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 III, Intent of Certifier, #33 Alveolar Hemorrhage, revised instruction and deleted codes K000-K149, Q380-Q388, S015, S024-S030, S032, S034, S099 in table.

3. Section III, Intent of Certifier, #48 Brain Damage, newborn, deleted the following codes from table: P030-P039, P100-P131 and P159. Also deleted nature of injury and external cause codes.

4. Section III, Intent of Certifier, #53 Fracture, deleted the following codes from the table under letter (a): C40-C41, C795, M80-M81, M83 and M88. Also changed letter (b) to "When reported due to or on the same line with."

5. Section III, Intent of Certifier, #54 Starvation NOS, deleted the following codes from the table: V010-Y899. Added the following codes
6. Section IV, Part A, 8, h, More than one malignant neoplasm qualified as metastatic, new instruction added as (4)(c).

7. Section V, Part R, 1, a.1, Drugs, medicaments and biological substances causing adverse effects in therapeutic use, added the following code to the list of alcoholic conditions that cannot be due to drug therapy: K852.

8. Section V, Part R, 2, a.1, Complications of surgical procedures, added the following codes to the list of alcoholic and hypertensive conditions that cannot be due to surgery: I150, I159 and K852.


10. Appendix A, added abbreviation HBP high blood pressure.

11. Appendix A, added abbreviation JAA juxtaposition of atrial appendage.

12. Appendix A, added another term to abbreviation PO by mouth.

13. Appendix A, added abbreviation PPROM preterm premature rupture of membranes.


Other manuals relating to coding causes of death are:

Part 2a, NCHS Instructions for Classifying the Underlying Cause of Death, 2013

Part 2c, ICD-10 ACME Decision Tables for Classifying the Underlying Causes of Death, 2013

Part 2k, Instructions for the Automated Classification of the Initiating and Multiple Causes of Fetal Death, 2013

Part 2s, SuperMICAR Data Entry Instruction, 2013

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 line (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)

<table>
<thead>
<tr>
<th>ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH</th>
<th>24. DATE PRONOUNCED DEAD (Mo/Day/Yr)</th>
<th>25. TIME PRONOUNCED DEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)</td>
<td>27. LICENSE NUMBER</td>
<td>28. DATE SIGNED (Mo/Day/Yr)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTUAL OR PRESUMED DATE OF DEATH</th>
<th>ACTUAL OR PRESUMED TIME OF DEATH</th>
<th>WAS MEDICAL EXAMINER OR CORONER CONTACTED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Mo/Day/Yr)</td>
<td>(Spel</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>APPROXIMATE INTERVAL</th>
<th>ONSET TO DEATH</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CAUSE OF DEATH (See instructions and examples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IMMEDIATE CAUSE (Final disease or condition resulting in death)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Due to (or as a consequence of):</td>
</tr>
<tr>
<td>b. Due to (or as a consequence of):</td>
</tr>
<tr>
<td>c. Due to (or as a consequence of):</td>
</tr>
<tr>
<td>d. Due to (or as a consequence of):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. WAS AN AUTOPSY PERFORMED?</td>
</tr>
<tr>
<td>34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>35. DID TOBACCO USE CONTRIBUTE TO DEATH?</th>
</tr>
</thead>
<tbody>
<tr>
<td>36. IF FEMALE:</td>
</tr>
<tr>
<td>37. MANNER OF DEATH</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>0 Yes</td>
</tr>
<tr>
<td>0 Probably</td>
</tr>
<tr>
<td>0 Pregnant at time of death</td>
</tr>
<tr>
<td>0 Natural</td>
</tr>
<tr>
<td>0 Not pregnant, but within 42 days of death</td>
</tr>
<tr>
<td>0 Homida</td>
</tr>
<tr>
<td>0 Accident</td>
</tr>
<tr>
<td>0 Unknown</td>
</tr>
<tr>
<td>0 Suicde</td>
</tr>
<tr>
<td>0 Pending Investigation</td>
</tr>
<tr>
<td>0 Could not be determined</td>
</tr>
<tr>
<td>0 Unknown if pregnant within past year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>38. DATE OF INJURY</th>
</tr>
</thead>
<tbody>
<tr>
<td>39. TIME OF INJURY</td>
</tr>
<tr>
<td>40. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, wooded area)</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>(Mo/Day/Yr)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>41. INJURY AT WORK?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Yes</td>
</tr>
</tbody>
</table>

| 42. LOCATION OF INJURY: State: |
| --- | --- |
| City or Town: |
| Apartment No.: |
| Zip Code: |

<table>
<thead>
<tr>
<th>43. DESCRIBE HOW INJURY OCCURRED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>44. IF TRANSPORTATION INJURY, SPECIFY:</td>
</tr>
<tr>
<td>0 Driver/Operator</td>
</tr>
<tr>
<td>0 Passenger</td>
</tr>
<tr>
<td>0 Pedestrian</td>
</tr>
<tr>
<td>0 Other (Specify)</td>
</tr>
</tbody>
</table>
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.

1. (a) Myocardial infarction
2. (b) Congestive heart failure
3. (c) Congenital heart disease
4. (d)
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)

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)

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)
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:
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

**1500** Congestive heart failure

**Excludes:** Any term indexed to 1500 qualified as advanced, grave, severe, or with a similar qualifier (15000)

*15000 Advanced congestive heart failure
Grave congestive heart failure
Severe congestive heart failure

**Includes:** Any term indexed to 1500 qualified as advanced, grave, severe, or with a similar qualifier

**1514** Myocarditis, unspecified

**Excludes:** Any term indexed to 1514 qualified as arteriosclerotic (15140)

*15140 Arteriosclerotic myocarditis

**Includes:** Any term indexed to 1514 qualified as arteriosclerotic

**1515** Myocardial degeneration

**Excludes:** Any term indexed to 1515 qualified as arteriosclerotic (15150)

*15150 Arteriosclerotic myocardial degeneration

**Includes:** Any term indexed to 1515 qualified as arteriosclerotic

**1600** Subarachnoid hemorrhage from carotid siphon and bifurcation

**Excludes:** Ruptured carotid aneurysm (into brain) (16000)

*16000 Ruptured carotid aneurysm (into brain)

**1606** Subarachnoid hemorrhage from other intracranial arteries

**Excludes:** Ruptured aneurysm (congenital) circle of Willis (16060)

*16060 Ruptured aneurysm (congenital) circle of Willis

**1607** Subarachnoid hemorrhage from intracranial artery, unspecified

**Excludes:** Ruptured berry aneurysm (congenital) brain (16070)
Ruptured miliary aneurysm (16070)

*16070 Ruptured berry aneurysm (congenital) brain
Ruptured miliary aneurysm

**1608** Other subarachnoid hemorrhage

**Excludes:** Ruptured aneurysm brain meninges (16080)
Ruptured arteriovenous aneurysm (congenital) brain (16080)
Ruptured (congenital) arteriovenous aneurysm cavernous sinus (16080)

*16080 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)
1619  Intracerebral hemorrhage, unspecified

**Excludes:** Any term indexed to 1619 qualified as bilateral, multiple, or similar term(22) (16190)

*I6190* Bilateral, multiple [or similar term(23)] intracerebral hemorrhages, unspecified

**Includes:** Any term indexed to 1619 qualified bilateral, multiple, or similar term(24)

1630  Cerebral infarction due to thrombosis of precerebral arteries

**Excludes:** Any term indexed to 1630 qualified as bilateral, multiple, or similar term(25) (16300)

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

**Includes:** Any term indexed to 1630 qualified as bilateral, multiple, or similar term(27)

1631  Cerebral infarction due to embolism of precerebral arteries

**Excludes:** Any term indexed to 1631 qualified as bilateral, multiple, or similar term(28) (16310)

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

**Includes:** Any term indexed to 1631 qualified as bilateral, multiple, or similar term(30)

1632  Cerebral infarction due to unspecified occlusion or stenosis of precerebral arteries

**Excludes:** Any term indexed to 1632 qualified as bilateral, multiple, or similar term(31) (16320)

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

**Includes:** Any term indexed to 1632 qualified as bilateral, multiple, or similar term(33)

1633  Cerebral infarction due to thrombosis of cerebral arteries

**Excludes:** Any term indexed to 1633 qualified as bilateral, multiple, or similar term(34) (16330)

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

**Includes:** Any term indexed to 1633 qualified as bilateral, multiple, or similar term(36)

1634  Cerebral infarction due to embolism of cerebral arteries

**Excludes:** Any term indexed to 1634 qualified as bilateral, multiple, or similar term(37) (16340)

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

**Includes:** Any term indexed to 1634 qualified as bilateral, multiple, or similar term(39)

1635  Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries

**Excludes:** Any term indexed to 1635 qualified as bilateral, multiple, or similar term(40) (16350)

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

**Includes:** Any term indexed to 1635 qualified as bilateral, multiple, or similar term(42)

1636  Cerebral infarction due to cerebral venous thrombosis, nonpyogenic

**Excludes:** Any term indexed to 1636 qualified as bilateral, multiple, or similar term(43) (16360)

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

**Includes:** Any term indexed to 1636 qualified as bilateral, multiple, or similar term(45)

1638  Other cerebral infarction
**Excludes:** Any term indexed to I638 qualified as bilateral, multiple, or similar term(46) (16380)
*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) (16390)
*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)(16400)
*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) (16910)
*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) (16930)
*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) (16940)
*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*
**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.

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.

- **(a) Pneumonia**  
  J189
- **(b) Arteriosclerosis**  
  I709
- **(c) Emphysema**  
  J439

These terms are codable one-term entities.

- **(a) Allergic vasculitis**  
  D690

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

- **(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.

- **(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
“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 N19

   **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
I (a) 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
    (b) Heart disease (rheumatic)
    (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)
    (b) Drug dependence (heroin) (cocaine)

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

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
I (a) AIDS-related tuberculosis
I (a) AIDS encephalopathy
I (a) HIV encephalopathy

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

<table>
<thead>
<tr>
<th>When reported as</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endstage Alzheimer’s, senile dementia</td>
<td></td>
</tr>
<tr>
<td>Senile dementia, Alzheimer’s</td>
<td></td>
</tr>
<tr>
<td>Senile dementia, Alzheimer’s type</td>
<td>G301</td>
</tr>
<tr>
<td>Senile dementia of the Alzheimer’s</td>
<td></td>
</tr>
</tbody>
</table>
When reported as:

- Alzheimer’s, dementia
- 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.

- (a) Cardiac arrest 1469
  (b) Congenital defects

  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.

- (a) Congestive heart failure 1500
  (b) Myocardial 1515
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  
(b) Rupture of esophageal varices  
(c) Cirrhosis of liver due to alcoholism  
(d)  
(e)  

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  
(b) ASHD  

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

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

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.

<table>
<thead>
<tr>
<th>Connection Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>after</td>
<td>incident to</td>
</tr>
<tr>
<td>arising in or during</td>
<td>incurred after</td>
</tr>
<tr>
<td>as (a) complication of</td>
<td>incurred during</td>
</tr>
<tr>
<td>as a result of</td>
<td>incurred in</td>
</tr>
<tr>
<td></td>
<td>secondary to (2°)</td>
</tr>
</tbody>
</table>
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 received from
in received from

I (a) Myocardial infarction 1219
(b) Nephritis due to arteriosclerosis N059
(c) Hypertension from toxic goiter I709
(d)
(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) 164

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

I (a) Death from heart attack 1219
(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)
I 1251
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
- cause of
- caused
- causing
- followed by
- induced
- leading to
- led to
- manifested by
- producing
- resulted in
- resulting in
- underlying
- with resultant
- with resulting
- resulting in
- underlying
- with resultant
- with resulting

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
- accompanied by
- consistent with
- with (c)
also precipitated by associated with predisposing (to)
complicated by superimposed on 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 J40
(b) Emphysema J439
(c) Cancer of lung 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
    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
    CVA I64
(b) Cerebral arteriosclerosis I672

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 I64
    due to cerebral hemorrhage I619
(b) Cerebral arteriosclerosis 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
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 C349 to above

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 J189
Heart murmur, arteriosclerosis 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
   (b) Malignant hypertension
   (c) Chronic nephritis
II Cancer of kidney

II Cancer of kidney

I (a) Cardiac failure
   (b) Arteriosclerotic heart disease
   (c) Emphysema and bronchitis
   (d)

II Pneumonia

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
   (b)
   (e) BPH

I (a) Cardiac arrest
   (b) Cirrhosis of liver
   (c) Alcoholism

II Bronchopneumonia

I (a) Congestive failure
   (b) ASHD
   (c)

II Pneumonia

I (a) Heart block
   (b) Degenerative myocarditis
   (c) Cerebral hemorrhage

II Bronchopneumonia

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

Code 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

Ⅲ 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 I250 E149
   (b) M.I.
   (c) CHF
   (d) Cardiovascular arteriosclerosis
Ⅲ Diabetes

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

Ⅲ 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 J1110
(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 C169 N039
(c) Chronic nephritis

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
(c) 2. Chronic nephritis N039

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  
(b) MI  
(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?  
(b) Meningitis, mastoiditis  
(c) Otitis media

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,  
(b) chronic hypotension  
(c) Cancer

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  
(b) ASHD

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  

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

I (a) Cardiac, respiratory arrest  

Code each site separately since this instruction does not apply to commas.
I. Cardiac respiratory arrest

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

d. When conditions are indexed together yet separated 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.

<table>
<thead>
<tr>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (a) Arteriosclerotic heart disease CVA I251 I64</td>
</tr>
<tr>
<td>(b)</td>
</tr>
<tr>
<td>(c)</td>
</tr>
<tr>
<td>II Arteriosclerosis I709</td>
</tr>
</tbody>
</table>

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).

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Pneumonia, probably aspiration</th>
<th>J189 T179 &amp;W80</th>
</tr>
</thead>
</table>

Disregard the “probably” and code both pneumonia and aspiration as indexed.

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Heart disease probably</th>
<th>1519</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(b) Acute myocardial infarction</td>
<td>1219</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Heart disease possibly acute myocardial infarction</th>
<th>1219</th>
</tr>
</thead>
</table>

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

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 C80
       or kidney

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

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

  **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)

1. (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, circulatory 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.”

1. (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.

1. (a) MI vs coronary aneurysm 1259

   **Code to 1259 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.

1. (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.

1. (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  
(b)  
(c)  
II Gastritis, healed  

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  
(b) Same  
(c) Hypertension  

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

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

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.

1. 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:

<table>
<thead>
<tr>
<th>Lines</th>
<th>Enter Reject Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (a) and I (b)</td>
<td>1</td>
</tr>
<tr>
<td>I (b) and I (c)</td>
<td>2</td>
</tr>
<tr>
<td>I (c) and I (d)</td>
<td>3</td>
</tr>
<tr>
<td>I (d) and I (e)</td>
<td>4</td>
</tr>
</tbody>
</table>

Inconsistent durations between more than two lines in Part I,

Reject 2

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).

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).

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

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

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.
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.

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

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.
1. (a) Pneumonia J181
   (b) 
   (c) 
   Al 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 (&).

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

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

1. (a) Respiratory arrest R092
   (b) Septicemia T814
   (c) 

2. Uremia, cholecystectomy N19 &Y836 &K802
   Al 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.

1. (a) Cardiac arrest I469
   (b) MI I219
   (c) ASHD I251
   (d) E149

2. Al 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.

1. (a) Cancer C349
II
Al 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
   Al 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
   Al 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 I258
   Al 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)
K. Amended certificates

When an “amended certificate” is submitted 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 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 Willis) (coronary)
          (peripheral) (racemose)
          (retina) (venous)
      aortic stenosis
      atresia
      atrophy of brain
      cyst of brain
      deformity
      displacement of organ
      ectopia of organ
      hypoplasia of organ
      pulmonary stenosis
      valvular heart disease (any valve)

   Female, 3 months
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

<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
<th>Code</th>
<th>Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>A32</td>
<td>E14</td>
<td>J13</td>
<td>R00</td>
<td></td>
</tr>
<tr>
<td>A35</td>
<td>E162</td>
<td>J14</td>
<td>R01</td>
<td></td>
</tr>
<tr>
<td>A40</td>
<td>E561</td>
<td>J15</td>
<td>R048</td>
<td></td>
</tr>
<tr>
<td>A41</td>
<td>E63</td>
<td>J16</td>
<td>R090</td>
<td></td>
</tr>
<tr>
<td>A56</td>
<td>E834</td>
<td>J18</td>
<td>R092</td>
<td></td>
</tr>
<tr>
<td>A74</td>
<td>E835</td>
<td>J43</td>
<td>R11</td>
<td></td>
</tr>
<tr>
<td>B30</td>
<td>F10</td>
<td>J80</td>
<td>R17</td>
<td></td>
</tr>
<tr>
<td>B370</td>
<td>F11</td>
<td>J849</td>
<td>R230</td>
<td></td>
</tr>
<tr>
<td>B371</td>
<td>F12</td>
<td>J96</td>
<td>R233</td>
<td></td>
</tr>
<tr>
<td>B372</td>
<td>F13</td>
<td>J981</td>
<td>R290</td>
<td></td>
</tr>
<tr>
<td>B373</td>
<td>F14</td>
<td>J982</td>
<td>R40</td>
<td></td>
</tr>
<tr>
<td>B374</td>
<td>F15</td>
<td>J984</td>
<td>R50</td>
<td></td>
</tr>
</tbody>
</table>
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  I  (a) GSW to head Suicide  S019 &W34

M. Sex limitations

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

<table>
<thead>
<tr>
<th>For Males Only</th>
<th>For Females Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>B260</td>
<td>A34</td>
</tr>
<tr>
<td>C60-C63</td>
<td>B373</td>
</tr>
<tr>
<td>D074-D076</td>
<td>C51-C58</td>
</tr>
<tr>
<td>D176</td>
<td>C796</td>
</tr>
<tr>
<td>D29.-</td>
<td>D06.-</td>
</tr>
<tr>
<td>D40.-</td>
<td>D070-D073</td>
</tr>
<tr>
<td>E29.-</td>
<td>D25-D28</td>
</tr>
<tr>
<td>E895</td>
<td>D39.-</td>
</tr>
<tr>
<td>F524</td>
<td>E28.-</td>
</tr>
<tr>
<td>I861</td>
<td>E894</td>
</tr>
<tr>
<td>L291</td>
<td>F525</td>
</tr>
<tr>
<td>N40-N50</td>
<td>F53.-</td>
</tr>
<tr>
<td>Q53-Q55</td>
<td>I863</td>
</tr>
<tr>
<td>Q98</td>
<td>L292</td>
</tr>
<tr>
<td>R86</td>
<td>L705</td>
</tr>
<tr>
<td>S312-S313</td>
<td>M800-M801</td>
</tr>
<tr>
<td></td>
<td>M810-M811</td>
</tr>
</tbody>
</table>
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  
(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.”

