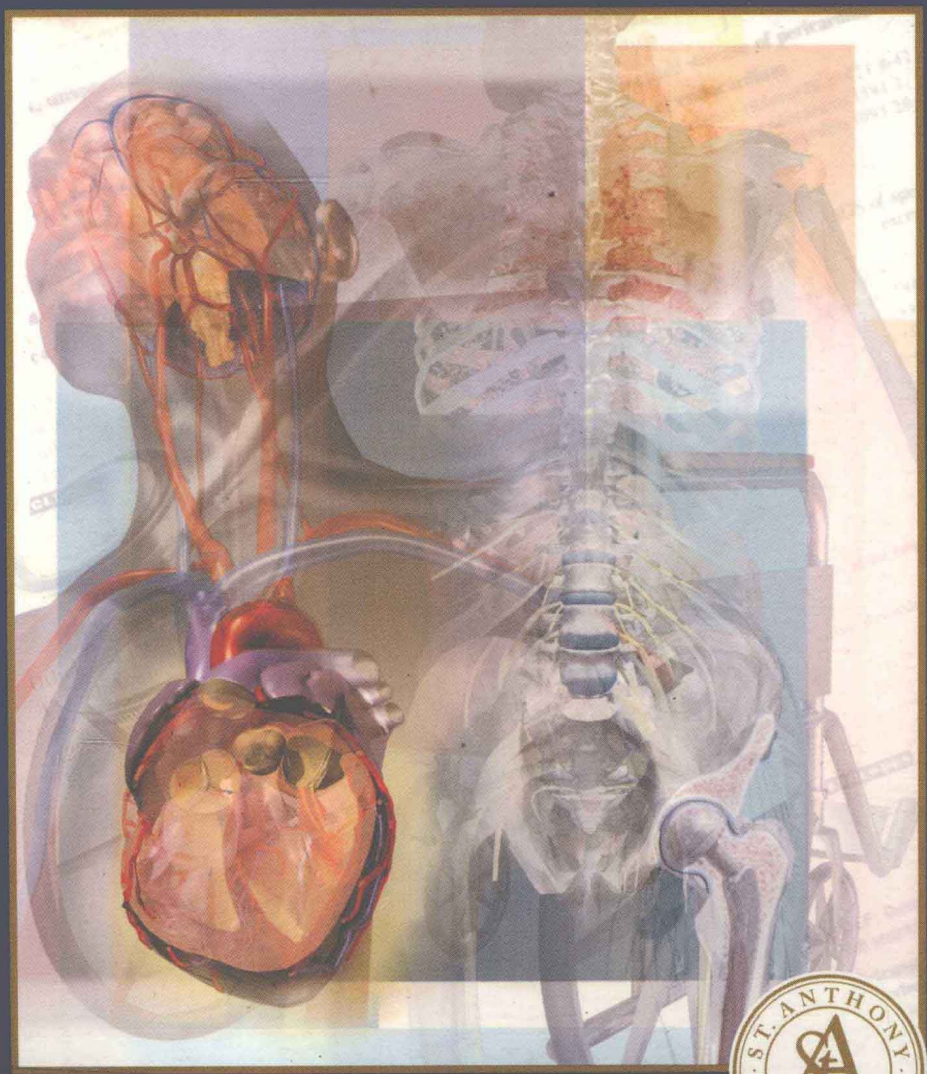
2002

ICD-9-CM EXPERT
FOR HOSPITALS, VOLUMES 1, 2 & 3



SIXTH EDITION

ST. ANTHONY PUBLISHING

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2002

ICD•9•CM

Expert for Hospitals
Volumes 1, 2, and 3

International Classification of Diseases

9th Revision

Clinical Modification

Sixth Edition

Effective October 1, 2001–September 30, 2002

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September 2001

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The codes contained in this book are the official code set issued by the U.S. Department of Health and Human Services, effective October 1, 2001 through September 30, 2002.

