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ICD-9-CM Expert

for Physicians
Volumes 1 & 2

International Classification of Diseases
9th Revision
Clinical Modification

Seventh Edition

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Ingenix 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 the case of adoption of additional ICD-9-CM code changes effective April 1, 2007, Ingenix will provide these code changes to you at no additional cost! Just check back at http://www.IngenixOnline.com and look for the ICD-9, CPT® and HCPCS Alerts link under the Quick Access Resources Menu to review the latest information concerning any new code changes.

Codes Valid October 1, 2006, through September 30, 2007

✓4th 483 Pneumonia due to other specified organism
AHA: N-D, '87, 5

483.0 Mycoplasma pneumoniae
Eaton's agent
Pleuropneumonia-like organism [PPLO]

483.1 Chlamydia
AHA: 4Q, '96, 31

483.8 Other specified organism

✓4th 484 Pneumonia in infectious diseases classified elsewhere
EXCLUDES *influenza with pneumonia, any form (487.0)*

484.1 Pneumonia in cytomegalic inclusion disease
Code first underlying disease, as (078.5)

484.3 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)
AHA: 4Q, '97, 40

484.7 Pneumonia in other systemic mycoses
Code first underlying disease
EXCLUDES *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)
EXCLUDES *pneumonia in:*
actinomycosis (039.1)
measles (055.1)
nocardiosis (039.1)
ornithosis (073.0)
Pneumocystis carinii (136.3)
salmonellosis (003.22)
toxoplasmosis (130.4)
tuberculosis (011.6)
tularemia (021.2)
varicella (052.1)

485 Bronchopneumonia, organism unspecified
Bronchopneumonia:
hemorrhagic
terminal
Pleurobronchopneumonia
Pneumonia:
lobular
segmental
EXCLUDES *bronchiolitis (acute) (466.11-466.19)*
chronic (491.8)
lipoid pneumonia (507.1)

486 Pneumonia, organism unspecified
EXCLUDES *hypostatic or passive pneumonia (514)*
influenza with pneumonia, any form (487.0)
inhalation or aspiration pneumonia due to foreign materials (507.0-507.8)
pneumonitis due to fumes and vapors (506.0)
AHA: 4Q, '99, 6; 3Q, '99, 9; 3Q, '98, 7; 2Q, '98, 4, 5; 1Q, '98, 8; 3Q, '97, 9; 3Q, '94, 10; 3Q, '88, 11

✓4th 487 Influenza
EXCLUDES *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
Influenzal:
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)

487.1 With other respiratory manifestations
Influenza NOS
Influenzal:
laryngitis
Influenzal:
pharyngitis
respiratory infection (upper) (acute)
AHA: ▶2Q, '05, 18;◀ 4Q, '99, 26

487.8 With other manifestations
Encephalopathy due to influenza
Influenza with involvement of gastrointestinal tract
EXCLUDES *"intestinal flu" [viral gastroenteritis] (008.8)*

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

AHA: 3Q, '88, 5

490 Bronchitis, not specified as acute or chronic
Bronchitis NOS:
catarrhal
with tracheitis NOS
Tracheobronchitis NOS
EXCLUDES *bronchitis:*
allergic NOS (493.9)
asthmatic NOS (493.9)
due to fumes and vapors (506.0)

✓4th 491 Chronic bronchitis
EXCLUDES *chronic obstructive asthma (493.2)*

491.0 Simple chronic bronchitis
Catarrhal bronchitis, chronic
Smokers' cough

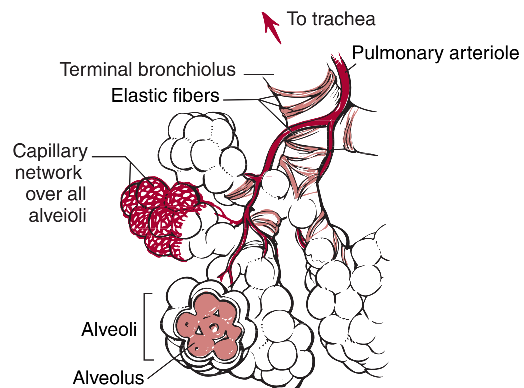
491.1 Mucopurulent chronic bronchitis
Bronchitis (chronic) (recurrent):
fetid
mucopurulent
purulent
AHA: 3Q, '88, 12

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.