   I (a) Nephritis  
      Duration  
      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

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

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

(1) For the purpose of interpreting these instructions:

<table>
<thead>
<tr>
<th>Consider these terms:</th>
<th>To mean:</th>
</tr>
</thead>
<tbody>
<tr>
<td>brief</td>
<td></td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (a) Aneurysm heart 1219</td>
</tr>
<tr>
<td>(b)</td>
</tr>
<tr>
<td>(c)</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (a) Heart failure 1509</td>
</tr>
<tr>
<td>(b) Bronchitis J209</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (a) Subacute pyelonephritis N10</td>
</tr>
</tbody>
</table>

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
   (b) Chronic lymphocytic leukemia
      C950
      C911

I (a) Exacerbation of chronic
   (b) lymphocytic leukemia
      C910
      C911

I (a) Chronic leukemia with conversion to
   (b) acute phase
      C951
      C950

I (a) Exacerbation of chronic
   (b) pyelonephritis
      N10
      N119

I (a) Exacerbation of bronchitis
   (b)
      J209

I (a) Acute exacerbation of chronic
   (b) bronchitis
      J209
      J42

I (a) Chronic obstructive lung disease exacerbation
   (b)
      J441
      J449

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
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
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.

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.

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.

| I     | (a) Ischemic heart disease       | 2 weeks     | years    | 1259 |

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.

<table>
<thead>
<tr>
<th>Date of death 10-6-98</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (a) MI</td>
<td>10/1/98 - I219</td>
</tr>
<tr>
<td>(b) Ischemic heart disease</td>
<td>10/6/98 I259</td>
</tr>
</tbody>
</table>

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

Date of death 10-6-98

<table>
<thead>
<tr>
<th>I (a) Aneurysm of heart</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/98 - 10/6/98 I219</td>
<td></td>
</tr>
</tbody>
</table>

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

Date of death 10-6-98

<table>
<thead>
<tr>
<th>I (a) Ischemic heart disease</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/98 - 10/6/98 I249</td>
<td></td>
</tr>
<tr>
<td>(b) Arteriosclerosis</td>
<td>1709</td>
</tr>
</tbody>
</table>

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
calcus  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.

1. (a) CVA 164
   (b) Thrombosis 1829
   (c) ASHD 1251

   **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 thrombosis 199 1219
   (c) ASHD 1251

   **Code** Thrombosis, cardiac (1219). 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).
(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 1709

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

I (a) Pulmonary embolism from leg veins 1269
(b) I803
(c)

Code I(a) pulmonary embolism (1269) and I(b) leg veins embolism (1803).

(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 failure 1469 R092

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

I (a) Cardiorespiratory arrest 1469 1509
(b) c insufficiency

Code Insufficiency, heart (1509) 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 1778

Code Vasculitis, kidney (1778). 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 1709 164
(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 hernaia 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** 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 1620  
(b) CVA 164  
(c)  
**Code** Hematoma, subdural, nontraumatic (1620) 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 1620  
**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 1620  
(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** 9 (a) Subdural hematoma S065  
(b) CVA 164  
(c)
Code the subdural hematoma as traumatic since the manner of death is accidental.

Place 1 (a) Cardiorespiratory arrest I469
0 (b) Subdural hematoma S065
   (c) Arteriosclerosis I709
MOD II Advanced age R54 &W18
A

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

Place 1 (a) Cerebral hematoma with S068 I672
9 (b) cerebral arteriosclerosis
   (c)
MOD II &X599
A

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 1620
    (b)
MOD II
N

Code I(a) as nontraumatic since Manner of Death box states “Natural.”
Code I(a) as nontraumatic since Manner of Death box states “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-C97
      R75
      Y431-Y434
      Y632
1. (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

   1. (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.

   1. (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:

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

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:

<table>
<thead>
<tr>
<th>Country Code</th>
<th>ICD Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A30</td>
<td>Leprosy</td>
<td>G608 Hereditary sensory neuropathy</td>
</tr>
<tr>
<td>E10-E14</td>
<td>Diabetes mellitus</td>
<td>G901 Familial dysautonomia</td>
</tr>
<tr>
<td>E538</td>
<td>Subacute combined degeneration (of spinal cord)</td>
<td>G950 Syringomyelia</td>
</tr>
<tr>
<td>F101</td>
<td>Alcohol abuse</td>
<td>Q059 Spina bifida, meningomyelocele</td>
</tr>
<tr>
<td>F102</td>
<td>Alcoholism</td>
<td></td>
</tr>
<tr>
<td>G600</td>
<td>Hypertrophic interstitial neuropathy</td>
<td>Y453 Indomethacin</td>
</tr>
<tr>
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<tr>
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</tr>
</tbody>
</table>
I (a) Charcot’s arthropathy
(b) Diabetes

4. General Paresis (A521)

a. Code G839 (Paralysis)

When reported due to or on the same line with:

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
<th>Code</th>
<th>Code</th>
<th>Code</th>
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<td>A022</td>
<td>A988</td>
<td>B690</td>
<td>D180-D181</td>
<td>I159</td>
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<td>A040</td>
<td>B003-B004</td>
<td>B719</td>
<td>D210</td>
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<td>A051</td>
<td>B010-B011</td>
<td>B75</td>
<td>D233-D234</td>
<td>I748</td>
</tr>
<tr>
<td>A066</td>
<td>B020-B022</td>
<td>B832</td>
<td>D320-D339</td>
<td>J108</td>
</tr>
<tr>
<td>A078</td>
<td>B03-B04</td>
<td>B888</td>
<td>D352</td>
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<td>A170-A179</td>
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<td>A190-A191</td>
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<td>M860-M949</td>
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<td>A260-A289</td>
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<td>B941</td>
<td>D448</td>
<td>O100-O16</td>
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<td>A321-A329</td>
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<td>B948-B949</td>
<td>D45-D479</td>
<td>O740-O749</td>
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<td>C470</td>
<td>D487</td>
<td>O900-O909</td>
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<td>A390-A394</td>
<td>B334-B338</td>
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<td>D489</td>
<td>O95</td>
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<td>E713</td>
<td>O994</td>
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<td>B450-B459</td>
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<td>R270-R278</td>
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<td>A680-A689</td>
<td>B49-B64</td>
<td>C770</td>
<td>G450-G459</td>
<td>R75</td>
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<td>C793-C794</td>
<td>G540-G729</td>
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<td>A800-A959</td>
<td>B676</td>
<td>C798-C97</td>
<td>G839-G98</td>
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<td>A981-A982</td>
<td>B679</td>
<td>D170</td>
<td>I10</td>
<td></td>
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</tbody>
</table>

I (a) CVA with general paresis
(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
- T20-T35
- T66-T79
- T90-T95
- T981-T982
- V010-W43
- W45-W77
- W81-X39
- X50-X599
- X70-X84
- X91-Y09
- Y20-Y369
- Y850-Y872
- Y890-Y899

I (a) General paresis
     (b) Brain injury
     (c) Auto accident

II

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Chronic Viral Hepatitis</th>
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<td>For Viral Hepatitis in Categories</td>
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<td>B161</td>
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<td>B181</td>
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<td>B172</td>
<td>B188</td>
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<tr>
<td>B178</td>
<td>B188</td>
</tr>
<tr>
<td>B179</td>
<td>B189</td>
</tr>
</tbody>
</table>

When reported as causing liver conditions in:

- K721, K7210
- K740-K742
- K744-K746
(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

<table>
<thead>
<tr>
<th>Bacterial organisms classified to A49.-</th>
<th>Viral organisms classified to B34.-</th>
<th>Organisms classified to other than A49.- or B34.-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escherichia coli</td>
<td>Adenovirus</td>
<td>Aspergillus</td>
</tr>
<tr>
<td>Haemophilus</td>
<td>Coronavirus</td>
<td>Candida</td>
</tr>
<tr>
<td>influenza</td>
<td>Coxsackie</td>
<td>Cytomegalovirus</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>Enterovirus</td>
<td>Fungus</td>
</tr>
<tr>
<td>Staphylococcal</td>
<td>Parvovirus</td>
<td>Meningococcal</td>
</tr>
<tr>
<td>Streptococcal</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Infectious conditions

<table>
<thead>
<tr>
<th>Abscess</th>
<th>Infection</th>
<th>Sepsis, Septicemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacteremia</td>
<td>Pneumonia</td>
<td>Septic Shock</td>
</tr>
<tr>
<td>Empyema</td>
<td>Pyemia</td>
<td>Words ending in “itis”</td>
</tr>
</tbody>
</table>

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 c_ 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 & hepatitis K819 B159
(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 meningitis J152 G003

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
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<td>G450-G459</td>
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<td>D760-E149</td>
<td>G600-G979</td>
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<td>I00-I989</td>
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<td>E65-E678</td>
<td>K20-L00</td>
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<td>L230-L309</td>
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<tr>
<td>F100-F199</td>
<td>L500-L599</td>
</tr>
</tbody>
</table>

I (a) Septicemia              A419
### 9. Polycythemia (D45)

Excludes:
- idiopathic
- primary
- rubra
- vera

**Code** D751 (Secondary polycythemia)

When reported due to:

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</tr>
</tbody>
</table>

- (a) Polycythemia
- (b) Pneumonia

- (a) Polycythemia
- (b) Chloromycetin therapy

- (a) Polycythemia vera
- (b) Emphysema

### 10. Hemolytic Anemia (D589)

**Code** D594 (Secondary hemolytic anemia)

When reported due to:
I (a) Hemolytic anemia
   (b) Hairy cell leukemia
   (c)

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

II Hypogammaglobulinemia
I (a) Secondary hemolytic
   (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
1. (a) Pneumonia
   (b) Sideroblastic anemia
   (c) Alcoholic cirrhosis

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

1. (a) CHF
   (b) Sideroblastic anemia
   (c) Chloramphenicol

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
I (a) CVA
(b) Hemorrhagic purpura
(c) Leukemia

13. Thrombocytopenia (D696)

**Code** D695 (Secondary thrombocytopenia)

When reported due to:
<table>
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<th>Code</th>
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<th>Third Column</th>
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</tbody>
</table>
I (a) Multiple hemorrhages
(b) Thrombocytopenia
(c) Cancer lung

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
15. Hyperaldosteronism (E269)

Code E261 (Secondary hyperaldosteronism)

When reported due to:

- MI (I219)
- Hyperaldosteronism (E261)
- 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
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  
(b)
I  (c) Drug use F199

Code drug use to F199. There is no complication reported due to the drug use.

I  (a) Cancer of pancreas C259

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

II  Steroid use

Do not code 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)
MOD II  Cocaine use F149  T405

A

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  I (a) Respiratory failure J969
9 (b) Acute drug use F199
(c)
MOD  II  &X42
A

Accident  Overdose of morphine

Code acute drug use to F199 since reported on the certificate with drug poisoning.

Place  I (a) Poisoning by drugs T509  &X44
9 (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)

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 ☐

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
### 22. Dissociative Disorder (F449)

**Code** F065 (Organic dissociative disorder)

When reported due to conditions classifiable to the following categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
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<td>L88</td>
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<td>I00-J989</td>
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<tr>
<td>L710-L719</td>
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</table>
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)
a. **Code** G214 (Vascular parkinsonism)

When reported due to:

- G214
- I672-I673
- I678-I679
- I698
- I709

  (a) Parkinsonism
  (b) Arteriosclerosis
  (c)

b. **Code** G219 (Secondary parkinsonism)

When reported due to:

- A170-A179
- A504-A539
- A810-A819
- A870-A89
- B003
- B010
- B021-B022
- B051
- B060
- B200-B24
- B261
- B375

  (a) Parkinson's disease
  (b) Tuberculotic meningitis
  (c)

  (a) Secondary Parkinson's disease
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

- (a) Cerebral edema
- (b) Cerebral sclerosis
- (a) Cerebral thrombosis
- (b) Cerebral sclerosis
- (a) ASHD
- (b)
- (c)
- II Cerebral sclerosis, hypertension

27. Myopathy (G729)

Code I429 (Cardiomyopathy)
When reported due to:

- A150-A1690
- A178
- A181
- A188
- B332
- B560-B575
- B948
- D500-D649
- D758
- E100-E149
- E40-E519
- E639
- E641
- E648-E649
- E660-E669
- E740
- E760-E769
- E831
- E880-E889
- I00-I259
- I300-I4290
- I514-I5150
- I700-I709
- P200-P220
- P916
- R31

I (a) Myopathy
(b) ASHD
(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
- F200-F99
- G000-G98
- H600-H749
- H950-J 80
- J82-J 989
- K700-K769
- L00-L989
- M000-N399
- N700-N889
- O000-Q999
- R02
- R040-R049
- R060-R068
- R090-R092
- R291
- R400-R402
- R54
- R560-R5800
- R600-R609
- R630
- R75
- S000-Y899

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
- K20-Q379
- Q390-R825
- R826
- R827-R892
- R893
- R894-R961
- R98-S014
- S017-S023
- S026-S028
- S033
- S035-S098
- S100-Y899

I (a) Respiratory Failure
   (b) Alveolar Hemorrhage

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
   (b) Diaphragmatic hernia
   (c)

35. Laennec's Cirrhosis NOS (K703)

Code K746 (Nonalcoholic Laennec's cirrhosis)

When reported due to:

- A000-B99
- C000-D539
- D730-D739
- E02-E0390
- E100-E149
- E500-E519
- E52
- E530-E849
- F110-F169
- K710-K718
- K730-K760
- K761
- K763
- K768-K851
- K853-K859
- K861-K909
- Q410-Q459Q900-Q999
- R75
- Y574-Y599
- Y640
- Y86
- Y870-Y872
- Y880
- Y881
- Y899
I (a) Cardiac arrest
(b) Laennec's cirrhosis
(c) Diabetes

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
- 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:
I (a) Perforated gastric ulcer
   (b) Gout
   (c) Waldenstrom’s macroglobulinemia

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
   (b) Polyarthrosis
   (c) Obesity
40. Coxarthrosis (M169)

Code (a) M166 (Coxarthrosis, secondary, bilateral):
(b) M167 (Coxarthrosis, secondary, NEC, (unilateral))

When reported due to:

- (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

- (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  
  (b) Arthrosis
  (c) Senility

    Code I(b) secondary arthrosis, M192, since reported due to senility.

43. **Kyphosis (M402)**

**Code** M401 (Secondary kyphosis)

When reported due to:

- A1690
- A180
- B902
- B91
- C400-C419
- C490-C499
- C795
- D166
- D480
- E200-E215
- E550-E559

  E890-E899  
  G110-G119  
  G20-G2000  
  G35-G379  
  G540-G549  
  G600-G839  
  G950-G959  
  G970-G979  
  M000-M120  
  M150-M1990

  M359-M489  
  M800-M949  
  M960-M969  
  Q050-Q059  
  Q760-Q799  
  Q850  
  Q870-Q878  
  Q893-Q999  
  S000-Y899

  M150-M1990

  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
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 (b) Osteonecrosis hip (c) Infective myositis

**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
(a) Anemia and gastric ulcer
(b) Menorrhagia with dysmenorrhea
(c) Cancer of endocervix

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:

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>O100-O209</td>
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<td>O230-O249</td>
<td>O621</td>
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<td>O260-O264</td>
<td>O670-O679</td>
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<td>O980-O998</td>
</tr>
<tr>
<td>O330-O349</td>
<td></td>
</tr>
</tbody>
</table>

I (a) Cardiac arrest
(b) Uterine inertia
(c) Diabetes mellitus of pregnancy

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)
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**

- (a) Cerebral hemorrhage
- (b) Fractured skull during birth

**Code** I(a) cerebral hemorrhage due to birth injury, P101, since reported due to a fracture skull occurring during birth.

**Female, 2 weeks**

- (a) Cerebral hemorrhage

**Male, 9 hours**

- (a) Cerebral hemorrhage
- (b) Fractured skull during birth
- (c)

**Code** I(a) anoxic brain damage, P219, since reported due to congenital heart disease.
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:

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<tr>
<th>Code 1</th>
<th>Code 2</th>
<th>Code 3</th>
<th>Code 4</th>
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<td>Q240-Q249</td>
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<td>R688-R799</td>
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<td>M800-M959</td>
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<td>N600-N96</td>
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b. When reported on the same line with:

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<td>I200-I339</td>
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<tr>
<td>I400-I519</td>
<td></td>
</tr>
</tbody>
</table>

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
   (b)
   (c)
II Prematurity
   
   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)

Code M844 (Pathological fracture)

a. When reported due to:

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<tr>
<th>Code 1</th>
<th>Code 2</th>
<th>Code 3</th>
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<td>A500-A509</td>
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<td>M359</td>
<td>M893-M895</td>
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b. When reported due to or on the same line with:

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<td>M88</td>
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<tr>
<td>C795</td>
<td>M83</td>
<td></td>
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</table>

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

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
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”

  1. (a) Osteosarcoma of leg  \( \text{C402} \)

     **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”

  1. (a) Melanoma of arm  \( \text{C436} \)

  Based on the note in the Index, code melanoma of arm as indexed under **Melanoma, site classification**.

  1. (a) Melanoma of stomach  \( \text{C169} \)

  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”

  1. (a) Sebaceous cell carcinoma nose  \( \text{C443} \)

     **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. Malignant neoplasms with primary site indicated

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

        Code carcinoma of bladder as secondary and code primary malignant neoplasm of kidney.

        I (a) Primary cancer of lung
            C349
        (b) Cancer of breast
            C798

        Code 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

        Code 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
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 C349

       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  
  (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  
  (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  
  (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  
  (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  
  (b) Astrocitoma  

  **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.
(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 lymphocytic leukemia 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  
Code each site primary.

I  (a) Cancer of breast  
   (b) Cancer of endometrium  
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:

<table>
<thead>
<tr>
<th>Site</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone</td>
<td>Lymph nodes</td>
</tr>
<tr>
<td>Brain</td>
<td>Mediastinum</td>
</tr>
<tr>
<td>Central nervous system</td>
<td>Meninges</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>Peritoneum</td>
</tr>
<tr>
<td>Heart</td>
<td>Pleura</td>
</tr>
<tr>
<td>Liver</td>
<td>Retroperitoneum</td>
</tr>
<tr>
<td>Lung</td>
<td>Spinal cord</td>
</tr>
</tbody>
</table>

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.

  II (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  

Code secondary malignant neoplasm of pleura and secondary malignant neoplasm of mediastinum on I(a).

I  (a) Peritoneal carcinoma  
II Liver carcinoma  

Code secondary malignant neoplasm of peritoneum on I(a) and secondary malignant neoplasm of liver in Part II.

I  (a) Cancer of brain  
   (b) Cancer of lung  

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  
   (b) Cancer of liver  

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  
   (b) Bladder cancer  
   (c) Colon cancer  

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  
II Mammary carcinoma  

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
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.

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### 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 teratoma

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 teratoma (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.