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- re-designed pages with intuitive symbols and color-coding
- fiscal year 2002 official ICD-9-CM codes
- summary of code changes for 2002
- new symbols indicating code changes and pages are dated to indicate when the changes occurred
- addition of the 1st and 2nd quarter 2001 AHA Coding Clinic for ICD-9-CM references
- the most current and complete official coding guidelines
- updated CC principal diagnosis exclusion list with each CC condition
- clinically-oriented illustrations
- comprehensive definitions
- check fourth- and fifth-digit symbols in the index and tabular sections
- age and sex edit symbols
- exclusive color coding and symbols for all major Medicare code edits, such as unacceptable principal diagnosis, manifestation codes, CC conditions, nonspecific diagnosis, and Medicare as secondary payer
- complex diagnosis alert
- major complication condition alert
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Cordially,

Elizabeth Boudrie

Elizabeth Boudrie
Vice President, Regulatory Services

IHEC/10/01

Preface

Since the federal government implemented diagnosis-related groups (DRGs) on October 1, 1983, medical record professionals and others have had to refer to many sources for ICD-9-CM codes and coding and reimbursement principles.

ICD-9-CM for Hospitals, Volumes 1, 2, and 3, has been designed with the hospital coder in mind. All three volumes of the most recent official government version of ICD-9-CM have been combined into one book.

Our technical experts have drawn upon their extensive hands-on experience to enhance the government's book with valuable features essential to correct coding and reimburse-ment. Without these enhancements, health information management departments would spend hours locating the information required to code each record accurately. Because of the thoroughness, accuracy, timeliness and ease of use of *ICD-9-CM for Hospitals*, health information departments nationwide have turned to them for their coding needs.

ICD-9-CM for Hospitals includes many of the enhancements described below in direct response to requests from our subscribers. As you review the content, you'll find the following:

- the complete ICD-9-CM official guidelines for coding and reporting, published by the U.S. Department of Health and Human Services and approved by the cooperating parties (American Hospital Association, American Health Infor-mation Management Association, Health Care Financing Administration and National Center for Health Statistics)
- all the official ICD-9-CM codes, indexes, notes, footnotes and symbols
- color-highlighted illustrations and clearly worded defini-tions integrated in the tabular, provide important clinical information
- exclusive color coding, symbols, and footnotes that alert coders to coding and reimbursement issues, including the majority of the Medicare code edits and identification of conditions that significantly affect DRG assignment of cardiovascular and HIV cases.
- the complication and comorbidity (CC) exclusion list, integrated beneath the applicable codes makes it easier to determine complications and comorbidities excluded with a particular principal diagnosis
- the American Hospital Association (AHA's) *Coding Clinic for ICD-9-CM* references, integrated beneath the applicable codes to provide easy reference to official coding advice as designated by the four cooperating parties (AHA, AHIMA, CMS, and NCHS)
- compliance symbol identifying diagnosis codes associated with DRGs targeted by the government for audit
- check fourth- and fifth-digit symbols identify codes that require the addition of a fourth or fifth digit for code specificity and validity
- symbols identify new codes and text revisions and pages are dated to indicate when the changes were made
- synopsis of the code changes for the current year
- color coding and symbol legend at the bottom of each page
- exclusive QuickFlip Color Tabs for quick, easy location of terms and codes in the index and tabular list

Please review "How to Use ICD-9-CM for Hospital's (Volumes 1, 2, and 3)" in this section to learn about the features that will help you assign and report correct codes, ensuring appropriate reimbursement.

USE OF OFFICIAL SOURCES

The *ICD-9-CM for Hospitals* contains the official U.S. Department of Health and Human Services, Ninth Revision, Sixth Edition ICD-9-CM codes, effective for the current year.

The color-coding, footnotes and symbols, which identify coding and reimbursement issues, are derived from official federal government sources, including the Medicare code editor (MCE).

The American Hospital Association (AHA) Coding Clinic for ICD-9-CM references are used with permission of the AHA.

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Introduction

HISTORY AND FUTURE OF ICD•9

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the official version of the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9 classifies morbidity and mortality information for statistical purposes, and for the indexing of hospital records by disease and operations, for data storage and retrieval.

