International Classification of Diseases
9th Revision, Clinical Modification

2009
Physicians' Professional

ICD-9-CM

Volumes 1 & 2

Codes valid for use October 1, 2008 – September 30, 2009
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Alphabetic Index to Diseases

Arthritis, arthritic – continued
due to or associated with – continued
rheucomatous, malignant (M9720/3) 202.3 713.2
rubella 056.71
salmonellosis 003.23
sarcoidosis 135 [713.7]
serum sickness 999.5 [713.6]
Staphylococcus 711.0 5
Streptococcus 711.0 5
syphilis (see also Syphilis) 094.0 [711.4 5]
syngonyemia 336.0 [713.5]
tabes dorsalis 282.49 [712.2]
tuberculosis (see also Tuberculosis, arthritic) 015.9 [711.4 5]
thyroid fever 062.0 [711.3 5]
ulcerative colitis (see also Colitis, ulcerative) 556.9 [713.1 5]
urethritis
nongonococcal (see also Urethritis, nongonococcal) 099.40 [711.1 5]
nonspecific (see also Urethritis, nongonococcal) 099.40 [711.1 5]
Reiter’s 099.3 [711.1 5]
viral disease NEC 079.99 [711.5 5]
erythema epidemicum 026.1
gonorhea 098.5 5
gouty (acute) 274.0
hypertrophic (see also Osteoarthritis) 715.9 5
spine 715.9
with myelopathy 721.91
idiopathic, blenorrhreal 099.3
in caisson disease 993.3 [713.8]
fibrotic or infectious (acute) (chronic) (subacute) NEC 711.3 5
nongonococcal 711.9 5
spine 712.0
inflammatory NEC 714.9
juvenile rheumatoid (chronic) (polyarticular) 714.30
acute 714.31
monarticular 714.33
polyarticular 714.32
lumbar (see also Spondylitis, lumbar) 721.3
meningococcal 036.82
meningeval NEC 716.3 5
migratory – see Fever, rheumatic neuropathic (Charcot’s) 094.0 [713.5]
diabetic 250.6 5 [713.5]
due to secondary diabetes 249.6 [713.5 5]
nonsyphilitic NEC 349.9 [713.5]
syngonyemia 336.0 [713.5]
tabetic 094.0 [713.5]
nodosa (see also Osteoarthritis) 715.9 5
spine 721.90
with myelopathy 721.91
nongonococcal NEC 716.3 5
spine 721.90
with myelopathy 721.91
ocular 270.91
ophthalmic NEC 722.91
syphilitic 094.0 [713.5]
syphilica deformans (Charcot) 094.0 [713.5]
temporomandibular joint 524.69
thoracic (see also Spondylolisthesis, thoracic) 721.2
toxic of menopause 716.3 5
transient 716.4 5
traumatic (chronic) (old) (post) 716.1 5
current injury – see nature of injury tuberculosis (see also Tuberculosis, arthritic) 015.9 5 [711.4 5]
urica, uratic 274.0
venereal 099.3 [711.1 5]
vertebral (see also Arthritis, spine) 721.90
villosus 716.8 5
von Bechterew’s 720.0
Arthrocele (see also Effusion, joint) 719.0 5
Arthrodysplasia 718.5
Arthrodysplasia – see Arthritis
Arthrodysplasia 718.5
Arthrogyrosis 728.3
multiplex, congenita 754.89
Arthrotakadysis 715.35
Arthritis 727.0
Arthro-onychodysplasia 756.89
Arthro-osteochondrodysplasia 756.89
Arthropathy (see also Arthritis) 716.9 5
Note – Use the following fifth-digit subclassification with categories 711-712, 716:
0 site unspecified
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
Behçet’s 136.1 [711.2 5]
Charcot’s 094.0 [713.5]
diabetic 250.6 5 [713.5]
due to secondary diabetes 249.6 [713.5 5]
syngonyemia 336.0 [713.5]
tabetic 094.0 [713.5]
crystal (deposited) – see Arthritis, due to crystals
goat 274.0
neurogenic, neuropathic (Charcot’s) (tabetic) 094.0 [713.5]
diabetic 250.6 5 [713.5]
due to secondary diabetes 249.6 [713.5 5]
nonsyphilitic NEC 349.9 [713.5]
syngonyemia 336.0 [713.5]
postasystolic NEC 009.0 [711.3 5]
postherapeutic, chronic (Jaccoud’s) 714.4
psoriatic 696.0
Arthropathy, arthritic – continued
pulmonary 731.2
specified NEC 716.6 5
syngomyelia 336.0 [713.5]
tabes dorsalis 094.0 [713.5]
tabetic 094.0 [713.5]
transient 716.4 5
traumatic 716.1 5
uric acid 274.0