<table>
<thead>
<tr>
<th>Extension</th>
<th>Infiltration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasion</td>
<td>in,</td>
</tr>
<tr>
<td>Involvement</td>
<td>into, of,</td>
</tr>
<tr>
<td>Metastatic</td>
<td>or to another site</td>
</tr>
<tr>
<td>Secondaries</td>
<td>Spread</td>
</tr>
</tbody>
</table>

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 C679 C791
(b) infiltration into the ureter

**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

Code primary malignant neoplasm of pancreas since one site is reported and it is not a common site.

I (a) Metastatic cancer of lung

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

Code as indexed. Melanoma is a morphological type of neoplasm and is indexed to C439.

I (a) Metastatic Hodgkin’s Disease

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

Code as indexed. Hypernephroma is a site specific neoplasm and is indexed to C64.

I (a) Metastatic meningioma

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.
1. (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.

1. (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.

1. (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.

1. (a) Metastatic sarcoma of stomach C169

   **Code** as indexed.

(5) If a single morphological type, other than a 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.

1. (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 lymph nodes C459 C779

   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  
Code to primary neoplasm of each site since adenocarcinoma and sarcoma are of different morphological types.

I  
(a) Metastatic cancer of pleura  
(b) Metastatic melanoma of back  

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  

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  
(b) Carcinoma of gallbladder  
(c) Metastatic carcinoma of colon  

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).

II  
Carcinoma of colon  

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  
(b) Metastatic cancer of prostate  

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  
II  Cancer of colon  
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 
(b) Metastatic cancer of breast  
(c) Metastatic cancer of lung  
Code secondary neoplasm of each site listed. All sites are reported as metastatic.

I  (a) Metastatic carcinoma of ovary  
(b) Carcinoma of lung  
(c) Metastatic pancreatic carcinoma  
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  
(b) Lung cancer  
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  
(b) Metastatic lung cancer  
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  
(b) Metastatic carcinoma of colon  
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 since 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.

1. (a) Generalized metastases
   (b) Melanoma of back
   (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.

1. (a) Secondary carcinoma of liver
   (b) Primary site unknown

   Code secondary liver carcinoma preceded with C80.

1. (a) Carcinoma of stomach
   (b) Primary site unknown

   Code secondary stomach carcinoma preceded with C80.

1. (a) Carcinoma of stomach
   (b) Primary site of carcinoma unknown

   Code I(a) secondary carcinoma of stomach preceded with C80. Code I(b) C80 for carcinoma since the term carcinoma is repeated.

1. (a) Cancer of intestines, stomach,
   (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
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.

   (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.

   (a) Metastatic cancer (primary bladder)  C80 C679

   Code C80 and primary cancer of the bladder.

   (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

   (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  
(b) Lung tumor     

\textit{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  
(b) Carcinoma in situ of breast     

\textit{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  
(b) Small intestine tumor     

\textit{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.

\textbf{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     

\textit{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     

\textit{Since} the morphological type of the term “carcinoma” is C80, code I(a), carcinoma in lung area, to the appropriate
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.

   - (a) Myocarditis 1090
     - (b) Rheumatic heart disease 1099

       Consider “myocarditis” to be described as “rheumatic” since reported with a heart disease specified as rheumatic.

   - (a) Cardiac tamponade 1092
     - (b) Rheumatic endocarditis 1091

       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.

   - (a) Heart disease 1099
     - (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.

   - (a) Rheumatic heart disease 1099
     - (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.

   - (a) Cardiac arrest 1469
     - (b) Rheumatic fever 100

       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.
(a) Heart failure
(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
(b) Rheumatic heart disease

Since there is a heart disease qualified as rheumatic reported on the record, code heart failure, 1509.

2. Distinguishing between active and chronic rheumatic heart disease

Rheumatic heart diseases are classifiable to 1010-1019, Rheumatic fever with heart involvement, or to 1050-1099, 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
(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
(b) Inactive rheumatic heart disease

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
(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.
(3) One of these heart diseases is pericarditis.

- (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.

- (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

- (a) Rheumatic heart disease I019
- (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.

- (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               1061
    (b) Mitral endocarditis with        1059 1051
    (c) mitral insufficiency

Code the diseases of both valves as rheumatic since there is no indication to the contrary.

I  (a) Mitral endocarditis c_          1059 1051 1050
    (b) insufficiency and stenosis
    (c) Aortic endocarditis            1069

Code the diseases of both valves as rheumatic since there is no indication to the contrary.

I  (a) Mitral valve disease          1059 1051 148
    (b) with insufficiency and
    (c) atrial fibrillation
II Aortic stenosis                  1060

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  1051 1050

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            1319
    (b) Mitral stenosis          1050

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:

- 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 1500
(b) Mitral stenosis 1342
(c) Arteriosclerosis 1709

Code the mitral stenosis as nonrheumatic since the certifier indicated it was due to a nonrheumatic cause.

I (a) Aortic and mitral insufficiency 1351 1340
(b) Subacute bacterial endocarditis 1330

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.

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  I (a) Asphyxia by hanging  T71  &X70
      9 (b)
      MOD  II 1st trimester pregnancy  O95

      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 O960-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 O97 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 a direct 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
1 (a) Septicemia O080
(b) Tubal pregnancy O001

Code I(a) Abortion, complicated by, septicemia (O080) and I(b) Pregnancy, tubal (O001).

Female, 20 years
1 (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
1 (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
1 (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 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  
(b) Delivery  
II  Rubella in first trimester  

**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)**.

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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  
      (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  
      (b) Obstructed labor  

   **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  
      (b) Anesthesia - delivery  

   **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
(b) Intestinal obstruction

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
(b) Hydrocephalus & hypoplasia
(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
(b) Hydrocephalus
II Meningomyelocele

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 weeks but less than 37 weeks..............P073
   42 or more completed weeks......................

Premature labor or delivery NOS.................................P073

Female, 3 hours
I (a) Respiratory distress syndrome
(b) Prematurity
II 26 weeks gestation

P220
P073
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)
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 cause. ICD-10 provides sequela codes for

- 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
- G09 Sequela of hyperalimentation
- I690-I698 Sequela of inflammatory diseases of central nervous system
- O970-O979 Sequela of cerebrovascular disease
- T900-T983* Death from sequela of obstetric causes
- Y850-Y859* Sequela of injuries, of poisoning, and of other consequences of external causes
- Y86* Sequela of transport accidents
- Y870-Y872* Sequela of other accidents
- Y880-Y893* Sequela of intentional self-harm, assault and events of undetermined intent
- Y890-Y899* Sequela with surgical and medical care as external cause
- 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.

   - (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, cured, healed, history of, inactive, old, quiescent, or remote, whether or not the residual (late) effect is specified, unless there is evidence of active tuberculosis.

   - (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, cured, healed, history of, old, quiescent, remote) tuberculosis of a different site, code both.

d. When there is evidence of active and inactive (ancient, arrested, cured, healed, 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.

   - (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.

   - (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 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, 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  
   [B941]
Code sequela of viral encephalitis, since a duration of 1 year is reported.

I (a) Old viral encephalitis
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
(b) Viral encephalitis
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**

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, cured, healed, 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
(b) Chickenpox
I (a) Chronic brain syndrome
(b) Meningococcal encephalitis

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, 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, 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 1693

Code sequela of cerebrovascular occlusion since the duration is one year or more.

I (a) History of CVA 9 mos 1694

Code sequela of CVA since “history of” CVA is reported.

d. The condition in I600-I6400, and I670-1671, 1674-1679 is reported with paralysis (any) stated to be ancient, 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 1694 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
  - (a) Sudden death  \( R95 \)

- Male, 3 weeks
  - (a) Sudden death, cause unknown  \( R95 \)
  - (b) \( R97 \)

- Female, 3 months
  - (a) SIDS, pneumonia  \( R95 \ J189 \)

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**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
  - (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)

**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. **Unknown cause (R97)**

Includes:

- Cause not found
- Immediate cause unknown
- Cause unknown
- No specific etiology identified
- Cause undetermined
- No specific known causes
- Could not be determined
- Nonspecific causes
- Etiology never determined
- Not known
- Etiology not defined
- Obscure etiology
- Etiology uncertain
- Undetermined
- Etiology unexplained
- Uncertain
- Etiology unknown
- Unclear
- Etiology undetermined
- Unexplained cause
- Etiology unspecified
- Unknown
- Final event undetermined
- ? Cause
- Immediate cause not determined
- ? 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  
(b) Cause unknown  
(c) Carcinomatosis

I (a) Unknown cause  

I (a) Intestinal obstruction  
(b) Unknown, possibly cancer

I (a) Amyloidosis  
(b) Chronic ulcerative colitis

II Cirrhosis of liver, cause unknown

Place  I (a) Cardiac arrest  
(b) Hip fracture  
MOD (c) Fall

A II 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  
(b)  

I (a) Unknown cause  
(b) Found dead
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......................
- 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
- Anaphylactic, 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
<table>
<thead>
<tr>
<th>Entity</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse (child) (elder) (spousal)</td>
<td>Hypothermia</td>
</tr>
<tr>
<td>Airway obstruction by foreign body</td>
<td>Immersion</td>
</tr>
<tr>
<td>Alcohol intoxication (any term meaning intoxication)</td>
<td>Impact injury (any site)</td>
</tr>
<tr>
<td>Anastomotic leak</td>
<td>Impact to a site (any)</td>
</tr>
<tr>
<td>*Asphyxia</td>
<td>Incised (wound)</td>
</tr>
<tr>
<td>*Aspiration</td>
<td>Ingestion of foreign body</td>
</tr>
<tr>
<td>Battered child (syndrome)</td>
<td>Lightning (struck by)</td>
</tr>
<tr>
<td>Bite</td>
<td>Mangled</td>
</tr>
<tr>
<td>Blunt blow to a site</td>
<td>Mechanical trauma</td>
</tr>
<tr>
<td>Blunt force injury (any site)</td>
<td>Overdose (of drug or alcohol)</td>
</tr>
<tr>
<td>Blunt force to a site (any)</td>
<td>Overheated</td>
</tr>
<tr>
<td>Blunt impact to a site (any)</td>
<td>Overexertion</td>
</tr>
<tr>
<td>Blunt injury (any site)</td>
<td>Poisoning (by substance)</td>
</tr>
<tr>
<td>Blunt trauma (any site)</td>
<td>Pulled trigger</td>
</tr>
<tr>
<td>Bullet (to site)</td>
<td>Puncture, punctured (any site)</td>
</tr>
<tr>
<td>Bullet wound</td>
<td>Puncture wound</td>
</tr>
<tr>
<td>Child neglect</td>
<td>Radiation burns</td>
</tr>
<tr>
<td>Choking on foreign body</td>
<td>Rape</td>
</tr>
<tr>
<td>Crushed by specified object</td>
<td>Razor cut</td>
</tr>
<tr>
<td>Cut</td>
<td>Shooting, shot (to site)</td>
</tr>
<tr>
<td>Drowning</td>
<td>Shotgun blast (to site)</td>
</tr>
<tr>
<td>Electrocution</td>
<td>Slash, slashed (any site)</td>
</tr>
<tr>
<td>Electrical burns</td>
<td>Smothered</td>
</tr>
<tr>
<td>Electrical shock</td>
<td>Snake bite</td>
</tr>
<tr>
<td>Exposure (to element) (cold, heat)</td>
<td>Stab</td>
</tr>
<tr>
<td>Firearm (any type) (discharge)</td>
<td>Sting</td>
</tr>
<tr>
<td>Flame burn</td>
<td>Strangulation</td>
</tr>
<tr>
<td>Foreign body in any site</td>
<td>Submersion</td>
</tr>
<tr>
<td>Freezing, froze, frostbite</td>
<td>Suffocation</td>
</tr>
<tr>
<td>Got too hot</td>
<td>Sunstroke</td>
</tr>
<tr>
<td>Gun went off</td>
<td>Suspension, suspended</td>
</tr>
<tr>
<td>Gunshot (to site)</td>
<td>Swallowed object</td>
</tr>
<tr>
<td>Gunshot wound</td>
<td>Toxicity (of substance)</td>
</tr>
<tr>
<td>Hanging (by neck)</td>
<td>Vehicular trauma</td>
</tr>
</tbody>
</table>
Heat exhaustion
Heat stress
Heat stroke
Weapon wound
.22, .32 or any caliber

(* 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,

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a) Gunshot wound of chest</th>
<th>S219 &amp;W34</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c)</td>
<td></td>
</tr>
<tr>
<td>MOD</td>
<td>II</td>
<td>Accident</td>
</tr>
<tr>
<td>A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a) Laceration of throat</th>
<th>S118</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b) Dog bite of shoulder,</td>
<td>S410 &amp;W54 T111 S119</td>
</tr>
<tr>
<td></td>
<td>(c) arm and neck</td>
<td></td>
</tr>
</tbody>
</table>

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).

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a) Fracture skull</th>
<th>S029</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b) Fell from window, crushed</td>
<td>S280 &amp;W13 S381</td>
</tr>
<tr>
<td></td>
<td>(c) chest and abdomen</td>
<td></td>
</tr>
</tbody>
</table>

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
0 (b) Injury kidney, liver and (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
9 (b) Blow to right temporal area

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
9 (b) Broken rib
(c) Fracture hip and arm

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
9 II Blunt impact injury to head
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 | I | (a) Aspiration | T179 &W78
0 | (b) Vomitus
II | Fx Hip Fall at home | S720 &W19

Amper sand 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 | I | (a) Aspiration of vomitus | T179 W78
0 | (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 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  I   (a) Aspiration of vomitus T179 W78
         9   (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.

<table>
<thead>
<tr>
<th>Place</th>
<th>I</th>
<th>(a) Drowning</th>
<th>T751 &amp;W74</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>II</td>
<td>(b) Alcohol intoxication</td>
<td>T519 X45</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drinking heavily</td>
<td>F101</td>
</tr>
</tbody>
</table>

Precede the code for the drowning with an ampersand since it is the first external cause reported. Code Part II as indexed.

<table>
<thead>
<tr>
<th>Place</th>
<th>I</th>
<th>(a) Alcohol intoxication and hip fx</th>
<th>T519 &amp;X45 §720</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>II</td>
<td>Fall while intoxicated</td>
<td>W19 T519</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>I</th>
<th>(a) Crushed chest</th>
<th>S280 &amp;X599</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>II</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Code Crushed (accidentally), X599 as indexed.

<table>
<thead>
<tr>
<th>Place</th>
<th>I</th>
<th>(a) Fracture of hip and arm</th>
<th>S720 T10 &amp;X590</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>II</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Code Fracture (circumstances unknown or unspecified), X590 as indexed.

<table>
<thead>
<tr>
<th>Place</th>
<th>I</th>
<th>(a) Penetrating wound of abdomen</th>
<th>S318 S219 &amp;X599</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>II</td>
<td>(b) and chest</td>
<td></td>
</tr>
</tbody>
</table>

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** I  (a) Brain injury 9  (b) Fracture of skull  
II  
**Code** Fracture (circumstances unknown or unspecified), X590.

**Place** I  (a) Fracture of hip 9  (b) Crushing hip injury  
II  
**Code** Crushed (accidentally), X599.

**Place** I  (a) Cerebral concussion and 9  (b) laceration of brain  
II  
**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 9  II  
**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 9  II  
**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
II (b) Crushing injury S770
&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
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
II (b) Wound T141
&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
Since pneumothorax is reported on the certificate with an injury, code pneumothorax as traumatic.

Consider cerebral hemorrhage to be traumatic since Accident is reported in the Manner of Death box.

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.

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 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  I (a) Cardiac arrest I469
   9      (b) Organic brain syndrome F069
          (c) Brain injury S069
          (d) Fall &W19
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.

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Traumatic cerebral thrombosis</th>
<th>S069</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(b) Fall</td>
<td>&amp;W19</td>
</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Traumatic coma</th>
<th>T149 R402</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(b) Fall</td>
<td>&amp;W19</td>
</tr>
</tbody>
</table>

*Code* trauma unspecified and coma separately.

4. Traumatic hemorrhage (T148, T149)

<table>
<thead>
<tr>
<th>Internal hemorrhage NOS</th>
<th>Due to or on same line with injury (any site)</th>
<th>Code the hemorrhage to T148, internal injury NOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemorrhage NOS</td>
<td>Due to injury of a specified site</td>
<td>Relate the hemorrhage to the site of the specified injury</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Due to injury NOS or multiple injuries NOS</td>
<td>Code the hemorrhage to T149, injury NOS</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Due to injury of multiple specified sites</td>
<td>Relate the hemorrhage to site of the first mentioned specified injury</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Due to internal injury NOS or internal injuries NOS</td>
<td>Code the hemorrhage to T148, internal injury NOS</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>On same line with injury of site</td>
<td>Relate the hemorrhage to the site of the specified injury</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>On same line with injury of multiple specified sites</td>
<td>Code the hemorrhage to T149, injury NOS</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>On same line with</td>
<td>Code the hemorrhage to T148,</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place</td>
<td>I (a)</td>
<td>Internal hemorrhage</td>
</tr>
<tr>
<td>-------</td>
<td>-------</td>
<td>----------------------</td>
</tr>
<tr>
<td>9</td>
<td>(b)</td>
<td>Crushed thorax</td>
</tr>
<tr>
<td></td>
<td>(c)</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a)</th>
<th>Hemorrhage</th>
<th>S799</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b)</td>
<td>Fracture of femur</td>
<td>S729</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c)</td>
<td></td>
<td>&amp;X590</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a)</th>
<th>Hemorrhage</th>
<th>S299</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b)</td>
<td>Laceration of chest</td>
<td>S219</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c)</td>
<td></td>
<td>&amp;X599</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a)</th>
<th>Hemorrhage</th>
<th>T149</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b)</td>
<td>Multiple injuries</td>
<td>T07</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c)</td>
<td></td>
<td>&amp;X599</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a)</th>
<th>Hemorrhage</th>
<th>S299</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b)</td>
<td>Injury of chest, lung and fractured rib</td>
<td>S299 S273 S223</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c)</td>
<td></td>
<td>&amp;X599</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a)</th>
<th>Contusion chest with hemorrhage</th>
<th>S202 S299</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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
1. (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

   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:

<table>
<thead>
<tr>
<th>Stated as</th>
<th>Code as indexed under</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilateral</td>
<td>Injury (or specified type of injury), site, bilateral</td>
</tr>
<tr>
<td>Both</td>
<td>Injury (or specified type of injury), site, both</td>
</tr>
</tbody>
</table>
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
   
   Fracture
   - hip
   - - both T025

2. Fracture of hips

   Fracture
   - hip S720

3. Multiple fractures of ribs

   Fracture
   - rib
   - - multiple S224

4. Fractures of ribs

   Fracture
   - rib S223

5. Multiple wounds of lower limb

   Wound
   - limb
   - - lower NEC
   - - - multiple sites T013

<table>
<thead>
<tr>
<th>1. Multiple injuries</th>
<th>Followed by specified type(s) of injuries</th>
<th>Code T07 and the specified injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Multiple injuries</td>
<td>Followed by specified site(s)</td>
<td>Code multiple injuries by site(s) only</td>
</tr>
<tr>
<td>3. Single site</td>
<td>Reported on same line with multiple types of injuries</td>
<td>Code the specified types of injuries of the reported site</td>
</tr>
</tbody>
</table>
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 9 (b) fracture skull and (c) laceration brain II &X599

2. Place I (a) Multiple injuries - head, neck, chest 9 II &X599

3. Place I (a) Fracture, laceration and contusion 9 (b) of leg (c) Fall from roof II &W13

4. Place I (a) Contusions, lacerations, fracture of trunk 9 (b) and extremities 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 I (a) 2nd and 3rd degree burns T203 T213
0 (b) of face, chest wall and abdomen (c) MOD A II &X00

Code 3rd degree burns of each site reported.

