ICD-10-CM

The Complete Official Draft Code Set

2011
## Contents

**Preface**  ................................................................................ iii  
ICD-10-CM Official Preface DRAFT ................................................... iii  

**Introduction**  ........................................................................ iv  
History and Future of ICD-10-CM ............................................................ iv  

**How to Use the ICD-10-CM (Draft 2011)** ........................................ v  
Steps to Correct Coding ................................................................. v  
Organization .................................................................................................. v  

**ICD-10-CM Draft Conventions** ................................................... vi  
Format ................................................................................................ vi  
Punctuation ............................................................................................. vi  
Abbreviations ............................................................................................... vi  
General Notes ............................................................................................... vi  

**ICD-10-CM Draft Official Guidelines for Coding and Reporting 2011**  
Section I. Conventions, general coding guidelines and chapter specific guidelines  3  
Section II. Selection of Principal Diagnosis .................................... 27  
Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services .......................................................... 28  

**ICD-10-CM Index to Diseases and Injuries** ................................. 33  

**ICD-10-CM Neoplasm Table** ...................................................... 371  

**ICD-10-CM Table of Drugs and Chemicals** ................................ 385  

**ICD-10-CM Index to External Causes** ........................................ 439  

**ICD-10-CM Tabular List of Diseases and Injuries** .......................... 475  

Chapter 1 Certain Infectious and Parasitic Diseases .................. 475  
Chapter 2 Neoplasms ........................................................................ 483  
Chapter 3 Diseases of the Blood and Blood-forming Organs ........ 523  
Chapter 4 Endocrine, Nutritional and Metabolic Diseases .......... 530  
Chapter 5 Mental and Behavioral Disorders ............................... 546  
Chapter 6 Diseases of the Nervous System .............................. 564  
Chapter 7 Diseases of the Eye and Adnexa ................................. 579  
Chapter 8 Diseases of the Ear and Mastoid Process ................. 610  
Chapter 9 Diseases of the Circulatory System ......................... 620  
Chapter 10 Diseases of the Respiratory System ...................... 654  
Chapter 11 Diseases of the Digestive System .............................. 665  
Chapter 12 Diseases of the Skin and Subcutaneous Tissue .......... 682  
Chapter 13 Diseases of the Musculoskeletal System and Connective Tissue .......................................................... 699  
Chapter 14 Diseases of the Genitourinary System ................. 777  
Chapter 15 Pregnancy, Childbirth and the Puerperium ............. 791  
Chapter 16 Certain Conditions Originating in the Perinatal Period .......................................................... 821  
Chapter 17 Congenital Malformations, Deformations and Chromosomal Abnormalities .......................................................... 830  
Chapter 18 Symptoms, Signs and Abnormal Clinical and Laboratory Findings .......................................................... 845  
Chapter 19 Injury, Poisoning and Certain Other Consequences of External Causes .......................................................... 860  
Chapter 20 External Causes of Morbidity ........................................ 1048  
Chapter 21 Factors Influencing Health Status and Contact With Health Services .......................................................... 1117
Section I. Conventions, general coding guidelines and chapter specific guidelines

The conventions, general guidelines and chapter specific guidelines are applicable to all health care settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines.

A. Conventions for the ICD-10-CM

The conventions for the ICD-10-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the Alphabetic Index and Tabular List of the ICD-10-CM as instructional notes.

1. The Alphabetic Index and Tabular List

The ICD-10-CM is divided into the Alphabetic Index, an alphabetical list of terms and their corresponding code, and the Tabular List, a chronological list of codes divided into chapters based on body system or condition. The Alphabetic Index consists of the following parts: the Index of Diseases and Injury, the Index of External Causes of Injury, the Table of Neoplasms and the Table of Drugs and Chemicals.

See Section I.C2. General guidelines

2. Format and Structure:

The ICD-10-CM Tabular List contains categories, subcategories and codes. Characters for categories, subcategories and codes may be either a letter or a number. All categories are 3 characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either 4 or 5 characters. Codes may be 8, 4, 5 or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character.

