09	M199-M1990	R001	X34-X39
E230	G312	M219	R008	X40-X48
E349	G361	M300	R012	X49-X599
E46	G373-G374	M301-M329	R161-R162	X65
E538	G450-G452	M352	R233	X69-Y369
E539-E54	G454-G459	M898	R291	Y400-Y601
E560-E639	G540	N000-N078	R31	Y603
E642	G903	N079	R398	Y605
E648	G92	N10-N219	R58-R5800	Y610-Y611
E649	G933	N250-N311	R75	Y613
E713	G936	N312-N319	R771	Y615
E740	G938	N320 N390	R780	Y617

E740	G938	N320-N390	R780	Y617
E750	G951	N392	R788	Y620-Y621
E752	G958	N398-N399	R798	Y623
E753	G961	N980-N989	R825	Y625
E755-E756	I00-I019	N991	R826	Y630-Y633
E768-E779	I10-I629	O360-O369	R827-R828	Y640-Y655
E782	I630-I6300	O430-O431	R829	Y658
E798	I631-I6310	O438	R893	Y66-Y831
E803	I633-I677	O439-O469	R897	Y840
E835	I678-I679	O60	T200	Y842
E871	I690-I891	O670-O689	T201-T289	Y848-Y849
E880	I898	O700-O719	T300	Y850-Y872
E888	I899-I972	O908	T301-T329	Y880-Y881
E890	I978	O980-O981	T360-T658	Y890-Y891
E898	I99	P070-P073	T659	Y899
F100	J00	P219	T66-T670	
F101-F102	J020	P221-P289	T68	

I	(a) Multiple hemorrhages	R5800
	(b) Thrombocytopenia	D695
	(c) Cancer lung	C349

14. Hyperparathyroidism (E213)

Code E211 (Secondary hyperparathyroidism)

When reported due to:

A180	D136-D137
A187	D300-D309
A188	D351-D353
B650-B839	D410-D419
B902-B908	D442-D444
C250-C259	E130-E139
C64-C689	E15-E215
C750-C752	E240-E259
C788	E270-E279
C790-C791	E892
C798	M880-M889
C900-C902	N000-N399
D017	Q600-Q649
D090-D091	Q770-Q789
D093	Q798

I	(a) Hypercalcemia	E835
	(b) Hyperparathyroidism	E211
	(c) Cancer parathyroid gland	C750

15. Hyperaldosteronism (E269)

Code E261 (Secondary hyperaldosteronism)

When reported due to:

A220-A229	E270-E46	I500-I509	T96-T97
B500-B54	E511-E519	I701	T983
B560-B575	E660-E669	I778	X40-X49
C740-C749	E713	K700-K709	X60-X69
C797	E86	K721-K7210	X85-X90
D093	E871	K730-K746	Y10-Y19
D350	E880	K850-K851	Y400-Y599
D441	E890	K853-K859	Y86-Y880
D448-D449	E892	N000-N399	
D840-D849	E895-E899	T360-T659	
E000-E249	I10-I150	T783	
E250-E269	I159	T880-T889	

I	(a) MI	I219
	(b) Hyperaldosteronism	E261
	(c) Renal artery stenosis	I701

16. Lactase Deficiency (E730)

Code E731 (Secondary lactase deficiency)

When reported due to:

E730-E749	K590-K599
K500	K630
K508-K510	K633
K519-K529	K639
K570	K900-K902
K574	K912
K580-K589	N200-N209

I	(a) Severe diarrhea	K529
	(b) Lactase deficiency	E731
	(c) Celiac disease	K900

Code I(b) secondary lactase deficiency, E731, since reported due to celiac disease.

17. Korsakov's Disease, Psychosis, or Syndrome (F106)

Code F04 (Nonalcoholic Korsakov's disease, psychosis, or syndrome)

When reported due to :

A000-D591	L920	S710-S729	T904
D592	L928-L932	S740-S799	T905
D593-D610	L951	S810-S829	T908
D611	L980-L981	S840-S899	T909
D612-E243	M000-N459	S910-S929	T910
E248-E519	N490-N809	S940-S999	T911-T915
E52	N990-N992	T012-T029	T918
E530-F09	N994-Q999	T041-T08	T919-T922
F200-G311	R54	T091	T924-T926
G318-G619	R75	T093-T10	T928
G620	S010-S029	T111	T929-T932
G622	S040-S050	T113-T12	T934-T936
G628-G720	S052-S099	T131	T938
G722-G98	S110-S129	T133-T139	T939
I00-I4250	S140-S199	T141-T142	T940-T953
I427-J989	S210-S229	T144-T329	T954
K20-K291	S240-S299	T340-T349	T958-T959
K293-K669	S310-S328	T351-T399	T96-X40
K710-K851	S340-S399	T410-T422	X43-X44
K853-K859	S410-S429	T425-T426	X46-Y449
K861-L109	S440-S499	T427	Y451-Y468
L129-L449	S510-S529	T428	Y480-Y485
L510-L599	S540-S599	T440-T509	Y500-Y899
L710-L719	S610-S628	T520-T889	
L88	S640-S69	T901-T903	

I	(a)	Korsakoff's psychosis	F04
	(b)	Wernicke's encephalopathy	E512
	(c)		

18. Drug Use NOS - Named Drug Use (F11-F16, F18-F19)

Code drug use NOS, F199, when reported anywhere on the certificate. Code use of named drug, F11-F16, F18-F19 with fourth character "9," when reported anywhere on the certificate and the named drug is listed in Volume 3, under Addiction/Dependence. If the named drug is not listed in Volume 3 under Addiction/Dependence, do not enter a code.

Exceptions:

(1) Complication(s) reported due to (named) drug use. Code the (named) drug use to the

appropriate external cause code for adverse effects of drugs in therapeutic use unless the drug is one not used for medical care purposes. Refer to Section V, Part R, 1, Drugs, medicaments, biological substances causing adverse effects in therapeutic use (Y40-Y59) for coding instructions.

(2) There is mention of drug poisoning anywhere on the certificate, code the (named) drug use to F11-F16, F18-F19, with fourth character "9," if listed in Volume 3 under Addiction/Dependence. If (named) drug is not indexed in Volume 3 under Addiction/Dependence, code F19, specified drug NEC with fourth character "9." Refer to Section V, Part Q, 2, Poisoning by drugs.

I	(a) Chronic alcoholism	F102
	(b)	
	(c)	
II	Drug use	F199

Code drug use to F199. There is no complication reported due to the drug use.

I	(a) Cancer of pancreas	C259
	(b)	
	(c)	
II	Methadone use	F119

Code methadone use to F119 as listed under Dependence in Volume 3. There is no complication reported due to the methadone use.

I	(a) Systemic lupus erythematosus	M329
	(b)	
	(c)	
II	Steroid use	

Do not scode steroid use. Steroid is not listed in Volume 3 under Addiction/Dependence and no complication is reported due to the steroid use.

I	(a) Diabetes	E139
	(b) Steroid use	Y427
	(c)	
II	Rheumatoid arthritis	&M069

Code the diabetes as a complication of the steroids given in therapeutic use for rheumatoid arthritis. Refer to Section V, Part R, 1, Drugs, medicaments, biological substances causing adverse effects in therapeutic use (Y40-Y59) for coding complications of drugs during therapeutic use.

I	(a) Bacterial endocarditis	&I330
	(b) Use of morphine	Y450
	(c)	

Code the bacterial endocarditis as a complication of the morphine given in

therapeutic use. Precede the complication with an ampersand since the condition requiring the drug is not reported. Refer to Section V, Part R, 1, Drugs, medicaments, biological substances causing adverse effects in therapeutic use (Y40-Y59) for coding complications of drugs during therapeutic use.

Place 9	I	(a) Acute cocaine poisoning	T405 &X42
		(b)	
		(c)	
MOD A	II	Cocaine use	F149 T405

Accident	Ingested cocaine

Code cocaine use to F149 as listed under Dependence in Volume 3 since reported on the certificate with drug poisoning. Refer to Section V, Part Q, 2, Poisoning by drugs for instructions in coding drug poisoning.

Place 9	I	(a) Respiratory failure	J969
		(b) Acute drug use	F199
		(c)	
MOD A	II		&X42 T402

Accident	Overdose of morphine

Code acute drug use to F199 since reported on the certificate with drug poisoning.

Place 9	I	(a) Poisoning by drugs	T509 &X44
		(b)	
		(c)	
	II	Use of sedatives	F139

Code use of sedative to F139 as listed under Dependence in Volume 3 since reported on the certificate with drug poisoning.

19. Tobacco Use (F179)

Code F179 (Tobacco use)

a. When age of the decedent is greater than or equal to (>=) 1 year

AND

b. When the certifier selects "Yes" or "Probably" in the tobacco box on the US Standard Certificate of Death.

Did tobacco use contribute to death?

Yes ☐ Probably ☐

No ☐ Unknown ☐

The F179 should follow the last code in Part II.

I	(a) Pneumonia	J189	
	(b) Lung cancer	C349	
II	COPD	J449	F179

Did tobacco use contribute to death?

Yes ☒ Probably ☐

No ☐ Unknown ☐

Female, 2 months

I	(a) Pneumonia	J189	
	(b)		
II			

Did tobacco use contribute to death?

Yes ☒ Probably ☐

No ☐ Unknown ☐

No F179 is necessary for the tobacco box entry since age of decedent is less than 1 year old.

20. Psychotic Episode NOS (F239)

Code F068 (Psychotic episode, organic NEC)

When reported due to or on the same line with conditions classifiable to the following categories:

A000-E899	L88	R042-R048
F068	L920	R060-R065
G000-G98	L92-L932	R068
H600-H709	L951	R090-R091
H720-H739	L980-L981	R291
I00-J989	M000-N459	R54
K20-L109	N490-N809	R600-R609
L120-L449	N990-N992	R75
L510-L599	N994-Q999	
L710-L719	R02	

I	(a) TIA's with psychotic episodes	G459	F068
	(b) Cerebral arteriosclerosis	I672	

(c) Arteriosclerosis I709

Code psychotic episode on I(a) F068, since reported on the same line with TIA (G459). It could also be coded to F068 since reported due to cerebral arteriosclerosis (I672).

21. Psychosis (any F29)

Code F09 (Psychosis, organic NEC)

When reported due to or on the same line with conditions classifiable to the following categories:

A000-E899	R75	S840-S899	T909
F09	S010-S029	S910-S929	T910
G000-G98	S040-S050	S940-S999	T911-T915
I00-J989	S052-S099	T012-T029	T918
K20-L109	S110-S129	T041-T08	T919-T922
L120-L449	S140-S199	T091	T924-T926
L510-L599	S210-S229	T093-T10	T928
L710-L719	S240-S299	T111	T929-T932
L88	S310-S328	T113-T12	T934-T936
L920	S340-S399	T131	T938
L928-L932	S410-S429	T133-T139	T939
L951	S440-S499	T141-T142	T940-T953
L980-L981	S510-S529	T144-T329	T954
M000-N459	S540-S599	T340-T349	T958-T959
N490-N809	S610-S628	T351-T889	T96-Y899
N950-N959	S640-S699	T901-T903	
N990-N992	S710-S729	T904	
N994-Q999	S740-S799	T905	
R54	S810-S829	T908	

I	(a) Pneumonia	J189	
	(b) Psychosis – cerebrovascular arteriosclerosis	F09	I672
	(c) Arteriosclerosis	I709	

22. Dissociative Disorder (F449)

Code F065 (Organic dissociative disorder)

When reported due to conditions classifiable to the following categories:

A000-E899	L88	R042-R048
F065	L920	R060-R065
G000-G98	L928-L932	R068
H600-H709	L951	R090-R091
H720-H739	L980-L981	R291
I00-J989	M000-N459	R54
K20-L109	N490-N809	R600-R609
L120-L449	N990-N992	R75

L510-L599	N994-Q999	S000-Y899
L710-L719	R02	

I	(a) Dissociative disorder	F065
	(b) Remote subdural hematoma	T905
	(c) Car accident	&Y850

Code I(a) organic dissociative disorder, F065, since reported due to an injury.

I	(a) Dissociative disorder	F065
	(b) Senility	R54

Code I(a) organic dissociative disorder, F065, since reported due to senility.

23. Personality Disorder (F609), Personality Change (Enduring) (F629)

Code F070 (Organic personality disorder)

When reported due to conditions classifiable to the following categories:

A000-E899	N490-N809	S440-S499	T093-T10
F070	N990-Q999	S510-S529	T111
G000-G98	R54	S540-S599	T113-T12
I00-J989	R75	S610-S628	T131
K20-L109	S010-S029	S640-S699	T133-T139
L120-L449	S040-S050	S710-S729	T141-T142
L510-L599	S052-S099	S740-S799	T144-T329
L710-L719	S110-S129	S810-S829	T340-T349
L88	S140-S199	S840-S899	T351-T889
L920	S210-S229	S910-S929	T901-T922
L928-L932	S240-S299	S940-S999	T924-T932
L951	S310-S328	T012-T029	T934-Y899
L980-L981	S340-S399	T041-T08	
M000-N459	S410-S429	T091	

Place	I	(a) Personality disorder	F070
9		(b) Head injury	S099
		(c) Assault	&Y09

Code I(a) organic personality disorder, F070, since reported due to a head injury.

I	(a) Personality disorder	F070
	(b) Meningioma brain	D320

Code I(a) organic personality disorder, F070, since reported due to a meningioma brain.

I	(a) Personality change	F070	
	(b) Jakob-Creutzfeldt Syndrome	A810	

Code I(a) organic personality disorder, F070, since reported due to Jakob-Creutzfeldt Syndrome.

24. Mental Disorder (any F99)

Code F069 (Organic mental disorder)

When reported due to or on the same line with conditions classifiable to the following categories:

A000-G98	M000-N459	S000-S199	T510-T519
H600-H709	N490-N809	T019	T66-T68
H720-H739	N990-N992	T028	T698-T758
I00-J989	N994-Q999	T029	T790-T799
K20-L109	R02	T049	T900-T911
L120-L449	R042-R048	T062	T913
L510-L599	R060-R065	T064	T918-T919
L710-L719	R068	T07-T08	T940-T950
L88	R090-R091	T093-T094	T958-T959
L920	R291	T140-T149	T97
L928-L932	R54	T200-T207	T981-T982
L951	R600-R609	T340-T341	V010-Y872
L980-L981	R75	T350-T352	

I	(a) Cardiorespiratory arrest	I469	
	(b) Heart failure	I509	
	(c) Multiple sclerosis and mental disorder	G35	F069

25. Parkinson's Disease (G20)
Advanced Parkinson's Disease (G2000)
Grave Parkinson's Disease (G2000)
Severe Parkinson's Disease (G2000)

a. Code G214 (Vascular parkinsonism)

When reported due to:

G214
I672-I673
I678-I679

I698
I709

I (a) Parkinsonism G214
(b) Arteriosclerosis I709
(c)

b. Code G219 (Secondary parkinsonism)

When reported due to:

A170-A179	B900	R75
A504-A539	B902	S000-T357
A810-A819	B91	T66-T876
A870-A89	B941	T900-T982
B003	B949	T983
B010	F200-F209	X50-X599
B021-B022	G000-G039	X70-X84
B051	G041-G09	X91-Y09
B060	G20-G2000	Y20-Y369
B200-B24	G218-G219	Y600-Y849
B261	G300-G309	Y850-Y872
B375	I950-I959	Y881-Y899

I (a) Parkinson's disease G219
(b) Tuberculous meningitis A170
(c)

I (a) Secondary Parkinson's disease G219
(b)
(c)

26. Cerebral Sclerosis (G379)

Code I672 (Cerebrovascular atherosclerosis)

a. When reported due to or on the same line with:

A500-A539	M100-M109
E000-E349	M300-M359
E660-E669	N000-N289
E700-E839	N390
E890-E899	Q600-Q619
I10-I150	Q630-Q639
I159	Q890-Q892
I672	R54
I700-I709	T383
I770	Y423
I99	

b. When reported as causing:

I600-I679

I690-I698

I	(a) Cerebral edema		G936	
	(b) Cerebral sclerosis		G379	
I	(a) Cerebral thrombosis		I633	
	(b) Cerebral sclerosis		I672	
I	(a) ASHD		I251	
	(b)			
	(c)			
II	Cerebral sclerosis, hypertension		1672	I10

27. Myopathy (G729)

Code I429 (Cardiomyopathy)

When reported due to:

A150-A1690	E648-E649	R54
A178	E660-E669	R75
A181	E740	T360-T66
A188	E760-E769	T97
B332	E831	X45
B560-B575	E880-E889	X65
B948	I00-I259	Y15
D500-D649	I300-I4290	Y400-Y599
D758	I514-I5150	Y842
E100-E149	I700-I709	Y86-Y872
E40-E519	P200-P220	Y883
E639	P916	
E641	R31	

I	(a) Myopathy	I429
	(b) ASHD	I251
	(c)	

Code I(a) cardiomyopathy, I429, since reported due to a specific heart condition.

28. Brain Damage, child (G809)

Code G939 (Brain damage)

When reported due to:

A000-F199	M000-N399	R400-R402
F200-F99	N700-N889	R54
G000-G98	O000-Q999	R560-R5800
H600-H749	R02	R600-R609
H950-J80	R040-R049	R630
J82-J989	R060-R068	R75
K700-K769	R090-R092	S000-Y899
L00-L989	R291	

Male, 11 years

I	(a) Cardiac arrest		I469
	(b) Brain damage		G809

Since the age of the decedent is less than 18 years of age and there is no indication of the cause of the brain damage, code G809, brain damage, child.

Male, 11 years

I	(a) Brain damage		G939
	(b) Down's syndrome		Q909

Since there is an indication of the cause of the brain damage, code brain damage, G939.

29. Paralysis (any G81, G82, or G83 excluding senile paralysis)

Code the paralysis for decedent age 28 days and over to G80 (Infantile cerebral palsy) with appropriate fourth character

When reported due to:

P000-P969

Female, 3 months

I	(a) Pneumonia	1wk	J189
	(b) Paraplegia	3 mos	G808
	(c) Injury spinal cord since birth		P115

Code the paraplegia on I(b) to infantile paraplegia, G808, since reported due to an injury of the spinal cord since birth.

30. Cataract (H269)

Code H264 (Secondary cataract)

When reported due to:

A1690	H269
B200-B24	H579
E100-E149	R54

E160-E162	R75
E711	T66
E742	Y493
E830	Y540
E835	Y576
H264	

I	(a) CVA	I64
	(b) Cataract	H264
	(c) Diabetes	E149

Code I(b), secondary cataract, H264, since reported due to diabetes (E149).

31. Varices NOS and Bleeding Varices NOS (I839)

Code (a) I859 (Esophageal varices) or
(b) I850 (Bleeding esophageal varices)

When reported due to or on same line with:

Alcoholic diseases classified to: F100-F109
Liver diseases classified to: B150-B199, B251, B942, K700-K769
Toxic effect of alcohol classified to: T510-T519, T97

I	(a) Varices	I859
	(b) Cirrhosis of liver	K746

I	(a) Bleeding varices	I850
	(b) Cirrhosis of liver	K746

32. Pneumoconiosis (J64)

Code J60 (Coal worker's pneumoconiosis)

When Occupation is reported as:

Coal miner
Coal worker
Miner

Occupation: Coal Miner

I	(a) Bronchitis	J40
	(b) Pneumoconiosis	J60

33. Alveolar Hemorrhage (Diffused) (K088)

Code R048 (Lung hemorrhage)

When reported anywhere on record with:

A000-J989	S017-S023

A000-J989	S017-S023
K20-Q379	S026-S028
Q390-R825	S033
R826	S035-S098
R827-R892	S100-Y899
R893	
R894-R961	
R98-S014	

I	(a) Respiratory Failure	J969
	(b) Alveolar Hemorrhage	R048

Code I(b) lung hemorrhage, R048, since alveolar hemorrhage is reported on the record with a condition classified to J969

34. Diaphragmatic Hernia in K44

Code Q790 (Congenital diaphragmatic hernia)

When reported as causing hypoplasia or dysplasia of lung NOS (Q336).

I	(a) Lung dysplasia	Q336
	(b) Diaphragmatic hernia	Q790
	(c)	

35. Laennec's Cirrhosis NOS (K703)

Code K746 (Nonalcoholic Laennec's cirrhosis)

When reported due to:

A000-B99	K710-K718	Y574-Y599
C000-D539	K730-K760	Y640
D730-D739	K761	Y86
E02-E0390	K763	Y870-Y872
E100-E149	K768-K851	Y880
E500-E519	K853-K859	Y881
E52	K861-K909	
E530-E849	Q410-Q459Q900-Q999	
F110-F169	R75	
F180-F199	T360-T509	
I050-I099	T520-T659	
I110-I119	T97	
I130-I4250	X40-X44	
I427-I519	X46-X49	
I81	Y400-Y572	
K500-K519	Y573	
K630-K639		

I	(a) Cardiac arrest	I469
	(b) Laennec's cirrhosis	K746
	(c) Diabetes	E149

Code I(b) nonalcoholic Laennec's cirrhosis since reported "due to" diabetes

36. Biliary Cirrhosis NOS (K745)

Code K744 (Secondary biliary cirrhosis)

When reported due to:

A000-B99	K763
C000-D539	K768-K909
D730-D739	Q410-Q459
E02-E0390	Q900-Q999
E100-E149	R75
E500-E849	R780
F100-F169	R826
F180-F199	R893
I050-I099	T360-T659
I110-I119	T97
I130-I519	X40-X49
I81	X65
K500-K519	Y15
K630-K639	Y400-Y599
K700-K718	Y640
K730-K760	Y86-Y880
K761	Y881

I	(a)	Biliary cirrhosis	K745
	(b)		
	(c)		
I	(a)	Primary biliary cirrhosis	K743
	(b)		
	(c)		
I	(a)	Secondary biliary cirrhosis	K744
	(b)		
	(c)		
I	(a)	Biliary cirrhosis	K744
	(b)	Carcinoma pancreas	C259
	(c)		

37. Lupus Erythematosus (L930), Lupus (L930)

Code M321 (Systemic lupus erythematosus with organ or system involvement)

When reported as causing a disease of the following systems:

Anemia

Anemia
Circulatory (including cardiovascular, lymph nodes, spleen)
Gastrointestinal
Musculoskeletal
Respiratory
Thrombocytopenia
Urinary

I	(a)	Nephritis	N059
	(b)	Lupus erythematosus	M321
	(c)		

38. Gout (M109)

Code M104 (Secondary gout)

When reported due to:

B200-B24	L578-L589
C880-C959	L930-L932
D45	L945
D550-D599	L951
D751	L981
D758	M100-M109
E168	R75
E740	T510-T519
F100-F102	T97
F109	X45
K700-K769	X65
L100-L109	Y15
L120-L449	Y86-Y872
L510-L569	

I	(a)	Perforated gastric ulcer	K255
	(b)	Gout	M104
	(c)	Waldenstrom's macroglobulinemia	C880

39. Polyarthrosis (M159)

Code M153 (Secondary multiple arthrosis)

When reported due to:

A399
B200-B24
E660-E669
G810-G839
M150-M1990
N924
N950-N959
R54

R75
S000-T983

I	(a) Hypostatic pneumonia	J182
	(b) Polyarthrosis	M153
	(c) Obesity	E669

Code I(b) secondary multiple arthrosis, M153, since reported due to obesity.

40. Coxarthrosis (M169)

Code (a) M166 (Coxarthrosis, secondary, bilateral):
(b) M167 (Coxarthrosis, secondary, NEC, (unilateral))

When reported due to:

I	(a) Pneumonia	J189
	(b) Debility	R53
	(c) Coxarthrosis	M167
	(d) Polyarthrosis	M159

Code I(c) secondary coxarthrosis, M167, since reported due to polyarthrosis (M159).

41. Gonarthrosis (M179)

Code (a) M174 (Secondary gonarthrosis, bilateral):
(b) M175 (Secondary gonarthrosis, (unilateral))

When reported due to:

A399
B200-B24
E660-E669
G810-G839
M150-M171
M174-M1990
N924
N950-N959
R54
R75

I	(a) Pneumonia, gonarthrosis	J189	M175
	(b) Hemiplegia	G819	
	(c) Old CVA	I694	

Code I(a) secondary gonarthrosis, M175, since reported due to hemiplegia.

42. Arthrosis (M199)

Code M192 (Secondary arthrosis)

When reported due to:

A399
B200-B24
E660-E669
G810-G839
M150-M190
M192-M1990
N924
N950-N959
R54
R75

I	(a) Pathological fractures	M844
	(b) Arthrosis	M192
	(c) Senility	R54

Code I(b) secondary arthrosis, M192, since reported due to senility.

43. Kyphosis (M402)

Code M401 (Secondary kyphosis)

When reported due to:

A1690	E890-E899	M359-M489
A180	G110-G119	M800-M949
B902	G20-G2000	M960-M969
B91	G35-G379	Q050-Q059
C400-C419	G540-G549	Q760-Q799
C490-C499	G600-G839	Q850
C795	G950-G959	Q870-Q878
D166	G970-G979	Q893-Q999
D480	M000-M120	S000-Y899
E200-E215	M150-M1990	
E550-E559	M320-M351	

I	(a) COPD	J449
	(b) Kyphosis	M401
	(c) Spinal osteoarthritis	M479

Code I(b) secondary kyphosis, M401, since reported due to spinal osteoarthritis.

44. Scoliosis (M419)

a. Code M414 (Neuromuscular scoliosis)

When reported due to:

A800-A809	G700-G709
B91	G800-G809
G111	M414

I	(a) Respiratory failure	J969
	(b) Severe scoliosis years	M414
	(c) Polio years	B91

Code I(b) neuromuscular scoliosis, M414, since reported due to polio (B91).

b. Code M415 (secondary scoliosis)

When reported due to:

A1690	G09	M415-M489
A180	G20-G2000	M800-M949
B902	G360-G379	M960-M969
C400-C419	G540-G549	Q050-Q059
C490-C499	G600-G64	Q760-Q799
C795	G950-G959	Q850
D166	G970-G979	Q870-Q878
D480	M000-M120	Q893-Q999
E200-E215	M150-M1990	S000-Y899
E550-E559	M320-M351	
E890-E899	M359-M413	

I	(a) Pneumonia	J189
	(b) Scoliosis	M415
	(c) Progressive systemic sclerosis	M340

Code I(b) secondary scoliosis, M415, since reported due to progressive systemic sclerosis.

45. Osteonecrosis (M879))

Code M873 (Secondary osteonecrosis)

When reported due to:

A000-A399	D550-D589	M860-M870
A400-A419	H650-H669	M873
A420-B889	J00-J399	M878-M889
B89	L00-L089	M894
B900-B949	M000-M1990	M910-M939
B99	M320-M351	N340-N343
C400-C419	M359	N390

C763	M420-M429	N700-N768
C795	M45-M461	R75
C810-C969	M462	
D160-D169	M463-M479	
D480	M600	

I	(a) Septicemia	A419	
	(b) Osteonecrosis hip	M873	
	(c) Infective myositis	M600	

Code I(b) secondary osteonecrosis, M873, since reported due to infective myositis (M600).

46. Dysmenorrhea (N946)

Code N945 (Secondary dysmenorrhea)

When reported due to:

C530-C55	N800-N809
C798	N840-N841
D060-D069	N850-N889
D073	N945
D250-D269	Q510-Q519
D390	Q528
N710-N739	

I	(a) Anemia and gastric ulcer	D649	K259
	(b) Menorrhagia with dysmenorrhea	N920	N945
	(c) Cancer of endocervix	C530	

Code I(b) secondary dysmenorrhea, N945, since reported due to cancer of endocervix (C530).

47. Cesarean Delivery for Inertia Uterus (O622)

Hypotonic Labor (O622)
Hypotonic Uterus Dysfunction (O622)
Inadequate Uterus Contraction (O622)
Uterine Inertia During Labor (O622)

Code O621 (Secondary uterine inertia)

When reported due to:

O100-O209	O440-O469
O230-O249	O621

O260-O264
O266-O269
O310
O330-O349
O670-O679
O95
O980-O998

I (a) Cardiac arrest O754
(b) Uterine inertia O621
(c) Diabetes mellitus of pregnancy O249

Code I(b) secondary uterine inertia, O621, since reported due to diabetes mellitus of pregnancy (O249).

48. Brain Damage, newborn (P112)

Code P219 (Anoxic brain damage, newborn)

When reported due to:

A000-P029
P040-P082
P132-P158
P200-R825
R826
R827-R892
R893
R894-R961
R98

Male, 9 hours

I (a) Brain damage P219
(b) Congenital heart disease Q249

Code I(a) anoxic brain damage, P219, since reported due to congenital heart disease.

49. Intracranial Nontraumatic Hemorrhage of Fetus and Newborn (P52)

Code P10 (Intracranial laceration and hemorrhage due to birth injury) with the appropriate fourth character

When reported due to:

P030-P039
P100-P112
P119
P130-P131
P159

Male, 9 hours

I	(a) Cerebral hemorrhage	P101
	(b) Fractured skull during birth	P130
	(c)	

Code I(a) cerebral hemorrhage due to birth injury, P101, since reported due to a fracture skull occurring during birth.

Female, 2 weeks

I	(a) Cerebral hemorrhage	P101
	(b) Birth injury	P159
	(c)	

Code I(a) cerebral hemorrhage due to birth injury, P101.

50. Septal Defect, (atrial), (auricular), (heart), (ventricular), (Q210, Q211, Q212, Q219)

Code I510 (Acquired septal defect) providing there is no indication the defect is congenital

a. When reported due to:

A000-A099	I400-I519	N990-N999	R502-R509
A181	I700-J80	P000-P049	R53-R54
A200-B89	J82-J989	P100-Q079	R560-R609
B908-E899	K20-K929	Q240-Q249	R634-R635
F100-F199	L890-L899	Q260-Q349	R64
G000-G419	L97	Q380-Q459	R688-R799
G450-G459	L984	Q600-Q799	R826
G500-G729	M000-M1990	Q850-R098	R893
G900-G98	M300-M549	R11	S000-Y899
H650-H839	M800-M959	R160-R18	
I00-I029	N000-N399	R222	
I10-I339	N600-N96	R300-R398	

b. When reported on the same line with:

I110-I119
I130-I139
I200-I339
I400-I519

I	(a) Cardiac arrest	I469
	(b) Ventricular septal defect	I510
	(c) Myocardial infarction	I219

51. Hypoplasia or Dysplasia of Lung NOS (Q336)

Code P280 (Primary atelectasis of newborn)

When reported anywhere on the record with the following codes and not reported due to diaphragmatic hernia in K44.

A500-A509
B200-B24
P000-P009
P011-P013
P050-P073
P220-P229
P280
P350-P399
P612
Q600-Q611
Q613-Q649
R75

I	(a) Hypoplasia lung		P280
	(b)		
	(c)		
II	Prematurity		P073

Female, 5 hrs.

I	(a) Dysplasia of lung	5 hrs	Q336
	(b)		
	(c)		
II	Hyaline membrane disease		P220

Code Q336, since the duration and age are the same indicating the condition was congenital.

52. Injury (S000-T149)

Code P10-P15 (Birth trauma)

a. When the age of decedent is less than 28 days

AND

b. There is no mention of external cause

AND

c. Reported due to a condition in P000-P969

Male, 5 days

I	(a) Femur fracture	P132
	(b) Breech delivery	P030

Code femur fracture as indexed under Birth, injury, fracture, femur.

53. Fracture (any site) (T142)

Code M844 (Pathological fracture)

a. When reported due to:

A180	D160-D169	M320-M351	M854-M879	Q799
A500-A509	D480	M359	M893-M895	T810-T819
A521	D489	M420-M429	M898-M939	T840-T849
A527-A539	E210-E215	M45-M519	M941-M949	T870-T889
A666	E550-E559	M600	M960	
C000-C399	E896-E899	M843-M851	M966-M969	
C430-C794	G120-G129		Q770-Q789	
C796-C97	M000-M1990			

b. When reported due to or on the same line with:

C40-C41	M80-M81	M88
C795	M83	

NOTE 1: If accident box is checked, do not enter an external cause code.

NOTE 2: If a fracture qualifies as pathological, all fractures reported of the same site will be coded pathological as well.

I	(a) Fracture hip	M844			
	(b) Osteoarthritis	M199			
I	(a) Myocardial infarction	I219			
	(b) ASHD	I251			
	(c)				
II	Fracture of spine due to arthritis causing fall	M844	M139	W19	
I	(a) Pneumonia	J189			
	(b) Osteoporosis fracture spine	M819	M844		
I	(a) Pneumonitis	J189			
	(b) Arteriosclerosis	I709			
	(c) Fracture femur	M844			
MOD A	II				

Accident	Spontaneous in bed

Code fracture of femur as pathological, M844, since the certifier indicated it was spontaneous. Do not enter code for "accident" in checkbox.

I	(a) Aspiration pneumonia	J690			
	(b) Left hip fracture	M844			
	(c)				
II	Hip fracture, anemia, osteoporosis	M844	D649	M819	

Code the hip fracture on (b) and in Part II as pathological, applying instruction b and note 2.

54. Starvation NOS (T730)

Code E46 (Malnutrition NOS)

When reported due to:

A000-E649	L100-L129	R13	T058
E670-F509	L400-L409	R54	T065-T08
F530-F539	L510-L539	R600-R609	T091-T099
F608-F609	L890-L899	R630	T141
F680-F73	L97	R633-R634	T148-T149
F920	L984	R75	T170-T217
F982-F983	M000-M1990	S010-S099	T270-T329
F989-G98	M300-N459	S110-S199	T360-T659
I00-J80	N700-N768	S210-S299	T800-T889
J82-J989	O000-Q079	S310-S399	T97
K020-K029	Q200-Q824	T019-T021	T983
K040-K069	Q850-Q999	T029	V010-X52
K080-K929	R11	T041	X54-Y05
			Y070-Y899

I	(a) Anemia	D649
	(b) Starvation	E46
	(c) Cancer of esophagus	C159

Code I(b) E46, malnutrition, since reported due to a neoplasm.

I	(a) Starvation	E46
	(b) Crushed abdomen	S381
II	Auto accident	&V499

Code I(a) E46, malnutrition, since reported due to an internal injury.

55. Compartment Syndrome (T796)

Code M622 (Nontraumaic compartment syndrome)

When reported due to:

A530-A539	F109	N040-N049
B200-B24	F449	N170-N19

B91	G10-G419	Q000-Q079
C000-D489	G450-G98	Q250-Q269
D610-D699	I250-I259	Q650-Q799
E000-E039	I48	Q900-Q999
E230-E237	I600-I99	R190
E40-E46	K310-K389	R198
E511-E52	K560-K567	R263
E630-E649	K590-K599	R402
E750-E752	K650-K659	R58-R5800
E754	K850-K869	R75
E872	K910-K919	
E890-E899	L890-L899	
F100-F102	L97-M999	

I	(a)	Compartment syndrome	M622
	(b)	Hemorrhagic pancreatitis	K859

Code I(a) M622 since reported due to pancreatitis.

SECTION IV - CLASSIFICATION OF CERTAIN ICD CATEGORIES

General information

Separate categories are provided in ICD-10 for coding malignant primary and secondary neoplasms (C00-C96), carcinoma in situ (D00-D09), benign neoplasms (D10-D36), and neoplasms of uncertain or unknown behavior (D37-D48). Categories and subcategories within these groups identify sites and/or morphological types.

Morphology describes the difference in type and structure of cells or tissues (histology) as seen under the microscope and behavior. The ICD classification of neoplasms consists of several major morphological groups (types) of neoplasms including the following:

Carcinomas including squamous cell carcinoma and adenocarcinoma
Sarcomas and other soft tissue tumors including mesotheliomas
Lymphomas including Hodgkin's lymphoma and non-Hodgkin's lymphoma
Site specific types (types that indicate the site of the primary neoplasm)
Leukemias
Other specified morphological groups

The morphological types of neoplasms are listed in ICD-10 following Chapter XX in Volume 1 and also appear in Volume 3. Morphology, behavior, and site must all be considered when coding neoplasms. This may take the form of a reference to the appropriate column in the "Neoplasm" listing in the Index when the morphological type could occur in several organs. For example:

Adenoma, villous (M8261/1) - see Neoplasm, uncertain behavior

Or to a particular part of that listing when the morphological type originates in a particular type of tissue. For example:

Fibromyxoma (M8811/0) - see Neoplasm, connective tissue, benign

The Index may give the code for the site assumed to be most likely when no site is reported for a morphological type.

For example:

Adenocarcinoma
- pseudomucinous (M8470/3)
- - specified site - see Neoplasm, malignant
- - unspecified site C56

Or the Index may give a code to be used regardless of the reported site when the vast majority of neoplasms of that particular morphological type occur in a particular site. For example:

Nephroma (M8960/3) C64

Always look up the morphological description in the Index before referring to the listing under "Neoplasm" for the site.

The morphological code numbers consist of five characters: the first four identify the histological type of the neoplasm and the fifth, following a slash, indicates its behavior. These morphological codes (M codes) are not used by NCHS for coding purposes.

The behavior of a neoplasm is an indication of how it will act. The following terms describe the behavior of neoplasms:

Malignant, primary site (capable of rapid growth and of spreading to nearby and distant sites)	C00-C76, C80-C96
Malignant secondary (spread from another site; metastases)	C77-C79
In-situ (confined to one site)	D00-D09
Benign (non-malignant)	D10-D36
Uncertain or unknown behavior (undetermined whether benign or malignant)	D37-D48

Unless it is specifically indexed, code a morphological term ending in "osis" in the same way as the tumor name to which "osis" has been added is coded. For example, code neuroblastomatosis in the same way as neuroblastoma. However, do not code hemangiomatosis that is specifically indexed to a different category in the same way as hemangioma.

All combinations of the order of prefixes in compound morphological terms are not indexed. For example, the term "chondrofibrosarcoma" does not appear in the Index, but "fibrochondrosarcoma" does. Since the two terms have the same prefixes (in a different order), code the chondrofibrosarcoma the same as fibrochondrosarcoma.

A. Malignant neoplasms (C00-C96)

The categories that have been provided for the classification of malignant neoplasms distinguish between those that are stated or presumed to be primary (originate in) of the particular site or types of tissue involved, those that are stated or presumed to be secondary (deposits, metastases, or spread from a primary elsewhere) of specified sites, and malignant neoplasms without specification of site. These categories are the following:

C00-C75	Malignant neoplasms, stated or presumed to be primary, of specified sites and different types of tissue, except lymphoid, hematopoietic, and related tissue
C76	Malignant neoplasms of other and ill-defined sites
C77-C79	Malignant secondary neoplasm, stated or presumed to be spread from another site, metastases of sites, regardless of morphological type of neoplasm
C80	Malignant neoplasm of unspecified site (primary) (secondary)

C81-C96 Malignant neoplasms, stated or presumed to be primary, of lymphoid, hematopoietic, and related tissue

In order to determine the appropriate code for each reported neoplasm, a number of factors must be taken into account including the morphological type of neoplasm and qualifying terms. Assign all malignant neoplasms to the appropriate category for the morphological type of neoplasm, i.e., to the code shown in the Index for the reported term.
Morphological types of neoplasm include categories C40-C41, C43, C44, C45, C46, C47, C49, C70-C72, and C80. Specific morphological types include:

C40-C41 Malignant neoplasm of bone and articular cartilage of other and unspecified sites

Osteosarcoma
Osteochondrosarcoma
Osteofibrosarcoma
Any neoplasm cross-referenced as "See also Neoplasm bone, malignant"

I (a) Osteosarcoma of leg C402

Code the morphological type "Osteosarcoma" to Neoplasm, malignant, bone of the specified site as cross-referenced.

C43 Malignant melanoma of skin

Melanosarcoma
Melanoblastoma
Any neoplasm cross-referenced as "See also Melanoma"

I (a) Melanoma of arm C436

Based on the note in the Index, code melanoma of arm as indexed under **Melanoma, site classification**.

I (a) Melanoma of stomach C169

Melanoma of stomach is not found under Melanoma in the Index. The term should be coded by site under Neoplasm, malignant.

C44 Other malignant neoplasm of skin

Basal cell carcinoma
Sebaceous cell carcinoma
Any neoplasm cross-referenced as "See also Neoplasm skin, malignant"

I (a) Sebaceous cell carcinoma nose C443

Code the morphological type "Sebaceous cell carcinoma" to Neoplasm, malignant, skin of the specified site as cross-referenced.

C49 Malignant neoplasm of other connective and soft tissue

Liposarcoma
Rhabdomyosarcoma
Any neoplasm cross-referenced as "See also Neoplasm, connective tissue, malignant"

I (a) Rhabdomyosarcoma abdomen C494

Code the morphological type "Rhabdomyosarcoma" to Neoplasm, malignant, connective tissue of the specified site as cross-referenced.

I (a) Sarcoma pancreas C259

Code the morphological type "Sarcoma" to Neoplasm, malignant, connective tissue of the specified site as cross-referenced. Refer to the "Note" under Neoplasm, malignant, connective tissue concerning sites that do not appear in this list.

C80 Malignant neoplasm without specification of site

Cancer
Carcinoma
Malignancy
Malignant tumor or neoplasm
Any neoplasm cross-referenced as "See also Neoplasm, malignant"

I (a) Carcinoma of stomach C169

Code the morphological type "Carcinoma" to Neoplasm, malignant, stomach as indexed.

I (a) Cancer prostate C61

Code the morphological type "Cancer" to Neoplasm, malignant, prostate as indexed.

I (a) Adenosarcoma breast C509

Code the morphological type "Adenosarcoma" to Neoplasm, malignant, of the specified site as cross-referenced.

C81-C96 Malignant neoplasms of lymphoid, hematopoietic, and related tissue

Leukemia
Lymphoma

I (a) Lymphoma of brain C859

Code Lymphoma NOS, C859, as indexed. Neoplasms in C81-C96 are coded by morphological type and not by site.

1. Neoplasms stated to be secondary

Categories C77-C79 include secondary neoplasms of specified sites regardless of the morphological type of the neoplasm. The Index contains a listing of secondary neoplasms of specified sites under "Neoplasm." Secondary neoplasms of specified sites without indication of the primary site require an additional code to identify the morphological type of neoplasm if the morphological type is classifiable to one of the following categories: C40, C41, C43, C44, C45, C46, C49, C70, C71, and C72.

I	(a) Secondary melanoma of lung		C439	C780

Melanoma is classified to C43; therefore, when stated secondary of a site, code Melanoma, unspecified site and secondary neoplasm of the reported site.

I	(a) Secondary carcinoma of intestine		C785

The morphological type of the term "carcinoma" is C80; therefore, code a secondary neoplasm code only.

2. <u>Malignant neoplasms with primary site indicated</u>

NOTE: If two or more malignant neoplasms are indicated as primary, refer to instructions under 5. Independent (primary) sites.

a. If a particular site is indicated as primary, it should be coded as primary and other neoplasms coded as secondary whether in Part I or Part II. The primary site may be indicated in one of the following ways:

(1) If two or more sites with the same morphology are reported, and one site is specified as primary in either Part I or II

I	(a) Carcinoma of bladder	C791
II	Primary in kidney	C64

<u>Code</u> carcinoma of bladder as secondary and code primary malignant neoplasm of kidney.

I	(a) Primary cancer of lung		C349
	(b) Cancer of breast		C798

<u>Code</u> primary malignant neoplasm of lung and code cancer of breast as secondary.

NOTE: This also applies when the same site is reported more than once and qualified as primary

I	(a) Met lung cancer	C780
II	(b) Primary lung cancer	C349

<u>Code</u> metastatic lung cancer on I(a) as secondary and code primary malignant cancer of lung on I(b).

(2) The specification of other sites as "secondary," "metastases," "metastasis," "spread," or a statement of "metastasis NOS" or "metastases NOS"

I	(a) Carcinoma of breast		C509
	(b) Secondaries in brain		C793

Code I(a) primary malignant neoplasm of breast, and I(b) to secondary malignant neoplasm of brain.

I	(a) Stomach metastases	C788	
	(b) Lung cancer	C349	

Code I(a) secondary neoplasm of stomach and I(b) primary malignant neoplasm of lung.

I	(a) Brain metastases	C793	
	(b) Liver cancer	C229	

Code I(a) secondary neoplasm of brain and I(b) primary malignant neoplasm of liver.

I	(a) Lung cancer with metastases	C349	C80

Code I(a) primary cancer of lung followed by the NOS code for metastases.

(3) Morphology indicates a primary malignant neoplasm

If a morphological type implies a primary site, such as hepatoma, consider this as if the word "primary" had been included.

I	(a) Hepatoma	C220

Code hepatoma as a primary neoplasm.

I	(a) Carcinoma	C80
	(b) Pseudomucinous adenocarcinoma	C56

Code I(a) Carcinoma as neoplasm malignant, unspecified site. Code I(b) to primary malignant neoplasm of ovary, since pseudomucinous adenocarcinoma of unspecified site is assigned to the ovary in the Index.

b. If a morphological type of malignant neoplasm indicating primary is reported in Part I or Part II with a different morphological type of malignant neoplasm that is stated primary, consider both neoplasms to be primary.