Place I (a) 2nd and 3rd degree burns 9 (b) (c) T303

Accident home house fire
2. When a percentage of burns or a percentage of body (entire, total) burns is reported, code to the percentage.

   Place  I (a) Burns of 50% of T315
   9 (b) body surface
   (c) MOD II &X06
   A

   **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  I (a) 30-40%, 2nd and 3rd degree burns of body T314
   0 (b) MOD II &X00
   (c) House fire

   **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  I (a) Burns, 76% of face, anterior trunk, and T200 T210 T300
   8 (b) extremities
   (c) MOD II &X00 T300
   A

   **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 I (a) Impact injury, upper arm
   9
   Indexed as:
   Injury
   - arm NEC T119
   - - upper S499
   - - - specified NEC S498

   Place I (a) Blunt injury, trunk
   9
   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 I (a) Fracture third cervical vertebra
   9 (b) Fall
   Indexed as:
   Fracture
   - vertebra T08
   - - cervical (teardrop) S129
   - - - specified NEC S122

   Place I (a) GSW right side of neck
   9
   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, pages XX-9 – XX-17. 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
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).

\[\begin{array}{l}
\text{(a) Laceration lung} & \text{S273} \\
\text{(b)} & \\
\text{(c) Accident} & \text{&V575}
\end{array}\]

\text{MOD II}

\[\begin{array}{c}
\text{Accident} \\
\text{Truck struck bridge} \\
\text{Driver}
\end{array}\]

\text{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.

\[\begin{array}{l}
\text{(a) Fractured skull} & \text{S029} \\
\text{(b)} & \\
\text{&V866}
\end{array}\]

\text{MOD II}

\[\begin{array}{c}
\text{Accident} \\
\text{Farm} \\
\text{Dune buggy} \\
\text{overturned-passenger}
\end{array}\]

\text{Code} to passenger of all-terrain or other off-road motor vehicle injured in nontraffic accident.

\[\begin{array}{l}
\text{(a) Drowning} & \text{T751 &V863} \\
\text{(b)} & \\
\text{&V863}
\end{array}\]

\text{MOD II}

\[\begin{array}{c}
\text{Accident} \\
\text{Snowmobile ran off road and went into pond}
\end{array}\]

\text{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.

\[\begin{array}{l}
\text{(a) Multiple internal injuries} & \text{T065} \\
\text{(b) Crushed by car} & \text{T147 &V031}
\end{array}\]

\text{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:

<table>
<thead>
<tr>
<th>pedestrian</th>
<th>versus (vs)</th>
<th>any vehicle (car, truck, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>any vehicle (car, truck, etc.)</td>
<td>versus (vs)</td>
<td>pedestrian</td>
</tr>
</tbody>
</table>

classify the victim as a pedestrian (V01-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

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

_________ _______ _____________________________
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.

   (a) Multiple injuries
   (b) Head injury

2. Consider a transport vehicle to be stationary when statements such as these are reported:
   (a) When alighting, boarding, entering, leaving, exiting, getting in or out of vehicle
   (b) Stated as stationary, parked, not in transit, not in motion

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.

   (a) Head injury

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.

   (a) Head injury

Refer to Table of land transport accidents under Victim and mode of transport. Select occupant of motor vehicle (traffic),
noncollision transport accident (V892).

Place 1 (a) Head injury S099
MOD II &W17
A

Accident Street Fell from parked car

Code as indexed under Fall, from, vehicle, stationary (W17).

5. Additional examples

1 (a) Fractures of ribs S223
(b)
(c)
MOD II &V234
A

Accident Driver of motorcycle that collided with taxicab

Code to motorcycle rider injured in collision with car, pick-up truck or van, driver (V234).

1 (a) Third degree burns T303
(b) Auto accident - car overturned &V489
(c)

Code to car occupant injured in noncollision transport accident, unspecified (V489).

1 (a) Fracture of ribs S223
(b) (c)
MOD II &V892
A

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
(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
(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
(b) 
(c) Auto vs. motor bike accident

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
(b) Driver - collision of car and bus
(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
(b) Bus and pick-up truck collision, driver
(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.

(a) Drowning T751 &V929
(b) Fell over-board

MOD II
A

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 &V892 MOD 8

<table>
<thead>
<tr>
<th>A</th>
<th>Accident</th>
<th>Highway</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>I</th>
<th>(a) Multiple head injuries &amp;V489 MOD II</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Multiple head injuries &amp;Y32 MOD II</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Multiple traumatic injuries &amp;Y03 MOD II</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Decedent run over by vehicle &amp;Y03 MOD II</th>
</tr>
</thead>
</table>

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.
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 | H | Hit and run - driver left scene of accident |

Homicide

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
- Place 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
- Place 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

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a) Fracture right hip</th>
<th>S720</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Fell at nursing home</td>
<td>&amp;W19</td>
</tr>
</tbody>
</table>

MOD
A Accident Nursing Home

Code external cause to fall, unspecified.

1. 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).

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a) Shock</th>
<th>T750</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b) Struck by lightning</td>
<td>&amp;X33</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a) Burns</th>
<th>T300</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>(b) House fire</td>
<td>&amp;X00</td>
</tr>
<tr>
<td></td>
<td>(c) House struck by lightning</td>
<td>&amp;X00</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a) Exposure</th>
<th>T758 X599</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b) Intoxication with hip fx</td>
<td>T519 &amp;X45 S720</td>
</tr>
<tr>
<td>II</td>
<td>X590</td>
<td></td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Type Firearm</th>
<th>Accidental</th>
<th>Intentional Self-harm</th>
<th>Assault</th>
<th>Undetermined Intent</th>
</tr>
</thead>
</table>
| 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:
<table>
<thead>
<tr>
<th>Handgun</th>
<th>W32</th>
<th>X72</th>
<th>X93</th>
<th>Y22</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 Caliber</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 Caliber</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38 Caliber</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45 Caliber</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>357 Magnum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>380 Caliber</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pistol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revolver Saturday night special</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rifle, shotgun, larger firearm</th>
<th>W33</th>
<th>X73</th>
<th>X94</th>
<th>Y23</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.06 (25 ought 6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.6 (30 ought 6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30/30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>308</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AK47</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M1 (carbine)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Machine gun</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rifle (army) (hunting) (military)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shotgun (8, 10, 12, 16, 20, 410 gauge, buckshot)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other and unspecified firearms</th>
<th>W34</th>
<th>X74</th>
<th>X95</th>
<th>Y24</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 mm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 Caliber gun</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Caliber gun</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Airgun</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BB gun</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pellet gun</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pellet pistol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very pistol (Flare)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 | I (a) Gunshot wound of femur | S711 &W34
|       | (b) Cleaning gun | T141

Code as accidental since reported due to cleaning gun.

| Place | I (a) Gunshot wound chest | S219 &W32
| MOD | II (b) Self-inflicted while playing Russian roulette |  

Code as handgun accident since Russian roulette is reported.

3. Nature of injury code
   a.

<table>
<thead>
<tr>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury NOS</td>
<td>any caliber bullet \ngun went off \npulled trigger \nspecified firearm</td>
<td>the nature of injury to wound</td>
</tr>
</tbody>
</table>
b. **When reported as**

<table>
<thead>
<tr>
<th>Gunshot or bullet entering and/or exiting a site</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>the nature of injury to wound of site(s)</td>
<td></td>
</tr>
</tbody>
</table>

c. **When reported as**

<table>
<thead>
<tr>
<th>Bullet (to site)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>the nature of injury to wound (of site(s))</td>
<td></td>
</tr>
</tbody>
</table>

4. Other firearm examples

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Gunshot wound chest (b) Self-inflicted</th>
<th>S219 &amp;Y24</th>
</tr>
</thead>
</table>

**Code** as undetermined gunshot since self-inflicted is reported and is unspecified as accidental or intentional.
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 II &Y079
    H

    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 II &Y079
    H

    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 II Injury occurred by child being struck T149 &Y079
    H

    ________
**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.

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Hypovolemic shock</th>
<th>T794</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>(b) Laceration of heart</td>
<td>S268</td>
</tr>
<tr>
<td>MOD</td>
<td>(c) Multiple stab wounds thorax</td>
<td>S217 &amp;X99</td>
</tr>
</tbody>
</table>

**Female, 1 year**

- **Place I** (a) Hypovolemic shock T794
- **0** (b) Laceration of heart S268
- **MOD 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** &J 690
- **(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>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Drowning and submersion</td>
</tr>
<tr>
<td>Table 2</td>
<td>*Hanging and mechanical strangulation (by external means)</td>
</tr>
<tr>
<td>Table 3</td>
<td>Fires (includes burns, gases, fumes in association with burns and fires)</td>
</tr>
<tr>
<td>Table 4</td>
<td>Ingestion, inhalation of gases, fumes, vapors (without fires, burns)</td>
</tr>
<tr>
<td>Table 5</td>
<td>Compression chest, crushed chest by external means</td>
</tr>
<tr>
<td>Table 6</td>
<td>Aspiration NOS, ingestion NOS, inhalation NOS or aspiration, ingestion, inhalation of substances or objects (W78, W79, W80)</td>
</tr>
</tbody>
</table>

*NOTE:* Interpret mechanical strangulation as strangulation caused by external means to the exterior of the body.

**Table 1. Drowning and submersion**

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>anoxia asphyxia strangulation suffocation</td>
<td>drowning submersion</td>
<td>upper line T751 and the appropriatev external cause code.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>lower line T751 only.</td>
</tr>
</tbody>
</table>
**Examples - Corresponding Table and Instruction 1.1**

<table>
<thead>
<tr>
<th>Place</th>
<th>1</th>
<th>(a) Asphyxia</th>
<th>T751 &amp;W69</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8</td>
<td>(b) Drowning</td>
<td>T751</td>
</tr>
<tr>
<td>MOD</td>
<td>A</td>
<td>(c)</td>
<td>T751</td>
</tr>
</tbody>
</table>

Accident | Drowned while swimming in river

<table>
<thead>
<tr>
<th>Place</th>
<th>1</th>
<th>(a) Asphyxia</th>
<th>T751 &amp;V909</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8</td>
<td>(b) Strangulation</td>
<td>T751</td>
</tr>
<tr>
<td>MOD</td>
<td>A</td>
<td>(c) Drowning</td>
<td>T751</td>
</tr>
</tbody>
</table>

Accident | Lake | Boat Overturned

<table>
<thead>
<tr>
<th>Place</th>
<th>1</th>
<th>(a) Anoxia</th>
<th>T751 &amp;W70</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8</td>
<td>(b) Drowning</td>
<td>T751</td>
</tr>
<tr>
<td>MOD</td>
<td>A</td>
<td>(c)</td>
<td>T751</td>
</tr>
</tbody>
</table>

Accident | Fell into Lake

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported on the same line with</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>anoxia asphyxia strangulation suffocation</td>
<td>drowning submersion</td>
<td>T751 and the appropriate external cause code.</td>
</tr>
</tbody>
</table>
Example - Corresponding Table and Instruction 1.2

Place  I  (a) Drowning - asphyxia T751 &W74
9
MOD (b)
A  II

(b) MOD

Example - Corresponding Table and Instruction 2.1

Place  I  (a) Asphyxia T71 &X70
0
MOD (b) Hanging T71
S  II

(c) MOD

Table 2. Hanging and mechanical strangulation (by external means)

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>asphyxia strangulation</td>
<td>hanging mechanical strangulation (by external means)</td>
<td>upper line T71 and the appropriate external cause code.</td>
</tr>
<tr>
<td></td>
<td>suffocation</td>
<td>compression of neck</td>
<td>lower line T71 only.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Examples - Corresponding Table and Instruction 2.1

Place  I  (a) Aspiration of vomitus T179 &W78
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
(b)
MOD 9 (c)
S II

Suicide Hanging by neck
<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Which is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>asphyxia strangulation suffocation</td>
<td>asphyxia strangulation suffocation</td>
<td>the external means of the mechanical strangulation (such as: ligature, rope around neck, sheet)</td>
<td>uppermost line to T71 and the appropriate external cause code.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>the next lower line to T71. lower line blank.</td>
</tr>
</tbody>
</table>

**Example - Corresponding Table and Instruction 2.3**

<table>
<thead>
<tr>
<th>Place</th>
<th>Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>I</td>
</tr>
<tr>
<td></td>
<td>(a) Asphyxia</td>
</tr>
<tr>
<td>MOD</td>
<td>(b) Suffocation</td>
</tr>
<tr>
<td>MOD</td>
<td>(c) Crib sheet</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>compression of neck stricture of neck</td>
<td>hanging mechanical strangulation (by external means) suffocation</td>
<td>upper line T71 only. lower line T71 and the appropriate external cause code.</td>
</tr>
</tbody>
</table>

**Example - Corresponding Table and Instruction 2.4**

<table>
<thead>
<tr>
<th>Place</th>
<th>Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>MOD</td>
</tr>
<tr>
<td>MOD</td>
<td>H</td>
</tr>
<tr>
<td>MOD</td>
<td>(a) Compression of neck</td>
</tr>
<tr>
<td>MOD</td>
<td>(b) Hanging</td>
</tr>
<tr>
<td>MOD</td>
<td>(c) Homicide</td>
</tr>
<tr>
<td>MOD</td>
<td>Hangin</td>
</tr>
<tr>
<td>MOD</td>
<td>T71</td>
</tr>
<tr>
<td>MOD</td>
<td>T71</td>
</tr>
<tr>
<td>MOD</td>
<td>&amp;X91</td>
</tr>
</tbody>
</table>
Instruction | When | Is reported on the record with | Code
---|---|---|---
5 | compression of neck, stricture of neck | hanging, mechanical strangulation (by external means) suffocation | compression of neck, stricture of neck to T71 only. T71 followed by the appropriate external cause code for the hanging, mechanical strangulation, suffocation.

Example - Corresponding Table and Instruction 2.5

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Compression of neck</th>
<th>(b)</th>
<th>(c) Strangulation by cord around neck</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>T71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>MOD</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>H</td>
<td></td>
</tr>
</tbody>
</table>

Homicide

Table 3. Fires (includes burns, gases, fumes in association with burns and fires)

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
</table>
| 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.
Examples - Corresponding Table and Instruction 3.1

<table>
<thead>
<tr>
<th>Place</th>
<th>MOD</th>
<th>Nature of Injury</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>A</td>
<td>(a) Suffocation</td>
<td>T599</td>
</tr>
<tr>
<td>0</td>
<td>A</td>
<td>(b) Inhalation of products of combustion</td>
<td>T599</td>
</tr>
<tr>
<td>0</td>
<td>A</td>
<td>(c) Fire</td>
<td>T599</td>
</tr>
</tbody>
</table>

Accident: Inhaled fumes in house fire

<table>
<thead>
<tr>
<th>Place</th>
<th>MOD</th>
<th>Nature of Injury</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>A</td>
<td>(a) Suffocation</td>
<td>T598</td>
</tr>
<tr>
<td>9</td>
<td>A</td>
<td>(b) Smoke inhalation</td>
<td>T598</td>
</tr>
<tr>
<td>9</td>
<td>A</td>
<td>(c) Fire</td>
<td>T598</td>
</tr>
</tbody>
</table>

Instruction: When Is reported due to Code

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>asphyxia suffocation</td>
<td>ingestion of gas, fumes, or vapors (carbon monoxide, products of combustion, smoke)</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>mention of a fire (specified)</td>
<td>the appropriate nature of injury code for the gas, fumes, vapor and the appropriate external cause code for the fire where required.</td>
</tr>
</tbody>
</table>
Example - Corresponding Table and Instruction 3.2

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Asphyxia - carbon monoxide</th>
<th>T58 &amp;X00</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>(b)</td>
<td></td>
</tr>
<tr>
<td>MOD</td>
<td>(c)</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>I I</td>
<td></td>
</tr>
</tbody>
</table>

Accident  Home  House Fire

Instruction When Is reported due to Code

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>asphyxia suffocation</td>
<td>burns NOS</td>
<td>upper line T300 and the appropriate external cause code.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(any degree)</td>
<td>lower line as indexed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(any percentage)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(any site)</td>
<td></td>
</tr>
</tbody>
</table>

Examples - Corresponding Table and Instruction 3.3

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Asphyxia</th>
<th>T300 &amp;X04</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>(b) Burns of chest and face</td>
<td>T210 T200</td>
</tr>
<tr>
<td>MOD</td>
<td>(c)</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>I I</td>
<td></td>
</tr>
</tbody>
</table>

Accident  Home  Ignition of kerosene

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Suffocation</th>
<th>T300 &amp;X00</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b) 3° burns</td>
<td>T303</td>
</tr>
<tr>
<td>MOD</td>
<td>(c)</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>I I</td>
<td></td>
</tr>
</tbody>
</table>
### Table 4. Ingestion, inhalation of gases, fumes, vapors (without fires, burns)

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>asphyxia suffocation</td>
<td>ingestion of gas, fumes, or vapors</td>
<td>upper line to the appropriate nature of injury code for the gas, fumes, or vapor and the appropriate external cause code.</td>
</tr>
</tbody>
</table>
lower line to the appropriate nature of injury code for the gas, fumes, or vapor.

