ICD-9-CM
Expert
for Physicians
Volumes 1 & 2

International Classification of Diseases
9th Revision
Clinical Modification

Seventh Edition

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Codes Valid October 1, 2006, through September 30, 2007
483 Pneumonia due to other specified organism

AHA: N-0, '97, 5

483.0 Mycoplasma pneumoniae
Eaton’s agent
Pneumonia-like organism (PPLO)

483.1 Chlamydia

483.8 Other specified organism

484 Pneumonia in infectious diseases classified elsewhere

484.1 Pneumonia in cytomegalic inclusion disease
Code first underlying disease, as (033.0-033.9)

484.2 Pneumonia in whooping cough
Code first underlying disease, as (033.0-033.9)

484.5 Pneumonia in anthrax
Code first underlying disease (022.1)

484.6 Pneumonia in aspergillosis
Code first underlying disease (117.3)

484.7 Pneumonia in other systemic mycoses
Code first underlying disease

EXCLUDED pneumonia in:
candidiasis (112.4)
coccidioidomycosis (114.0)
histoplasmosis (115.0-115.9 with fifth-digit 5)

484.8 Pneumonia in other infectious diseases classified elsewhere
Code first underlying disease, as:
Q fever (083.0)
typhoid fever (002.0)

EXCLUDED pneumonia in:
actinomycosis (039.1)
measles (055.1)
noocardiosis (039.1)
oculosis (073.0)
Pneumocystis carinii (136.3)
salmonellosis (003.22)
streptococcal pneumonia (480.0-480.9)
tuberculosis (011.6)
tularemia (021.2)
varicella (052.1)

485 Bronchopneumonia, organism unspecified

Bronchopneumonia: Pneumonia:
hemorrhagic lobular terminal
segmental

Pleurobronchopneumonia

EXCLUDED bronchitis (acute) (466.11-466.19)
chronic (491.8)
lipoid pneumonia (507.1)

486 Pneumonia, organism unspecified

EXCLUDED hypostatic or passive pneumonia (514)
inhalation or aspiration pneumonia due to foreign materials (507.0-507.8)
pneumonitis due to fumes and vapors (506.0)

AHA: 4Q, '99, 9; 3Q, '99, 7; 2Q, '99, 4, 5; 1Q, '99, 8; 3Q, '98, 9; 3Q, '99, 5; 2Q, '98, 11

487 Influenza

EXCLUDED Hemophilus influenzae (H. influenzae):
infection NOS (041.5)
laryngitis (464.00-464.01)
meningitis (320.0)

487.0 With pneumonia
Influenza with pneumonia, any form
Influenza:
bronchopneumonia
pneumonia

Use additional code to identify the type of pneumonia (480.0-480.9, 481, 482.0-482.9, 483.0-483.8, 485)

CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND ALLIED CONDITIONS (490-496)

490 Bronchitis, not specified as acute or chronic

Bronchitis NOS:
catarrhal
with tracheitis NOS
Trachobronchitis NOS

EXCLUDED bronchitis:
asthmatic bronchitis (acute) NOS (493.9)
chronic obstructive asthma (493.2)

491 Chronic bronchitis

EXCLUDED chronic obstructive asthma (493.2)

491.0 Simple chronic bronchitis
Catarhal bronchitis, chronic
Smokers' cough

491.1 Mucopurulent chronic bronchitis
Bronchitis (chronic), recurrent:
fever
mucopurulent
purulent

Common Code

EXCLUDES asthmatic bronchitis (acute) NOS (493.9)
chronic obstructive asthma (493.2)

AHA: 30, '98, 5

DEF: Chronic bronchial infection characterized by both mucus and pus secretions in the bronchial tree; recurs after asymptomatic periods; signs are coughing, expectoration and secondary changes in the lung.

491.2 Obstructive chronic bronchitis
Bronchitis:
emphysematous
obstructive (chronic) (diffuse)

Bronchitis with:
chronic airway obstruction
emphysema

EXCLUDED asthmatic bronchitis (acute) NOS (493.9)
chronic obstructive asthma (493.2)

AHA: 30, '98, 9; 4Q, '99, 25; 2Q, '99, 21

491.20 Without exacerbation

Emphysema with chronic bronchitis

AHA: 30, '97, 9

Bronchioli and Alveoli

To trachea

Terminal bronchiolus

Pulmonary arteriole

Elastic fibers

Capillary network over all alveoli

Alveoli

Alveolus
### V66.3–V70.2 V Codes Tabular List

<table>
<thead>
<tr>
<th>V Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>V66.3</td>
<td>Following psychotherapy and other treatment for mental disorder</td>
</tr>
<tr>
<td>V66.4</td>
<td>Following treatment of fracture</td>
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<tr>
<td>V66.5</td>
<td>Following other treatment</td>
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<td>V66.6</td>
<td>Following combined treatment</td>
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<td>V66.7</td>
<td>Encounter for palliative care</td>
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<tr>
<td>V66.8</td>
<td>Consultation or instruction for mental disorders</td>
</tr>
<tr>
<td>V66.9</td>
<td>Unspecified convalescence</td>
</tr>
<tr>
<td>V67.0</td>
<td>Follow-up examination</td>
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<tr>
<td>V67.1</td>
<td>Follow-up examination</td>
</tr>
<tr>
<td>V67.2</td>
<td>Follow-up examination</td>
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<tr>
<td>V67.3</td>
<td>Follow-up examination</td>
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<tr>
<td>V67.4</td>
<td>Follow-up examination</td>
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<tr>
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<td>V67.8</td>
<td>Follow-up examination</td>
</tr>
<tr>
<td>V67.9</td>
<td>Follow-up examination</td>
</tr>
<tr>
<td>V68</td>
<td>Issue of medical certificates</td>
</tr>
</tbody>
</table>