This modification of ICD-9 supplants the Eighth Revision International Classification of Diseases, Adapted for Use in the United States (ICDA-8) and the Hospital Adaptation of ICDA (H-ICDA).

The concept of extending the International Classification of Diseases for use in hospital indexing was originally developed in response to a need for a more efficient basis for storage and retrieval of diagnostic data. In 1950, the U.S. Public Health Service and the Veterans Administration began independent tests of the International Classification of Diseases for hospital indexing purposes. The following year, the Columbia Presbyterian Medical Center in New York City adopted the International Classification of Diseases, Sixth Revision, with some modifications for use in its medical record department. A few years later, the Commission on Professional and Hospital Activities (CPHA) in Ann Arbor, Mich., adopted the International Classification of Diseases with similar modifications for use in hospitals participating in the Professional Activity Study.

The problem of adapting ICD for indexing hospital records was taken up by the U.S. National Committee on Vital and Health Statistics through its subcommittee on hospital statistics. The subcommittee reviewed the modifications made by the various users of ICD and proposed that uniform changes be made. This was done by a small working party.

In view of the growing interest in the use of the International Classification of Diseases for hospital indexing, a study was undertaken in 1956 by the American Hospital Association and the American Medical Record Association (then the American Association of Medical Record Librarians) of the relative efficiencies of coding systems for diagnostic indexing. This study indicated the International Classification of Diseases provided a suitable and efficient framework for indexing hospital records. The major users of the International Classification of Diseases for hospital indexing purposes then consolidated their experiences, and an adaptation was first published in December 1959. A revision was issued in 1962 and the first "Classification of Operations and Treatments" was included.

In 1966, the international conference for revising the International Classification of Diseases noted the eighth revision of ICD had been constructed with hospital indexing in mind and considered the revised classification suitable, in itself, for hospital use in some countries. However, it was recognized that the basic classification might provide inadequate detail for diagnostic indexing in other countries. A group of consultants was asked to study the eighth revision of ICD (ICD-8) for applicability to various users in the United States. This group recommended that further detail be provided for coding of hospital and morbidity data. The American Hospital Association was requested to develop the needed adaptation proposals. This was done by an advisory committee (the Advisory Committee to the Central Office on ICDA). In 1968 the United States Public Health Service published the product, Eighth Revision International Classification of Diseases, Adapted for Use in the United States. This became commonly known as ICDA-8, and beginning in 1968 it served as the basis for coding diagnostic data for both official morbidity and mortality statistics in the United States.

In 1968, the CPHA published the Hospital Adaptation of ICDA (H-ICDA) based on both the original ICD-8 and ICDA-8. In 1973, CPHA published a revision of H-ICDA, referred to as H-ICDA-2. Hospitals throughout the United States were divided

in their use of these classifications until January 1979, when ICD-9-CM was made the single classification intended primarily for use in the United States, replacing these earlier related, but somewhat dissimilar, classifications.

Physicians have been required by law to submit diagnosis codes for Medicare reimbursement since the passage of the Medicare Catastrophic Coverage Act of 1988. This act requires physician offices to include the appropriate diagnosis codes when billing for services provided to Medicare beneficiaries on or after April 1, 1989. The Health Care Financing Administration designated ICD-9-CM as the coding system physicians must use.

In 1993 the World Health Organization published the newest version of International Classification of Diseases, Tenth Revision, ICD-10. This version contains the greatest number of changes in the history of ICD. There are more codes (5,500 more than ICD-9) to allow more specific reporting of diseases and newly recognized conditions. ICD-10 consists of three volumes; tabular list (volume I), instructions (volume 2) and the alphabetic index (volume 3). It contains 21 chapters including two supplementary ones. The codes are alphanumeric (A00–T98, V01–Y98 and Z00–Z99). Currently ICD-10 is being used in some European countries with implementation expected after the year 2000 in the United States.

