International Classification of Diseases
9th Revision, Clinical Modification

2009
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ICD-9-CM
Volumes 1 & 2

Codes valid for use October 1, 2008 – September 30, 2009

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1	*shoulder region*
2	*upper arm*
3	*forearm*
4	*hand*
5	*pelvic region and thigh*
6	*lower leg*
7	*ankle and foot*
8	*other specified sites*
9	*multiple sites*

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5 **361.1 Retinoschisis and retinal cysts**
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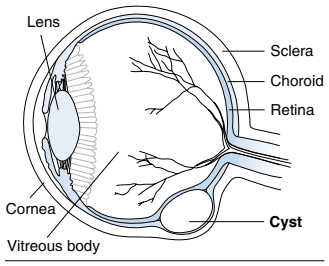
✖ **361.10 Retinoschisis, unspecified**
361.11 Flat retinoschisis
361.12 Bullous retinoschisis
361.13 Primary retinal cysts

Retinal cysts



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Retinal detachment without retinal defect
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5 **361.3 Retinal defects without detachment**
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✖ **361.30 Retinal defect, unspecified**
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361.31 Round hole of retina without detachment
361.32 Horseshoe tear of retina without detachment
Operculum of retina without mention of detachment
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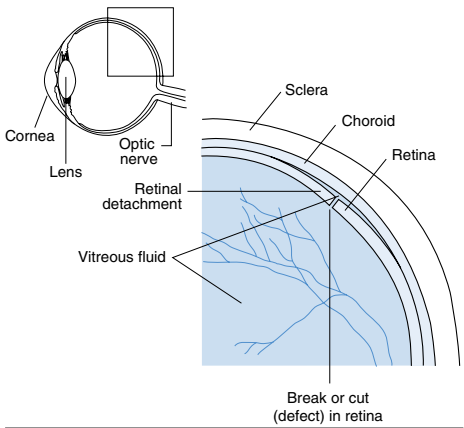
5 **361.8 Other forms of retinal detachment**

Retinal detachment



361.81 Traction detachment of retina
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✖ **361.89 Other**
AHA: 3Q 1999, 12

✖ **361.9 Unspecified retinal detachment**
AHA: Nov-Dec 1987, 10

4 **362 Other retinal disorders**
Excludes *chorioretinal scars (363.30-363.35)*
chorioretinitis (363.0-363.2)

5 **362.0 Diabetic retinopathy**
Code first diabetes (▶249.5,◀ 250.5)
AHA: 4Q 2005, 65; 3Q 1991, 8; 4Q, 2007, 156

+ ***362.01 Background diabetic retinopathy***
Diabetic retinal microaneurysms
Diabetic retinopathy NOS
+ ***362.02 Proliferative diabetic retinopathy***
AHA: 3Q 1996, 5;
+ ***362.03 Nonproliferative diabetic retinopathy NOS***
AHA: 4Q, 2007, 14
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AHA: 4Q, 2007, 14
+ ***362.05 Moderate nonproliferative diabetic retinopathy***
AHA: 4Q, 2007, 14
+ ***362.06 Severe nonproliferative diabetic retinopathy***
AHA: 4Q 2005, 67; 4Q, 2007, 14
+ ***362.07 Diabetic macular edema***
Diabetic retinal edema
Note: *Code 362.07 must be used with a code for diabetic retinopathy (362.01-362.06)*

Coding Guidelines Note: *Code 362.07, is only present with diabetic retinopathy. Another code from subcategory 362.0x, must be used with code 362.07. Codes under subcategory 362.0x are diabetes manifestation codes, so they must be used following the appropriate diabetes code. OG Ref I.C.3.a.4.a*

AHA: 4Q, 2007, 14, 156

5 **362.1 Other background retinopathy and retinal vascular changes**
✖ **362.10 Background retinopathy, unspecified**
AHA: 1Q 2006, 12
362.11 Hypertensive retinopathy
Coding Guidelines Note: *Two codes are necessary to identify hypertensive retinopathy. First assign the code 362.11, Hypertensive retinopathy, then the appropriate code from categories 401-405 to indicate the type of hypertension. OG Ref I.C.7.a.6*
AHA: 3Q 1990, 3; 4Q, 2007, 164
362.12 Exudative retinopathy
Coats' syndrome
AHA: 3Q 1999, 12
362.13 Changes in vascular appearance
Vascular sheathing of retina
Use additional code for any associated atherosclerosis (440.8)
362.14 Retinal microaneurysms NOS
362.15 Retinal telangiectasia
362.16 Retinal neovascularization NOS
Neovascularization:
choroidal subretinal
✖ **362.17 Other intraretinal microvascular abnormalities**
Retinal varices
362.18 Retinal vasculitis
Eales' disease
Retinal:
arteritis perivasculitis
endarteritis phlebitis

