Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

July 2019
A-01-19-00502

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect, Report (A-01-19-00502)

WHY DID OIG CREATE THE GUIDE?

Decades of Office of Inspector General (OIG) work has uncovered widespread problems in providing safe, high-quality care and reporting problems when they occur. Much of this work has focused on abuse and neglect of Medicare and Medicaid beneficiaries. This work has shown that Medicare and Medicaid beneficiaries are being treated for injuries in hospital emergency rooms that may be the result of abuse or neglect, and these events are not always reported as required. It has also shown that claims data can be used to identify critical incidents involving Medicaid beneficiaries in group homes and nursing homes. Our work has also demonstrated that health insurance claims submitted to programs such as Medicare and Medicaid can be used to identify thousands of beneficiaries who are the victims of abuse or neglect. OIG most recently identified and reported on potential abuse and neglect in the audit reports *CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect* (A-01-17-00513), *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* (A-01-16-00509), and *Alaska Did Not Fully Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities* (A-09-17-02006). These audit reports identified tens of thousands of Medicare and Medicaid beneficiaries who were potentially victims of abuse or neglect. Some of these beneficiaries were subjected to incidents of severe abuse or neglect, such as physical and sexual assault. These beneficiaries were identified by using analytical techniques on Medicare and Medicaid claims data.

Because we have consistently found that many incidents of potential abuse or neglect are not reported, oversight and enforcement authorities are not always able to pursue legal, administrative, or other appropriate remedies to protect the health, safety, and rights of program beneficiaries. OIG has developed an approach that uses the medical diagnosis codes included in Medicare and Medicaid claims data to target medical records for review. In many of our reports, we found our methodology to be an effective approach to help address unreported abuse and neglect. For example, the *CMS Could Use Medicare Data to Identify Instances of Potential Abuse or Neglect* report identified more than 30,000 Medicare claims that explicitly indicated potential abuse or neglect. We found that almost 30 percent of those incidents had not been reported to law enforcement.

OIG created this guide because we are committed to supporting our public and private sector partners in their efforts to curtail this ongoing problem. Those partners include State Medicaid Fraud Control Units, Survey Agencies, Adult and Child Protective Service Agencies, as well as compliance and risk management officials working at insurance providers, hospitals, nursing homes, and group homes. These partners can use this guide to develop their own unique processes for analyzing claims data to help identify (1) unreported instances of abuse or neglect, (2) beneficiaries or patients who may require immediate intervention to ensure their safety, (3) providers exhibiting patterns of abuse or neglect, and (4) instances in which providers did not comply with mandatory-reporting requirements.

WHAT DOES THE GUIDE INCLUDE?

This guide explains our approach when using claims data to identify incidents of potential abuse or neglect of vulnerable populations. The guide is based on the methodology that OIG developed in our extensive work on identifying unreported critical incidents, particularly those involving potential abuse or neglect.

The guide includes a flow chart showing key decision points in the process and the detailed lessons that the OIG has learned using this approach. We encourage our public and private sector partners to use this guide to develop a process unique to their circumstances and apply it to any vulnerable population they deem appropriate. The source of the data could include Medicaid Management Information Systems claims data, private payor insurance claims data, or similar data sets. Analyzing the data allowed us to select medical records that helped identify individual incidents of unreported abuse or neglect and patterns and trends of abuse or neglect involving specific providers, beneficiaries, or patients who may require immediate intervention to protect their health, safety, and rights.

This guide also provides technical information, such as examples of medical diagnosis codes, to support our public and private sector partners with analyzing their own claims data to help combat abuse and neglect. In addition, this guide includes links to OIG's and other agencies' reports that address abuse and neglect and links to other useful websites.