I	(a) Sarcoma of thigh	C492
II	Primary liver carcinoma	C229

Code each neoplasm as indexed. Both I(a) Sarcoma of thigh and Part II Primary liver carcinoma are primary malignant neoplasms.

3. Site specific neoplasms

a. Certain neoplasms are classified or indexed directly to a specific site. Classify morphological types of neoplasms that appear in the Index with specific codes (site specific neoplasms) e.g. "Hepatocarcinoma (M8170/3) C220," as indexed.

I (a) Renal cell carcinoma C64

Code renal cell carcinoma as indexed.

b. If there is a conflict between the code for a site specific neoplasm and the stated site, code the site specific neoplasm as indexed and code the stated site as secondary. Enter the code for the secondary neoplasm on the same line with and immediately following the code for the site specific neoplasm.

I (a) Hepatocarcinoma of brain C220 C793

Code hepatocarcinoma as indexed and code secondary malignant neoplasm of brain as the second entry on I(a).

c. When a site specific neoplasm is reported due to the same site specific neoplasm, code each as indexed.

I (a) Bronchogenic carcinoma C349
(b) Bronchogenic carcinoma C349

Code I(a) and I(b) to bronchogenic carcinoma, as indexed.

d. If the only thing reported is a site specific neoplasm and a malignant neoplasm of the same site, with or without metastases, code both as primary.

I (a) Hepatocellular cancer C220
(b) Liver cancer C229

Code both the hepatocellular cancer and liver cancer as primary.

I (a) Oat cell cancer C349
(b) Lung cancer C349

Code both the oat cell cancer and lung cancer as primary.

I (a) Liver cancer and hepatocellular carcinoma with mets C229 C220 C80

Code both the liver cancer and hepatocellular carcinoma as primary. Code metastases to NOS as indexed.

4. Other morphological types of neoplasms

If adenocarcinoma, cancer, carcinoma, neoplasm (malignant) or tumor (malignant) of a site, except neoplasms classifiable to C81-C96, are reported due to a morphological type of neoplasm of unspecified site, code the neoplasm on the upper line qualified by the morphological type, and do not enter a code for the morphological type of unspecified site on the lower line if:

a. The morphological type of neoplasm reported on the lower line is C80.

I (a) Tumor of upper lung C341
(b) Carcinoma

Code the tumor on I(a) modified by the morphological type (C80) on I(b). Leave line I(b) blank.

I (a) Cancer of bladder C679
(b) Papillary carcinoma

Code the cancer on I(a) modified by the morphological type (C80) on I(b). Leave line I(b) blank.

b. The morphological type of neoplasm of unspecified site on the lower line is classified to the same site as the neoplasm on the upper line.

I (a) Cancer of brain C719
(b) Astrocytoma

Code the specified site on I(a) modified by the morphological type of unspecified site on I(b) since they are classified to the same site. Leave I(b) blank.

I (a) Adenocarcinoma of stomach C169
(b) Linitis plastica

Code the specified site on I(a) modified by the morphological type of unspecified site on I(b) since they are classified to the same site. Leave I(b) blank.

c. The morphological type of neoplasm of unspecified site on the lower line is classified according to the site affected, e.g., the malignant neoplasms classifiable to the following categories: C40, C41, C43, C44, C47, C49, C70, C71, and C72. Code the neoplasm on the upper line qualified by the morphological type on the lower line, and do not enter a code for the morphological type of unspecified site on the lower line.

I (a) Adenocarcinoma of face C433
(b) Melanoma

Code melanoma of face on I(a) and leave I(b) blank.

I (a) Carcinoma of leg C492
(b) Fibroliposarcoma

Code fibroliposarcoma of leg on I(a) and leave I(b) blank.

5. Independent (primary) sites

The presence of more than one primary neoplasm could be indicated in one of the following ways:

- mention of two different anatomical sites
- or two distinct morphological types (e.g., hypernephroma and intraductal carcinoma)
- or by a mix of a morphological type that implies a specific site, plus a second site.

It is highly unlikely that one primary would be due to another primary malignant neoplasm except for a group of malignant neoplasms of lymphoid, hematopoietic, and related tissue (C81-C96), within which, one form of malignancy may terminate in another (e.g., leukemia may follow non-Hodgkin's lymphoma).

a. If two or more sites are mentioned in Part I and there is no indication that either site is primary or secondary, code each site as indexed.

I	(a)	Cancer of stomach 3 months	C169
	(b)	Cancer of breast 1 year	C509

Code to primary malignant neoplasm of each site mentioned, since it is unlikely that one primary malignant neoplasm would be due to another.

I	(a)	Carcinoma of colon and rectum	C189 C20

Code both sites as primary and enter both on I(a).

b. If two or more morphological types of malignant neoplasm occur, one reported due to the other or reported anywhere on the record, code each as indexed.

I	(a)	Lymphosarcoma of mesentery	C850
II		Adenocarcinoma of cecum	C180

Code each as though the other had not been reported since there are two different morphological types of malignant neoplasms.

I	(a)	Cancer of esophagus	C159
	(b)	Hodgkin's sarcoma	C817

Code the cancer of the esophagus as primary and code the Hodgkin's sarcoma as indexed. They are different morphological types.

I	(a)	Leukemia	C959
II		Carcinoma of breast	C509

Code each neoplasm as indexed. Two different morphological types are mentioned.

c. If two or more morphological types of malignant neoplasm occur in lymphoid,

hematopoietic, or related tissue (C81-C96), code each as indexed. When acute exacerbation of, or blastic crisis (acute) in, chronic leukemia is reported, code both the acute form and chronic form. If stated acute and chronic, code both as indexed.

I	(a) Acute lymphocytic leukemia	C910	
	(b) Non-Hodgkin's lymphoma	C859	

Code each as indexed since both are morphological types classified within the categories C81-C96.

I	(a) Chronic lymphocytic leukemia with blastic crisis	C911	C910

Code both chronic lymphocytic leukemia and acute lymphocytic leukemia.

I	(a) Acute exacerbation of chronic	C910	C911
	(b) lymphocytic leukemia		

Code to the acute and chronic form when reported as acute exacerbation of a chronic form of leukemia and code both on the same line.

d. Do not use a neoplasm in a due to position to determine secondary and primary.

I	(a) Carcinoma of head of pancreas	C250
	(b) Carcinoma of tail of pancreas	C252

Code primary malignant neoplasm of head of pancreas for I(a) and code primary malignant neoplasm of tail of pancreas for I(b).

I	(a) Cancer of stomach	C169
	(b) Cancer of gallbladder	C23

Code each site primary.

I	(a) Cancer of breast	C509
	(b) Cancer of endometrium	C541

Code each site primary.

6. Metastases

Metastases is the spread of a primary malignant neoplasm to another site; therefore, metastases of a site is always secondary.

a. When malignancy NOS or any morphological type classifiable to C80 is reported with metastases of a site on a line, code C80 and the secondary neoplasm.

I	(a) Malignancy with metastases of bladder	C80 C791

Code malignancy as first entry on I(a) and code secondary bladder neoplasm as the second neoplasm on I(a).

b. Although malignant cells can metastasize anywhere in the body, certain sites are more common than others and must be treated differently. If one of the common sites of metastases (excluding lung) is qualified by the word "metastatic," it should be coded as secondary (see other neoplasm instructions). However, if one of these sites appears alone on a death certificate and is not qualified by the word "metastatic," it should be considered primary.

Common sites of metastases:

Bone	Lymph nodes
Brain	Mediastinum
Central nervous system	Meninges
Diaphragm	Peritoneum
Heart	Pleura
Liver	Retroperitoneum
Lung	Spinal cord

Ill-defined sites (sites classifiable to C76)

I (a) Cancer of brain C719

Code primary cancer of brain since it is reported alone on the certificate.

- (1) Special Instruction: Lung

The lung poses special problems in that it is a common site for both metastases and primary malignant neoplasms.

- Lung should be considered as a common site of metastases whenever it appears in Part I with sites not on this list.
- If lung is mentioned anywhere on the certificate and the only other sites are on the list of common sites of metastases, consider lung primary.
- However, when the bronchus or bronchogenic cancer is mentioned, this neoplasm should be considered primary.

I (a) Carcinoma of lung C349

Code primary malignant neoplasm of lung since it is reported alone on the certificate.

I (a) Cancer of bone C795
(b) Carcinoma of lung C349

Code primary malignant neoplasm of lung on I(b) since bone is on the list of common sites of metastases and lung can, therefore, be assumed to be primary.

I (a) Carcinoma of bronchus C349

(b) Carcinoma of breast C509

Code primary malignant neoplasm of bronchus on I(a) and primary malignant neoplasm of breast on I(b). Do not code I(a) as secondary malignant neoplasm, because bronchus is excluded from the list of common sites.

- (2) Special Instruction: Lymph Node

  Malignant neoplasm of lymph nodes not specified as primary should be assumed to be secondary.

  I (a) Cancer of cervical lymph nodes C770

  Code secondary malignant neoplasm of cervical lymph nodes.

7. Multiple sites

a. If all sites reported (anywhere on certificate) are on the list of common sites of metastases, code to secondary neoplasm of each site of the morphological type involved, unless lung is mentioned, in which case code to (C349) primary malignant neoplasm of lung.

I (a) Cancer of liver C787
(b) Cancer of abdomen C798

Code to secondary neoplasm of both sites since both are on the list of common sites of metastases. Abdomen is one of the ill-defined sites included in the C76.- category.

I (a) Malignant carcinoma of pleura and mediastinum C782 C781

Code secondary malignant neoplasm of pleura and secondary malignant neoplasm of mediastinum on I(a).

I (a) Peritoneal carcinoma C786
II Liver carcinoma C787

Code secondary malignant neoplasm of peritoneum on I(a) and secondary malignant neoplasm of liver in Part II.

I (a) Cancer of brain C793
(b) Cancer of lung C349

Code I(a) secondary cancer of brain since brain is on the list of common sites. Code I(b) primary cancer of lung because the only other site mentioned is on the list of common sites.

b. If one or more of the common sites of metastases, excluding lung, is reported and one or more site(s) or one or more morphological type(s) is mentioned on the certificate, none

specified as primary, code the common site(s) secondary and the other site(s) or morphological type(s) primary.

I	(a)	Cancer of stomach	C169
	(b)	Cancer of liver	C787

Code I(a) primary cancer of stomach and code I(b) secondary cancer of liver since liver is on the list of common sites and stomach is not.

I	(a)	Liver cancer	C787
	(b)	Bladder cancer	C679
	(c)	Colon cancer	C189

Code I(a) secondary neoplasm of liver since liver is on the list of common sites of metastases. Code I(b) and I(c) as primary.

I	(a)	Peritoneal cancer	C786
II		Mammary carcinoma	C509

Code I(a) secondary peritoneal cancer since peritoneum is on the list of common sites. Code Part II primary carcinoma of breast.

I	(a)	Brain carcinoma	C793
II		Melanoma of scalp	C434

Code I(a) secondary brain carcinoma since brain is on the list of common sites. Code Part II melanoma of scalp.

NOTE: If a malignant neoplasm of lymphatic, hematopoietic, or related tissue (C81-C96) is reported in one part and one of the common sites is mentioned in the other part, code the common site primary.

I	(a)	Brain cancer	C793
	(b)	Lymphoma	C859

Code I(a) secondary brain cancer since brain is on the list of common sites and is reported in the same part with a neoplasm indexed to C859.

I	(a)	Brain cancer	C719
II		Lymphoma	C859

Code I(a) primary brain cancer. Brain is on the list of common sites of metastases, but it is reported in one part and a neoplasm indexed to C859 is reported in the other part.

c. If lung is mentioned in the same part with another site(s), not on the list of common sites, or one or more morphological type(s), code the lung as secondary and the other site(s) primary.

I	(a)	Lung cancer	C780
	(b)	Stomach cancer	C169

Code secondary lung cancer on I(a) and code primary stomach cancer on I(b) since both are in the same part.

I	(a)	Lung cancer	C780
	(b)	Leukemia	C959

Code secondary lung cancer on I(a) and code leukemia on I(b) since both are in the same part.

I	(a)	Bladder carcinoma	C679
II		Lung cancer, breast cancer	C780 C509

Code I(a) primary bladder carcinoma and code primary breast cancer in Part II. Code secondary lung cancer in Part II. Lung is in the same part with another site.

d. If lung is mentioned in one part, and one or more site(s), not on the list of common sites, or one or more morphological type(s) is mentioned in the other part, code the lung as primary and the other site(s) or other morphological type primary.

I	(a)	Stomach cancer	C169
II		Lung cancer	C349

Code primary stomach cancer on I(a) and code primary lung cancer in Part II. Lung is mentioned in one part and the other site is mentioned in the other part.

I	(a)	Leukemia	C959
II		Lung cancer	C349

Code leukemia on I(a) and code primary lung cancer in Part II. Lung is mentioned in one part and the other morphological type is mentioned in the other part.

8. Metastatic neoplasms

The adjective "metastatic" is used in two ways–sometimes meaning a secondary neoplasm from a primary elsewhere and sometimes denoting a primary that has given rise to metastases. Neoplasms qualified as metastatic are **always** malignant, either primary or secondary. In order to avoid confusion, use the following to determine whether to code a metastatic neoplasm as primary or secondary.

a. Malignant neoplasm described as "from" or "metastatic from" a specified site should be interpreted as primary of that site and all other sites should be coded as secondary unless stated as primary whether in Part I or Part II.

I	(a)	Metastatic teratoma from ovary	C80
	(b)		C56

Interpret as: I (a) Metastatic teratoma

(b) Primary ovary cancer

Then, code I(b) to primary malignant neoplasm of ovary since it states metastatic from ovary. Code I(a) to C80, malignant neoplasm, unspecified site.

I	(a)	Metastatic cancer from kidney	C80
	(b)		C64

Interpret as: I (a) Metastatic cancer

(b) Primary kidney cancer

Then, code I(b) to primary malignant neoplasm of kidney since it states metastatic from kidney. Code I(a) to C80, malignant neoplasm, unspecified site.

I	(a)	Carcinomatosis	C80
	(b)	Metastatic from bowel	C260
II		Carcinoma of rectum	C785

Code I(b) primary neoplasm of bowel. Code the site in Part II as secondary.

b. Malignant neoplasms of morphological type C80 of unspecified site described "to a site" or "metastatic to a site" should be interpreted as secondary of that site(s).

I	(a)	Metastatic carcinoma to the rectum	C785

Code to secondary malignant neoplasm of rectum. The word "to" indicates that the rectum is secondary.

I	(a)	Metastatic carcinoma to lungs and liver	C780	C787

Code I(a) secondary neoplasm of lungs and liver since the record states "metastatic to."

I	(a)	Metastatic carcinoma to lungs and liver	C780	C787
	(b)	Bladder carcinoma	C679	

Code I(a) secondary neoplasm of lungs and liver since it states "metastatic to" and code I(b) primary malignant bladder carcinoma.

c. Malignant neoplasms described as "from a site to a site" should be interpreted as primary of the site stated "from" and secondary of all other sites unless stated primary whether in Part I or Part II

I	(a)	Metastatic cancer from bowel to liver	C787
	(b)	C260	

Code I(a) secondary liver neoplasm. Interpret metastatic cancer from bowel to be a statement of primary and code I(b) primary cancer of bowel.

I (a) Metastatic cancer from liver to abdomen C798
(b) C229

Code secondary malignant neoplasm of abdomen on I(a) and primary malignant neoplasm of liver on I(b).

I (a) Malignant neoplasm of bone from leg C795
(b) C765

Code I(a) secondary bone neoplasm. Interpret metastatic neoplasm of bone from leg to be a statement of primary and code I(b) primary malignant neoplasm of leg.

d. Malignant neoplasm described as (of) a site to a site should be interpreted as primary of the site preceding "to a site" and all other sites should be coded as secondary unless stated as primary, whether in Part I or Part II.

I (a) Cancer of breast C509
(b) Metastatic to mediastinum C781

Code I(a) to primary malignant neoplasm of breast and I(b) to secondary malignant neoplasm of mediastinum since it is reported as "metastatic to." Enter the codes on the lines where reported.

I (a) Metastatic liver cancer to the brain C229 C793
II Esophageal cancer C788

Code liver cancer as primary since it is the site preceding "to a site" and code other sites as secondary.

e. If the morphological type of neoplasm classifiable to one of the following categories: C40, C41, C43, C44, C45, C46, C49, C70, C71, and C72 is described as "to a site" or "metastatic to a site," code the morphological type of unspecified site and code the site that follows as secondary.

I (a) Metastatic osteosarcoma to brain C419 C793

Code to malignant neoplasm of bone since this is the unspecified site of osteosarcoma. Code secondary brain neoplasm.

f. Consider any form of the following terms as synonymous with "metastases or metastatic to" when these terms follow or are reported as due to a malignant neoplasm classifiable to C00-C76, C80, C81-C96.

Extension Infiltration Invasion Involvement Metastatic Secondaries Spread	in, into, of, or to another site

I (a) Ca of stomach with invasion of lung — C169 C780

Code cancer of stomach primary and invasion of lung as secondary.

I (a) Carcinoma of bladder with
(b) infiltration into the ureter — C679 C791

Code carcinoma of bladder as primary and code secondary carcinoma of ureter since it is the site following "infiltration into."

g. The terms "metastatic" and "metastatic of" should be interpreted as follows:

(1) If one site is mentioned and this is qualified as metastatic, code to malignant primary of that particular site if the morphological type is C80 and the site is not a common site of metastases, excluding lung.

I (a) Metastatic carcinoma of pancreas — C259

Code primary malignant neoplasm of pancreas since one site is reported and it is not a common site.

I (a) Metastatic cancer of lung — C349

Code to primary malignant neoplasm of lung since no other site is mentioned.

(2) If no site is reported but the morphological type is qualified as metastatic, code to primary site unspecified of the particular morphological type involved. Do not use "metastatic" to qualify a malignant neoplasm, stated or presumed to be primary, of lymphoid, hematopoietic, and related tissue, classifiable to C81-C96 as secondary.

I (a) Metastatic melanoma — C439

Code as indexed. Melanoma is a morphological type of neoplasm and is indexed to C439.

I (a) Metastatic Hodgkin's Disease — C819

Code a morphological type of neoplasm that is classified to C81-C96 as indexed regardless of whether qualified as metastatic.

(3) Site-specific neoplasms reported as metastatic

(a) When a site specific neoplasm is qualified as metastatic, code as indexed.

I (a) Metastatic hypernephroma — C64

Code as indexed. Hypernephroma is a site specific neoplasm and is indexed to C64.

I (a) Metastatic meningioma C709

Metastatic meningioma is a malignant site specific morphological type of neoplasm. Code as indexed under Meningioma, malignant.

(b) If there is a conflict between the code for a site specific neoplasm and the stated site, code the site specific neoplasm as indexed and consider the stated site to be qualified as secondary and code accordingly. Enter the code for the secondary site on the same line with and immediately following the code for the site specific neoplasm.

I (a) Metastatic renal cell carcinoma C64 C780
(b) of lung

Code the site specific neoplasm, renal cell carcinoma followed by the code for secondary neoplasm of lung.

I (a) Metastatic hepatoma of brain C220 C793

Code the site specific neoplasm, hepatoma as indexed followed by the code for secondary brain neoplasm.

(4) If a single morphological type and a site, other than a common site, code to the specific category for the morphological type and site involved.

I (a) Metastatic melanoma of arm C436

Code to malignant melanoma of skin of arm (C436), since in this case the ill-defined site of arm is a specific site for melanoma, not a common site of metastases classifiable to C76.

I (a) Metastatic sarcoma of stomach C169

Code as indexed.

(5) If a single C80 morphological type is qualified as metastatic and the site mentioned is one of the common sites of metastases **except lung**, code to secondary malignant neoplasm of the site mentioned. If the single site is lung, qualified as metastatic, code to primary of lung.

I (a) Metastatic cancer of peritoneum C786

Code to secondary cancer of peritoneum since peritoneum is on the list of common sites of metastases and the morphological type of neoplasm is classified to C80.

I (a) Metastatic cancer of lung C349

Code to primary malignant neoplasm of lung, C349, since no other site is mentioned.

(6) If a single morphological type, other than C80 type, is qualified as metastatic and the site mentioned is one of the common sites of metastases **except lung**, code the unspecified site for the morphological type. Code the common site as secondary and as a second entry on the same line.

I (a) Metastatic rhabdomyosarcoma of C499 C771
(b) hilar lymph nodes

Code to unspecified site for rhabdomyosarcoma and code the lymph nodes as secondary.

I (a) Metastatic sarcoma of lung C349

Code to malignant neoplasm of lung since lung is not considered a common site for this instruction.

Exception: Metastatic mesothelioma or Kaposi's sarcoma

1. If site IS indexed under "Mesothelioma or Kaposi's sarcoma," assign that code.

I (a) Metastatic mesothelioma of liver C457

Code site as indexed under mesothelioma.

I (a) Metastatic mesothelioma of mesentery C451

Code as indexed under mesothelioma.

2. If site is NOT indexed under "Mesothelioma or Kaposi's sarcoma" and site reported is NOT a common site of metastases - assign code for specified site NEC.

I (a) Metastatic mesothelioma of kidney C457

Code mesothelioma specified site NEC. Kidney is not a common site of metastases.

3. If site is NOT indexed under "Mesothelioma or Kaposi's sarcoma" and site reported IS a common site of metastases - assign code for unspecified site and secondary code for common site.

I (a) Metastatic mesothelioma of C459 C779
(b) lymph nodes

Code the morphological type as the first entry followed by the code for the site not indexed under mesothelioma.

I (a) Metastatic Kaposi's of brain C469 C793

Code the morphological type and code brain as secondary. Brain is on the list of common sites of metastases.

I (a) Kaposi's sarcoma of brain C467

This instruction does not apply since Kaposi's sarcoma is not qualified as metastatic. Code Kaposi's sarcoma, specified site, since not qualified as metastatic.

(7) When morphological types of neoplasms classifiable to C40, C41, C43, C44, C45, C46, C47, C49, C70, C71, and C72 without mention of a site are jointly reported with the same morphological type of neoplasm with mention of a site, code the morphological type of unspecified site as indexed.

I (a) Metastatic rhabdomyosarcoma C499
(b) Rhabdomyosarcoma kidney C64

Code to unspecified site of rhabdomyosarcoma on I(a) and code rhabdomyosarcoma kidney as indexed.

h. More than one malignant neoplasm qualified as metastatic.

(1) If two or more sites with a morphology of C80, not on the list of common sites of metastases, are reported and all are qualified as "metastatic" code as follows:

(a) If the sites are in the same anatomical system code each site as primary.

C150-C269 Digestive system

C300-C399 Respiratory system

C400-C419 Bone and articular cartilage of limbs, other, and unspecified sites

C490-C499 Connective and soft tissue

C510-C579 Female genital organ

C600-C639 Male genital organ

C64-C689 Urinary organ

C690-C699 Eye and adnexa

C700-C729 Central nervous system

C73 -C759 Thyroid and other endocrine glands

I (a) Metastatic stomach carcinoma C169
(b) Metastatic pancreas carcinoma C259

Code both sites primary since they are a C80 morphological type, are in the same organ system, and neither is on the list of common sites of metastases.

(b) If the sites are in different anatomical systems, code each as secondary.

I	(a)	Metastatic carcinoma of stomach	C788
	(b)	Metastatic carcinoma of bladder	C791

Code secondary neoplasm of each site listed. Stomach and bladder are in two different anatomical systems.

(2) If two or more morphological types are qualified as metastatic, code to malignant neoplasms, each independent of the other.

I	(a)	Metastatic adenocarcinoma of bowel	C260
	(b)	Metastatic sarcoma of uterus	C55

Code to primary neoplasm of each site since adenocarcinoma and sarcoma are of different morphological types.

I	(a)	Metastatic cancer of pleura	C782
	(b)	Metastatic melanoma of back	C435

Code I(a) to secondary neoplasm of pleura since pleura is on the list of common sites of metastases. Code I(b) to melanoma of back (C435) from the site list under melanoma.

(3) If a morphology implying site and an independent anatomical site are both qualified as metastatic, code to secondary malignant neoplasm of each site.

I	(a)	Metastatic colonic and renal cell carcinoma	C785 C790

Code both sites as secondary.

(4) If more than one site with a morphology of C80 is mentioned code as follows:

(a) If all but one site is qualified as metastatic and/or appear on the list of common sites of metastases, including lung, code to primary neoplasm of the site that is not qualified as metastatic or not on the list of common sites of metastases, irrespective of the order of entry or whether it is in Part I or Part II. Code all other sites as secondary.

I	(a)	Metastatic carcinoma of stomach	C788
	(b)	Carcinoma of gallbladder	C23
	(c)	Metastatic carcinoma of colon	C785

Code primary carcinoma of gallbladder since it is the only site not specified as metastatic. Assign a primary code on I(b) and secondary codes on I(a) and I(c).

I	(a)	Metastatic carcinoma of stomach	C788
	(b)	Metastatic carcinoma of lung	C780
II		Carcinoma of colon	C189

Code I(a) and I(b) secondary and code primary carcinoma of colon in Part II since

this is the only malignant neoplasm not qualified as metastatic, even though it is in Part II.

I	(a)	Cancer of kidney	C64
	(b)	Metastatic cancer of prostate	C798

Code I(a) primary cancer of kidney since the only other site on the record is qualified as metastatic. Code I(b) secondary cancer of prostate since it is qualified as metastatic.

I	(a)	Metastatic cancer of ovary	C796
II		Cancer of colon	C189

Code I(a) secondary and code part II primary. There are two sites reported and one is qualified as metastatic while the second site is not reported metastatic.

(b) If all sites are qualified as metastatic and/or are on the list of common sites of metastases, including lung, code to secondary malignant neoplasm of all reported sites.

I	(a)	Metastatic cancer of stomach	C788
	(b)	Metastatic cancer of breast	C798
	(c)	Metastatic cancer of lung	C780

Code secondary neoplasm of each site listed. All sites are reported as metastatic.

I	(a)	Metastatic carcinoma of ovary	C796
	(b)	Carcinoma of lung	C780
	(c)	Metastatic pancreatic carcinoma	C788

Code to secondary malignant neoplasm of each site. Lung is on the list of common sites of metastases and ovary and pancreas are both reported as metastatic.

I	(a)	Metastatic stomach cancer	C788
	(b)	Lung cancer	C780

Code to secondary malignant neoplasm of each site. Lung is on the list of common sites of metastases and stomach cancer is reported as metastatic.

I	(a)	Carcinoma of spine	C795
	(b)	Metastatic lung cancer	C780

Code to secondary malignant neoplasm of each site. Spine is on the list of common sites of metastases and lung is reported as metastatic.

I	(a)	Metastatic carcinoma of abdomen	C798
	(b)	Metastatic carcinoma of colon	C785

Code both sites as secondary since both are qualified as metastatic.

I	(a) Metastatic brain carcinoma	C793	
	(b) Metastatic lung carcinoma	C780	

Code both sites as secondary malignant neoplasm since both are qualified as metastatic.

(c) If one site is qualified as metastatic and there are other sites specified as "secondary", "metastases", "metastasis", "spread", or a statement of "metastasis NOS" or "metastases NOS", code the site qualified metastatic as primary and all other sites secondary, whether in Part I or Part II. If, however, lung is mentioned in one part and the metastatic neoplasm in the other part, code lung primary.

I	(a) Metastatic breast cancer with brain metastases	C509	C793
II	Lung cancer	C349	

Code I(a) as primary cancer of breast sicne there is a statement of metastases on the record. Code brain metastases as secondary since metastases are always secondary. Code Part II as primary lung cancer since it is reported in a different part from the metastatic neoplasm.

(5) When a metastatic malignant neoplasm is reported on a record with a malignant neoplasm of the same site whether stated as metastatic or not, code both primary.

I	(a) Metastatic gastric carcinoma	C169
	(b) Gastric carcinoma	C169

Code primary gastric carcinoma on I(a) and code primary gastric carcinoma on I(b).

(6) If two or more sites with a morphology of C40, C41, C43, C44, C45, C46, C47, C49, C70, C71, and C72 are reported and all sites are qualified as metastatic, add an additional code to identify the morphological type of neoplasm. Code the morphological type of neoplasm to the unspecified site category, i.e., to "9." Enter this code on the same line with and preceding the code for the first mentioned secondary site.

I	(a) Metastatic leiomyosarcoma arm, stomach and brain	C499 C798 C788 C793

Code leiomyosarcoma, the morphological type of neoplasm, to C499 and code the reported sites as secondary neoplasms since all three sites are qualified as metastatic.

I	(a) Metastatic sarcoma of stomach and small intestine	C499	C788	C784

Code the sarcoma, the morphological type of neoplasm, to C499 and code the

reported sites as secondary neoplasms.

I (a) Metastatic squamous cell carcinoma of head and neck C449 C798

Since the reported sites are marked with a # sign in the Index, code the morphological type to malignant neoplasm of skin, C449, and code the reported sites as secondary neoplasms.

I	(a)	Metastatic squamous cell carcinoma of head	C449 C798
	(b)	Metastatic squamous cell carcinoma of neck	C798

Since the reported sites are marked with a # sign in the Index, code the morphological type to malignant neoplasm of skin, C449, and code the reported sites as secondary neoplasms. Enter C449 for the morphological type as first code on I (a) preceding the first secondary site. Enter only the secondary code on line b.

9. Primary site unknown

Consider the following terms as equivalent to "primary site unknown

? Origin (Questionable origin)
? Primary (Questionable primary)
? Site (Questionable site)
? Source (Questionable source)
Undetermined origin
Undetermined primary
Undetermined site
Undetermined source
Unknown origin
Unknown primary
Unknown site
Unknown source

a. When the statement, "primary site unknown," or its equivalent, appears anywhere on the certificate with a site specific neoplasm or a neoplasm classifiable to C81-C96, code the neoplasm as though the statement did not appear on the certificate.

I	(a)	Renal cell carcinoma	C64
	(b)	Primary site unknown	

Code renal cell carcinoma (C64) as though the statement "primary site unknown" was not on the certificate.

I	(a)	Reticulum cell sarcoma	C833
II		Undetermined source	

Code reticulum cell sarcoma (C833) as though the statement "undetermined source"

was not on the certificate.

b. When primary site unknown or its equivalent appears on the certificate with a morphological type of neoplasm classifiable to C40, C41, C43, C44, C45, C46, C47, C49, C70, C71, and C72, add an additional code to identify the morphological type of neoplasm. Code the morphological type of neoplasm to the unspecified site category. This additional code should be entered on the same line with and preceding the code for the first mentioned secondary site.

I	(a) Generalized metastases	C80	
	(b) Melanoma of back	C439	C798
	(c) Primary site unknown		

Code I(b) melanoma, unspecified site, followed by the code for the secondary site reported.

c. When "primary site unknown," or its equivalent, appears on the certificate with neoplasms classified to morphological type C80, (classifiable to C00-C76), code all reported sites as secondary and precede the first neoplasm code with C80.

I	(a) Secondary carcinoma of liver	C80	C787
	(b) Primary site unknown		

Code secondary liver carcinoma preceded with C80.

I	(a) Carcinoma of stomach	C80	C788
	(b) Primary site unknown		

Code secondary stomach carcinoma preceded with C80.

I	(a) Carcinoma of stomach	C80	C788
	(b) Primary site of carcinoma unknown	C80	

Code I(a) secondary carcinoma of stomach preceded with C80. Code I(b) C80 for carcinoma since the term carcinoma is repeated.

I	(a) Cancer of intestines, stomach,	C80 C785 C788 C798
	(b) and abdomen	
	(c) Unknown primary	

Code all sites as secondary; precede the first code with C80.

d. When "primary site unknown" or its equivalent appears on the certificate and a doubtful expression such as presumed or probably is reported qualifying a specific site(s), interpret the primary to be the site(s) following the doubtful qualifying expression and code as primary.

I	(a) Cancer, unk primary, presumed lung	C349
	(b) Primary site unknown	

Code primary lung cancer.

10. Primary examples

a. When a morphological type of C80, not qualified as metastatic, is reported with a site stated to be primary, code primary of the site.

I (a) Carcinoma, breast primary C509

Code primary malignant neoplasm of breast.

b. When a morphological type of C80 is qualified as metastatic and reported with a site stated to be primary, code C80 and primary of the site.

I (a) Metastatic cancer (primary bladder) C80 C679

Code C80 and primary cancer of the bladder.

I (a) Mestastatic cancer probably breast primary C80 C509

Code C80 and primary cancer of the breast.

11. Implication of malignancy

Mention on the certificate that a neoplasm has produced metastases (secondaries) means it must be coded as malignant, even though this neoplasm without mention of metastases would be classified to some other section of Chapter II.

Code neoplasms indexed to D00-D09 (in situ neoplasms), D10-D36 (benign neoplasms), or D37-D48 (neoplasms of uncertain or unknown behavior) to a primary malignant neoplasm category in C00-C76 (whether or not on the list of common sites of metastases) if reported on the record with the following conditions:

a. Metastases NOS and metastases of a site

I (a) Breast tumor with metastases C509 C80

Code I(a) to primary malignant neoplasm of breast and code metastases NOS. Code breast tumor as malignant neoplasm of breast since it is reported with metastases NOS.

I (a) Brain metastasis C793
(b) Lung tumor C349

Code I(a) secondary neoplasm of brain and I(b) primary malignant neoplasm of lung since the lung tumor is reported with metastases of a site.

b. Any neoplasm indexed to C77-C79 in Volume III

I (a) Lymph node cancer C779

(b) Carcinoma in situ of breast C509

Code the carcinoma in situ of breast as primary malignant neoplasm of breast since it is reported with a neoplasm that is indexed to C779. Malignant neoplasm of lymph node is indexed to secondary neoplasm.

c. A common site of metastases (excluding lung) qualified by the word "metastatic."

I (a) Metastatic liver cancer C787
(b) Small intestine tumor C179

Code I(a) as secondary neoplasm of liver and code primary malignant neoplasm of small intestine on I(b), since the small intestine tumor is reported with a common site of metastases qualified by the word "metastatic."

d. If a, b, or c do not apply, code the neoplasm in D00-D09, D10-D36, D37-D48 as indexed.

12. Sites with prefixes or imprecise definitions

Neoplasms of sites prefixed by "peri," "para," "supra," "infra," etc. or described as in the "area" or "region" of a site, unless these terms are specifically indexed, should be coded as follows: for morphological types classifiable to one of the categories C40, C41, C43, C44, C45, C46, C47, C49, C70, C71, and C72, code to the appropriate subdivision of that category; otherwise, code to the appropriate subdivision of C76 (other and ill-defined sites).

I (a) Fibrosarcoma in the region of the leg C492

Code I(a) fibrosarcoma in the region of the leg to the appropriate subdivision of the category, malignant neoplasm of connective and soft tissue of lower limb.

I (a) Carcinoma in lung area C761

Since the morphological type of the term "carcinoma" is C80, code I(a), carcinoma in lung area, to the appropriate subdivision of C76 (other and ill-defined sites).

13. Malignant neoplasms described with "either/or"

Malignant neoplasms of more than one site described as "or" and both sites are classified to the same anatomical system, code the residual category for the system. If the sites are in different systems, and are in the same morphological category, code to the residual category for the morphological type.

I (a) Cancer of kidney or bladder C689

Code C689, malignant neoplasm of other and unspecified urinary organs.

I (a) Cancer of gallbladder or kidney C80

Code to C80, malignant neoplasm without specification of site since there is more than one site qualified by the statement "or" and the sites are in different systems.

I	(a)	Osteosarcoma of lumbar vertebrae	C419
	(b)	or sacrum	

Code to malignant neoplasm of bone unspecified (C419). Both sites separated by the "or" are indexed to bone.

14. Mass or lesion with malignant neoplasms

When mass or lesion is reported with malignant neoplasms, code mass or lesion as indexed.

I	(a)	Lung mass	R91
	(b)	Carcinomatosis	C80

Code mass as indexed. Do not consider as malignant mass.

I	(a)	Metastatic lung carcinoma	C349
II		Lung lesion	J984

Code lung lesion as indexed.

B. Rheumatic heart diseases

1. Heart diseases considered to be described as rheumatic

a. When rheumatic fever (I00) or any heart disease that is specified as rheumatic is reported anywhere on the death certificate, consider conditions listed in categories I300-I319, I339, I340-I38, I400-I409, I429, and I514-I519 to be described as rheumatic unless there is indication they were due to a nonrheumatic cause.

I	(a)	Myocarditis	I090
	(b)	Rheumatic heart disease	I099

Consider "myocarditis" to be described as "rheumatic" since reported with a heart disease specified as rheumatic.

I	(a)	Cardiac tamponade	I092
	(b)	Rheumatic endocarditis	I091
	(c)		

Consider "cardiac tamponade" to be described as "rheumatic" since reported with a heart disease specified as rheumatic.

b. When rheumatic fever and a heart disease are jointly reported, enter a separate code for the rheumatic fever only when it is not used to qualify a heart disease as rheumatic. This applies whether or not the heart disease is stated or classified as rheumatic.

I (a) Heart disease I099
(b) Rheumatic fever

Consider "heart disease" to be described as "rheumatic." Do not enter a separate code for rheumatic fever since it is used to qualify the heart disease as rheumatic.

I (a) Rheumatic heart disease I099
(b) Rheumatic fever

Code "rheumatic heart disease" as indexed. Do not enter a separate code for rheumatic fever since the heart disease is qualified as rheumatic.

I (a) Cardiac arrest I469
(b) Rheumatic fever I00

Cardiac arrest is not one of the conditions considered to be described as rheumatic when reported with rheumatic fever. Code each condition as indexed.

c. When a condition listed in category I50.- is indicated to be due to rheumatic fever and there is no mention of another heart disease that is classifiable as rheumatic, consider the condition in I50.- to be described as rheumatic.

I (a) Heart failure I099
(b) Rheumatic fever

Since there is no other heart disease classified as rheumatic, use the rheumatic fever to qualify the heart disease on I(a) as rheumatic.

I (a) Heart failure I509
(b) Rheumatic heart disease I099

Since there is a heart disease qualified as rheumatic reported on the record, code heart failure, I509.

2. Distinguishing between active and chronic rheumatic heart disease

Rheumatic heart diseases are classifiable to I010-I019, Rheumatic fever with heart involvement, or to I050-I099, Chronic rheumatic heart diseases, depending upon whether the rheumatic process was active or inactive at the time of death.

a. When rheumatic fever or any rheumatic heart disease is stated to be active, recurrent, or recrudescent, code all rheumatic heart diseases as active. Conversely, code all rheumatic heart diseases as inactive if rheumatic fever or any rheumatic heart disease is stated to be inactive.

I (a) Endocarditis I011
(b) Active rheumatic fever

Code I(a), active rheumatic endocarditis since the rheumatic fever is stated as

active. Leave I(b) blank.

I	(a)	Heart failure	I509
	(b)	Inactive rheumatic heart disease	I099
	(c)		

Code I(a) as indexed since another heart disease classified as rheumatic is reported. Code I(b) as indexed since stated as inactive.

b. When there is no statement of active, recurrent, recrudescent, or inactive, code all heart diseases that are stated to be rheumatic or that are considered to be described as rheumatic as active if any of the following instructions apply:

(1) The interval between onset of rheumatic fever and death was less than one year.

I	(a)	Endocarditis - 6 months	I011
	(b)	Rheumatic fever - 9 months	

(2) One or more of these heart diseases (listed in Section IV, Part B, 1, a) is stated to be acute or subacute.

NOTE: This does not mean rheumatic fever stated to be acute or subacute.

I	(a)	Acute myocarditis	I012
	(b)	Rheumatic heart disease	I019

I	(a)	Rheumatic heart disease	I099
	(b)	Acute rheumatic fever	

(3) One of these heart diseases is pericarditis.

I	(a)	Pericarditis	I010
	(b)	Rheumatic heart disease	I019

(4) At least one of these heart diseases is "carditis," "endocarditis" (any valve), "heart disease," "myocarditis," or "pancarditis" with a stated duration of less than one year.

I	(a)	Endocarditis - 9 months	I011
	(b)	Rheumatic heart disease	I019

(5) At least one of these heart diseases is "carditis," "endocarditis" (any valve), "heart disease," "myocarditis," or "pancarditis" without a duration and the age of the decedent was less than 15 years.

Age: 10 years

I	(a)	Rheumatic heart disease	I019
	(b)	Rheumatic fever	

c. In the absence of the previous mentioned indications of an active rheumatic process, consider all heart diseases that are stated to be rheumatic or that are considered to be

described as rheumatic as inactive and code to categories I050-I099.

Age: 75 years

I	(a)	Rheumatic heart disease	I099
	(b)	Rheumatic fever	

Code I(a) as indexed, there is no indication the rheumatic process was active. Leave line I(b) blank.

3. Valvular diseases jointly reported

a. When diseases of the mitral, aortic, and tricuspid valves, not qualified as rheumatic, are jointly reported, whether on the same line or on separate lines, code the disease of all valves as rheumatic unless there is indication to the contrary.

I	(a)	Mitral insufficiency and aortic stenosis	I051 I060
	(b)		

Code both valvular diseases as rheumatic since there is no indication to the contrary.

I	(a)	Aortic insufficiency	I061
	(b)	Mitral endocarditis with	I059 I051
	(c)	mitral insufficiency	

Code the diseases of both valves as rheumatic since there is no indication to the contrary.

I	(a)	Mitral endocarditis c	I059 I051 I050
	(b)	insufficiency and stenosis	
	(c)	Aortic endocarditis	I069

Code the diseases of both valves as rheumatic since there is no indication to the contrary.

I	(a)	Mitral valve disease	I059 I051 I48
	(b)	with insufficiency and	
	(c)	atrial fibrillation	
II		Aortic stenosis	I060

Code the diseases of both valves as rheumatic since there is no indication to the contrary.

b. When mitral insufficiency, incompetence, or regurgitation is jointly reported with mitral stenosis NOS (or synonym), code all these conditions as rheumatic unless there are indications to the contrary.

I	(a)	Mitral insufficiency with mitral stenosis	I051 I050

Code the mitral insufficiency as rheumatic since it is reported with mitral stenosis and there is no indication to the contrary.

4. Valvular diseases not indicated to be rheumatic

In the Classification, certain valvular diseases, i.e., disease of mitral valve (except insufficiency, incompetence, and regurgitation without stenosis) and disease of tricuspid valve are included in the rheumatic categories even though not indicated to be rheumatic. This classification is based on the assumption that the vast majority of such diseases are rheumatic in origin. Do not use these diseases to qualify other heart diseases as rheumatic. Code these diseases as nonrheumatic if reported due to one of the nonrheumatic causes on the following list.

I	(a) Pericarditis	I319
	(b) Mitral stenosis	I050

Although mitral stenosis is classified to a rheumatic category, do not use it to qualify the pericarditis as rheumatic.

a. When valvular heart disease (I050-I079, I089 and I090) not stated to be rheumatic is reported due to:

A1690	C73-C759	E804-E806	J030
A188	C790-C791	E840-E859	J040-J042
A329	C797-C798	E880-E889	J069
A38	C889	F110-F169	M100-M109
A399	D300-D301	F180-F199	M300-M359
A500-A549	D309	I10-I139	N000-N289
B200-B24	D34-D359	I250-I259	N340-N399
B376	D440-D45	I330-I38	Q200-Q289
B379	E02-E0390	I420-I4290	Q870-Q999
B560-B575	E050-E349	I511	R75
B908	E65-E678	I514-I5150	T983
B909	E760-E769	I700-I710	Y400-Y599
B948	E790-E799	J00	Y883
C64-C65	E802	J020	

Code nonrheumatic valvular disease (I340-I38) with appropriate fourth character.

I	(a) Mitral stenosis and aortic stenosis	I342 I350
	(b) Hypertension	I10

Code I(a) as separate one-term entities to nonrheumatic mitral and aortic stenosis since they are reported "due to" a nonrheumatic condition.

I	(a) Mitral insufficiency	I340
	(b) Goodpasture's syndrome & RHD	M310 I099

Code I(a) to nonrheumatic mitral insufficiency since it is reported "due to" a nonrheumatic condition. Apply this instruction even though rheumatic heart disease is entered as the second entry on I(b).

b. Consider diseases of the aortic, mitral, and tricuspid valves to be nonrheumatic if they are reported on the same line due to a nonrheumatic cause in the previous list. Similarly, consider diseases of these three valves to be nonrheumatic if any of them are reported due to the other and that one, in turn, is reported due to a nonrheumatic cause in the previous list.

I	(a) Mitral disease	I349
	(b) Aortic stenosis	I350
	(c) Arteriosclerosis	I709

Classify both valvular diseases as nonrheumatic. The mitral disease is reported due to the aortic disease which is, in turn, reported due to a nonrheumatic cause.

I	(a) Congestive heart failure	I500
	(b) Mitral stenosis	I342
	(c) Arteriosclerosis	I709

Code the mitral stenosis as nonrheumatic since the certifier indicated it was due to a nonrheumatic cause.

I	(a) Aortic and mitral insufficiency	I351 I340
	(b) Subacute bacterial endocarditis	I330

Code the valvular diseases as nonrheumatic since they are reported due to a nonrheumatic cause.

