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DESK REFERENCE

Coders' Desk Reference for ICD-10-CM Diagnoses

Clinical descriptions with answers to your toughest ICD-10-CM coding questions

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Contents

Introduction

Coders' Desk Reference for Diagnoses is an ICD-10-CM coding reference that provides comprehensive lay descriptions of diseases, injuries, poisonings, and other conditions. It has been developed for coders, billers, and other health care professionals in all health care settings, including medical offices, hospitals, post-acute care settings, and health insurance companies. It is also a valuable reference for educators and students who seek to expand their understanding of diagnostic coding. The goal is to enrich the user's clinical understanding of ICD-10-CM so that code selection becomes more accurate.

It should be noted that this diagnostic coding reference is intended to be used with an official ICD-10-CM code book. The *Coders' Desk Reference for Diagnoses* does not include the comprehensive index or guidelines found in the official ICD-10-CM, nor does it include coding instructions from the tabular section. Information related to includes and excludes notes have also been omitted as providing this information would be redundant to what is readily available in an official ICD-10-CM code book. For these reasons, *Coders' Desk Reference for Diagnoses* does not replace an official code book; however, used in conjunction with a code book, this reference provides an unparalleled clinical roadmap to code selection.

Format

The *Coders' Desk Reference for Diagnoses* follows the organization of the tabular section of ICD-10-CM with the same 22 chapters beginning with Chapter 1: Certain Infectious and Parasitic Diseases and ending with Chapter 22: Codes for Special Purposes (U00-U85).

Each chapter is organized using a format similar to the tabular section of ICD-10-CM with chapters subdivided into blocks, alphanumeric categories, subcategories, and codes. Chapters begin with a general overview of diseases and other conditions classified to the chapter. Following the chapter overview, each chapter is divided into the various blocks where information is provided related to categories included in the block. This is followed by the lay descriptions. Lay descriptions may be provided at the category, subcategory, or code level.

Not all categories, subcategories, or codes have been represented in the *Coders' Desk Reference for Diagnoses*. The 2021 edition of *Coders' Desk Reference for Diagnoses* focuses on:

- A subset of the new fiscal year 2021 diagnosis codes released by the National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS)
- Codes regularly encountered in various health care settings
- Codes that require in-depth clinical information in order to differentiate the represented condition from similar conditions that would be captured with other, more specific codes

Additional codes and lay descriptions will gradually be incorporated into future editions. Due to the structure of ICD-10-CM, many categories, subcategories, and codes have been updated with more robust official descriptions. In some cases, official code descriptions supply enough information about the disease process and any associated manifestations that provide additional narrative would be redundant. Also, codes in many categories and subcategories provide information related to site and/or laterality. Although site and laterality are important for valid code selection, they do not need additional explanations beyond the related disease process provided at the category or subcategory level.

ICD-10-CM Codes and Lay Descriptions

The codes in *Coders' Desk Reference for Diagnoses* are based on the official version of the *International Classification of Diseases, 10th Revision, Clinical Modification* effective October 1, 2020.

Coders' Desk Reference for Diagnoses is organized in a hierarchical context, similar to how the ICD-10-CM code book is organized with lay descriptions provided at the three, four, five, and/or six character level. Lay descriptions at the category level provide a broad overview of diseases or other conditions classified to the category. Category-level lay descriptions may be followed by subcategory and/or code level lay descriptions. Lay descriptions at the subcategory and code levels build on the information provided at the category level. The category level will be the most general and provides information relevant to all subcategories and codes in the category. The subcategory is more specific with the code level lay description providing the most detailed information about the disease, injury, or other condition.

Because some lay descriptions are not carried to the code level, the book uses a dash (-) to differentiate invalid codes from valid codes.

Valid Code

A valid code in the *Coders' Desk Reference for Diagnoses* is any code for which a dash (-) is **not** appended to the end of an alphanumeric code. Valid codes may be three characters to seven characters long.

Prefixes and Suffixes

The uniquely efficient language of medicine is possible thanks to the prefixes and suffixes attached to roots. Changing prefixes and suffixes allows subtle and overt changes in meaning of the terms. The following prefixes and suffixes are paired with their meanings.