OIG Reports

All Settings Including Medical Facilities

- Using Medicare Data To Identify Potential Abuse/Neglect: A-01-17-00513

Nursing Homes and Skilled Nursing Facilities

- Potential Abuse/Neglect at SNFs: A-01-16-00509
- A Few States Fall Short in Investigations: OEI-01-16-00330
- Nursing Facility Compliance: OEI-07-13-00010
- Adverse Events at SNFs: OEI-06-11-00370
- Criminal Convictions of Nurses' Aides: OEI-07-10-00422
- California's Unidentified and Unreported Deficiencies: A-09-09-00114
- Nursing Home Employment of Staff With Criminal Records: OEI-07-09-00110

Group Homes

- Alaska Group Homes: A-09-17-02006
- Featured Topic: Group Homes
- Joint Report on Best Practices
- Maine Group Homes: A-01-16-00001
- Massachusetts Group Homes: A-01-14-00008
- Connecticut Group Homes: A-01-14-00002

Reports by Other Agencies

Nursing Homes and Skilled Nursing Facilities

- GAO: Nursing Home Quality: GAO-18-694T
- GAO: Nursing Home Abuse/More Can Be Done: GAO-02-312
- GAO: Nursing Home Abuse/Shortcomings Exist: GAO-02-448T

Group Homes and Intermediate Care Facilities

- CT: 10 Year Mortality Study

How To Conduct Data Mining To Detect Incidents of Potential Abuse or Neglect

Key Decision Points To Help Identify Unreported Incidents of Abuse or Neglect

- Download a flow chart of "Decision Points."
- Download a detailed "Lessons Learned" document that corresponds with the flow chart.

List of Possible Diagnosis Codes for Use During Data Mining

- Examples of diagnosis codes used to identify potential critical incidents for our **Critical Incidents Involving Medicaid Beneficiaries with Developmental Disabilities** review.
  Download Excel Spreadsheet
- Examples of diagnosis codes used to identify potential incidents of unreported abuse or neglect of **Medicare beneficiaries being treated at SNFs.**
  Download Excel Spreadsheet
- Examples of diagnosis codes we used to identify potential incidents of physical and sexual abuse, rape, maltreatment, and abandonment in our **Using Medicare Data to Identify Potential Abuse or Neglect** review.
  Download Excel Spreadsheet
- Download all diagnosis codes in one spreadsheet
- Download all diagnosis codes in one PDF

Key Decision Points To Help Identify Unreported Incidents of Abuse or Neglect

1. **Identify Risk Areas**
    a. Example: Identify a risk area such as individuals with developmental disabilities.
2. **Determine Reporting Requirements for Risk Areas**
    a. Example: SNFs and nursing facilities must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown sources and misappropriation of resident property, are reported in accordance with State law through established procedures.
3. **Determine Diagnosis Codes or Procedure Codes That Correspond to Risk Areas**
    a. Example: Physical abuse is reportable; therefore, medical diagnosis code "Z0471, Encounter for examination and observation following alleged adult physical abuse" was included in our data analytic techniques.
4. **Determine Data Available for Use During Data Analysis**
    a. Example: We used the claims contained in the Alaska State Medicaid Management Information System for the group home review.
5. **Identify Claims Using Analytic Techniques Data That Contains Identifying Markers Such as Specific Diagnosis Codes**
    a. Example: We matched all Medicare beneficiaries receiving services at SNFs to all Medicare hospital ER claims containing specific diagnosis codes that were submitted during their SNF stays to identify those Medicare beneficiaries who received a hospital ER service while at a SNF.
6. **Investigate, Audit, or Review Resulting Data**
    a. Example: Obtain medical records or investigative records that describe the identified incident and determine if the incident was reported.
7. **Address the Identified Problem**
    a. Example: We recommended the State agency in Alaska perform analytical procedures, such as data matches, on Medicaid claims data to identify potential critical incidents that have not been reported and investigate as needed to protect the health, safety, and rights of program beneficiaries.