C. Pregnancy, childbirth, and the puerperium (O00-O99)

1. General information

Conditions classifiable to categories O00-O99 are limited to deaths of females of childbearing age. Some of the maternal conditions are also the cause of death in newborn infants. Always refer to the age and sex of the decedent before coding a condition to O00-O99.

Obstetric deaths are classified according to time elapsed between the obstetric event and the death of the woman:

O95	Obstetric death of unspecified cause
O960-O969	Death from any obstetric cause occurring more than 42 days but less than one year after delivery
O970-O979	Death from sequela of obstetric causes (death occurring one year or more after delivery)

The standard certificate of death contains a separate item regarding pregnancy. Any positive response to one of the following items should be taken into consideration when coding pregnancy related deaths:

- ☐ Pregnant at time of death
- ☐ Not pregnant, but pregnant within 42 days of death

☐ Not pregnant, but pregnant 43 days to 1 year before death

If the third option from the previous list is marked and the decedent is greater than 54 years old, code as pregnancy record only when there is a condition reported which indicates the person was pregnant either at the time of death or pregnant 43 days to 1 year before death.

The following are valid single character codes used in the separate checkbox item regarding pregnancy on some variations of the standard death certificate. These codes are to be taken into consideration when coding pregnancy related deaths.

1 - Not pregnant within the past year

2 - Pregnant at the time of death

3 - Not pregnant, but pregnant within 42 days of death

4 - Not pregnant, but pregnant 43 days to 1 year before death

7 - Not on certificate

8 - Not applicable

9 - Unknown

Consider the pregnancy to have terminated 42 days or less prior to death unless a specific length of time is written in by the certifier. Take into consideration the length of time elapsed between pregnancy and death if reported as more than 42 days.

Maternal deaths are subdivided into two groups:

Direct obstetric deaths (O00-O97): those resulting from obstetric complications of the pregnant state (pregnancy, labor and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

Indirect obstetric deaths (O98-O99): those resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by physiologic effects of pregnancy.

When coding pregnancies, code any direct obstetric cause to O00-O97 and any indirect obstetric cause to O98-O99.

2. Pregnancy or childbirth without mention of complication

a. Do not assign a separate code for "pregnancy" or "delivery" if any other condition is reported other than nature of injuries and external causes (S000-Y899).

Female, 39 years

Place 9	I	(a) Asphyxia by hanging	T71	&X70
		(b)		
MOD S	II	1st trimester pregnancy	O95	

Suicide

Code I(a) to nature of injury and external cause. Code pregnancy in Part II to Pregnancy, death from (O95) since the only other reported condition is classified to a nature of injury and external cause.

b. When pregnancy or delivery is the only entry on the certificate, apply the following

instructions:

(1) Code to category O95 if death occurred 42 days or less after termination of pregnancy or when there is no indication of when the pregnancy terminated.

Female, 28 years
I (a) Pregnancy O95

Code "pregnancy" to Pregnancy, death from (O95) since it is the only entry on the certificate.

(2) Code to category O969 if death resulted from direct or indirect obstetric causes that occurred more than 42 days but less than one year after termination of the pregnancy.

Female, 28 years
I (a) Childbirth - 3 months O969

Code childbirth to death from any obstetric cause occurring more than 42 days but less than one year after delivery.

(3) Code to category O979 if death occurred 1 year or more after termination of pregnancy.

Female, 28 years
I (a) Pregnancy - 1 year O979

Code to death from sequela of an obstetric cause.

3. Pregnancy with abortive outcome (O000-O089)

a. Code all complications of conditions listed in categories O000-O029 to the appropriate subcategory of O08 and also code O000-O029 as indexed. To determine the appropriate subcategory for O08, refer to the Index under Abortion, complicated by and select appropriate fourth character from last column.

Female, 28 years
I (a) Septicemia O080
(b) Tubal pregnancy O001

Code I(a) Abortion, complicated by, septicemia (O080) and I(b) Pregnancy, tubal (O001).

Female, 20 years
I (a) Shock O083
(b) Ectopic pregnancy O009

Code I(a) Abortion, complicated by, shock (O083) and I(b) Ectopic, pregnancy

(O009).

b. Code all complications of conditions listed in categories O03-O07 to the appropriate subcategory of O08 and also code O03-O07 with fourth character "9." To determine the appropriate subcategory for O08, refer to the Index under Abortion, complicated by and select appropriate fourth character from last column.

Female, 22 years

I	(a) Pulmonary embolism	O082
	(b) Spontaneous abortion	O039

Code I(a) Abortion, complicated by, pulmonary embolism (O082) and I(b) Abortion, spontaneous (O039).

c. When conditions in categories O00-O07 are reported in Part I or Part II of the death certificate with:

(1) a direct obstetric complication classifiable to category O08, code the complication to category O08 with the appropriate fourth character. Also code O00-O02 as indexed or O03-O07 with fourth character "9."

Female, 31 years

I	(a) Cardiac arrest	O088
	(b) Abortion	O069

Code I(a) Abortion, complicated by, cardiac arrest, a direct obstetric complication and I(b) Abortion NOS.

(2) an indirect obstetric complication classifiable to categories O98-O99, code the O98-O99. Also code the O00-O02 as indexed or O03-O07 with fourth character "9."

Female, 25 years

I	(a) Abortion	O069
II	Rheumatic heart disease	O994

Code I(a) Abortion NOS (O069). Code Pregnancy, complicated by rheumatic heart disease (O994), an indirect obstetric cause.

(3) both a direct and an indirect obstetric complication, code the direct complications to O08 with the appropriate fourth character and the indirect complications to O98-O99. Also code the O00-O02 as indexed or O03-O07 with fourth character "9."

Female, 33 years

I	(a) Renal failure	O084
	(b) Abortion	O069
II	Anemia	O990

Code I(a) Abortion, complicated by, renal failure. Direct complications of abortions are classified to category O08 with the appropriate fourth character. Code I(b) Abortion NOS. Code Part II Pregnancy, complicated by, anemia, an indirect obstetric

complication.

4. Other complications of pregnancy, childbirth and puerperium (O00-O99)

a. If death occurred more than 42 days but less than 1 year after termination of pregnancy, code all direct and indirect obstetric complications to O960-O969.

Female, 28 years

I	(a) Cardiomyopathy		O960
	(b) Childbirth	3 months	

Code cardiomyopathy as a direct obstetric cause occurring more than 42 days but less than 1 year after childbirth.

Female, 28 years

I	(a) Intracerebral hemorrhage		O961
	(b) Childbirth	3 months	

Code intracerebral hemorrhage as an indirect obstetric cause occurring more than 42 days but less than 1 year after childbirth.

b. If death occurred 1 year or more after termination of pregnancy, code all direct and indirect obstetric complications to O970-O979.

Female, 28 years

I	(a) Cardiomyopathy		O970
	(b) Childbirth	1 year	

Code to O970, Death from sequela of direct obstetric causes. Cardiomyopathy is a direct obstetric cause. **Do not** enter a code on I(b) for childbirth.

Female, 28 years

I	(a) Intracerebral hemorrhage		O971
	(b) Childbirth	1 year	

Code to O971, Death from sequela of indirect obstetric cause. Intracerebral hemorrhage is an indirect obstetric cause. **Do not** enter a code on I(b) for childbirth.

c. Code all complications of pregnancy, childbirth, and the puerperium to categories O00-O75, O85-O92, O96-O99. When delivery is mentioned on the certificate, consider complications to be of delivery unless otherwise specified.

(1) When both direct and indirect obstetric causes are reported on the same certificate code as indexed to appropriate code in Chapter XV.

(2) When a complication is reported and not indexed to a direct or indirect obstetric code, assign the complication to O98-O99 with the appropriate fourth character. Refer to

Volume I for correct code assignment.

Female, 35 years

I	(a) Thrombosis	1 hr	O229
	(b) Pregnancy	8 mos	
II	Obesity		O992

Code I(a) to Pregnancy, complicated by, thrombosis. Do not enter a code on I(b) for pregnancy. Code Part II to Pregnancy, complicated by, endocrine diseases NEC as indexed. Obesity is an endocrine disorder.

Female, 29 years

I	(a) Acute anemia	O990
	(b) Massive postpartum hemorrhage	O721
	(c) Delivered liveborn	

Code I(a) to Anemia, complicating pregnancy, childbirth or the puerperium, an indirect obstetric cause. Code I(b) to Hemorrhage, postpartum, a direct obstetric cause. **Do not** enter a code on I(c) for delivery NOS.

Female, 21 years

I	(a) Gram negative sepsis	O988
	(b) Congenital anomalies of ureters	O998
II	30 weeks pregnant	

Code I(a) to Pregnancy, complicated by, septicemia, an indirect obstetric cause. Code I(b) to Pregnancy, complicated by, congenital malformation, an indirect obstetric cause. **Do not** enter a code in Part II for pregnancy.

Female, 28 years

I	(a) Aspiration pneumonia	O995
	(b) Delivery	
II	Rubella in first trimester	O985

Code the indirect causes, aspiration pneumonia and rubella to the appropriate code in Chapter XV. Do not enter a code for delivery on I(b).

5. Delivery reported with anesthetic death or anesthesia

a. When delivery (normal) NOS is reported with anesthetic death, code O748 only. When reported with anesthesia, code O749 only.

Female, 29 years

I	(a) Anesthetic death	O748
	(b) Delivery	

Code I(a) to O748, other complications of anesthesia during labor and delivery. Do

not enter code on I(b) for delivery.

b. When anesthetic death is reported with a complication(s) of delivery or puerperium, code O748 and the code(s) for complication(s) of pregnancy, delivery, or puerperium.

Female, 26 years

I	(a) Anesthetic death	O748
	(b) Obstructed labor	O669

Code Delivery, complicated by, anesthetic death on I(a). Code I(b) as indexed.

c. When anesthesia is reported with a complication(s) of delivery or puerperium, code O749 and the code(s) for complication(s) of pregnancy, delivery, or the puerperium.

Female, 28 years

I	(a) Prolonged labor	O639
	(b) Anesthesia - delivery	O749

Code prolonged labor as a complication of delivery. Code "anesthesia-delivery" to O749.

Female, 34 years

I	(a) Cardiac arrest	O742
	(b) Anesthesia	O749
	(c) Obstructive labor	O669

Code I(a) cardiac arrest as a complication of anesthesia. Code the anesthesia on I(b) to O749. Code I(c) as indexed.

6. Operative delivery

a. Code an operative delivery such as cesarean section or hysterectomy to O759.

b. Code reported complications of the operative delivery to complications of obstetric surgery (O754).

c. Code conditions reported due to complications of operative delivery as indexed under complication of delivery and/or the puerperium.

Female, 18 years

I	(a) Cardiac arrest	O742
	(b) Anesthesia during C-section	O749
	(c) Premature separation of placenta	O759
	(d)	O459

Code I(a) cardiac arrest as a complication of anesthesia. Code O749 for the anesthesia. There is no complication of the C-section; therefore, code the C-section to O759. Code premature separation of placenta as indexed on line I(d).

Female, 27 years

I	(a) Pulmonary embolism	O882
	(b) Pelvic thrombosis	O754
	(c) C-section delivery	O759

Code I(a) Puerperal, embolism (pulmonary). Code I(b) as a complication of the operative delivery. Code I(c) Delivery, cesarean, as indexed.

Female, 39 years

I	(a) Pneumonia	O995
	(b) Peritoneal hemorrhage	O754
	(c) Cesarean section delivery	O759

Code I(a) O995, an indirect obstetric cause. Pneumonia is reported due to the complication and coded as complicating delivery. Code I(b) as a complication of the operative delivery. Code I(c) Delivery, cesarean, as indexed.

Female, 30 years

I	(a) Pneumonia	24 hr	O995
	(b) Pulmonary embolism	3 days	O754
II			O759

Operation Block: C-section

Code I(a) an indirect obstetric cause. Code I(b) as a complication of the operative delivery reported in Part II. Code Part II cesarean section as indexed.

Female, 28 years

I	(a) Pneumonia	O754
	(b) C-section	O759
II		O759 O321

Operation Block: C-section for breech presentation

Code I(a) as a complication of the operative delivery. Code cesarean section on I (b) as indexed. Code cesarean section and breech presentation as indexed in Part II.

D. Congenital conditions

1. The Classification does not provide congenital and acquired codes for all conditions. When no provision is made for a distinction, disregard the statement of congenital or acquired and code the NOS code.

Female, 45 years

I	(a) Patent ductus arteriosus - acquired	Q250
	(b) Pneumonia	J189

Code I(a) to Q250 since patent ductus arteriosus does not have an acquired code.

Male, 33 years

I	(a) Gastric hemorrhage	K922
	(b) Gastric ulcer - congenital	K259

Code I(b) to K259 since gastric ulcer does not have a congenital code.

2. When a condition specified as "congenital" is reported "due to" another condition not specified as congenital, code both conditions as congenital.

Male, 2 months

I	(a) Peritonitis – birth	P781
	(b) Intestinal obstruction	Q419

Code the condition on I(b) as congenital.

3. Code hydrocephalus (G91.0, 1, 2, 8, 9) (any age) to Q039 (congenital hydrocephalus) when it is reported with another cerebral or other central nervous system condition (Q00-Q07, Q280-Q283) which is classified as congenital.

Male, 3 months

I	(a) Cerebral anoxia	G931
	(b) Hydrocephalus & hypoplasia	Q039 Q061
	(c) of spinal cord	

Code hydrocephalus NOS to Q039 since the hypoplasia of spinal cord is classified as congenital.

Male, 3 months

I	(a) Cerebral anoxia	G931
	(b) Hydrocephalus	Q039
II	Meningomyelocele	Q059

Code the hydrocephalus NOS to Q039 since the meningomyelocele is classified as congenital.

E. Conditions of early infancy (P000-P969)

1. When reported on certificate of infant, code the following entries as indicated:

Birth weight of	2 pounds (999 gms) or under	P070
	Over 2 pounds (1000 gms) but not more than 5 ½ pounds (2499 gms)	P071
	10 pounds (4500 gms) or more	P080
Gestation of	Less than 28 weeks	P072
	28 weeksbut less than 37 weeks	P073
	42 or more completed weeks	P082

Female, 3 hours

I	(a) Respiratory distress syndrome	P220	
	(b) Prematurity	P073	
II	26 weeks gestation	P072	

Code Gestation, less than 28 weeks to P072.

Male, 8 hours

I	(a) Respiratory failure	P285	
	(b) Prematurity, 23 weeks	P073	P072

Code I(b) as two separate conditions. Code prematurity as indexed P073 and code P072 for "23 weeks." The 23 weeks is an implied length of gestation.

2. When a multiple birth or low birth weight is reported on an infant's death certificate outside of Part I or Part II, code this entity as the last entry in Part II.

Male, 29 minutes - Twin A

I	(a) Immature	P073	
	(b) Weight 1,500 grams - twin	P071	P015
II	Atelectasis	P281	P015

Code "twin" as the last entry in Part II.

Male, 5 minutes

4 lbs.	I (a) Immaturity of lung	P280	
	(b)		
	(c)		
	II	P071	

Code P071 for "4 lbs." as last entry in Part II.

3. When "termination of pregnancy" or "abortion" (legal) other than criminal is the only reported cause of an infant death, code P964. Do not code P964 if any other codable entry is reported.

Female, 3 minutes

I	(a) Legal abortion	P964

Since "legal abortion" is the only entry on the certificate, code P964, as indexed.

4. When a condition classifiable to P703-P720, P722-P749 is the only cause(s) reported on a newborn's death, code P969. If reported with other perinatal conditions, code as indexed.

Male, 7 days

(a)	Hypomagnesemia	P969
(b)		
(c)		

Code the hypomagnesemia to P969, even though it is indexed to P712 since it is the only cause of death reported.

Female, 2 weeks
(a) Hypoglycemia P704
(b) Maternal diabetes P701

Code I(a) as indexed since reported with another perinatal condition.

F. Sequela

A sequela is a late effect, an after effect, or a residual of a disease, nature of injury or external ca

B900-B909	Sequela of tuberculosis
B91	Sequela of acute poliomyelitis
B92	Sequela of leprosy
B940-B949	Sequela of other and unspecified infectious and parasitic diseases
E640-E649	Sequela of malnutrition and other nutritional deficiencies
E68	Sequela of hyperalimentation
G09	Sequela of inflammatory diseases of central nervous system
I690-I698	Sequela of cerebrovascular disease
O970-O979	Death from sequela of obstetric causes
T900-T983*	Sequela of injuries, of poisoning, and of other consequences of external causes
Y850-Y859*	Sequela of transport accidents
Y86*	Sequela of other accidents
Y870-Y872*	Sequela of intentional self-harm, assault and events of undetermined intent
Y880-Y883*	Sequela with surgical and medical care as external cause
Y890-Y899*	Sequela of other external causes

* See **Section V, Part S** for instructions for coding sequela of injuries and external causes.

NOTE: When conditions in categories A000-A310, A318-A427, A429-A599, A601-A70, A748-B001, B003-B004, B007, B009-B069, B080, B082-B085, B09-B199, B25-B279, B330-B349, B370-B49, B58-B64, B99 are mentioned on the record with HIV (B20-B24, R75), do not consider the infectious or parasitic condition as a sequela.

When there is evidence death resulted from residual effects rather than the active phase of conditions for which the Classification provides a sequela code, code the appropriate sequela category. Code specified residual effects separately. Apply the following instructions to the sequela categories.

1. B900-B909 Sequela of tuberculosis

Use these subcategories for the classification of tuberculosis (conditions in A162-A199) if:

a. A statement of a late effect or sequela of the tuberculosis is reported.

I (a) Pulmonary fibrosis J841

(b) Sequela of pulmonary tuberculosis B909

Code sequela of pulmonary tuberculosis (B909) since "sequela of" is stated.

b. The tuberculosis is stated to be ancient, arrested, by history, cured, healed, history, history of, inactive, old, quiescent, or remote, whether or not the residual (late) effect is specified, unless there is evidence of active tuberculosis.

I (a) Arrested pulmonary tuberculosis B909

Code arrested pulmonary tuberculosis, B909, since there is no evidence of active tuberculosis.

c. When there is evidence of active tuberculosis of a site with inactive (ancient, arrested, by history, cured, healed, history, history of, old, quiescent, remote) tuberculosis of a **different** site, code both.

d. When there is evidence of active and inactive (ancient, arrested, by history, cured, healed, history, history of, old, quiescent, remote) tuberculosis of the **same** site, code active tuberculosis of the site only.

NOTE: Do not use duration to code sequela of tuberculosis.

I (a) Respiratory failure J969
(b) Pneumonia J189
(c) Pulmonary tuberculosis 2 years A162

Code pulmonary tuberculosis as active. Do not use duration of the tuberculosis to indicate sequela.

2. B91 Sequela of acute poliomyelitis

Use this category for the classification of poliomyelitis (conditions in A800-A809) if:

a. A statement of a late effect or sequela of acute poliomyelitis is reported.

I (a) Sequela of acute poliomyelitis B91

Code sequela of acute poliomyelitis as indexed.

b. A chronic condition or a condition with a duration of one year or more that was due to the acute poliomyelitis is reported.

I (a) Paralysis - 1 year G839
(b) Acute poliomyelitis B91

Code sequela of acute poliomyelitis, since the paralysis has a duration of 1 year.

c. The poliomyelitis is stated to be by history, history, history of, old, or the interval between onset of the poliomyelitis and death is indicated to be one year or more whether or not the

residual (late) effect is specified.

I (a) Old polio B91

Code old polio.

d. The poliomyelitis is not stated to be acute or active and the interval between the onset of the poliomyelitis and death is not reported.

I (a) Poliomyelitis B91
(b)
(c)

I (a) ASHD I251
(b)
(c)
II Poliomyelitis B91

I (a) Paralysis G839
(b) Polio B91
(c)

I (a) Poliomyelitis with B91 G839
(b) paralysis
(c)

3. B92 Sequela of leprosy

Use this category for the classification of leprosy (conditions in A30) if:

a. A statement of a late effect or sequela of the leprosy is reported.

b. A chronic condition or a condition with a duration of one year or more that was due to leprosy is reported.

4. B940 Sequela of trachoma

Use this subcategory for the classification of trachoma (conditions in A710-A719) if:

a. A statement of a late effect or sequela of the trachoma is reported.

I (a) Late effects of trachoma B940

b. The trachoma is stated to be healed or inactive, whether or not the residual (late) effect is specified.

I (a) Healed trachoma B940

c. A chronic condition such as blindness, cicatricial entropion or conjunctival scar that was due to

the trachoma is reported unless there is evidence of active infection.

I	(a) Conjunctival scar		H112
	(b) Trachoma		B940

5. B941 Sequela of viral encephalitis

Use this subcategory for the classification of viral encephalitis (conditions in A830-A839, A840-A849, A850-A858, A86) if:

a. A statement of a late effect or sequela of the viral encephalitis is reported.

I	(a) Late effects of viral encephalitis		B941

Code sequela of viral encephalitis as indexed.

b. A chronic condition or a condition with a duration of one year or more that was due to the viral encephalitis is reported.

I	(a) Chronic brain syndrome		F069
	(b) Viral encephalitis		B941

Code sequela of viral encephalitis, since a resultant chronic condition is reported.

c. The viral encephalitis is stated to be ancient, by history, history, history of, old, remote, or the interval between onset of the viral encephalitis and death is indicated to be one year or more whether or not the residual (late) effect is specified.

I	(a) St. Louis encephalitis	1 yr	B941

Code sequela of viral encephalitis, since a duration of 1 year is reported.

I	(a) Old viral encephalitis		B941

Code sequela of viral encephalitis, since it is stated "old."

d. Brain damage, cerebral fungus, CNS damage, epilepsy, hydrocephalus, mental retardation, paralysis (G810-G839) is reported due to the viral encephalitis.

I	(a) Paralysis		G839
	(b) Viral encephalitis		B941

Code sequela of viral encephalitis since paralysis is reported due to the viral encephalitis.

6. B942 Sequela of viral hepatitis

Use this subcategory for the classification of viral hepatitis (conditions in B150-B199) if:

A statement of a late effect or sequela of the viral hepatitis is reported.

7. B948 Sequela of other specified infectious and parasitic diseases
B949 Sequela of unspecified infectious and parasitic diseases

Use B948 for the classification of other specified infectious and parasitic diseases (conditions in A000-A099, A200-A289, A310-A70, A740-A799, A811-A829, A870-B09, B250-B89) and

Use B949 for the classification of only the terms "infectious disease NOS" and "parasitic disease NOS" if:

a. A statement of a late effect or sequela of the infectious or parasitic disease is reported.

b. The infectious or parasitic disease is stated to be ancient, arrested, by history, cured, healed, history, history of, inactive, old, quiescent, or remote, whether or not the residual (late) effect is specified, unless there is evidence of activity of the disease.

c. A chronic condition or a condition with a duration of one year or more that was due to the infectious or parasitic disease is reported.

I	(a) Reye's syndrome	1 yr	G937
	(b) Chickenpox		B948
I	(a) Chronic brain syndrome		F069
	(b) Meningococcal encephalitis		B948

d. There is indication the interval between onset of the infectious or parasitic disease and death was one year or more, whether or not the residual (late) effect is specified.

8. E640-E649 Sequela of malnutrition and other nutritional deficiencies

Use Sequela Code	For Categories
E640	E40-E46
E641	E500-E509
E642	E54
E643	E550-E559
E648	E51-E53 E610-E638 E56-E60
E649	E639

Use these subcategories for the classification of malnutrition and other nutritional deficiencies (conditions in E40-E639) if:

a. A statement of a late effect or sequela of malnutrition and other nutritional deficiencies (E40-E639) is reported.

I	(a) Cardiac arrest		I469
	(b) Sequela of malnutrition		E640

b. A condition with a duration of one year or more is qualified as rachitic or that was due to rickets (E55.-) is reported.

I	(a) Scoliosis	3 years	M419
	(b) Rickets		E643

9. E68 Sequela of hyperalimentation

Use this category for the classification of hyperalimentation (conditions in E67 and hyperalimentation NOS in R632) if:

a. A statement of a late effect or sequela of the hyperalimentation is reported.

b. A condition with a duration of one year or more that was due to hyperalimentation is reported.

10. G09 Sequela of inflammatory diseases of central nervous system

Use this category for the classification of intracranial abscess or pyogenic infection (conditions in G000-G009, G030-G049, G060-G069, G08) if:

a. A statement of a late effect or sequela of the condition in G000-G009, G030-G049, G060-G069, G08 is reported.

b. A condition with a duration of one year or more that was due to the condition in G000-G009, G030-G049, G060-G069, G08 is reported.

c. The condition in G000-G009, G030-G049, G060-G069, G08 is stated to be ancient, by history, history, history of, old, remote, or the interval between onset of this condition and death is indicated to be one year or more, whether or not the residual (late) effect is specified.

d. Brain damage, cerebral fungus, CNS damage, epilepsy, hydrocephalus, mental retardation, paralysis (G810-G839) is reported due to a condition in G000-G009, G030-G049, G060-G069, G08.

I	(a) Hydrocephalus	G919
	(b) Meningitis	G09

11. I690-I698 Sequela of cerebrovascular disease

Use this category for the classification of cerebrovascular disease (conditions in I600-I64, I670-I671, I674-I679) if:

a. A statement of a late effect or sequela of a cerebrovascular disease is reported.

I	(a) Sequela of cerebral infarction	I693

Code sequela of cerebral infarction as indexed.

b. A condition with a duration of one year or more that was due to one of these cerebrovascular diseases is reported.

I	(a) Hemiplegia	1 year	G819
	(b) Intracranial hemorrhage		I692

Code sequela of other nontraumatic intracranial hemorrhage since the residual effect (hemiplegia) has a duration of one year.

c. The condition in I600-I6400, I670-I671, I674-I679 is stated to be ancient, by history, history, history of, old, remote, or the interval between onset of this condition and death is indicated to be one year or more, whether or not the residual (late) effect is specified.

I	(a) Brain damage	G939
	(b) Remote cerebral thrombosis	I693

Code sequela of cerebral thrombosis since the cerebral thrombosis is reported as remote.

I	(a) Old intracerebral hemorrhage	I691

Code sequela of intracerebral hemorrhage since the intracerebral hemorrhage is stated as old.

I	(a) Cerebrovascular occlusion	6 yrs	I693

Code sequela of cerebrovascular occlusion since the duration is one year or more.

I	(a) History of CVA	9 mos	I694

Code sequela of CVA since "history of" CVA is reported.

d. The condition in I600-I6400, and I670-I671, I674-I679 is reported with paralysis (any) stated to be ancient, by history, history, history of, old, remote, or the interval between onset of this condition and death is indicated to be one year or more whether or not the residual (late) effect is specified.

I	(a) CVA with old hemiplegia	I694	G819

Code sequela of CVA since it is reported with hemiplegia stated as old.

12. O970-O979 Sequela of obstetric cause

Use this category for the classification of an obstetric cause (conditions in O00-O927) if:

a. A statement of a late effect or sequela of the direct obstetric cause is reported.

b. A chronic condition or a condition with a duration of one year or more that was due to the direct obstetric cause is reported.

G. Ill-defined and unknown causes

1. Sudden infant death syndrome (R95)

Includes:
Cot death
Crib death
SDII, SID, SIDS, SUD, SUDI, SUID
Sudden (unexpected) (unattended) (unexplained)
- death (cause unknown) (in infancy) (syndrome)
- infant death (syndrome)

Causing death at ages under 1 year

Excludes:

The listed conditions causing death at ages one year or over (R960)

Female, 6 months			
I	(a) Sudden death	R95	
Male, 3 weeks			
I	(a) Sudden death, cause unknown	R95	
	(b) R97		
Female, 3 months			
I	(a) SIDS, pneumonia	R95	J189

2. Other sudden death and other unspecified cause (R960-R961, R98-R99)

Code R960-R961, R98-R99 only when:

a. A term(s) classifiable to one of these codes is the only entry (or entries) on the death certificate.

b. The only other entry on the death certificate is classifiable to R97 (cause unknown).

Female, 2 years		
I	(a) Sudden death	R960
	(b) Crib death	R960

c. When more than one term classifiable to two or more of these categories is reported, code

only one in this priority: R960, R961, R98, R99.

(1) Instantaneous death (R960)

Includes:
Cot death
Crib death
SDII, SID, SIDS, SUD, SUDI, SUID
Sudden (unexpected) (unattended) (unexplained)
- death (cause unknown) (in infancy) (syndrome)
- infant death (syndrome)

Causing death at age 1 year or over

Excludes:

The listed conditions causing death at ages under one year (R95).

Male, 3 years
I (a) Sudden death, cause unknown — R960
(b) R97

Female, 2 years
I (a) SIDS, pneumonia — J189

(2) Death occurring in less than 24 hours from onset of symptoms, not otherwise explained (R961)

I (a) Died—no sign of disease — R961

(3) Unattended death (R98)

I (a) Found dead — R98
(b) Investigation pending

I (a) Found dead at foot of steps — R98
(b) Natural causes

(4) Ill-defined and unspecified cause of mortality (R99)

Includes:

Bone(s) found
Dead on arrival (DOA)
Diagnosis deferred
Died without doctor in attendance
Inquest pending
Natural cause(s)
Natural causes, cause unknown
Natural causes uncertain
Natural causes undetermined
Natural causes unknown

Natural causes unspecified
Natural disease undetermined
No doctor
Pending examination (any type)
(pathological) (toxicological)
Pending investigation (police)
Skeleton
Uncertain natural causes
Undetermined natural causes
Undetermined natural disease
Undiagnosed disease
Unknown natural causes
Unspecified natural causes

Excludes:

Unknown cause (R97)

NOTE: When a term from the preceding list is reported immediately preceding or following a term from the Unknown Cause (R97) list, assign R99 only.

I	(a) DOA	R99
	(b) Cause unknown	R97
I	(a) No doctor	R99
	(b) Pending investigation	R99
I	(a) Cause unknown	R97
	(b) Pending pathological examination	R99
I	(a) Natural causes, cause unknown	R99

3. <u>Unknown cause (R97)</u>

Includes:

Cause not found
Cause unknown
Cause undetermined
Could not be determined
Etiology never determined
Etiology not defined
Etiology uncertain
Etiology unexplained
Etiology unknown
Etiology undetermined
Etiology unspecified
Final event undetermined
Immediate cause not determined
Immediate cause unknown
No specific etiology identified
No specific known causes
Nonspecific causes
Not known
Obscure etiology
Undetermined
Uncertain
Unclear
Unexplained cause
Unknown
? Cause
? Etiology

a. Use this category for the classification of the listed terms except when the term in R97 is reported

(1) On the same line with and preceding a condition qualified as "possible," "probable," etc.

(2) In "Describe How Injury Occurred" (Item 43) of the death certificate.

In such cases, **do not** enter a code for the term in R97.

I	(a) G. I. hemorrhage	K922
	(b) Cause unknown	R97
	(c) Carcinomatosis	C80
I	(a) Unknown cause	R97
I	(a) Intestinal obstruction	K566
	(b) Unknown, possibly cancer	C80
I	(a) Amyloidosis	E859
	(b) Chronic ulcerative colitis	K519
	(c)	
II	Cirrhosis of liver, cause unknown	K746 R97
I	(a) Cardiac arrest	I469
	(b) Hip fracture	S720
	(c) Fall	&W19
II		

Place 9
MOD A

Accident	43	Unknown

b. If the term in R97 is reported in Part I on the same line with and following the condition to which it applies, enter the code for unknown cause on the next due to line whether or not "cause unknown" is in parentheses beside the condition in Volume 3. Code the conditions on each of the remaining lines in Part I, if there are any, as though they had been reported on the succeeding line(s).

Female, 3 months

I	(a) SIDS, cause unknown	R95
	(b)	R97
I	(a) Unknown cause	R97
	(b) Found dead	R98
I	(a) Unknown	R97
	(b) Known to have had ASHD	I251 J42
	(c) and chronic bronchitis	

I	(a)	Gastric ulcer, cause unknown	K259
	(b)	Rheumatoid arthritis	R97
	(c)		M069

SECTION V - EFFECTS OF EXTERNAL CAUSE OF INJURY AND EXTERNAL CAUSES OF INJURY AND POISONING

In ICD-10, the Nature of Injury Chapter (XIX) is part of the main Classification but certain effects of external causes are classified in Chapters I-XVIII. The external cause codes (Chapter XX) are intended for use, where relevant, to identify the external cause of conditions classifiable to Chapters I-XVIII, as well as to Chapter XIX. While not all external causes will have a corresponding code in Chapter XIX, an external cause code is required when a code from Chapter XIX is applicable.

A. External cause code (E-Code) concept

An external cause of injury may be classified to Accidents (V01-X59), Intentional self harm (X60-X84, and Sequela of external causes (Y85-Y89). When unspecified, assume all external cause one-term entities to be accidental unless the External Causes of Injury Index provides otherwise.

The objective in assigning the external cause codes is to combine into the entity being coded any related entries on the record that will permit the assignment of the most specific external cause codes in accordance with the intent of the certifier. After the determination of the most specific external cause code is made, enter this code where it is first encountered on the record. Do not repeat the same external cause code when it is reported on other lines. When more than one external cause is reported, code each external cause code where it is first encountered on the certificate.

The death certificate provides a specific place for information concerning the external cause of injury that is usually entered on the lines below the line labeled "Part II." However, a description of the external cause is reported frequently in Part I and may be repeated in the space provided for this information.

When such statements as: "jumped or fell," "don't know," "accident or suicide," "accident or homicide," "undetermined," or "open verdict" are reported, code the external cause as "undetermined." The "undetermined" categories include self-inflicted injuries, except poisoning, when not specified whether accidental or with intent to harm.

1. Use of Index

ICD-10 provides separate indexing in Volume 3, Section II for the external causes of injury, with frequent references to Volume 1. The External Causes of Injury Index provides a double axis of indexing — descriptions of the circumstances under which the accident or violence occurred and the agent involved in the occurrence. Usually, the "lead terms" in the External Causes of Injury Index describe the circumstances of the injury with a secondary (indented) entry naming the agent involved.

Fall from building W13

Locate the E-code for "fall":

Fall, falling
- from, off
- - building W13.-

2. Use of Tabular List

After locating the external cause code in the Index, always refer to Volume 1 since certain external cause codes for transport accidents require a fourth character not provided for in the Index. When ICD-10 provides a fourth character subcategory for an external cause code, always code the fourth character.

Fell from boat V929

Locate the E-code for "fall":

Fall
- from
- - boat, ship, watercraft NEC (with drowning or submersion) V92.-

In Volume 1, the fourth character describes the type of boat. Code the fourth character "9," unspecified watercraft.

The Classification provides a fourth character for use with categories W00-Y34, except Y06.- and Y07.-, to identify the place of occurrence of the external cause. NCHS uses a separate field for this purpose. Only the three-character category codes are assigned in multiple cause coding.

House fire X00

Locate the E-code for "House fire":
House Fire (uncontrolled) X00.-

In Volume 1, a fourth character identifying the place of occurrence is required. Assign code 0 (home) to the place of occurrence variable in the field provided for this variable.

3. Place of occurrence of external cause

Enter a one-character place of occurrence code (0-9), for external causes of injury classifiable to W00-Y34, except Y06.- and Y07.-, **if the effects of the external cause are classifiable to Chapter XIX**. Do not enter a place code for external causes classifiable to any other external cause code. Use only the information reported in the medical certification section of the death certificate or additional information (AI) to determine the place code. Refer to Appendix D for the list of place of occurrence codes.

4. Manner of death (Item 37) on death certificate

a. Affecting multiple cause codes

(1) When separate check boxes for indicating whether an external cause was accidental, suicidal, homicidal, undetermined, or pending investigation appear on the medical certification form, treat the check box entry as a one-term entity.

(2) When "accident," "pending," "unknown," or "undetermined" is written in the "check box" or is one of the items checked **and no condition is coded to Chapter XIX**, disregard the check box entry for assignment of codes.

(3) When "suicide" or "homicide" is written in the "check box", or is one of the items checked **and no condition is coded to Chapter XIX**, assign the appropriate external cause code preceded by Injury NOS, T149.

(4) When "unknown" or "open verdict" is written in the check box **and there is a condition(s) coded to Chapter XIX**, code the external cause to the appropriate "event of undetermined intent" category.

(5) When "pending," "pending investigation," "deferred," or "unclassified" is reported in the

check box **and there is a condition(s) coded to Chapter XIX**, code the external cause as indexed.

(6) Enter a code for an entry in a check box for **"natural cause" only** if this is the only codable entry on the certificate or the only other codable entry is "unknown cause" (R97).

b. As a separate variable

Enter an alpha character manner of death code (N, A, S, H, P, or C) in the appropriate data position for any entry in the manner of death check box. **Use only the information reported in the manner of death box to assign the code.**

Code the manner of death as:

Natural	N
Accident	A
Suicide	S
Homicide	H
Pending Investigation	P
Could not be determined	C
Blank	Blank

5. Nature of injury and external cause code lists

Since certain entities state or imply cause (E-code) and effect (N-code), ICD-10 provides both N-codes and E-codes for many terms. Determination must be made whether to code nature of injury code only, external cause code only, or both nature of injury and external cause codes for such terms. Use the following lists as **guides** in classifying these terms. When ICD-10 provides a nature of injury code for an entity that does **not** appear on either list, use the nature of injury code only.

The E-code is only coded the first time external information is mentioned. A term requiring a N-code is coded each time it is reported.

Nature of injury code only (N-Code)

Allergy
Anaphylactic reaction
Anaphylactic shock
Anaphylaxic, anaphylaxis
Anoxia
Bezoar
Burns
Cremation
Crushed
Decapitation
Deceleration injury
Drug NOS or named drug (when it means drug poisoning)
Drug synergism
Exhaustion
Fracture
Inattention at birth
Incineration
Injury NOS (any site)
Intoxication when due to a drug
Lacerations
Lack of care
Mucus plug
Multiple injuries
Polypharmacy (when it means drug poisoning)
Scald
Severed
Smoke
Starvation
Trauma NOS (any site)
Traumatic
Traumatic death
Traumatic injury (any site)
Traumatism
Wound (penetrating)

External cause code only (E-code)

Abandonment
Accident, accidental
Arson
Assault
Beaten
Blow to any site
Blunt force NOS
Blunt impact NOS
Conflagration
Desertion
Excessive heat
Explosion
Explosive blasts to site(s)
Fall
Fight
Fire
Flood
Foreign body
Heat
Hitting any site
Homicide, homicidal
Hot environment
Hot weather
Impact
Inhalation
Physical violence
Projectile
Reaction of drug with a reported complication
Striking any site
Suicide, suicidal

Entities Requiring nature of injury and external cause codes on the same line (N\E Codes)

Abuse (child) (elder) (spousal)
Airway obstruction by foreign body
Alcohol intoxication (any term meaning intoxication)
Anastomotic leak
*Asphyxia
*Aspiration
Battered child (syndrome)
Bite
Blunt blow to a site
Blunt force injury (any site)
Blunt force to a site (any)
Blunt impact to a site (any)
Blunt injury (any site)
Blunt trauma (any site)
Bullet (to site)
Bullet wound
Child neglect
Choking on foreign body
Crushed by specified object
Cut
Drowning
Electrocution
Electrical burns
Electrical shock
Exposure (to element) (cold, heat)
Firearm (any type) (discharge)
Flame burn
Foreign body in any site
Freezing, froze, frostbite
Got too hot
Gun went off
Gunshot (to site)
Gunshot wound
Hypothermia
Immersion
Impact injury (any site)
Impact to a site (any)
Incised (wound)
Ingestion of foreign body
Inhalation injury (any)
*Inhalation of foreign body
Lightning (struck by)
Mangled
Mechanical trauma
Overdose (of drug or alcohol)
Overheated
Overexertion
Poisoning (by substance)
Pulled trigger
Puncture, punctured (any site)
Puncture wound
Radiation burns
Rape
Razor cut
Shooting, shot (to site)
Shotgun blast (to site)
Slash, slashed (any site)
Smothered
Snake bite
Stab
Sting
Strangulation
Submersion
Suffocation
Sunstroke
Suspension, suspended
Swallowed object
Toxicity (of substance)

Hanging (by neck)	Vehicular trauma
Heat exhaustion	Weapon wound
Heat stress	.22, .32 or any caliber
Heat stroke	

(* This does not apply when certain localized effects result from asphyxia, aspiration, or inhalation. Refer to Section V, Part O.)

B. Placement of nature of injury and external cause codes

When a nature of injury code and an external cause code are required for an entity, enter the nature of injury code followed by the external cause code on the same line.

Place	I	(a) Gunshot wound of chest	S219	&W34	
9		(b)			
		(c)			
MOD	II				
A					
		Accident			

Since "gunshot wound" requires a nature of injury and an E-code, enter on I(a) the nature of injury code for wound of chest followed by the most specific E-code for gunshot, accidental. Code place of occurrence as 9 (unspecified). Code manner of death as A (accident).

When entries requiring nature of injury codes and external cause codes are reported on the same line in Part I, code **the first nature of injury code** followed by the **most specific external cause code**; then code any remaining conditions for the line in the order indicated by the certifier.

Place	I	(a) Laceration of throat	S118		
9		(b) Dog bite of shoulder,	S410	&W54	T111
		(c) arm and neck			

Code the nature of injury code only for I(a). On I(b), code the nature of injury code for "bite of shoulder" followed by the E-code for dog bite followed by the remaining nature of injury codes for "bite arm and neck." Code place of occurrence as 9 (unspecified).

Place	I	(a) Fracture skull	S029		
9		(b) Fell from window, crushed	S280	&W13	S381
		(c) chest and abdomen			

I(a) requires a nature of injury code only. I(b) requires both nature of injury and E-code since the external cause and injuries are reported on this line. Code first nature of injury code followed by the external cause code, followed by the remaining nature of injury codes. Code place of occurrence as 9 (unspecified).

Place	I	(a) Renal failure	N19		
0		(b) Injury kidney, liver and	S370	&W11	S361

(c) spleen. Fell from ladder at home

Code I(b) injury kidney followed by external cause code for the fall, followed by the remaining injuries. Code place of occurrence as 0 (home).

Place	I	(a) Cerebral laceration & contusion	S062	
9		(b) Blow to right temporal area	&X599	

Code I(a) to the nature of injury code only, and I(b) to the external cause code only. Code place of occurrence as 9 (unspecified).

In Part II, code each entry in the same order as entered on the certificate. For entities requiring both nature of injury and external cause codes, enter the nature of injury code followed by the external cause code. Enter the information recorded in the special spaces that have been provided on the medical certification form for recording information about external causes of injury following any codes that are applicable to Part II.

Place	I	(a) Crushed chest	S280		
9		(b) Broken rib	S223		
		(c)			
	II	Fracture hip and arm	S720	T10	&W24

43 | Run over by a forklift

In Part II, code each entry in the order entered on the certificate. Code place of occurrence as 9 (unspecified).

Place	I	(a) Subdural hematoma	S065	
9	II	Blunt impact injury to head	S099	&Y00
MOD				
H				

Homicide

43 | Struck on head with a blunt object by another person

Since the entry in Part II requires both nature of injury and external cause codes, enter the nature of injury code followed by the most specific external cause code. Code place of occurrence as 9 (unspecified).

Place	I	(a) Head wound	S019		
9		II	&W34	S062	S019
MOD					
A					

Accident

43 | Cerebral laceration, GSW of head

Code external cause code first in Part II since manner of death box requires an external cause code. Code place of occurrence as 9 (unspecified).

C. Use of ampersand

1. Use an ampersand to identify the following
   a. The most specific external cause code causing injuries or poisoning.
   b. Certain localized effects of poisonous substances (X45-X49) or aspiration (W78,W79, W80) when classifiable to Chapters I-XVIII.
   c. Ampersand the E-code for aspiration (W78-W80) anytime it is reported.

Place				
0	I	(a) Aspiration	T179	&W78
		(b) Vomitus		
	II	Fx Hip Fall at home	S720	&W19

Ampersand both the E-code for aspiration and the E-code for fall at home.

Exceptions to c:

1. When reported **due to:**
   - nature of injury codes
   - medical and surgical care
   - other external causes

2. When a nature of injury code other than T179 is reported as the **first** condition on the lowest used line in Part I.

Place			
0	I	(a) Aspiration of vomitus	T179 W78
		(b) Fx hip	S720
	II	Fall at home	&W19

Do not ampersand the E-code for aspiration since both Exception 1 and 2 apply.

2. More than one external cause reported
   a. In determining the most specific external cause code, consider all of the information reported on the record. If two or more external causes are reported and the nature of injuries and/or the order in which the conditions are reported indicates that one of the external causes led to the condition that terminated in death, precede the code for this external cause by an ampersand. If no determination can be made, precede the code for the first mentioned external cause with an ampersand.

Place				
9	I	(a) Aspiration of vomitus	T179	W78
		(b) Internal chest injury	S279	
		(c) Fall down stairs	&W10	

The order in which the conditions are reported indicates that the fall down stairs led to aspiration; therefore, the ampersand precedes the code for this external cause.