Prefixes

Prefixes are one half of the medical language equation and are attached to the beginning of words. For example, the prefix "eu-," meaning good or well, combined with the Greek word for death, "thanatos," produces euthanasia — a good death.

a-, an-	without, away from, not
ab-	from, away from, absent
acanth(o)-	thorny, spine
acro-	extremity, top, highest point
ad-	indicates toward, adherence to, or increase
adeno-	relating to a gland
adip(o)-	relating to fat
aero-	relating to gas or air
agglutin-	stick together, clump
alb-	white in color
alge(si)-	awareness to pain
all(o)-	indicates difference or divergence from the norm
ambi-	both sides; about or around (also amphi-)
ambly-	dull, dimmed
an-	without
andro-	male
angi-	relating to a vessel
aniso-	dissimilar, unequal, or asymmetrical
ankylo-	bent, crooked, or two parts growing together
ante-	in front of, before
antero-	before, front, anterior
anti-	in opposition to, against
antro-	relating to a chamber or cavity
aphth(o)-	ulcer
arch-	beginning, first, principal (also arche-, archi-)
archo-	relating to the rectum or anus
arterio-	relating to an artery
arthro-	relating to a joint
astro-	star-like or shaped
atelo-	incomplete or imperfect
auto-	relating to the self
axio-	relating to an axis (also axo-)
balano-	relating to the glans penis or glans clitoridis
baro-	relating to weight or heaviness
basi(o)-	relating to the base or foundation
bi-	double, twice, two
blasto-	relating to germs
blenn(o)-	relating to mucus
blepharo-	relating to the eyelid
brachi(o)-	relating to the arm
brachy-	short
brady-	meaning slow or prolonged
broncho-	relating to the trachea
bucc(o)-	relating to the cheek
cac-	meaning diseased or bad (also caci-, caco-)
cardio-	relating to the heart
cari(o)-	rot, decay
carpo-	relating to the wrist
cata-	down from, down, according to
cathar(o)-	purging, cleansing
caud(o)-	lower part of body
celo-	indicating a tumor or hernia; cavity
cerebr(o)-	relating to the brain
cervico-	relating to the neck or neck of an organ
chilo-	relating to the lip (also cheilo-)
chole-	relating to the gallbladder
choledocho-	relating to the common bile duct
chondr(o)-	relating to cartilage
chromo-	color
cirrho-	yellow in color
cleid(o)-	relating to the clavicle
coel-	cavity, ventricle
coen(o)-	common, shared
cole(o)-	sheath

Abbreviations, Acronyms, and Symbols

The acronyms, abbreviations, and symbols used by health care providers speed communications. The following list includes the most often seen acronyms, abbreviations, and symbols. In some cases, abbreviations have more than one meaning. Multiple interpretations are separated by a slash (/). Abbreviations of Latin phrases are punctuated.

<	less than
≤	less than or equal to
>	greater than
≥	greater than or equal to
@	at
6-PGD	deficiency of 6 phosphogluconate dehydrogenase
A	assessment/blood type
a (ante)	before
a fib	atrial fibrillation
a flutter	atrial flutter
A2	aortic second sound
AA	aggregative adherence
AAA	abdominal aortic aneurysms
AAL	anterior axillary line
AAMI	age-associated memory impairment
AAROM	active assistive range of motion
AAT	alpha-1 antitrypsin
ab	abortion
AB	blood type
abd	abdomen
ABE	acute bacterial endocarditis
ABG	arterial blood gas
abn.	abnormal
ABO	referring to ABO incompatibility
ACA	Affordable Care Act
ACC	American College of Cardiology
ACD	absolute cardiac dullness
ACDMPV	alveolar capillary dysplasia with misalignment of pulmonary veins
ACE	angiotensin converting enzyme/ adrenal cortical extract
ACL	anterior cruciate ligament
ACLS	advanced cardiac life support
aCML	atypical chronic myeloid leukemia
ACP	acid phosphatase
ACPO	acute colonic pseudo-obstruction
acq.	acquired
ACS	acute coronary syndrome
ACTH	adrenocorticotropic hormone
ACVD	acute cardiovascular disease
a.d.	right ear/to, up to
ADA	adenosine deaminase
ADD	attention deficit disorder
ADE	acute disseminated encephalomyelitis
ADH	antidiuretic hormone
ADHD	attention deficit hyperactivity disorder
ADL	activities of daily living
adm	admission, admit
ADM	alcohol, drug or mental disorder
ADO	autosomal dominant osteopetrosis
ADP	adenosine diphosphate
AE	above the elbow
AED	antiepileptic drugs
AF	atrial fibrillation
AFB	acid fast bacilli
AFF	atypical femoral fracture
AFH	angiofollicular lymph node hyperplasia
AFP	alpha-fetoprotein
A/G	albumin-globulin ratio
AGA	appropriate (average) for gestational age
AGC	atypical glandular cells
AGN	acute glomerulonephritis
AgNO3	silver nitrate
AGUS	atypical glandular cells of undetermined significance
AHA	American Heart Association/American Hospital Association
AHC	acute hemorrhagic conjunctivitis
AHIMA	American Health Information Management Association
AHTR	acute hemolytic transfusion reaction
AI	aortic insufficiency/aromatase inhibitor

Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99)

This chapter covers diseases caused by infectious and parasitic organisms, which include diseases generally recognized as communicable or transmissible. Only a small percentage of organisms in the environment cause disease. Most bacteria, viruses, fungi, and other microorganisms found in the external environment (e.g., air, water, and soil) or the internal environment (e.g., on or within our bodies) are harmless or even beneficial. Disease is caused almost exclusively by microorganisms that are human pathogens, also referred to as pathogenic microorganisms, except in persons or hosts whose immune systems are weakened, which allows normally harmless microorganisms to cause opportunistic infections.

This chapter is organized primarily by the type of infectious organism or parasite, such as infections caused by bacteria, viruses, and mycoses and parasitic diseases caused by protozoa and helminths. There are also some code blocks organized by site of infection, such as intestinal infectious diseases, and other code blocks organized by mode of transmission, such as infections with a predominantly sexual mode of transmission, arthropod-borne viral fevers, and viral hemorrhagic fevers.

The chapter is broken down into the following code blocks:

A00-A09	Intestinal infectious diseases
A15-A19	Tuberculosis
A20-A28	Certain zoonotic bacterial diseases
A30-A49	Other bacterial diseases
A50-A64	Infections with a predominantly sexual mode of transmission
A65-A69	Other spirochetal diseases
A70-A74	Other diseases caused by chlamydiae
A75-A79	Rickettsioses
A80-A89	Viral infections of the central nervous system
A90-A99	Arthropod-borne viral fevers and viral hemorrhagic fevers
B00-B09	Viral infections characterized by skin and mucous membrane lesions
B10	Other human herpesviruses
B15-B19	Viral hepatitis
B20	Human immunodeficiency virus [HIV] disease
B25-B34	Other viral diseases
B35-B49	Mycoses
B50-B64	Protozoal diseases
B65-B83	Helminthiases
B85-B89	Pediculosis, acariasis and other infestations
B90-B94	Sequelae of infectious and parasitic diseases
B95-B97	Bacterial and viral infectious agents
B99	Other infectious diseases

There are a few infectious conditions that are excluded from this chapter, including certain localized infections that are classified in specific body-system chapters. For example:

- Suppurative otitis media is classified in Chapter 8 Diseases of the Ear and Mastoid Process
- Influenza and other acute respiratory infections are classified in Chapter 10 Diseases of the Respiratory System
- Pyogenic arthritis is classified in Chapter 13 Diseases of the Musculoskeletal System and Connective Tissue

Intestinal Infectious Diseases (A00-A09)

Intestinal infectious diseases are caused primarily by ingestion of contaminated food or water. Less common means of infection include handling contaminated food products or other contaminated items or coming in direct contact with infected animals.

The first symptoms of intestinal infectious diseases usually involve the gastrointestinal tract and may include abdominal pain or cramping, nausea, vomiting, and/or diarrhea, although some microorganisms may produce other initial symptoms. For example, *Clostridium botulinum* causes foodborne botulism poisoning and often produces neurological symptoms initially.

Intestinal infections usually remain localized to the intestinal tract and often resolve without medical treatment. In most cases, infections requiring treatment only need supportive care such as replacement of lost fluids and maintenance of electrolyte balance. In some cases, particularly the very young, the elderly, or individuals with immune system disorders or chronic health conditions, a localized

infection is typically accompanied by fever, body aches, headache, and local lymph node inflammation. While most symptoms resolve within several days to a week, the blisters resolve more slowly over a two- to six-week period.

B00.1 Herpesviral vesicular dermatitis

Herpesviral blisters of the skin, also called cold sores, are the most common manifestation related to the herpes simplex virus, with the lips and face being the most common sites of infection. Most people contract the infection during infancy or childhood from an adult who carries the virus. Carriers most often spread the virus when they are not suffering from a current outbreak. The initial infection is commonly accompanied by flu-like symptoms including fever, headache, body aches, and malaise. After the symptoms of the initial infection resolve, the virus remains dormant in the nervous system and subsequent outbreaks, triggered by stressors, can occur. Common stressors that trigger outbreaks include physical stressors such as sun exposure, extreme cold, illness or surgery, or fever; emotional stressors involving family, relationships, work, or school; and in women, hormone changes related to the menstrual cycle.