Lessons Learned: A More Detailed Explanation on How To Help Identify Unreported Instances of Abuse or Neglect

OIG issued a series of reports that detailed problems with the quality of care and the identification, reporting, and investigation of incidents of potential abuse or neglect of Medicare and Medicaid beneficiaries. Because we have consistently found that many incidents of potential abuse or neglect are not reported, oversight and enforcement authorities are not always able to pursue legal, administrative, and other appropriate remedies to protect the health, safety, and rights of program beneficiaries. Therefore, OIG has developed an approach that uses the medical diagnosis codes included in Medicare and Medicaid claims data to target medical records for review and found it to be an effective approach to help address unreported abuse and neglect.

OIG created this guide because we are committed to supporting our public and private sector partners in their efforts to curtail this ongoing problem. Those partners can use this guide to develop their own unique processes for analyzing claims data to help identify (1) unreported instances of abuse or neglect, (2) beneficiaries or patients who may require immediate intervention to ensure their safety, (3) providers exhibiting patterns of abuse or neglect, or (4) instances in which providers did not comply with mandatory-reporting requirements.

1. Identify Risk Areas
    a. We identified risk areas based on our organization's mission statement, the HHS's Strategic Plan, congressional interest, media reports, and other public inquiries.
        i. This ensured our audit objectives were aligned with our organizational goals, such as "safeguard the public against preventable injuries and violence or their results."
    b. We refined these risk areas, such as elder abuse and abuse of individuals with developmental disabilities, by identifying subgroups or elements that were covered by the organization's mandate or goals.
        i. For example, we refined elder abuse to "potential abuse or neglect of Medicare beneficiaries."

2. Determine Reporting Requirements for Risk Areas
    a. We further refined our risk areas by determining the reporting requirements for the risk areas through an in-depth analysis of all related Federal and State legal requirements.

i. For example, we refined the Federal legal requirements regarding the "potential abuse or neglect of Medicare beneficiaries" to the Federal legal requirements for the reporting of potential abuse or neglect of Medicare beneficiaries residing in skilled nursing facilities (SNFs) who had a hospital emergency room (ER) Medicare claim.

b. This allowed us to focus on the reporting requirements for Medicare beneficiaries residing in SNFs who were victims of potential abuse or neglect.
    i. For example, SNFs and nursing facilities must ensure that all alleged violations involving mistreatment, neglect, or abuse (including injuries of unknown sources and misappropriation of resident property) are reported in accordance with State law through established procedures.

3. Determine Diagnosis Codes or Procedure Codes That Correspond to Risk Areas
    a. We used our audit objectives to develop specific tasks needed to meet our objective.
        i. For example, we reviewed Medicare claims to determine what data these claims contained that could be used to determine the prevalence of incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs who had a hospital ER Medicare claim"
            1. In this case, every Medicare claim contained a medical diagnosis code assigned by the treating medical provider that described the injury or disease treated.
        ii. We then used all medical diagnosis codes to identify those diagnosis codes that we determined would identify specific conditions we were looking for.
            1. In this case, we reviewed data related to the causes of death of vulnerable populations to determine the corresponding medical diagnosis codes related to these deaths.
                a. This analysis led us to medical diagnosis codes that were indicative of potential abuse or neglect because those codes corresponded to the causes of death of vulnerable populations.
                b. For example, physical abuse is reportable; therefore, medical diagnosis code "Z0471, Encounter for examination and observation following alleged adult physical abuse" was included in our data analytic techniques.
        iii. We have not yet identified and compiled a complete set of codes that can be used in all cases to identify potential abuse or neglect. The diagnosis

codes used can vary based on the population and objective. For example, in three of our recent reports:

1. The *CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect* (A-01-17-00513) report focused on 17 diagnosis codes that explicitly indicate physical abuse, sexual abuse, rape, neglect or abandonment, or other maltreatment.
2. The *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* (A-01-16-00509) report focused on 580 diagnosis indicating head injuries, bodily injuries, and safety and medical issues.
3. The *Alaska Did Not Fully Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities* (A-09-17-02006) report focused on 618 diagnosis codes indicating head injuries, bodily injuries, sexual trauma, and neglect.

