ICD-9-CM
for Hospitals – Volumes 1, 2 & 3

2014 Standard

International Classification of Diseases
9th Revision
Clinical Modification
Sixth Edition

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Optum is committed to providing you with the ICD-9-CM code update information you need to code accurately and to be in compliance with HIPAA regulations. In case of adoption of additional ICD-9-CM code changes effective April 1, 2014, Optum will provide these code changes to you at no additional cost! Just check back at www.optumcoding.com/productalerts to review the latest information concerning any new code changes.

Codes Valid October 1, 2013, through September 30, 2014
Diseases of the Circulatory System  

451.89 Other
- Axillary vein
- Subclavian vein
- Jugular vein
- Thrombophlebitis of breast (Mondor’s disease)


451.9 Of unspecified site

452 Portal vein thrombosis
- Portal (vein) obstruction
  - Excludes: hepatic vein thrombosis (453.0)
  - phlebitis of portal vein (572.1)

CC Excl: 249.70-249.91, 250.70-250.93, 452, 453.40-453.9, 459.89-459.9

453 Other venous embolism and thrombosis

AHA: 1Q, ’11, 19-21; 1Q, ’92, 16

453.0 Budd-Chiari syndrome
- Hepatic vein thrombosis

CC Excl: 249.70-249.91, 250.70-250.93, 453.0, 453.40-453.9, 459.89-459.9

453.1 Thrombophlebitis migrans

CC Excl: 249.70-249.91, 250.70-250.93, 453.1, 453.40-453.9, 459.89-459.9

453.2 Of inferior vena cava

CC Excl: 249.70-249.91, 250.70-250.93, 453.2, 453.40-453.79, 453.81-453.9, 459.89-459.9

453.3 Of renal vein

CC Excl: 249.70-249.91, 250.70-250.93, 453.3, 453.40-453.9, 459.89-459.9

453.4 Acute venous embolism and thrombosis of deep vessels of lower extremity

AHA: 4Q, ’09, 88-92; 3Q, ’08, 16

11 453.40 Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity
- Deep vein thrombosis NOS
- DVT NOS

CC Excl: 249.70-249.91, 250.70-250.93, 453.40-453.9, 459.89-459.9

AHA: 1Q, ’12, 18

11 453.41 Acute venous embolism and thrombosis of deep vessels of proximal lower extremity
- Femoral
- Thigh
- Iliac
- Upper leg NOS
- Popliteal

CC Excl: See code: 453.40

AHA: 4Q, ’04, 79

11 453.42 Acute venous embolism and thrombosis of deep vessels of distal lower extremity
- Calf
- Peroneal
- Lower leg NOS
- Tibial

CC Excl: See code: 453.40

453.5 Chronic venous embolism and thrombosis of deep vessels of lower extremity

Use additional code, if applicable, for associated long-term (current) use of anticoagulants (V58.61)

Excludes: personal history of venous thrombosis and embolism (V12.51)

AHA: 4Q, ’09, 88-92

453.50 Chronic venous embolism and thrombosis of unspecified deep vessels of lower extremity

CC Excl: See code: 453.40

453.51 Chronic venous embolism and thrombosis of deep vessels of proximal lower extremity
- Femoral
- Thigh
- Iliac
- Upper leg NOS
- Popliteal

CC Excl: See code: 453.40

11 HAC when reported with procedure codes 00.85–00.87, 81.51, 81.52, 81.54 and POA = N.
453.52–453.81 Diseases of the Circulatory System

453.52 Chronic venous embolism and thrombosis of deep vessels of distal lower extremity
   Calf
   Peroneal
   Lower leg NOS
   Tibial
   **CC Excl:** See code: 453.40

453.6 Venous embolism and thrombosis of superficial vessels of lower extremity
   Saphenous vein (greater) (lesser)
   Use additional code, if applicable, for associated long-term (current) use of anticoagulants (V58.61)
   **CC Excl:** See code: 453.40
   **AHA:** 4Q, ’09, 88-92

453.7 Chronic venous embolism and thrombosis of other specified vessels
   Use additional code, if applicable, for associated long-term (current) use of anticoagulants (V58.61)
   **EXCLUDE:** personal history of venous thrombosis and embolism (V12.51)
   **AHA:** 4Q, ’09, 88-92

453.71 Chronic venous embolism and thrombosis of superficial veins of upper extremity
   Antecubital vein
   Basilic vein
   Cephalic vein
   **CC Excl:** 249.70-249.91, 250.70-250.93, 453.40-453.79, 453.81-453.9, 459.89-459.9