ICD-9-CM BACKGROUND

In February 1977, a steering committee was convened by the National Center for Health Statistics to provide advice and counsel in developing a clinical modification of ICD-9. The organizations represented on the steering committee included the following:

- American Association of Health Data Systems
- American Hospital Association
- American Medical Record Association
- Association for Health Records
- Council on Clinical Classifications
- Centers for Medicare and Medicaid Services (formerly known as Health Care Financing Administration,) Department of Health and Human Services
- WHO Center for Classification of Diseases for North America, sponsored by the National Center for Health Statistics, Department of Health and Human Services

The Council on Clinical Classifications was sponsored by the following:

- American Academy of Pediatrics
- American College of Obstetricians and Gynecologists
- American College of Physicians
- American College of Surgeons
- American Psychiatric Association
- Commission on Professional and Hospital Activities

The steering committee met periodically in 1977. Clinical guidance and technical input were provided by task forces on classification from the Council on Clinical Classification's sponsoring organizations.

ICD-9-CM is a clinical modification of the World Health Organization's ICD-9. The term "clinical" is used to emphasize the modification's intent: to serve as a useful tool to classify morbidity data for indexing medical records, medical care review, and ambulatory and other medical care programs, as well as for basic health statistics. To describe the clinical picture of the patient, the codes must be more precise than those needed only for statistical groupings and trend analysis.

CHARACTERISTICS OF ICD-9-CM

ICD-9-CM far exceeds its predecessors in the number of codes provided. The disease classification has been expanded to include health-related conditions and to provide greater specificity at the fifth-digit level of detail. These fifth digits are not optional; they are intended for use in recording the information substantiated in the clinical record.

Volume I (tabular list) of ICD-9-CM contains five appendices:

Appendix A:	Morphology of Neoplasms
Appendix B:	Glossary of Mental Disorders
Appendix C:	Classification of Drugs by American Hospital

Formulary Service List Number and Their ICD-9-CM Equivalents

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.

Volume 3 (procedure index and procedure tabular) of ICD-9-CM contains codes for operations and procedures. The format for the tabular is the same as volume 1 disease tabular, except the codes consist of two digits with one or two digits following the decimal point. Conventions in the index follow volume 2 conventions except some subterms appear immediately below the main term rather than following alphabetizing rules

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 optional manifestation code appears in brackets (e.g., diabetic cataract 250.5 [366.41]).

How to Use the ICD•9•CM for Hospitals (Voumes 1, 2, & 3)

This *ICD-9-CM for Hospitals* is based on the official version of the International Classification of Diseases, Ninth Revision, Clinical Modification, Sixth Edition, issued by the U.S. Department of Health and Human Services. Annual code changes are implemented by the government and are effective Oct. 1 and valid through Sept. 30 of the following year.

The code book is totally compatible with its parent system, ICD-9, thus meeting the need for comparability of morbidity and mortality statistics at the international level.

This book is consistent with the content of the government's version of ICD-9-CM. However, to accommodate the coder's approach to coding, the alphabetic index has been placed before the tabular list in both the disease and procedure classifications. This allows the user to locate the correct codes in a logical, natural manner by locating the term in the index, then confirming the accuracy of the code in the tabular list.

STEPS TO CORRECT CODING

1. Look up the main term in the alphabetic index and scan the subterm entries as appropriate. Follow any cross-references such as "see" and "see also." Do not code from the alphabetic index without verifying the accuracy of the code in the tabular list.
2. Locate the code in the numerically arranged tabular list.
3. Observe the punctuation, footnotes, cross-references, color-coded prompts and other conventions described in the 'Conventions' section.
4. To determine the appropriateness of the code selection, read all instructional material:
   - "includes" and "*excludes*" notes
   - "*see*," "*see also*" and "*see category*" cross-references
   - "use additional code" and "*code first underlying disease*" instructions
   - "code also" and "*omit code*" notes
   - fourth- and fifth-digit requirements
   - CC exclusions
5. Consult definitions, relevant illustrations, CC exclusions, color coding and reimbursement prompts, the check fourth- and fifth-digit, age and sex symbols. Refer to the color/symbol legend at the bottom of each page for symbols. Refer to the list of footnotes that is included in the "Additional Conventions" section of this book for a full explanation of a footnote associated with a code.
6. Consult the official ICD-9-CM guidelines for coding and reporting, and refer to the AHA's Coding Clinic for ICD-9-CM for coding guidelines governing the use of specific codes.
7. Confirm and transcribe the correct code.