✓5th 491.2 Obstructive chronic bronchitis
Bronchitis:
emphysematous
obstructive (chronic) (diffuse)
Bronchitis with:
chronic airway obstruction
emphysema
EXCLUDES *asthmatic bronchitis (acute) NOS (493.9)*
chronic obstructive asthma (493.2)
AHA: 3Q, '97, 9; 4Q, '91, 25; 2Q, '91, 21

491.20 Without exacerbation
Emphysema with chronic bronchitis
AHA: 3Q, '97, 9

Bronchioli and Alveoli



V66.3 Following psychotherapy and other treatment for mental disorder PDx

V66.4 Following treatment of fracture PDx

V66.5 Following other treatment PDx

V66.6 Following combined treatment PDx

V66.7 Encounter for palliative care SDx

End-of-life care
Terminal care
Hospice care
Code first underlying disease

AHA: 2Q, '05, 9; 4Q, '03, 107; 1Q, '98, 11; 4Q, '96, 47, 48

V66.9 Unspecified convalescence PDx

AHA: 4Q, '99, 8

✓4th **V67 Follow-up examination**

INCLUDES surveillance only following completed treatment

EXCLUDES *surveillance of contraception (V25.40-V25.49)*

AHA: 2Q. '03, 5; 4Q, '94, 48

✓5th **V67.0 Following surgery**

AHA: 4Q, '00, 56; 4Q, '98, 69; 4Q, '97, 50; 2Q, '95, 8;1Q, '95, 4; 3Q, '92, 11

V67.00 Following surgery, unspecified

V67.01 Follow-up vaginal pap smear ♀

Vaginal pap-smear, status-post hysterectomy for malignant condition
Use additional code to identify:
acquired absence of uterus (V45.77)
personal history of malignant neoplasm (V10.40-V10.44)

EXCLUDES *vaginal pap smear status-post hysterectomy for non-malignant condition (V76.47)*

V67.09 Following other surgery

EXCLUDES *sperm count following sterilization reversal (V26.22)*
sperm count for fertility testing (V26.21)

AHA: 3Q, '03, 16; 3Q, '02, 15

V67.1 Following radiotherapy

V67.2 Following chemotherapy

Cancer chemotherapy follow-up

V67.3 Following psychotherapy and other treatment for mental disorder

V67.4 Following treatment of healed fracture

EXCLUDES *current (healing) fracture aftercare (V54.0-V54.9)*

AHA: 1Q, '90, 7

✓5th **V67.5 Following other treatment**

V67.51 Following completed treatment with high-risk medications, not elsewhere classified

EXCLUDES *long-term (current) drug use (V58.61-V58.69)*

AHA: 1Q, '99, 5, 6; 4Q, '95, 61 ; 1Q, '90, 18

V67.59 Other

V67.6 Following combined treatment

V67.9 Unspecified follow-up examination

✓4th **V68 Encounters for administrative purposes**

V68.0 Issue of medical certificates PDx

Issue of medical certificate of:
cause of death
fitness
incapacity

EXCLUDES *encounter for general medical examination (V70.0-V70.9)*

V68.1 Issue of repeat prescriptions PDx

Issue of repeat prescription for:
appliance
glasses
medications

EXCLUDES *repeat prescription for contraceptives (V25.41-V25.49)*

V68.2 Request for expert evidence PDx

✓5th **V68.8 Other specified administrative purpose**

V68.81 Referral of patient without examination or treatment PDx

V68.89 Other PDx

V68.9 Unspecified administrative purpose PDx

✓4th **V69 Problems related to lifestyle**

AHA: 4Q, '94, 48

V69.0 Lack of physical exercise

V69.1 Inappropriate diet and eating habits

EXCLUDES *anorexia nervosa (307.1)*
bulimia (783.6)
malnutrition and other nutritional deficiencies (260-269.9)
other and unspecified eating disorders (307.50-307.59)

V69.2 High-risk sexual behavior

V69.3 Gambling and betting

EXCLUDES *pathological gambling (312.31)*

V69.4 Lack of adequate sleep

Sleep deprivation

EXCLUDES *insomnia (780.52)*

V69.5 Behavioral insomnia of childhood P

AHA: 4Q, '05, 99

DEF: Behaviors on the part of the child or caregivers that cause negative compliance with a child's sleep schedule; results in lack of adequate sleep.