The ICD-10-CM uses an indented format for ease in reference.

3. Use of codes for reporting purposes

For reporting purposes only codes are permissible, not categories or subcategories, and any applicable 7th character is required.

4. Placeholder character

The ICD-10-CM utilizes a placeholder character “X”. The “X” is used as a placeholder at certain codes to allow for future expansion. An example of this is in the poisoning, adverse effects, and toxic effects.

Where a placeholder exists, the X must be used in order for the code to be considered a valid code.

5. 7th Characters

Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category or as the notes in the Tabular List instruct. The 7th character must always be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder “X” must be used to fill in the empty characters.

6. Abbreviations

a. Alphabetic Index abbreviations

NEC “Not elsewhere classified”

This abbreviation in the Alphabetic Index represents “other specified”. When a specific code is not available for a condition, the Alphabetic Index directs the coder to the “other specified” code in the Tabular List.

NOS “Not otherwise specified”

This abbreviation is the equivalent of unspecified.

b. Tabular List abbreviations

NEC “Not elsewhere classified”

This abbreviation in the Tabular List represents “other specified”. When a specific code is not available for a condition the Tabular List includes an NEC entry under a code to identify the code as the “other specified” code.

NOS “Not otherwise specified”

This abbreviation is the equivalent of unspecified.

7. Punctuation

a. Brackets are used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Alphabetic Index to identify manifestation codes.

b. Parentheses are used in both the Alphabetic Index and Tabular List to enclose terms that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.

Colors are used in the Tabular List after an incomplete term which needs one or more of the modifiers following the color to make it assignable to a given category.

8. Use of “and”

When the term “and” is used in a narrative statement it represents and/or.

9. Other and Unspecified codes

a. “Other” codes

Codes titled “other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist. The Alphabetic Index entries with NEC in the free designate “other” codes in the Tabular List. These entries represent specific disease entities for which no specific code exists in the term is included within an “other” code.

b. “Unspecified” codes

Codes titled “unspecified” are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the “other unspecified” code may represent both other and unspecified.

10. Includes Notes

This note appears immediately under a three character code title to further define, or give examples of, the content of the category.

11. Inclusion terms

List of terms is included under some codes. These terms are the conditions for which a code is to be used. The terms may be synonyms of the code title, or in the case of “other specified” codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Alphabetic Index may also be assigned to a code.

12. Excludes Notes

The ICD-10-CM has two types of excludes notes. Each type of note has a different definition for use but they are all similar in that they indicate that codes excluded from each other are independent of each other.

a. Excludes1

A type 1 Excludes note is a pure excludes note. It means “NOT CODED HERE!” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

b. Excludes2

A type 2 excludes note represents “Not included here”. An excluded2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time when an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, where appropriate.

13. Etiology/manifestation convention (“code first”, “use additional code” and “in diseases classified elsewhere” notes)

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the
<table>
<thead>
<tr>
<th>Aarskog’s syndrome</th>
<th>Abnormal, abnormality, abnormalities (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal, specimen, respiratory</td>
<td>Abnormal, abnormality, abnormalities (continued)</td>
</tr>
<tr>
<td>Abnormal, diagnostic imaging</td>
<td>Abnormal, abnormality, abnormalities (continued)</td>
</tr>
<tr>
<td>Abnormal, diagnostic imaging</td>
<td>Abnormal, abnormality, abnormalities (continued)</td>
</tr>
<tr>
<td>Abnormal, diagnostic imaging</td>
<td>Abnormal, abnormality, abnormalities (continued)</td>
</tr>
<tr>
<td>Abnormal, diagnostic imaging</td>
<td>Abnormal, abnormality, abnormalities (continued)</td>
</tr>
<tr>
<td>Abnormal, diagnostic imaging</td>
<td>Abnormal, abnormality, abnormalities (continued)</td>
</tr>
</tbody>
</table>