ORGANIZATION

Introduction

The introductory material in this book includes the history and future of ICD-9-CM as well as an overview of the classification system

Official ICD-9-CM Conventions

This section provides a full explanation of all the official footnotes, symbols, instructional notes, and conventions found in the official government version

Additional Conventions

Exclusive color-coding, symbols, and notations have been included in the *ICD-9-CM for Hospitals*, Volumes 1, 2 & 3, to alert coders to important coding and reimbursement issues. This section provides a full explanation of the additional conventions used throughout this book.

Coding Guidelines
Included in this book are the official ICD-9-CM coding guidelines as approved by the four cooperating parties of the ICD-9-CM Coordination and Maintenance Committee. Failure to comply with the official coding guidelines may result in denied or delayed claims.

Synopsis of Code Changes
This section includes a complete listing of all new code changes for the current year.

Disease Classification: Alphabetic Index to Diseases
The Alphabetic Index to Diseases is separated by tabs labeled with the letters of the alphabet, contains diagnostic terms for illnesses, injuries and reasons for encounters with health care professionals. Both the Table of Drugs and Chemicals and the Alphabetic Index to External Causes of Injury and Poisoning are easily located with the tabs in this section.

Disease Classification: Tabular List of Diseases
The Tabular List of Diseases arranges the ICD-9-CM codes and descriptors numerically. Tabs divide this section into chapters, identified by the code range on the tab.

The tabular list includes two supplementary classifications:

- V Codes—Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01–V82)
- E Codes—Supplementary Classification of External Causes of Injury and Poisoning (E800–E999)

ICD-9-CM includes five official appendixes.

- Appendix A — Morphology of Neoplasms
- Appendix B — Glossary of Mental Disorders
- Appendix C — Classification of Drugs by AHFS 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 circumstances, help further define a diagnostic statement, maintain a tumor registry and aid in classifying new drugs.

Procedure Classification: Alphabetic Index to Procedures
The Alphabetic Index to Procedures lists common surgical and procedural terminology.

Procedure Classification: Tabular List of Procedures
The Tabular List of Procedures numerically arranges the procedure codes and their descriptors.

RESOURCES

Listed below are the exclusive resources found ONLY in the ICD-9-CM Expert for Hospitals, Volumes 1, 2 & 3 books.

Dx/MDC/DRG List
Provides the complete list of diagnosis codes and the MDC and DRG to which they group, except when a secondary diagnosis affects DRG assignment for a quick audit.

CC Condition List
A complete list of all codes considered CC (Complications and Comorbidities) that will affect DRG assignment. This an essential auditing tool for assigning the most appropriate DRG.

Pharmacological Listings
The most common generic and brand names of drugs are linked with the disease processes to assist in the identification of CC, thereby improving DRG assignment practices.

Valid Three-digit Code Table
ICD-9-CM is composed of codes with either 3, 4, or 5 digits. A code is invalid if it has not been coded to the full number of digits required for that code. There are a certain number codes that are valid for reporting as three digit codes. A list of the valid three-digit code is included as a convenient reference when auditing claims.

ICD•9•CM for Official Conventions

ICD-9-CM FOOTNOTES, SYMBOLS, INSTRUCTIONAL NOTES AND CONVENTIONS

This *ICD-9-CM for Hospitals* preserves all the footnotes, symbols, instructional notes and conventions found in the government's official version. Accurate coding depends upon understanding the meaning of these elements.

The following appear in the disease tabular list, unless otherwise noted.

OFFICIAL GOVERNMENT SYMBOLS

§ The section mark preceding a code denotes a footnote on the page. This symbol is used in the Tabular List of Diseases and in the Tabular List of Procedures.