4. Determine Data Available for Use During Analysis
    a. We selected data sets that contained information that was aligned with our objectives and allowed us to meet those objectives.
        i. For example, we used the Medicare National Claims History File for audits related to Medicare and either the CMS Transformed Medicaid Statistical Information System or State Medicaid Management Information System for audits related to Medicaid.
    b. To perform this analysis, it was important that the data contain information that would allow us to identify the beneficiary, the medical diagnosis code, and the provider.

5. Identify Claims Using Analytic Techniques Data That Contains Identifying Markers, Such as Specific Diagnosis Codes
    a. We used data analytic techniques, such as data matching, to identify claims that contained the identifying markers we were looking for.
        i. For example, we matched all Medicare beneficiaries receiving services at SNFs to all Medicare hospital ER claims submitted during their SNF stays to identify those Medicare beneficiaries who received a hospital ER service while at a SNF.
            1. This analysis used the “From” and “Through” dates of service for the SNF Medicare claims to identify any hospital ER Medicare claims that were provided to those Medicare beneficiaries within their SNF stay.

ii. We then filtered these data to only include the medical diagnosis codes we were looking for.
    1. For example, we selected any Medicare claim containing a diagnosis code of "Z0471, Encounter for examination and observation following alleged adult physical abuse" that was submitted for the ER treatment of a Medicare beneficiary during that beneficiary's SNF stay.

6. Investigate, Audit, or Review the Resulting Data
    a. We then reviewed the data that resulted from our analytic techniques in light of our objectives.
        i. For example, we requested the medical records supporting both the SNF services and the ER treatment that the Medicare beneficiaries received because these records contained evidence, such as clinical notes, that documented why the Medicare beneficiaries were treated at a hospital ER.
    b. We examined the medical record to determine if it contained evidence of the incident being reported.
        i. We also compared the medical record to the CMS Automated Survey Processing Environment Complaints/Incidents Tracking System to determine if the incident of potential abuse and neglect was reported or unreported.
        ii. If the incident was not reported, we also had experts review the records we obtained to determine if it should have been reported.
            1. For example, we provided the medical records supporting the treatment of "Z0471, Encounter for examination and observation following alleged adult physical abuse" to determine if those experts felt the underlying incidents represented incidents of potential abuse or neglect.

7. Address the Identified Problem
    a. Our goal was to produce an audit report containing recommendations that addressed any weaknesses we identified in the system of internal controls used by an organization to protect the health, safety, and rights of program beneficiaries.
        i. For example, if we found unreported incidents of Medicaid beneficiaries receiving services at group homes who were treated for "TX7611XA, alleged adult physical abuse," then we would include in our audit report recommendations that addressed how the audited organization could

identify these unreported incidents and potentially prevent future similar unreported incidents from occurring.

Examples of diagnosis codes we used to identify potential incidents of physical and sexual abuse, rape, maltreatment, and abandonment in our **Using Medicare Data to Identify Potential Abuse or Neglect** review.

Diagnosis Code	Description
T7411XA	Adult physical abuse, confirmed, initial encounter
T7601XA	Adult neglect or abandonment, suspected, initial encounter
T7621XA	Adult sexual abuse, suspected, initial encounter
T7421XA	Adult sexual abuse, confirmed, initial encounter
99581	Adult physical abuse
T7611XA	Adult physical abuse, suspected, initial encounter
Z0441	Encounter for examination and observation following alleged adult rape
V715	Observation following rape
T7491XA	Unspecified adult maltreatment, confirmed, initial encounter
T7401XA	Adult neglect or abandonment, confirmed, initial encounter
99584	Adult neglect (nutritional)
99580	Adult maltreatment, unspecified
T7691XA	Unspecified adult maltreatment, suspected, initial encounter
Z0471	Encounter for examination and observation following alleged adult physical abuse
99583	Adult sexual abuse
99585	Other adult abuse and neglect
V7181	Abuse and neglect