5 **362.2 Other proliferative retinopathy**
DEF: Abnormal blood vessel development and acute retinal changes in premature infants.

● ✖ **362.20 Retinopathy of prematurity, unspecified** N
Retinopathy of prematurity NOS
362.21 Retrolental fibroplasia
▶Cicatricial retinopathy of prematurity◀
DEF: Abnormal development of retinal blood vessels into the clear gel at the back of the eye in premature infants, causing scar tissue formation and retinal loosening or detachment.

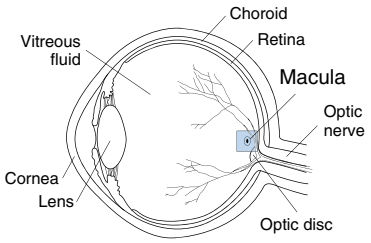
● **362.22 Retinopathy of prematurity, stage 0** N
● **362.23 Retinopathy of prematurity, stage 1** N
● **362.24 Retinopathy of prematurity, stage 2** N
● **362.25 Retinopathy of prematurity, stage 3** N
● **362.26 Retinopathy of prematurity, stage 4** N
● **362.27 Retinopathy of prematurity, stage 5** N
✖ **362.29 Other nondiabetic proliferative retinopathy**
AHA: 3Q 1996, 5

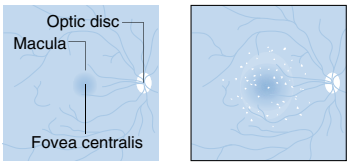
5 **362.3 Retinal vascular occlusion**
✖ **362.30 Retinal vascular occlusion, unspecified**
362.31 Central retinal artery occlusion
362.32 Arterial branch occlusion
362.33 Partial arterial occlusion
Hollenhorst plaque
Retinal microembolism
362.34 Transient arterial occlusion
Amaurosis fugax
AHA: 1Q 2000, 16
362.35 Central retinal vein occlusion
AHA: 2Q 1993, 6
362.36 Venous tributary (branch) occlusion
362.37 Venous engorgement
Occlusion:
of retinal vein
incipient of retinal vein
partial of retinal vein

5 **362.4 Separation of retinal layers**
Excludes *retinal detachment (serous) (361.2)*
rhegmatogenous (361.00-361.07)
✖ **362.40 Retinal layer separation, unspecified**
362.41 Central serous retinopathy
DEF: Fluid seepage from the choroid into the retina, causing the retinal layers to fill and separate from each other.
362.42 Serous detachment of retinal pigment epithelium
Exudative detachment of retinal pigment epithelium
362.43 Hemorrhagic detachment of retinal pigment epithelium

5 **362.5 Degeneration of macula and posterior pole**
Excludes *degeneration of optic disc (377.21-377.24)*
hereditary retinal degeneration [dystrophy] (362.70-362.77)
✖ **362.50 Macular degeneration (senile), unspecified**

Macular degeneration





Normal Macular degeneration

362.51 Nonexudative senile macular degeneration
Senile macular degeneration:
atrophic dry
362.52 Exudative senile macular degeneration
Kuhnt-Junius degeneration
Senile macular degeneration:
disciform wet
362.53 Cystoid macular degeneration
Cystoid macular edema
362.54 Macular cyst, hole, or pseudohole
362.55 Toxic maculopathy
Use additional E code to identify drug, if drug induced
362.56 Macular puckering
Preretinal fibrosis
362.57 Drusen (degenerative)
DEF: Small, bright deposits or accumulations of material seen in the retina and/or optic disc that are associated with a variety of eye diseases including macular degeneration, hereditary retinal degeneration, and loss of peripheral vision.