Place	I	(a) Gunshot wound of head	S019	&X95
9		(b) Stab wound of chest	S219	X99
MOD	II			
H				

Homicide

The order in which the external causes are reported does not indicate which event occurred first; therefore, precede the code for the gunshot wound with an ampersand since it is the first external cause reported.

Place	I	(a) Head trauma	S099	
9	II	Alcohol intoxication, auto accident	T519	X45 &V499

Precede the code for the auto accident with an ampersand. Alcohol intoxication did not cause the head trauma.

b. When alcohol intoxication (or any term meaning intoxication) is reported with another external cause other than aspiration, precede the code for the first mentioned external cause with an ampersand.

When alcohol intoxication is reported with drugs, refer to Section V, Part Q, 4, Poisoning by alcohol and drugs.

When alcohol intoxication is reported with exposure or hypothermia, refer to Section V, Part L, 2, Exposure, cold exposure and hypothermia.

Place	I	(a) Head trauma	S099
9		(b) Auto Accident	&V499
		(c) Alcohol intoxication	T519 X45

Precede the code for the auto accident with an ampersand since it is the first external cause reported.

Place	I	(a) Drowning	T751	&W74
9		(b) Alcohol intoxication	T519	X45
	II	Drinking heavily	F101	

Precede the code for the drowning with an ampersand since it is the first external cause reported. Code Part II as indexed.

Place	I	(a) Alcohol intoxication and hip fx	T519	&X45	S720
9	II	Fall while intoxicated	W19	T519	

Precede the code for the alcohol intoxication with an ampersand since it is the first

external cause reported.

D. Certifications with mention of nature of injury and without mention of external cause

All certifications that have an entry classifiable to Chapter XIX must have an external cause code. When only one type of injury is reported without indication of the external cause and the External Cause Index provides a code for this type of injury, code accordingly. If the External Cause Index does not provide a code for the type of injury, code to Accident, unspecified (X599). When no external cause is reported and the external cause code must be assumed, code the external cause code as the last entry in Part II.

Place				
9	I	(a) Crushed chest	S280	
	II		&X599	

Code Crushed (accidentally), X599 as indexed.

Place				
9	I	(a) Fracture of hip and arm	S720	T10
	II		&X590	

Code Fracture (circumstances unknown or unspecified), X590 as indexed.

Place				
9	I	(a) Penetrating wound of abdomen	S318	S219
		(b) and chest		
	II		&X599	

Code Wound (accidental) NEC, X599 as indexed.

If different types of injuries are reported without indication of the external cause, use the injury reported in the lowest due to position to assign the appropriate external cause code for this injury. If more than one injury is reported on the lowest line, assign the appropriate external cause code for the first mentioned injury.

Place			
9	I	(a) Brain injury	S069
		(b) Fracture of skull	S029
	II		&X590

Code Fracture (circumstances unknown or unspecified), X590.

Place			
9	I	(a) Fracture of hip	S720
		(b) Crushing hip injury	S770
	II		&X599

Code Crushed (accidentally), X599.

Place				
9	I	(a) Cerebral concussion and	S060	S062
		(b) laceration of brain		
	II		&X599	

Concussion is not indexed in External Cause Index. Code to Accident, unspecified, X599.

These generalizations do not apply if the place of occurrence of the injury was highway, street, road, or alley. Refer to instructions for transport accidents in Section V, Part J.

Implied site of injury

Relate most injuries of an unspecified site to a condition of a specified site, whether or not qualified as generalized, multiple, or stated plural, following general instructions for relating disease conditions.

Exceptions:

Do not relate

Injury(ies) (generalized) (internal) (multiple)
Trauma(s) (generalized) (internal) (multiple)
Wound(s) (generalized) (internal) (multiple)

Place	I	(a) Crushed skull with multiple fractures	S071	S029
9	II		&X599	

Code crushed skull followed by multiple skull fractures relating the injury of unspecified site to the site of the injury that is reported on the same line. Since there is no external cause reported, code Crushed (accidentally) as indexed in Part II.

Place	I	(a) Fractured neck and contusions	S129	S109
9	II		&X590	

Code fractured neck followed by neck contusion relating the injury of unspecified site to the site of the injury that is reported on the same line. Since there is no external cause reported, code Fracture (circumstances unknown or unspecified) as indexed in Part II.

Place	I	(a) Fracture of hip	S720
9		(b) Crushing injury	S770
	II		&X599

Code crushing injury hip since there is only one site reported either on the line above or below the fracture. Since there is no external cause reported, code Crushed (accidentally) as indexed in Part II.

Place	I	(a) Fracture of skull with generalized trauma	S029	T07
9	II		&X590	

Code the generalized trauma as indexed. Do not relate to the site of the injury reported on the same line with it. Since there is no external cause reported, code Fracture (circumstances unknown or unspecified) as indexed in Part II.

Place	I	(a) Skull fracture	S029
9		(b) Wound	T141
	II		&X599

Code I(b) to Wound as indexed. Do not relate to the site of the fracture reported on

the upper line. Since there is no external cause reported, code Wound (accidental) NEC, X599 as indexed in Part II.

E. Conditions qualified as traumatic

1. Some conditions are indexed directly to a nontraumatic category but the Classification also provides a traumatic code. Consider these conditions to be traumatic and code as traumatic:
   a. When they are qualified as "traumatic"
   b. Or they are reported on the certificate with:
      - Injury or trauma (any specified type or site)
      - An external cause
      - The **Manner of Death** is Accident, Homicide, Suicide, Pending Investigation or Undetermined

Exception:

Do not apply this instruction if:
- the condition is reported due to a nontraumatic condition
- W78–W80 is the only external cause reported
- poisoning is reported

Place 6	I	(a) Pneumothorax	S270
		(b) Fracture rib	S223
	II		&X590

Place of injury- Factory

Since pneumothorax is reported on the certificate with an injury, code pneumothorax as traumatic.

Place 9	I	(a) Cerebral hemorrhage	S062
		(b)	
		(c)	
MOD A	II		&X599

Accident

Consider cerebral hemorrhage to be traumatic since Accident is reported in the Manner of Death box.

	I	(a) Cardiorespiratory failure	R092
		(b) Intracerebral hemorrhage	I619
		(c) Meningioma	D329
MOD	II		

A

Accident

Since intracerebral hemorrhage is reported due to a disease condition, code as nontraumatic. Do not enter an E-code for Accident reported in the check box since no condition is coded to Chapter XIX.

Place	I	(a) Subarachnoid hemorrhage	S066
9		(b) Fall	&W19
MOD	II		
N			

Natural

Code subarachnoid hemorrhage as traumatic since it is reported on the certificate with an external cause, disregarding Natural in the Manner of Death box.

Exceptions:

a. Code emphysema, encephalitis, and meningitis to the nature of injury code only when they are stated to be "traumatic" or are reported **due to** or **on the same line with** an injury or external cause.

Place	I	(a) Emphysema	T797
9		(b) Injury chest	S299
		(c) Fall	&W19

Code I(a) emphysema, traumatic since the condition is reported due to an injury.

Place	I	(a) Internal injury	T148
9		(b) Fall from ladder	&W11
	II	Meningitis	G039

Do not code the meningitis as traumatic since it is not reported due to or on the same line with an injury or external cause. Code place of occurrence as 9 (unspecified).

b. Code the following terms to the traumatic category **only** when stated "traumatic:"

blindness (H540-H549)
epilepsy (G400-G409)
gastrointestinal hemorrhage (any K922)
pneumonia (classifiable to J120-J168)

Place	I	(a) Pneumonia	J189
9		(b) Fracture hip	S720
	II	Fall	&W19

Code I(a) pneumonia as indexed since it is not reported as traumatic.

I	(a)	Traumatic epilepsy	T905
	(b)	Head injury	T909
	(c)	Fall from ladder	&Y86

Code epilepsy to the nature of injury code since it is stated traumatic.

c. When the traumatic form of a condition is classified to Chapters I-XVIII, code as traumatic **only** when stated to be "traumatic"

Place				
9	I	(a)	Cardiac arrest	I469
		(b)	Organic brain syndrome	F069
		(c)	Brain injury	S069
		(d)	Fall	&W19

Code organic brain syndrome as indexed since it is not stated "traumatic."

2. When a condition of a specified site is stated to be traumatic but there is no provision in the Classification for coding the condition as traumatic, code to injury unqualified of the site.

Place				
9	I	(a)	Traumatic cerebral thrombosis	S069
		(b)	Fall	&W19

Code Injury, cerebral.

3. When a condition that does not indicate a specified site is stated to be traumatic, but there is no provision in the Classification for coding the condition as traumatic code trauma unspecified and the condition separately.

Place				
9	I	(a)	Traumatic coma	T149 R402
		(b)	Fall	&W19

Code trauma unspecified and coma separately.

4. Traumatic hemorrhage (T148, T149)

Internal hemorrhage NOS	1	**Due to or on same line with** injury (any site)	Code the hemorrhage to T148, internal injury NOS
Hemorrhage NOS	2	**Due to** injury of a specified site	Relate the hemorrhage to the site of the specified injury
	3	**Due to** injury NOS or multiple injuries NOS	Code the hemorrhage to T149, injury NOS
	4	**Due to** injury of multiple specified sites	Relate the hemorrhage to site of the first mentioned specified injury
	5	**Due to** internal injury NOS or internal injuries NOS	Code the hemorrhage to T148, internal injury NOS

		internal injuries NOS	injury NOS
	6	**On same line with** injury of site	Relate the hemorrhage to the site of the specified injury
	7	**On same line with** injury of multiple specified sites	Code the hemorrhage to T149, injury NOS
	8	**On same line with** internal injury NOS or internal injuries NOS	Code the hemorrhage to T148, internal injury NOS
	9	**Due to and on same line with** injuries of different specified sites	Relate the hemorrhage to the site of the injury that is entered on the same line with hemorrhage

									Instruction Number
Place 9	I	(a)	Internal hemorrhage	T148					1
		(b)	Crushed thorax	S280					
		(c)							
	II			&X599					
Place 9	I	(a)	Hemorrhage	S799					2
		(b)	Fracture of femur	S729					
		(c)							
	II			&X590					
Place 9	I	(a)	Hemorrhage	S299					2
		(b)	Laceration of chest	S219					
		(c)							
	II			&X599					
Place 9	I	(a)	Hemorrhage	T149					3
		(b)	Multiple injuries	T07					
		(c)							
	II			&X599					
Place 9	I	(a)	Hemorrhage	S299					4
		(b)	Injury of chest, lung and	S299	S273	S223			
		(c)	fractured rib						
	II			&X599					
Place 9	I	(a)	Contusion chest with	S202	S299				6
		(b)	hemorrhage						
		(c)							
	II			&X599					
Place 9	I	(a)	Laceration of liver, lung,	S361	S273	S360	T149		7
		(b)	& spleen with hemorrhage						
		(c)							
	II	Fracture rt. femur		S729	&X599				
Place 9	I	(a)	Cerebral contusion	S062					9
		(b)	with hemorrhage						
		(c)	Injury of chest, lung, back	S299	S273	S399			
	II			&X599					

F. Assumption of nature of injury code

When an external cause is reported on a certificate without a nature of injury code, assign both a nature of injury and an external cause code. Assume the nature of injury to be Injury NOS, T149 and place it preceding the external cause code.

Place				
	I	(a) Respiratory failure	J969	
9		(b) Fire	T149	&X09

I(b) is an external cause code only. Since there is not a nature of injury reported on the certificate, code nature of injury T149 preceding the external code for fire.

Place				
	I	(a) Subarachnoid hemorrhage	I609	
9		(b) Stroke	I64	
		(c) Fall	T149	&W19

Do not code the hemorrhage on I(a) as traumatic since it is reported due to a nontraumatic condition. I(c) is an external cause code only and there is not a nature of injury reported on the certificate. Code nature of injury T149 preceding the external code for fall.

Place				
	I	(a) Struck by falling tree	&W20	
9	II	Head wound	S019	

I(a) is an external cause code only. Since there is a nature of injury on the certificate, do not code T149 preceding the external code.

Place				
	I	(a) Struck by falling tree	T149	&W20
9	II	Respiratory failure	J969	

I(a) is an external cause code only. Since there is not a nature of injury on the certificate, code T149 preceding the external code.

Exceptions:

1. When conditions classified to categories A000-R99 are reported due to "second hand smoke"

I	(a) Pulmonary emphysema	J439
	(b) Second hand smoke	X49

I	(a) Lung cancer	C349
	(b) Second hand smoke	X49

I	(a) Cardiac arrest	I469
	(b) Second hand smoke	X49

2. Anthrax is reported with accident, suicide, homicide or undetermined

When anthrax (A220-A229) is reported with accident, suicide or homicide anywhere on the record (including in the check box) or undetermined in the check box only, code the anthrax as indexed and code the external cause code as:

- Accident specified (X58)
- Suicide specified (X83)
- Homicide specified (Y08)
- Undetermined specified (Y33)

Anthrax designated as an act of terrorism is classified to U016.

MOD	I (a)	Inhalation anthrax	A221
H	II		Y08

Homicide

Code I(a) as indexed under Anthrax, inhalation. Code an E-code only in Part II for homicide based upon the check box entry. Also enter a H for Homicide in the Manner of Death item.

I	(a)	Anthrax	A229
	(b)	Homicide	Y08

Code I(a) as indexed. Code an E-code only on I(b); do not assume an injury code.

3. When conditions in J680-J709 are reported due to an external cause not considered to be medical or surgical care, refer to Section V, Part O, Guides for differentiating between effects of external causes classifiable to Chapters I-XVIII and Chapter XIX.
4. If a pathological fracture and an external event are reported, no assumption of a nature of injury code is required.

G. Multiple injuries (T00-T07)

When injury (of a site) or specified type of injury (of a site) is:

Stated as	Code as indexed under
Bilateral	Injury (or specified type of injury), site, bilateral
Both	Injury (or specified type of injury), site, both
Multiple	Injury (or specified type of injury), site, multiple

Do not consider the plural form of injury or the plural form of a site to indicate multiple. Do not consider "right and left" as bilateral or both.

Examples of injuries:

1. Fracture of both hips T025

   Fracture

- hip
- - both T025

2. Fracture of hips S720

   Fracture
   - hip S720

3. Multiple fractures of ribs S224

   Fracture
   - rib
   - - multiple S224

4. Fractures of ribs S223

   Fracture
   - rib S223

5. Multiple wounds of lower limb T013

   Wound
   - limb
   - - lower NEC
   - - - multiple sites T013

1. Multiple injuries	**Followed by** specified type(s) of injuries	Code T07 and the specified injuries
2. Multiple injuries	**Followed by** specified site(s)	Code multiple injuries by site(s) only
3. Single site	**Reported on same line with** multiple types of injuries	Code the specified types of injuries of the reported site
4. More than one site	**Reported on same line with** multiple types of injuries	Code the specified type of injury immediately preceding the reported sites to the sites code all other injuries to the NOS code

1. Place I	(a) Multiple injuries with		T07 S029 S062
9	(b) fracture skull and		
	(c) laceration brain		
II			&X599
2. Place I	(a) Multiple injuries - head, neck, chest		S097 S197 S297
9			
II			&X599
3. Place I	(a) Fracture, laceration and contusion		T12 T131 T130
9	(b) of leg		

	(c) Fall from roof		&W13
4. Place I 9	(a) Contusions, lacerations, fracture of trunk (b) and extremities		T140 T141 T021 T142
II			&X599

H. Burns: multiple degrees of burns/percentage of body surface burned

1. When multiple degrees of burns are reported, with or without mention of sites, code the most severe degree only.

Place 0	I	(a) 2nd and 3rd degree burns (b) of face, chest wall and abdomen (c)	T203	T213
MOD A	II		&X00	

Accident	home	house fire

Code 3rd degree burns of each site reported.

Place 9	I	(a) 2nd and 3rd degree burns (b) (c)	T303
	II		&X09

Code 3rd degree burns of unspecified body region.

2. When a percentage of burns or a percentage of body (entire, total) burns is reported, code to the percentage.

Place 9	I	(a) Burns of 50% of (b) body surface (c)	T315	
MOD A	II		&X06	

Accident	clothing caught on fire

Code burns involving 50-59% of body surface.

3. When specified degrees of burns are reported with the percentage of body surface involved, code only the percentage of body surface involved.

Place 0	I	(a) 30-40%, 2nd and 3rd degree burns of body (b) (c)	T314
	II	House fire	&X00

Code burns involving 40-49% of body surface.

4. When a percentage of burns of specified sites is reported, code to burn of site(s) involved.

Place 8	I	(a) Burns, 76% of face, anterior trunk, and (b) extremities (c)	T200 T210 T300
MOD A	II		&X00 T300

Accident	burned in fire in abandoned shack

Code unspecified degree burns of each site reported. In Part II, code burned as burn of unspecified body region, unspecified degree.

I. Specified types and sites of injuries

1. When specified **types** of injuries of sites are reported, code to site only. Do not use Index entries of "specified type NEC" or "specified NEC" (usually .8) .

Place 9	I	(a) Impact injury, upper arm	S499	&X599

Indexed as:

Injury
- arm NEC T119
- - **upper S499**
- - - specified NEC S498

Place 9	I	(a) Blunt injury, trunk	T099	&X599

Indexed as:
Injury
- **trunk T099**
- - specified type NEC T098

2. When specified **sites** of injuries are reported, do not use Index entries of "specified type NEC" or "specified NEC". Use only if indexed as "specified site NEC" or "specified part NEC."

Place 9	I	(a) Fracture third cervical vertebra	S129
		(b) Fall	&W19

Indexed as:

Fracture
- vertebra T08
- - **cervical (teardrop) S129**
- - - specified NEC S122

Place 9 I (a) GSW right side of neck S118 &W34

Indexed as:

Wound
- neck S119
- - **specified part NEC S118**

J. Transportation accidents (V01-V99)

The main axis of classification for land transports (V01-V89) is the victim's mode of transportation. The vehicle of which the injured person is an occupant is identified in the first two characters since it is seen as the most important for prevention purposes.

Definitions and examples relating to transport accidents are in Volume 1, Chapter XX. Refer to these definitions when any means of transportation (aircraft and spacecraft, watercraft, motor vehicle, railway, other road vehicle) is involved in causing death.

For classification purposes, a motor vehicle not otherwise specified is **NOT** equivalent to a car. Motor vehicle accidents where the type of vehicle is unspecified are classified to V87-V89.

A vehicle not otherwise specified is **NOT** equivalent to a motor vehicle **unless** the accident occurred on the street, highway, road(way), etc. Vehicle accidents where the type of vehicle is unspecified are classified to V87-V89.

Additional information about type of transports are given below

(1) Car (automobile) includes blazer, jeep, minivan, sport utility vehicle

(2) Pick-up truck or van includes ambulance, motor home, or truck (farm) (utility)

(3) Heavy transport vehicle includes armored car, dump truck, fire truck, panel truck, semi, tow truck, tractor trailer, 18-wheeler

(4) A special all-terrain vehicle (ATV) or motor vehicle designed primarily for off-road use includes dirt bike, dune buggy, four-wheeler, go cart, golf cart, race car, snowmobile, three-wheeler

(5) Motor vehicle includes passenger vehicle (private), street sweeper

1. Use of the Index and Tabular List

The Classification provides a Table of land transport accidents in Volume 3,

Section II. This table is referenced with any land transport accident if the mode of transport is known. Since the Index does not always provide a complete code, reference to Volume 1, Chapter XX is required.

For V01-V09, the fourth character indicates whether a pedestrian was injured in a nontraffic accident, traffic accident, or unspecified whether traffic or nontraffic accident.

For V10-V79, the fourth character represents the status of the victim, i.e., whether the decedent was driver, passenger, etc. For each means of transportation, there is a different set of fourth characters. Each means of transportation is preceded by its set of fourth characters in Volume 1.

- Car overturned, killing driver V485

  In the Index refer to:

  Overturning
  - transport vehicle NEC (see also Accident, transport) V89.9

  Accident
  - transport (involving injury to) (see also Table of land transport accidents) V99

  In the Table of land transport accidents, select the intersection of:

  Under **Victim and mode of transport,** select
  Occupant of:
  - car (automobile)

  Under **In collision with or involved in:** select
  Noncollision transport accident

  The code is V48.-. From Volume 1 the fourth character is 5, driver injured in traffic accident.

- Auto collision with animal V409

  In the Index refer to:

  Collision (accidental) NEC (see also Accident, transport) V89.9

  Accident
  - transport (involving injury to) (see also Table of land transport accidents) V99

  In the Table of land transport accidents, select the intersection of:

  Under **Victim and mode of transport,** select
  Occupant of:
  - car (automobile)

  Under **In collision with or involved in**: select
  Pedestrian or animal

The code is V40.-. From Volume 1, determine the fourth character is 9, unspecified car occupant injured in traffic accident.

2. Classifying accidents as traffic or nontraffic.

If an event is unspecified as to whether it is a traffic or nontraffic accident, it is assumed to be:

a. A traffic accident when the event is classifiable to categories V02-V04, V10-V82 and V87.

b. A nontraffic accident when the event is classifiable to categories V83-V86. These vehicles are designed primarily for off-road use.

c. Consider category V05 to be unspecified whether traffic or nontraffic if no place is indicated or if the place is railroad (tracks).

d. Consider category V05 to be traffic if place is railway crossing.

e. Consider accidents involving occupants of motor vehicles as traffic when the place is indicated

or if the place is railroad (tracks).

I (a) Laceration lung S273
(b)
(c) Accident &V575

MOD A II

Accident	Truck struck bridge	Driver

Code to occupant of pick-up truck or van injured in collision with fixed or stationary object, driver. When a motor vehicle strikes another vehicle or object, assume the collision occurred on the highway unless otherwise indicated.

I (a) Fractured skull S029
(b)

MOD A II &V866

Accident	Farm	Dune buggy overturned-passenger

Code to passenger of all-terrain or other off-road motor vehicle injured in nontraffic accident.

I (a) Drowning T751 &V863

MOD A II

Accident	Snowmobile ran off road and went into pond

Code to unspecified occupant of all-terrain or other off road motor vehicle injured in traffic accident. Code as traffic accident since the accident originated on the road.

3. Status of victim

a. General coding instructions relating to transport accidents are in Volume 1, Chapter XX. Refer to these instructions for clarification of the status of the victim when not clearly stated.

I (a) Multiple internal injuries T065
(b) Crushed by car T147 &V031

Code to pedestrian injured in collision with car, pick-up truck or van, traffic. Refer to Volume 1, Chapter XX, instruction 3, Crushed by car. The victim is classified as a pedestrian. Refer to Table of land transport accidents. Victim and mode of transport, pedestrian, in collision (with) car. Refer to Volume 1 for fourth character.

b. In classifying motor vehicle traffic accidents, a victim of less than 14 years of age is assumed to be a passenger provided there is evidence the decedent was an occupant of the motor vehicle. A statement such as "thrown from car," "fall from," "struck head on dashboard," "drowning," or "carbon monoxide poisoning" is sufficient.

Female, 4 years old

I	(a)	Fractured skull	S029
	(b)	Struck head on windshield when car	&V476
	(c)	struck tree that had fallen across road	

Code to car occupant injured in collision with fixed or stationary object, passenger (V476).

c. When transport accident descriptions do not specify the victim as being a vehicle occupant and the victim is described as:

pedestrian	versus (vs)	any vehicle (car, truck, etc.)
any vehicle (car, truck, etc.)	versus (vs)	pedestrian

classify the victim as a pedestrian (V0l-V09).

4. Coding categories V01-V89

a. When drowning occurs as a result of a motor vehicle accident NOS, code as noncollision transport accident. The assumption is the motor vehicle ran off the highway into a body of water. If drowning results from a specified type of motor vehicle accident, code the appropriate E-code for the specified type of motor vehicle accident.

	I	(a) Drowning	T751 &V589
MOD A	II		

Accident	Street	Truck accident

Refer to Table of land transport accidents. Code to occupant of truck injured in noncollision transport accident, unspecified.

	I	(a) Drowning	T751 &V435
MOD A	II		

Accident	Street	Driver-2 car collision

Refer to Table of land transport accidents. Code to occupant of car injured in collision with car, driver.

b. When falls from transport vehicles occur, apply the following instructions:

(1) Consider a transport vehicle to be in motion unless there is clear indication the vehicle was not in transit. Refer to Table of land transport accidents, specified type of vehicle reported, noncollision. Refer to Volume 1 for appropriate fourth character.

	I (a) Multiple injuries		T07
MOD A	II		&V583

Accident	Home	Fell from truck in driveway

Refer to Table of land transport accidents under Victim and mode of transport. Select occupant of pick-up truck, noncollision transport accident, (V58.-). Refer to Volume 1 for fourth character and select 3, unspecified occupant of pick-up truck, nontraffic accident.

(2) Consider statements like these as stationary:

(a) Coded as transports with 4th character .4

alighting	leaving
boarding	exiting
entering	getting in or out of vehicle

(b) Coded as fall

stationary
parked
not in transit
not in motion

	I (a) Head injury		S099
MOD A	II		&V784

Accident	Street	Fell alighting from bus

Refer to Table of land transport accidents under Victim and mode of transport. Select occupant of bus, noncollision transport accident, (V78.-). Refer to Volume 1 for fourth character and select 4, person injured while boarding or alighting.

	I (a) Head injury		S099
MOD A	II		&V892

Accident	Street	Fell on curb as he was exiting his daughter's vehicle

Refer to Table of land transport accidents under Victim and mode of transport. Select occupant of motor vehicle (traffic), noncollision transport accident (V892).

Place 4	I	(a) Head injury	S099
MOD A	II		&W17

Accident	Street	Fell from parked car

Code as indexed under Fall, from, vehicle, stationary (W17).

5. Additional examples

	I	(a) Fractures of ribs	S223
		(b)	
		(c)	
MOD A	II		&V234

Accident	Driver of motorcycle that collided with taxicab

Code to motorcycle rider injured in collision with car, pick-up truck or van, driver (V234).

	I	(a) Third degree burns	T303
		(b) Auto accident - car overturned	&V489
		(c)	

Code to car occupant injured in noncollision transport accident, unspecified (V489).

	I	(a) Fracture of ribs	S223
		(b)	
		(c)	
MOD A	II		&V892

Accident	Street	Vehicle Accident

Code to person injured in unspecified motor vehicle accident, traffic (V892). Code as motor vehicle accident since the accident occurred on the street.

6. Occupant of special all-terrain or other motor vehicle designed primarily for off-road use, injured in transport accident (V86)

This category includes accidents involving an occupant of any off-road vehicle. The fourth character indicates whether the decedent was injured in a nontraffic or traffic accident. Unless stated to the contrary, these accidents are assumed to be nontraffic.

	I	(a) Multiple injuries	T07

(b) Driver of snowmobile that collided with auto &V860

Code to driver of all-terrain or other off-road motor vehicle injured in traffic accident since the collision occurred with an automobile.

I (a) Injuries of head S099
(b) Fracture both legs T025
(c) Driver of ATV &V865

Code to driver of all-terrain or other off-road motor vehicle injured in nontraffic accident.

I (a) Head injuries S099
(b) Overturning snowmobile &V869

Code to unspecified occupant of all-terrain or other off-road motor vehicle injured in nontraffic accident.

I (a) Fracture skull S029
(b) ATV accident &V869

Code to unspecified occupant of all-terrain or other off-road motor vehicle injured in nontraffic accident (V869)

7. Traffic accident of specified type but victim's mode of transport unknown (V87) Nontraffic accident of specified type but victim's mode of transport unknown (V88)

a. If more than one type of vehicle is mentioned, do not make any assumptions as to which vehicle was occupied by the victim unless the vehicles are the same. Instead, code to the appropriate categories V87-V88. Statements such as these do not indicate status of victim:

- Auto (passenger) vs. truck
- Car vs. truck, driver
- Driver, car vs. truck
- Passenger car vs. truck
- Car vs. truck, driver
- Driver-car vs. truck

I (a) Intrathoracic injury S279
(b)
(c) Auto vs. motor bike accident &V870

Do not make any assumption as to which vehicle the victim was occupying. Using the Index, code:

Accident
- transport (involving injury to) (see also Table of land transport accidents) V99
- - person NEC (unknown means of transportation) (in) V99
- - - collision (between)

- - - - car (with)
- - - - - two- or three-wheeled motor vehicle (traffic) V87.0

I (a) Multiple injuries T07
(b) Driver - collision of car and bus &V873
(c)

Do not make any assumption as to which vehicle the victim was driving. Using the Index, code:

Accident
- transport (involving injury to) (see also Table of land transport accidents) V99
- - person NEC (unknown means of transportation) (in) V99
- - - collision (between)
- - - - car (with)
- - - - - bus (traffic) V87.3

b. If reported types of vehicles are not indexed under Accident, transport, person, collision, code V877 for traffic and V887 for nontraffic.

I (a) Multiple injuries T07
(b) Bus and pick-up truck collision, driver &V877
(c)

Do not make any assumption as to which vehicle the victim was driving. Collision between bus and pick-up is not indexed under Accident, transport, person, collision. Code V877.

8. Water transport accidents (V90-V94)

The fourth character subdivision indicates the type of watercraft. Refer to Volume 1, Chapter XX, Water transport accidents for a list of the fourth character subdivisions.

I (a) Drowning T751 &V929
(b) Fell over-board

MOD A II

Accident

Code drowning, due to fall overboard. Use fourth character "9," unspecified watercraft.

9. Air and space transport accidents (V95-V97)

For air and space transport accidents, the victim is only classified as an occupant.

Military aircraft is coded to V958, Other aircraft accidents injuring occupant, since a military aircraft is not considered to be either a private aircraft or a commercial aircraft. Where death of military personnel is reported with no specification as to whether the airplane was a commercial or private craft, code V958.

10. Miscellaneous coding instructions (V01-V99)

a. When multiple deaths occur from the same transportation accident, all the certifications should be examined, and when appropriate, the information obtained from one may be applied to all. There may be other information available such as newspaper articles. A query should be sent to the certifier if necessary to obtain the information.

b. When classifying accidents which involve more than one kind of transport, use the following order of precedence:

aircraft and spacecraft (V95-V97)
watercraft (V90-V94)
other modes of transport (V01-V89, V98-V99)

I	(a) Multiple fractures and internal injuries	T029 T148
	(b) Driver of car killed when a private plane	&V973
	(c) collided with car on highway after forced landing.	

Code to person on ground injured in air transport accident following above order of precedence. Refer to Index under Accident, transport, aircraft, person, on ground.

c. When no external cause information is reported and the place of occurrence of the injury was highway, street, road(way), or alley, assign the external cause code to person injured in unspecified motor vehicle accident occurring on the highway.

	I	(a) Head injuries and fracture	S099 S029
MOD	II		&V892
A			

Accident	Highway

Code to person injured in unspecified motor vehicle accident, traffic since the accident occurred on the highway.

d. Homicide, suicide or undetermined in manner of death

(1) When "undetermined" is reported in the manner of death box with transport accidents, code the external cause as accidental unless a statement on the certificate **clearly establishes** an investigation has not determined whether accidental, homicidal, or suicidal.

	I	(a) Multiple head injuries	S097
		(b) Car ran off cliff	&V489
MOD	II		
C			

Undetermined

Code I(a) as indexed. Code I(b) as unspecified car occupant injured in noncollision transport accident. Do not code to undetermined since there is no statement that clearly establishes an investigation resulted in an undetermined verdict.

Place	I	(a) Multiple head injuries	S097
8		(b)Car ran off cliff	&Y32
MOD	II	Police report indicates possible suicide or accident. Verdict pending.	
C			

Undetermined

Code I(a) as indexed. Code I(b) as indexed under Crash, transport vehicle, motor NEC, undetermined since there is a statement, which clearly establishes an investigation of "undetermined intent," is pending.

(2) When "homicide" is reported in the manner of death box with transport accidents, code the external cause as accidental unless a statement on the certificate **clearly establishes** an intentional act of homicide occurred.

Place	I	(a) Multiple traumatic injuries	T07
8		(b) Decedent run over by vehicle several times in parking lot	&Y03
MOD	II		
H			

Homicide

Code I(a) as indexed. Code I(b) as indexed under Assault, crashing of motor vehicle. Homicide is coded since there was evidence the victim was repeatedly run over.

	I	(a) Multiple traumatic injuries	T07
		(b) Struck by car while walking on side of road	&V031
MOD	II		
H			

Homicide | Hit and run – driver left scene of accident

Code I(a) as indexed. Code pedestrian struck by car on I(b). Do not code as homicide since there is no statement of intentional homicide.

(3) When "suicide" is reported in the manner of death box with transport accidents, code the external cause qualified as suicide.

e. Garbage /dump truck accidents

When accidents involving garbage/dump trucks are reported and information indicates the mechanism of the body or truck bed caused the injuries, assign the E-code based on reported information. Usually, the statement of events will be falling on, struck by, or

caught in and external codes W20, W22, or W23 will be used.

Place	I	(a) Crushed chest	S280
4		(b) Dump truck body fell on chest	&W20
MOD	II		
A			

Accident	Street

Code external cause to Struck (by), object, falling, W20.

Place	I	(a) Fracture skull	S029
4		(b) Struck by dump truck body	&W22
MOD	II		
A			

Accident	Street

Code external cause to Struck (by), object, W22.

Place	I	(a) Crushed chest	S280
4		(b) Caught in compactor of garbage truck	&W23
MOD	II		
A			

Accident	Street

Code external cause to Caught, between, objects, W23.

K. Falls

1. Other fall on same level (W18)

Code W18 if other or additional information is reported about the fall such as:

Fell from standing height
Fell moving from wheelchair to bed
Fell striking head
Fell striking object
Fell to floor
Fell while transferring from chair to bed
Fell while walking
Lost balance and fell

Place	I	(a) Fracture right hip	S720
0	II	Lost balance and fell to floor	&W18
MOD			

A

Accident	Home

Code external cause to other fall on same level.

2. Unspecified fall (W19)

Code W19, unspecified fall, for terms such as:

Fall
Fell
Fell at a place

Place	I	(a) Fracture right hip	S720
1	II	Fell at nursing home	&W19
MOD			
A			

Accident	Nursing Home

Code external cause to fall, unspecified.

3. Falls with other external events

When fall is reported more information must be obtained in order to assign the most appropriate code. This information will be reported in Part I and Part II of the medical certification, also the place of injury and the description of how injury occurred.

1. Is a vehicle or transport involved?

   YES: Refer to coding instructions for categories V01 - V89. This includes reference to table of land transport accidents. This section also includes specific instructions for fall from transport vehicle.

   NOTE: fall from animal: see V80-

2. Is a fire involved?

   YES: Refer to coding instructions for categories X00 - X09. Review Threats to Breathing, Table 3, Fire.

3. Is machinery in operation involved?

   YES: See code categories W28 - W31.

4. Is drowning or submersion in water involved?

   YES: Refer to coding instructions for categories W65 - W74. Review Threats to Breathing, Table 1, Drowning and submersion, if applicable.

5. Is struck by a falling object involved?

YES: See code categories W20 - W49

6. Is a human stampede or pushed by a crowd involved?

YES: Code W52

If none of the above, see code categories W00 - W19 for specific codes.

L. Natural and environmental factors

1. Lightning

Code X33 only when the decedent is injured from direct contact with lightning.

Code injuries, such as stroke or shock, due to direct contact with lightning to T750.

Code burn(s) due to lightning to burn(s) (T200-T289, T300-T319).

Place	I	(a) Shock	T750		
9		(b) Struck by lightning	T750	&X33	
Place	I	(a) Burns	T300		
0		(b) House fire	&X00		
		(c) House struck by lightning			

When a secondary fire results from lightning, code to the fire. Do not enter a code for lightning.

2. Exposure, cold exposure and hypothermia

When exposure, cold exposure or hypothermia is reported anywhere on the record with another stated or implied external cause, code the nature of injury code (T68-T699, T758) and the E-code for the exposure, cold exposure or hypothermia (X599, X31). Do not modify the nature of injury code for exposure NOS. Ampersand the external cause code for the other event.

Place	I	(a) Exposure	T758	X599	
9		(b) Intoxication with hip fx	T519	&X45	S720
	II		X590		
Place	I	(a) Hypothermia with drowning	T68	X31	T751
9		(b)			
		(c)			
Place	I	(a) Exposure	T758	X83	
4		(b)			
		(c)			
MOD	II	Multiple fractures	T029	&X80	
S					

Suicide | Jumped from bridge

Suicide	Jumped from bridge

Place 9	I	(a) Exposure to cold	T699	X31	
		(b)			
		(c)			
	II	MVA	&V892		
Place 9	I	(a) Exposure and hypothermia	T758	X31	T68
		(b) Unconsciousness	R402		
		(c)			
MOD A	II	Blunt trauma to head	S099	&W18	T758

Accident	Exposed to elements after falling and striking head

Place 9	I	(a) Hypothermia	T68	X31	
		(b)			
		(c)			
	II	Alcohol intoxication	T519	&X45	

M. Firearms and firearm injuries

1. Coding specific types of firearms

The type of firearm involved in a death is identified at the three character level. Use the following guide to identify the type of firearm:

Type Firearm	Accidental	Intentional Self-harm	Assault	Undetermined Intent
Handgun 25 Caliber 32 Caliber 38 Caliber 45 Caliber 357 Magnum 380 Caliber Pistol Revolver Saturday night special	W32	X72	X93	Y22
Rifle, shotgun, larger firearm 25.06 (25 ought 6) 30.6 (30 ought 6) 30/30 308 AK47 M1 (carbine) M14	W33	X73	X94	Y23

M16 Machine gun Rifle (army) (hunting) (military) Shotgun (8, 10, 12, 16, 20, 410 gauge, buckshot)				
Other and unspecified firearms 9 mm 22 Caliber gun 30 Caliber gun Airgun BB gun Pellet gun Pellet pistol Very pistol (Flare)	W34	X74	X95	Y24

2. External cause code

a.

When reported as	**Code**
"playing with gun" NOS or "cleaning gun" NOS	external cause as accidental (W32-W34)
"playing Russian roulette" (whether or not stated suicide)	external cause as handgun accident (W32)

Place 9 I (a) Gunshot wound of femur S711 &W34
(b) Cleaning gun T141

Code as accidental since reported due to cleaning gun.

Place 9 I (a) Gunshot wound chest S219 &W32
(b)Self-inflicted while playing Russian roulette
MODS II

Suicide

Code as handgun accident since Russian roulette is reported.

3. Nature of injury code

a.

When	**Is reported due to**	**Code**
Injury NOS	any caliber bullet gun went off pulled trigger specified firearm	the nature of injury to wound

Place 9 I (a) Injury T141
(b) Rifle T141 &W33

b.

When reported as	**Code**
Gunshot or bullet entering and/or exiting a site	the nature of injury to wound of site(s)

Place 9 I (a) Bullet entering chest & S219 &W34 S212
(b) exiting back

c.

When reported as	**Code**
Bullet (to site) Gunshot (to site) Shooting, shot (to site) Shotgun blast (to site)	the nature of injury to wound (of site(s))

Place 9 I (a) Shot in head S019 &W34

4. Other firearm examples

Place 9	I	(a) Gunshot wound chest (b) Self-inflicted	S219	&Y24	

Code as undetermined gunshot since self-inflicted is reported and is unspecified as accidental or intentional.

Place 9	I	(a) Gunshot injury chest (b) and lung	S219	&W34	S273

Code the nature of injury to wound of sites and external code to accidental gunshot wound

N. Child abuse, battering and other maltreatment (Y070-Y079)

Code to Child battering and other maltreatment (Y070-Y079) if the age of the decedent is under 18 years and the cause of death meets one of the following criteria:

1. The certifier specifies abuse, battering, beating, or other maltreatment, even if homicide is not specified.

Male, 3 years

	I	(a) Traumatic head injuries	S099
		(b)	
		(c)	
MOD H	II		&Y079

Homicide	Home	Deceased had been beaten

2. The certifier specifies homicide and injury or injuries with indication of more than one episode of injury, i.e., current injury coupled with old or healed injury consistent with a history of child abuse.

Male, 1-1/2 years

	I	(a) Anoxic encephalopathy	G931	
		(b) Subdural hematoma	S065	
		(c) Old and recent contusions of body	T910	T090
MOD H	II		&Y079	

Homicide

3. The certifier specifies homicide and multiple injuries consistent with an assumption of battering or beating, if assault by a peer, intruder, or by someone unknown to the child cannot be reasonably inferred from the reported information.

Female, 1 year

	I	(a) Massive internal bleeding	T148

		(b) Multiple internal injuries	T065	
		(c)		
MOD H	II	Injury occurred by child being struck	T149	&Y079

Homicide

Exception:

Deaths at ages under 18 years for which the cause of death certification specifies homicide and an injury occurring as an isolated episode, with no indication of previous mistreatment, should not be classified to Y070-Y079. This excludes from Y070-Y079 deaths due to injuries specified to be the result of events such as shooting, stabbing, hanging, fighting, or involvement in robbery or other crime, because it cannot be assumed such injuries were inflicted simply in the course of punishment or cruel treatment.

Female, 1 year

Place 0	I	(a) Hypovolemic shock	T794	
		(b) Laceration of heart	S268	
		(c) Multiple stab wounds thorax	S217	&X99
MOD H	II	Stabbed with kitchen knife by mother	T141	

Homicide | Home

O. Guides for differentiating between effects of external causes classifiable to Chapters I - XVIII and Chapter XIX

Categories in Chapters I-XVIII and XIX are mutually exclusive. Where provision has been made for coding effects of an external cause to Chapters I-XVIII, do not use a nature of injury code.

The effects of external causes classifiable to Chapters I-XVIII are primarily those associated with drugs, medicaments and biological substances, surgical procedures, and other medical procedures. Refer to Section V, Part R, Complications of medical and surgical care (Y40-Y84).

A limited number of conditions that can result from other external causes, e.g., certain localized effects of fumes, vapors and nonmedicinal chemical substances and respiratory conditions from aspiration of foreign substances are also classified to Chapters I-XVIII. It is intended that Chapters I-XVIII be used to identify the localized effects and the substance be identified by the external cause code in Chapter XX.

To determine if the conditions reported due to external causes, other than drugs, medicaments, and biological substances, surgical procedures, and other medical procedures, are classified to localized effects in Chapters I-XVIII or to the nature of injury in Chapter XIX – look up the stated condition in the Index and scan the listing under this condition for qualifying terms that relate to the reported external cause. For example, to determine whether pneumonia due to aspiration of vomitus should be coded to Chapter X or to Chapter XIX, look up "Pneumonia, aspiration, due to, food (regurgitated), milk, vomit." This determination cannot be made by looking up "Aspiration." Where there is provision in the Index for coding a condition due to an external cause to Chapter I-XVIII, take the external cause into account if it modifies the coding.

	I	(a) Pneumonia	&J690
		(b) Aspiration of vomitus	W78

Code Pneumonia, aspiration, due to vomit. Code "aspiration of vomitus" as an

external cause code only.

I	(a) Pneumonia	&J690	
	(b) Aspiration	W80	
	(c) Cancer of lung	C349	

Code Pneumonia, aspiration. Code I(b) "aspiration" as an external cause code only.

I	(a) Pneumonia	&J690
	(b) Asphyxia	W80
	(c) Aspiration	

Code Pneumonia, aspiration. Code I(b) external cause code only.

I	(a) Pneumonia	&J680
	(b) Smoke inhalation	X00
II	House fire	

Code Pneumonia, in (due to), fumes and vapors (J680). Code I(b) external cause code only.

I	(a) Acute pulmonary edema	&J681	
	(b) Inhaled gasoline fumes	X46	

Code Edema, pulmonary, acute, due to, chemicals fumes or vapors (J681). Code I(b) external cause code only.

Place				
9	I	(a) Pneumonia	J189	
		(b) Cardiac arrest	I469	
		(c) Aspiration of vomitus	T179	&W78

Code each entity as indexed. Do not code the pneumonia on I(a) due to aspiration of vomitus since it is reported due to another condition.

P. Threats to breathing

Certain effects of external causes can be classified to more than one nature of injury code depending on the type of external cause. Some of these effects are "anoxia," "asphyxia," "aspiration," "choking," "compression of neck," "obstruction of a site," "strangulation," "stricture of neck," and "suffocation."

The most frequently reported external causes which result in these effects are "aspiration, ingestion, and inhalation of objects and substances," "drowning," "fires," "fumes, gases and vapors," "hanging," "mechanical strangulation and suffocation," and "submersion."

The following pages contain tables that are used as guides in coding these types of external causes and effects.

In general, if the specific external cause is not in Tables 1-5, it will most likely be in Table 6, which contains the most frequently reported external causes which result in asphyxia, suffocation, etc. If not in any of the tables, code the effect as indexed.

Table	Title
Table 1	Drowning and submersion
Table 2	*Hanging and mechanical strangulation (by external means)
Table 3	Fires (includes burns, gases, fumes in association with burns and fires)
Table 4	Ingestion, inhalation of gases, fumes, vapors (without fires, burns)
Table 5	Compression chest, crushed chest by external means
Table 6	Aspiration NOS, ingestion NOS, inhalation NOS or aspiration, ingestion, inhalation of substances or objects (W78, W79, W80)

***NOTE:** Interpret mechanical strangulation as strangulation caused by external means to the exterior of the body.

Table 1. Drowning and submersion

Instruction	When	Is reported due to	Code
1	anoxia asphyxia strangulation suffocation	drowning submersion	upper line T751 and the appropriate external cause code. lower line T751 only.