B00.2 Herpesviral gingivostomatitis and pharyngotonsillitis

Infection of the mouth and gums (gingivostomatitis) or the throat and tonsils (pharyngotonsillitis) is another manifestation of herpes simplex virus infection. Gingivostomatitis is a common manifestation in children presenting as painful blisters or sores of the mouth or gums, in addition to fever, irritability, and refusal of food and/or liquids. The main symptom of pharyngotonsillitis is sore throat due to the blisters or sores. The symptoms usually resolve over one to two weeks.

B00.3 Herpesviral meningitis

Meningitis is inflammation of the membranes that cover the brain and spinal cord. Symptoms of meningitis include fever, light sensitivity, headache, and a stiff neck.

B00.4 Herpesviral encephalitis

Approximately 10 percent of all encephalitis cases are caused by herpes simplex virus 1 or 2. Encephalitis is an infection or inflammation of the brain. Symptoms include those seen in meningitis—fever, light sensitivity, headache, and a stiff neck—along with other neurological symptoms suggesting brain involvement, such as seizures, confusion, personality and behavior changes, sleepiness, and coma.

B00.5- Herpesviral ocular disease

Both strains of herpes simplex virus, HSV-1 and HSV-2, can cause infections involving the eye and ocular adnexa, but the majority is caused by HSV-1. The infection is spread by direct contact or from the mouth to the eye via the trigeminal nerve. Most symptomatic infections involving the eye are believed to be secondary infections caused by reactivation of the virus in the trigeminal ganglion. The most common manifestations of HSV ocular disease is conjunctivitis.

B00.51 Herpesviral iridocyclitis

Iridocyclitis is an infection or inflammation of the iris and ciliary body, also referred to as anterior uveitis. Iridocyclitis presents with a red painful eye, sensitivity to light (photophobia), and tearing or drainage from the eye.

B00.52 Herpesviral keratitis

Keratitis is an inflammation of the cornea. In herpes simplex virus infections, the inflammation is characterized by dendritic lesions that begin as small raised vesicles in the corneal epithelium and may progress to corneal ulcers. These may eventually penetrate the basement membrane of the corneal epithelium. Further damage, including corneal erosion, persistent corneal epithelial defects, stromal erosion, and necrosis, may occur and may eventually cause corneal blindness. Symptoms of HSV keratitis include pain, sensitivity to bright light, vision changes, redness, and tearing. Aggressive treatment is required to prevent progression of the disease that may result in blindness.

B00.53 Herpesviral conjunctivitis

The most common ocular manifestation of herpesviral infection is conjunctivitis and the most common type of conjunctivitis seen in herpes simplex virus infection (HSV) is follicular. Follicular conjunctivitis is characterized by the development of follicles, which are clumps of lymphocytes that function like miniature lymph nodes in response to the infection. The follicles appear as small yellowish or grayish elevations on the conjunctiva. A less common form is dendritic conjunctivitis, which affects the epithelial cells of the conjunctiva. Both strains of herpes simplex virus, HSV-1 and HSV-2, can cause conjunctivitis, but the majority is caused by HSV-1. The infection is spread by direct contact or from the mouth to the eye via the trigeminal nerve. Most symptomatic infections involving the eye are believed to be secondary infections caused by reactivation of the virus in the trigeminal ganglion.

B00.59 Other herpesviral disease of eye

Herpesviral manifestations affecting the eyelid including dermatitis and blepharitis are included here.

Chapter 6: Diseases of the Nervous System (G00-G99)

The nervous system is a complex network of specialized organs, tissues, and cells that coordinate the body's actions and functions. It consists of two main subdivisions: the central nervous system and the peripheral nervous system. The central nervous system includes the brain, the spinal cord, and the membranes that cover these structures. The peripheral nervous system includes the sense organs and the nerves that link the organs, muscles, and glands to the central nervous system.

The central nervous system (CNS) is the control center for almost all functions of the body and comprises two major structures: the brain and the spinal cord. The brain resides in and is protected by the cranial bones and the spinal cord extends from the base of the brain, residing in and protected by the spinal column.