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>asphyxia</td>
<td>ingestion of gas, fumes, or vapors</td>
<td>the appropriate nature of injury code for the gas, fumes, or vapor and the appropriate external cause code.</td>
</tr>
<tr>
<td></td>
<td>suffocation</td>
<td>inhalation</td>
<td></td>
</tr>
</tbody>
</table>

Example - Corresponding Table and Instruction 4.2

<table>
<thead>
<tr>
<th>Place</th>
<th>4 (a) Suffocation by inhalation of propane gas</th>
<th>T598 &amp;X47</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>(b)</td>
<td></td>
</tr>
<tr>
<td>MOD</td>
<td>(c)</td>
<td></td>
</tr>
<tr>
<td>MOD</td>
<td>(c)</td>
<td></td>
</tr>
<tr>
<td>MOD</td>
<td>(c)</td>
<td></td>
</tr>
</tbody>
</table>

| Accident | Home   | Inhaled propane gas                      | |
|----------|--------|------------------------------------------| |
Table 5. Compression chest, crushed chest by external means

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>asphyxia suffocation</td>
<td>crushed chest</td>
<td>upper line S280 plus the appropriate external cause code. lower line S280.</td>
</tr>
</tbody>
</table>

**Example - Corresponding Table and Instruction 5.1**

<table>
<thead>
<tr>
<th>MOD</th>
<th>Place</th>
<th>(a) Asphyxia</th>
<th>(b) Crushed chest</th>
<th>(c) MVA</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>I</td>
<td>S280</td>
<td>S280</td>
<td>W892</td>
<td></td>
</tr>
<tr>
<td></td>
<td>II</td>
<td>Accident</td>
<td>Street</td>
<td>MVA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>asphyxia suffocation</td>
<td>compression chest</td>
<td>upper line S299 plus the appropriate external cause code. lower line S299.</td>
</tr>
</tbody>
</table>

**Example - Corresponding Table and Instruction 5.2**

<table>
<thead>
<tr>
<th>Place</th>
<th>I</th>
<th>(a) Suffocation</th>
<th>(b) Compression chest</th>
<th>(c) Tractor accident</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td></td>
<td>S299</td>
<td>S299</td>
<td>W30</td>
</tr>
</tbody>
</table>

MOD | I | (a) Asphyxia | (b) MVA | (c) Street | (d) Accident |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>S280</td>
<td>S280</td>
<td>&amp;W892</td>
<td>W30</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>asphyxia aspiration choking obstruction of a site occlusion of a site strangulation suffocation</td>
<td>aspiration NOS ingestion NOS inhalation NOS or aspiration ingestion inhalation of substances or objects</td>
<td>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.</td>
</tr>
</tbody>
</table>

Examples - Corresponding Table and Instruction 6.1

<table>
<thead>
<tr>
<th>Place</th>
<th>I</th>
<th>(a) Strangulation</th>
<th>T179 &amp;W79</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td></td>
<td>(b) Aspiration of food</td>
<td>T179</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(c)</td>
<td></td>
</tr>
</tbody>
</table>

Place I (a) Asphyxia T179 &W78
<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>asphyxia aspiration choking obstruction of a site occlusion of a site strangulation suffocation</td>
<td>foreign body in a site (such as: blood, food, gum, medicine, mucus, vomitus)</td>
<td>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.</td>
</tr>
</tbody>
</table>

Example - Corresponding Table and Instruction 6.2

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Obstruction of pharynx</th>
<th>T172 &amp;W79</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b) Bolus of meat in throat</td>
<td>T172</td>
</tr>
<tr>
<td></td>
<td>(c)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>asphyxia aspiration choking obstruction of a site</td>
<td>foreign body NOS (such as: blood, food, gum, medicine, mucus, vomitus)</td>
<td>upper line to T17 plus appropriate fourth character and the appropriate external cause</td>
</tr>
</tbody>
</table>
Examples - Corresponding Table and Instruction 6.3

<table>
<thead>
<tr>
<th>Place</th>
<th>I</th>
<th>II</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(a) Obstruction of trachea</td>
<td>T174 &amp;W79</td>
</tr>
<tr>
<td></td>
<td>(b) Bolus of meat</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place</th>
<th>I</th>
<th>II</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(a) Asphyxia</td>
<td>T179 &amp;W78</td>
</tr>
<tr>
<td></td>
<td>(b) Aspiration</td>
<td>T179</td>
</tr>
<tr>
<td></td>
<td>(c) Vomitus</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>asphyxia aspiration choking obstruction of a site occlusion of a site strangulation suffocation</td>
<td>aspiration NOS ingestion NOS inhalation NOS or aspiration ingestion inhalation</td>
<td>on the same line, T17 with appropriate fourth character and the appropriate external cause code (W78, W79, W80). of substances or objects</td>
</tr>
</tbody>
</table>

Example - Corresponding Table and Instruction 6.4
**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 9

1. (a) Choked by peanut obstructing trachea T174 &W79

(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 1

1. (a) Choked on chicken bone T179 &W79

(b)

(c)

II
Place I (a) Obstruction airway by bolus of food T179 &W79
(b)
(c)

### 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
(b) C.V.A 164
(c) 164

### 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

<table>
<thead>
<tr>
<th>Instruction</th>
<th>When</th>
<th>Is reported due to</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>aspiration NOS ingestion NOS inhalation NOS or aspiration ingestion inhalation of substances or objects</td>
<td>injuries (other than those classified to T17-) and/or an external cause (other than W78, W79, W80)</td>
<td>upper line T17 plus appropriate fourth character. Also, code the appropriate W78, W79, W80 if not previously coded. lower line as indexed.</td>
</tr>
</tbody>
</table>

### Examples - Corresponding Table and Instruction 6.9

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Aspiration of vomitus</th>
<th>(b) Strangulation</th>
<th>(c) Hanging</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>T179 &amp;W78</td>
<td>T71 &amp;X70</td>
<td>T71</td>
</tr>
<tr>
<td>MOD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>T71</td>
</tr>
</tbody>
</table>

**Suicide**

**Home**

**Hanged Self**

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Choked</th>
<th>(b) Aspiration of blood</th>
<th>(c) Crushed chest</th>
<th>Car vs. Pedestrian</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>T179 W80</td>
<td>T179</td>
<td>S280</td>
<td>&amp;V031</td>
</tr>
</tbody>
</table>

II Car vs. Pedestrian
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.

<table>
<thead>
<tr>
<th>Place</th>
<th>(a) Aplastic anemia</th>
<th>D612</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b) Benzene poisoning</td>
<td>T521</td>
</tr>
</tbody>
</table>

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 | (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 &892
(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 &87
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 &67
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 &46
0  (b) Inhalation of aerosol substance T659
(c)  
MOD  A II Breathed “PAM” (freon) in plastic bag T535
c. Intoxication by certain substances or toxic poisoning due to disease

When ammonia intoxication (NH), carbon dioxide intoxication (CO), 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.

<table>
<thead>
<tr>
<th>I (a)</th>
<th>Ammonia intoxication</th>
<th>R798</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cirrhosis of liver</td>
<td></td>
</tr>
<tr>
<td>I (b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Code I(a) as indexed, Intoxication, ammonia, due to disease (R798).

<table>
<thead>
<tr>
<th>I (a)</th>
<th>Carbon dioxide intoxication</th>
<th>R068</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chronic pulmonary emphysema</td>
<td></td>
</tr>
<tr>
<td>I (b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Code I(a) as indexed, Intoxication, carbon dioxide, due to disease (R068).

<table>
<thead>
<tr>
<th>I (a)</th>
<th>Toxic poisoning</th>
<th>R688</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gastroenteritis</td>
<td></td>
</tr>
<tr>
<td>I (b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a)</th>
<th>Toxic nephritis</th>
<th>&amp;X48 N144</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>II</td>
<td>Organophosphate poisoning, accidental</td>
<td>T600</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a)</th>
<th>Toxic GI hemorrhage</th>
<th>&amp;X49 K922</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td></td>
<td>Carbolic acid</td>
<td>T540</td>
</tr>
</tbody>
</table>

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  I (a) Toxic diarrhea &X48 K521
9     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  I (a) Cardiac arrest I469
9     (b) Digitalis toxicity T460 &X44
(c) Congestive heart failure 1500

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  I (a) Shock R578
(b) Insulin overdose  
(c) Diabetes

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  I (a) Respiratory failure  
(b) Drug intoxication
II Ingested undetermined amount of drugs

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  I (a) Took overdose of drug  
II Overdose of barbiturates

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  I (a) Toxic hemolytic anemia  
(b) Levodopa toxicity

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
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 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

(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 II Took unknown amount of T423 T390 MOD barbiturates and aspirin A

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:

Code X44, Accidental poisoning by and exposure to other and unspecified drugs, medicaments and
Place 9 (a) Drug intoxication T509 &X44
(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 9 (a) Drug toxicity T509 &X64
(b) Overdose of salicylates T390 T423
(c) and seconal
MOD II Overdose of drugs T509

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 MOD 9 (a) Darvon and promazine T404 &Y14 T433
(b) intoxication
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  I  (a) Gunshot wound brain  S069 &X74
  9  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  I  (a) Combined effects of alcohol  T519 X45 T509 &X44
  9  (b) and drugs
MOD
 A

(b) 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.

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a) Alcohol ingestion</th>
<th>F109</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b) Barbiturate intoxication</td>
<td>T423 &amp;X41</td>
</tr>
</tbody>
</table>

Code I(a) alcohol ingestion as indexed and code the nature of injury and external cause for barbiturate intoxication on I(b).

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a) Alcoholism</th>
<th>F102</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>II Alcohol and barbiturate</td>
<td>T519 X45 T423 &amp;X41</td>
</tr>
<tr>
<td>MOD</td>
<td>Accident</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a) Barbiturate toxicity</th>
<th>T423 &amp;X61</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>II Barbiturate and alcohol intoxication</td>
<td>T423 T519 X65</td>
</tr>
<tr>
<td>MOD</td>
<td>Suicide</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>I (a) Poisoning by alcohol</th>
<th>T519 &amp;X45</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>II Toxic levels of heroin and flunitrazepam</td>
<td>T401 X44 T424</td>
</tr>
</tbody>
</table>

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  I  (a) Intoxication
9

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  I  (a) Acute intoxication
9  (b) Darvon & alcohol poisoning
MOD II
S

**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  I  (a) Intoxication
9  (b) Carbon monoxide inhalation
MOD II
A

**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.
   
   (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).

   (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.

   (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.

   (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.

   (a) Pneumonia J958
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
   (b) Cerebral arteriogram
   (c) Brain tumor

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:

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Neoplasms</td>
<td>C000-D45, D47-D489</td>
</tr>
<tr>
<td>Diabetes</td>
<td>E10-E14 (EXCEPT: Steroids Y425, Y427)</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>D66-D682</td>
</tr>
<tr>
<td>Alcoholic disorders</td>
<td>E244, E52, F101-F109, G312, G405, G621, G721, H246, K292, K700-K709, K852, K860, L278, R780, R826, R893</td>
</tr>
<tr>
<td>Rheumatic fever or rheumatic heart</td>
<td>I00-I099</td>
</tr>
<tr>
<td>Disease</td>
<td>Code(s)</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Arteriosclerosis and arteriosclerotic conditions</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td>J09-J118</td>
</tr>
<tr>
<td>Hernia</td>
<td>K400-K469</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>Q000-Q999</td>
</tr>
</tbody>
</table>

This is not an all inclusive list.

I (a) Lung cancer
(b) Drug therapy

Since lung cancer is not considered a complication of drug therapy, no code is assigned for I(b).

I (a) Pancytopenia
(b) Lung cancer chemotherapy

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
(b) Drug therapy

Do not code the drug therapy since conditions stated as congenital cannot be considered as complications.

I (a) Nephritis 6 months
(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 &R0921469
(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 to Y590, Adverse effect in therapeutic use.

I (a) Pulmonary embolism I269
(b) Estrogen to control excessive menses Y425 &N920

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).

<table>
<thead>
<tr>
<th>Place</th>
<th>1 (a) Respiratory failure</th>
<th>J969</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(b) Ingestion of mixed sedatives</td>
<td>T426 &amp;X41</td>
</tr>
</tbody>
</table>

**MOD A**

**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.

<table>
<thead>
<tr>
<th>Place</th>
<th>1 (a) Cerebral anoxia</th>
<th>G931</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>(b) Ingestion of barbiturates</td>
<td>T423 &amp;X41</td>
</tr>
<tr>
<td></td>
<td>Had been drinking</td>
<td>F109</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>1 (a) Hemorrhage</th>
<th>K922</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(b) Ulcer of stomach</td>
<td>K259</td>
</tr>
<tr>
<td></td>
<td>(c) Cortisone therapy</td>
<td>Y420</td>
</tr>
<tr>
<td></td>
<td>II Scleroderma</td>
<td>&amp;M349</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Place</th>
<th>1 (a) Renal failure</th>
<th>&amp;N19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(b) Ingested antidiabetic drug</td>
<td>Y423</td>
</tr>
</tbody>
</table>
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
(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 | 1500 |
|   | (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 D.M., AS, immunosuppression E149 I709
(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.

1. (a) Hypercorticosteronism  
   (b) Steroids - 6 years  
   (c) Arthritis

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:

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Neoplasms</td>
<td>C000-D489</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>D66, D67, D680, D681, D682</td>
</tr>
<tr>
<td>Diabetes</td>
<td>E10-E14</td>
</tr>
<tr>
<td>Alcoholic disorders</td>
<td>E52, E244, F101-F109, G312, G405, G621, G721, K860, I426, K292, K700-K709, K852, L278, R780, R826, R893</td>
</tr>
<tr>
<td>Rheumatic fever or rheumatic heart disease</td>
<td>I00-I099</td>
</tr>
<tr>
<td>Hypertensive diseases</td>
<td>I11-I139, I150, I159</td>
</tr>
</tbody>
</table>
Coronary artery disease
Coronary disease

Ischemic cardiomyopathy

Chronic or degenerative myocarditis

Arteriosclerosis and arteriosclerotic conditions except those classified to I219

Calcus or stones of any type or site

Influenza

Hernia except ventral (incisional)

Diverticulitis

Rheumatoid arthritis

Collagen diseases

Congenital malformations

This is not an all inclusive list.

I
(a) Myocardial infarction
(b) Arteriosclerosis
(c) Surgery

Since arteriosclerosis is not accepted as a complication of surgery, do not code the surgery.

I
(a) Diabetic gangrene
(b) Leg amputation

Do not code the leg amputation (surgery) since there is no indication of a surgical complication.

I
(a) Pneumonia
(b) Brain tumor removal

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
Do not code the surgery on 1(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

1. (a) Lymphedema
   1972
   (b) Postmastectomy
   Y836
   (c) Breast cancer
   &C509

   **Code 1(a) using Step 1**

   Lymphedema
   ^postmastectomy 197.2

2. (a) Hemorrhage
   T828
   (b) Coronary artery bypass graft
   &Y832
   (c) Coronary heart disease
   &I259

   **Code 1(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.

3. (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  
(b) Thyroid surgery  
(c) Thyroid cancer

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  
(b) Surgery

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  
(b) Surgery

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  
(b) Surgery

Code I(a) using **Step 4 (d).**
**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.**

1. (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.**

1. (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.**

1. (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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Index Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>Mesenteric embolism</td>
<td>K918</td>
</tr>
<tr>
<td>(b)</td>
<td>Gallbladder surgery</td>
<td>Y839</td>
</tr>
<tr>
<td>(c)</td>
<td>Gallstones</td>
<td>&amp;K802</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Index Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>Anemia</td>
<td>T818</td>
</tr>
<tr>
<td>(b)</td>
<td>Surgery</td>
<td>&amp;Y839</td>
</tr>
</tbody>
</table>

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.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Index Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>Cardiac arrest</td>
<td>I469</td>
</tr>
<tr>
<td>(b)</td>
<td>Brain death</td>
<td>T818</td>
</tr>
<tr>
<td>(c)</td>
<td>Surgery</td>
<td>&amp;Y839</td>
</tr>
</tbody>
</table>

**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
Cholecystectomy..............................................K802
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.........................J 9840
Mammary artery(internal) implant........................I251
Nephrectomy....................................................N289
Revascularization of heart....................................I251
Revascularization, myocardial...............................I251
T and A.........................................................
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:

<table>
<thead>
<tr>
<th>Reason for Surgery</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postsurgical hypothyroidism</td>
<td>E079</td>
</tr>
<tr>
<td>Postsurgical hypoinsulinemia</td>
<td>K869</td>
</tr>
<tr>
<td>Postsurgical blind loop syndrome</td>
<td>K639</td>
</tr>
<tr>
<td>Other and unspecified postsurgical malabsorption</td>
<td>K639</td>
</tr>
</tbody>
</table>

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 &C349K259
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 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) Cholecystectomy Y838 &K802

Code I(a), CHF (congestive heart failure), as the complication of surgery. Code I(b), cholecystectomy, Y838 K802. Cholecystectomy 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  
(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  

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.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>p.o</td>
<td>postoperative status postop</td>
</tr>
<tr>
<td>post-named surgery</td>
<td>status p.o.</td>
</tr>
</tbody>
</table>

p.o postoperative status postop
post-named surgery status p.o.
(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, sepsis
- adhesions, hematoma, septicemia
- aspiration, infarction, septic shock
- atelectasis, infection, shock
- bowel obstruction, occlusion, thrombophlebitis
- cardiac arrest, peritonitis, thrombosis
- embolism, phlebitis, wound infection
- fistula, phlebothrombosis
- gas gangrene, pneumonia
- hemolysis, pneumothorax
- hemolytic, renal failure (acute)
- 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 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
Postoperative embolism, as indexed to T817 and Y836 as indexed under Complication, appendectomy. Precede the E-code with an ampersand. 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

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

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

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

Postoperative ileus to be the complication since no other
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.

<table>
<thead>
<tr>
<th>Acute renal failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspiration</td>
</tr>
<tr>
<td>Atelectasis</td>
</tr>
<tr>
<td>Bacteremia</td>
</tr>
<tr>
<td>Condition</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cardiac arrest (any I469)</td>
</tr>
<tr>
<td>Disseminated intravascular coagulopathy (DIC)</td>
</tr>
<tr>
<td>Embolism (any site)</td>
</tr>
<tr>
<td>Gas gangrene</td>
</tr>
<tr>
<td>Hemolysis, hemolytic infection</td>
</tr>
<tr>
<td>Hemorrhage NOS</td>
</tr>
<tr>
<td>Infarction (any site)</td>
</tr>
<tr>
<td>Infection NOS</td>
</tr>
<tr>
<td>Occlusion (any site)</td>
</tr>
<tr>
<td>Phlebitis (any site)</td>
</tr>
<tr>
<td>Phlebothrombosis (any site)</td>
</tr>
<tr>
<td>Pneumonia (J120-J168, J180-J189, J690, J698)</td>
</tr>
<tr>
<td>Pneumothorax</td>
</tr>
<tr>
<td>Pulmonary insufficiency</td>
</tr>
<tr>
<td>Renal failure (acute) NOS</td>
</tr>
<tr>
<td>Septicemia (any A400-A419)</td>
</tr>
<tr>
<td>Shock (R570-R579)</td>
</tr>
<tr>
<td>Thrombophlebitis (any site)</td>
</tr>
<tr>
<td>Thrombosis (any site)</td>
</tr>
</tbody>
</table>

I (a) Pneumonia J958
(b) Diabetic gangrene, amputation &E145 Y835
(c) Cancer of stomach &C169

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) 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
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 1269
(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 K659
- 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)
(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.

(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-).