Examples - Corresponding Table and Instruction 1.1

Place	I	(a) Asphyxia	T751	&W69
8		(b) Drowning	T751	
MOD		(c)		
A	II		T751	

Accident	Drowned while swimming in river

	I	(a) Asphyxia	T751	&V909
		(b) Strangulation	T751	
MOD		(c) Drowning	T751	
A	II			

Accident	Lake	Boat Overturned

Place	I	(a) Anoxia	T751	&W70
8		(b) Drowning	T751	
MOD		(c)		
A	II			

Accident	Fell into Lake

Instruction	**When**	**Is reported on the same line with**	**Code**
2	anoxia asphyxia strangulation suffocation	drowning submersion	T751 and the appropriate external cause code.

Example - Corresponding Table and Instruction 1.2

Place	I	(a) Drowning - asphyxia	T751	&W69
8		(b)		
MOD		(c)		
A	II			

Accident	Pond

Table 2. Hanging and mechanical strangulation (by external means)

Instruction	**When**	**Is reported due to**	**Code**
1	asphyxia strangulation suffocation	hanging mechanical strangulation (by external means) compression of neck	upper line T71 and the appropriate external cause code. lower line T71 only.

Examples - Corresponding Table and Instruction 2.1

Place	I	(a) Asphyxia	T71	&X70
0		(b) Hanging	T71	
MOD		(c)		
S	II			

Suicide	Home

Place	I	(a) Aspiration of vomitus	T179	&W78
0		(b) Strangulation	T71	&X70
MOD		(c) Hanging	T71	
S	II		T71	

Suicide	Home	Hanged Self

	I	(a) Asphyxia	T71	&V499
		(b) Compression of neck	T71	
		(c) Auto accident		
	II			

Instruction	When	Is reported on the record with	Code
2	**asphyxia** **strangulation** **suffocation**	**hanging** **mechanical strangulation** **(by external means)** **compression of neck**	the asphyxia, strangulation, suffocation, T71 followed by the appropriate external cause code. T71 only where the hanging, mechanical strangulation, compression of neck is reported.

Example - Corresponding Table and Instruction 2.2

Place	I	(a) Suffocation by hanging	T71	&X70
9		(b)		
MOD		(c)		
S	II		T71	

Suicide	Hanging by neck

Male 1 month old

Place	I	(a) Suffocation	T71	&W75
9		(b)		
MOD		(c)		
A	II			

Accident	Co-sleeping with adults

Accident	Co-sleeping with adults

Instruction	When	Is reported due to	Which is reported due to	Code
3	asphyxia strangulation suffocation	asphyxia strangulation suffocation	the external means of the mechanical strangulation (such as: ligature, rope around neck, sheet)	uppermost line to T71 and the appropriate external cause code. the next lower line to T71. lower line blank.

Example - Corresponding Table and Instruction 2.3

Place	I	(a) Asphyxia	T71	&W75
9		(b) Suffocation	T71	
		(c) Crib sheet		
	II			

Instruction	When	Is reported due to	Code
4	compression of neck stricture of neck	hanging mechanical strangulation (by external means) suffocation	upper line T71 only. lower line T71 and the appropriate external cause code.

Example - Corresponding Table and Instruction 2.4

Place	I	(a) Compression of neck	T71	
9		(b) Hanging	T71	&X91
MOD		(c)		
H	II		T71	

Homicide	Hanging

Instruction	When	Is reported on the record with	Code
5	compression of neck stricture of	hanging mechanical strangulation (by external means)	compression of neck, stricture of neck to T71 only.

	neck	suffocation	T71 followed by the appropriate external cause code for the hanging, mechanical strangulation, suffocation.

Example - Corresponding Table and Instruction 2.5

Place	I	(a) Compression of neck	T71	
9		(b)		
MOD		(c)		
H	II	Strangulation by cord around neck	T71	&X91

Homicide

Table 3. Fires (includes burns, gases, fumes in association with burns and fires)

Instruction	When	Is reported due to		Code
1	asphyxia suffocation	ingestion, inhalation	of gas, fumes, or vapors (carbon monoxide, products of combustion, smoke)	the asphyxia, suffocation to the nature of injury code for the gas, fumes, vapor and the appropriate external cause code for the fire where required.
		with mention of a fire (specified)		lower line to the appropriate natu of injury code for the gas, fumes, vapor.

Examples - Corresponding Table and Instruction 3.1

Place	I	(a) Suffocation	T599	&X00
0		(b) Inhalation of products of combustion	T599	
MOD		(c)		
A	II		T599	

Accident | Inhaled fumes in house fire

Place	I	(a) Suffocation	T598	&X09
9		(b) Smoke inhalation	T598	
MOD		(c) Fire		
A	II			

Accident

Instruction	When	Is reported on the record with		Code
2	asphyxia suffocation	ingestion, inhalation	of gas, fumes, or vapors (carbon monoxide, products of combustion, smoke)	the asphyxia, suffocation to the nature of injury code for the gas, fumes, vapor and the appropriate external cause code for the fire where required. the appropriate nature of injury code for the gas, fumes, vapor where reported.
		with mention of a fire (specified)		

Example - Corresponding Table and Instruction 3.2

Place	I	(a) Asphyxia - carbon monoxide	T58	&X00
0		(b)		
MOD		(c)		
A	II			

Accident	Home	House Fire

Instruction	When	Is reported due to	Code
3	asphyxia suffocation	burns NOS (any degree) (any percentage) (any site)	upper line T300 and the appropriate external cause code. lower line as indexed.

Examples - Corresponding Table and Instruction 3.3

Place	I	(a) Asphyxia	T300	&X04
0		(b) Burns of chest and face	T210	T200
MOD		(c)		
A	II			

Accident	Home	Ignition of kerosene

Place	I	(a) Suffocation	T300	&X00
9		(b) 3° burns	T303	

MOD (c)
A II

Accident	Burning Bldg.

Instruction	When	Is reported due to	Code
4	asphyxia suffocation	fire NOS specified fire	upper line T300 and the appropriat external cause code. lower line blank.

Instruction	When	Is reported on the record with	Code
5	asphyxia suffocation	fire NOS specified fire	the asphyxia, suffocation T300, followed by the appropriate extern cause code for the fire.

Example - Corresponding Table and Instruction 3.5

Place I (a) Asphyxia, fire in house T300 &X00
0 (b)
(c)
II

Table 4. Ingestion, inhalation of gases, fumes, vapors (without fires, burns)

Instruction	When	Is reported due to		Code
1	asphyxia suffocation	ingestion, inhalation	of gas, fumes, or vapors	upper line to the appropriate nature of injury code for the gas, fumes, or vapor and the appropriate external cause code. lower line to the appropriate nature of injury code for the gas, fumes, or vapor.

Example - Corresponding Table and Instruction 4.1

Place I (a) Asphyxia T58 &X67
0 (b) Inhalation of carbon monoxide T58
MOD (c)

S II T58

Suicide	Home	Inhaled car exhaust fumes in garage

Instruction	When	Is reported due to		Code
2	asphyxia suffocation	ingestion, inhalation	of gas, fumes, or vapors	the appropriate nature of injury code for the gas, fumes, or vapor and the appropriate external cause code.

Example - Corresponding Table and Instruction 4.2

Place I (a) Suffocation by inhalation of propane gas T598 &X47
0 (b)
MOD (c)
A II T598

Accident	Home	Inhaled propane gas

Table 5. Compression chest, crushed chest by external means

Instruction	When	Is reported due to	Code
1	asphyxia suffocation	crushed chest	upper line S280 plus the appropriate external cause code. lower line S280.

Example - Corresponding Table and Instruction 5.1

I (a) Asphyxia S280 &V892
(b) Crushed chest S280
MOD (c) MVA
A II

Accident	Street	MVA

Instruction	When	Is reported due to	Code
2	asphyxia suffocation	compression chest	upper line S299 plus the appropriate external cause code. lower line S299.

Example - Corresponding Table and Instruction 5.2

Place	I	(a) Suffocation	S299	&W30
7		(b) Compression chest	S299	
MOD		(c) Tractor accident		
A	II			

Accident	Farm	Tractor overturned on victim

Table 6. Aspiration NOS, ingestion NOS, inhalation NOS, or aspiration, ingestion, inhalation of substances or objects (W78, W79, W80)

EXCLUDES: Ingestion, inhalation of drugs and poisonous substances

Instruction	When	Is reported due to	Code
1	asphyxia aspiration choking obstruction of a site occlusion of a site strangulation suffocation	aspiration NOS ingestion NOS inhalation NOS **or** aspiration / ingestion / inhalation — of substances or objects	upper line to T17 plus appropriate fourth character and the appropriate external cause code (W78, W79, W80). lower line to T17 with appropriate fourth character.

Examples - Corresponding Table and Instruction 6.1

Place	I	(a) Strangulation	T179	&W79
9		(b) Aspiration of food	T179	
		(c)		
	II			

Place	I	(a) Asphyxia	T179	&W78

9		(b) Aspiration	T179	
		(c) Vomitus		
	II			
Place	I	(a) Choked	T179	W80
9		(b) Aspiration of blood	T179	
		(c) Crushed chest	S280	
	II	Car vs. Pedestrian	&V031	

Instruction	When	Is reported due to	Code
2	asphyxia aspiration choking obstruction of a site occlusion of a site strangulation suffocation	foreign body in a site (such as: blood, food, gum, medicine, mucus, vomitus)	upper line to T17 plus appropriate fourth character and the appropriate external cause code (W78, W79, W80). lower line to T17 with appropriate fourth character.

Example - Corresponding Table and Instruction 6.2

Place	I	(a) Obstruction of pharynx	T172	&W79
9		(b) Bolus of meat in throat	T172	
		(c)		
	II			

Instruction	When	Is reported due to	Code
3	asphyxia aspiration choking obstruction of a site occlusion of a site strangulation suffocation	foreign body NOS (such as: blood, food, gum, medicine, mucus, vomitus)	upper line to T17 plus appropriate fourth character and the appropriate external cause code (W78, W79, W80). lower line blank.

Examples - Corresponding Table and Instruction 6.3

Place	I	(a) Obstruction of trachea	T174	&W79
9		(b) Bolus of meat		
		(c)		
	II			
Place	I	(a) Asphyxia	T179	&W78

9	(b) Aspiration (c) Vomitus		T179
	II		

Instruction	When	Is reported due to		Code
4	asphyxia aspiration choking obstruction of a site occlusion of a site strangulation suffocation	aspiration NOS ingestion NOS inhalation NOS or aspiration ingestion inhalation	of substances or objects	on the same line, T17 with appropriate fourth character and the appropriate external cause code (W78, W79, W80).

Example - Corresponding Table and Instruction 6.4

Place	I	(a) Asphyxia by aspiration of vomitus	T179	&W78
9		(b)		
		(c)		
	II			

Instruction	**When**	**Is reported due to**	**Code**
5	asphyxia aspiration choking obstruction of a site occlusion of a site strangulation suffocation	foreign body in a site (such as: blood, food, gum, medicine, mucus, vomitus)	on the same line, T17 with appropriate fourth character and the appropriate external cause code (W78, W79, W80).

Example - Corresponding Table and Instruction 6.5

Place	I	(a) Choked by peanut obstructing trachea	T174	&W79
9		(b)		
		(c)		
	II			

Instruction	When	Is reported due to	Code
6	asphyxia aspiration choking obstruction of a site occlusion of a site strangulation suffocation	foreign body NOS (such as: blood, food, gum, medicine, mucus, vomitus)	on the same line, T17 with appropriate fourth character and the appropriate external cause code (W78, W79, W80).

Examples - Corresponding Table and Instruction 6.6

Place	I	(a) Choked on chicken bone	T179	&W79
9		(b)		
		(c)		
	II			

Place	I	(a) Obstruction airway by bolus of food	T179	&W79
9		(b)		
		(c)		
	II			

Instruction	When	Is reported due to	Code
7	aspiration NOS aspiration of substances strangulation NOS strangulation by substances	a disease	upper line T17 plus appropriate fourth character and the appropriate W78, W79, W80 if not previously coded. lower line as indexed.

Example - Corresponding Table and Instruction 6.7

Place	I	(a) Aspiration	T179	&W80
9		(b) C.V.A	I64	
		(c)		
	II			

Instruction	When	Is reported due to	Code
8	aspiration NOS	vomiting	upper line T179, W78. lower line R11.

Example - Corresponding Table and Instruction 6.8

Place	I	(a) Aspiration	T179	&W78
9		(b) Vomiting	R11	
		(c)		
	II			

Instruction	When		Is reported due to	Code
9	aspiration NOS ingestion NOS inhalation NOS or aspiration ingestion inhalation	of substances or objects	injuries (other than those classified to T17-) and/or an external cause (other than W78, W79, W80)	upper line T17 plus appropriate fourth character. Also, code the appropriate W78, W79, W80 if not previously coded. lower line as indexed.

Examples - Corresponding Table and Instruction 6.9

Place	I	(a) Aspiration of vomitus	T179	&W78
0		(b) Strangulation	T71	&X70
MOD		(c) Hanging	T71	
S	II		T71	

Suicide	Home	Hanged Self

Place	I	(a) Choked	T179	W80
9		(b) Aspiration of blood	T179	
		(c) Crushed chest	S280	
	II	Car vs. Pedestrian	&V031	

Place	I	(a) Aspiration	T179	W80
9		(b) Drowning	T751	&W74
MOD		(c)		
A	II			

Accident

Q. Poisoning

When poisoning (any) is reported for the substance.

When poisoning by fumes, gas, liquids, or solids is reported, refer to Index under "Poisoning (acute)" to determine the nature of injury code for the substance.

To determine the external cause code when a poisonous substance is ingested, inhaled, injected, or taken, refer to the description of such circumstances (acts) for example, Ingestion, Inhalation, or Took.

When a condition is reported due to poisoning and the Index provides a code for the condition qualified as "toxic," use this code. If the Index does not provide a code for the condition qualified as "toxic," code the condition as indexed.

1. Poisoning by substances other than drugs

Assume poisoning (self- inflicted) by a substance to be accidental unless otherwise indicated.

Place					
	I	(a) Aplastic anemia	D612		
9		(b) Benzene poisoning	T521	&X46	

Code I(a) Anemia, aplastic, toxic. Code I(b) to nature of injury and external cause code for benzene poisoning from Table of Drugs and Chemicals.

Place				
	I	(a) Toxic poisoning	T659	&X46
9		(b) Drank turpentine	T528	

Code I(a), nature of injury code for poison NOS and the most specific external cause code (turpentine) taking into account the entire certificate. Code nature of injury for turpentine on I(b).

a. Carbon monoxide poisoning

Code carbon monoxide poisoning from motor vehicle exhaust gas to noncollision motor vehicle accident (traffic) according to type of motor vehicle involved unless there is indication the motor vehicle was not in transit. Consider statements of "sleeping in car," "sitting in parked car," "in parked car" or place stated as "garage" to indicate the motor vehicle was "not in transit." Assume "not in transit" in self-harm (intentional) and self-inflicted cases.

	I	(a) Carbon monoxide poisoning	T58 &V892
		(b)	
		(c)	
	II	Motor vehicle exhaust gas	T58

Code I(a) nature of injury for carbon monoxide and most specific external cause. Code external cause to person injured in unspecified motor vehicle accident, traffic. Refer to Table of land transport accidents under Victim and mode of transport. Select occupant of motor vehicle (traffic), noncollision transport accident. Code nature of injury for exhaust gas in Part II.

Place				
	I	(a) Poisoned by carbon monoxide	T58	&X47
9	II	Sitting in parked car		

Code I(a) nature of injury and external cause for carbon monoxide from Table of drugs and chemicals. The external cause includes poisoning by gas, motor exhaust, not in transit.

Place	I	(a) Carbon monoxide inhalation	T58	&X67
5	II	Found in garage. Suicide.		

Code I(a) nature of injury and external cause for carbon monoxide from Table of drugs and chemicals. The external cause includes intentional self-harm poisoning by gas, motor exhaust, not in transit.

b. Inhalation and sniffing sprays and aerosol substances

When inhalation of sprays, aerosol substances, etc. is reported, code to the appropriate accidental poisoning category for the external cause.

Exceptions:

"Glue sniffing" and "cocaine sniffing" and "huffing" are indexed to mental and behavioral disorders due to psychoactive substance use (F181, F142, F181).

Place	I	(a) Toxicity	T659	&X46
0		(b) Inhalation of aerosol substance	T659	
		(c)		
MOD	II	Breathed "PAM" (freon) in plastic bag	T535	
A				

Accident	Home

Code I(a) nature of injury code for toxicity as indexed. Code external cause to accidental inhalation of freon gas or spray (X46), the specific substance indicated by the certifier. Code nature of injury for aerosol on I(b) and freon in Part II.

c. Intoxication by certain substances or toxic poisoning due to disease

When ammonia intoxication (NH), carbon dioxide intoxication (C0), or toxic poisoning is reported due to a disease, **do not** code to poisoning. When due to a disease, code ammonia intoxication to R798, carbon dioxide intoxication to R068, and toxic poisoning to R688.

I	(a) Ammonia intoxication	R798
	(b) Cirrhosis of liver	K746

Code I(a) as indexed, Intoxication, ammonia, due to disease (R798).

I	(a) Carbon dioxide intoxication	R068
	(b) Chronic pulmonary emphysema	J439

Code I(a) as indexed, Intoxication, carbon dioxide, due to disease (R068).

I	(a) Toxic poisoning	R688
	(b) Gastroenteritis	A099

Code I(a) as indexed, Poisoning, toxic, from a disease (R688).

d. Condition qualified as "toxic" with poisoning reported

(1) When a condition is qualified as "toxic" and there is indication of poisoning on the certificate, code the external cause code for the poisoning where the "toxic" is reported, followed by the condition code. If the Classification provides a code for the condition qualified as "toxic," use this code. If no provision is made for qualifying the condition as toxic, code to the unspecified code for the condition.

Place				
9	I	(a) Toxic nephritis	&X48	N144
	II	Organophosphate poisoning, accidental	T600	

Code most specific external cause code on I(a) where toxic is reported followed by condition code for toxic nephritis as indexed. Code nature of injury for organophosphate in Part II.

Place				
9	I	(a) Toxic GI hemorrhage	&X49	K922
		(b) Carbolic acid	T540	

Code most specific external cause code on I(a) where toxic is reported followed by condition code for GI hemorrhage as indexed. The Classification does not provide a code for GI hemorrhage qualified as toxic. Code nature of injury for carbolic acid on I(b).

Place				
9	I	(a) Toxic diarrhea	&X48	K521
	II	Rat poison	T604	

Code most specific external cause code on I(a) where toxic is reported followed by condition code for toxic diarrhea as indexed. Code nature of injury for rat poison in Part II.

(2) When a condition is qualified as "toxic" and there is no indication of poisoning on the certificate, code the condition as indexed to the unspecified code.

I	(a) Toxic anemia	D612

Code toxic anemia as indexed since there is no indication of poisoning on the certificate.

2. Poisoning by drugs

a. When the following statements are reported, see Table of Drugs and Chemicals and code as accidental poisoning unless otherwise indicated.

Interpret all these statements to mean poisoning by drug and code as poisoning whether or

not the drug was given in treatment:

Drug taken inadvertently
Lethal (amount) (dose) (quantity) of a drug
Overdose of drug
Poisoning by a drug
Toxic effects of a drug
Toxic reaction to a drug
Toxicity (of a site) by a drug
Wrong dose taken accidentally
Wrong drug given in error

Place				
9	I	(a) Cardiac arrest	I469	
		(b) Digitalis toxicity	T460	&X44
		(c) Congestive heart failure	I500	

Code digitalis toxicity to digitalis poisoning. Code nature of injury and external cause code for digitalis poisoning on I(b). Do not ampersand a disease condition when poisoning from a drug occurs while the drug is being administered for medical reasons.

Place				
9	I	(a) Shock	R578	
		(b) Insulin overdose	T383	&X44
		(c) Diabetes	E149	

Code I(a) shock, toxic since reported due to poisoning. Code insulin overdose to insulin poisoning. Code nature of injury and external cause code for insulin poisoning on I(b). Do not ampersand a disease condition when poisoning from a drug occurs while the drug is being administered for medical reasons.

b. Interpret the term "intoxication by drug" to mean poisoning by drug unless indicated or stated to be due to drug therapy or as a result of treatment for a condition (refer to Section V, Part R, 1, (6), "Intoxication by drug" due to drug therapy).

Place				
9	I	(a) Respiratory failure	J969	
		(b)Drug intoxication	T509	&X44
	II	Ingested undetermined amount of drugs	T509	

Code "drug intoxication" to poisoning when there is no indication the drug was given for therapy. Code I(b) nature of injury and external cause code for drug poisoning. Code nature of injury code for drug NOS in Part II.

c. When poisoning by drug NOS is reported in Part I and a specified drug is reported in Part II, code the external cause code to the specified drug.

Place				
9	I (a)	Took overdose of drug	T509	&X41
	II	Overdose of barbiturates	T423	

Code "took overdose of drug" as accidental unless otherwise specified. Code I(a) nature of injury for drug NOS and external cause code to the specified drug reported in Part II. Code nature of injury for barbiturates in Part II.

d. When a condition is qualified as "toxic" or "drug induced" and there is indication of drug poisoning on the certificate, code the external cause code for the drug poisoning where the "toxic" or "drug induced" is reported, followed by the condition code. If the Classification provides a code for the condition qualified as "toxic" or "drug induced," use this code. If no provision is made for qualifying the condition as "toxic" or "drug induced," whichever applies, code to the unspecified code for the condition. Code the nature of injury code for poisoning by the specified drug.

Place 9	I	(a) Toxic hemolytic anemia	&X41	D594
		(b) Levodopa toxicity	T428	

Code most specific external cause on I(a) where toxic is reported followed by condition code for toxic hemolytic anemia as indexed. Code nature of injury for levodopa on I(b).

When a condition is qualified as "toxic" and there is no indication of drug poisoning on the certificate, code the condition as indexed.

When a condition is qualified as "drug induced" and there is no mention of drug poisoning on the certificate, code as a complication of drug therapy).

e. Poisoning by combination of drugs (X40-X44)

(1) When poisoning by a combination of drugs is stated or indicated to be accidental, intentional self-harm (suicide), or undetermined code as follows:

(a) When poisoning by a combination of drugs classified to the same external cause code is reported, use that external cause code.

Place 9	I	(a) Doxepin and barbiturate overdose	T430	&X41	T423

Code external cause code to X41 since both doxepin and barbiturates are indexed to this code. Code nature of injury for each drug reported.

Place 9	I	(a) Doxepin and prozac overdose	T430	&X61	T432
MOD S					

Suicide

Code external cause code to X6l since both doxepin and prozac are indexed to this code. Code nature of injury for each drug reported.

(b) When poisoning from a single drug is reported in Part I with a combination of drugs in Part II, code the external cause code for the drug reported in Part I. Code the nature of injury for each drug reported.

Place	I	(a) Acute barbiturate intoxication	T423	&X41
9	II	Took unknown amount of	T423	T390
MOD		barbiturates and aspirin		
A				

Accident

Code external cause code to X41, accidental poisoning by barbiturates, the single drug reported in Part I. Code nature of injury for barbiturates on I(a) and for barbiturates and aspirin in Part II.

(c) When poisoning by a combination of drugs classified to different external cause codes is reported and (b) does not apply, use the following external cause codes when the manner of death is reported as:

Accident	Code X44, Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances.
Intentional self-harm (Suicide)	Code X64, Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances.
Undetermined	Code Y14, Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent.

Place	I	(a) Drug intoxication	T509	&X44
9		(b) Digitalis, cocaine	T460	T405

The external cause code for accidental poisoning by digitalis is X44 and for cocaine is X42. Since the drugs are assigned to different external cause codes, code X44, Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances. Code nature of injury for each drug reported.

Place	I	(a) Drug toxicity	T509	&X64
9		(b) Overdose of salicylates	T390	T423
		(c) and seconal		
MOD	II	Overdose of drugs	T509	
S				

Suicide

The external cause code for intentional self-harm (suicide) by salicylates is X60 and for seconal, X61. Since the drugs are assigned to different external cause codes, code X64, Intentional self poisoning by and exposure to other and unspecified drugs, medicaments and

biological substances. Code nature of injury for each drug reported.

Place 9	I	(a) Darvon and promazine (b) intoxication	T404	&Y14	T433
MOD C	II	Drug intoxication	T509		

Undetermined

The external cause code for poisoning of undetermined intent by darvon is Y12 and for promazine, Y11. Since the drugs are assigned to different external cause codes, code Y14, Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent. Code nature of injury for each drug reported.

3. Percentage of drug(s) in blood

When a percentage (%) of any drug(s) in the blood, code the nature of injury code for the drug if there is mention of drug poisoning elsewhere on the record.

When a complication is reported due to a percentage (%) of any drug(s), code as a complication of drug therapy unless otherwise indicated.

When a percentage (%) of any drug(s) in the blood without mention of drug poisoning or a complication, do not enter a code for the drug.

Place 9	I	(a) Gunshot wound brain	S069	&X74
	II	.05 mg. barbiturates in blood		
MOD S				

Suicide

Since there is no mention of poisoning or a complication of the barbiturates, **do not** enter a code for the percentage of drug in the blood.

4. Poisoning by alcohol and drugs

When alcoholism or alcohol poisoning (any F10-, R780, R826, R893, T510-T519) is reported in Part I with drug poisoning in Part I, code the alcohol to the appropriate code (F10-, R780, R826, R893, T510-T519), the nature of injury code for the drug and code the appropriate external cause code for the drug preceded by an ampersand. If alcohol poisoning is reported, code the external cause code for alcohol also, but do not precede this code with an ampersand. Interpret the following statements to mean poisoning by alcohol and drugs and code the appropriate E-code for alcohol poisoning:

Alcohol and drug interaction
Alcohol and drug synergism
Combination of alcohol and drugs
Combined action alcohol and drugs
Combined effects of alcohol and drugs
Mixed effects of alcohol and drugs
Synergistic effects of alcohol and drugs

Place 9	I	(a) Combined effects of alcohol	T519	X45	T509	&X44
		(b) and drugs				
MOD A	II	Ingested alcohol and drugs	F109	T509		

Accident

Interpret I(a) as alcohol poisoning and drug poisoning. Code the nature of injury and external cause for the alcohol and drugs. Precede the E-code for the drugs with an ampersand. In Part II, code the ingested alcohol as indexed. Code nature of injury for drugs as last entry.

Place 9	I	(a) Alcohol ingestion	F109	
		(b) Barbiturate intoxication	T423	&X41

Code I(a) alcohol ingestion as indexed and code the nature of injury and external cause for barbiturate intoxication on I(b).

Place 9	I	(a) Alcoholism	F102		
	II	Alcohol and barbiturate	T519	X45 T423	&X41
MOD A		intoxication			

Accident

Code alcoholism as indexed in Part I. Code the nature of injury and external cause for the alcohol and barbiturate intoxication in Part II. Precede the E-code for the drug with an ampersand.

Place 9	I	(a) Barbiturate toxicity	T423	&X61	
	II	Barbiturate and	T423	T519	X65
MOD S		alcohol intoxication			

Suicide

Code I(a) nature of injury for barbiturate T423 and external cause code X61 for suicidal barbiturate toxicity. Precede the E-code for barbiturate with an ampersand. Code the nature of injury and external cause for barbiturate and alcohol intoxication as indexed Part II.

Place 9	I	(a) Poisoning by alcohol	T519	&X45	
	II	Toxic levels of heroin and flunitrazepam	T401	X44	T424

Code I (a) nature of injury for alcohol, T519 and external cause X45. Precede the E-code for alcohol with an ampersand. Code the nature of injury and external cause

for the heroin and flunitrazepam in Part II.

5. Intoxication (acute) NOS

When intoxication (acute) NOS is reported, code the nature of injury code for alcohol as indexed and the appropriate external cause for alcohol poisoning.

When intoxication (acute) NOS is reported "due to" drugs or poisonous substances, code the intoxication to the nature of injury code for the first substance reported in the "due to" position.

Exception:

Intoxication (acute) NOS "due to" drug(s) with indication the drug was being given for therapy.

Place 9	I	(a) Intoxication	T519	&X45

Code intoxication as indexed to T519 and code the external cause code for alcohol poisoning X45. Precede the external cause code with an ampersand.

Place 9	I	(a) Acute intoxication	T404
		(b) Darvon & alcohol poisoning	T404 &X62 T519 X65
MOD S	II		

Suicide

Code I(a) T404, the nature of injury code for darvon since this is the first substance reported in the "due to" position. Code I(b) to the nature of injury and external cause code for darvon poisoning and alcohol poisoning. Precede the external cause code for darvon poisoning with an ampersand. Do not ampersand external cause code for alcohol poisoning.

Place 9	I	(a) Intoxication	T58	
		(b) Carbon monoxide inhalation	T58	&X47
MOD A	II			

Accident

Code I(a) T58, the nature of injury for the substance (carbon monoxide) reported in "due to" position. Code I(b) to the nature of injury and external cause code for carbon monoxide inhalation. Precede the external cause code with an ampersand.

NOTE: See Appendix H for additional drug examples.

R. Complications of medical and surgical care (Y40-Y84)

Code any complication, abnormal reaction, misadventure to patient, or other adverse effect that occurred as a result of

or during medical care except obstetrical procedures to the appropriate category in Chapters I-XIX, but take into account the medical care if it modifies the code assignment. Assign the appropriate external cause (E-code) pertaining to the medical care regardless of whether the complication is classified to Chapters I-XVIII or to Chapter XIX.

The E-code distinguishes between:

1. Drugs, medicaments and biological substances causing adverse effects in therapeutic.
2. Misadventures to patients during surgical and medical care (Y60-Y69).
3. Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure (Y83-Y84).

Use of ampersand (More than one instruction may apply)

1. Always precede the condition that necessitated the medical or surgical care with an ampersand the first time it is reported. Generally, the first condition on the lowest used line will be the reason for medical care.

I	(a) Pneumonia	J958
	(b) Surgery	Y839
	(c) Pulmonary hemorrhage	R048
	(d) Lung cancer	&C349

2. Precede the external cause (Y40-Y84) with an ampersand **if the complication** is classified to Chapter XIX (T80-T88).

I	(a) Pulmonary embolism	T817
	(b) Surgery	&Y839

3. Precede the first complication with an ampersand **if the complication** is classified to Chapter I-XVIII and the condition requiring medical or surgical care is **NOT** reported.

I	(a) Renal failure	&N19
	(b) Drug therapy	Y579

4. If the medical or surgical care was administered for an injury, precede the code for the external cause of the injury with an ampersand.

	I	(a) Pneumonia	J958
Place		(b) Surgery	Y839
9		(c) Fracture of hip	S720
		(d) Fall	&W19

5. If two or more conditions for which the medical or surgical care could be administered are reported and the reason for treatment cannot be determined, precede the first condition with an ampersand.

I	(a) Pneumonia	J958
	(b) Surgery	Y839
II	Lung cancer, gastric ulcer	&C349 K259

6. If the medical care was administered for diagnostic purposes, precede the code for the

condition that was found or confirmed by the diagnostic finding with an ampersand the first time it is reported.

I	(a)	Cerebral edema	G978
	(b)	Cerebral arteriogram	Y848
	(c)	Brain tumor	&D432

1. Drugs, medicaments and biological substances causing adverse effects in therapeutic use (Y40-Y59)

a. Complications of drugs

Although almost any condition reported due to drug therapy is regarded as a complication, there are a few diseases that are not considered complications.

The drug therapy (Y40-Y59) is not coded when there is no evidence of a complication.

Interpret "due to drug therapy" as a condition(s) on an upper line with drug therapy as the first condition on the next lower line.

(1) The following are not regarded as complications of drug therapy.

(a) These conditions due to drug therapy:

Infectious and parasitic diseases	A000-A309, A320-A329, A360-A399, A420-A449, A481-A488, A500-A690, A692-B199, B250-B349, B500-B942, B949 (**EXCEPT:** Antineoplastic drugs Y431-Y433; Immunosuppressive agents Y434) B200-B24
Neoplasms	C000-D45, D47-D489
Diabetes	E10-E14 (**EXCEPT:** Steroids Y425, Y427)
Hemophilia	D66-D682
Alcoholic disorders	E244, E52, F101-F109, G312, G405, G621, G721, I426, K292, K700-K709, K852, K860, L278, R780, R826, R893
Rheumatic fever or rheumatic heart disease	I00-I099
Arteriosclerosis and arteriosclerotic conditions	
Influenza	J09-J118
Hernia	K400-K469
Congenital malformations	Q000-Q999

This is <u>not</u> an all inclusive list.

I	(a)	Lung cancer	C349
	(b)	Drug therapy	

<u>Since</u> lung cancer is not considered a complication of drug therapy, no code is

assigned for I(b).

I	(a) Pancytopenia		D619
	(b) Lung cancer chemotherapy		C349

Do not code the chemotherapy since there is no reported complication. Lung cancer is the first condition on the next lower line.

(b) Any condition stated as congenital, familial, hereditary, idiopathic or conditions with a duration that predates the drug therapy.

I	(a) Congenital cardiomyopathy		I424
	(b) Drug therapy		

Do not code the drug therapy since conditions stated as congenital cannot be considered as complications.

I	(a) Nephritis	6 months	N059
	(b) Drug therapy	2 months	
			Reject 1

Do not code the drug therapy on I(b). The nephritis cannot be considered as a complication since it occurred prior to the drug therapy.

(2) Code any condition classifiable to Chapters I-XVIII that could result from a drug, medicament, or biological substance (including anesthesia) known or presumed to have been properly administered to the appropriate category in these chapters.

If the Classification provides a code for the condition reported as "due to drug" or "drug induced," use this code. If no provision is made for the condition reported as "due to drug" or "drug induced," code to the unspecified code for the condition.

When a condition classifiable to Chapters I-XVIII is reported due to a drug reaction (named drug) NOS, e.g., insulin reaction, code the condition as indexed and code the drug reaction to the external cause code.

Classify only those complications that cannot be assigned to Chapters I-XVIII to Chapter XIX (T80.-, T88.-).

I	(a) Respiratory and cardiac arrest	&R092	I469
	(b) Local anesthesia reaction	Y483	

Code the conditions reported on I(a) as complications of local anesthesia since the local anesthesia is presumed to have been properly administered. Precede the first complication with an ampersand. Since a complication is reported, assign only an external cause on I(b) indicating Adverse effect in therapeutic use.

I	(a) Drug reaction	T887	&Y400
	(b) Penicillin		

Code the drug reaction on I(a) to nature of injury and external cause since no specified complication is reported. Precede the E-code with an ampersand. Do not enter a code for penicillin on I(b) since it was coded on I(a).

I	(a) Encephalitis	&G040	
	(b) Measles vaccination	Y590	

Code the encephalitis as a complication of the measles vaccine since the measles vaccine is presumed to have been properly administered. Encephalitis is indexed following vaccination or other immunization procedure. Precede the complication (G040) with an ampersand. Code the measles vaccination toY590, Adverse effect in therapeutic use.

I	(a) Pulmonary embolism	I269	
	(b) Estrogen to control excessive	Y425	&N920
	(c) menses		

Code the pulmonary embolism as a complication of the estrogen since the estrogen is presumed to have been properly administered. Code the estrogen as Adverse effect in therapeutic use and excessive menses as indexed. Precede the code for excessive menses with an ampersand to indicate the condition requiring treatment.

(3) Unless there are indications to the contrary, assume the drug, medicament, or biological substance was used for medical care purposes and was properly administered in correct dosage. **Do not** make this assumption **if:**

- The drug was one which is not used for medical care purposes, e.g., LSD or heroin,

or

- It was an analgesic, sedative, narcotic or psychotropic drug (or combination thereof) or drug NOS **AND** the certifier indicated the death was due to an "accident" "suicide" or it occurred under "undetermined circumstances ,"

or

- One or more of these drugs was taken in conjunction with alcohol

Code to poisoning (refer to Section V, Part Q, 2, Poisoning by drugs).

Place 9 MOD A	I	(a) Respiratory failure	J969	
		(b) Ingestion of mixed sedatives	T426	&X41

Accident

Code I(a) as indexed. Code I(b) nature of injury and external cause code for accidental poisoning by mixed sedatives. Code as poisoning since the drug is a

sedative and the certifier indicated the death was due to an accident. Precede the E-code with an ampersand.

Place				
9	I	(a) Cerebral anoxia	G931	
		(b) Ingestion of barbiturates	T423	&X41
	II	Had been drinking	F109	

Code I(a) as indexed. Code I(b), accidental ingestion of barbiturates since the drug is a sedative and it was taken in conjunction with alcohol. Precede the E-code with an ampersand. Code Part II as indexed.

(4) When the condition for which the drug is usually administered is reported elsewhere on the certificate, code this condition as indexed, preceded by an ampersand to identify the condition requiring treatment.

I	(a) Hemorrhage	K922	
	(b) Ulcer of stomach	K259	
	(c) Cortisone therapy	Y420	
II	Scleroderma	&M349	

The ulcer of the stomach is the complication of the cortisone therapy. Code the E-code for cortisone on I(c). Since cortisone is used in treatment of scleroderma, precede this condition with an ampersand.

When a complication occurs as the result of a drug being given in treatment and the condition requiring the drug is not reported elsewhere on the certificate, **do not** assume a disease condition.

When a complication classifiable to Chapters I-XVIII occurs as the result of a drug being administered in therapeutic use and the condition requiring the treatment is not reported, place an ampersand preceding the code for the complication.

I	(a) Renal failure	&N19	
	(b) Ingested antidiabetic drug	Y423	

The renal failure on I(a) is the complication of the antidiabetic drug. Code the E-code for antidiabetic drug on I(b). **Do not** assume a disease condition requiring therapy even though antidiabetic drug is one used in the treatment of diabetes. Precede the complication with an ampersand.

(5) "Drug induced" complications

When a condition is stated to be "drug induced," consider the condition to be a complication of drug therapy, unless otherwise indicated. Code as follows:

(a) If the complication is classified to Chapter I-XVIII, code the E-code for the drug, followed by the code for the complication.

I	(a) Drug induced aplastic anemia	Y579	D611
II	Carcinoma of lung	&C349	

Code I(a) Y579, complication of an unspecified drug, and the "drug induced aplastic anemia" as indexed. Ampersand the carcinoma of lung as the condition requiring treatment.

I	(a) Drug induced polyneuropathy	Y579	&G620

Code I(a) Y579, complication of an unspecified drug, and the "drug induced polyneuropathy" as indexed. Place an ampersand preceding the code for the complication.

(b) If the complication is classified to Chapter XIX, code the nature of injury code for the complication followed by the E-code for the drug. Place an ampersand preceding the E-code.

I	(a) Chloramphenicol induced reaction	T887	&Y402
	(b) Septicemia	&A419	

Code I(a) as a complication of the drug (named). Code the nature of injury for the complication followed by the E-code for the named drug. Place an ampersand preceding the E-code and the septicemia to indicate the condition requiring treatment.

(6) "Intoxication by drug" due to drug therapy

When "intoxication by drug" is reported or indicated to be treatment for a condition or due to drug therapy, consider these to be complications of drug therapy, not poisoning.

I	(a) Cardiac arrest	I469	
	(b) Digitalis intoxication	T887	&Y520
	(c) ASHD	&I251	

Code the digitalis intoxication as drug therapy since it is indicated as treatment for a condition by its position on the record. Code the intoxication as indexed under Intoxication, drug, correct substance properly administered and the E-code for digitalis.

(7) Gastric Hemorrhage as a Complication of Steroids, NSAIDS, Aspirin

When gastric hemorrhage is reported as the first condition on the lowest used line in Part I, and aspirin, steroids or NSAIDS are reported elsewhere on the certificate, consider the gastric hemorrhage as a complication of drug therapy and code as indexed. Code the appropriate e-code for the drug to the adverse effect in therapeutic use (Y40-Y59). If reported, ampersand the condition for which the drug was administered.

(8) Combined effects of two or more drugs

When a complication is reported due to the combined effects of two or more drugs,

code the complication as indexed. On the next lower line, code the appropriate E-code (Y400-Y599). To determine the appropriate E-code, refer to the column for "Adverse effect in therapeutic use" in the Table of drugs and chemicals. (refer to Section V, Part R, 1 (3) when coded as poisoning)

(a) When the drugs are classified to different fourth characters of the same three-character category, code the appropriate E-code with the fourth character for "other."

I	(a) Cardiac arrest	I469	
	(b) Valium and sleeping pills	Y478	
	(c) Anxiety	&F419	

Code I(b) to the appropriate E-code for the combined effects of two drugs in therapeutic use classified to the same three-character category.

(b) When the drugs are classified to different three-character categories, code the E-code to Y578, "Other drugs and medicaments."

I	(a) Congestive heart failure	I500	
	(b) Cor pulmonale	&I279	
II	Hemorrhage from anticoagulant and aspirin	R5800	Y578

Code Y578, the appropriate E-code for combined effect of two drugs in therapeutic use classified to different three-character categories.

(9) Complications of chemotherapy

(a) When a complication of chemotherapy is reported, code the complication as indexed and Y579 unless a malignancy is reported on the certificate. When the complication is classified to Chapters I-XVIII and the reason for the chemotherapy is not reported, precede the complication with an ampersand.

I	(a) Aplastic anemia	&D611
	(b) Chemotherapy	Y579

Code I(a), aplastic anemia due to drugs (D611) and code I(b) Y579, adverse effect of unspecified drug in correct usage. Precede the complication with an ampersand.

(b) When a complication of chemotherapy is reported with mention of a malignancy on the certificate, consider the chemotherapy to be antineoplastic drugs and code E-code Y433.

I	(a) Purpura	D692
	(b) Chemotherapy	Y433
	(c) Leukemia	&C959

Code I(a) as indexed. Consider the chemotherapy on I(b) as antineoplastic drugs

and code Y433. Ampersand the leukemia as the condition requiring treatment.

(10) Complications of immunosuppression

Immunosuppression can be drug therapy or a complication of drug therapy. Code immunosuppression as **drug therapy** unless reported **due to** a drug, then code as a complication of the drug (D849). If the drug is not reported elsewhere on the certificate, code Y434 for the immunosuppressive drug.

I	(a) Pneumonia and sepsis	J189	A419
	(b) Immunosuppression	D849	
	(c) Chemotherapy for carcinoma of brain	Y433	
	(d)	&C719	

Since the immunosuppression is due to chemotherapy, consider as a complication. Ampersand the carcinoma of brain as the condition requiring treatment.

I	(a) Immunosuppression	D849
	(b) Vancomycin	Y408
	(c) Acute bacterial endocarditis	&I330

Since the immunosuppression is due to a drug, consider as a complication. Ampersand the acute bacterial endocarditis as the condition requiring treatment.

I	(a) Infection	B99
	(b) Immunosuppression for	Y434
	(c) Carcinoma of prostate	&C61

Consider the infection as a complication of drug therapy (immunosuppression) on I(b). Ampersand the carcinoma of prostate as the condition requiring treatment.

I	(a) Cardiorespiratory arrest	I469
	(b) Sepsis	A419
	(c) Immunosuppression for	Y434
	(d) Rheumatoid vasculitis	&M052

Consider the sepsis as a complication of drug therapy (immunosuppression) on I(c). Ampersand the rheumatoid vasculitis as the condition requiring treatment.

I	(a) Sepsis	A419
	(b) Immunosuppression	Y427
	(c) Renal transplant	&N289
II	Steroid therapy	

Consider the sepsis as a complication of drug therapy (immunosuppression) on I(b). Code external cause code to steroids, the immunosuppressive drug reported elsewhere on the certificate. Code and ampersand Disease, kidney, as the condition for which the renal transplant was performed and the condition requiring the

immunosuppressive drug.

I	(a) Respiratory arrest	R092
	(b) Septicemia	A419
	(c) Immunosuppression	Y434
II	Renal transplant	&N289

Consider the septicemia as a complication of drug therapy (immunosuppression) on I(c). In Part II, code and ampersand Disease, kidney, as the condition for which the renal transplant was performed and the condition requiring the immunosuppressive drug.

I	(a) Bacteremia	A499
	(b) Immunosuppression	Y434
	(c)	
II	Idiopathic thrombocytopenia purpura	&D693

Consider the bacteremia as a complication of drug therapy (immunosuppression) on I(b). Ampersand the idiopathic thrombocytopenia purpura as the condition requiring treatment.

I	(a) Cardiac arrest	I469
	(b) ASHD	I251
	(c)	
II	DM, AS, immunosuppression	E149 I709

Do not enter a code for the immunosuppression since there is not a reported complication.

(11) Drugs administered for one year or more

When a complication is reported due to a drug being administered for one year or more, consider the drug was given on a continuing basis. Code as a current complication; **do not** code as sequela.

I	(a) Hypercorticosteronism	E242
	(b) Steroids - 6 years	Y427
	(c) Arthritis	&M139

Consider the steroids as being administered on a continuing basis for six years. Code as a current complication of the drug. Code I(a) Hypercorticosteronism, correct substance properly administered (E242).