Examples of diagnosis codes used to identify potential incidents of unreported abuse or neglect of **Medicare beneficiaries being treated at SNFs.**

Diagnosis Code	Description (Head Injuries)
S0001XA	Abrasion of scalp
S0003XA	Contusion of scalp
S0012XA	Contusion of left eyelid and periocular area
S00511A	Abrasion of lip
S00512A	Abrasion of oral cavity
S0081XA	Abrasion of other part of head
S0083XA	Contusion of other part of head
S0093XA	Contusion of unspecified part of head
S0101XA	Laceration without foreign body of scalp
S01111A	Laceration without foreign body of right eyelid and periocular area
S01112A	Laceration without foreign body of left eyelid and periocular area
S0121XA	Laceration without foreign body of nose
S01511A	Laceration without foreign body of lip
S0181XA	Laceration without foreign body of other part of head
S0191XA	Laceration without foreign body of unspecified part of head
S022XXA	Fracture of nasal bones
S02401A	Maxillary fracture, unspecified
S028XXA	Fractures of other specified skull and facial bones
S0511XA	Contusion of eyeball and orbital tissues, right eye
S060X0A	Concussion without loss of consciousness
S062X0A	Diffuse traumatic brain injury without loss of consciousness
S065X0A	Traumatic subdural hemorrhage without loss of consciousness
S065X9A	Traumatic subdural hemorrhage with loss of consciousness
S066X9A	Traumatic subarachnoid hemorrhage with loss of consciousness
S098XXA	Other specified injuries of head
S0990XA	Unspecified injury of head
S0993XA	Unspecified injury of face

Examples of diagnosis codes used to identify potential incidents of unreported abuse or neglect of **Medicare beneficiaries being treated at SNFs.**

Diagnosis Code	Description (Bodily Injuries)
S12001A	Unspecified nondisplaced fracture of first cervical vertebra
S12031A	Nondisplaced posterior arch fracture of first cervical vertebra
S20212A	Contusion of left front wall of thorax
S22079A	Unspecified fracture of T9-T10 vertebra
S300XXA	Contusion of lower back and pelvis
S301XXA	Contusion of abdominal wall
S30810A	Abrasion of lower back and pelvis
S3121XA	Laceration without foreign body of penis
S32591A	Other specified fracture of right pubis
S32601A	Unspecified fracture of right ischium
S3992XA	Unspecified injury of lower back
S40011A	Contusion of right shoulder
S40022A	Contusion of left upper arm
S42001A	Fracture of unspecified part of right clavicle
S43005A	Unspecified dislocation of left shoulder joint
S43102A	Unspecified dislocation of left acromioclavicular joint
S72001A	Fracture of unspecified part of neck of right femur
S72002A	Fracture of unspecified part of neck of left femur
S72012A	Unspecified intracapsular fracture of left femur
S72021A	Displaced fracture of epiphysis (separation) (upper) of right femur
S72031A	Displaced midcervical fracture of right femur
S72111A	Displaced fracture of greater trochanter of right femur
S72141A	Displaced intertrochanteric fracture of right femur
S72142A	Displaced intertrochanteric fracture of left femur
S72145A	Nondisplaced intertrochanteric fracture of left femur
S7221XA	Displaced subtrochanteric fracture of right femur
S72491A	Other fracture of lower end of right femur
S7290XA	Unspecified fracture of unspecified femur
T148	Other injury of unspecified body region

Examples of diagnosis codes used to identify potential incidents of unreported abuse or neglect of **Medicare beneficiaries being treated at SNFs.**