5 **362.6 Peripheral retinal degenerations**
Excludes *hereditary retinal degeneration [dystrophy] (362.70-362.77)*
retinal degeneration with retinal defect (361.00-361.07)
✖ **362.60 Peripheral retinal degeneration, unspecified**
362.61 Paving stone degeneration
362.62 Microcystoid degeneration
Blessig's cysts
Iwanoff's cysts
362.63 Lattice degeneration
Palisade degeneration of retina
362.64 Senile reticular degeneration
362.65 Secondary pigmentary degeneration
Pseudoretinitis pigmentosa
362.66 Secondary vitreoretinal degenerations

5 **362.7 Hereditary retinal dystrophies**
✖ **362.70 Hereditary retinal dystrophy, unspecified**
✚ ***362.71 Retinal dystrophy in systemic or cerebroretinal lipidoses***
Code first underlying disease, as:
cerebroretinal lipidoses (330.1)
systemic lipidoses (272.7)
✚✖ ***362.72 Retinal dystrophy in other systemic disorders and syndromes***
Code first underlying disease, as:
Bassen-Kornzweig syndrome (272.5)
Refsum's disease (356.3)
362.73 Vitreoretinal dystrophies
Juvenile retinoschisis
362.74 Pigmentary retinal dystrophy
Retinal dystrophy, albipunctate
Retinitis pigmentosa
✖ **362.75 Other dystrophies primarily involving the sensory retina**
Progressive cone (-rod) dystrophy
Stargardt's disease
DEF: Stargardt's disease: genetic condition causing degeneration of the macula, occurring by age 20, with rapid loss of visual acuity and abnormal pigmentation of the macula.
362.76 Dystrophies primarily involving the retinal pigment epithelium
Fundus flavimaculatus
Vitelliform dystrophy
362.77 Dystrophies primarily involving Bruch's membrane
Dystrophy:
hyaline
pseudoinflammatory foveal
Hereditary drusen

5 **V26.4 General counseling and advice**

Coding Guidelines Note: If the purpose of genetic counseling is associated with procreative management, a code from V26.3 should be assigned as the primary code, followed by a code from category V84. Any additional codes would be assigned if there is a family/personal history. (OG Ref I.C.18.d.3)

AHA: 4Q, 2007, 201, 208

V26.41 Procreative counseling and advice using natural family planning
AHA: 4Q, 2007, 35, 99

✖ **V26.49 Other procreative management counseling and advice**
AHA: 4Q, 2007, 35

5 **V26.5 Sterilization status**

Coding Guidelines Note: A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. (OG Ref I.C.18.d.3)

AHA: 4Q, 2007, 194, 208

V26.51 Tubal ligation status ♀ 2
Excludes *infertility not due to previous tubal ligation (628.0-628.9)*
AHA: 4Q, 2007, 35

V26.52 Vasectomy status ♂ 2
AHA: 4Q, 2007, 35

5 **V26.8 Other specified procreative management**
AHA: 4Q, 2007, 100

V26.81 Encounter for assisted reproductive fertility procedure cycle ♀ I
Patient undergoing in vitro fertilization cycle
Use additional code to identify the type of infertility
Excludes *pre-cycle diagnosis and testing – code to reason for encounter*
AHA: 4Q, 2007, 35, 99-100, 208

✖ **V26.89 Other specified procreative management**
AHA: 4Q, 2007, 35, 208

✖ **V26.9 Unspecified procreative management**
AHA: 4Q, 2007, 208

4 **V27 Outcome of delivery**
Note: This category is intended for the coding of the outcome of delivery on the mother's record.

Coding Guidelines Note: These codes are not to be used on subsequent maternal records or on the newborn record. (OG Ref I.C.11.a.5)

When an attempted termination of pregnancy results in a liveborn fetus assign code 644.21, with an appropriate code from category V27. The procedure code for the attempted termination of pregnancy should also be assigned. (OG Ref I.C.11.k.4)

The outcome of delivery should be included on all maternal delivery records. (OG Ref I.C.18.d.10)

AHA: 2Q 1991, 16; 4Q, 2007, 178, 202, 238

V27.0 Single liveborn ♀ M 2
AHA: 4Q 2005, 81; 2Q 2003, 9; 2Q 2002, 10; 1Q 2001, 10; 3Q 2000, 5; 4Q 1998, 77; 4Q 1995, 59; 1Q 1992, 9