#### V68.1 Issue of repeat prescriptions
- Issue of repeat prescription for:
  - appliances
  - glasses
  - medications

#### V68.2 Request for expert evidence

#### V68.3 Other specified administrative purpose

#### V68.4 Referral of patient without examination or treatment

#### V68.5 Other specified administrative purpose

#### V68.6 Referral of patient without examination or treatment

#### V68.7 Referral of patient without examination or treatment

#### V68.8 Other specified administrative purpose

#### V68.9 Unspecified administrative purpose

#### V67.0 Other specified administrative purpose

#### V67.1 Other specified administrative purpose

#### V67.2 Other specified administrative purpose

#### V67.3 Other specified administrative purpose

#### V67.4 Other specified administrative purpose

### Persons without reported diagnosis encountered during examination and investigation of individuals and populations

#### Note: Non-specific abnormal findings disclosed at the time of these examinations are classifiable to categories 790-796.

#### V70 General medical examination
- Use additional code(s) to identify any special screening examination(s) performed (V73.0-V82.9)

#### V70.0 Routine general medical examination at a health care facility
- Health checkup

#### V70.1 General psychiatric examination, requested by the authority

#### V70.2 General psychiatric examination, other and unspecified

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**Newborn Age:** 0  **Pediatric Age:** 0-17  **Maternity Age:** 12-55  **Adult Age:** 15-124
ICD-9-CM OFFICIAL GUIDELINES FOR CODING AND REPORTING

Effective December 1, 2005

The guidelines have been updated to include the V Code Table.

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS) have been updated to include the V Code Table.

The 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 in 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. These guidelines are based on the coding and sequencing instructions in Volumes 1, 2, and 3 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 health care settings. Volume 3 procedure codes have been adopted for inpatient procedures reported by hospitals. A joint effort between the health care 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 health care 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
Appendix D: Classification of Industrial Accidents According to Agency

Appendix E: List of Three-Digit Categories

These appendices are included as a reference to provide further information about the patient’s clinical picture, to further define a diagnostic statement, to aid in classifying new drugs or to reference three-digit categories.

Volume 2 (Alphabetic Index) of ICD-9-CM contains many diagnostic terms that do not appear in volume 1 since the index includes most diagnostic terms currently in use.

THE DISEASE CLASSIFICATION

ICD-9-CM is totally compatible with its parent system, ICD-9, thus meeting the need for comparability of morbidity and mortality statistics at the international level. A few fourth-digit codes were created in existing three-digit rubrics only when the necessary detail could not be accommodated by the use of a fifth-digit subclassification. To ensure that each rubric of ICD-9-CM collapses back to its ICD-9 counterpart the following specifications governed the ICD-9-CM disease classification:

Specifications for the Tabular List:
1. Three-digit rubrics and their contents are unchanged from ICD-9.
2. The sequence of three-digit rubrics is unchanged from ICD-9.
3. Three-digit rubrics are not added to the main body of the classification.
4. Unsubdivided three-digit rubrics are subdivided where necessary to:
   - add clinical detail
   - isolate terms for clinical accuracy
5. The modification in ICD-9-CM is accomplished by adding a fifth digit to existing ICD-9 rubrics, except as noted under #7 below.
6. The optional dual classification in ICD-9 is modified.
   - Duplicate rubrics are deleted:
     - four-digit manifestation categories duplicating etiology entries
     - manifestation inclusion terms duplicating etiology entries
   - Manifestations of disease are identified, to the extent possible, by creating five-digit codes in the etiology rubrics.
   - When the manifestation of a disease cannot be included in the etiology rubrics, provision for its identification is made by retaining the ICD-9 rubrics used for classifying manifestations of disease.
7. The format of ICD-9-CM is revised from that used in ICD-9.
   - American spelling of medical terms is used.
   - Inclusion terms are indented beneath the titles of codes.
   - Codes not to be used for primary tabulation of disease are printed in italics with the notation, “code first underlying disease.”

Specifications for the Alphabetic Index:
1. The format of the Alphabetic Index follows that of ICD-9.
2. When two codes are required to indicate etiology and manifestation, the manifestation code appears in brackets (e.g., diabetic cataract 250.5 [366.41].)

THE ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

The four cooperating parties involved in maintaining the ICD-9-CM classification system include representatives of the American Hospital Association (AHA), the Centers for Medicare and Medicaid Services (CMS), the National Center for Health Statistics (NCHS), and the American Health Information Management Association (AHIMA).

Proposals for changes to the ICD-9-CM classification system are submitted and discussed in two open forum meetings held in April and October of each year at the Headquarters of the Centers for Medicare and Medicaid Services, Baltimore, Maryland. Comments received during and after the meetings are then discussed by the Committee. A notice of the new codes and code revisions approved by the Committee are published in the Federal Register as part of the proposed and final rule for the changes to the inpatient prospective payment system. The complete official document of changes to the classification system is released as the Addenda for the International Classification of Diseases, Ninth Revision, Clinical Modification, Sixth Edition, Volumes 1, 2 and 3.