V69.8 Other problems related to lifestyle

Self-damaging behavior

V69.9 Problem related to lifestyle, unspecified

PERSONS WITHOUT REPORTED DIAGNOSIS ENCOUNTERED DURING EXAMINATION AND INVESTIGATION OF INDIVIDUALS AND POPULATIONS ▶(V70-V82)◀

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

✓4th **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 PDx

Health checkup

EXCLUDES *health checkup of infant or child (V20.2)*
pre-procedural general physical examination (V72.83)

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

V70.2 General psychiatric examination, other and unspecified PDx

Coding Guidelines

ICD-9-CM OFFICIAL GUIDELINES FOR CODING AND REPORTING

Effective December 1, 2005
Narrative changes appear in bold text
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), 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 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
2. Locate each term in the Alphabetic Index
3. Level of detail in coding
4. Code or codes from 001.0 through V86.1
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

C. Chapter-specific coding guidelines
1. Chapter 1: Infectious and Parasitic Diseases (001–139)
   a. Human immunodeficiency virus (HIV) infections
   b. Septicemia, systemic inflammatory response syndrome . . . (SIRS), sepsis, severe sepsis, and septic shock
2. Chapter 2: Neoplasms (140–239)
   a. Treatment directed at the malignancy
   b. Treatment of secondary site
   c. Coding and sequencing of complications
   d. Primary malignancy previously excised
   e. Admissions/encounters involving chemotherapy and radiation therapy
   f. Admission/encounter to determine extent of malignancy
   g. Symptoms, signs, and ill-defined conditions listed in chapter 16
   h. Encounter for prophylactic organ removal
3. Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240–279)
   a. Diabetes mellitus
4. Chapter 4: Diseases of Blood and Blood-Forming Organs (280–289)
   a. Anemia of chronic disease
5. Chapter 5: Mental Disorders (290–319)
   Reserved for future guideline expansion
6. Chapter 6: Diseases of Nervous System and Sense Organs (320–389)
   Reserved for future guideline expansion
7. Chapter 7: Diseases of Circulatory System (390–459)
   a. Hypertension
   b. Cerebral infarction/stroke/cerebrovascular accident (CVA)
   c. Postoperative cerebrovascular accident
   d. Late effects of cerebrovascular disease
   e. Acute myocardial infarction (AMI)
8. Chapter 8: Diseases of Respiratory System (460–519)
   a. Chronic obstructive pulmonary disease [COPD] and asthma
   b. Chronic obstructive pulmonary disease [COPD] and bronchitis
9. Chapter 9: Diseases of Digestive System (520–579)
   Reserved for future guideline expansion
10. Chapter 10: Diseases of Genitourinary System (580–629)
   a. Chronic kidney disease
11. Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium (630–677)
   a. General rules for obstetric cases
   b. Selection of OB principal or first-listed diagnosis
   c. Fetal conditions affecting the management of the mother
   d. HIV infection in pregnancy, childbirth and the puerperium
   e. Current conditions complicating pregnancy
   f. Diabetes mellitus in pregnancy
   g. Gestational diabetes
   h. Normal delivery, code 650
   i. The postpartum and peripartum eriods
   j. Code 677 Late effect of complication of pregnancy
   k. Abortions
12. Chapter 12: Diseases Skin and Subcutaneous Tissue (680–709)
   Reserved for future guideline expansion
13. Chapter 13: Diseases of Musculoskeletal and Connective Tissue (710–739)
   Reserved for future guideline expansion

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 I 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.*