Coding Guidelines Note: This code is the only outcome of delivery code appropriate for use with 650. (OG Ref I.C.11.c.3)

V27.1 Single stillborn ♀ M 2

V27.2 Twins, both liveborn ♀ M 2

V27.3 Twins, one liveborn and one stillborn ♀ M 2

V27.4 Twins, both stillborn ♀ M 2

✖ **V27.5 Other multiple birth, all liveborn** ♀ M 2

✖ **V27.6 Other multiple birth, some liveborn** ♀ M 2

✖ **V27.7 Other multiple birth, all stillborn** ♀ M 2

✖ **V27.9 Unspecified outcome of delivery** ♀ M 2

4 **V28 Encounter for antenatal screening of mother**
Excludes *abnormal findings on screening-code to findings*
▶*suspected fetal conditions affecting management of pregnancy (655.00-655.93, 656.00-656.93, 657.00-657.03, 658.00-658.93)*◀
▶*suspected fetal conditions not found (V89.01-V89.09)*◀

Coding Guidelines Note: A screening code is listed as the primary code if the reason for the visit is a screening exam, but is not necessary if the screening is adherent to a routine examination. It may be used as an additional code if the screening is done during an office visit for other health problems. Should a condition be discovered during the screening, the code for the condition may be assigned as an additional diagnosis. The V code indicates that a screening exam is planned. (OG Ref I.C.18.d.5)

Use category V28 in those circumstances when none of the problems or complications included in the codes from the Obstetrics chapter exist. (OG Ref I.C.18.d.11)

AHA: 1Q 2004, 11; 4Q, 2007, 197. 202, 208, 238

V28.0 Screening for chromosomal anomalies by amniocentesis ♀ M

V28.1 Screening for raised alpha-fetoprotein levels in amniotic fluid ♀ M

✖ **V28.2 Other screening based on amniocentesis** ♀ M

▲ **V28.3 Encounter for routine screening for malformation using ultrasonics** ♀
▶Encounter for routine fetal ultrasound NOS◀
▶*Excludes* *encounter for fetal anatomic survey (V28.81)*◀
▶*genetic counseling and testing (V26.31-V26.39)*◀

V28.4 Screening for fetal growth retardation using ultrasonics ♀

V28.5 Screening for isoimmunization ♀

V28.6 Screening for Streptococcus B ♀ M
AHA: 4Q 1997, 46; 4Q, 2007, 35

5 **V28.8 Other specified antenatal screening** ♀

● **V28.81 Encounter for fetal anatomic survey** ♀ M

● **V28.82 Encounter for screening for risk of pre-term labor** ♀ M

● ✖ **V28.89 Other specified antenatal screening** ♀ M
Chorionic villus sampling
Genomic screening
Nuchal translucency testing
Proteomic screening
AHA: 3Q 1999, 16

✖ **V28.9 Unspecified antenatal screening** ♀

4 **V29 Observation and evaluation of newborns for suspected condition not found**
▶*Excludes* *suspected fetal conditions not found (V89.01-V89.09)*◀
Note: This category is to be used for newborns, within the neonatal period (the first 28 days of life), who are suspected of having an abnormal condition resulting from exposure from the mother or the birth process, but without signs or symptoms, and which, after examination and observation, is found not to exist.

Coding Guidelines Note: Assign a category V29 code for suspected conditions not found, to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined, after study, not to be present. Do not use a category V29 code when the patient has identified signs or symptoms of a suspected problem; code the sign or symptom. Category V29 may be assigned as a principal code for readmissions or encounters when the V30 code no longer applies. (OG Ref I.C.11.c.1)

AHA: 1Q 2000, 25; 4Q 1994, 47; 1Q 1994, 9; 4Q 1992, 21; 4Q, 2007, 98, 181-182, 198, 203, 208, 238

V29.0 Observation for suspected infectious condition N I
AHA: 1Q 2001, 10; 4Q, 2007, 36

V29.1 Observation for suspected neurological condition N I
AHA: 4Q, 2007, 36

V29.2 Observation for suspected respiratory condition N I
AHA: 4Q, 2007, 36