453.72 Chronic venous embolism and thrombosis of deep veins of upper extremity
   Brachial vein
   Radial vein
   Ulnar vein
   **CC Excl:** See code: 453.71

453.73 Chronic venous embolism and thrombosis of upper extremity, unspecified
   **CC Excl:** See code: 453.71

453.74 Chronic venous embolism and thrombosis of axillary veins
   **CC Excl:** See code: 453.71

453.75 Chronic venous embolism and thrombosis of subclavian veins
   **CC Excl:** See code: 453.71

453.76 Chronic venous embolism and thrombosis of internal jugular veins
   **CC Excl:** See code: 453.71

453.77 Chronic venous embolism and thrombosis of other thoracic veins
   Brachiocephalic (innominate)
   Superior vena cava
   **CC Excl:** See code: 453.71

453.79 Chronic venous embolism and thrombosis of other specified veins
   **CC Excl:** See code: 453.71c

453.8 Acute venous embolism and thrombosis of other specified veins
   **EXCLUDE:** cerebral (434.0-434.9)
   coronary (410.00-410.92)
   intracranial venous sinus (325)
   nonpyogenic (437.6)
   mesenteric (537.0)
   portal (452)
   precerebral (433.0-433.9)
   pulmonary (415.19)
   **AHA:** 4Q, ’09, 88-92; 3Q, ’91, 16; M-A, ’87, 6

453.81 Acute venous embolism and thrombosis of superficial veins of upper extremity
   Antecubital vein
   Cephalic vein
   Basilic vein
   **CC Excl:** See code: 453.71
## Procedures and Interventions, Not Elsewhere Classified

### 00.46--00.50

#### Insertion of two vascular stents

| AHA: | Q, '09, 12; 4Q, '05, 105-106 |

#### Insertion of three vascular stents

| AHA: | Q, '06, 119 |

#### Insertion of four or more vascular stents

#### SuperSaturated oxygen therapy

| Aqueous oxygen (AO) therapy | SuperOxygenation infusion therapy SSO2 |

- Code also any:
  - injection or infusion of thrombolytic agent (99.10)
  - insertion of coronary artery stent(s) (36.06-36.07)
  - intracoronary artery thrombolytic infusion (36.04)
  - number of vascular stents inserted (00.45-00.48)
  - number of vessels treated (00.40-00.43)
  - open chest coronary artery angioplasty (36.03)
  - other removal of coronary obstruction (36.09)
  - percutaneous transluminal coronary angioplasty (PTCA) (00.66)
  - procedure on vessel bifurcation (00.44)
  - transluminal coronary atherectomy (17.55)

**NOTE**
- other oxygen enrichment (99.96)
- other perfusion (39.97)

| AHA: | Q, '08, 162 |

### 00.5 Other cardiovascular procedures

#### Implantation of cardiac resynchronization pacemaker without mention of defibrillation, total system [CRT-P]

| NOTE | Device testing during procedure — omit code |

- Biventricular pacemaker
- Biventricular pacing without internal cardiac defibrillator
- BIV pacemaker
- Implantation of cardiac resynchronization (biventricular) pulse generator pacing device, formation of pocket, transvenous leads including placement of lead into left ventricular coronary venous system, and intraoperative procedures for evaluation of lead signals
- That with CRT-P generator and one or more leads

**NOTE**
- Implantation of cardiac resynchronization defibrillator, total system [CRT-D] (00.51)
  - insertion or replacement of any type pacemaker device (37.80-37.87)
  - replacement of cardiac resynchronization:
    - defibrillator, pulse generator only [CRT-D] (00.54)
    - pacemaker, pulse generator only [CRT-P] (00.53)

| AHA: | Q, '05, 3-9; 4Q, '02, 100 |
Procedures and Interventions, Not Elsewhere Classified 00.51–00.54

00.51  Implantation of cardiac resynchronization defibrillator, total system [CRT-D]

<table>
<thead>
<tr>
<th>NOTE</th>
<th>Device testing during procedure — omit code</th>
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<tbody>
<tr>
<td>BIV defibrillator</td>
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<tr>
<td>Biventricular defibrillator</td>
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<tr>
<td>Biventricular pacing with internal cardiac defibrillator</td>
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<tr>
<td>BIV ICD</td>
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<tr>
<td>BIV pacemaker with defibrillator</td>
<td></td>
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<tr>
<td>BIV pacing with defibrillator</td>
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Implantation of cardiac resynchronization (biventricular) pulse generator with defibrillator [AICD], formation of pocket, transvenous leads, including placement of lead into left ventricular coronary venous system, intraoperative procedures for evaluation of lead signals, and obtaining defibrillator threshold measurements. That with CRT-D generator and one or more leads