**ICD-10-CM Index to Diseases and Injuries**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ablatio, ablation</td>
<td>Q58.8</td>
</tr>
<tr>
<td>Abnormal, abnormality, abnormalities</td>
<td>Q33.7</td>
</tr>
<tr>
<td>Ablepharia, ablepharon</td>
<td>Q33.7</td>
</tr>
<tr>
<td>Aberrant</td>
<td>Q62.0</td>
</tr>
<tr>
<td>Abdominalgia</td>
<td>Q79.1</td>
</tr>
<tr>
<td>Abdomen, abdominal</td>
<td>Q79.1</td>
</tr>
<tr>
<td>Abderhalden-Kaufmann-Lignac syndrome</td>
<td>Q79.1</td>
</tr>
<tr>
<td>Abasia</td>
<td>Q33.7</td>
</tr>
<tr>
<td>Aarskog’s syndrome</td>
<td>Q62.0</td>
</tr>
<tr>
<td>Abnormal, abnormality, abnormalities</td>
<td>Q33.7</td>
</tr>
<tr>
<td>Abnormal, specimen, respiratory</td>
<td>Q33.7</td>
</tr>
<tr>
<td>Abnormal, specimen, digestive</td>
<td>Q33.7</td>
</tr>
<tr>
<td>Abnormal, specimen, respiratory organs</td>
<td>Q33.7</td>
</tr>
</tbody>
</table>

**Note:** The above table provides a partial list of conditions and their corresponding codes as per the ICD-10-CM index. For a comprehensive list, refer to the full ICD-10-CM manual. Copyright © 2011 Ingenix.
Diseases of the Circulatory System

ICD-10-CM Draft (2011)

126.99 Other pulmonary embolism without acute cor pulmonale
- Acute pulmonary embolism NOS
- Pulmonary embolism: chronic NOS

127 Other pulmonary heart diseases
- Primary pulmonary hypertension
- Secondary pulmonary hypertension

127.1 Kyphoscoliotic heart disease
- Other secondary pulmonary hypertension
- Pulmonary hypertension NOS

127.8 Other specified pulmonary heart diseases
- Other pulmonary embolism without acute cor pulmonale
- Pulmonary embolism NOS
- Pulmonary embolism: chronic NOS

130 Acute pericarditis
- Infectious pericarditis
- Rupture of pericardium
- Pericardial effusion
- Cardiac tamponade

131.1 Acute and subacute endocarditis
- Nonrheumatic mitral valve disorders
- Nonrheumatic aortic valve disorders
- Nonrheumatic atrial valve disorders

131.2 Infective endocarditis
- Bacterial endocarditis
- Fungal endocarditis
- Viral endocarditis

131.3 Echocardiography
- Transthoracic echocardiogram
- Transesophageal echocardiogram

131.4 Mitral valve disorders
- Mitral valve prolapse
- Mitral valve insufficiency
- Mitral stenosis

131.5 Aortic valve disorders
- Aortic valve insufficiency
- Aortic valve stenosis
- Aortic regurgitation

131.6 Nonrheumatic mitral valve disorders
- Mitral valve prolapse
- Mitral valve regurgitation

131.7 Nonrheumatic aortic valve disorders
- Aortic valve regurgitation
- Aortic valve stenosis

131.8 Nonrheumatic atrial valve disorders
- Atrial valve regurgitation
- Atrial valve stenosis

131.9 Other specified cardiac valve disorders
- Mitral valve prolapse
- Mitral valve regurgitation

131.0 Other specified heart valve disorders
- Mitral valve stenosis
- Mitral valve insufficiency

132 Coronary artery disease
- Coronary artery bypass grafting
- Percutaneous coronary intervention

133 Cardiac arrest
- Out-of-hospital cardiac arrest
- In-hospital cardiac arrest

134.8 Nonrheumatic mitral valve insufficiency
- Mitral valve regurgitation
- Mitral valve prolapse
- Mitral valve stenosis