Arthroplasty (see also Loose, body, joint) 718.1 5
Arthroptysis 719.8 5
ankle 719.87
elbow 719.82
foot 719.87
hand 719.84
hip 719.85
knee 719.86
multiple sites 719.89
pelvic region 719.85
shoulder (region) 719.81
specified NEC 719.88
wrist 719.83
Arthropysis (see also Arthritis, pyogenic) 711.0 5
Arthroscopic surgical procedure converted to open procedure V64.43
Arthrosis (deformans) (degenerative) (see also Osteoarthritis) 715.9 5
Charcot’s 094.0 [713.5]
polyarticular 094.0 [713.5]
spine (see also Spondylitis, spine) 721.90
Arthus phenomenon 995.21
due to correct substance properly administered 995.21
overdose or wrong substance given or taken 977.0
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Arthritis, articular – see also condition
disc disorder (reducing or non-reducing) 524.63
spondylothesis 756.12
Articulation anterior 524.27
posterior 524.27
reverse 524.27
Artificial
device (prosthetic – see Fitting, device
insemination V26.1
menopause (states) (symptoms) (syndrome) 527.4
opening status (functioning) (without complication) V44.9
anus (colostomy) V44.3
colostomy V44.3
cystostomy V44.50
appendectomy V44.52
cutaneous-vesicostomy V44.51
specified type NEC V44.59
terectoromy V44.4
gastrostomy V44.1
ileostomy V44.2
intestinal tract NEC V44.4
jejunoanostomy V44.4
nephrostomy V44.6
specified site NEC V44.8
traceostomy V44.0
uretrostomy V44.6
urethrostomy V44.6
urinary tract NEC V44.6
vagina V44.7
vagina status V44.7
ARV (disease) (illness) (infection) – see Human immunodeficiency virus (disease) (illness) (infection)
Arytenoid – see condition
Asbestosis (occupational) 501
Asboe-Hansen’s disease (incontinent pigments) 757.33
Ascarisiasis (intestinal) (lung) 127.0
Ascariiasis 127.0
Acarieiasis 127.0
Ascariis 127.0
limbolicrudes (infestation) 127.0
pneumonia 127.0
Ascending – see condition
361.01 Recent detachment, partial, with single defect
361.02 Recent detachment, partial, with multiple defects
361.03 Recent detachment, partial, with giant tear
361.04 Recent detachment, partial, with retinal dialysis
361.05 Recent detachment, total or subtotal
361.06 Old detachment, partial
361.07 Old detachment, total or subtotal
361.1 Retinoschisis and retinal cysts
361.10 Retinoschisis, unspecified
361.11 Flat retinoschisis
361.12 Bullous retinoschisis
361.13 Primary retinal cysts
361.14 Secondary retinal cysts
361.19 Other
361.2 Serous retinal detachment
361.3 Retinal defects without detachment
361.30 Retinal defect, unspecified
361.31 Round hole of retina without detachment
361.32 Horseshoe tear of retina without detachment
361.33 Multiple defects of retina without detachment
361.8 Other forms of retinal detachment
361.81 Traction detachment of retina
362 Other retinal disorders
362.0 Diabetic retinopathy
362.01 Background diabetic retinopathy
362.02 Proliferative diabetic retinopathy
362.03 Nonproliferative diabetic retinopathy NOS
362.04 Mild nonproliferative diabetic retinopathy
362.05 Moderate nonproliferative diabetic retinopathy
362.06 Severe nonproliferative diabetic retinopathy
362.07 Diabetic macular edema
362.09 Other
362.1 Other background retinopathy and retinal vascular changes
362.10 Background retinopathy, unspecified
362.11 Hypertensive retinopathy
362.12 Exudative retinopathy
362.13 Changes in vascular appearance
362.14 Retinal microaneurysms NOS
362.15 Retinal telangiectasia
362.16 Retinal neovascularization NOS
362.17 Other intraretinal microvascular abnormalities
362.18 Retinal vasculitis
362.2 Other proliferative retinopathy
362.21 Retrolental fibroplasia
361.89 Other
361.9 Unspecified retinal detachment