2. Surgical procedures as the cause of abnormal reaction of the patient or later complication (Y83)

a. Complications of surgical procedures

Although almost any condition reported due to surgery is regarded as a complication of surgery, there are few diseases that are not considered complications. The surgical procedure (Y83) is not coded when there is no evidence of a surgical complication.

Interpret "due to surgery" as a condition(s) on an upper line with a surgical procedure as the first condition on the next lower line.

(1) The following are not regarded as complications of surgical procedures:

(a) These conditions reported due to surgery:

Infectious and parasitic diseases	A000-A309, A320-A329, A360-A399, A420-A449, A481-A488, A500-A690, A692-B349, B500-B978
Neoplasms	C000-D489
Hemophilia	D66, D67, D680, D681, D682
Diabetes	E10-E14
Alcoholic disorders	E52, E244, F101-F109, G312, G405, G621, G721, K860, I426, K292, K700-K709, K852,L278, R780, R826, R893
Rheumatic fever or rheumatic heart disease	I00-I099
Hypertensive diseases	I11-I139, I150, I159
Coronary artery disease Coronary disease	I251
Ischemic cardiomyopathy	I255
Chronic or degenerative myocarditis	I514
Arteriosclerosis and arteriosclerotic conditions except those classified to I219	
Calculus or stones of any type or site	
Influenza	J09-J118
Hernia except ventral (incisional)	K400-K429 K440-K469
Diverticulitis	K570-K579
Rheumatoid arthritis	M050-M089
Collagen diseases	M300-M359
Congenital malformations	Q000-Q999

This is not an all inclusive list.

I (a) Myocardial infarction I219
(b) Arteriosclerosis I709
(c) Surgery

Since arteriosclerosis is not accepted as a complication of surgery, do not code the

surgery.

I (a) Diabetic gangrene E145
(b) Leg amputation

Do not code the leg amputation (surgery) since there is no indication of a surgical complication.

I (a) Pneumonia J189
(b) Brain tumor removal D432

Do not code the removal since there is no complication. Brain tumor is the first condition on the next lower line.

(b) Do not accept conditions with a duration which predates the surgery

I (a) MI 2 weeks I219
(b) Surgery 2 days
Reject 1

Do not code the surgery on I(b). Since the MI occurred before the surgery was performed it cannot be a complication.

(2) When a condition reported due to a **named** surgical (operative) procedure can be considered as a complication or abnormal reaction, code as follows:

STEP 1: Determine if the complication is in the Index qualified by the named surgery reported

I (a) Lymphedema I972
(b) Postmastectomy Y836
(c) Breast cancer &C509

Code I(a) using **Step 1**

Lymphedema
- postmastectomy I97.2

I (a) Hemorrhage T828
(b) Coronary artery bypass graft &Y832
(c) Coronary heart disease &I259

Code I(a) using **Step 1**

Hemorrhage
- due to or associated with
- - device, implant or graft
- - - heart NEC T82.8

"Coronary" is not indexed, but is located in the heart; therefore, heart can be used in place of coronary.

NOTE: Before continuing to **STEP 2** (below), it is important to determine the nature of the named surgery.

I	(a) Hemorrhage	T828
	(b) Cardiac revascularization	&Y832
	(c) Cardiovascular disease	&I516

Revascularization is defined as the re-establishment of adequate blood supply to a part, by means of a vascular graft. Code I(a) as indexed:

Hemorrhage
- due to or associated with
- - device, implant or graft
- - - heart NEC T82.8

STEP 2: If the Index does not qualify the complication with the named surgery, determine if the complication is indexed under Complications (from) (of), surgical procedure.

I	(a) Hemorrhage	T810
	(b) Postlaminectomy	&Y836
	(c) Intervertebral disc degeneration	&M513

The Index does not qualify hemorrhage as postlaminectomy. Code I(a) as indexed:

Complications (from) (of)
- surgical procedure
- - hemorrhage or hematoma (any site) T81.0

Code I(b), as indexed under Complication, laminectomy.

I	(a) Intestinal obstruction	K913
	(b) Colostomy	Y833
	(c) Ulcerative colitis	&K519

Code I(a) as indexed

Complications (from) (of)
- surgical procedure
- - intestinal obstruction K91.3

Code I(b), surgery, as indexed under Complications, colostomy. Code I(c), ulcerative colitis, as indexed and precede with an ampersand indicating the reason for the surgery.

STEP 3: If the Index does not qualify the complication with the named surgery nor is the complication indexed under Complications (from) (of), surgical procedures, determine if the named surgery is indexed under Complications (from) (of).

I	(a) Stroke	T828
	(b) Coronary artery bypass	&Y832
	(c) Arteriosclerotic heart disease	&I251

The Index does not qualify stroke with coronary artery bypass nor is stroke indexed under Complications, surgical procedures; therefore, code I(a) using **Step 3:**

Complications (from) (of)
- coronary artery (bypass) graft
- - specified NEC T82.8

Stroke is neither an infection nor an inflammation nor mechanical; therefore, select "specified NEC."

I	(a) MI	T828
	(b) Postfemoral bypass graft	&Y832
	(c) Peripheral vascular disease	&I739

Code I(a) as indexed

Complications (from) (of)
- graft
- - femoral artery (bypass) - See Complications, graft, arterial

Complications (from) (of)
- graft
- - arterial
- - - specified NEC T82.8

Code I(b), Y832, as indexed under Complication, graft. Precede the E-code (Y832) by an ampersand.

I	(a) Cerebral embolism	T858
	(b) Bypass	&Y832

Code I(a) as indexed

Complications (from) (of)
- bypass (see also Complications, graft)

Complications (from) (of)
- graft
- - specified NEC T85.8

Code I(b), Y832, as indexed under Complications, bypass. Precede the E-code

(Y832) by an ampersand.

I	(a)	Anemia	T858
	(b)	Gastrointestinal bypass	&Y832
	(c)	Diverticulitis	&K579

Code I(a) as indexed

Complications (from) (of)
- bypass (see also Complications, graft)

Complications (from) (of)
- graft
- - intestinal tract
- - - specified NEC T85.8

Code I(b), Y832, as indexed under Complications, bypass. Precede the E-code (Y832) by an ampersand. Code I(c), Diverticulitis, K579, as indexed. Precede the code (K579) by an ampersand to indicate the reason for surgery.

(3) When a condition that is

(a) reported due to a **named** surgery cannot be assigned a code using **STEP 1- STEP 3** or

(b) reported due to a surgery (operation) (of a site) NOS, and can be considered as a complication or abnormal reaction, code as follows:

STEP 4: Determine if the complication is in the Index, qualified:

(a) as reported
(b) with any term meaning "due to" **surgery** (see Section II, Part C, 2, a, "Due to" written in or implied)
(c) as surgical or as complicating surgery
(d) as postoperative or postsurgical
(e) as postprocedural
(f) during or resulting from a procedure, **so stated**
(g) resulting from a procedure, **so stated**

I	(a)	Pulmonary insufficiency following	&J952
	(b)	Surgery	Y839

Code I(a) as reported using **Step 4 (a)**

Insufficiency
- pulmonary
- - following
- - - surgery J952

Precede the code J952 by an ampersand. Code I(b), surgery, Y839, as indexed under Complication, surgical operation NEC.

I	(a)	Hypothyroidism	E890
	(b)	Thyroid surgery	Y839
	(c)	Thyroid cancer	&C73

Code I(a) using **Step 4 (b)**. Refer to "due to" list in Section II, Part C, 2, a, "Due to" written in or implied.

Hypothyroidism
- due to
- - surgery E890

Thyroid surgery is equivalent to surgery NOS.

I	(a)	Cardiac insufficiency	T818
	(b)	Surgery	&Y839

Code I(a) using **Step 4 (c)**

Insufficiency
- cardiac
- - complicating surgery T818

Code I(b), surgery, Y839, as indexed under Complication, surgical operation NEC. Precede the E-code (Y839) by an ampersand.

I	(a)	Pneumonia	&J958
	(b)	Surgery	Y839

Code I(a) using **Step 4 (d)**. Indexed as Pneumonia (see also Pneumonitis).

Pneumonitis
- postoperative J958

Precede the code J958 by an ampersand. Code I(b), surgery, Y839, as indexed under Complication, surgical operation NEC.

I	(a)	Renal failure	&N990
	(b)	Surgery	Y839

Code I(a) using **Step 4 (e)**

Failure
- renal

- - postprocedural N99.0

Precede the code N990 by an ampersand. Code I(b), surgery, Y839, as indexed under Complication, surgical operation NEC.

I	(a)	Cerebral anoxia	&G978
	(b)	Surgery	Y839

Code I(a) using **Step 4 (f)**

Anoxia
- cerebral
- - during or resulting from a procedure G97.8

Precede the code G978 by an ampersand. Code I(b), surgery, Y839, as indexed under Complication, surgical operation NEC.

I	(a)	Anoxic brain damage	&G978
	(b)	Surgery	Y839

Code I(a) using **Step 4 (g)**

Damage
- brain
- - anoxic
- - - resulting from a procedure G97.8

Precede the code G978 by an ampersand. Code I(b), surgery, Y839, as indexed under Complication, surgical procedure NEC.

STEP 5: If the Index does not provide for the complication qualified with any of the terms defined in the previous steps, determine if the complication is indexed under Complications (from)(of), surgical procedure.

NOTE: If a "named" surgery is reported, this step has already been completed in **Step 2**.

I	(a)	Hyperglycemia	&E891
	(b)	Surgery	Y839

Code I(a) as indexed

Complications (from) (of)
- surgical procedure
- - hyperglycemia E89.1

Precede the code E891 by an ampersand. Code I(b), surgery, Y839, as indexed

under Complication, surgical operation NEC.

NOTE: Do not apply Step 6 when assigning a complication code for conditions classified to R00-R99.

STEP 6: If the Index does not provide for the complication as above, determine if:

(a) the site of the complication is in the Index under Complications (from) (of), surgical procedure

or

(b) the system in which the complication occurred (based upon the code assigned in the Index) is in the Index under Complications (from)(of), surgical procedure.

I	(a) MI	T818
	(b) Surgery	&Y839

Code I(a) using **Step 6 (a)**

Complications (from)(of)
- surgical procedure
- - cardiac T81.8

The site of a myocardial infarction is the muscle tissue of the heart which is synonymous with cardiac. Code I(b), surgery, Y839, as indexed under Complication, surgical operation NEC. Precede the E-code with an ampersand.

I	(a) Uremia	&N998
	(b) Surgery	Y839

Code I(a) using **Step 6 (b)**

Complications (from) (of)
- surgical procedure
- - genitourinary
- - - specified NEC N99.8

Uremia NOS is indexed to N19 which indicates this condition is a specified disease in the genitourinary system.

I	(a) Mesenteric embolism	K918
	(b) Gallbladder surgery	Y839
	(c) Gallstones	&K802

Code I(a) using **Step 6 (b)**

Complications (from)(of)
- surgical procedure

- - digestive system
- - - specified NEC K91.8

Mesenteric embolism is indexed to K550 which indicates that this condition is a specified disease in the digestive system.

STEP 7: When a reported complication cannot be classified to a system which is indexed, code to T818, other complications of procedures, not elsewhere classified.

I	(a) Anemia	T818
	(b) Surgery	&Y839

Anemia is not indexed as due to surgery or as postoperative. Anemia is a disease of the blood-forming organs and neither the term nor the body system is indexed under Complication (from) (of), surgical procedure.

Code I(a) as indexed

Complications (from)(of)
- surgical procedure
- - specified NEC T81.8

Code I(b), surgery, Y839, as indexed under Complication, surgical operation NEC. Precede the E-code with an ampersand.

I	(a) Cardiac arrest	I469
	(b) Brain death	T818
	(c) Surgery	&Y839

Code line I(b) using **Step 7**. Brain death is not a codable condition but can be a complication of surgery.

Complications (from) (of)
- surgical procedure
- - specified NEC T818

Code I(c) surgery, Y839, as indexed under Complication, surgical operation NEC. Precede the E-code with an ampersand.

b. Condition necessitating surgery

(1) When a complication of surgery is reported and the underlying condition which necessitated the surgery is stated or implied, place an ampersand (&) preceding this condition to indicate the reason for surgery.

I	(a) Pulmonary embolism	T817

	(b) Surgery for	&Y839
	(c) Gangrene of foot	&R02

Code the pulmonary embolism as the complication, Y839 for the surgery, and precede the code for gangrene with an ampersand to identify the reason for surgery. Precede the surgery code with an ampersand since the complication is coded to Chapter XIX.

(2) When the condition necessitating the surgery is not stated or implied and the complication is classifiable to Chapters I-XVIII, place an ampersand preceding the code for the complication.

I	(a) Renal failure	&N990
	(b) Surgery	Y839

Code I(a), renal failure, N990, as the complication of the surgery (Y839) on I(b). Precede the N990 with an ampersand since it is classified to Chapter I-XVIII and the reason for the surgery is not reported.

(3) **Do not** ampersand a condition necessitating surgery unless a complication of the surgical procedure is coded.

I	(a) ASHD	I251
II	SP mastectomy, Cancer of breast	C509

Do not precede the reason for surgery, C509 with an ampersand since no complication of the mastectomy is reported.

(4) When the condition that necessitated the surgery is not reported, but the organ or site is implied by the operative term, code disease of the organ or site.

Exception:

Appendectomy

Code appendicitis (K37) when appendectomy is the only operative procedure reported. If appendectomy is reported with other abdominal or pelvic surgery, assume the appendectomy to be incidental to the other surgery and **do not** code K37.

Use the following codes when these surgical procedures are reported and the condition necessitating the surgery is not reported:

Aorta (with any other vessel NEC) bypass or graft	I779
Aorta coronary bypass or graft	I251
Atrio-ventricular shunt	G919
Bariatric surgery	E668
Billroth (I or II)	K3190
Brock valvulotomy	Q223
Cardiac revascularization	I251
Carotid endarterectomy	I679
Choledochoduodenostomy	K839
Cholecystectomy	K829
Cholelithotomy	K802
Colostomy	K639
Coronary artery bypass graft (CABG)	I251

Coronary endarterectomy	I251
Coronary revascularization	I251
Endarterectomy (artery) (aorta)	I779
Femoral bypass	I779
Femoral-popliteal bypass	I779
Gastrectomy	K3190
Gastric stapling	E668
Gastroenterostomy	K929
Gastro-intestinal surgery NOS	K929
Gastrojejunostomy	K929
Gastrojejunectomy	K929
Herniorrhaphy	code hernia
Hip fixation	S720
Hip pinning	S720
Hip prosthesis	M259
Hip replacement	M259
Hysterectomy	N859
Ileal conduit	N399
Ileal loop	N399
Iliofemoral bypass	I779
Lobectomy-when indicating lung	J9840
Mammary artery(internal) implant	I251
Nephrectomy	N289
Revascularization of heart	I251
Revascularization, myocardial	I251
T and A	J359
Thoracoplasty	J989
Tonsillectomy	J359
Ureterosigmoid bypass	N399
Ureterosigmoidostomy	N399
Vein stripping	I839
Ventricular peritoneal shunt	G919
Vineberg operation	I251

When the condition that necessitated the surgery is not reported, do not assume a disease condition for surgical procedures such as:

amputation	pelvic exenteration
arteriovenous shunt	portocaval shunt
chordotomy	radical neck dissection
craniotomy	rhizotomy
cystostomy	sympathectomy
D & C	tracheotomy
gastrostomy	tracheostomy
laminectomy	tubal ligation
laparotomy	vagotomy
lobectomy NOS	vasectomy
lobotomy	vas ligation

If one of these types of procedures is the only entry on the certificate, code R99.

When the following complications of surgery are reported and the reason for the surgery is not reported, use the following codes as the reason the surgery was performed:

	Reason for Surgery Code		
Postsurgical hypothyroidism	E079		
Postsurgical hypoinsulinemia	K869		
Postsurgical blind loop syndrome	K639		
Other and unspecified postsurgical malabsorption	K639		
I (a) Postsurgical blind loop syndrome	Y839	K912	&K639

When a complication is reported due to:

"Surgery" with the underlying condition that necessitated the surgery stated, code:

the complication to Chapters I-XIX, the surgery to the appropriate external cause code (Y83-) preceded by an ampersand, if required, and the underlying condition necessitating the surgery preceded by an ampersand.

I	(a) Hemorrhage	T810		
	(b) Surgery	&Y839		
	(c) Ca. of lung	&C349		

Code I(a) as postoperative hemorrhage (T810). Code the external cause code for the surgical procedure and precede by an ampersand. Code C349, cancer of lung and precede by an ampersand to identify the stated underlying condition for which surgery was performed.

I	(a) Pulmonary hemorrhage	R048		
	(b) Lung cancer	&C349		
II	Pneumonia due to surgery for pulmonary hemorrhage	J958	Y839	R048

Code line I(a) and (b) as indexed. Precede cancer of lung with an ampersand to indicate the underlying reason for which surgery was performed. Since the first entry in Part II, pneumonia, is reported due to surgery, code as a complication of surgery.

"Surgery" with the condition which necessitated the surgery not stated and only one condition for which surgery could have been performed is reported, code:

the complication to Chapters I-XIX, the surgery to the appropriate external cause code (Y83-) preceded by an ampersand, if required. Since only one condition for which the surgery could have been performed is reported, code the condition and precede with an ampersand to identify the reason for the surgery.

I	(a) Mesenteric thrombosis	K918
	(b) Surgery	Y839
II	ASHD	&I251

Code mesenteric thrombosis as the complication of the surgery and code Y839 for

the surgery. Since ASHD is the only condition on the certificate for which surgery could have been performed, precede the code for this condition by an ampersand.

"Surgery" with the condition which necessitated the surgery not stated and two or more conditions for which surgery could have been performed are reported, code:

the complication to Chapters I-XIX and the surgery to appropriate external cause code (Y83-) preceded by an ampersand, if required. Ampersand the first mentioned condition for which the surgery could have been performed.

I	(a) Wound dehiscence	T813	
	(b) Surgery	&Y839	
II	Cancer of lung, gastric ulcer	&C349	K259

Code I(a), wound dehiscence, T813, as the complication of the surgery and code I(b), surgery, Y839. Code Part II as indexed and precede the code for cancer of lung by an ampersand since it is the first mentioned condition for which the surgery could have been performed.

"Surgery" without indication of the condition which necessitated the surgery, code:

the complication to Chapters I-XIX, and the surgery to appropriate external cause code (Y83-) only. If the complication is classifiable to Chapters I-XVIII, precede the code for the complication with an ampersand.

I	(a) Shock & hemorrhage	T811	T810
	(b) Surgery	&Y839	

Code I(a), shock and hemorrhage, T811 T810, both as complications of the surgery. Code I(b), surgery, Y839 and precede the code by an ampersand.

Surgical procedure such as **aneurysmectomy**, **cholelithotomy, hemorrhoidectomy** or **herniorrhaphy** which indicates the condition for which the surgery was performed, code:

the complication to Chapters I-XIX, the surgery to the appropriate external cause code (Y83-) preceded by an ampersand, if required, and code the condition implied by the surgery following the external cause code for the surgery. Place an ampersand preceding the code for the condition.

I	(a) CHF	I978
	(b) Cholelithotomy	Y838 &K802

Code I(a), CHF (congestive heart failure), as the complication of surgery. Code I(b), cholelithotomy, Y838 K802. Cholelithotomy indicates cholelithiasis (K802) was the condition for which surgery was performed. Precede K802 by an ampersand.

Surgical procedure that indicates an organ or site with one related condition for which the surgery could have been performed, code:

the complication to Chapters I-XIX, the surgery to the appropriate external cause code (Y83-)

preceded by an ampersand, if required. Code the condition for which surgery could have been performed and precede with an ampersand.

I	(a) MI	T818
	(b) Gastrectomy	&Y836
II	Bleeding gastric ulcer	&K254

Code I(a), MI, as the complication of the surgery. Code I(b), gastrectomy, Y836, as indexed and precede with an ampersand. Code Part II, bleeding gastric ulcer, as indexed and precede with an ampersand to indicate it was the condition for which surgery was performed.

I	(a) Cardiac arrest	T828
	(b) CABG	&Y832
II	Heart disease	&I519

Code I(a), cardiac arrest, as the complication of the surgery. Code I(b), CABG, Y832 as indexed and precede with an ampersand. Code Part II, heart disease, as indexed and precede with an ampersand to indicate it was the condition for which surgery was performed.

Surgical procedure that indicates an organ or site without a related condition for which the surgery could have been performed, code:

the complication to Chapters I-XIX, the surgery to the appropriate external cause code (Y83-) preceded by an ampersand, if required, and code disease of the organ or site following the external cause code for the surgery. Place an ampersand preceding the code for the condition.

I	(a) Cardiac arrest	I469
	(b) Pneumonia	J958
	(c) Pancreatectomy	Y836 &K869

Code I(a), cardiac arrest, as indexed. Code I(b), pneumonia, as the complication of the surgery. Code I(c), pancreatectomy, as indexed, and since the surgery indicates a disease of the pancreas, code this as the reason for surgery. Precede K869 by an ampersand.

Prophylactic or nontherapeutic surgery, code

the complication to Chapters I-XIX, and the surgery to the appropriate external cause code (Y83-) preceded by an ampersand, if required. Do not assume or ampersand a disease condition. When the complication is classifiable to Chapters I-XVIII, precede the code for the complication with an ampersand.

I	(a) Sepsis	A419
	(b) Infection	T814
	(c) Liposuction	&Y838
II		

Code I(a), sepsis, as indexed. Code I(b), infection, as the complication of the nontherapeutic surgery. Code I(c) as a specified type of surgical operation.

c. Conditions qualified as postoperative

(1) When the following postoperative terms or a synonymous term qualifies a condition, determination must be made as to whether the condition is a surgical complication or the condition for which the surgery was performed.

p.o	postoperative	status postop
post-named surgery (postgastrectomy)	status p.o.	status postoperative
postop	status post-named surgery (status post gastrectomy)	status post surgery

(2) The following conditions are common complications of surgery. Code these conditions as postoperative complications when preceded by or followed by one of the postoperative terms except when it is stated elsewhere on the certificate as the reason the surgery was performed.

abscess	hemorrhage, hematoma	sepsis
adhesions	infarction	septicemia
aspiration	infection	septic shock
atelectasis	occlusion	shock
bowel obstruction	peritonitis	thrombophlebitis
cardiac arrest	phlebitis, phlebothrombosis	thrombosis
embolism	pneumonia	wound infection
fistula	pneumothorax	
gas gangrene	renal failure (acute)	
hemolysis, hemolytic		
infection		

This list is not all inclusive.

(3) When "postoperative," "postop," "status postoperative," etc., qualifies (preceding or following) a complication:

(a) If the complication is classified to Chapters I-XVIII, code the external cause code followed by the code for the complication.

I (a) Pneumonia postgastrectomy — Y836 J958 &K3190

Code pneumonia as the complication of surgery when reported as "postoperative" or a synonymous term. Since the reason for surgery is not stated, code disease stomach and precede by an ampersand to indicate the reason for surgery.

I (a) Postgastrectomy dumping syndrome — Y836 K911
(b)
(c) Carcinoma of stomach — &C169

Code I(a), Y836, as indexed under Complication, gastrectomy, and K911, as indexed under Syndrome, dumping. Code I(c) C169, as indexed under Neoplasm, stomach, malignant. Place an ampersand (&) preceding C169 to identify the underlying reason for surgery.

I	(a) Pulmonary edema	J958	
	(b) P.O. bowel obstruction	Y839	K566
	(c) Ca. of cecum	&C180	
II	Surgery for bowel obstruction	K566	

Code I(a), pulmonary edema, as the complication of surgery. Code I(b) to surgery Y839 and code bowel obstruction as indexed K566 since it is stated as the reason for surgery. Code I(c), cancer of cecum, as indexed and precede the code by an ampersand to indicate the underlying reason for surgery. Part II, do not enter a code for surgery since P.O. was reported on line (b) and a surgery code was entered there. Code bowel obstruction as indexed.

(b) If the complication is classified to Chapter XIX, code the nature of injury code followed by the external cause code.

I	(a) Sepsis and anuria	A419	R34
	(b) P.O. peritonitis	T814	&Y839
	(c) P.O. ca. of colon $\bar{c}$ obstruction	&C189	K566

Code peritonitis as the complication as indexed under Peritonitis, postprocedural, T814. Code Y839 for the procedure. Peritonitis is considered to be a complication of surgery when reported as "postop" and not reported as the reason for surgery. Place an ampersand preceding the surgery code and the cancer of colon to identify the underlying reason for surgery.

I	(a) Cardiac arrest	I469	
	(b) Peritonitis, postop	T814	&Y839
	(c) Cholelithiasis	&K802	

Code I(a) as indexed. Code I(b), peritonitis, as the complication, T814 and Y839 for the procedure. Peritonitis is considered a complication of surgery when reported as "staus postop" and not reported as the reason for surgery. Precede the E-code with an ampersand. Code I(c), cholelithiasis, as indexed and precede the code by an ampersand to indicate the condition necessitating surgery.

I	(a) MI postgastrectomy	T818	&Y836
II	Gastric ulcer surgery	&K259	

Code I(a), M.I. postgastrectomy, T818 Y836. M.I. is considered to be a complication of surgery when reported as "postoperative" and not reported as the reason for surgery. Precede the E-code with an ampersand. Code Part II, gastric ulcer, K259 as indexed and precede the code by an ampersand to indicate the condition necessitating surgery. Do not enter a code in Part II for surgery since gastrectomy was reported on I(a) and the code was entered there.

I	(a) Postoperative embolism	T817	&Y836
	(b) Appendectomy		
	(c) Acute appendicitis	&K358	

Code I(a), postoperative embolism, as indexed to T817 and Y836 as indexed under Complication, appendectomy. Precede the E-code with an ampersand. Code I(c), acute appendicitis, as indexed and precede the code by an ampersand to identify the underlying condition that necessitated surgery.

I	(a)	Heart failure	I509	
	(b)	ASHD	&I251	
II		Thrombophlebitis, postoperative	T817	&Y839

Code I(a) and I(b) as indexed. Code Part II, thrombophlebitis, postoperative, T817 Y839. Precede the E-code (Y839) by an ampersand. Thrombophlebitis is considered to be a complication of surgery when reported as "postoperative" and not reported as the condition that necessitated surgery. Precede the code on I(b), I251 (ASHD), by an ampersand to indicate the underlying condition necessitating surgery.

I	(a)	Pneumonia	J189	
	(b)	P.O. infection (wound)	T814	&Y839
	(c)	Intestinal obstruction	&K566	

Code I(a) as indexed. Code I(b), p.o. infection (wound), T814 Y839. Precede the E-code with an ampersand. Infection is considered to be a complication of surgery when reported as "postop" and not reported as the reason for surgery. Code I(c), intestinal obstruction, K566 and precede the code by an ampersand to indicate the condition necessitating surgery.

(c) When "postoperative intestinal obstruction" (any K560-K567) is reported and no condition which could have necessitated the procedure is reported:

(i) Code the postoperative intestinal obstruction as the condition which necessitated the surgical procedure if another condition is reported due to the postoperative obstruction.

I	(a)	Peritonitis	T814	
	(b)	Postoperative bowel	&Y839	&K566
	(c)	obstruction		

Code I(a), peritonitis, as the complication of surgery. Code I(b), postoperative bowel obstruction Y839 K566. Precede the E-code with an ampersand. Precede the K566 with an ampersand to indicate the condition necessitating surgery.

(ii) Code the postoperative intestinal obstruction to K913 as the complication if no other condition is reported due to postoperative obstruction.

I	(a)	Postoperative ileus	Y839	&K913

Code I(a) Y839 K913. Precede K913 by an ampersand. Consider the postoperative ileus to be the complication since no other condition is reported due to this

condition.

NOTE:

(4) Status post - When status post (s/p) qualifies a condition, disregard the statement of status post and code the condition as indexed. This applies whether or not surgery is mentioned elsewhere on the certificate.

I	(a) Cardiogenic shock	R570	
	(b) Myocardial infarction	I219	
	(c) Ischemic heart disease; status post MI; CABG	I259	I219

Code each condition as indexed. No code is entered for the surgery since no complication is reported. Assume the ischemic heart disease was the reason the CABG was performed.

I	(a) S/P cardiac arrest	I469
	(b) Arteriosclerosis	I709
II	S/P gastrectomy, cancer stomach	C169

Code each condition as indexed. No code is entered for the surgery since no complication is reported.

I	(a) Status post MI	I219
	(b) ASHD	I251

Code the MI as indexed.

d. Complication as first entry on lowest used line in Part I

(1) When one of the conditions listed below is reported as the first entry on the lowest used line in Part I with surgery (any) reported on same line or in Part II, code this condition as a complication of surgery.

Do not apply this instruction:

(a) When the surgery is stated to have been performed 28 days or more prior to death.

(b) When the condition on the lowest used line predates the surgery.

(c) When the surgery is stated to have been performed for the condition reported as the first entry on the lowest line.

Acute renal failure
Aspiration
Atelectasis
Bacteremia
Cardiac arrest (any I469)
Disseminated intravascular coagulopathy (DIC)
Embolism (any site)

Gas gangrene
Hemolysis, hemolytic infection
Hemorrhage NOS
Infarction (any site)
Infection NOS
Occlusion (any site)
Phlebitis (any site)
Phlebothrombosis (any site)
Pneumonia (J120-J168, J180-J189, J690, J698)
Pneumothorax
Pulmonary insufficiency
Renal failure (acute) NOS
Septicemia (any A400-A419)
Shock (R570-R579)
Thrombophlebitis (any site)
Thrombosis (any site)

I	(a) Pneumonia	J958	
	(b)		
	(c)		
II	Diabetic gangrene, amputation	&E145	Y835

Code pneumonia as a complication of the amputation since it is the first entry on the lowest used line in Part I and surgery, not indicated to have been performed 28 days or more prior to death, is reported in Part II.

I	(a) Pneumonia	J189	
	(b) Pulmonary embolism, gastrectomy	T817	&Y836
	(c)		
II	Cancer of stomach	&C169	

Code pulmonary embolism as a complication of gastrectomy since it is the first entry on the lowest used line in Part I and gastrectomy, not stated to have been performed 28 days or more prior to death, is reported on the same line as the embolism.

Date of death 09/17/96

I	(a) Pleural effusion	J90	
	(b) Pulmonary embolism & pneumonia	T817	J189
	(c)		
II		&Y839	

Operation block
/ 9/15/96 /

NOTE: When a date is entered in the operation block, code as if surgery was performed on that date.

Code I(a) as indexed. Code pulmonary embolism as the complication of surgery since this condition is the first condition on the lowest used line in Part I and surgery

was performed less than 28 days prior to death.

I	(a) Pulmonary infarction	I269	
	(b)		
	(c)		
II	Cardiac catheterization		

Cardiac catheterization is not classified as a surgical procedure; therefore, do not code the pulmonary infarction as a complication.

(2) When any of the conditions listed below are reported as the first entry on the lowest used line in Part I and **abdominal or pelvic surgery** is reported on the same line or in Part II, code complication as indexed and the surgery to appropriate external cause code (Y83-) where it is indicated on the record by the certifier.

Peritonitis Intestinal obstruction (K560-K567)

I	(a) Pneumonia	J189	
	(b) Peritonitis	K659	
	(c) Intestinal obstruction	K913	
II	Colostomy - ulcerative colitis	Y833	&K519

Code intestinal obstruction on I(c) as a complication of the surgery reported in Part II, since the surgery was abdominal and there is no indication that this procedure was performed 28 days or more prior to death.

(3) When any of the conditions listed below are reported as the first entry on the lowest used line in Part I and **surgery of the same site or region** is reported on the same line or in Part II, code complication as indexed and the surgery to appropriate external cause code (Y83-) where it is indicated on the record by the certifier.

Hemorrhage of a site Fistula of site(s)

I	(a) Pneumonia	J189	
	(b) Gastrointestinal hemorrhage	T810	
II	Gastrectomy for stomach cancer	&Y836	&C169

Code gastrointestinal hemorrhage as a complication of the surgery reported in Part II since the surgery was of the same region and there is no indication that surgery was performed 28 days or more prior to death.

(4) When conditions listed in paragraph d(1), (2), and (3) are reported as the first entry on the lowest used line in Part I and **surgery stated to have been performed 28 days or more prior to death** is reported on the same line or in Part II, code condition as indexed. Do not code as a complication of the surgery.

I	(a) Congestive heart failure	I500	
	(b) Shock	R579	
	(c) Acute renal failure	N179	
II	Surgery performed 6 wks. ago for colon cancer	C189	

Code all conditions on this record as indexed. Do not code acute renal failure as a complication of surgery since the surgery was performed 28 days or more prior to death.

(5) When adhesions are reported as the first entry on the lowest used line in Part I and **surgery stated to have been performed less than one year prior to death** is reported on same line or in Part II, code adhesions to K918 and code the surgery to appropriate E-code (Y83-).

I	(a) Septic shock	A419	
	(b) Peritonitis	K659	
	(c) Adhesions	K918	
II	Surgery - 6 mos. ago for ca. of colon	Y839	&C189

Code adhesions on I(c) as a complication of surgery and code the external cause code for the surgery as the first entry in Part II. Code the condition for which surgery was performed and precede by an ampersand.

(6) When adhesions are reported as the first entry on the lowest used line in Part I and **surgery stated to have been performed one year or more prior to death** is reported on same line or in Part II, code adhesions to K918, Other postprocedural disorders of the digestive system and code the surgery to Y883, sequela of surgery.

I	(a) Renal failure	N19	
	(b) Intestinal obstruction	K566	
	(c) Adhesions	K918	
II	Surgery - 16 months ago for diverticulitis	Y883	&K579

Code adhesions on I(c) as a complication of the surgery reported in Part II. Since this surgery was performed more than 1 year ago, code Y883 for the sequela of surgery. Code diverticulitis as the condition for which surgery was performed.

e. Ill-defined condition as first entry on lowest used line in Part I

When an ill-defined condition classifiable to the following codes:

I461 (Sudden cardiac death, so described)

I959 (Hypotension, unspecified)

I99 Except occlusion and infarction (Other and unspecified disorders of circulatory system)

J960 (Acute respiratory failure)

J969 (Respiratory failure, unspecified)

P285 (Respiratory failure of newborn)

R000-R568, R590-R948, R960-R99 (Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere

classified) is reported as the first entry on the lowest used line in Part I with surgery reported on the same line or in Part II, proceed:

(1) Code the ill-defined condition, then code the remaining conditions as if the ill-defined condition had not been reported.

I	(a) Senility and MI	R54	T818
II	Gastrectomy	&Y836	&K3190

Code senility on I(a) R54 as indexed. Then code MI as if senility had not been reported. MI is coded as the complication of the surgery reported in Part II. Gastrectomy indicates a disease of the stomach. Precede both the code for the surgery and the code for Disease, stomach, with an ampersand.

I	(a) Renal failure	N990	
	(b) Cause unknown	R97	
II	Mastectomy	Y836	&N649

Code cause unknown on I(b) as indexed, then code renal failure as the complication of the surgery reported in Part II as if cause unknown had not been reported. Code Part II, mastectomy, Y836 N649. Code Disease, breast as the condition necessitating the mastectomy and precede it by an ampersand.

Exceptions:

Code each entry as indexed when:

The first entry on the lowest line in Part I is classifiable to	**And a condition classifiable to one of the following codes is reported on the same line or in Part II**
I461	A520 B24 B332 I010-I099 I110-I119 I130-I139 I260-I4290 I510-I518 M349 P293 Q200-Q269
J960	E841 E849
J969	E841 E849
R000 Tachycardia, unspecified	I010-I099 I110-I119 I130-I461 I470-I519 J380-J399
R002 Palpitations	I010-I099 I110-I119 I130-I461 I470-I519
R010 Benign and innocent cardiac murmurs R011 Cardiac murmur, unspecified R012 Other cardiac sounds	I010-I099 I110-I119 I130-I461 I470-I519
R02 Gangrene NEC	A480 E135 K410

	E100-E104	E136	K412
	E105	E137	K413
	E106	E139	K419
	E107	E140-E144	K420
	E109	E145	K429
	E110-E114	E146	K430
	E115	E147	K439
	E116	E149	K440
	E117	I702	K449
	E119	I709	K450
	E120-E124	I730-I739	K458
	E125	K352-K389	K460
	E126	K400	K469
	E127	K402	
	E129	K403	
	E130-E134	K409	

R030 Elevated blood pressure reading, without diagnosis of hypertension	I10-I139

The first entry on the lowest line in Part I is classifiable to	**And a condition classifiable to one of the following codes is reported on the same line or in Part II**

R040 Epistaxis	C300-C319C783	I10
	C910-C959	J00-J019
	D023	J068-J069
	D140	J300-J311
	D385	J320-J348
		J393-J399
R041 Hemorrhage from throat	C090-C148	D141
	C320-C329	D370
	C783	D380
	C798	J00
	C910-C959	J020-J040
	D000	J042-J069
	D020	J311-J312
	D104-D109	J350-J399
R042 Hemoptysis R048 Hemorrhage from other sites in respiratory passages	A162-A1690	D141-D143
	C320-C349	D380-D381
	C780	J040-J22
	C783	J370-J387
	C910-C959	J393-J989
	D020-D022	
R05 Cough	F453	J111
	J101	J1110
	J1010	R042
R060 Dyspnea	A162-A1690	D381-D383
	B909	D385-D386
	C33-C399	J40-J989
	C780-C783	P221
	D142-D159	

The first entry on the lowest line in Part I is classifiable to	**And a condition classifiable to one of the following codes is reported on the same line or in Part II**

R061 Stridor	J385
R062 Wheezing	A162-A1690 B909 C33-C399 C780-C783 D142-D159 D381-D383 D385-D386 J40-J989 P221
R064 Hyperventilation	F453
R066 Hiccough	F453
R090 Asphyxia	T360-T659
R104 Other and unspecified abdominal pain	R100 R193
R11 Nausea and vomiting	J1010 J108 J1110 J118 K250-K289 K800-K820
R17 Unspecified jaundice	B150-B199 C220-C259 C787-C788 K700-K839
R18 Ascites	C160-C269 C56 C784 C787-C788 C796 C80-C969 K700-K709 K740-K746
R233 Spontaneous ecchymoses	D690-D699

The first entry on the lowest line in Part I is classifiable to	**And the condition classifiable to one of the following codes is reported on the same line or in Part II**
R250 Abnormal head movements R251 Tremor, unspecified R252 Cramp and spasm R253 Fasciculation R258 Other and unspecified abnormal involuntary movements	G110-G119 G20-G259 G400-G419 G510 G800-G839
R260 Ataxic gait R261 Paralytic gait R262 Difficulty in walking, not elsewhere classified R268 Other and unspecified abnormalities of gait and mobility	A521
R270 Ataxia, unspecified	A521 A523 G110-G119
R278 Other and unspecified lack of coordination	A521 G110-G119
R290 Tetany	E200-E209
R291 Meningismus	J1010 J108 J1110 J118
R298 Other and unspecified symptoms and signs involving the nervous and musculoskeletal	G800-G839

systems	

The first entry on the lowest line in Part I is classifiable to	**And a condition classifiable to one of the following codes is reported on the same line or in Part II**	
R300 Dysuria R301 Vesical tenesmus R309 Painful micturition, unspecified	C600-C689 C790-C791 C796 C798 D060-D061	D280-D309 D390-D419 N000-N999 Q600-Q649
R31 Unspecified hematuria	B508 B54 C600-C689 C790-C791 C796 C798	D060-D061 D280-D309 D390-D419 N000-N999 Q600-Q649
R32 Unspecified urinary incontinence R33 Retention of urine	C600-C689 C790-C791 C796 C798 D060-D061	D280-D309 D390-D419 N000-N999 Q600-Q649
R34 Anuria and oliguria	C600-C689 C790-C791 C796 C798 D060-D061	D280-D309 D390-D419 N000-N999 Q600-Q649 T795
R35 Polyuria R36 Urethral discharge R390 Extravasation of urine R391 Other difficulties with micturition R392 Extrarenal uremia R398 Other and unspecified symptoms and signs involving the urinary system	C600-C689 C790-C791 C796 C798 D060-D061	D280-D309 D390-D419 N000-N999 Q600-Q649

The first entry on the lowest line in Part I is classifiable to	**And a condition classifiable to one of the following codes is reported on the same line or in Part II**	
R400 Somnolence R401 Stupor	E100 E107 E110 E117 E120 E127 E130 E137 E140	E147 E15 K729 S020-S024 S026-S029 S060-S099 T902 T905-T909
R402 Coma, unspecified	E100 E101 E102-E106 E107 E109 E110 E111 E112-E116 E117 E119	E132-E136 E137 E139 E140 E141 E142-E146 E147 E149 E15 E160-E162

R400 Somnolence R401 Stupor	E100 E147 E107 E15 E110 K729 E117 S020-S024 E120 S026-S029 E127 S060-S099 E130 T902 E137 T905-T909 E140
R402 Coma, unspecified	E100 E132-E136 E101 E137 E102-E106 E139 E107 E140 E109 E141 E110 E142-E146 E111 E147 E112-E116 E149 E117 E15 E119 E160-E162 E120 K729 E121 S020-S024 E122-E126 S026-S029 E127 S060-S099 E129 T902 E130 T905-T909 E131
R529 Pain, unspecified	G547
R568 Other and unspecified convulsions	A35 G400-G419 O100-O11 O13-O16
The first entry on the lowest line in Part I is classifiable to	**And a condition classifiable to one of the following codes is reported on the same line or in Part II**
R590 Localized enlarged lymph nodes	B270-B279 C810-C969
R591 Generalized enlarged lymph nodes	B24 B589 B270-B279 C810-C969 B588
R599 Enlarged lymph nodes, unspecified	B270-B279 C810-C969
R600 Localized edema R601 Generalized edema	E43 N000-N058 E877 N059
R609 Edema, unspecified	E43 E877 N000-N058
R628 Other lack of expected normal physiological development	B24 E45 E46
R630 Anorexia	F500

	B588
R599 Enlarged lymph nodes, unspecified	B270-B279 C810-C969
R600 Localized edema R601 Generalized edema	E43 N000-N058 E877 N059
R609 Edema, unspecified	E43 E877 N000-N058
R628 Other lack of expected normal physiological development	B24 E45 E46
R630 Anorexia	F500
R631 Polydipsia	E232 N251
R64 Cachexia	B24 E41 E46
R730 Abnormal glucose tolerance test	E100-E162 E891
R780 Finding of alcohol in blood	F101-F109

The first entry on the lowest line in Part I is classifiable to	**And a condition classifiable to one of the following codes is reported on the same line or in Part II**
R788 Finding of other specified substances, not normally found in blood	A000-A079 A090-A499 J13-J159 J180-J189
R798 Other specified abnormal findings of blood chemistry	E100 E127 E101 E129 E102-E106 E130 E107 E131 E109 E132-E136 E110 E137 E111 E139 E112-E116 E140 E117 E141 E119 E142-E146 E120 E147 E121 E149 E122-E126
R799 Abnormal finding of blood chemistry, unspecified	E101 E127 E107 E131 E111 E137 E117 E141 E121 E147
R80 Isolated proteinuria	C900 N000-N079 D511 N170-N19 D649 N250-N289
R81 Glycosuria	E100-E149 E748
R823 Hemoglobinuria	B508 B54 D595-D596

The first entry on the lowest line in Part I is classifiable to	And a condition classifiable to one of the following codes is reported on the same line or in Part II
R824 Acetonuria	E101 E127 E107 E131 E111 E137 E117 E141 E121 E147
R826 Abnormal urine levels of substances chiefly nonmedicinal as to source	F101-F109
R893 Abnormal findings in specimens from other organs, systems and tissues	F101-F109

I (a) Pneumonia J189
(b) Coma R402
II Surgery for diabetic gangrene E145

Code I(a) and I(b) as indexed. Coma is reported as the first condition on the lowest used line, **but** diabetic gangrene is reported in Part II. Therefore, pneumonia cannot be coded as a complication of surgery. Do not enter a code for surgery since no complication is reported.

I (a) Aspiration pneumonia J690
(b) Jaundice R17
II Cholecystectomy for gallstones K802

Code I(a) and I(b) as indexed. Jaundice is reported as the first condition on the lowest used line with gallstones reported in Part II. Therefore, aspiration pneumonia cannot be coded as a complication of surgery. Code Part II, K802 (gallstones). Do not enter a code for the cholecystectomy since no complication was reported.

I (a) Sepsis A419
(b) Gangrene, pneumonia, and R02 J189 I709
(c) arteriosclerosis
II Surgery

Code I(a) and I(b) as indexed. Gangrene is reported as the first condition on the lowest used line, but arteriosclerosis is reported on the same line; therefore, pneumonia cannot be a complication of surgery. Do not enter a code for surgery since no complication is reported.

f. Relating condition for which surgery was performed to the site of the surgery

(1) When a condition of unspecified site is reported with surgery of a defined site, code the condition of unspecified site to the defined site.