ICD-9-CM CONVENTIONS USED IN THE TABULAR LIST

In addition to the symbols and footnotes above, the ICD-9-CM disease tabular has certain abbreviations, punctuation, symbols and other conventions. Our *ICD-9-CM for Hospitals* preserves these conventions. Proper use of the conventions will lead to efficient and accurate coding.

Abbreviations

NEC **Not elsewhere classifiable**

This abbreviation is used when the ICD-9-CM system does not provide a code specific for the patient's condition.

NOS **Not otherwise specified**

This abbreviation is the equivalent of 'unspecified' and is used only when the coder lacks the information necessary to code to a more specific four-digit subcategory.

[ ] Brackets enclose synonyms, alternative terminology or explanatory phrases:

482.2 Pneumonia due to Hemophilus influenzae [H. influenzae]

( ) Parentheses enclose supplementary words, called nonessential modifiers, that may be present in the narrative description of a disease without affecting the code assignment:

198.4 Other parts of nervous system
Meninges (cerebral) (spinal)

: Colons are used in the tabular list after an incomplete term that needs one or more of the modifiers that follow in order to make it assignable to a given category:

021.1 Enteric tularemia
Tularemia:
cryptogenic
intestinal
typhoidal

} Braces enclose a series of terms, each of which is modified by the statement appearing to the right of the brace:

560.2 Volvulus

Knotting
Strangulation
Torsion
Twist
} of intestine, bowel, or colon

OTHER CONVENTIONS

Boldface Boldface type is used for all codes and titles in the tabular list.

Italicized Italicized type is used for all exclusion notes and to identify codes that should not be used for describing the primary diagnosis.

INSTRUCTIONAL NOTES

These notes appear only in the Tabular List of Diseases

Includes An includes note further defines or clarifies the content of the chapter, subchapter, category, subcategory or subclassification. The includes note in the example below applies only to category 461.

Excludes Terms following the word "*Excludes*" are not classified to the chapter, subchapter, category, subcategory or specific subclassification code under which it is found. The note also may provide the location of the excluded diagnosis. Excludes notes are italicized.

461 Acute sinusitis

INCLUDES
abscess
empyema
infection
inflammation
suppuration
} acute, of sinus (accessory) (nasal)

EXCLUDES *chronic or unspecified sinusitis (473.0-473.9)*

Use additional code:

This instruction signals the coder that an additional code should be used if the information is available to provide a more complete picture of that diagnosis.

330 Cerebral degenerations usually manifest in childhood
Use additional code to identify
associated mental retardation

Code first underlying disease:

This instruction is used in those categories not intended for primary tabulation of disease. These codes, called manifestation codes, may never be used alone or indicated as the primary diagnosis (i.e., sequenced first). They must always be preceded by another code.

The code and its descriptor appear in italics in the tabular list. The instruction "Code first underlying disease" is usually followed by the code or codes for the most common underlying disease (etiology). Record the code for the etiology or origin of the disease, and then record the italicized manifestation code in the next position.

590.81 Pyelitis or pyelonephritis in diseases classified elsewhere
Code first underlying disease as:
tuberculosis (016.0)

Omit code

"*Omit code*" is used to instruct the coder that no code is to be assigned. When this instruction is found in the Alphabetic Index to Diseases the medical term should not be coded as a diagnosis.

Metaplasia
cervix—*omit code*

When used in Volume 3, 'omit code' is meant to indicate procedures that do not merit separate code assignments, such as minor procedures preformed in conjunction with more extensive procedures or procedures that represent an operative approach.

Arthrotomy 80.10
as operative approach—*omit code*

Additional Conventions

NEW AND REVISED TEXT SYMBOLS

- ● A bullet at a code or line of text indicates that that the entry is new.
- ▲ A triangle in the Tabular List indicates that the code title is revised. In the Alphabetic Index the triangle indicates that a code has changed.
- ▶◀ These symbols appear at the beginning and at the end of a section of new or revised text.

When these symbols appear on a page there will be a date on the lower outside corner of the page indicating the date of the change, (e.g., October 2001).