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<thead>
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<th>Code</th>
<th>Description</th>
</tr>
</thead>
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<td>Recent detachment, partial, with single defect</td>
</tr>
<tr>
<td>361.02</td>
<td>Recent detachment, partial, with multiple defects</td>
</tr>
<tr>
<td>361.03</td>
<td>Recent detachment, partial, with giant tear</td>
</tr>
<tr>
<td>361.04</td>
<td>Recent detachment, partial, with retinal dialysis</td>
</tr>
<tr>
<td>361.05</td>
<td>Recent detachment, total or subtotal</td>
</tr>
<tr>
<td>361.06</td>
<td>Old detachment, partial</td>
</tr>
<tr>
<td>361.07</td>
<td>Old detachment, total or subtotal</td>
</tr>
<tr>
<td>361.1</td>
<td>Retinoschisis and retinal cysts</td>
</tr>
<tr>
<td>361.10</td>
<td>Retinoschisis, unspecified</td>
</tr>
<tr>
<td>361.11</td>
<td>Flat retinoschisis</td>
</tr>
<tr>
<td>361.12</td>
<td>Bullous retinoschisis</td>
</tr>
<tr>
<td>361.13</td>
<td>Primary retinal cysts</td>
</tr>
<tr>
<td>361.14</td>
<td>Secondary retinal cysts</td>
</tr>
<tr>
<td>361.19</td>
<td>Other</td>
</tr>
<tr>
<td>361.2</td>
<td>Serous retinal detachment</td>
</tr>
<tr>
<td>361.3</td>
<td>Retinal defects without detachment</td>
</tr>
<tr>
<td>361.30</td>
<td>Retinal defect, unspecified</td>
</tr>
<tr>
<td>361.31</td>
<td>Round hole of retina without detachment</td>
</tr>
<tr>
<td>361.32</td>
<td>Horseshoe tear of retina without detachment</td>
</tr>
<tr>
<td>361.33</td>
<td>Multiple defects of retina without detachment</td>
</tr>
<tr>
<td>361.8</td>
<td>Other forms of retinal detachment</td>
</tr>
<tr>
<td>361.81</td>
<td>Traction detachment of retina</td>
</tr>
</tbody>
</table>

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: 3Q 1990, 3; 4Q, 2007, 164

AHA: 4Q 2005, 12

AHA: 3Q 1990, 3; 4Q, 2007, 164

AHA: 4Q, 2007, 14

AHA: 3Q 1990, 3; 4Q, 2007, 164

AHA: 3Q 1990, 3; 4Q, 2007, 164

AHA: 3Q 1990, 3; 4Q, 2007, 164

AHA: 4Q, 2007, 14

AHA: 4Q, 2007, 14

AHA: 3Q 1990, 3; 4Q, 2007, 164

AHA: 4Q, 2007, 14

AHA: 4Q, 2007, 14

AHA: 3Q 1990, 3; 4Q, 2007, 164

AHA: 4Q, 2007, 14

AHA: 4Q, 2007, 14
362.22  Retinopathy of prematurity, stage 0
362.23  Retinopathy of prematurity, stage 1
362.24  Retinopathy of prematurity, stage 2
362.25  Retinopathy of prematurity, stage 3
362.26  Retinopathy of prematurity, stage 4
362.27  Retinopathy of prematurity, stage 5
362.29  Other nondiabetic proliferative retinopathy

AHA: 3Q 1996, 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
362.34  Transient arterial occlusion

AHA: 1Q 2000, 16

362.35  Central retinal vein occlusion
362.36  Venous tributary (branch) occlusion
362.37  Venous engorgement

Occlusion:
- of retinal vein
- incipient of retinal vein
- partial of retinal vein

AHA: 2Q 1993, 6

362.38  Central retinal vein occlusion

AHA: 3Q 1996, 5

362.39  Venous tributary (branch) occlusion

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

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

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

Presetinal 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.

