

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

EXTERNAL CAUSES OF MORBIDITY

Section 97260

(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. 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.

(b) For encounter occurring on or after October 1, 2015: The external causes of morbidity shall be coded according to the ICD-10-CM External Causes of Morbidity (V00-Y99). The external Cause of morbidity that resulted in the injury or health condition shall be listed first. Additional cause of morbidity codes shall be reported if necessary to describe the mechanisms that contributed to, or the causal events surrounding the injury or health condition.

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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 on or after October 1, 2015:

PRINCIPAL EXTERNAL CAUSE OF MORBIDITY	PRESENT ON ADMISSION										
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	Y = Yes										
	N = No										
	U = Unknown										
	W = Clinically Undetermined										
	blank = Exempt from POA reporting (1 or E also accepted)										
OTHER EXTERNAL CAUSES OF MORBIDITY	PRESENT ON ADMISSION										
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Reporting Requirements:

- Duplicate external cause codes will not be accepted on the same data record. This is consistent with the *ICD-10-CM Official Guidelines for Coding and Reporting*.
- Codes from the ICD-10-CM Codebook, Chapter 20, External Causes of Morbidity (V00—Y99) must never be reported in the Other Diagnoses code fields. Such codes must only be reported in the External Cause of Morbidity code fields.

Principal external cause code: The principal external cause code is defined as the external cause of injury or health condition which describes the mechanism that resulted in the most severe injury or health condition. If sequencing the external cause of the most severe injury as the principal external cause code is contradictory to the guidelines given in ICD-10-CM, OSHPD reporting requirements take precedence.

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Other external cause codes:

- Defined as additional ICD-10-CM codes from the range V00-Y99 necessary to completely describe the mechanisms that contributed to or the causal events surrounding the injuries or health conditions.

Place of occurrence codes (category Y92) are:

- Invalid as the principal external cause code.
- Reported to OSHPD if the principal external cause code does not specify the place of occurrence.

Activity (category Y93) and Status (category Y99) codes

- These codes should be reporting if the codes are necessary to describe the mechanisms that contributed to the injury, or the causal events surrounding the injury or health condition.
- Activity and status codes are only reported on the first incident of treatment.

Assignment of 7th Character

Assignment of the 7th character for codes assigned from Chapter 19 in the ICD-10-CM codebook is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time. Initial encounter is used while the patient is receiving active treatment for the condition. Subsequent encounter is used for care received in the healing or recovery phase.

Assignment of the 7th character identifying initial, subsequent, or sequela encounter for external cause should match the 7th character of the code assigned for the associated injury or condition of the hospitalization.

Please refer to the ICD-10-CM Official Guidelines for Coding and Reporting for further clarification (<http://www.cdc.gov/nchs/icd/icd10cm.htm>).

Example

Treated in ED and Transferred:

If the patient was first diagnosed and treated in the ED of Hospital A and then transferred to the ED of Hospital B, both Hospital A & B would report the external cause code as an initial encounter.

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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-10-CM Official Guidelines for Coding and Reporting*.

<http://www.cdc.gov/nchs/icd/icd10cm.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 as confirmed (74.-) then an appropriate code from the external cause assault section (X92—Y08) should be added to identify the cause of any physical injuries. A perpetrator code (Y07) should be added when the perpetrator of the abuse is known.