The brain can be subdivided into several regions:

- The cerebral hemispheres form the largest part of the brain, occupying the anterior and middle cranial fossae in the skull.
- The diencephalon includes the thalamus, hypothalamus, epithalamus, and subthalamus, and forms the central core of the brain.
- The midbrain is located at the junction of the middle and posterior cranial fossae.
- The pons is in the anterior part of the posterior cranial fossa; fibers within the pons connect one cerebral hemisphere with its opposite cerebellar hemisphere.
- The medulla oblongata is continuous with the spinal cord and controls the respiratory and cardiovascular systems.
- The cerebellum overlies the pons and medulla and controls motor functions that regulate muscle tone, coordination, and posture.

The spinal column, which encloses the spinal cord, consists of vertebrae linked by intervertebral discs and held together by ligaments. The spinal cord extends from the medulla at the base of the brain to the first lumbar vertebra. The outer layer of the spinal cord consists of nerve fibers enclosed in a myelin-sheath that conduct impulses triggered by pressure, pain, heat, and other sensory stimuli or conduct motor impulses activating muscles and glands. The inner layer, or gray matter, is primarily composed of nerve cell bodies. The central canal, within the gray matter, circulates the cerebrospinal fluid.

The brain and spinal cord are covered by three membranes: the dura mater, arachnoid, and pia mater, collectively defined as the meninges. The dura mater lies closest to the skull and functions as a protective layer and as a collection area for cerebral spinal fluid (CSF) and blood that needs to be returned to general circulation. The arachnoid is the middle layer that is a loose sac surrounding the brain. Arteries and veins of the brain, as well as CSF, can be found in the space below the arachnoid membrane or subarachnoid space. The layer closest to the brain is the pia mater. This layer adheres very closely to the surface of the brain and spinal cord and contains small blood vessels.

There are 31 pairs of spinal nerves that deliver sensory impulses from the peripheral nervous system to the spinal cord, which in turn relays them to the brain. Conversely, motor impulses generated in the brain are relayed by the spinal cord to the spinal nerves, which pass the impulses to peripheral nerves in the muscles and glands.

The chapter is broken down into the following code blocks:

G00-G09	Inflammatory diseases of the central nervous system
G10-G14	Systemic atrophies primarily affecting the central nervous system
G20-G26	Extrapyramidal and movement disorders
G30-G32	Other degenerative diseases of the nervous system
G35-G37	Demyelinating diseases of the central nervous system
G40-G47	Episodic and paroxysmal disorders
G50-G59	Nerve, nerve root and plexus disorders
G60-G65	Polyneuropathies and other disorders of the peripheral nervous system
G70-G73	Diseases of myoneural junction and muscle
G80-G83	Cerebral palsy and other paralytic syndromes
G89-G99	Other disorders of the nervous system

Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (MØØ-M99)

This chapter classifies diseases and disorders of the bones, muscles, cartilage, fascia, ligaments, synovia, tendons, and bursa.

Connective tissue disorders classified to Chapter 13 are those primarily affecting the musculoskeletal system. Injuries and certain congenital disorders of the musculoskeletal system are classified elsewhere.

Many codes for the manifestation of musculoskeletal diseases due to specified infections and other diseases and disorders classified elsewhere are included in this chapter. Also included are many codes describing the residuals of previous diseases, disorders, and injuries classified as late effects. These codes often can be identified by the term "acquired" in the description.

The chapter is broken down into the following code blocks:

MØØ-MØ2	Infectious arthropathies
MØ4	Autoinflammatory syndromes
MØ5-M14	Inflammatory polyarthropathies
M15-M19	Osteoarthritis
M2Ø-M25	Other joint disorders
M26-M27	Dentofacial anomalies [including malocclusion] and other disorders of jaw
M3Ø-M36	Systemic connective tissue disorders
M4Ø-M43	Deforming dorsopathies
M45-M49	Spondylopathies
M5Ø-M54	Other dorsopathies
M6Ø-M63	Disorders of muscles
M65-M67	Disorders of synovium and tendon
M7Ø-M79	Other soft tissue disorders
M8Ø-M85	Disorders of bone density and structure
M86-M9Ø	Other osteopathies
M91-M94	Chondropathies
M95	Other disorders of the musculoskeletal system and connective tissue
M96	Intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhere classified
M97	Periprosthetic fracture around internal prosthetic joint
M99	Biomechanical lesions, not elsewhere classified

Infectious Arthropathies (MØØ-MØ2)

This category includes infections of the articular joints of bones, and must be differentiated from infections of the bones classifiable to osteomyelitis. Direct microbial contamination may cause a primary infection of the articular joints. The routes of infection include open fractures, surgical procedures, diagnostic needle aspirations, and therapeutic drug injections. Infectious arthropathies are due to an acute, destructive bacterial process in a joint following infection, usually occurring as acute monoarticular (single joint) arthritis. The knee and large joints are most often involved.