135.0 Endocarditis
- Nonrheumatic mitral valve disorders
- Nonrheumatic aortic valve disorders
- Nonrheumatic atrial valve disorders

135.1 Other specified cardiac valve disorders
- Mitral valve prolapse
- Mitral valve regurgitation

135.2 Nonrheumatic aortic valve disorders
- Aortic valve regurgitation
- Aortic valve stenosis

135.3 Nonrheumatic atrial valve disorders
- Atrial valve regurgitation
- Atrial valve stenosis

135.4 Aortic valve disorders
- Aortic valve insufficiency
- Aortic valve stenosis

135.5 Atrial valve disorders
- Atrial valve regurgitation
- Atrial valve stenosis

135.6 Other specified cardiac valve disorders
- Mitral valve prolapse
- Mitral valve regurgitation

135.7 Acute myocarditis
- Acute myocarditis: cardiomyopathy
- Acute myocarditis: noncardiomyopathy

135.8 Chronic myocarditis
- Chronic myocarditis: cardiomyopathy
- Chronic myocarditis: noncardiomyopathy

135.9 Other specified cardiac disorders
- Myocardial infarction
- Myocarditis

136.0 Myocardial infarction
- Acute myocardial infarction
- Chronic myocardial infarction

136.1 Myocardial ischemia
- Acute myocardial ischemia
- Chronic myocardial ischemia

136.2 Myocardial reperfusion syndrome
- Acute myocardial reperfusion syndrome
- Chronic myocardial reperfusion syndrome

136.3 Myocardial dysfunction
- Acute myocardial dysfunction
- Chronic myocardial dysfunction

136.4 Coronary artery disease
- Coronary artery bypass grafting
- Percutaneous coronary intervention
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Appropriate 7th Character</th>
</tr>
</thead>
<tbody>
<tr>
<td>S87</td>
<td>Crushing injury of lower leg</td>
<td>A: initial encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D: subsequent encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: sequla</td>
</tr>
<tr>
<td>S87.0</td>
<td>Crushing injury of knee</td>
<td>A: initial encounter</td>
</tr>
<tr>
<td>S87.08</td>
<td>Crushing injury of unspecified knee</td>
<td>D: subsequent encounter</td>
</tr>
<tr>
<td>S87.81</td>
<td>Crushing injury of right knee</td>
<td>S: sequla</td>
</tr>
<tr>
<td>S87.82</td>
<td>Crushing injury of left knee</td>
<td></td>
</tr>
<tr>
<td>S87.83</td>
<td>Crushing injury of unspecified lower leg</td>
<td></td>
</tr>
<tr>
<td>S87.831</td>
<td>Salter-Harris Type I physeal fracture of lower end of left tibia</td>
<td></td>
</tr>
<tr>
<td>S87.8312</td>
<td>Salter-Harris Type I physeal fracture of lower end of unspecified tibia</td>
<td></td>
</tr>
<tr>
<td>S87.839</td>
<td>Salter-Harris Type III physeal fracture of lower end of unspecified tibia</td>
<td></td>
</tr>
<tr>
<td>S87.842</td>
<td>Salter-Harris Type IV physeal fracture of lower end of unspecified tibia</td>
<td></td>
</tr>
<tr>
<td>S87.849</td>
<td>Salter-Harris Type IV physeal fracture of lower end of unspecified tibia</td>
<td></td>
</tr>
<tr>
<td>S88</td>
<td>Traumatic amputation of lower leg</td>
<td>A: initial encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D: subsequent encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: sequla</td>
</tr>
<tr>
<td>S88.0</td>
<td>Traumatic amputation at knee level</td>
<td>A: initial encounter</td>
</tr>
<tr>
<td>S88.01</td>
<td>Complete traumatic amputation at knee level</td>
<td>D: subsequent encounter</td>
</tr>
<tr>
<td>S88.02</td>
<td>Partial traumatic amputation at knee level</td>
<td>S: sequla</td>
</tr>
<tr>
<td>S88.021</td>
<td>Partial traumatic amputation at knee level, right lower leg</td>
<td></td>
</tr>
<tr>
<td>S88.022</td>
<td>Partial traumatic amputation at knee level, left lower leg</td>
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</tr>
<tr>
<td>S88.029</td>
<td>Partial traumatic amputation at knee level, unspecified lower leg</td>
<td></td>
</tr>
<tr>
<td>S88.1</td>