I (a) Aneurysm I719
II Operation for aortic aneurysm I719

Code I(a), aneurysm of unspecified site to aortic aneurysm, I719, since the surgery is of a defined site. Code aortic aneurysm in Part II. Do not enter a code for the surgery since there is no reported complication.

(2) When a condition of a site is reported with surgery of a more defined part of the site, code the condition to the more specified site.

I	(a) Carcinoma colon	C186		
II	Left colectomy			

Code I(a), carcinoma colon to carcinoma left colon, C186, since the surgery is of a more specified part of the colon. Do not enter a code for the surgery since there is no reported complication.

I	(a) Valvular heart disease	I059	I069	
II	Status post mitral and aortic valve repair			

Code I(a) valvular heart disease of unspecified valve to disease, mitral and aortic valves since the surgery is of specified valves. Do not enter a code for the surgery since there is no reported complication.

(3) When a condition of a site is reported with surgery for the same condition of unspecified or a less defined part of the site, code the condition to the most defined site.

I	(a) Cancer of head of pancreas	C250		
II	Pancreatectomy for cancer	C250		

Code I(a), cancer head of pancreas, C250. Code Part II as cancer of head of pancreas since elsewhere a more defined site was reported of the condition for which surgery was performed. Do not enter a code for the surgery since there is no reported complication.

(4) Do not apply these instructions when more than one condition or a condition of multiple specified sites which could have necessitated the surgery is reported.

I	(a) Cardiac arrest	I469			
	(b) Respiratory arrest	R092			
	(c) Carcinoma of lung, liver, brain	C349	C787	C793	
II	Findings of operation: Carcinoma	C80			

Code I(a), I(b) and I(c) as indexed and according to neoplasm instructions. Code Part II, carcinoma, C80. Do not code the carcinoma to a more defined site since multiple specified sites are reported for which the surgery could have been performed. Do not enter a code for the surgery since there is no reported complication.

g. Complications of amputation and amputation stump

When a complication (stated or implied) occurs as a result of an amputation, code the complication to Chapters I-XIX. When the complication is classifiable to Chapters I-XVIII and the condition that necessitated the amputation is not reported, precede the code for the complication with an ampersand.

I	(a) Renal failure	&N990
	(b) Below knee amputation of leg	Y835

Code I(a), renal failure, N990 as the complication of surgery. Code I(b), below knee amputation of leg, Y835. Precede the N990 with an ampersand since it is classified to Chapter XIV and the condition that necessitated the amputation is not reported.

When there is a complication of an amputation stump, code the complication to T873-T876 or to the appropriate code in Chapters I-XVIII. (Do not use T873-T876 for "stump" of internal organs).

I	(a) Infected amputation stump	T874	&Y835
	(b) Osteosarcoma of leg	&C402	

Code I(a), infected amputation stump T874 Y835. Precede the E-code, Y835, by an ampersand. Code I(b), osteosarcoma of leg, C402. Precede C402 by an ampersand to indicate the condition that necessitated the amputation.

3. Complications of medical procedures other than surgical (Y84)

Medical procedures are any type of nonsurgical procedures used in the treatment of diseases or injuries. Although almost any condition reported due to medical procedures is regarded as a complication, there are a few diseases that are not considered complications. Do not code the conditions listed under 2. a. (1) (a) and (b) in Section V, Part R as complications of medical procedures. The medical procedure (Y84) is not coded when there is no evidence of a complication. If the reason for the medical procedure is not reported, do not assume a disease condition.

Interpret "due to medical procedures" as a condition(s) on an upper line with a medical procedure as the first condition on the next lower line.

a. When a condition is reported due to a named medical procedure other than a surgical operation or is modified by a named procedure and can be considered as a complication(s) or adverse effect, code as follows:

STEP 1: Determine if the complication is in the Index qualified by the specific procedure reported.

I	(a) Kidney blockage	&N990
	(b) Postcystoscopic procedure	Y848

Code I(a) as indexed using **Step 1**

Block
- kidney
- - postcystoscopic or postprocedural N99.0.

Code I(b) Y848 as indexed under Complication, procedures other than surgical operation, specified NEC. Precede N990 with an ampersand.

STEP 2: If the Index does not qualify the complication with the specified procedure, determine if the procedure is indexed under Complications (from) (of).

I (a) Urinary tract infection T835
(b) Post-indwelling urinary catheter &Y846

Code I(a) using **Step 2**

Complications (from) (of)
- catheter (device)
- - urinary (indwelling)
- - - infection or inflammation T83.5

Select infection or inflammation since urinary tract infection is an infectious condition.

Code I(b) Y846 as indexed under Complication, catheter, catheterization (urinary). Precede the E-code with an ampersand.

I (a) Pulmonary embolism T838
(b) Catheter &Y846

Code I(a) using **Step 2**

Complications (from) (of)
- catheter (device)
- - specified NEC T83.8

Select specified since pulmonary embolism is a specified complication.

Code I(b) Y846 as indexed under Complication, catheter, catheterization (urinary). Precede the E-code with an ampersand.

When the Index does not provide for the term as specified in **STEP 1** and **STEP 2**, code the complication as if procedure NOS was reported instead of the named medical procedure as defined in the following instructions:

NOTE: Before continuing to **STEP 3**, it is important to determine the nature of the named procedure.

b. When a condition that is

(1) reported due to a named procedure cannot be assigned a code using **STEP 1** or **STEP 2** or

(2) reported due to a procedure other than surgical operation NOS or therapy NOS, and can be considered as a complication(s) or adverse effect, code as follows:

STEP 3: Determine if the complication is in the Index, qualified:

(a) as reported

(b) with any term meaning "due to" procedure or medical care (see Section II, Part C, 2, a, "Due to" written in or implied)

(c) as postprocedural

I (a) Renal failure &N990
(b) Paracentesis Y844

Code I(a) as indexed using **Step 3 (c)**

Failure
- renal
- - postprocedural N99.0

Code I(b) Y844 as indexed under Complication, paracentesis. Precede N990 with an ampersand.

STEP 4: If the Index does not provide a code for the complication in Steps 1-3, determine if:

(a) the site of the complication is in the Index under Complications (from) (of)

- medical procedure
or

(b) the system in which the complication occurred (based upon the code assigned in the Index) is in the Index under

Complications (from) (of)
- medical procedure

(c) the system in which the complication occurred (based upon the code assigned in the Index) is in the Index under

Complications (from) (of)
- postprocedural

I (a) Cardiac arrest T818
(b) Therapy &Y849
(c) Arteriosclerotic heart disease &I251

Code I(a) using **Step 4 (a)**

Complications (from) (of)
- medical procedure
- - cardiac T81.8

Select cardiac since this is the site of the complication.

Code I(b) Y849 as indexed under Complication, procedures other than surgical operation. Precede the E-code and the condition requiring treatment with an ampersand.

I	(a)	Pulmonary edema	&J958
	(b)	Endotracheal tube	Y848

Code I(a) using **Step 4 (b)**

Complications (from) (of)
- medical procedure
- - respiratory
- - - specified NEC J95.8

Select respiratory, specified since pulmonary edema is classified to J81, a specified disease in the respiratory system.

Code I(b) Y848 as indexed under Complication, procedures other than surgical operation, specified NEC. Precede J958 with an ampersand.

I	(a)	Stroke	I64
	(b)	Cerebral embolism	T817
	(c)	Renal angiogram	&Y848

Code I(b) using **Step 4 (b)**

Complications (from) (of)
- medical procedure
- - circulatory T81.7

Select circulatory since cerebral embolism is classified to I634, a specified disease in the circulatory system.

Code I(c) Y848 as indexed under Complication, procedures other than surgical operation, specified NEC. Precede the E-code with an ampersand.

STEP 5: When a reported specified complication cannot be classified to a system that is indexed, code T818, Other complications of procedures, not elsewhere classified.

I	(a)	Shock	R579
	(b)	Coagulation disorder	T818
	(c)	Hyperthermia therapy	&Y848

Coagulation disorder is not indexed as due to a procedure or as postprocedural. This condition is classified to D689, a disease of the blood-forming organs. Neither the term nor the body system is indexed under Complications (from) (of), medical procedure.

Code I(b) using **Step 5**

Complications (from) (of)
- procedure
- - specified T81.8

Select specified since coagulation disorder is a specified complication.

Code I(c) Y848 as indexed under Complication, procedures other than surgical operation, specified NEC. Precede the E-code with an ampersand.

4. Complications of procedures involving administration of drugs, radiation, and instruments

a. Many procedures (e.g., angiogram, barium enema, pyelogram) involve the administration of drugs and the use of x-ray or radioactive substances and various instruments. When complications of these procedures are reported, determine, if possible, which specific part of the procedure caused the complication. Assign the appropriate codes for the complication and the procedure. When the complication is classified to Chapters I-XVIII and the reason for the procedure is not reported, precede the code for the complication with an ampersand. If the reason for the medical care is not reported, do not assume a disease condition.

I	(a) Pulmonary embolism	T828	
	(b) Cardiac catheterization	&Y840	
	(c) Ventricular septal defect	&Q210	

Code I(a) as the complication of the catheterization. Code I(b) as indexed, Y840 and precede with an ampersand. Code I(c) as indexed and precede with an ampersand to indicate the reason for the procedure.

I	(a) Barium impaction of intestine	Y575	K564
	(b) Barium enema		
	(c) Colon polyps	&K635	

Code the barium on I(a) to adverse effect in therapeutic use, Y575, since it was the drug that caused the impaction. Code the complication, impaction, as indexed, Impaction, intestine, K564. Do not enter a code on I(b) for barium since it was coded on I(a). Code I(c) as indexed and precede with an ampersand to indicate the reason for the procedure.

I	(a) Anaphylactic shock	T886
	(b) Contrast medium (aortogram)	&Y575
II	Dissecting aortic arch aneurysm	&I710

Code I(a) as the complication of the contrast medium. Indexed as Shock, anaphylactic, correct substance properly administered. Code I(b) contrast medium as adverse effect in therapeutic use, since the drug caused the anaphylactic shock.

Code Part II as indexed and precede with an ampersand to indicate the reason for the procedure.

I	(a) Peritonitis	K659
	(b) Hemorrhage of colon	K918
	(c) Barium enema	Y848
	(d) Diverticulitis	&K579

Code I(a) as indexed. Code I(b) as the complication of the administration of the enema. Code I(c) barium enema, Y848, since the hemorrhage most likely resulted from the administration of the enema rather than the barium. Code I(d) as indexed and precede with an ampersand to indicate the reason for the procedure.

I	(a) Cerebral hemorrhage	T817
	(b) Cerebral arteriogram	&Y848

Code I(a) as the complication of the arteriogram. Code I(b) cerebral arteriogram, Y848, since the hemorrhage resulted from the procedure and precede with an ampersand. Do not assume a disease condition for the cerebral arteriogram.

b. When a complication results from the administration of anesthesia, code the complication as indexed and code the appropriate external cause code (Y480-Y485) (refer to Section V, Part R, 1, Drugs, medicaments and biological substances causing adverse effects in therapeutic use).

I	(a) Cardiac failure	I509
	(b) Anesthesia for prostate surgery	Y484
	(c)	&N429

Code I(a) as indexed and as the complication of the anesthesia. Code I(b) anesthesia to adverse effect in therapeutic use, Y484, since it was the anesthesia that caused the heart failure. Code I(c) N429, disease prostate, as the reason for surgery and precede with an ampersand.

I	(a) Cardiac failure	T818
	(b) Prostate surgery under anesthesia	&Y839
	(c) Benign prostatic hypertrophy	&N40

Code I(a) as indexed under Failure, heart, complicating surgery. Code I(b) prostate surgery as indexed. Code I(c) as indexed and precede with an ampersand to indicate the reason for surgery.

5. Complications of radiation during medical care (Y842)

When a complication results from exposure to radiation, except radio-frequency radiation, infrared heaters or lamps and visible or ultraviolet light sources, consider as exposure of patient to radiation during medical care unless there is information on the certificate that indicates otherwise. Code complications of radiation during medical care as follows:

a. Complications qualified as "radiation," "radiation-induced," "due to radiation," or "following

radiation"

(1) Coding the complication

(a) If the Index provides a code for the complication qualified by one of these terms, use that code.

(b) If the Index does not provide a code for the complication qualified by one of these terms, code the complication as indexed without the qualifier.

(2) Placement of codes

(a) If the complication is qualified as "radiation" or "radiation-induced" and classified to Chapters I-XVIII, code the external cause code followed by the code for the complication.

(b) If the complication is qualified as "radiation" or "radiation-induced" and classified to Chapter XIX, code the nature of injury code followed by the external cause code.

b. Code the external cause code to Y842, (Radiological procedure and radiotherapy).

c. Use of ampersand

(1) If the reason for the radiation therapy is reported, precede this condition with an ampersand.

(2) If the reason for the radiation therapy is not reported and a malignant neoplasm is reported, precede the neoplasm with an ampersand.

(3) If the reason for the radiation therapy is not reported and the complication is classified to Chapters I-XVIII, precede the complication with an ampersand.

I	(a) Pulmonary edema	J81
	(b) Radiation pneumonitis	Y842 J700
	(c) Radiation therapy for cancer of breast	
	(d)	&C509

Code I(b) to the external cause as indexed where the radiation is first reported followed by the code for the complication. Pneumonitis is the complication of the radiation and is indexed, Pneumonitis, radiation. Precede the code for cancer of breast with an ampersand to indicate the reason for the radiation.

I	(a) Carcinomatosis	C80
	(b) Oat cell carcinoma	&C349
	(c)	
II	X-ray fibrosis - lung	Y842 J701

Code Part II to the external cause as indexed followed by the code for the complication. Fibrosis of lung is the complication and is indexed, Fibrosis, lung, following radiation. Code I(b) as indexed and precede with an ampersand to indicate the reason for the radiation.

I	(a) Pneumonia	J700
	(b) Radiation	Y842

(c) Carcinoma of face &C760

Pneumonia is the complication of the radiation reported on I(b). Code I(a) as indexed, Pneumonia, radiation. Code the external cause as indexed on I(b). Code I(c) as indexed and precede with an ampersand to indicate the reason for the radiation.

I (a) Debility R53
(b) Radiation therapy Y842
(c) Hodgkin's disease &C819

Debility is the complication of the radiation reported on I(b). Code I(a) as indexed since the Classification does not provide a code for radiation debility. Code the external cause as indexed on I(b). Code I(c) as indexed and precede with an ampersand to indicate the reason for the radiation.

I (a) Radiation-induced acute Y842 J700
(b) bronchitis
II Carcinoma of trachea &C33

Code I(a) to the external cause as indexed, followed by the code for the complication. Acute bronchitis is the complication and is indexed Bronchitis, acute, due to radiation. Code Part II as indexed and precede with an ampersand to indicate the reason for the radiation.

I (a) Alopecia L581
(b) Radiation Y842
II Hodgkin's granuloma &C817

Alopecia is the complication of the radiation reported on I(b). Code I(a) as indexed under Alopecia, X-ray. Code the external cause as indexed on I(b). Code Part II as indexed and precede with an ampersand to indicate the reason for the radiation.

I (a) Peritonitis K659
(b) Intestinal fistula &K632
(c) Radiation therapy Y842

Intestinal fistula is the complication of the radiation reported on I(c). Code I(b) as indexed since the Classification does not provide a code for radiation intestinal fistula. Code the external cause as indexed on I(c). Precede the complication (intestinal fistula) with an ampersand since it is classified to Chapters I-XVIII and the reason for the radiation was not reported.

d. When radiation fibrosis is reported without a site or of a site not indexed, code the fibrosis to T66, Complications, radiation.

I (a) Cerebral anoxia G931
(b) Carcinoma of tongue &C029

II Radiation fibrosis, upper airway obstruction T66 &Y842 J988

Code Part II Complications, radiation for the fibrosis and the external cause as indexed. Code the nature of injury followed by the external cause. Place an ampersand preceding the E-code and the condition on I(b) to indicate the reason for the radiation.

I (a) Radiation pelvic fibrosis T66 &Y842
(b) Carcinoma of uterus &C55

Code I(a) Complications, radiation for the pelvic fibrosis and the external cause as indexed. Code the nature of injury followed by the external cause. Place an ampersand preceding the E-code and the condition on I(b) to indicate the reason for the radiation.

6. Misadventures to patients during surgical and medical care (Y60-Y69)

Except for poisoning, overdose of drug and wrong drug given in error, code most misadventures (accidents or errors) to patients during surgical and medical care to Complications of surgical and medical care (T800-T889) in the nature of injury chapter and to Y600-Y69 in the external cause chapter. Code burns from local applications or irradiation to burns in the nature of injury chapter and to Y600-Y69 in the external cause chapter. Code trauma from instruments during delivery to Chapter XV and do not use an external cause. A limited number of conditions attributable to misadventure to patient (Y600-Y69) in the external cause code, e.g., serum hepatitis, are classified to Chapters I-XVIII.

Indications of Misadventures

Hemorrhage (of a site) Rupture (of a site)	Stated as intraoperative or during medical and surgical care
Cut or cutting (of a site) Perforation (of a site) Puncture (of a site) Laceration (of a site)	Reported as postoperative, intraoperative, during or due to medical and surgical care
Burns (of a site)	From local applications or irradiation
Serum hepatitis	From blood transfusions
Fracture (thoracic area)	From cardiopulmonary resuscitation From Heimlich maneuver

This list is not all inclusive.

When a misadventure to patient during surgical and medical care (classifiable to Y600-Y69) is reported and the condition which necessitated the surgical or medical care is stated or implied, precede the code for this condition with an ampersand. Apply the instructions for Condition necessitating Surgery in Section V, Part R, 2, b.

I (a) Hemorrhage during T810
(b) craniotomy &Y600
(c) Brain tumor &D432

Code I(a) Complication, surgical procedure, hemorrhage. Since "during" is stated, interpret I(b) as a misadventure and code Misadventure, hemorrhage, surgical operation. Code I(c) as indexed and precede with an ampersand to indicate the reason for surgery.

I	(a)	Perforation of colon	T812	
	(b)	Colostomy	&Y600	&K639

Code I(a) Perforation, surgical. Interpret I(b) as a misadventure and code Misadventure, perforation, surgical operation. Since the surgery indicates a disease of the colon, code this as the reason for surgery. Precede K639 with an ampersand

I	(a)	Cardiac tamponade	I319	
	(b)	Perforation of auricle by cardiac catheter	T812	&Y605
II		Therapeutic misadventure	T889	

The perforation occurred during a cardiac catheterization. Code I(b) as accidental perforation of organ during a procedure, and accidental perforation during a heart catheterization. Code Part II as indexed, Misadventure (prophylactic) (therapeutic).

I	(a)	Peritonitis	K659	
	(b)	Accidental perforation of	T812	&Y607
	(c)	colon		
II		Self-administered tap water enema		

I(b) is a reported misadventure occurring during medical care. Code T812, accidental perforation during a procedure and Y607, accidental perforation during the administration of an enema.

I	(a)	Serum hepatitis	B169	
	(b)	Blood transfusion	Y640	
	(c)	Leukemia	&C959	

Serum hepatitis is a misadventure occurring during a blood transfusion. Code I(a) B169, serum hepatitis, and I(b) Y640, Contaminated medical or biological substance transfused or infused. Code I(c) as indexed and precede with an ampersand to indicate the reason for the transfusion.

I	(a)	Burns	T300	
	(b)	Radiation therapy	&Y632	
	(c)	Cancer of esophagus	&C159	

Code I(a) T300, radiation burns. Code I(b) Y632, Overdose of radiation given during therapy. Code I(c) as indexed and precede with an ampersand to indicate the reason for the radiation.

I	(a)	Rib fracture	T818	

	(b)	Cardiopulmonary resuscitation	&Y658
	(c)	Pulmonary embolism	&I269

Rib fracture due to cardiopulmonary resuscitation is considered a misadventure. Code I(a) Complications, medical procedure, specified NEC T818. Code I(b) Misadventure, specified type Y658. Code I(c) as indexed and precede with an ampersand to indicate the reason for cardiopulmonary resuscitation.

I	(a)	HIV	B24
	(b)	Blood transfusion	
	(c)	Hemophilia	D66

Code I(a) and I(c) as indexed. No code for I(b) since there are no complications reported. Do not consider HIV (any B20-B24) as a misadventure occurring during a blood transfusion.

S. Sequela of injuries, poisonings, and other consequences of external causes

A sequela is a late effect, an after effect, or a residual of a nature of injury or external cause. The Classification provides categories T900-T983 for sequela of nature of injury codes and Y850-Y899 for sequela of external causes. There are separate instructions for determining if the nature of injury or the external cause should be coded as sequela. **If either the nature of injury or the external cause requires a sequela code, both the nature of injury and the external cause must be coded to a sequela category.**

1. Sequela of injuries, poisoning, and other consequences of external causes (T900-T983)

Use these categories for the classification of injuries and poisonings (conditions in S00-T88) if:

a. A statement of sequela of the condition in S00-T88 is reported unless the interval between date of injury and date of death is less than 1 year.

I	(a)	Sequela of hip fracture	T931
	(b)		
	(c)		
II			&Y86

Code I(a) to T931 since it is stated as a sequela of hip fracture. Code Part II as sequela of accident NEC.

b. The condition in S00-T88 is stated to be ancient, by history, healed, history, history of, late effect of, old, remote, regardless of reported duration, or the interval between onset of this condition and death is indicated to be 1 year or more, whether or not the residual (sequela) effect is specified.

		Date of death 12/1/98		
	I	(a)	Old head injury	T909
MOD	II			&Y86

A

Accident	Farm	Date of injury 9/3/98	Tractor overturned

Code I(a) old head injury to Sequela, injury, head since it is stated as old. Interpret "tractor overturning on farm" as contact with agricultural machinery. Code Part II accident - tractor overturned to sequela of other accidents since it resulted in an injury stated as old.

c. A condition with a duration of 1 year or more that was due to the condition in S00-T88 is reported.

I	(a) Paralysis	16 mos.	T941
	(b) Spinal cord injury		T913
	(c) Auto accident		&Y850

Code I(a) paralysis to sequela of traumatic paralysis since it is reported due to trauma and has a duration of 1 year or more. Code I(b) spinal cord injury to Sequela, injury, spinal, cord since it caused a condition of 1 year or more. Code I(c) auto accident, to Sequela, motor vehicle accident.

d. More than one nature of injury or a nature of injury and an external cause are reported on the same line with a duration of 1 year or more, apply the duration to each condition.

I	(a) Head injury and skull fracture	Years	T909	T902
	(b)			
II	Fall		&Y86	

Code both conditions on I(a) as sequela. Do not disregard the duration since there is more than one injury on same line.

I	(a) Gunshot wound head	Years	T901	&Y86

Code both head wound and gunshot as sequela. Apply duration to nature of injury and external cause.

2. Sequela of external causes (Y850-Y899)

Y850 Sequela of motor vehicle accident (includes V01-V89)
Y859 Sequela of other and unspecified transport accidents (includes V90-V99)
Y86 Sequela of other accidents (excludes W78-W80)
Y870 Sequela of intentional self-harm
Y871 Sequela of assault
Y872 Sequela of events of undetermined intent
Y880 Sequela of adverse effects caused by drugs, medicaments, and biological substances in therapeutic use
Y881 Sequela of misadventures to patients during surgical and medical procedures
Y882 Sequela of adverse incidents associated with medical devices in diagnostic and therapeutic use
Y883 Sequela of surgical and medical procedures as the cause of abnormal reaction of the patient, or of later complication, without

mention of misadventure at the time of the procedure
Y890 Sequela of legal intervention
Y891 Sequela of war operations
Y899 Sequela of unspecified external cause

Use the preceding categories with the appropriate fourth characters for the classification of external causes of injury (V010-Y849) if:

a. A statement of sequela of the external cause is reported unless the interval between date of external cause and date of death is less than 1 year.

I	(a) Paralysis, sequela of		T941	&Y86
	(b) fall down steps			

Code I(a) to sequela of traumatic paralysis and sequela of fall down the steps.

b. An injury that is stated to be ancient, by history, healed, history, history of, late effect of, old, remote, or a delayed union that was due to the external cause is reported.

	I (a) Pneumonia		J189	
MOD	(b) Debility		R53	
A	(c) Nonunion of hip fracture		M841	
	II Inanition		R64	Y86
	Accident	Fell at home		

Code I(c) as indexed. Code sequela of fall last in Part II since the fall resulted in nonunion of the fracture.

I	(a) ASHD	I251	
II	Old fractured hip	T931	&Y86

Code I(a) ASHD as indexed. Code Part II old fractured hip, T931 Y86, since the injury was specified as old.

c. If the external cause is stated to be ancient, by history, history, history of, old, remote, regardless of reported duration, or the interval between onset of the external cause and death is indicated to be 1 year or more.

	I (a) Old fall, fractured hip	6 months	T931	&Y86
	(b)			
	(c)			
MOD	II		T931	
A				
	Accident	Fell and fractured hip 6 months ago		

Code as sequela since the external cause is stated as "old."

d. A condition with a duration of 1 year or more that was due to the external cause is reported.

I	(a) Subdural hematoma	1 year	T905	
	(b) Fall		&Y86	

Code I(a) subdural hematoma, T905, since it is reported to be of 1 year or more duration. Code I(b) fall, Y86, since it resulted in a condition of 1 year or more duration.

I	(a) Esophageal stricture years		K222	
	(b) Ingestion of lye		T97	&Y870
II	Suicide attempt			

Code I(a) esophageal stricture as indexed. Code I(b) ingestion of lye, T97 Y870, since it resulted in a condition of 1 year or more duration.

e. The interval between the time of occurrence of the external cause and death is indicated to be 1 year or more, whether or not the residual (sequela) effect is specified.

Date of death 11/1/96

I	(a) Bronchopneumonia	J180	
MOD II	Contusion brain	T905	&Y850

A

Accident	Street	Date of injury 5/20/95	Bicycle (operator) vs. truck

Code I(a) bronchopneumonia as indexed. Code sequela of nature of injury and external cause since the date of injury is 1 year or more prior to death.

I	(a) Cardiac arrest	I469		
	(b) Pacemaker failure weeks	T983	&Y883	&I519
	(c) Had pacemaker implanted 3 years ago			

Code I(a) cardiac arrest as indexed. Code I(b) pacemaker failure to seqeula T983 and Y883 since duration of implanted pacemaker is 3 years. Code I519, Disease, heart since pacemaker indicates a heart disease. Precede I519 with an ampersand as reason for the surgery. Do not enter a code on I(c).

f. The complication of the external cause classified to Chapters I-XVIII and the external cause is reported on the same line and the duration is 1 year or more.

I	(a) Radiation enteritis	3 years	Y883 K520
	(b) Lung cancer		&C349

Code I(a) as a sequela of radiation therapy. Do not disregard the duration. Precede the code for the lung cancer with an ampersand to indicate the reason for medical care.

APPENDIX A - STANDARD ABBREVIATIONS AND SYMBOLS

When an abbreviation is reported on the certificate, refer to this list to determine what the abbreviation represents**. If an abbreviation represents more than one term, determine the correct abbreviation by using other information on the certificate.** If no determination can be made, use abbreviation for first term listed.

A2GDM	class A2 gestational diabetes mellitus
AAA	abdominal aortic aneurysm
AAS	aortic arch syndrome
AAT	alpha-antitrypsin
AAV	AIDS-associated virus
AB	abdomen; abortion; asthmatic bronchitis
ABD	abdomen
ABE	acute bacterial endocarditis
ABS	acute brain syndrome
ACA	adenocarcinoma
ACD	arteriosclerotic coronary disease
ACH	adrenal cortical hormone
ACT	acute coronary thrombosis
ACTH	adrenocorticotrophic hormone
ACVD	arteriosclerotic cardiovascular disease
ADEM	acute disseminated encephalomyelitis
ADH	antidiuretic hormone
ADS	antibody deficiency syndrome
AEG	air encephalogram
AF	auricular or atrial fibrillation; acid fast
AFB	acid-fast bacillus
AGG	agammaglobulinemia
AGL	acute granulocytic leukemia
AGN	acute glomerulonephritis
AGS	adrenogenital syndrome
AHA	acquired hemolytic anemia; autoimmune hemolytic anemia
AHD	arteriosclerotic heart disease
AHHD	arteriosclerotic hypertensive heart disease
AHG	anti-hemophilic globulin deficiency
AHLE	acute hemorrhagic leukoencephalitis
AI	aortic insufficiency; additional information
AIDS	acquired immunodeficiency syndrome
AKA	above knee amputation
AKI	acute kidney injury
ALC	alcoholism
ALL	acute lymphocytic leukemia

ALS	amyotrophic lateral sclerosis
AMA	advanced maternal age; against medical advice; antimitochondrial antibody(ies)
AMI	acute myocardial infarction
AML	acute myelocytic leukemia
ANS	arteriolonephrosclerosis
AOD	arterial occlusive disease
AODM	adult onset diabetes mellitus
AOM	acute otitis media
AP	angina pectoris; anterior and posterior repair; artificial pneumothorax; anterior pituitary
A&P	anterior and posterior repair
APC	auricular premature contraction; acetylsalicylic acid, acetophenetidin, and caffeine
APE	acute pulmonary edema; anterior pituitary extract
APH	antepartum hemorrhage
AR	aortic regurgitation
ARC	AIDS-related complex
ARDS	adult respiratory distress syndrome
ARF	acute respiratory failure; acute renal failure
ARM	artificial rupture of membranes
ARV	AIDS-related virus
ARVD	arrhythmogenic right ventricular dysplasia
AS	arteriosclerotic; arteriosclerosis; aortic stenosis
ASA	acetylsalicylic acid (aspirin)
ASAD	arteriosclerotic artery disease
ASCAD	arteriosclerotic coronary artery disease
ASCD	arteriosclerotic coronary disease
ASCHD	arteriosclerotic coronary heart disease
ASCRD	arteriosclerotic cardiorenal disease
ASCVA	arteriosclerotic cerebrovascular accident
ASCVD	arteriosclerotic cardiovascular disease
ASCVR	arteriosclerotic cardiovascular renal disease
ASCVRD	arteriosclerotic cardiovascular renal disease
ASD	atrial septal defect
ASDHD	arteriosclerotic decompensated heart disease
ASHCVD	arteriosclerotic hypertensive cardiovascular disease
ASHD	arteriosclerotic heart disease; atrioseptal heart defect
ASHHD	arteriosclerotic hypertensive heart disease
ASHVD	arteriosclerotic hypertensive vascular disease
ASO	arteriosclerosis obliterans
ASPVD	arteriosclerotic peripheral vascular disease
ASVD	arteriosclerotic vascular disease
ASVH(D)	arteriosclerotic vascular heart disease
AT	atherosclerosis; atherosclerotic; atrial tachycardia; antithrombin
ATC	all-terrain cycle
ATN	acute tubular necrosis

ATS	arteriosclerosis
ATSHD	arteriosclerotic heart disease
ATV	all-terrain vehicle
AUL	acute undifferentiated leukemia
AV	arteriovenous; atrioventricular; aortic valve
AVF	arterio-ventricular fibrillation; arteriovenous fistula
AVH	acute viral hepatitis
AVNRT	atrioventricular nodal re-entrant tachycardia
AVP	aortic valve prosthesis
AVR	aortic valve replacement
AVRT	atrioventricular nodal re-entrant tachycardia
AWMI	anterior wall myocardial infarction
AZT	azidothymidine
BA	basilar artery; basilar arteriogram; bronchial asthma
B&B	bronchoscopy and biopsy
BBB	bundle branch block
B&C	biopsy and cauterization
BCE	basal cell epithelioma
BE	barium enema
BEH	benign essential hypertension
BGL	Bartholin's gland
BKA	below knee amputation
BL	bladder; bucolingual; blood loss; Burkitt's lymphoma
BMR	basal metabolism rate
BNA	bladder neck adhesions
BNO	bladder neck obstruction
BOMSA	bilateral otitis media serous acute
BOMSC	bilateral otitis media serous chronic
BOW	'bag of water' (membrane)
B/P, BP	blood pressure
BPH	benign prostate hypertrophy
BSA	body surface area
BSO	bilateral salpingo-oophorectomy
BSP	Bromosulfaphthalein (test)
BTL	bilateral tubal ligation
BUN	blood, urea, and nitrogen test
BVL	bilateral vas ligation
B&W	Baldy-Webster suspension (uterine)
BX	biopsy
BX CX	biopsy cervix
Ca	cancer
CA	cancer; cardiac arrest; carotid arteriogram
CABG	coronary artery bypass graft
CABS	coronary artery bypass surgery

CABS	coronary artery bypass surgery
CAD	coronary artery disease
CAG	chronic atrophic gastritis
CAO	coronary artery occlusion; chronic airway obstruction
CAS	cerebral arteriosclerosis
CASCVD	chronic arteriosclerotic cardiovascular disease
CASHD	chronic arteriosclerotic heart disease
CAT	computerized axial tomography
CB	chronic bronchitis
CBC	complete blood count
CBD	common bile duct; chronic brain disease
CBS	chronic brain syndrome
CCF	chronic congestive failure
CCI	chronic cardiac or coronary insufficiency
CF	congestive failure; cystic fibrosis; Christmas factor (PTC)
CFT	chronic follicular tonsillitis
CGL	chronic granulocytic leukemia
CGN	chronic glomerulonephritis
CHA	congenital hypoplastic anemia
CHB	complete heart block
CHD	congestive heart disease; coronary heart disease; congenital heart disease; Chediak-Higaski Disease
CHF	congestive heart failure
C2H5OH	ethyl alcohol
CI	cardiac insufficiency; cerebral infarction
CID	cytomegalic inclusiondisease
CIS	carcinoma in situ
CJD	Creutzfeldt-Jakob Disease
CLD	chronic lung disease; chronic liver disease
CLL	chronic lymphatic leukemia; chronic lymphocytic leukemia
CMID	cytomegalic inclusion disease
CML	chronic myelocytic leukemia
CMM	cutaneous malignant melanoma
CMV	cytomegalic virus
CNHD	congenital nonspherocytic hemolytic disease
CNS	central nervous system
CO	carbon monoxide
COAD	chronic obstructive airway disease
CO2	carbon dioxide
COBE	chronic obstructive bullous emphysema
COBS	chronic organic brain syndrome
COFS	cerebro-oculo-facio-skeletal
COOMBS	test for Rh sensitivity
COLD	chronic obstructive lung disease
COPD	chronic obstructive pulmonary disease

COPD	chronic obstructive pulmonary disease
COPE	chronic obstructive pulmonary emphysema
CP	cerebral palsy; cor pulmonale
C&P	cystoscopy and pyelography
CPB	cardiopulmonary bypass
CPC	chronic passive congestion
CPD	cephalopelvic disproportion; contagious pustular dermatitis
CPE	chronic pulmonary emphysema
CRD	chronic renal disease
CREST	calcinosis cutis, Raynaud's phenomenon, sclerodactyly, and telangiectasis
CRF	cardiorespiratory failure; chronic renal failure
CRST	calcinosis cutis, Raynaud's phenomenon, sclerodactyly, and telangiectasis
CS	coronary sclerosis; cesarean section; cerebro-spinal
CSF	cerebral spinal fluid
CSH	chronic subdural hematoma
CSM	cerebrospinal meningitis
CT	computer tomography; cerebral thrombosis; coronary thrombosis
CTD	congenital thymic dysplasia
CU	cause unknown
CUC	chronic ulcerative colitis
CUP	cystoscopy, urogram, pyelogram (retro)
CUR	cystocele, urethrocele, rectocele
CV	cardiovascular; cerebrovascular
CVA	cerebrovascular accident
CV accident	cerebral vascular accident
CVD	cardiovascular disease
CVHD	cardiovascular heart disease
CVI	cardiovascular insufficiency; cerebrovascular insufficiency
CVRD	cardiovascular renal disease
CWP	coal worker's pneumoconiosis
CX	cervix
DA	degenerative arthritis
DBI	phenformin hydrochloride
D&C	dilation and curettage
DCR	dacrocystorhinostomy
D&D	drilling and drainage; debridement and dressing
D&E	dilation and evacuation
DFU	dead fetus in utero
DIC	disseminated intravascular coagulation
DILD	diffuse infiltrative lung disease
DIP	distal interphalangeal joint; desquamative interstitial pneumonia
DJD	degenerative joint disease
DM	diabetes mellitus
DMT	dimethyltriptamine

DOA	dead on arrival
DOPS	diffuse obstructive pulmonary syndrome
DPT	diphtheria, pertussis, tetanus vaccine
DR	diabetic retinopathy
DS	Down's syndrome
DT	due to; delirium tremens
D/T	due to; delirium tremens
DU	diagnosis unknown; duodenal ulcer
DUB	dysfunctional uterine bleeding
DUI	driving under influence
DVT	deep vein thrombosis
DWI	driving while intoxicated
DX	dislocation; diagnosis; disease
EBV	Epstein-Barr virus
ECCE	extracapsular cataract extraction
ECG	electrocardiogram
E coli	Escherichia coli
ECT	electric convulsive therapy
EDC	expected date of confinement
EEE	Eastern equine encephalitis
EEG	electroencephalogram
EFE	endocardial fibroelastosis
EGL	eosinophilic granuloma of lung
EH	enlarged heart; essential hypertension
EIOA	excessive intake of alcohol
EKC	epidemic keratoconjunctivitis
EKG	electrocardiogram
EKP	epikeratoprosthesis
ELF	elective low forceps
EMC	encephalomyocarditis
EMD	electromechanical dissociation
EMF	endomyocardial fibrosis
EMG	electromyogram
EN	erythema nodosum
ENT	ear, nose, and throat
EP	ectopic pregnancy
ER	emergency room
ERS	evacuation of retained secundines
ESRD	end-stage renal disease
EST	electric shock therapy
ETOH	ethyl alcohol
EUA	exam under anesthesia
EWB	estrogen withdrawal bleeding
FB	foreign body

FBS	fasting blood sugar
Fe	symbol for iron
FGD	fatal granulomatous disease
FHS	fetal heart sounds
FHT	fetal heart tone
FLSA	follicular lymphosarcoma
FME	full-mouth extraction
FS	frozen section; fracture site
FT	full term
FTA	fluorescent treponemal antibody test
FTD	fronto-temporal dementia
5FU	fluorouracil
FUB	functional uterine bleeding
FULG	fulguration
FUO	fever unknown origin
FX	fracture
FYI	for your information
GAS	generalized arteriosclerosis
GB	gallbladder; Guillain-Barre (syndrome)
GC	gonococcus; gonorrhea; general circulation (systemic)
GE	gastroesophageal
GEN	generalized
GERD	gastroesophageal reflux disease
GI	gastrointestinal
GIB	gastrointestinal bleeding
GIST	gastrointestinal stromal tumor
GIT	gastrointestinal tract
GMSD	grand mal seizure disorder
GOK	God only knows
GSW	gunshot wound
GTT	glucose tolerance test
Gtt	drop
GU	genitourinary; gastric ulcer
GVHR	graft-versus-host reaction
GYN	gynecology
HA	headache
HAA	hepatitis-associated antigen
HASCVD	hypertensive arteriosclerotic cardiovascular disease
HASCVR	hypertensive arteriosclerotic cardiovascular renal disease
HASHD	hypertensive arteriosclerotic heart disease
HBP	high blood pressure
HC	Huntington's chorea
HCAP	health care associated pneumonia
HCPS	Hantivirus (cardio) pulmonary syndrome Hantavirus cardiopulmonary syndrome

HCPS	Hantivirus (cardio) pulmonary syndrome, Hantavirus cardiopulmonary syndrome
HCT	hematocrit
HCVD	hypertensive cardiovascular disease
HCVRD	hypertensive cardiovascular renal disease
HD	Hodgkin's disease; heart disease
HDN	hemolytic disease of newborn
HDS	herniated disc syndrome
HEM	hemorrhage
HF	heart failure; hay fever
HGB; Hgb	hemoglobin
HHD	hypertensive heart disease
HIV	human immunodeficiency virus
HMD	hyaline membrane disease
HN2	nitrogen mustard
HNP	herniated nucleus pulposus
H/O	history of
HPN	hypertension
HPS	Hantavirus pulmonary syndrome
HPVD	hypertensive pulmonary vascular disease
HRE	high-resolution electrocardiology
HS	herpes simplex; Hurler's syndrome
HSV	herpes simplex virus
HTLV	human T-cell lymphotropic virus
HTLV	human T-cell lymphotropic
III/LAV	virus-III/lymphadenopathy- associated virus
HTLV-3	human T-cell lymphotropic virus-III
HTLV-III	human T-cell lymphotropic virus-III
HTN	hypertension
HVD	hypertensive vascular disease
Hx	history of
IADH	inappropriate antidiuretic hormone
IASD	interatrial septal defect
ICCE	intracapsular cataract extraction
ICD	intrauterine contraceptive device
I&D	incision and drainage
ID	incision and drainage
IDA	iron deficiency anemia
IDD	insulin-dependent diabetes
IDDI	insulin-dependent diabetes
IDDM	insulin-dependent diabetes mellitus
IGA	immunoglobin A
IHD	ischemic heart disease
IHSS	idiopathic hypertrophic subaortic stenosis
IIAC	idiopathic infantile arterial calcification

ILD	ischemic leg disease
IM	intramuscular; intramedullary; infectious mononucleosis
IMPP	intermittent positive pressure
INAD	infantile neuroaxonal dystrophy
INC	incomplete
INE	infantile necrotizing encephalomyelopathy
INF	infection; infected; infantile; infarction
INH	isoniazid; inhalation
INS	idiopathic nephrotic syndrome
IRDM	insulin resistant diabetes mellitus
IRHD	inactive rheumatic heart disease
IRIS	immune reconstitution inflammatory syndrome
ISD	interatrial septal defect
ITP	idiopathic thrombocytopenic purpura
IU	intrauterine
IUCD	intrauterine contraceptive device
IUD	intrauterine device (contraceptive); intrauterine death
IUP	intrauterine pregnancy
IV	intervenous; intravenous
IVC	intravenous cholangiography; inferior vena cava
IVCC	intravascular consumption coagulopathy
IVD	intervertebral disc
IVH	intraventricular hemorrhage
IVP	intravenous pyelogram
IVSD	intraventricular septal defect
IVU	intravenous urethrography
IWMI	inferior wall myocardial infarction
JAA	juxtaposition of atrial appendage
JBE	Japanese B encephalitis
KFS	Klippel-Feil syndrome
KS	Klinefelter's syndrome
KUB	kidney, ureter, bladder
K-W	Kimmelstiel-Wilson disease or syndrome
LAP	laparotomy
LAV	lymphadenopathy-associated virus
LAV/HTLV-III	lymphadenopathy-associated virus/human T-cell lymphotrophic virus-III
LBBB	left bundle branch block
LBNA	lysis bladder neck adhesions
LBW	low birth weight
LBWI	low birth weight infant
LCA	left coronary artery
LDH	lactic dehydrogenase
LE	lupus erythematosus; lower extremity; left eye
LKS	liver, kidney, spleen

LL	lower lobe
LLL	left lower lobe
LLQ	lower left quadrant
LMA	left mentoanterior (position of fetus)
LML	left middle lobe; left mesiolateral
LMCAT	left middle cerebral artery thrombosis
LML	left mesiolateral; left mediolateral (episiotomy)
LMP	last menstrual period; left mento-posterior (position of fetus)
LN	lupus nephritis
LOA	left occipitoanterior
LOMCS	left otitis media chronic serous
LP	lumbar puncture
LRI	lower respiratory infection
LS	lumbosacral; lymphosarcoma
LSD	lysergic acid diethylamide
LSK	liver, spleen, kidney
LUL	left upper lobe
LUQ	left upper quadrant
LV	left ventricle
LVF	left ventricular failure
LVH	left ventricular hypertrophy
MAC	mycobacterium avium complex
MAI	mycobacterium avium intracellulare
MAL	malignant
MBAI	mycobacterium avium intracellulare
MBD	minimal brain damage
MCA	metastatic cancer; middle cerebral artery
MD	muscular dystrophy; manic depressive; myocardial damage
MDA	methylene dioxyamphetamine
MEA	multiple endocrine adenomatosis
MF	myocardial failure; myocardial fibrosis; mycosis fungoides
MGN	membranous glomerulonephritis
MHN	massive hepatic necrosis
MI	myocardial infarction; mitral insufficiency
MPC	meperidine, promethazine, chlorpromazine
MRS	methicillin resistant staphylococcal
MRSA	methicillin resistant staphylococcal aureus
MRSAU	methicillin resistant staphylococcal aureus
MS	multiple sclerosis; mitral stenosis
MSOF	multi-system organ failure
MT	malignant teratoma
MUA	myelogram
MVP	mitral valve prolapse
MVR	mitral valve regurgitation; mitral valve replacement

