

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
CALIFORNIA EMERGENCY DEPARTMENT AND
AMBULATORY SURGERY DATA REPORTING MANUAL,
MEDICAL INFORMATION REPORTING FOR CALIFORNIA, FOURTH EDITION**

OTHER EXTERNAL CAUSE OF INJURY

Section 97261

(a) For encounters occurring up to and including September 30, 2015: The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe 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 on 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 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 encounter record. 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.

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring up to and including September 30, 2015:

OTHER E-CODES				
ICD-9-CM CODE				
E				
E				
E				
E				

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Reporting Requirements

- The external cause of injury, poisoning, or adverse effect shall be coded to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), using the E-codes.
- 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 Principal or Other External Cause of Injury code fields.
- An E-code is to be included for the first reported encounter during which the injury, poisoning, or adverse effect was first diagnosed and/or treated. If a patient was first diagnosed in a doctor's office and then sent to an ED or AS facility, the E-code is to be reported on the ED or AS record. OSHPD does not collect data from physician's offices.

FREESTANDING AMBULATORY CLINICS

If the injury or poisoning or adverse effect was first diagnosed and/or treated during the AS encounter, then report the E-Code on the AS encounter record.

HOSPITALS

If the injury or poisoning or adverse effect was first diagnosed and/or treated during the ED or AS encounter, then report the E-Code on the ED or AS encounter record.

However, if the ED or AS encounter resulted in a same-hospital admission and your hospital combines the ED or AS record with the inpatient record, then the E-code would be reported on the inpatient record.

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Other E-codes:

- Defined as additional ICD-9-CM codes from the range E800-E999 necessary to completely describe the mechanisms that contributed to the causal events surrounding the injury, poisoning, or adverse effect.
- Four other E-codes in addition to the principal E-code may be reported to OSHPD.
- 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 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.
- If none of the reported E-codes describe the place of occurrence, then include a place of occurrence E-code as one of the four Other E-codes.
- 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.
- If none of the reported E-codes describe the place of occurrence, then include a place of occurrence E-code as one of the four Other E-codes.

Refer to Section 97260, Principal External Cause of Injury, for more information and examples on reporting E-codes.