<td>Traumatic amputation at level between knee and ankle</td>
<td>A: initial encounter</td>
</tr>
<tr>
<td>S88.11</td>
<td>Complete traumatic amputation at level between knee and ankle, right lower leg</td>
<td>D: subsequent encounter</td>
</tr>
<tr>
<td>S88.12</td>
<td>Complete traumatic amputation at level between knee and ankle, left lower leg</td>
<td>S: sequla</td>
</tr>
<tr>
<td>S88.119</td>
<td>Complete traumatic amputation at level between knee and ankle, unspecified lower leg</td>
<td></td>
</tr>
<tr>
<td>S88.121</td>
<td>Partial traumatic amputation at level between knee and ankle and ankle, right lower leg</td>
<td></td>
</tr>
<tr>
<td>S88.122</td>
<td>Partial traumatic amputation at level between knee and ankle, left lower leg</td>
<td></td>
</tr>
<tr>
<td>S88.129</td>
<td>Partial traumatic amputation at level between knee and ankle, unspecified lower leg</td>
<td></td>
</tr>
<tr>
<td>S88.9</td>
<td>Traumatic amputation of lower leg, level unspecified</td>
<td>A: initial encounter</td>
</tr>
<tr>
<td>S88.91</td>
<td>Complete traumatic amputation of lower leg, level unspecified</td>
<td>D: subsequent encounter</td>
</tr>
<tr>
<td>S88.911</td>
<td>Complete traumatic amputation of right lower leg, level unspecified</td>
<td>S: sequla</td>
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<tr>
<td>S88.912</td>
<td>Complete traumatic amputation of left lower leg, level unspecified</td>
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<tr>
<td>S88.919</td>
<td>Complete traumatic amputation of unspecified lower leg, level unspecified</td>
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</tr>
<tr>
<td>S88.921</td>
<td>Partial traumatic amputation of right lower leg, level unspecified</td>
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<tr>
<td>S88.922</td>
<td>Partial traumatic amputation of left lower leg, level unspecified</td>
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</tr>
<tr>
<td>S89</td>
<td>Other and unspecified injuries of lower leg</td>
<td>A: initial encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D: subsequent encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S: sequla</td>
</tr>
<tr>
<td>S89.0</td>
<td>Physical fracture of lower end of tibia</td>
<td>A: initial encounter</td>
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<tr>
<td>S89.01</td>
<td>Salter-Harris Type I physeal fracture of lower end of tibia</td>
<td>D: subsequent encounter</td>
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<td>S89.04</td>
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<td>S89.08</td>
<td>Unspecified physical fracture of lower end of tibia</td>
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<td>S89.081</td>
<td>Unspecified physical fracture of upper end of tibia</td>
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<td>S89.09</td>
<td>Partial traumatic amputation of unspecified lower end of tibia</td>
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<td>S89.1</td>
<td>Partial traumatic amputation of unspecified lower end of tibia</td>
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<td>S89.18</td>
<td>Unspecified physical fracture of lower end of tibia</td>
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<td>S89.181</td>
<td>Unspecified physical fracture of upper end of tibia</td>
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<td>S89.28</td>
<td>Unspecified physical fracture of unspecified lower end of tibia</td>
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<td>S89.281</td>
<td>Unspecified physical fracture of unspecified lower end of tibia</td>
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<td>S89.39</td>
<td>Unspecified physical fracture of unspecified lower end of tibia</td>
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