Diseases of the Circulatory System

421 Acute and subacute endocarditis

- Bacterial endocarditis (421.0-421.9)
  - Subacute bacterial endocarditis (421.0-421.9)
  - Acute bacterial endocarditis (421.1)
  - Subacute endocarditis (421.2)
  - Acute endocarditis (421.3)
  - Subacute infective endocarditis (421.4)
- Acute and subacute bacterial endocarditis
  - Endocarditis (acute and subacute)

422 Acute myocarditis

- Acute myocarditis (422.0)
- Acute myocarditis, unspecified (422.9)
- Acute myocarditis, acute or subacute (422.1)
- Acute or subacute (interstitial) myocarditis (422.2)
- Acute myocarditis, unspecified (422.9)

423 Other diseases of pericardium

- Pericarditis (acute)
  - Myocarditis (acute)
  - Pericarditis, acute and subacute (423.0)
  - Adhesive pericarditis (423.1)
  - Constrictive pericarditis (423.2)
  - Hemopericardium (423.3)
  - Cardiac tamponade (423.4)

424 Other diseases of endocardium

- Endocarditis, unspecified (424.0)
- Other specified diseases of endocardium (424.1)
- Unspecified disease of endocardium (424.2)

Cardiac Tamponade

- Normal
- Cardiac Tamponade

- Pericardial space
- Fluid accumulation

- Inflammation
  - Granulomatous
  - Non-specific granulomatous
  - Pannus
  - Vegetation
  - Leukocytic

- Fibrous adhesions

- Constrictive pericarditis
- Hemopericardium
- Cardiac tamponade

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Diseases of the Circulatory System

432–437.4 Diseases of the Circulatory System

435.9 Transient cerebral ischemia

433.3 Multiple and bilateral cerebral embolism

Requires fifth digit. Valid digits are in any condition classifiable to categories 430–435.

432–437.4 Tabular List

432 Other and unspecified intracranial hemorrhage

432.0 Nontraumatic extracranial hemorrhage

432.1 Subdural hemorrhage

432.9 Unspecified intracranial hemorrhage

433 Occlusion and stenosis of precerebral arteries

433.0 Basilar artery

433.1 Carotid artery

433.9 Other specified precerebral artery

434 Occlusion of cerebral arteries

434.0 Basilar artery syndrome

434.1 Vertebral artery syndrome

434.2 Other and unspecified intracranial hemorrhage

434.3 Subclavian steal syndrome

434.5 Other specified transient cerebral ischemia

434.6 Acute, but ill-defined, cerebrovascular disease

435 Cerebrovascular insufficiency (chronic) with transient focal neurological signs and symptoms

435.0 Basilar artery syndromes

435.1 Vertebral artery syndrome

435.2 Subclavian steal syndrome

435.3 Vertebrobasilar artery syndrome

435.4 Other specified transient cerebral ischemia

435.5 Unspecified transient cerebral ischemia

436 Other and ill-defined cerebrovascular disease

437 Cerebrovascular disease

437.0 Cerebral arteriosclerosis

437.1 Other generalized ischemic cerebrovascular disease

437.2 Hypertensive encephalopathy

437.3 Cerebral aneurysm, ruptured

437.4 Cerebral arteritis

Requires fifth-digit validity criteria under each code. See appropriate category for codes and definitions.
V Codes

V28.6 Screening for Streptococcus B

V28.8 Other specified antenatal screening

V28.81 Encounter for fetal anatomic survey

V28.82 Encounter for screening for risk of pre-term labor

V28.89 Other specified antenatal screening

V29 Observation and evaluation of newborns and infants for suspected condition not found

V29.0 Observation for suspected infectious condition

V29.1 Observation for suspected neurological condition

V29.8 Observation for other specified suspected condition

V29.81 Observation for unspecified suspected condition

Liveborn Infants According to Type of Birth (V30-V39)

V30 Single liveborn

V31 Twin, mate liveborn

V32 Twin, mate stillborn

V33 Twin, unspecified

V34 Other multiple, mates all stillborn

V35 Other multiple, mates all liveborn

V36 Other multiple, mates live and stillborn

V37 Other multiple, unspecified

V38 Unspecified

V40 Mental and behavioral problems

V40.0 Problems with learning

V40.1 Problems with communication (including speech)

V40.2 Other mental problems

V40.3 Other behavioral problems

V40.9 Unspecified mental or behavioral problem

V41 Problems with special senses and other special functions

V41.0 Problems with sight

V41.1 Other eye problems

V41.2 Problems with hearing

V41.3 Other ear problems

V41.4 Problems with voice production

V41.5 Problems with smell and taste

V41.6 Problems with swallowing and mastication

V41.7 Problems with sexual function

V41.8 Problems with special functions

V41.9 Unspecified problem with special functions

V42 Organ or tissue replaced by transplant

V42.0 Kidney

V42.1 Heart

V42.2 Heart valve

V42.3 Skin

V42.4 Bone

V42.5 Cornea

V42.6 Lung

V42.7 Liver

V42.8 Other specified organ or tissue

V42.81 Bone marrow

V42.82 Peripheral stem cells

V42.83 Pancreas

Person with a Condition Influencing their Health Status (V40-V49)

These categories are intended for use when these conditions are recorded as “diagnoses” or “problems.”

V40 Mental and behavioral problems

V40.0 Problems with learning

V40.1 Problems with communication (including speech)

V40.2 Other mental problems

V40.3 Other behavioral problems

V40.9 Unspecified mental or behavioral problem

V41 Problems with special senses and other special functions

V41.0 Problems with sight

V41.1 Other eye problems

V41.2 Problems with hearing

V41.3 Other ear problems

V41.4 Problems with voice production

V41.5 Problems with smell and taste

V41.6 Problems with swallowing and mastication

V41.7 Problems with sexual function

V41.8 Problems with special functions

V41.9 Unspecified problem with special functions

V42 Organ or tissue replaced by transplant

V42.0 Kidney

V42.1 Heart

V42.2 Heart valve

V42.3 Skin

V42.4 Bone

V42.5 Cornea

V42.6 Lung

V42.7 Liver

V42.8 Other specified organ or tissue

V42.81 Bone marrow

V42.82 Peripheral stem cells

V42.83 Pancreas

A code from the V28-V39 series may be sequenced below the V20 on the newborn medical record. Requires a fifth digit. See beginning of section V20-V29 for codes and definitions.
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
   17. Syndromes
   18. Documentation of Complications of Care

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
      c. Methicillin Resistant Staphylococcus aureus (MRSA) Conditions
   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, immunotherapy and radiation therapy
      f. Admission/encounter to determine extent of malignancy
      g. Symptoms, signs, and ill-defined conditions listed in Chapter 16 associated with neoplasms
      h. Admission/encounter for pain control/management
      i. Malignant neoplasm associated with transplanted organ
   3. Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunology 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)
      a. Pain - Category 338
      b. Glaucoma
   7. Chapter 7: Diseases of Circulatory System (390-459)
      a. Hypertension