ADDITIONAL DIGITS REQUIRED

- ✓3rd This symbol indicates that the code requires a third digit.
- ✓4th This symbol indicates that the code requires a fourth digit.
- ✓5th This symbol indicates that a code requires a fifth digit.

DEFINITIONS

DEF: This symbol indicates a definition of disease or procedure term. The definition will appear in blue type in the Disease Tabular Lists.

AHA *CODING CLINIC FOR ICD-9-CM* REFERENCES

The four cooperating parties have designated the AHA's Coding Clinic for ICD-9-CM as the official publication for coding guidelines. The references are identified by the notation AHA: followed by the issue, year and page number.

In the example below, AHA Coding Clinic for ICD-9-CM, third quarter 1991, page 15, contains a discussion on code assignment for vitreous hemorrhage:

379.23 Vitreous hemorrhage
AHA: 3Q, '91, 15

The table below explains the abbreviations in the Coding Clinic references:

J-F	January/February
M-A	March/April
M-J	May/June
J-A	July/August
S-O	September/October
N-D	November/December
1Q	First quarter
2Q	Second quarter
3Q	Third quarter
4Q	Fourth quarter

MEDICARE CODE EDITS

Fiscal intermediaries use the Medicare code editor (MCE) to check the coding accuracy on claims. The Medicare code edits are listed below:

1. Invalid diagnosis or procedure code
2. E-code as principal diagnosis
3. Duplicate of principal diagnosis (PDx) (as applied to a secondary diagnosis)
* 4. Age conflict
* 5. Sex conflict
* 6. Manifestation code as principal diagnosis
* 7. Nonspecific principal diagnosis
* 8. Questionable admission
*9. Unacceptable principal diagnosis
*10. Nonspecific OR procedure
*11. Noncovered procedure
12. Open biopsy check
*13. Medicare as secondary payer (MSP alert)
*14. Bilateral procedure
15. Invalid age
16. Invalid sex
17. Invalid discharge status

Starred edits are identified by colors, symbols or footnotes as described on the next page.

Age and Sex Edit Symbols

The age edits below address OCE edits and are used to detect inconsistencies between the patient's age and diagnosis. They

appear in the Tabular List of Diseases to the right of the code description.

Newborn Age: 0

These diagnoses are intended for newborns and neonates and the patient's age must be 0 years

Pediatric Age: 0-17

These diagnoses are intended for children and the patient's age must between 0 and 17 years

Maternity Age: 12-55

These diagnoses are intended for the patients between the age of 12 and 55 years

Adult Age: 15-124

These diagnoses are intended for the patients between the age of 15 and 124 years.

The sex symbols below address MCE edits and are used to detect inconsistencies between the patient's sex and diagnosis. They appear in the Tabular Lists to the right of the code description:

♂ **Male diagnosis only**

This symbol appears to the right of the code description. This reference appears in the disease tabular list.

♀ **Female diagnosis only**

This symbol appears to the right of the code description. This reference appears in the disease tabular list.

Color Coding

For a quick reference to the color codes and their meaning, refer to the color/symbol legend located at the bottom of each page.

To alert the coder to important reimbursement issues affected by the code assignment, color bars have been added. The colors represent Medicare code edits as well as other reimbursement issues.

Color coding appears in both tabular lists. Some codes carry more than one color. Please note that the same color may appear in the disease and procedure tabular lists, but with different meanings.

Disease Tabular List

Manifestation Code

These codes will appear in italic type as well as with a blue color bar over the code title. A manifestation code is not allowed to be reported as a primary diagnosis because each describes a manifestation of some other underlying disease, not the disease itself. This is also referred to as mandatory multiple coding. Code the underlying disease first. A Code first underlying disease instructional note will appear with underlying disease codes identified. In the Alphabetic Index these codes are listed as the secondary code in slanted bracket with the code for the underlying disease listed first. Medicare code edit (MCE) 6

Unacceptable PDx

These codes will appear with a gray color bar over the code title. These codes do not describe a current illness or injury, but a circumstance which influences a patient's health status. These are considered an unacceptable principal diagnosis for inpatient admission. Medicare code edit (MCE) 9