MVR	mitral valve regurgitation; mitral valve replacement
NACD	no anatomical cause of death
NAFLD	nonalcoholic fatty liver disease
NCA	neurocirculatory asthenia
NDI	nephrogenic diabetes insipidus
NEG	negative
NFI	no further information
NFTD	normal full-term delivery
NG	nasogastric
NH3	symbol for ammonia
NIDD	non-insulin-dependent diabetes
NIDDI	non-insulin-dependent diabetes
NIDDM	non-insulin-dependent diabetes mellitus
NSTEMI	non-ST-elevation myocardial infarction
N&V	nausea and vomiting
NVD	nausea, vomiting, diarrhea
OA	osteoarthritis
OAD	obstructive airway disease
OB	obstetrical
OBS	organic brain syndrome
OBST	obstructive; obstetrical
OD	overdose; oculus dexter (right eye); occupational disease
OHD	organic heart disease
OLT	orthotopic liver transplant
OM	otitis media
OMI	old myocardial infarction
OMS	organic mental syndrome
OPCA	olivopontocerebellar atrophy
ORIF	open reduction, internal fixation
OS	oculus sinister (left eye); occipitosacral (fetal position)
OT	occupational therapy; old TB
OU	oculus uterque (each eye); both eyes
PA	pernicious anemia; paralysis agitans; pulmonary artery; peripheral arteriosclerosis
PAC	premature auricular contraction; phenacetin, aspirin, caffeine
PAF	paroxysmal auricular fibrillation
PAOD	peripheral arterial occlusive disease; peripheral arteriosclerosis occlusive disease
PAP	primary atypical pneumonia
PAS	pulmonary artery stenosis
PAT	pregnancy at term; paroxysmal auricular tachycardia
Pb	chemical symbol for lead
PCD	polycystic disease
PCF	passive congestive failure
PCP	pentachlorophenol; pneumocystis carinii pneumonia
PCT	porphyria cutanea tarda

PCV	polycythemia vera
PDA	patent ductus arteriosus
PE	pulmonary embolism; pleural effusion; pulmonary edema
PEG	percutaneous endoscopic gastrostomy; pneumoencephalography
PEGT	percutaneous endoscopic gastrostomy tube
PET	pre-eclamptic toxemia
PG	pregnant; prostaglandin
PGH	pituitary growth hormone
PH	past history; prostatic hypertrophy; pulmonary hypertension
PI	pulmonary infarction
PID	pelvic inflammatory disease; prolapsed intervertebral disc
PIE	pulmonary interstitial emphysema
PIP	proximal interphalangeal joint
PKU	phenylketonuria
PMD	progressive muscular dystrophy
PMI	posterior myocardial infarction; point of maximum impulse
PML	progressive multifocal leukoencephalopathy
PN	pneumonia; periarteritis nodosa; pyelonephritis
PO	postoperative; by mouth
POC	product of conception
POE	point (or portal) of entry
POSS	possible; possibly
PP	postpartum
PPD	purified protein derivative test for tuberculosis
PPH	postpartum hemorrhage
PPLO	pleuropneumonia-like organism
PPS	postpump syndrome
PPT	precipitated; prolonged prothrombin time
PREM	prematurity
PROB	probably
PPROM	preterm premature rupture of membranes
PROM	premature rupture of membranes
PSVT	paroxysmal supraventricular tachycardia
PT	paroxysmal tachycardia; pneumothorax; prothrombin time
PTA	persistent truncus arteriosus
PTC	plasma thromboplastin component
PTCA	percutaneous transluminal coronary angioplasty
PTLA	percutaneous transluminal laser angioplasty
PU	peptic ulcer
PUD	peptic ulcer disease; pulmonary disease
PUO	pyrexia of unknown origin
P&V	pyloroplasty and vagotomy
PVC	premature ventricular contraction
PVD	peripheral vascular disease; pulmonary vascular disease

	p p p y
PVI	peripheral vascular insufficiency
PVL	periventricular leukomalacia
PVT	paroxysmal ventricular tachycardia
PVS	premature ventricular systole (contraction)
PWI	posterior wall infarction
PWMI	posterior wall myocardial infarction
PX	pneumothorax
R	right
RA	rheumatoid arthritis; right atrium; right auricle
RAAA	ruptured abdominal aortic aneurysm
RAD	rheumatoid arthritis disease; radiation absorbed dose
RAI	radioactive iodine
RBBB	right bundle branch block
RBC	red blood cells
RCA	right coronary artery
RCS	reticulum cell sarcoma
RD	Raynaud's disease; respiratory disease
RDS	respiratory distress syndrome
RE	regional enteritis
REG	radioencephalogram
RESP	respiratory
RHD	rheumatic heart disease
RLF	retrolental fibroplasia
RLL	right lower lobe
RLQ	right lower quadrant
RMCA	right middle cerebral artery
RMCAT	right middle cerebral artery thrombosis
RML	right middle lobe
RMLE	right mediolateral episiotomy
RNA	ribonucleic acid
RND	radical neck dissection
R/O	rule out
RSA	reticulum cell sarcoma
RSR	regular sinus rhythm
Rt	right
RT	recreational therapy; right
RTA	renal tubular acidosis
RUL	right upper lobe
RUQ	right upper quadrant
RV	right ventricle
RVH	right ventricular hypertrophy
RVT	renal vein thrombosis
RX	drugs or other therapy or treatment
SA	sarcoma; secondary anemia

SA	sarcoma, secondary anemia
SACD	subacute combined degeneration
SARS	severe acute respiratory syndrome
SBE	subacute bacterial endocarditis
SBO	small bowel obstruction
SBP	spontaneous bacterial peritonitis
SC	sickle cell
SCC	squamous cell carcinoma
SCI	subcoma insulin; spinal cord injury
SD	spontaneous delivery; septal defect; sudden death
SDAT	senile dementia Alzheimer's type
SDII	sudden death in infancy
SDS	sudden death syndrome
SEPT	septicemia
SF	scarlet fever
SGA	small for gestational age
SH	serum hepatitis
SI	saline injection
SIADH	syndrome of inappropriate antidiuretic hormone
SICD	sudden infant crib death
SID	sudden infant death
SIDS	sudden infant death syndrome
SIRS	systemic inflammatory response syndrome
SLC	short leg cast
SLE	systemic lupus erythematosus; Saint Louis encephalitis
SMR	submucous resection
SNB	scalene node biopsy
SO or S&O	salpingo-oophorectomy
SOB	shortness of breath
SOM	secretory otitis media
SOR	suppurative otitis, recurrent
S/P	status post
SPD	sociopathic personality disturbance
SPP	suprapubic prostatectomy
SQ	subcutaneous
S/R	schizophrenic reaction; sinus rhythm
S/p P/T	schizophrenic reaction, paranoid type
SSE	soapsuds enema
SSKI	saturated solution potassium iodide
SSPE	subacute sclerosing panencephalitis
STAPH	staphylococcal; staphylococcus
STB	stillborn
STREP	streptococcal; streptococcus
STS	serological test for syphilis

STSG	split thickness skin graft
SUBQ	subcutaneous
SUD	sudden unexpected death
SUDI	sudden unexplained death of an infant
SUID	sudden unexpected infant death
SVC	superior vena cava
SVD	spontaneous vaginal delivery
SVT	superventricular tachycardia
Sx	symptoms
SY	syndrome
T&A	tonsillectomy and adenoidectomy
TAH	total abdominal hysterectomy
TAL	tendon achilles lengthening
TAO	triacetyloleandomycin (antibiotic); thromboangiitis obliterans
TAPVR	total anomalous pulmonary venous return
TAR	thrombocytopenia absent radius (syndrome)
TAT	tetanus anti-toxin
TB	tuberculosis; tracheobronchitis
TBC, Tbc	tuberculosis
TCI	transient cerebral ischemia
TEF	tracheoesophageal fistula
TF	tetralogy of Fallot
TGV	transposition great vessels
THA	total hip arthroplasty
TI	tricuspid insufficiency
TIA	transient ischemic attack
TIE	transient ischemic episode
TL	tubal ligation
TM	tympanic membrane
TOA	tubo-ovarian abscess
TP	thrombocytopenic purpura
TR	tricuspid regurgitation, transfusion reaction
TSD	Tay-Sachs disease
TTP	thrombotic thrombocytopenic purpura
TUI	transurethral incision
TUR	transurethral resection (NOS) (prostate)
TURP	transurethral resection of prostate
TVP	total anomalous venous return
UC	ulcerative colitis
UGI	upper gastrointestinal
UL	upper lobe
UNK	unknown
UP	ureteropelvic
UPJ	ureteropelvic junction

p j

URI	upper respiratory infection
UTI	urinary tract infection
VAMP	vincristine, amethopterine, 6-mercaptopurine, and prednisone
VB	vinblastine
VC	vincristine
VD	venereal disease
VDRL	venereal disease research lab
VEE	Venezuelan equine encephalomyelitis
VF	ventricular fibrillation
VH	vaginal hysterectomy; viral hepatitis
VL	vas ligation
VM	viomycin
V&P	vagotomy and pyloroplasty
VPC, VPCS	ventricular premature contractions
VR	valve replacement
VSD	ventricular septal defect
VT	ventricular tachycardia
WBC	white blood cell
WC	whooping cough
WE	Western encephalomyelitis
W/O	without
WPW	Wolfe-Parkinson-White syndrome
YF	yellow fever
ZE	Zollinger-Ellison (syndrome)
'	minute
"	second(s)
<	less than
>	greater than
↓	decreased
↑	increased; elevated
$\overline{c}$	with
$\overline{s}$	without
$\frac{00}{11}$	secondary to
$\frac{00}{11}$ to	secondary to

APPENDIX B - SYNONYMOUS SITES/TERMS

When a condition of a stated anatomical site is indexed in Volume 3, code condition of stated site as indexed. If stated

site is not indexed, code condition of synonymous site.

Alimentary canal	Gastrointestinal tract
Body	Torso, trunk
Brain	Anterior fossa, basal ganglion, central nervous system, cerebral, cerebrum, frontal, occipital, parietal, pons, posterior fossa, prefrontal, temporal, III and IV ventricle **NOTE:** Do not use brain when ICD provides for CNS under the reported condition.
Cardiac	Heart
Chest	Thorax
Geriatric	Senile
Greater sac	Peritoneum
Hepatic	Liver
Hepatocellular	Liver
Intestine	Bowel, colon
Kidney	Renal
Larynx	Epiglottis, subglottis, supraglottis, vocal cords
Lesser sac	Peritoneum
Nasopharynx, pharynx	Throat
Pulmonary	Lung
Right\left hemispheric	Code brain
Hemispheric NOS	Do not assume brain
Right\left ventricle	Heart
Third\fourth ventricle	Brain
LLL, LUL, RLL, RML, RUL	Lobes of the lungs when reported with lobectomy, pneumonia, etc.

APPENDIX C - GEOGRAPHIC CODES

Alabama	AL
Alaska	AK
Arizona	AZ

Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
District of Columbia	DC
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Puerto Rico	PR
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT

Vermont	VT
Virginia	VA
Virgin Islands	VI
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY
Territories and Outlying Areas	
American Samoa	AS
Federated States of Micronesia	FM
Guam	GU
Marshall Islands	MH
Northern Mariana Islands	MP
Palau	PW
Puerto Rico	PR
Virgin Islands (US)	VI

US Minor Outlying Islands UM*

Baker Island
Howland Island
Jarvis Island
Johnston Atoll
Kingman Reef
Midway Islands
Navassa Island
Palmyra Atoll
Wake Island

*Not recognized as a valid USPS State abbreviation

APPENDIX D - CODE FOR PLACE OF OCCURRENCE

0. Home

Excludes: Abandoned or derelict house (8)
Home under construction, but not yet occupied (6)
Institutional place of residence (1)
Office in home (5)

About home
Apartment
Bed and breakfast
Boarding house

Cabin (any type)
Caravan (trailer) park - residential
Condominium
Farm house
Dwelling
Hogan
Home premises
Home sidewalk
Home swimming pool
House (residential) (trailer)
Noninstitutional place of residence
Penthouse
Private driveway to home
Private garage
Private garden to home
Private walk to home
Private wall to home
Residence
Rooming house
Storage building at apartment
Swimming pool in private home, private garden, apartment or residence
Townhome
Trailer camp or court
Yard (any part) (area) (front) (residential)
Yard to home

1. Residential institution

Almshouse
Army camp
Assisted Living
Board and care facility
Children's home
Convalescent home
Correctional center
Detox center
Dormitory
Fraternity house
Geriatric center
Halfway house
Home for the sick
Hospice
Institution (any type)
Jail
Mental Hospital
Military (camp) (reservation)
Nurse's home
Nursing home
Old people's home
Orphanage
Penitentiary
Pensioner's home
Prison
Prison camp
Reform school
Retirement home

Sorority house
State hospital

2. School, other institution and public administrative area

Excludes: Building under construction (6)
Residential institution (1)
Sports and athletic areas (3)

Armory
Assembly hall
Campus
Child center
Church
Cinema
Clubhouse
College
Country club (grounds)
Court house
Dance hall
Day nursery (day care)
Drive in theater
Fire house
Gallery
Health club
Health resort
Health spa
Hospital (parking lot)
Institute of higher learning
Kindergarten
Library
Mission
Movie house
Museum
Music hall
Night club
Opera house
Playground, school
Police precinct
Police station or cell
Post office
Private club
Public building
Public hall
Salvation army
School (grounds) (yard)
School (private) (public) (state)
Theatre
Turkish bath
University
YMCA
Youth center
YWCA

3. Sports and athletics area

Excludes: Swimming pool or tennis court in private home or garden (0)

Baseball field
Basketball court
Cricket ground
Dude ranch
Fives court
Football field
Golf course
Gymnasium
Hockey field
Ice palace
Racecourse
Riding school

Rifle range - NOS
Skating rink
Sports ground
Sports palace
Squash court
Stadium
Swimming pool (private) (public)
Tennis court

4. Street and highway

Alley
Border crossing
Bridge NOS
Freeway
Interstate
Motorway
Named street/highway/interstate
Pavement
Road (public)
Roadside
Sidewalk NOS
Walkway

5. Trade and service area

Excludes: Garage in private home (0)

Airport
Animal hospital
Bank
Bar
Body shop
Cafe
Car dealership
Casino
Electric company
Filling station
Funeral home
Garage - place of work
Garage away from highway except home
Garage building (for car storage)
Garage NOS
Gas station
Hotel (pool)
Laundry Mat
Loading platform - store
Mall
Market (grocery or other commodity)
Motel
Office (building) (in home)
Parking garage
Radio/television broadcasting station
Restaurant
Salvage lot, named
Service station

Shop, commercial
Shopping center (shopping mall)
Spa
Station (bus) (railway)
Store
Subway (stairs)
Tourist court
Tourist home
Warehouse

6. Industrial and construction areas

Building under construction
Coal pit
Coal yard
Construction (area, job or site)
Dairy processing plant
Dockyard
Dry dock
Electric tower
Factory (building) (premises)
Foundry
Gas works
Grain elevator
Gravel pit
Highway under construction
Industrial yard
Loading platform - factory
Logging operation area
Lumber yard
Mill pond
Oil field
Oil rig and other offshore installations
Oil well
Plant, industrial
Power-station (coal) (nuclear) (oil)
Produce building
Railroad track or trestle
Railway yard
Sand pit
Sawmill
Sewage disposal plant
Shipyard
Shop
Substation (power)
Subway track
Tannery
Tunnel under construction
Water filtration plant
Wharf Workshop

7. Farm

Excludes: Farm house and home premises of farm (0)

Barn NOS

Barnyard
Corncrib
Cornfield
Dairy (farm) NOS
Farm buildings
Farm pond or creek
Farmland under cultivation
Field, numbered or specialized
Gravel pit on farm
Orange grove
Orchard
Pasture
Ranch NOS
Range NOS
Silo
State Farm

8. Other specified places

Abandoned gravel pit
Abandoned public building or home
Air force firing range
Balcony
Bar pit or ditch
Beach NOS (named) (private)
Beach resort
Boy's camp
Building NOS
Bus stop
Camp
Camping grounds
Campsite
Canal
Caravan site NOS
Cemetery
City dump
Community jacuzzi
Creek (bank) (embankment)
Damsite
Derelict house
Desert
Ditch
Dock NOS
Driveway
Excavation site
Fairgrounds
Field NOS
Forest
Fort
Hallway
Harbor
Hill
Holiday camp
Irrigation canal or ditch
Junkyard
Military training ground
Mountain
Mountain resort
Named city
Named lake
Named room
Named town
Nursery NOS
Open field
Park (amusement) (any) (public)
Parking lot
Parking place
Pier
Pipeline (oil)
Place of business NOS
Playground NOS
Pond or pool (natural)
Porch
Power line pole
Prairie
Private property
Public place NOS
Public property
Railway line
Reservoir (water)
Resort NOS
River
Room (any)
Sea
Seashore NOS
Seashore resort
Sewer
Specified address
Stream
Swamp
Trail (bike)

Kitchen
Lake NOS
Lake resort
Manhole
Marsh
Vacation resort
Woods
Zoo

9. Unspecified place

Bathtub
Bed
Camper (trailer)
Commode
Country
Downstairs
Fireplace
Hot tub
Jobsite
Near any place
On job
Outdoors NOS
Parked car
Rural
Sofa
Table
Tree
Vehicle (any)

APPENDIX E - ACTIVITY CODES

The ICD-10 provides a subclassification for use with external causes and injuries to indicate the activity of the injured person at the time the event occurred. This appendix is designed to document the ICD-10 activity code information but it is not entered in manual coding.

Information may be scattered over different parts of the medical certification, Part I, Part II, 41, 43, etc. However, do not use the information in "Injury at work?" block to code this variable.

If no information concerning the activity of the injured person is reported on the certificate, the item is left blank. "While drinking alcohol" or "while driving" is not considered as a codable activity. When two or more codes appear to be appropriate for the information reported, activity code 8 is assigned.

0 While engaged in sports activity

Physical exercise with a described functional element such as:

. golf
. jogging
. riding
. school athletics
. skiing
. swimming
. trekking
. waterskiing

1 While engaged in leisure activity

Hobby activities
Leisure time activities with an entertainment element such as going to the cinema, to a dance or to a party
Participation in sessions and activities of voluntary organizations

Excludes: sport activities (0)

2 While working for income

Paid work (manual) (professional)
Transportation (time) to and from such activities
Work for salary, bonus and other types of income

3 While engaged in other types of work

Domestic duties such as:
. caring for children and relatives
. cleaning
. cooking
. gardening
. household maintenance
Duties for which one would not normally gain an income
Learning activities, e.g. attending school session or lesson
Undergoing education

4 While resting, sleeping, eating and other vital activities

Personal hygiene

8 While engaged in other specified activities

APPENDIX F - INVALID AND SUBSTITUTE CODES

The following categories are invalid for underlying cause coding in the United States registration areas. Substitute code(s) for use in underlying cause coding appears to the right.

Use the substitute codes when conditions classifiable to the following codes are reported:

Invalid Codes	Substitute Codes
A150-A153	A162
A154	A163
A155	A164
A156	A165
A157	A167
A158	A168
A159	A169
A160-A161	A162
B95-B97 Code the disease(s) classified to other chapters modified by the organism. Do not enter a code for the organism.	
F70.-	F70 (3-characters only)
F71.-	F71 (3-characters only)
F72.-	F72 (3-characters only)
F73.-	F73 (3-characters only)
F78.-	F78 (3-characters only)
F79.-	F79 (3-characters only)
I151-I158 -	R99
I23.-	I21 or I22
I240	I21 or I22
I252	I258
I65-I66	I63
O08.-	O00 - O07
O80.-	O95
O81-O84	O759
P95	P969

R69	R95-R99

APPENDIX G - CODES FOR SPECIAL PURPOSES (U00-U99)
Provisional assignment of new codes (U00-U99)

1. Terrorism Classification (*U01-*U03)

NCHS has developed a set of new codes within the framework of the ICD that will allow the identification of deaths from terrorism reported on death certificates through the National Vital Statistics System. Terrorism-related ICD-10 codes for mortality have been assigned to the "U" category which has been designated by WHO for use by individual countries. The asterisk preceding the alphanumeric code indicates the code was introduced by the United States and is not officially part of the ICD.

To classify a death as terrorist-related, it is necessary for the incident to be designated as such by the Federal Bureau of Investigation (FBI). Neither a medical examiner nor a coroner who would be completing/certifying the death certificate, nor the nosologist coding the death certificate would determine that an incident is an act of terrorism. If an incident or event is confirmed by the FBI as terrorism, it may be so described on the certificate. If the incident is confirmed as terrorism after the death certificate is completed, the certificate can be recoded at a later date.

Not to be used unless notified by NCHS

Tabular List

Assault (homicide)

*U01-*U02

*U01 Terrorism

Includes: assault-related injuries resulting from the unlawful use of force or violence against persons or property to intimidate or coerce a Government, the civilian population, or any segment thereof, in furtherance of political or social objectives

*U01.0 Terrorism involving explosion of marine weapons

Depth-charge
Marine mine
Mine NOS, at sea or in harbor
Sea-based artillery shell
Torpedo
Underwater blast

*U01.1 Terrorism involving destruction of aircraft

Includes: aircraft used as a weapon

Aircraft:
- burned
- exploded

- shot down

Crushed by falling aircraft

*U01.2 Terrorism involving other explosives and fragments

Antipersonnel bomb (fragments)
Blast NOS
Explosion (of):
- NOS
- artillery shell
- breech-block
- cannon block
- mortar bomb
- munitions being used in terrorism
- own weapons

Fragments from:
- artillery shell
- bomb
- grenade
- guided missile
- land-mine
- rocket
- shell
- shrapnel

Mine NOS

*U01.3 Terrorism involving fires, conflagration and hot substances

Asphyxia Burns Other injury	originating from fire caused directly by fire-producing device or indirectly by any conventional weapon

Petrol bomb

Collapse of Fall from Falling from Hit by object Jump from	burning building or structure

Conflagration

Fire Melting Smoldering	of fittings or furniture

*U01.4 Terrorism involving firearms

Bullet
- carbine
- machine gun
- pistol
- rifle

- rubber (rifle)

Pellets (shotgun)

*U01.5 Terrorism involving nuclear weapons

Blast effects
Exposure to ionizing radiation from nuclear weapon
Fireball effects
Heat
Other direct and secondary effects of nuclear weapons

*U01.6 Terrorism involving biological weapons

Anthrax
Cholera
Smallpox

*U01.7 Terrorism involving chemical weapons

Gases, fumes and chemicals:
- Hydrogen cyanide
- Phosgene
- Sarin

*U01.8 Terrorism, other specified

Lasers
Battle wounds
Drowned in terrorist operations NOS
Piercing or stabbing object injuries

*U01.9 Terrorism, unspecified

*U02 Sequelae of terrorism

Intentional self-harm (suicide)

*U03

*U03 Terrorism

*U03.0 Terrorism involving explosions and fragments

Includes: destruction of aircraft used as a weapon

Aircraft:
- burned
- exploded
- shot down

Antipersonnel bomb (fragments)
Blast NOS
Explosion (of):

- NOS
- artillery shell
- breech-block
- cannon block
- mortar bomb
- munitions being used in terrorism
- own weapons

Fragments from:
- artillery shell
- bomb
- grenade
- guided missile
- land-mine
- rocket
- shell
- shrapnel

Mine NOS

*U03.9 Terrorism by other and unspecified means

SECTION II – External causes of injury

Air
- blast in terrorism U01.2

Asphyxia, asphyxiation
- by
- - chemical in terrorism U01.7
- - fumes in terrorism (chemical weapons) U01.7
- - gas (*see also* Table of drugs and chemicals)
- - - in terrorism (chemical weapons) U01.7
- from
- - fire (*see also* Exposure, fire)
- - - in terrorism U01.3

Bayonet wound
- in
- - terrorism U01.8

Blast (air) in terrorism U01.2
- from nuclear explosion U01.5
- underwater U01.0

Burn, burned, burning (by) (from) (on)
- chemical (external) (internal)
- - in terrorism (chemical weapons) U01.7
- in terrorism (from fire-producing device) NEC U01.3
- - nuclear explosion U01.5
- - petrol bomb U01.3

Casualty (not due to war) NEC
- terrorism U01.9

Collapse
- building
- - burning (uncontrolled fire)
- - - in terrorism U01.3

- structure
- - burning (uncontrolled fire)
- - - in terrorism U01.3

Crash
- aircraft (powered)
- - in terrorism U01.1

Crushed
- by, in
- - falling
- - - aircraft
- - - - in terrorism U01.1

Cut, cutting (any part of body) (by) (*see also* Contact, with, by object or machine)
- terrorism U01.8

Drowning
- in
- - terrorism U01.8

Effect(s) (adverse) of
- nuclear explosion or weapon in terrorism (blast) (direct) (fireball) (heat) (radiation) (secondary) U01.5

Explosion (in) (of) (on) (with secondary fire)
- terrorism U01.2

Exposure to
- fire (with exposure to smoke or fumes or causing burns, or secondary explosion)
- - in, of, on, starting in
- - - terrorism (by fire-producing device) U01.3
- - - - fittings or furniture (burning building) (uncontrolled fire) U01.3
- - - - from nuclear explosion U01.5

Fall, falling
- from, off
- - building
- - - burning (uncontrolled fire)
- - - - in terrorism U01.3
- - structure NEC
- - - burning (uncontrolled fire)
- - - - in terrorism U01.3

Fireball effects from nuclear explosion in terrorism U01.5

Heat (effects of) (excessive)
- from
- - nuclear explosion in terrorism U01.5

Infection, infected (opportunistic)
- coronavirus NEC
- - severe acute respiratory syndrome (SARS) U04.9

Injury, injured NEC
- by, caused by, from
- - terrorism – *see* Terrorism
- due to
- - terrorism – *see* Terrorism

Jumped, jumping
- from
- - building (*see also* Jumped, from, high place)
- - - burning (uncontrolled fire)
- - - - in terrorism U01.3
- - structure (*see also* Jumped, from, high place)
- - - burning (uncontrolled fire)
- - - - in terrorism U01.3

Poisoning (by) (*see also* Table of drugs and chemicals)
- in terrorism (chemical weapons) U01.7
Radiation (exposure to)
- in
- - terrorism (from or following nuclear explosion) (direct) (secondary) U01.5
- - - laser(s) U01.8
- laser(s)
- - in terrorism U01.8
Sequelae (of)
- in terrorism U02
Shooting, shot (*see also* Discharge, by type of firearm)
- in terrorism U01.4
Struck by
- bullet (*see also* Discharge, by type of firearm)
- - in terrorism U01.4
- missile
- - in terrorism – *see* Terrorism, missile
- object
- - falling
- - - from, in, on
- - - - building
- - - - - burning (uncontrolled fire)
- - - - - - in terrorism U01.3
Suicide, suicidal (attempted) (by)
- explosive(s) (material)
- - in terrorism U03.0
- in terrorism U03.9
Terrorism (by) (in) (injury) (involving) U01.9
- air blast U01.2
- aircraft burned, destroyed, exploded, shot down U01.1
- - used as a weapon U01.1
- anthrax U01.6
- asphyxia from
- - chemical (weapons) U01.7
- - fire, conflagration (caused by fire-producing device) U01.3
- - - from nuclear explosion U01.5
- - gas or fumes U01.7
- bayonet U01.8
- biological agents (weapons) U01.6
- blast (air) (effects) U01.2
- - from nuclear explosion U01.5
- - underwater U01.0
- bomb (antipersonnel) (mortar) (explosion) (fragments) U01.2
- - petrol U01.3
- bullet(s) (from carbine, machine gun, pistol, rifle, rubber (rifle), shotgun) U01.4
- burn from
- - chemical U01.7
- - fire, conflagration (caused by fire-producing device) U01.3
- - - from nuclear explosion U01.5
- - gas U01.7
- burning aircraft U01.1
- chemical (weapons) U01.7
- cholera U01.6
- conflagration U01.3
- crushed by falling aircraft U01.1

- depth-charge U01.0
- destruction of aircraft U01.1
- disability as sequelae one year or more after injury U02
- drowning U01.8
- effect (direct) (secondary) of nuclear weapon U01.5
- - sequelae U02
- explosion (artillery shell) (breech-block) (cannon block) U01.2
- - aircraft U01.1
- - bomb (antipersonnel) (mortar) U01.2
- - - nuclear (atom) (hydrogen) U01.5
- - depth-charge U01.0
- - grenade U01.2
- - injury by fragments (from) U01.2
- - land-mine U01.2
- - marine weapon(s) U01.0
- - mine (land) U01.2
- - - at sea or in harbor U01.0
- - - marine U01.0
- - missile (explosive) (guided) NEC U01.2
- - munitions (dump) (factory) U01.2
- - nuclear (weapon) U01.5
- - other direct and secondary effects of U01.5
- - own weapons U01.2
- - sea-based artillery shell U01.0
- - torpedo U01.0
- exposure to ionizing radiation from nuclear explosion U01.5
- falling aircraft U01.1
- fire or fire-producing device U01.3
- firearms U01.4
- fireball effects from nuclear explosion U01.5
- fragments from artillery shell, bomb NEC, grenade, guided missile, land-mine, rocket, shell, shrapnel U01.2
- gas or fumes U01.7
- grenade (explosion) (fragments) U01.2
- guided missile (explosion) (fragments) U01.2
- - nuclear U01.5
- heat from nuclear explosion U01.5
- hot substances U01.3
- hydrogen cyanide U01.7
- land-mine (explosion) (fragments) U01.2
- laser(s) U01.8
- late effect (of) U02
- lewisite U01.7
- lung irritant (chemical) (fumes) (gas) U01.7
- marine mine U01.0
- mine U01.2
- - at sea U01.0
- - in harbor U01.0
- - land (explosion) (fragments) U01.2
- - marine U01.0
- missile (explosion) (fragments) (guided) U01.2
- - marine U01.0
- - nuclear U01.5
- mortar bomb (explosion) (fragments) U01.2
- mustard gas U01.7

- nerve gas U01.7
- nuclear weapons U01.5
- pellets (shotgun) U01.4
- petrol bomb U01.3
- piercing object U01.8
- phosgene U01.7
- poisoning (chemical) (fumes) (gas) U01.7
- radiation, ionizing from nuclear explosion U01.5
- rocket (explosion) (fragments) U01.2
- saber, sabre U01.8
- sarin U01.7
- screening smoke U01.7
- sequelae effect (of) U02
- shell (aircraft) (artillery) (cannon) (land-based) (explosion) (fragments) U01.2
- - sea-based U01.0
- shooting U01.4
- - bullet(s) U01.4
- - pellet(s) (rifle) (shotgun) U01.4
- shrapnel U01.2
- smallpox U01.6
- stabbing object(s) U01.8
- submersion U01.8
- torpedo U01.0
- underwater blast U01.0
- vesicant (chemical) (fumes) (gas) U01.7
- weapon burst U01.2

Date of death 9/11/2001

PLACE 5	I	(a) Burns	T300
		(b) Terrorist attack on the Pentagon	&U011
MOD H	II		

Homicide	The Pentagon	Date of injury 9/11/2001

Code as terrorism involving destruction of aircraft. The FBI declared the Pentagon incident an act of terrorism.

Date of death 9/11/2001

PLACE 5	I	(a) Chest trauma	S299
		(b)	
MOD H	II	World Trade Center Disaster	&U011

Homicide	World Trade Center	Date of injury 9/11/2001

Code as terrorism involving destruction of aircraft. The FBI declared the World Trade Center incident an act of terrorism.

2. Severe Acute Respiratory Syndrome [SARS] (U04)

Tabular List

U04 Severe acute respiratory syndrome [SARS]

U04.9 Severe acute respiratory syndrome [SARS], unspecified

SECTION I – Alphabetical index to diseases and nature of injury

Syndrome
- respiratory
- - severe acute U04.9
- severe acute respiratory syndrome (SARS) U04

APPENDIX H - ADDITIONAL DRUG EXAMPLES

1. Place 9 I (a) Ingested overdose of opiates and ingested alcohol T406 &X42 F109

   Code I(a) nature of injury and external cause code for opiate overdose. Code ingested alcohol as indexed. No evidence of alcohol and drug synergism is reported.

2. Place 9 I (a) Ingested overdose of (opiates) and ingested alcohol T406 &X42 F109

   Code I(a) nature of injury and external cause code for opiate overdose. Code ingested alcohol as indexed. No evidence of alcohol and drug synergism is reported.

3. Place 9 I (a) Intoxication by the use of cocaine and opiates T405 &X42 T406

   Code I(a) nature of injury and external cause code for cocaine and opiate intoxication. Since the drugs are assigned to the same external cause code, code X42. Do not enter a Chapter V code (F codes).

4. Place 9 I (a) Intoxication by the use of (cocaine and opiates) T405 &X42 T406

   Code I(a) nature of injury and external cause code for cocaine and opiates intoxication. Since the drugs are assigned to the same external cause code, code X42. Do not enter a Chapter V code (F codes).

5. Place 9 I (a) Toxic effects of cocaine abuse T405 &X42 F141

Interpret I(a) as cocaine poisoning and cocaine abuse. Code nature of injury and external cause code for cocaine poisoning and cocaine abuse as indexed.

6. Place 9 — I (a) Toxic effects of illicit drug abuse — T509 &X44 F191

Interpret I(a) as drug poisoning and drug abuse. Code nature of injury and external cause code for drug poisoning and drug abuse as indexed.

7. Place 9 — I (a) Mixed drug intoxication alcohol and cocaine — T519 X45 T405 &X42

Interpret I(a) as poisoning and code nature of injury and external cause code for alcohol and cocaine. Precede the external cause code for the cocaine poisoning with an ampersand.

8. Place 9 — I (a) Mixed drug intoxication (alcohol and cocaine) — T519 X45 T405 &X42
(b)
II Used combination cocaine and alcohol — F149 F109

Interpret I(a) as poisoning and code nature of injury and external cause code for alcohol and cocaine. Precede the external cause code for cocaine poisoning with an ampersand. In Part II, code cocaine use as indexed under Dependence, due to, cocaine, and alcohol as indexed under Use, alcohol.

9. Place 9 — I (a) Multiple drug intoxication including — T509 &X44 T402 T424 T430
(b) oxycodone, diazepam, and doxepin

Code the nature of injury code for drug NOS as first entry on I(a). Since the drugs are assigned to different external cause codes, code X44 followed by the nature of injury code for each drug reported.

10. Place 9 — I (a) Drug (heroin) intoxication — T401 &X42

Code I(a) nature of injury and external cause code for heroin intoxication.

11. Place 9 — I (a) Acute multiple drug intoxication (oxycodone — T402 &X44 T424
(b) and alprazolam)
II Took overdose — T509

Code I(a) nature of injury and external cause code for oxycodone and alprazolam intoxication. Since the drugs are assigned to different external cause codes, code X44. Code the nature of injury code for drug NOS in Part II.

12. Place	I	(a) Acute multiple drug intoxication (ethanol,	T510 X45 T402	
&X44 T424				
9		(b) oxycodone and alprazolam)		

Interpret I(a) as alcohol poisoning and drug poisoning. Code the nature of injury and external cause for the alcohol and drugs. Since the drugs are assigned to different external cause codes, code X44 and precede with an ampersand.

13. Place	I	(a) Acute combined drug intoxication	T509	&X44
9		(b) (oxycodone, with diazepam and ethyl	T402	X45 T424
T510				
		(c) alcohol)		
MOD	II		T509	F109
A				

Accident	Took drugs and drank alcoholic beverages

Code the nature of injury for drug NOS as first entry on I(a). Since the drugs are assigned to different external cause codes, code X44. Code the nature of injury for each drug reported on I(b) and the nature of injury and external cause for alcohol. Code the nature of injury for drug NOS and code alcohol as indexed under Drinking, drank (alcohol).

14. Place	I	(a) Acute intoxication due to ethanol	T510		
9		(b) abuse, opiate abuse	F101	F111	
MOD	II	Drug reaction	T509	X44	&X45
A					

Accident

Code I(a) to the nature of injury code for ethanol since this is the first substance reported in the "due to" position. Code I(b) as indexed. Code Part II to drug poisoning since drug NOS is reported and the certifier stated the death was due to an accident. Code the external code for ethanol poisoning as the last code in Part II and precede with an ampersand.

15. Place	I	(a) Intoxication	T402		
9		(b) Morphine, Cocaine poisoning	T402	&X42	T405

Code I(a) to the nature of injury code for morphine since this is the first substance

reported in the "due to" position. Code the nature of injury and external cause code for morphine and cocaine on I(b).

16. Place 9	I	(a) Acute intoxication due to the	T404		
		(b) combined effects of fentanyl	T404	&X42	T406
		(c) and opiates			

Code I(a) to the nature of injury code for fentanyl since this is the first substance reported in the due to position. Code the nature of injury and external cause code for fentanyl and opiates on I (b).

17. Place 9 MOD A	I	(a) Cardiac arrhythmia associated with hydroxyzine	I499	T435	&X41
		(b) injection			
		(c)			
	II	Hydroxyzine injection	T435		
		Accident			

Code first condition on I(a) as indexed. Code hydroxyzine injection as poisoning since it is a psychotropic drug and the certifier reported the death was due to an accident. Code nature of injury for hydroxyzine Part II.

18.	I	(a) Cardiac arrhythmia associated with hydroxyzine	I499		
		(b) injection			
		(c)			
	II	Hydroxyzine injection			

Code first condition on I(a) as indexed. No code required for the hydroxyzine injection since no complication is reported. It is considered drug therapy since the certifier did not report accident or undetermined in the manner of death block.

19. Place T406 9 MOD A	I	(a) Acute cardiac arrhythmia precipitated by	I499	T405	&X42
		(b) cocaine and opiates			
		(c)			
	II	Drug abuse, cocaine and opiates	F141	F111	
		Accident			

Code first condition on I(a) as indexed. Code cocaine and opiates as poisoning since the drugs are narcotics and the certifier reported the death was due to an accident. Code the nature of injury and external cause code for cocaine and opiate poisoning. Since the drugs are assigned to the same external cause code, code X42. Code cocaine abuse and opiates abuse as indexed in Part II.

20. Place	I	(a) Acute intravenous narcotism (heroin)	F112		

9		(b)			
	II	Methadone overdose, heroin injection	T403	&X42	T401

Code I(a) F112, acute intravenous heroin narcotism. Consider the methadone overdose and heroin injection as poisoning. Heroin is not used for medical care purposes.

21. Place 9 MOD A	I	(a) Acute intravenous narcotism heroin overdose	F192	T401	&X42
	II				

Accident

Intrepret I(a) as two separate entities. Code acute intravenous narcotism as first entity and code a nature of injury and an external cause code for heroin overdose as second entity.

22. Place 9	I	(a) Acute intravenous narcotism	F112		
		(b) Morphine			
	II	Intravenous use of drugs	F199		

Consider I(b) as continuation of I(a). Code I(a) acute intravenous morphine narcotism and Part II as indexed.

23.	I	(a) Drug dependence (heroin, cocaine)	F112	F142

Code I(a) heroin and cocaine dependence as indexed.

24. Place 9	I	(a) Renal failure	N19	
		(b) Drug induced hepatotoxicity	T509	&X44

Code I(a) as indexed. Code I(b) as poisoning since toxicity (of a site) by a drug is one of the terms that is interpreted as poisoning.

25. Place 9	I	(a) Effects of cocaine and methamphetamine use	F149	F159	
		(b)			
MOD A	II	Drug intake	T509	&X44	

Accident

Code I(a) as indexed applying intent of certifier instructions for coding use of drugs. Code drug intake as poisoning since drug NOS is reported and the certifier reported

the death was due to an accident.

26. Place 9 MOD A	I	(a) Adverse effects of drugs	T509	&X44
	II		T509	

Accident	Subject took drugs

Code I(a) to drug poisoning since drug NOS is reported and the certifier stated the death was due to an accident. Code the nature of injury for drug in Part II.

27.	I	(a) Gastric ulcer	K259
		(b) Drug intake	Y579
		(c) Arthritis	&M139

Code the gastric ulcer as a complication of the drug reported on I(b). Code the E-code for drug therapy on I(b). It is considered drug therapy since the certifier did not indicate the death was due to an accident or it occurred under undetermined circumstances or the drug was taken in conjunction with alcohol. Code I(c) as indexed and precede with an ampersand.

28. Place 9 MOD A	I	(a) Combined toxicity	T659	&X44
		(b) Heroin and amphetamine	T401	T436
	II			

Accident

Code I(a) to nature of injury for Toxicity NOS, T659 as indexed. Code external cause to X44 since the drugs are classified to different external cause codes.

29. Place 9 MOD A	I	(a) Poisoning	T659	&X44
		(b) Heroin and amphetamine	T401	T436
	II			

Accident

Code I(a) to nature of injury for Poisoning NOS, T659 as indexed. Code external cause to X44 since the drugs are classified to different external cause codes.

30. Place T510 Y15 9 MOD C	I	(a) Mixed drug poisoning (cocaine,	T405	&Y12	T406
		(b) opiate, ethanol)			
		(c)			
	II	Consumed ethanol with illicit drugs	F109	T509	

Undetermined

Interpret I(a) as poisoning and code nature of injury and external cause for cocaine, opiate and ethanol. Precede the external cause for the drugs with an ampersand. In Part II, code consumed ethanol as indexed under Consumption, ethanol and code the nature of injury for drug.

31. Place 9	I	(a) Subdural hematoma	I620	
		(b) Anticoagulation	Y442	
		(c) Arrhythmia	&I499	
	II	Amiodarone lung toxicity	T462	&X44

Code I(a) as nontraumatic. Code the E-code for drug therapy on I(b). Code I(c) as indexed and precede with an ampersand to identify the reason for treatment. Code Part II as poisoning since toxicity (of a site) by a drug is one of the terms that is interpreted as poisoning.

32.	I	(a) Cardiac Arrest	I469	
		(b) Bleeding	&R5800	
MOD N		(c) Over coumadinization	Y442	

Natural

Code I(a) as indexed. Code the bleeding as a complication of the drug reported on I(c). Drug, medicament or biological substance is assumed to be used for medical care unless there are indications to the contrary.

33. Place 9	I	(a) Combined opiate and stimulant poisoning	T406	&X44	T509
		(b) Usage of hydrocodone and cocaine	F119	F149	
MOD A	II		T406	T509	

Accident	Used lethal combination of opiates and stimulant drugs

Code I(a) nature of injury and external cause for opiate and stimulant poisoning. Since the drugs are assigned to different external cause codes, code X44. Code I(b) as indexed applying intent of certifier instructions for use of drugs. Refer to Table of drugs and chemicals to find hydrocodone, T402. In Volume 1, the title of category T402 is "Other opioids". Code hydrocodone use to Addiction, opioids, with fourth character **.**9, F119. In Part II, code the nature of injury for opiates and stimulant drugs, since "Lethal (amount) (dose) (quantity) of a drug" is interpreted to mean poisoning.

34. Place	I	(a) Combined analgesic and antihistaminic	T398	&X44	T450

T432
9 antidepressant poisoning
MOD (b) Usage of fentanyl promethazine doxylamine F199
A II F199

Accident	Used combination of prescription drugs

Code I(a) nature of injury and external cause for analgesic, antihistaminic and antidepressant poisoning. Since the drugs are assigned to different external cause codes, code X44. Code I(b) and Part II as indexed applying intent of certifier instructions for use of drugs.

35. Place I (a) Combined ethanol and methadone intoxication T510 X45 T403
&X42
9 II Toxic use of drug and ethanol T509 T510

Interpret I(a) as poisoning and code nature of injury and external cause code for ethanol and methadone. Precede the external cause code for the methadone poisoning with an ampersand. Interpret Part II as poisoning and code nature of injury for drug and ethanol.

36. Place I (a) Adverse reaction to drugs and ethanol T509 &Y14 T510
Y15
0
MOD II F109 F139 F119
C

Undetermined	Used ethanol, citalopram, hydrocodone and metaxalone

Interpret I(a) as poisoning and code nature of injury and external cause code for drugs and ethanol. Precede the external cause code for drug poisoning with an ampersand. In Part II, code use of ethanol and each named drug as indexed. Citalopram and metaxalone use are both assigned to F139. Code only the first mentioned; do not repeat a code on a line.

37. Place I (a) Adverse effects of acetaminophen and alcohol T391 &X40 T519
X45
0
MOD II F199 F109
A

Accident	Drug and alcohol use

Interpret I(a) as poisoning and code nature of injury and external cause code for acetaminophen and alcohol. Precede the external cause code for acetaminophen

poisoning with an ampersand. In Part II, code drug use and alcohol use as indexed.

38. Place 9	I	(a) Polypharmacy		T509
MOD A	II			&X44

Accident

Interpret I(a) as poisoning since the certifier reported the death was due to an accident. Assign the nature of injury for drug on line I(a) since polypharmacy is on the N-only list. Assign the E-code for drug NOS in Part II preceded by an ampersand.

39. Place 9	I	(a) Cardiac arrest	I469
		(b) ASCVD	I250
MOD N	II	Polypharmacy	

Natural

Code condition on I(a) and I(b) as indexed. No code required for the polypharmacy since no complication is reported. It is considered drug therapy since the certifier did not report accident or undetermined in the manner of death block.

40. Place T432 9	I	(a) Acute polypharmacy intoxication (morphine and venlafaxine)	T402 &X44
MOD A	II	Polypharmacy present	T509

Accident | Ingested pharmaceutical substances

Code I(a) nature of injury and external cause code for morphine and venlafaxine intoxication. Since the drugs are assigned to different external cause codes, code X44. Code the nature of injury code for drug NOS in Part II.