EXCLUDES
- Implantation of cardiac resynchronization pacemaker, total system [CRT-P] (00.50)
- Implantation or replacement of automatic cardioverter/defibrillator, total system [AICD] (37.94)
- Replacement of cardiac resynchronization defibrillator, pulse generator only [CRT-D] (00.54)

AHA: 3Q, '08, 18; 1Q, '07, 16, 17; 3Q, '05, 3-9; 4Q, '02, 99, 100

00.52  Implantation or replacement of transvenous lead [electrode] into left ventricular coronary venous system

EXCLUDES
- Implantation of cardiac resynchronization pacemaker, total system [CRT-P] (00.50)
- Pacemaker, total system [CRT-P] (00.50)
- Initial insertion of transvenous lead [electrode] (37.70-37.72)
- Replacement of transvenous atrial and/or ventricular lead(s) [electrodes] (37.76)

00.53  Implantation or replacement of cardiac resynchronization pacemaker, pulse generator only [CRT-P]

| NOTE | Device testing during procedure — omit code |

Implantation of CRT-P device with removal of any existing CRT-P or other pacemaker device

EXCLUDES
- Implantation of cardiac resynchronization pacemaker, total system [CRT-P] (00.50)
- Implantation or replacement of cardiac resynchronization defibrillator, pulse generator only [CRT-D] (00.54)
- Insertion or replacement of any type pacemaker device (37.80-37.87)

AHA: 3Q, '05, 3-9

00.54  Implantation or replacement of cardiac resynchronization defibrillator, pulse generator device only [CRT-D]

| NOTE | Device testing during procedure — omit code |

Implantation of CRT-D device with removal of any existing CRT-D, CRT-P pacemaker, or defibrillator device

EXCLUDES
- Implantation of automatic cardioverter/defibrillator pulse generator only (37.96)
- Implantation of cardiac resynchronization defibrillator, total system [CRT-D] (00.51)
- Implantation or replacement of cardiac resynchronization pacemaker, pulse generator only [CRT-P] (00.53)

AHA: 3Q, '05, 3-9; 4Q, '02, 100
Official ICD-9-CM Guidelines for Coding and Reporting

Effective October 1, 2011

Note: Since no official ICD-9-CM addendum to the guidelines was released in 2012, the guidelines included in this book stand as the official guidelines effective October 1, 2012, through September 30, 2013.

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government’s Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). These guidelines should be used as a companion document to the official version of the ICD-9-CM as published on CD-ROM by the U.S. Government Printing Office (GPO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-9-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. These guidelines are included on the official government version of the ICD-9-CM, and also appear in “Coding Clinic for ICD-9-CM” published by the AHA.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in Volumes I, II and III of ICD-9-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Volumes 1-2) have been adopted under HIPAA for all healthcare settings. Volume 3 procedure codes have been adopted for inpatient procedures reported by hospitals. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses and procedures that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for outpatient coding and reporting.

Section I. Conventions, general coding guidelines and chapter specific guidelines

A. Conventions for the ICD-9-CM
   1. Format:
   2. Abbreviations
      a. Index abbreviations
      b. Tabular abbreviations
   3. Punctuation
   4. Includes and Excludes Notes and Inclusion terms
   5. Other and Unspecified codes
      a. “Other” codes
      b. “Unspecified” codes
   6. Etiology/manifestation convention (“code first”, “use additional code” and “in diseases classified elsewhere” notes)
   7. “And”
   8. “With”
   9. “See” and “See Also”

B. General Coding Guidelines
   1. Use of Both Alphabetic Index and Tabular List
   2. Locate each term in the Alphabetic Index
   3. Level of Detail in Coding
   4. Code or codes from 001.0 through V91.99
   5. Selection of codes 001.0 through 999.9
   6. Signs and symptoms
   7. Conditions that are an integral part of a disease process
   8. Conditions that are not an integral part of a disease process
   9. Multiple coding for a single condition
   10. Acute and Chronic Conditions
   11. Combination Code
   12. Late Effects
   13. Impending or Threatened Condition
   14. Reporting Same Diagnosis Code More than Once
   15. Admissions/Encounters for Rehabilitation
   16. Documentation for BMI and Pressure Ulcer Stages