Questionable Admission

These codes will also appear with a gray color bar over the code title. These codes identify a condition that usually is insufficient justification for hospital admission. Since these codes are considered an unacceptable principal diagnoses for inpatient admission, they are color coded in the same manner as the "unacceptable PDx codes". Medicare code edit (MCE) 8

Nonspecific PDx

These codes will have a yellow color bar over the code title. While these codes are considered valid ICD-9-CM codes, for inpatients discharged alive a more specific principal diagnosis should be assigned. These codes are used when the neither the diagnostic statement nor the documentation provides enough information to assign a more specified diagnosis code. These codes may be stated as "Unspecified" or "Not otherwise specified (NOS)." Medicare code edit (MCE) 7

Procedure Tabular List

Non-specific OR Procedure

While this code is a valid unspecific or not otherwise specified (NOS) procedure code, a more precise code should be used. The code is recognized as a nonspecific operating

room procedure ONLY if ALL OR procedures performed are coded NOS. Medicare Code Edit (MCE 10)

Valid OR
A procedure that triggers a change in DRG assignment.

Non-OR Procedure
A non-operating room procedure that affects DRG assignment.

Footnotes

All footnotes are identified by a numerical superscript that appears to the upper left of the code:

[1]718.5 Ankylosis of joint

The footnote 1 indicates "Nonspecific PDx = 0". This mans that when code 718.50, Ankylosis of the joint, site unspecified, the diagnosis is considered a nonspecific principal diagnosis. While this code may be valid according to ICD-9-CM, a more precise diagnosis should be used for the principal diagnosis for inpatient admission.

The following list identifies the meaning of each footnote number and the classification in which the footnote appears:

Disease Tabular

1 Nonspecific PDx = 0

2 Nonspecific PDx = 9

3 These V codes may be used as principal diagnosis on Medicare patients.

4 This V code, with the fourth digit of 1 or 2, is unacceptable as a principal diagnosis.

5 These codes, with the fourth digit of 0 or 1, may be used as a principal diagnosis for Medicare patients.

6 Rehabilitation codes acceptable as a principal diagnosis when accompanied by a secondary diagnosis reflecting the condition treated.

7 These V codes are acceptable as principal diagnosis when accompanied by a diagnosis of personal history of malignancy. These codes group to DRG 465.

8 Questionable admission = 0

9 The codes with fifth-digit of 1 are considered a major complication condition that causes DRG assignment from DRG 121 to DRG 122.

Procedure Tabular

10 Valid OR procedure code if accompanied by one of the following codes: 37.80, 37.81, 37.82, 37.85, 37.86, 37.87.

11 Valid OR procedure code if accompanied by one of the following codes: 37.80, 37.83.

12 Valid OR procedure code if accompanied by one of the following codes: 37.80, 37.85, 37.86, 37.87.

13 Valid OR procedure code if accompanied by any one of the following codes: 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87.

14 Valid OR procedure code if accompanied by any other pacemaker procedure except 37.72, 37.76.

15 Valid OR procedure code if accompanied by any other pacemaker procedure except 37.70, 37.71, 37.73, 37.76.

16 Nonspecific OR procedure = 0.

17 Noncovered procedure only if none of the following codes are present as either a principal or secondary diagnosis: 200.00-202.08, 202.80-202.98, 204.01, 205.01, 206.01, 207.01, 208.01.

18 Noncovered procedure only if none of the following codes are present as either a principal or secondary diagnosis: 204.00-208.91, 279.12, 279.2, 284.0-284.9

19 Noncovered procedure unless diagnosis code is present from 250.00–250.93 and 585, V42.0 or V43.89

Other Notations

Disease Tabular

CC Exclusion List
A exclusive feature of *ICD-9-CM for Hospitals* is the integration of the government's CC exclusion list with each affected code.

The CC exclusion list indicates secondary diagnosis codes that are excluded as CC conditions with certain principal diagnoses. This exclusion occurs because the cited conditions are