(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.
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:

<p>| 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 |</p>
<table>
<thead>
<tr>
<th>The first entry on the lowest line in Part I is classifiable to</th>
<th>And a condition classifiable to one of the following codes is reported on the same line or in Part II</th>
</tr>
</thead>
<tbody>
<tr>
<td>I461</td>
<td>A520</td>
</tr>
<tr>
<td></td>
<td>B24</td>
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<tr>
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<td>B332</td>
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<td>I010-I099</td>
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<td>I110-I119</td>
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<td>I130-I139</td>
</tr>
<tr>
<td>J960</td>
<td>E841</td>
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<td>E849</td>
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<tr>
<td>J969</td>
<td>E841</td>
</tr>
<tr>
<td></td>
<td>E849</td>
</tr>
<tr>
<td>R000</td>
<td>Tachycardia, unspecified</td>
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<td>I110-I119</td>
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<tr>
<td></td>
<td>I130-I461</td>
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<tr>
<td>R002</td>
<td>Palpitations</td>
</tr>
<tr>
<td></td>
<td>I110-I119</td>
</tr>
<tr>
<td>R010</td>
<td>Benign and innocent cardiac murmurs</td>
</tr>
<tr>
<td>R011</td>
<td>Cardiac murmur, unspecified</td>
</tr>
<tr>
<td>R012</td>
<td>Other cardiac sounds</td>
</tr>
<tr>
<td>R02</td>
<td>Gangrene NEC</td>
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<td>-E104</td>
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<td>E110-E11</td>
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<td>E125</td>
</tr>
<tr>
<td>Code</td>
<td>Condition</td>
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<td>--------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>R030</td>
<td>Elevated blood pressure reading, without diagnosis of hypertension</td>
</tr>
<tr>
<td></td>
<td>The first entry on the lowest line in Part I is classifiable to</td>
</tr>
<tr>
<td>R040</td>
<td>Epistaxis</td>
</tr>
<tr>
<td>R041</td>
<td>Hemorrhage from throat</td>
</tr>
<tr>
<td>R042</td>
<td>Hemoptysis</td>
</tr>
<tr>
<td>R048</td>
<td>Hemorrhage from other sites in respiratory passages</td>
</tr>
<tr>
<td>R05</td>
<td>Cough</td>
</tr>
<tr>
<td>R060</td>
<td>Dyspnea</td>
</tr>
<tr>
<td></td>
<td>And a condition classifiable to one of the following codes is reported on the same line or in Part II</td>
</tr>
<tr>
<td></td>
<td>The first entry on the lowest line in Part I is classifiable to</td>
</tr>
<tr>
<td>R061</td>
<td>Stridor</td>
</tr>
<tr>
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</tr>
<tr>
<td>R062</td>
<td>Wheezing</td>
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</tr>
<tr>
<td>R064</td>
<td>Hyperventilation</td>
</tr>
<tr>
<td>R066</td>
<td>Hiccough</td>
</tr>
<tr>
<td>R090</td>
<td>Asphyxia</td>
</tr>
<tr>
<td>R104</td>
<td>Other and unspecified abdominal pain</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>R11</td>
<td>Nausea and vomiting</td>
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<tr>
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</tr>
<tr>
<td>R17</td>
<td>Unspecified jaundice</td>
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<tr>
<td>R18</td>
<td>Ascites</td>
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<td></td>
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</tr>
<tr>
<td>R233</td>
<td>Spontaneous ecchymoses</td>
</tr>
</tbody>
</table>

The first entry on the lowest line in Part I is classifiable to one of the following codes is reported on the same line or in Part II.

<table>
<thead>
<tr>
<th>R250</th>
<th>Abnormal head movements</th>
<th>G110-G119</th>
</tr>
</thead>
<tbody>
<tr>
<td>R251</td>
<td>Tremor, unspecified</td>
<td>G20-G259</td>
</tr>
<tr>
<td>R252</td>
<td>Cramp and spasm</td>
<td>G400-G419</td>
</tr>
<tr>
<td>R253</td>
<td>Fasciculation</td>
<td>G510</td>
</tr>
<tr>
<td>R258</td>
<td>Other and unspecified abnormal involuntary movements</td>
<td>G800-G839</td>
</tr>
<tr>
<td>R260</td>
<td>Ataxic gait</td>
<td>A521</td>
</tr>
<tr>
<td>R261</td>
<td>Paralytic gait</td>
<td></td>
</tr>
<tr>
<td>R262</td>
<td>Difficulty in walking, not due to fracture</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Codes</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>R278</td>
<td>Other and unspecified lack of coordination</td>
<td>A521</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G110-G119</td>
</tr>
<tr>
<td>R290</td>
<td>Tetany</td>
<td>E200-E209</td>
</tr>
<tr>
<td>R291</td>
<td>Meningismus</td>
<td>J1010</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J1110</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J108</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J118</td>
</tr>
<tr>
<td>R298</td>
<td>Other and unspecified symptoms and signs involving the nervous and musculoskeletal systems</td>
<td>G800-G839</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>R300</td>
<td>Dysuria</td>
<td>C600-C689C7 D280-D309</td>
</tr>
<tr>
<td>R301</td>
<td>Vesical tenesmus</td>
<td>C90-C791 D390-D419</td>
</tr>
<tr>
<td>R309</td>
<td>Painful micturition, unspecified</td>
<td>C796 N000-N999</td>
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<td></td>
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<td>C798 Q600-Q649</td>
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<td>R31</td>
<td>Unspecified hematuria</td>
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<td>C600-C689 D280-D309</td>
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<td>C796 N000-N999</td>
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<td>D060-D061</td>
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<tr>
<td>R32</td>
<td>Unspecified urinary incontinence</td>
<td>C600-C689C7 D280-D309</td>
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<tr>
<td>R33</td>
<td>Retention of urine</td>
<td>C90-C791 D390-D419</td>
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<td>C796 N000-N999</td>
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<td>C798 Q600-Q649</td>
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<tr>
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<td>D060-D061</td>
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<tr>
<td>R34</td>
<td>Anuria and oliguria</td>
<td>C600-C689C7 D280-D309</td>
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<td></td>
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<td>C90-C791 D390-D419</td>
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<td>C796 N000-N999</td>
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<tr>
<td>R35</td>
<td>Polyuria</td>
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<td>R36</td>
<td>Urethral discharge</td>
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<td>R390</td>
<td>Extravasation of urine</td>
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<tr>
<td>R391</td>
<td>Other difficulties with</td>
<td>C798 Q600-Q649</td>
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<td>Condition</td>
<td>Codes</td>
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<tr>
<td>micturition</td>
<td>D060-D061</td>
<td></td>
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<tr>
<td>R392 Extrarenal uremia</td>
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</tr>
<tr>
<td>R398 Other and unspecified symptoms and signs involving the urinary system</td>
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</table>

The first entry on the lowest line in Part I is classifiable to one of the following codes is reported on the same line or in Part II:

<table>
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<tr>
<th>Condition</th>
<th>Codes</th>
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<tbody>
<tr>
<td>R400 Somnolence</td>
<td>E100-E107, E147, E110, E15, E117, K729, E120, S020-S024, E127, S026-S029, E130, S060-S099, E137, T902, E140, T905-T909</td>
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<td>R401 Stupor</td>
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<th>Condition</th>
<th>Codes</th>
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<table>
<thead>
<tr>
<th>Condition</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>R529 Pain, unspecified</td>
<td>G547</td>
</tr>
<tr>
<td>R568 Other and unspecified convulsions</td>
<td>A35G400-G419, O100-O11, O13-O16</td>
</tr>
</tbody>
</table>

The first entry on the lowest line in Part I is classifiable to one of the following codes is reported on the same line or in Part II:

<table>
<thead>
<tr>
<th>Condition</th>
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<tbody>
<tr>
<td>R400 Somnolence</td>
<td>E100-E107, E147, E110, E15, E117, K729, E120, S020-S024, E127, S026-S029, E130, S060-S099, E137, T902, E140, T905-T909</td>
</tr>
<tr>
<td>R401 Stupor</td>
<td></td>
</tr>
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</table>

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<th>Codes</th>
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<th>Codes</th>
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<td>G547</td>
</tr>
<tr>
<td>R568 Other and unspecified convulsions</td>
<td>A35G400-G419, O100-O11, O13-O16</td>
</tr>
<tr>
<td>The first entry on the lowest line in Part I is classifiable to</td>
<td>And a condition classifiable to one of the following codes is reported on the same line or in Part II</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
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<tr>
<td>R590 Localized enlarged lymph nodes</td>
<td>B270-B279</td>
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<td>C810-C969</td>
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<tr>
<td>R591 Generalized enlarged lymph nodes</td>
<td>B24</td>
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<td>B270-B279</td>
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<td>B589</td>
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<tr>
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<td>C810-C969</td>
</tr>
<tr>
<td>R599 Enlarged lymph nodes, unspecified</td>
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<td>C810-C969</td>
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<tr>
<td>R600 Localized edema</td>
<td>E43</td>
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<tr>
<td>R601 Generalized edema</td>
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<td>N000-N058</td>
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<td>R609 Edema, unspecified</td>
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<td>E877</td>
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<tr>
<td></td>
<td>N000-N058</td>
</tr>
<tr>
<td>R628 Other lack of expected normal physiological development</td>
<td>B24</td>
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<tr>
<td></td>
<td>E45</td>
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<tr>
<td></td>
<td>E46</td>
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<tr>
<td>R630 Anorexia</td>
<td>F500</td>
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<tr>
<td>R631 Polydipsia</td>
<td>E232</td>
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<tr>
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<td>N251</td>
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<tr>
<td>R64 Cachexia</td>
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<td>E41</td>
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<td>E46</td>
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<tr>
<td>R730 Abnormal glucose tolerance test</td>
<td>E100-E162</td>
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<tr>
<td>R780 Finding of alcohol in blood</td>
<td>F101-F109</td>
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<tr>
<td>R788 Finding of other specified substances, not normally found in blood</td>
<td>A000-A079</td>
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<td>A090-A499</td>
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<td>J13-J159</td>
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<td></td>
<td>J180-J189</td>
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<tr>
<td>R798 Other specified abnormal</td>
<td>E100</td>
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<td>E127</td>
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<td>Code</td>
<td>Description</td>
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<td>-----------------------------------------------------------------------------</td>
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<td>E109</td>
<td>Abnormal finding of blood chemistry, unspecified</td>
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<td>E111</td>
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<td>E112-E116</td>
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<td>E117</td>
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<td>E122-E126</td>
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<tr>
<td>R799</td>
<td>Isolated proteinuria</td>
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<tr>
<td>C900</td>
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<td>D511</td>
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<td>R80</td>
<td>Glycosuria</td>
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<td>E100-E149</td>
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<td>E748</td>
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<td>R81</td>
<td>Hemoglobinuria</td>
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<td>B508</td>
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<td>B54</td>
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<td>D595-D596</td>
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<td>R823</td>
<td>Acetonuria</td>
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<td>E101</td>
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<td>E107</td>
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<td>E117</td>
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</tr>
<tr>
<td>E121</td>
<td></td>
</tr>
<tr>
<td>R824</td>
<td>Abnormal urine levels of substances chiefly nonmedicinal as to source</td>
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<tr>
<td>E101</td>
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<td>E107</td>
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<td>E117</td>
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<tr>
<td>E121</td>
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<tr>
<td>R826</td>
<td>Abnormal findings in specimens from other organs, systems and tissues</td>
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<tr>
<td>F101-F109</td>
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<td>R893</td>
<td></td>
</tr>
<tr>
<td>F101-F109</td>
<td></td>
</tr>
</tbody>
</table>
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 arteriosclerosis R02 J189 I709
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
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
II Pancreatectomy for cancer

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
(b) Respiratory arrest
(c) Carcinoma of lung, liver, brain
II Findings of operation: Carcinoma

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
(b) Below knee amputation of leg

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
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).

1. (a) Infected amputation stump  T874 &Y835
   (b) Osteosarcoma of leg &C402

   Code 1(a), infected amputation stump T874 Y835. Precede the E-code, Y835, by an ampersand. Code 1(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.

   1. (a) Kidney blockage &N990
      (b) Postcystoscopic procedure Y848

   Code 1(a) as indexed using **Step 1**

      Block
      "kidney
      - postcystoscopic or postprocedural N99.0.

   Code 1(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).
1. (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.**

1. (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)
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 |
| I   | (b) Cardiac catheterization | &Y840 |
| I   | (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 |
| I   | (b) Barium enema | &K635 |
| I   | (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 |
| I   | (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 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.

   Part I
   
   (a) Pulmonary edema J81
   (b) Radiation pneumonitis Y842 J700
   (c) Radiation therapy for cancer of breast &C509

   Code Part 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.

   Part II
   
   (a) Carcinomatosis C80
   (b) Oat cell carcinoma &C349
   (c) 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
d. When radiation fibrosis is reported 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 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**

<table>
<thead>
<tr>
<th>Hemorrhage (of a site)</th>
<th>Stated as intraoperative or during medical and surgical care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rupture (of a site)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cut or cutting (of a site)</th>
<th>Reported as postoperative, intraoperative, during or due to medical and surgical care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perforation (of a site)</td>
<td></td>
</tr>
<tr>
<td>Puncture (of a site)</td>
<td></td>
</tr>
<tr>
<td>Laceration (of a site)</td>
<td></td>
</tr>
</tbody>
</table>

| 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  
(b) craniotomy  
(c) Brain tumor  

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  
(b) Colostomy  

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  
(b) Perforation of auricle by cardiac catheter  

II Therapeutic misadventure  

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  
(b) Accidental perforation of  
(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
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  
(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, healed, 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  
(b)  
(c)  
MOD &Y86

A Accident Farm Date of injury tractor overturned

9/3/98

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.  
(b) Spinal cord injury  
(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  
(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, healed, history of, late effect of, old, remote, or a delayed union that was due to the external cause is reported.

I (a) Pneumonia MOD (b) Debility A(c) Nonunion of hip fracture III Inanition

<table>
<thead>
<tr>
<th>MOD</th>
<th>(b)</th>
<th>(c)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Debility</td>
<td>R53</td>
</tr>
<tr>
<td></td>
<td>Nonunion of hip fracture</td>
<td>M841</td>
</tr>
<tr>
<td>I</td>
<td>Inanition</td>
<td>R64 Y86</td>
</tr>
</tbody>
</table>
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, 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