362.6  Peripheral retinal degenerations

Excludes
- hereditary retinal degeneration
[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

Palsade degeneration of retina

362.64  Senile reticular degeneration

362.65  Secondary pigmentary degeneration

Pseudooretinits pigmentosa

362.66  Secondary vitreoretinal degenerations

362.67  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

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Additional Digit Required
Unspecified/Other Specified Code
Manifestation Code
Revised Text
New Code
Revised Code
<table>
<thead>
<tr>
<th>V Codes</th>
<th>Tabular List</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>V26.4</strong></td>
<td>General counseling and advice</td>
</tr>
<tr>
<td><strong>Guidelines Note:</strong> 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)</td>
<td></td>
</tr>
<tr>
<td><strong>V26.41</strong></td>
<td>Procreative counseling and advice using natural family planning</td>
</tr>
<tr>
<td><strong>AHA:</strong></td>
<td>4Q, 2007, 201, 208</td>
</tr>
<tr>
<td><strong>V26.49</strong></td>
<td>Other procreative management counseling and advice</td>
</tr>
<tr>
<td><strong>AHA:</strong></td>
<td>4Q, 2007, 35, 99</td>
</tr>
<tr>
<td><strong>V26.5</strong></td>
<td>Sterilization status</td>
</tr>
<tr>
<td><strong>Guidelines Note:</strong> 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)</td>
<td></td>
</tr>
<tr>
<td><strong>V26.51</strong></td>
<td>Tubal ligation status</td>
</tr>
<tr>
<td><strong>Excludes</strong></td>
<td>infertility not due to previous tubal ligation (628.0-628.9)</td>
</tr>
<tr>
<td><strong>AHA:</strong></td>
<td>4Q, 2007, 35</td>
</tr>
<tr>
<td><strong>V26.52</strong></td>
<td>Vasectomy status</td>
</tr>
<tr>
<td><strong>AHA:</strong></td>
<td>4Q, 2007, 35</td>
</tr>
<tr>
<td><strong>V26.8</strong></td>
<td>Other specified procreative management</td>
</tr>
<tr>
<td><strong>Guidelines Note:</strong> The outcome of delivery should be included on all maternal delivery records. (OG Ref I.C.11.c.1)</td>
<td></td>
</tr>
<tr>
<td><strong>V26.81</strong></td>
<td>Encounter for assisted reproductive fertility procedure cycle</td>
</tr>
<tr>
<td>Patient undergoing in vitro fertilization cycle Use additional code to identify the type of infertility</td>
<td></td>
</tr>
<tr>
<td><strong>Excludes</strong></td>
<td>pre-cycle diagnosis and testing – code to reason for encounter</td>
</tr>
<tr>
<td><strong>AHA:</strong></td>
<td>4Q, 2007, 35, 99-100, 208</td>
</tr>
<tr>
<td><strong>V26.89</strong></td>
<td>Other specified procreative management</td>
</tr>
<tr>
<td><strong>AHA:</strong></td>
<td>4Q, 2007, 35, 208</td>
</tr>
<tr>
<td><strong>V26.9</strong></td>
<td>Unspecified procreative management</td>
</tr>
<tr>
<td><strong>AHA:</strong></td>
<td>4Q, 2007, 208</td>
</tr>
<tr>
<td><strong>V27</strong></td>
<td>Outcome of delivery</td>
</tr>
<tr>
<td><strong>Guidelines Note:</strong> This category is intended for the coding of the outcome of delivery on the mother’s record.</td>
<td></td>
</tr>
<tr>
<td><strong>Coding Guidelines Note:</strong> These codes are not to be used on subsequent maternal records or on the newborn record. (OG Ref I.C.11.f.5)</td>
<td></td>
</tr>
<tr>
<td>**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)</td>
<td></td>
</tr>
<tr>
<td>**The outcome of delivery should be included on all maternal delivery records. (OG Ref I.C.13.d.10)</td>
<td></td>
</tr>
<tr>
<td><strong>AHA:</strong></td>
<td>2Q 1991, 16; 4Q, 2007, 178, 202, 238</td>
</tr>
<tr>
<td><strong>V27.0</strong></td>
<td>Single liveborn</td>
</tr>
<tr>
<td><strong>AHA:</strong></td>
<td>4Q 2005, 81; 2Q 2003, 9; 2Q 2002, 10; 1Q 2001, 10; 3Q 2000, 5; 4Q 1998, 77; 4Q 1995, 59; 1Q 1992, 9</td>
</tr>
<tr>
