EXTERNAL CAUSE OF INJURY AND PRESENT ON ADMISSION INDICATOR

Section 97227

(a) The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable. An E-code is to be reported on the record for the first episode of care reportable to the Office during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. If the E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the discharge record. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect.

(b) Effective with discharges on or after July 1, 2008, whether the patient's External Cause of Injury was present on admission shall be reported as one of the following:

(1) Y. Yes. Condition was present at the time of inpatient admission.

(2) N. No. Condition was not present at the time of inpatient admission.

(3) U. Unknown. Documentation is insufficient to determine whether the condition was present on admission or not.

(4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present on admission or not.

(5)(blank) Exempt from present on admission reporting.

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for discharges occurring on or after July 1, 2008.

PRINCIPAL E-CODE

E

PRESENT ON ADMISSION

OTHER E-CODES

E
E
E
E

PRESENT ON ADMISSION

Y = Yes
N = No
U = Uncertain
W = Clinically Undetermined
(blank) = Exempt from POA reporting

Reporting Requirements:

- Duplicate E-codes will not be accepted on the same data record. This is consistent with the guidelines for E-codes in *Coding Clinic for ICD-9-CM.*
- If more than one drug or substance caused a poisoning or adverse effect, report all E-codes necessary to describe all substances.
- Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E000-E030, E800-E999) must never be reported in the Other Diagnoses code fields. Such codes must only be reported in the External Cause of Injury code fields.

Principal E-code: The principal E-code is defined as the external cause of injury or poisoning or adverse effects which describes the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If sequencing the external cause of the most severe injury as the principal E-code is contradictory to the guidelines given in ICD-9-CM, OSHPD reporting requirements take precedence.

An E-code is to be reported for when the injury, poisoning, and/or adverse effect was **first diagnosed and/or treated by a reporting facility**.

Other E-codes:

- Defined as additional ICD-9-CM codes from the range E800-E999 necessary to completely describe the mechanisms that contributed to or the causal events surrounding the injuries, poisonings, or adverse effects.
- Include category E849 (place of occurrence) if documented in the medical record.
- Status and Activity E-codes are not required by OSHPD. Facilities may report these only if there is room on the record after reporting the required E-codes.

Place of occurrence codes (category E849) are:

- Invalid as the principal E-code.
- Reported to OSHPD if the principal E-code does not specify the place of occurrence.
- Reported to OSHPD as unspecified (E849.9) when the place of occurrence is not specified in the medical record.

Number of Other E-codes: Four other E-codes in addition to the principal E-code may be reported to OSHPD.

- When multiple E-codes are required to completely classify the cause(s), the principal E-code and up to three additional E-codes need to describe **how** it happened. If the principal E-code does not include a description of **where** it happened, report the E-code for the place of occurrence (E849.x) in the remaining field.
- If your reporting format limits the number of E-codes that can be used in reporting to OSHPD, refer to the *Coding Clinic for ICD-9-CM* for coding multiple E-codes in the same three-digit categories or different three-digit categories. In either case, include the E-code for the place of occurrence (E849.x).

Examples

First New Event: Injury During the Stay:
If the patient attempts suicide with a drug overdose during the stay at Hospital A, the E-code(s) needs to be reported by Hospital A.

First New Event: Drug Reaction During the Stay:
If the patient has an adverse effect of a prescribed medication during the stay at Hospital A, the E-code(s) needs to be reported by Hospital A.

Treated in ED and Transferred:
If the patient was first diagnosed and treated in the ED of Hospital A and then transferred to the Hospital B, the E code(s) needs to be reported on the ED record of Hospital A.

Treated and Transferred:
If the patient was first treated and admitted to Hospital A and then transferred to Hospital B, the E-code(s) needs to be reported by Hospital A.

Parameters for Reporting Present on Admission on or after July 1, 2009:

Follow the reporting requirements in the Appendix “Present on Admission Reporting Guidelines” in the *ICD-9-CM Official Guidelines for Coding and Reporting*.

http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

DISCUSSION

Domestic Violence, Abuse, and Neglect using Diagnosis and E-codes

Domestic violence, abuse, and neglect are considered to be underreported and underdiagnosed. Community awareness of these circumstances is growing and there is a need for data collection on its incidence. Using this data, the healthcare communities can then develop solutions in helping both the victims and the perpetrators.

If the incident of domestic violence, abuse, or neglect is documented in the patient record, the ICD-9-CM classification system provide codes for:

- diagnosis of physical abuse, mental abuse, sexual abuse, and neglects (physical, emotional, educational, medical, or social) using the 995.5 and 995.8 series,

- specific associated injuries using 001-999 series,

- external causes for the nature of these incidents and the perpetrator using the assault E codes and the E967 series,

- past history of physical or emotional abuse using the V15.4 series, and

- counseling for victims and/or perpetrators using the V61.1-V61.2 series, and/or V62.83 code.

The codes for these incidences are assigned only when the physician documents the abuse, neglect, or domestic violence. The narrative descriptions should not be interpreted as abuse without the physician's confirmation. In accordance with the Penal Code and AMA reporting policy, physicians who suspect abuse should report it to the appropriate authorities.

Coding Clinic for ICD-9-CM published the Child and Adult Abuse Guidelines in the Official Guidelines for Coding and Reporting at:
http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

Penal Codes:
Refer to California Penal Code sections 11160-11163 for reporting injuries and sections 11164-11174 for reporting child abuse and neglect.

American Medical Association:
Refer to “Diagnostic and Treatment Guidelines on Elder Abuse and Neglect”, issued in 1993 or any of AMA updated policies for reporting child or elder injuries to authorities at http://www.ama-assn.org/ and use the search box for the title.

Consent Manual by California Healthcare Association:
Refer to release of information without patient authorization when there is suspected child abuse and neglect [42 C.F.R. section 2.12(c)(6)]. Refer to statutory reporting requirements for abuse of elders or dependent adults [California Penal Code sections 288 and 368; Welfare and Institutions Code sections 15610 and 15630-15634}.