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
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 sequela 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
ARD 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
AVP aortic valve prosthesis
AVR aortic valve replacement
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
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BNA</td>
<td>bladder neck adhesions</td>
</tr>
<tr>
<td>BNO</td>
<td>bladder neck obstruction</td>
</tr>
<tr>
<td>BOMSA</td>
<td>bilateral otitis media serous acute</td>
</tr>
<tr>
<td>BOMSC</td>
<td>bilateral otitis media serous chronic</td>
</tr>
<tr>
<td>BOW</td>
<td>'bag of water' (membrane)</td>
</tr>
<tr>
<td>B/P, BP</td>
<td>blood pressure</td>
</tr>
<tr>
<td>BPH</td>
<td>benign prostate hypertrophy</td>
</tr>
<tr>
<td>BSA</td>
<td>body surface area</td>
</tr>
<tr>
<td>BSO</td>
<td>bilateral salpingo-oophorectomy</td>
</tr>
<tr>
<td>BSP</td>
<td>Bromosulfaphthalein (test)</td>
</tr>
<tr>
<td>BTL</td>
<td>bilateral tubal ligation</td>
</tr>
<tr>
<td>BUN</td>
<td>blood, urea, and nitrogen test</td>
</tr>
<tr>
<td>BVL</td>
<td>bilateral vas ligation</td>
</tr>
<tr>
<td>B&amp;W</td>
<td>Baldy-Webster suspension (uterine)</td>
</tr>
<tr>
<td>BX</td>
<td>biopsy</td>
</tr>
<tr>
<td>BX CX</td>
<td>biopsy cervix</td>
</tr>
<tr>
<td>Ca</td>
<td>cancer</td>
</tr>
<tr>
<td>CA</td>
<td>cancer; cardiac arrest; carotid arteriogram</td>
</tr>
<tr>
<td>CABG</td>
<td>coronary artery bypass graft</td>
</tr>
<tr>
<td>CABS</td>
<td>coronary artery bypass surgery</td>
</tr>
<tr>
<td>CAD</td>
<td>coronary artery disease</td>
</tr>
<tr>
<td>CAG</td>
<td>chronic atrophic gastritis</td>
</tr>
<tr>
<td>CAO</td>
<td>coronary artery occlusion; chronic airway obstruction</td>
</tr>
<tr>
<td>CAS</td>
<td>cerebral arteriosclerosis</td>
</tr>
<tr>
<td>CASCVD</td>
<td>chronic arteriosclerotic cardiovascular disease</td>
</tr>
<tr>
<td>CASHD</td>
<td>chronic arteriosclerotic heart disease</td>
</tr>
<tr>
<td>CAT</td>
<td>computerized axial tomography</td>
</tr>
<tr>
<td>CB</td>
<td>chronic bronchitis</td>
</tr>
<tr>
<td>CBC</td>
<td>complete blood count</td>
</tr>
<tr>
<td>CBD</td>
<td>common bile duct; chronic brain disease</td>
</tr>
<tr>
<td>CBS</td>
<td>chronic brain syndrome</td>
</tr>
<tr>
<td>CCF</td>
<td>chronic congestive failure</td>
</tr>
<tr>
<td>CCI</td>
<td>chronic cardiac or coronary insufficiency</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>CF</td>
<td>congestive failure; cystic fibrosis; Christmas factor (PTC)</td>
</tr>
<tr>
<td>CFT</td>
<td>chronic follicular tonsillitis</td>
</tr>
<tr>
<td>CGL</td>
<td>chronic granulocytic leukemia</td>
</tr>
<tr>
<td>CGN</td>
<td>chronic glomerulonephritis</td>
</tr>
<tr>
<td>CHA</td>
<td>congenital hypoplastic anemia</td>
</tr>
<tr>
<td>CHB</td>
<td>complete heart block</td>
</tr>
<tr>
<td>CHD</td>
<td>congestive heart disease; coronary heart disease; congenital heart disease; Chediak-Higashi Disease</td>
</tr>
<tr>
<td>CHF</td>
<td>congestive heart failure</td>
</tr>
<tr>
<td>C2H5OH</td>
<td>ethyl alcohol</td>
</tr>
<tr>
<td>CI</td>
<td>cardiac insufficiency; cerebral infarction</td>
</tr>
<tr>
<td>CID</td>
<td>cytomegalic inclusion disease</td>
</tr>
<tr>
<td>CIS</td>
<td>carcinoma in situ</td>
</tr>
<tr>
<td>CJD</td>
<td>Creutzfeldt-Jakob Disease</td>
</tr>
<tr>
<td>CLD</td>
<td>chronic lung disease; chronic liver disease</td>
</tr>
<tr>
<td>CLL</td>
<td>chronic lymphatic leukemia; chronic lymphocytic leukemia</td>
</tr>
<tr>
<td>CMLD</td>
<td>cytomegalic inclusion disease</td>
</tr>
<tr>
<td>CML</td>
<td>chronic myelocytic leukemia</td>
</tr>
<tr>
<td>CMM</td>
<td>cutaneous malignant melanoma</td>
</tr>
<tr>
<td>CMV</td>
<td>cytomegalic virus</td>
</tr>
<tr>
<td>CNHD</td>
<td>congenital nonspherocytic hemolytic disease</td>
</tr>
<tr>
<td>CNS</td>
<td>central nervous system</td>
</tr>
<tr>
<td>CO</td>
<td>carbon monoxide</td>
</tr>
<tr>
<td>COAD</td>
<td>chronic obstructive airway disease</td>
</tr>
<tr>
<td>CO2</td>
<td>carbon dioxide</td>
</tr>
<tr>
<td>COBE</td>
<td>chronic obstructive bullous emphysema</td>
</tr>
<tr>
<td>COBS</td>
<td>chronic organic brain syndrome</td>
</tr>
<tr>
<td>COFS</td>
<td>cerebro-oculo-facio-skeletal</td>
</tr>
<tr>
<td>COOMBS</td>
<td>test for Rh sensitivity</td>
</tr>
<tr>
<td>COLD</td>
<td>chronic obstructive lung disease</td>
</tr>
<tr>
<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>COPE</td>
<td>chronic obstructive pulmonary emphysema</td>
</tr>
<tr>
<td>CP</td>
<td>cerebral palsy; cor pulmonale</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>EKC</td>
<td>epidemic keratoconjunctivitis</td>
</tr>
<tr>
<td>EKG</td>
<td>electrocardiogram</td>
</tr>
<tr>
<td>EKP</td>
<td>epikeratoprosthesis</td>
</tr>
<tr>
<td>ELF</td>
<td>elective low forceps</td>
</tr>
<tr>
<td>EMC</td>
<td>encephalomyocarditis</td>
</tr>
<tr>
<td>EMD</td>
<td>electromechanical dissociation</td>
</tr>
<tr>
<td>EMF</td>
<td>endomyocardial fibrosis</td>
</tr>
<tr>
<td>EMG</td>
<td>electromyogram</td>
</tr>
<tr>
<td>EN</td>
<td>erythema nodosum</td>
</tr>
<tr>
<td>ENT</td>
<td>ear, nose, and throat</td>
</tr>
<tr>
<td>EP</td>
<td>ectopic pregnancy</td>
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<tr>
<td>ER</td>
<td>emergency room</td>
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<tr>
<td>ERS</td>
<td>evacuation of retained secundines</td>
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<tr>
<td>ESRD</td>
<td>end-stage renal disease</td>
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<tr>
<td>EST</td>
<td>electric shock therapy</td>
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<tr>
<td>ETOH</td>
<td>ethyl alcohol</td>
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<tr>
<td>EUA</td>
<td>exam under anesthesia</td>
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<td>EWB</td>
<td>estrogen withdrawal bleeding</td>
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<tr>
<td>FB</td>
<td>foreign body</td>
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<td>FBS</td>
<td>fasting blood sugar</td>
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<td>Fe</td>
<td>symbol for iron</td>
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<td>FGD</td>
<td>fatal granulomatous disease</td>
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<td>FHS</td>
<td>fetal heart sounds</td>
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<td>FHT</td>
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<td>FS</td>
<td>frozen section; fracture site</td>
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<td>fluorescent treponemal antibody test</td>
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<td>5FU</td>
<td>fluorouracil</td>
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<td>FULG</td>
<td>fulguration</td>
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<td>FUO</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>FX</td>
<td>fracture</td>
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<tr>
<td>FYI</td>
<td>for your information</td>
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<td>GAS</td>
<td>generalized arteriosclerosis</td>
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<tr>
<td>GB</td>
<td>gallbladder; Guillain-Barre (syndrome)</td>
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<td>GC</td>
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<td>GEN</td>
<td>generalized</td>
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<td>GERD</td>
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<td>gastrointestinal bleeding</td>
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<td>GIST</td>
<td>gastrointestinal stromal tumor</td>
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<td>GIT</td>
<td>gastrointestinal tract</td>
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<tr>
<td>GMSD</td>
<td>grand mal seizure disorder</td>
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<td>GOK</td>
<td>God only knows</td>
</tr>
<tr>
<td>GSW</td>
<td>gunshot wound</td>
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<td>GTT</td>
<td>glucose tolerance test</td>
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<td>drop</td>
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<td>GU</td>
<td>genitourinary; gastric ulcer</td>
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<td>GVHR</td>
<td>graft-versus-host reaction</td>
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<td>GYN</td>
<td>gynecology</td>
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<tr>
<td>HA</td>
<td>headache</td>
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<tr>
<td>HAA</td>
<td>hepatitis-associated antigen</td>
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<tr>
<td>HASCVD</td>
<td>hypertensive arteriosclerotic cardiovascular disease</td>
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<tr>
<td>HASCVR</td>
<td>hypertensive arteriosclerotic cardiovascular renal disease</td>
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<td>hypertensive arteriosclerotic heart disease</td>
</tr>
<tr>
<td>HBP</td>
<td>high blood pressure</td>
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<tr>
<td>HC</td>
<td>Huntington's chorea</td>
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<td>HCAP</td>
<td>health care associated pneumonia</td>
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<td>HCPS</td>
<td>Hantivirus (cardio) pulmonary syndrome, Hantavirus cardiopulmonary syndrome</td>
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<td>HCT</td>
<td>hematocrit</td>
</tr>
<tr>
<td>HCVD</td>
<td>hypertensive cardiovascular disease</td>
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<td>HCVRD</td>
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<td>HD</td>
<td>Hodgkin's disease; heart disease</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>HDN</td>
<td>hemolytic disease of newborn</td>
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<td>HDS</td>
<td>herniated disc syndrome</td>
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<td>HEM</td>
<td>hemorrhage</td>
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<tr>
<td>HF</td>
<td>heart failure; hay fever</td>
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<td>HGB; Hgb</td>
<td>hemoglobin</td>
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<td>hypertensive heart disease</td>
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<td>HIV</td>
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<td>hyaline membrane disease</td>
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<td>HN2</td>
<td>nitrogen mustard</td>
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<td>HNP</td>
<td>herniated nucleus pulposus</td>
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<td>H/O</td>
<td>history of</td>
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<td>HPN</td>
<td>hypertension</td>
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<tr>
<td>HPS</td>
<td>Hantavirus pulmonary syndrome</td>
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<tr>
<td>HPVD</td>
<td>hypertensive pulmonary vascular disease</td>
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<tr>
<td>HRE</td>
<td>high-resolution electrocardiology</td>
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<td>HS</td>
<td>herpes simplex; Hurler’s syndrome</td>
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<td>HSV</td>
<td>herpes simplex virus</td>
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<td>HTLV</td>
<td>human T-cell lymphotropic virus</td>
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<tr>
<td>HTLV</td>
<td>human T-cell lymphotropic</td>
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<td>III/LAV</td>
<td>virus-III/lymphadenopathy-associated virus</td>
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<td>Hx</td>
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<tr>
<td>IADH</td>
<td>inappropriate antidiuretic hormone</td>
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<td>IASD</td>
<td>interatrial septal defect</td>
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<td>ICCE</td>
<td>intracapsular cataract extraction</td>
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<tr>
<td>ICD</td>
<td>intrauterine contraceptive device</td>
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<tr>
<td>I&amp;D</td>
<td>incision and drainage</td>
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<td>ID</td>
<td>incision and drainage</td>
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<tr>
<td>IDA</td>
<td>iron deficiency anemia</td>
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<tr>
<td>IDD</td>
<td>insulin-dependent diabetes</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>IDDI</td>
<td>insulin-dependent diabetes</td>
</tr>
<tr>
<td>IDDM</td>
<td>insulin-dependent diabetes mellitus</td>
</tr>
<tr>
<td>IGA</td>
<td>immunoglobulin A</td>
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<tr>
<td>IHD</td>
<td>ischemic heart disease</td>
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<tr>
<td>IHSS</td>
<td>idiopathic hypertrophic subaortic stenosis</td>
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<tr>
<td>ILD</td>
<td>ischemic leg disease</td>
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<tr>
<td>IM</td>
<td>intramuscular; intramedullary; infectious mononucleosis</td>
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<td>IMPP</td>
<td>intermittent positive pressure</td>
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<td>INAD</td>
<td>infantile neuroaxonal dystrophy</td>
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<tr>
<td>INC</td>
<td>incomplete</td>
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<tr>
<td>INE</td>
<td>infantile necrotizing encephalomyelopathy</td>
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<tr>
<td>INF</td>
<td>infection; infected; infantile; infarction</td>
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<tr>
<td>INH</td>
<td>isoniazid; inhalation</td>
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<tr>
<td>INS</td>
<td>idiopathic nephrotic syndrome</td>
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<tr>
<td>IRDM</td>
<td>insulin resistant diabetes mellitus</td>
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<tr>
<td>IRHD</td>
<td>inactive rheumatic heart disease</td>
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<tr>
<td>ISD</td>
<td>interatrial septal defect</td>
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<tr>
<td>ITP</td>
<td>idiopathic thrombocytopenic purpura</td>
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<tr>
<td>IU</td>
<td>intrauterine</td>
</tr>
<tr>
<td>IUCD</td>
<td>intrauterine contraceptive device</td>
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<tr>
<td>IUD</td>
<td>intrauterine device (contraceptive); intrauterine death</td>
</tr>
<tr>
<td>IUP</td>
<td>intrauterine pregnancy</td>
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<tr>
<td>IV</td>
<td>intervenous; intravenous</td>
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<tr>
<td>IVC</td>
<td>intravenous cholangiography; inferior vena cava</td>
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<tr>
<td>IVCC</td>
<td>intravascular consumption coagulopathy</td>
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<tr>
<td>IVD</td>
<td>intervertebral disc</td>
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<td>IVH</td>
<td>intraventricular hemorrhage</td>
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<td>IVP</td>
<td>intravenous pyelogram</td>
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<td>IVSD</td>
<td>intraventricular septal defect</td>
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<tr>
<td>IVU</td>
<td>intravenous urethrography</td>
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<tr>
<td>IWMI</td>
<td>inferior wall myocardial infarction</td>
</tr>
<tr>
<td>JAA</td>
<td>juxtaposition of atrial appendage</td>
</tr>
<tr>
<td>JBE</td>
<td>Japanese B encephalitis</td>
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</table>
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
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
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>NG</td>
<td>nasogastric</td>
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<tr>
<td>NH3</td>
<td>symbol for ammonia</td>
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<tr>
<td>NIDD</td>
<td>non-insulin-dependent diabetes</td>
</tr>
<tr>
<td>NIDD</td>
<td>non-insulin-dependent diabetes</td>
</tr>
<tr>
<td>NIDDM</td>
<td>non-insulin-dependent diabetes mellitus</td>
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<tr>
<td>NSTEMI</td>
<td>non-ST-elevation myocardial infarction</td>
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<tr>
<td>N&amp;V</td>
<td>nausea and vomiting</td>
</tr>
<tr>
<td>NVD</td>
<td>nausea, vomiting, diarrhea</td>
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<tr>
<td>OA</td>
<td>osteoarthritis</td>
</tr>
<tr>
<td>OAD</td>
<td>obstructive airway disease</td>
</tr>
<tr>
<td>OB</td>
<td>obstetrical</td>
</tr>
<tr>
<td>OBS</td>
<td>organic brain syndrome</td>
</tr>
<tr>
<td>OBST</td>
<td>obstructive; obstetrical</td>
</tr>
<tr>
<td>OD</td>
<td>overdose; oculus dexter (right eye); occupational disease</td>
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<tr>
<td>OHD</td>
<td>organic heart disease</td>
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<td>OLT</td>
<td>orthotopic liver transplant</td>
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<tr>
<td>OM</td>
<td>otitis media</td>
</tr>
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<td>OMI</td>
<td>old myocardial infarction</td>
</tr>
<tr>
<td>OMS</td>
<td>organic mental syndrome</td>
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<td>ORIF</td>
<td>open reduction, internal fixation</td>
</tr>
<tr>
<td>OS</td>
<td>oculus sinister (left eye); occipitosacral (fetal position)</td>
</tr>
<tr>
<td>OT</td>
<td>occupational therapy; old TB</td>
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<tr>
<td>OU</td>
<td>oculus uterque (each eye); both eyes</td>
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<tr>
<td>PA</td>
<td>pernicious anemia; paralysis agitans; pulmonary artery; peripheral arteriosclerosis</td>
</tr>
<tr>
<td>PAC</td>
<td>premature auricular contraction; phenacetin, aspirin, caffeine</td>
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<tr>
<td>PAF</td>
<td>paroxysmal auricular fibrillation</td>
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<tr>
<td>PAOD</td>
<td>peripheral arterial occlusive disease; peripheral arteriosclerosis occlusive disease</td>
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<td>PAP</td>
<td>primary atypical pneumonia</td>
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<tr>
<td>PAS</td>
<td>pulmonary artery stenosis</td>
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<tr>
<td>PAT</td>
<td>pregnancy at term; paroxysmal auricular tachycardia</td>
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<tr>
<td>Pb</td>
<td>chemical symbol for lead</td>
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<td>PCD</td>
<td>polycystic disease</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<td>PCF</td>
<td>passive congestive failure</td>
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<td>PCP</td>
<td>pentachlorophenol; pneumocystis carinii pneumonia</td>
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<td>porphyria cutanea tarda</td>
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<td>PCV</td>
<td>polycythemia vera</td>
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<td>PDA</td>
<td>patent ductus arteriosus</td>
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<td>pulmonary embolism; pleural effusion; pulmonary edema</td>
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<td>percutaneous endoscopic gastrostomy; pneumoencephalography</td>
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<tr>
<td>PEGT</td>
<td>percutaneous endoscopic gastrostomy tube</td>
</tr>
<tr>
<td>PET</td>
<td>pre-eclamptic toxemia</td>
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<tr>
<td>PG</td>
<td>pregnant; prostaglandin</td>
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<tr>
<td>PGH</td>
<td>pituitary growth hormone</td>
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<tr>
<td>PH</td>
<td>past history; prostatic hypertrophy; pulmonary hypertension</td>
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<tr>
<td>PI</td>
<td>pulmonary infarction</td>
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<tr>
<td>PID</td>
<td>pelvic inflammatory disease; prolapsed intervertebral disc</td>
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<tr>
<td>PIE</td>
<td>pulmonary interstitial emphysema</td>
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<td>PIP</td>
<td>proximal interphalangeal joint</td>
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<td>PKU</td>
<td>phenylketonuria</td>
</tr>
<tr>
<td>PMD</td>
<td>progressive muscular dystrophy</td>
</tr>
<tr>
<td>PMI</td>
<td>posterior myocardial infarction; point of maximum impulse</td>
</tr>
<tr>
<td>PML</td>
<td>progressive multifocal leukoencephalopathy</td>
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<tr>
<td>PN</td>
<td>pneumonia; periarteritis nodosa; pyelonephritis</td>
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<tr>
<td>PO</td>
<td>postoperative; by mouth</td>
</tr>
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<td>POC</td>
<td>product of conception</td>
</tr>
<tr>
<td>POE</td>
<td>point (or portal) of entry</td>
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<td>POSS</td>
<td>possible; possibly</td>
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<tr>
<td>PP</td>
<td>postpartum</td>
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<td>PPD</td>
<td>purified protein derivative test for tuberculosis</td>
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<td>PPH</td>
<td>postpartum hemorrhage</td>
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<td>PPLO</td>
<td>pleuropneumonia-like organism</td>
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<tr>
<td>PPS</td>
<td>postpump syndrome</td>
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<tr>
<td>PPT</td>
<td>precipitated; prolonged prothrombin time</td>
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<tr>
<td>PREM</td>
<td>prematurity</td>
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<td>PROB</td>
<td>probably</td>
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<td>Acronym</td>
<td>Full Form</td>
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<td>PPROM</td>
<td>preterm premature rupture of membranes</td>
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<tr>
<td>PROM</td>
<td>premature rupture of membranes</td>
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<tr>
<td>PSVT</td>
<td>paroxysmal supraventricular tachycardia</td>
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<tr>
<td>PT</td>
<td>paroxysmal tachycardia; pneumothorax; prothrombin time</td>
</tr>
<tr>
<td>PTA</td>
<td>persistent truncus arteriosus</td>
</tr>
<tr>
<td>PTC</td>
<td>plasma thromboplastin component</td>
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<td>PTCA</td>
<td>percutaneous transluminal coronary angioplasty</td>
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<td>PTLA</td>
<td>percutaneous transluminal laser angioplasty</td>
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<td>PU</td>
<td>peptic ulcer</td>
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<td>PUD</td>
<td>peptic ulcer disease; pulmonary disease</td>
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<td>PUO</td>
<td>pyrexia of unknown origin</td>
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<td>pyloroplasty and vagotomy</td>
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<tr>
<td>PVC</td>
<td>premature ventricular contraction</td>
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<tr>
<td>PVD</td>
<td>peripheral vascular disease; pulmonary vascular disease</td>
</tr>
<tr>
<td>PVI</td>
<td>peripheral vascular insufficiency</td>
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<td>PVL</td>
<td>periventricular leukomalacia</td>
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<td>PVT</td>
<td>paroxysmal ventricular tachycardia</td>
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<td>PVS</td>
<td>premature ventricular systole (contraction)</td>
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<td>posterior wall infarction</td>
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<td>PWMI</td>
<td>posterior wall myocardial infarction</td>
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<td>PX</td>
<td>pneumothorax</td>
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<td>R</td>
<td>right</td>
</tr>
<tr>
<td>RA</td>
<td>rheumatoid arthritis; right atrium; right auricle</td>
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<td>RAAAA</td>
<td>ruptured abdominal aortic aneurysm</td>
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<tr>
<td>RAD</td>
<td>rheumatoid arthritis disease; radiation absorbed dose</td>
</tr>
<tr>
<td>RAI</td>
<td>radioactive iodine</td>
</tr>
<tr>
<td>RBBB</td>
<td>right bundle branch block</td>
</tr>
<tr>
<td>RBC</td>
<td>red blood cells</td>
</tr>
<tr>
<td>RCA</td>
<td>right coronary artery</td>
</tr>
<tr>
<td>RCS</td>
<td>reticulum cell sarcoma</td>
</tr>
<tr>
<td>RD</td>
<td>Raynaud's disease; respiratory disease</td>
</tr>
<tr>
<td>RDS</td>
<td>respiratory distress syndrome</td>
</tr>
<tr>
<td>RE</td>
<td>regional enteritis</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>REG</td>
<td>radioencephalogram</td>
</tr>
<tr>
<td>RESP</td>
<td>respiratory</td>
</tr>
<tr>
<td>RHD</td>
<td>rheumatic heart disease</td>
</tr>
<tr>
<td>RLF</td>
<td>retrolental fibroplasia</td>
</tr>
<tr>
<td>RLL</td>
<td>right lower lobe</td>
</tr>
<tr>
<td>RLQ</td>
<td>right lower quadrant</td>
</tr>
<tr>
<td>RMCA</td>
<td>right middle cerebral artery</td>
</tr>
<tr>
<td>RMCAT</td>
<td>right middle cerebral artery thrombosis</td>
</tr>
<tr>
<td>RML</td>
<td>right middle lobe</td>
</tr>
<tr>
<td>RMLE</td>
<td>right mediolateral episiotomy</td>
</tr>
<tr>
<td>RNA</td>
<td>ribonucleic acid</td>
</tr>
<tr>
<td>RND</td>
<td>radical neck dissection</td>
</tr>
<tr>
<td>R/O</td>
<td>rule out</td>
</tr>
<tr>
<td>RSA</td>
<td>reticulum cell sarcoma</td>
</tr>
<tr>
<td>RSR</td>
<td>regular sinus rhythm</td>
</tr>
<tr>
<td>Rt</td>
<td>right</td>
</tr>
<tr>
<td>RT</td>
<td>recreational therapy; right</td>
</tr>
<tr>
<td>RTA</td>
<td>renal tubular acidosis</td>
</tr>
<tr>
<td>RUL</td>
<td>right upper lobe</td>
</tr>
<tr>
<td>RUQ</td>
<td>right upper quadrant</td>
</tr>
<tr>
<td>RV</td>
<td>right ventricle</td>
</tr>
<tr>
<td>RVH</td>
<td>right ventricular hypertrophy</td>
</tr>
<tr>
<td>RVT</td>
<td>renal vein thrombosis</td>
</tr>
<tr>
<td>RX</td>
<td>drugs or other therapy or treatment</td>
</tr>
<tr>
<td>SA</td>
<td>sarcoma; secondary anemia</td>
</tr>
<tr>
<td>SACD</td>
<td>subacute combined degeneration</td>
</tr>
<tr>
<td>SARS</td>
<td>severe acute respiratory syndrome</td>
</tr>
<tr>
<td>SBE</td>
<td>subacute bacterial endocarditis</td>
</tr>
<tr>
<td>SBO</td>
<td>small bowel obstruction</td>
</tr>
<tr>
<td>SBP</td>
<td>spontaneous bacterial peritonitis</td>
</tr>
<tr>
<td>SC</td>
<td>sickle cell</td>
</tr>
<tr>
<td>SCC</td>
<td>squamous cell carcinoma</td>
</tr>
<tr>
<td>SCI</td>
<td>subcoma insulin; spinal cord injury</td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TR</td>
<td>tricuspid regurgitation, transfusion reaction</td>
</tr>
<tr>
<td>TSD</td>
<td>Tay-Sachs disease</td>
</tr>
<tr>
<td>TTP</td>
<td>thrombotic thrombocytopenic purpura</td>
</tr>
<tr>
<td>TUI</td>
<td>transurethral incision</td>
</tr>
<tr>
<td>TUR</td>
<td>transurethral resection (NOS) (prostate)</td>
</tr>
<tr>
<td>TURP</td>
<td>transurethral resection of prostate</td>
</tr>
<tr>
<td>TVP</td>
<td>total anomalous venous return</td>
</tr>
<tr>
<td>UC</td>
<td>ulcerative colitis</td>
</tr>
<tr>
<td>UGI</td>
<td>upper gastrointestinal</td>
</tr>
<tr>
<td>UL</td>
<td>upper lobe</td>
</tr>
<tr>
<td>UNK</td>
<td>unknown</td>
</tr>
<tr>
<td>UP</td>
<td>ureteropelvic</td>
</tr>
<tr>
<td>UPJ</td>
<td>ureteropelvic junction</td>
</tr>
<tr>
<td>URI</td>
<td>upper respiratory infection</td>
</tr>
<tr>
<td>UTI</td>
<td>urinary tract infection</td>
</tr>
<tr>
<td>VAMP</td>
<td>vincristine, amethopterine, 6-mercaptopurine, and prednisone</td>
</tr>
<tr>
<td>VB</td>
<td>vinblastine</td>
</tr>
<tr>
<td>VC</td>
<td>vincristine</td>
</tr>
<tr>
<td>VD</td>
<td>venereal disease</td>
</tr>
<tr>
<td>VDRL</td>
<td>venereal disease research lab</td>
</tr>
<tr>
<td>VEE</td>
<td>Venezuelan equine encephalomyelitis</td>
</tr>
<tr>
<td>VF</td>
<td>ventricular fibrillation</td>
</tr>
<tr>
<td>VH</td>
<td>vaginal hysterectomy; viral hepatitis</td>
</tr>
<tr>
<td>VL</td>
<td>vas ligation</td>
</tr>
<tr>
<td>VM</td>
<td>viomycin</td>
</tr>
<tr>
<td>V&amp;P</td>
<td>vagotomy and pyloroplasty</td>
</tr>
<tr>
<td>VPC, VPCS</td>
<td>ventricular premature contractions</td>
</tr>
<tr>
<td>VR</td>
<td>valve replacement</td>
</tr>
<tr>
<td>VSD</td>
<td>ventricular septal defect</td>
</tr>
<tr>
<td>VT</td>
<td>ventricular tachycardia</td>
</tr>
<tr>
<td>WBC</td>
<td>white blood cell</td>
</tr>
<tr>
<td>WC</td>
<td>whooping cough</td>
</tr>
<tr>
<td>WE</td>
<td>Western encephalomyelitis</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Alimentary canal</th>
<th>Gastrointestinal tract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body</td>
<td>Torso, trunk</td>
</tr>
<tr>
<td>Brain</td>
<td>Anterior fossa, basal ganglion, central nervous system, cerebral, cerebrum, frontal, occipital, parietal, pons, posterior fossa, prefrontal, temporal, III and IV ventricle</td>
</tr>
</tbody>
</table>