<td><strong>Coding Guidelines Note:</strong> This code is the only outcome of delivery code appropriate for use with 650. (OG Ref I.C.11.c.3)</td>
<td></td>
</tr>
<tr>
<td><strong>V27.1</strong></td>
<td>Single stillborn</td>
</tr>
<tr>
<td><strong>V27.2</strong></td>
<td>Twins, both liveborn</td>
</tr>
<tr>
<td><strong>V27.3</strong></td>
<td>Twins, one liveborn and one stillborn</td>
</tr>
<tr>
<td><strong>V27.4</strong></td>
<td>Twins, both stillborn</td>
</tr>
<tr>
<td><strong>X</strong></td>
<td>Other multiple birth, all liveborn</td>
</tr>
<tr>
<td><strong>X</strong></td>
<td>Other multiple birth, some liveborn</td>
</tr>
<tr>
<td><strong>X</strong></td>
<td>Other multiple birth, all stillborn</td>
</tr>
<tr>
<td><strong>V27.9</strong></td>
<td>Unspecified outcome of delivery</td>
</tr>
<tr>
<td><strong>V28</strong></td>
<td>Encounter for antenatal screening of mother</td>
</tr>
<tr>
<td><strong>Excludes</strong></td>
<td>abnormal findings on screening-code to findings</td>
</tr>
<tr>
<td><strong>X</strong></td>
<td>suspected fetal conditions affecting management of pregnancy (655.00-655.93, 656.00-656.93, 657.00-657.03, 658.00-658.93)</td>
</tr>
<tr>
<td><strong>X</strong></td>
<td>suspected fetal conditions not found (V89.01-V89.09)</td>
</tr>
<tr>
<td><strong>Guidelines Note:</strong> A screening code is listed as the primary code if the reason for the visit is to examine a screening 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)</td>
<td></td>
</tr>
<tr>
<td><strong>V28.0</strong></td>
<td>Screening for chromosomal anomalies by amniocentesis</td>
</tr>
<tr>
<td><strong>V28.1</strong></td>
<td>Screening for raised alpha-fetoprotein levels in amniotic fluid</td>
</tr>
<tr>
<td><strong>V28.2</strong></td>
<td>Other screening based on amniocentesis</td>
</tr>
<tr>
<td><strong>V28.3</strong></td>
<td>Encounter for routine screening for malformation using ultrasonics</td>
</tr>
<tr>
<td><strong>Excludes</strong></td>
<td>encounter for fetal anatomic survey (V28.81)</td>
</tr>
<tr>
<td><strong>V28.4</strong></td>
<td>Screening for fetal growth retardation using ultrasonics</td>
</tr>
<tr>
<td><strong>V28.5</strong></td>
<td>Screening for isoimmunization</td>
</tr>
<tr>
<td><strong>V28.6</strong></td>
<td>Screening for Streptococcus B</td>
</tr>
<tr>
<td><strong>AHA:</strong></td>
<td>4Q 1997, 46; 4Q, 2007, 35</td>
</tr>
<tr>
<td><strong>V28.8</strong></td>
<td>Other specified antenatal screening</td>
</tr>
<tr>
<td><strong>V28.81</strong></td>
<td>Encounter for fetal anatomic survey</td>
</tr>
<tr>
<td><strong>V28.82</strong></td>
<td>Encounter for screening for risk of pre-term labor</td>
</tr>
<tr>
<td><strong>X</strong></td>
<td>Other specified antenatal screening</td>
</tr>
<tr>
<td><strong>V28.89</strong></td>
<td>Chronic villus sampling</td>
</tr>
<tr>
<td><strong>V29</strong></td>
<td>Observation and evaluation of newborns for suspected condition not found</td>
</tr>
<tr>
<td><strong>Excludes</strong></td>
<td>suspected fetal conditions not found (V89.01-V89.09)</td>
</tr>
<tr>
<td><strong>Note:</strong> 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.</td>
<td></td>
</tr>
<tr>
<td><strong>Coding Guidelines Note:</strong> 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)</td>
<td></td>
</tr>
<tr>
<td><strong>V29.0</strong></td>
<td>Observation for suspected infectious condition</td>
</tr>
<tr>
<td><strong>AHA:</strong></td>
<td>1Q 2001, 10; 4Q, 2007, 36</td>
</tr>
<tr>
<td><strong>V29.1</strong></td>
<td>Observation for suspected neurological condition</td>
</tr>
<tr>
<td><strong>AHA:</strong></td>
<td>4Q, 2007, 36</td>
</tr>
<tr>
<td><strong>V29.2</strong></td>
<td>Observation for suspected respiratory condition</td>
</tr>
<tr>
<td><strong>AHA:</strong></td>
<td>4Q, 2007, 36</td>
</tr>
</tbody>
</table>