Diagnosis Code	Description (Safety)
T17590A	Other foreign object in bronchus causing asphyxiation
T17890A	Other foreign object in other parts of respiratory tract, causing asphyxiation
T17920A	Food in respiratory tract, part unspecified causing asphyxiation
T17990A	Other foreign object in respiratory tract, causing asphyxiation
T18128A	Food in esophagus causing other injury
T383X1A	Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental
T402X1A	Poisoning by other opioids, accidental (unintentional)
T40601A	Poisoning by unspecified narcotics, accidental (unintentional)
T40604A	Poisoning by unspecified narcotics, undetermined
T424X1A	Poisoning by benzodiazepines, accidental (unintentional)
T43591A	Poisoning by other antipsychotics and neuroleptics, accidental
T80211A	Bloodstream infection due to central venous catheter
Z043	Encounter for examination and observation following other accident

Examples of diagnosis codes used to identify potential incidents of unreported abuse or neglect of **Medicare beneficiaries being treated at SNFs.**

Diagnosis Code	Description (Medical)
I96	Gangrene
J690	Pneumonitis due to inhalation of food and vomit
L89154	Pressure ulcer of sacral region, stage 4
L89224	Pressure ulcer of left hip, stage 4
R579	Shock, unspecified
R6521	Severe sepsis with septic shock

Examples of diagnosis codes used to identify potential critical incidents for our **Critical Incidents Involving Medicaid Beneficiaries with Developmental Disabilities** review.

Diagnosis Code	Description (Head Injuries)
850.90	Concussion —not otherwise specified (NOS)
851.00	Cerebral Cortex Contusion
870.00	Laceration of the Eyelid Skin/Periocular
873.00	Open Wound of Scalp
873.40	Open Wound of Face NOS
873.42	Open Wound of Forehead
873.43	Open Wound of Lip
873.44	Open Wound of Jaw
873.52	Open Wound Forehead - Complicated
873.80	Open Wound of Head —not elsewhere classifiable (NEC)
873.90	Open Wound Head NEC - Complicated
920.00	Contusion Face/Scalp/Neck
959.01	Head Injury, Unspecified
959.09	Injury, Face and Neck
R22.0	Localized swelling, mass and lump, head
R22.1	Localized swelling, mass and lump, neck
S00.81XA	Abrasion of other part of head, initial encounter
S00.91XA	Abrasion of unspecified part of head, initial encounter
S01.01XA	Laceration without foreign body of scalp, initial encounter
S01.23XA	Puncture wound without foreign body of nose, initial encounter
S01.81XA	Laceration without foreign body of oth part of head, initial encounter
S01.91XA	Laceration without foreign body of unspecified part of head, initial encounter
S05.12XA	Contusion of eyeball and orbital tissues, left eye, initial encounter
S06.0X0A	Concussion without loss of consciousness, initial encounter
S06.0X0D	Concussion without loss of consciousness, subsequent encounter
S08.0XXA	Avulsion of scalp, initial encounter
S09.90XA	Unspecified injury of head, initial encounter

Examples of diagnosis codes used to identify potential critical incidents for our **Critical Incidents Involving Medicaid Beneficiaries with Developmental Disabilities** review.