**NOTE:** Do not use brain when ICD provides for CNS under the reported condition.
<table>
<thead>
<tr>
<th>Medical Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac</td>
<td>Heart</td>
</tr>
<tr>
<td>Chest</td>
<td>Thorax</td>
</tr>
<tr>
<td>Geriatric</td>
<td>Senile</td>
</tr>
<tr>
<td>Greater sac</td>
<td>Peritoneum</td>
</tr>
<tr>
<td>Hepatic</td>
<td>Liver</td>
</tr>
<tr>
<td>Hepatocellular</td>
<td>Liver</td>
</tr>
<tr>
<td>Intestine</td>
<td>Bowel, colon</td>
</tr>
<tr>
<td>Kidney</td>
<td>Renal</td>
</tr>
<tr>
<td>Larynx</td>
<td>Epiglottis, subglottis, supraglottis, vocal cords</td>
</tr>
<tr>
<td>Lesser sac</td>
<td>Peritoneum</td>
</tr>
<tr>
<td>Nasopharynx, pharynx</td>
<td>Throat</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Lung</td>
</tr>
<tr>
<td>Right\left hemispheric</td>
<td>Code brain</td>
</tr>
<tr>
<td>Hemispheric NOS</td>
<td>Do not assume brain</td>
</tr>
<tr>
<td>Right\left ventricle</td>
<td>Heart</td>
</tr>
<tr>
<td>Third\fourth ventricle</td>
<td>Brain</td>
</tr>
<tr>
<td>LLL, LUL, RLL, RML, RUL</td>
<td>Lobes of the lungs when reported with lobectomy, pneumonia, etc.</td>
</tr>
</tbody>
</table>

**APPENDIX C - GEOGRAPHIC CODES**

<table>
<thead>
<tr>
<th>State</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>AL</td>
</tr>
<tr>
<td>Alaska</td>
<td>AK</td>
</tr>
<tr>
<td>Arizona</td>
<td>AZ</td>
</tr>
<tr>
<td>State</td>
<td>Abbreviation</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Arkansas</td>
<td>AR</td>
</tr>
<tr>
<td>California</td>
<td>CA</td>
</tr>
<tr>
<td>Colorado</td>
<td>CO</td>
</tr>
<tr>
<td>Connecticut</td>
<td>CT</td>
</tr>
<tr>
<td>Delaware</td>
<td>DE</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>DC</td>
</tr>
<tr>
<td>Florida</td>
<td>FL</td>
</tr>
<tr>
<td>Georgia</td>
<td>GA</td>
</tr>
<tr>
<td>Hawaii</td>
<td>HI</td>
</tr>
<tr>
<td>Idaho</td>
<td>ID</td>
</tr>
<tr>
<td>Illinois</td>
<td>IL</td>
</tr>
<tr>
<td>Indiana</td>
<td>IN</td>
</tr>
<tr>
<td>Iowa</td>
<td>IA</td>
</tr>
<tr>
<td>Kansas</td>
<td>KS</td>
</tr>
<tr>
<td>Kentucky</td>
<td>KY</td>
</tr>
<tr>
<td>Louisiana</td>
<td>LA</td>
</tr>
<tr>
<td>Maine</td>
<td>ME</td>
</tr>
<tr>
<td>Maryland</td>
<td>MD</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>MA</td>
</tr>
<tr>
<td>Michigan</td>
<td>MI</td>
</tr>
<tr>
<td>Minnesota</td>
<td>MN</td>
</tr>
<tr>
<td>Mississippi</td>
<td>MS</td>
</tr>
<tr>
<td>Missouri</td>
<td>MO</td>
</tr>
<tr>
<td>Montana</td>
<td>MT</td>
</tr>
<tr>
<td>Nebraska</td>
<td>NE</td>
</tr>
<tr>
<td>Nevada</td>
<td>NV</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>NH</td>
</tr>
<tr>
<td>New Jersey</td>
<td>NJ</td>
</tr>
<tr>
<td>New Mexico</td>
<td>NM</td>
</tr>
<tr>
<td>New York</td>
<td>NY</td>
</tr>
<tr>
<td>North Carolina</td>
<td>NC</td>
</tr>
<tr>
<td>North Dakota</td>
<td>ND</td>
</tr>
<tr>
<td>Ohio</td>
<td>OH</td>
</tr>
</tbody>
</table>
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
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 Marianas Islands MP
Palau            PW
Puerto Rico      PR
Virgin Islands (US) VI

**US Minor Outlying Islands**

Baker Island
Howland Island
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
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  Police station or cell
Assembly hall  Post office
Campus  Private club
Child center  Public building
Church  Public hall
Cinema  Salvation army
Clubhouse  School (grounds) (yard)
College  School (private) (public) (state)
Country club (grounds)  Theatre
Court house  Turkish bath
Dance hall  University
Day nursery (day care)  YMCA
Drive in theater  Youth center
Fire house  YWCA
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
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  
Shipyards  
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**

<table>
<thead>
<tr>
<th>Place</th>
<th>Other Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandoned gravel pit</td>
<td>Military training ground</td>
</tr>
<tr>
<td>Abandoned public building or home</td>
<td>Mountain</td>
</tr>
<tr>
<td>Air force firing range</td>
<td>Mountain resort</td>
</tr>
<tr>
<td>Balcony</td>
<td>Named city</td>
</tr>
<tr>
<td>Bar pit or ditch</td>
<td>Named lake</td>
</tr>
<tr>
<td>Beach NOS (named) (private)</td>
<td>Named room</td>
</tr>
<tr>
<td>Beach resort</td>
<td>Named town</td>
</tr>
<tr>
<td>Boy's camp</td>
<td>Nursery NOS</td>
</tr>
<tr>
<td>Building NOS</td>
<td>Open field</td>
</tr>
<tr>
<td>Bus stop</td>
<td>Park (amusement) (any) (public)</td>
</tr>
<tr>
<td>Camp</td>
<td>Parking lot</td>
</tr>
<tr>
<td>Camping grounds</td>
<td>Parking place</td>
</tr>
<tr>
<td>Campsite</td>
<td>Pier</td>
</tr>
<tr>
<td>Canal</td>
<td>Pipeline (oil)</td>
</tr>
<tr>
<td>Caravan site NOS</td>
<td>Place of business NOS</td>
</tr>
<tr>
<td>Cemetery</td>
<td>Playground NOS</td>
</tr>
</tbody>
</table>
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
Kitchen
Lake NOS
Lake resort
Manhole
Marsh

9. Unspecified place

Bathtub
Bed
Camper (trailer)
Commode
Country
Downstairs
Fireplace
Hot tub
Jobsite
Near any place
On job
Outdoors 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)
Vacation resort
Woods
Zoo
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:

<table>
<thead>
<tr>
<th>Invalid Codes</th>
<th>Substitute Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A150-A153</td>
<td>A162</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>B95-B97</td>
<td>Code the disease(s) classified to other chapters modified by the organism. Do not enter a code for the organism.</td>
</tr>
<tr>
<td>F70.-</td>
<td>F70 (3-characters only)</td>
</tr>
<tr>
<td>F71.-</td>
<td>F71 (3-characters only)</td>
</tr>
<tr>
<td>F72.-</td>
<td>F72 (3-characters only)</td>
</tr>
<tr>
<td>F73.-</td>
<td>F73 (3-characters only)</td>
</tr>
<tr>
<td>F78.-</td>
<td>F78 (3-characters only)</td>
</tr>
<tr>
<td>F79.-</td>
<td>F79 (3-characters only)</td>
</tr>
<tr>
<td>I151-I158</td>
<td>R99</td>
</tr>
<tr>
<td>I23.-</td>
<td>I21 or I22</td>
</tr>
<tr>
<td>I240</td>
<td>I21 or I22</td>
</tr>
<tr>
<td>I252</td>
<td>I258</td>
</tr>
<tr>
<td>I65-I66</td>
<td>I63</td>
</tr>
<tr>
<td>O08.-</td>
<td>O00 - O07</td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asphyxia originating from fire</td>
<td>causing directly by fire-producing device or indirectly by any conventional weapon</td>
</tr>
<tr>
<td>Burns</td>
<td></td>
</tr>
<tr>
<td>Other injury</td>
<td>by any conventional weapon</td>
</tr>
<tr>
<td>Petrol bomb</td>
<td></td>
</tr>
<tr>
<td>Collapse of</td>
<td></td>
</tr>
<tr>
<td>Fall from</td>
<td></td>
</tr>
<tr>
<td>Falling from burning building</td>
<td>or structure</td>
</tr>
<tr>
<td>Hit by object</td>
<td></td>
</tr>
<tr>
<td>Jump from</td>
<td></td>
</tr>
<tr>
<td>Conflagration</td>
<td></td>
</tr>
<tr>
<td>Fire</td>
<td></td>
</tr>
<tr>
<td>Melting</td>
<td>of fittings or furniture</td>
</tr>
<tr>
<td>Smoldering</td>
<td></td>
</tr>
</tbody>
</table>

### *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 Terrorism

*U03 Terrorism involving explosions and fragments

*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

d 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

d 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) U01.7
- 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
Fireball effects from nuclear explosion in terrorism U01.5
Heat (effects of) (excessive)
  "from
  - - nuclear explosion in terrorism U01.5

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
Date of death 9/11/2001

PLACE 5

(a) Burns T300
(b) Terrorist attack on the Pentagon &U011

MOD II H

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

(a) Chest trauma S299
(b) World Trade Center Disaster &U011

MOD II H

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
   (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
   (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
   (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
   (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
   (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
   (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
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) 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) 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.

11. Place 9
    I (a) Acute multiple drug intoxication (ethanol,  T510 X45  T402 &X44 T424
        (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.

12. Place 9
    I (a) Acute combined drug intoxication  T509 &X44
        (b) (oxycodone, with diazepam and ethyl  T402 X45  T424 T510
13. 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 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) Intoxication T402 9 (b) Morphine, Cocaine poisoning T402 &X42 T405 MOD II

**Code** I (a) to the nature of injury code for morphine 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) Acute intoxication due to the T404 9 (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).

16. Place I (a) Cardiac arrhythmia associated with hydroxyzine I499 T435 &X41 9 (b) Injection MOD II Hydroxyzine injection T435 (c)

**Code** I (b) injection
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.

17. I (a) Cardiac arrhythmia associated with hydroxyzine injection (b) 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.

18. Place 9 MOD A I (a) Acute cardiac arrhythmia precipitated by cocaine and opiates (b) Drug abuse, cocaine and opiates

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.

19. Place 9 I (a) Acute intravenous narcotism (heroin) (b) Methadone overdose, heroin injection

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.

20. Place 9 MOD A I (a) Acute intravenous narcotism heroin overdose
Interpret 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.

21. 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.

22. I (a) Drug dependence (heroin, cocaine) F112 F142

   Code I(a) heroin and cocaine dependence as indexed.

23. 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.

24. Place
    9 MOD A I (a) Effects of cocaine and methamphetamine use F149 F159
        (b) Drug intake T509 &X44

   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.

25. Place
    9 MOD A I (a) Adverse effects of drugs T509 &X44
        II Subject took drugs T509

   Code I(a) to drug poisoning since drug NOS is reported and the certifier stated the death was due to an accident. Code the
26. 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.

27. Place
 I (a) Combined toxicity T659 &X44
(b) Heroin and amphetamine T401 T436

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.

28. Place
 I (a) Poisoning T659 &X44
(b) Heroin and amphetamine T401 T436

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.

29. Place
 I (a) Mixed drug poisoning (cocaine, opiate, ethanol) T405 &Y12 T406 T510 Y15
(b) opiate, ethanol
(c) Consumed ethanol with illicit drugs F109 T509

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.

30. Place  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.

31. I (a) Cardiac Arrest I469
    (b) Bleeding &R5800
    (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.

32. Place  I (a) Combined opiate and stimulant poisoning T406 &X44 T509
           (b) Usage of hydrocodone and cocaine F119 F149
II T406 T509

    Accident

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.

33. Place  I (a) Combined analgesic and antihistaminic antidepressant poisoning T398 &X44 T450 T432
           (b) Usage of fentanyl promethazine doxylamine F199
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.

34. Place

<table>
<thead>
<tr>
<th></th>
<th>I</th>
<th>(a) Combined ethanol and methadone intoxication</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>II</td>
<td>Toxic use of drug and ethanol</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>T510  X45  T403  &amp;X42</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>T509  T510</td>
<td></td>
</tr>
</tbody>
</table>

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.

35. Place

<table>
<thead>
<tr>
<th></th>
<th>I</th>
<th>(a) Adverse reaction to drugs and ethanol</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>II</td>
<td>F109  F139  F119</td>
<td></td>
</tr>
</tbody>
</table>

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.

36. Place

<table>
<thead>
<tr>
<th></th>
<th>I</th>
<th>(a) Adverse effects of acetaminophen and alcohol</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>II</td>
<td>F199  F109</td>
<td></td>
</tr>
</tbody>
</table>

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.
Endnotes

1 (Popup - Note)
Similar terms include modifiers such as many, numerous, recurrent, repeated, serial, series, or several.

2 (Popup - Note)
Similar terms include modifiers such as many, numerous, recurrent, repeated, serial, series, or several.

3 (Popup - Note)
Similar terms include modifiers such as many, numerous, recurrent, repeated, serial, series, or several.

4 (Popup - Note)
Similar terms include modifiers such as many, numerous, recurrent, repeated, serial, series, or several.

5 (Popup - Note)
Similar terms include modifiers such as many, numerous, recurrent, repeated, serial, series, or several.

6 (Popup - Note)
Similar terms include modifiers such as many, numerous, recurrent, repeated, serial, series, or several.

7 (Popup - Note)
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