The categories in this code block are as follows:

MØØ	Pyogenic arthritis
MØ1	Direct infections of joint in infectious and parasitic diseases classified elsewhere
MØ2	Postinfective and reactive arthropathies

MØØ.- Pyogenic arthritis

This category represents forms of arthritis due to an acute inflammation of the synovial membranes with purulent effusion into the joint specifically caused by a bacterial infection. It may also be referred to in the medical record documentation as suppurative or septic arthritis or suppurative synovitis. Signs and symptoms of pyogenic arthritis include fever, joint pain, decreased range of motion, and swelling and redness over the affected joint. Gross examination of aspirated synovial (joint) fluid confirms the presence of pus (pyarthrosis); a gram stain and culture may detect microorganisms and crystals. Pyogenic or septic arthritis has the potential to progress and become chronic resulting in sinus formation, osteomyelitis, and joint deformity. Septic arthritis is classified by bacterial organism, including staphylococcal, pneumonococcal, and streptococcal. All other bacterial causes of arthritis are included in the other bacterial subcategory. Conditions classified here are further specified by site and laterality.

Chapter 20: External Causes of Morbidity (V00-Y99)

This chapter classifies external causes of injury and other adverse effects. Common external causes include automobile accidents, falls, bites, fire (flames), smoke, and drowning.

Most often external cause codes are used in conjunction with codes from Chapter 19 Injury, Poisoning, and Certain other Consequences of External Causes; however, these codes can be used with codes from any chapter to provide additional information on conditions that may be a consequence of an external cause.

External cause codes are the means by which data is reported and collected on how an injury occurred (mechanism), what the injured person was doing when the injury occurred (activity), where the injury occurred (place of occurrence), and the status of the person at the time the injury occurred, such as work (e.g., civilian, military, volunteer, or other), leisure, or other non-work. In some cases, intent is also captured by the external cause code. For example, a handgun injury may be accidental, due to an assault, or self-inflicted with the intent of causing self-harm.

About one-third of all emergency department visits are due to injuries. Collecting data related to the external cause of these injuries is important to understanding the circumstances surrounding an injury and in developing policies and procedures to help prevent future injuries. This data may be used by the health care facility, public health departments, employers, and third-party payers to address health care delivery needs, develop public health policy and education resources, address workplace injury risks, and develop strategies to reduce the risk of injury.

External cause codes are organized into several large sections that contain multiple code blocks for related types of external causes, such as transport accidents (V00-V99) and other external causes of accidental injury (W00-X58). Most of these large sections contain multiple related code blocks.

Because most codes for external causes are self-explanatory, only key points related to the most common external causes of injury are discussed in this chapter.

Transport Accidents (V00-V99)

Motor vehicle accidents classified in this section represent the third most common cause of emergency department visits due to injury.

The categories in this code block are as follows:

V00-V09	Pedestrian injured in transport accident
V10-V19	Pedal cycle rider injured in transport accident
V20-V29	Motorcycle rider injured in transport accident
V30-V39	Occupant of three-wheeled motor vehicle injured in transport accident
V40-V49	Car occupant injured in transport accident
V50-V59	Occupant of pick-up truck or van injured in transport accident
V60-V69	Occupant of heavy transport vehicle injured in transport accident
V70-V79	Bus occupant injured in transport accident
V80-V89	Other land transport accidents
V90-V94	Water transport accidents
V95-V97	Air and space transport accidents
V98-V99	Other and unspecified transport accidents

Other External Causes of Accidental Injury (W00-X58)

Falls represent the most common external cause of injury resulting in emergency department visits. Falls (W00-W19) may occur on the same level or from one level to another. Falls on the same level may result from slipping, tripping, stumbling, or just losing one's balance. Falls from one level to another include a fall from a bed, playground equipment, sidewalk curb, tree, or cliff. Jumping or diving into water with a resulting injury is also included in this code block.

The second most common external cause of injury resulting in emergency department visits is accidental striking against or being struck by an inanimate object (W20-W22) or animate object (W50-W64). External cause of injury codes in these categories include being accidentally struck by a ball, bat, racquet, hockey stick or puck, or being accidentally run into or struck by a person or animal.

The categories in this code block are as follows:

W00-W19	Slipping, tripping, stumbling and falls
W20-W49	Exposure to inanimate mechanical forces