Diagnosis C	Description (Bodily Injuries)
805.60	Fracture Sacrum/Coccyx - Closed
812.00	Fracture Up End Humerus NOS (unspecified) - Closed
812.03	Fracture of Greater Tuberosity of the Humerus - Closed
812.21	Fracture Humerus Shaft - Closed
813.05	Fracture Radius Head - Closed
813.42	Fracture Distal Radius NEC (other) - Closed
813.81	Fracture Radius NOS - Closed
816.12	Fracture Distal Phalanx, Hand - Open
822.00	Fracture Patella - Closed
823.20	Fracture Shaft Tibia - Closed
823.21	Fracture Shaft Fibula - Closed
824.20	Fracture Lateral Malleolus - Closed
824.80	Fracture Ankle NOS - Closed
831.00	Dislocated Shoulder NOS - Closed
881.01	Open Wound of Elbow
891.00	Open Wound Knee/Leg/Ankle
922.10	Contusion of Chest Wall
922.40	Contusion Genital Organs
923.03	Contusion of Upper Arm
923.10	Contusion of Forearm
923.11	Contusion of Elbow
923.21	Contusion of Wrist
924.11	Contusion of Knee
924.90	Contusion NOS
927.30	Crushing Injury Finger
959.11	Other Injury Chest Wall
959.19	Other Injury of Other Sites of the Trunk
959.20	Shoulder/Upper Arm Injury NOS
959.50	Finger Injury NOS
959.70	Lower Leg Injury NOS
S20.20XA	Contusion of thorax, unspecified, initial encounter
S20.212A	Contusion of left front wall of thorax, initial encounter
S29.9XXA	Unspecified injury of thorax, initial encounter
S30.1XXA	Contusion of abdominal wall, initial encounter
S39.92XA	Unspecified injury of lower back, initial encounter
S42.201A	Unspecified fracture of upper end of right humerus, initial encounter
S42.291A	Other displaced fracture of upper end of right humerus, initial encounter for closed fracture
S42.321A	Displaced transverse fracture shaft of humerus, right arm, initial encounter
S43.101A	Unspecified dislocation of right acromioclavicular joint, initial encounter
S49.92XA	Unspecified injury of left shoulder and upper arm, initial encounter
S52.122A	Displaced fracture of head of left radius, initial encounter for closed fracture
S52.125D	Nondisplaced fracture of head of left radius, subsequent encounter for closed fracture with routine healing
S52.135A	Nondisplaced fracture of neck of left radius, initial encounter for closed fracture
S52.381A	Bent bone of right radius, initial encounter for closed fracture
S52.521D	Torus fracture lower end of right radius, subsequent encounter for fracture with routine healing
S69.91XA	Unspecified injury of right wrist, hand and finger(s), initial encounter
S73.004A	Unspecified dislocation of right hip, initial encounter
S73.005A	Unspecified dislocation of left hip, initial encounter
S73.005D	Unspecified dislocation of left hip, subsequent encounter
S73.015A	Posterior dislocation of left hip, initial encounter
S73.015D	Posterior dislocation of left hip, subsequent encounter
T14.90	Injury, unspecified

Examples of diagnosis codes used to identify potential critical incidents for our **Critical Incidents Involving Medicaid Beneficiaries with Developmental Disabilities** review.

Diagnosis Code	Description (Medical)
599.70	Hematuria, Unspecified
599.71	Gross Hematuria
E86.0	Dehydration
R31.9	Hematuria, Unspecified

Examples of diagnosis codes used to identify potential critical incidents for our **Critical Incidents Involving Medicaid Beneficiaries with Developmental Disabilities** review.

Diagnosis Code	Description (Safety)
931.00	Foreign Body in Ear
932.00	Foreign Body in Nose
933.00	Foreign Body in Pharynx
935.10	Foreign Body Esophagus
938.00	Foreign Body Digestive System NOS
995.59	Other Child Abuse & Neglect
995.81	Adult Maltreatment
995.83	Adverse Effect NEC - Adult Sexual Abuse
R09.01	Asphyxia
T16.1XXA	Foreign body in right ear, initial encounter
T22.062A	Burn of unspecified degree of left scapular region, initial encounter
T22.069	Burn of unspecified degree of unspecified scapular region, subsequent encounter
T23.271A	Burn of second degree of right wrist, initial encounter
T25.021A	Burn of unspecified degree of right foot, initial encounter
T38.3X1A	Poisoning by insulin and oral hypoglycemic drugs, accidental, initial
T39.012A	Poisoning by aspirin, intentional self-harm
T51.94XA	Toxic effect of unspecified alcohol, undetermined, initial encounter
T76.11XA	Adult physical abuse, suspected, initial encounter
V71.5	Observation Following Rape
Z04.1	Encounter for exam and observation following transport accident
Z04.41	Encounter for exam and observation following alleged adult rape