

Official ICD-9-CM Guidelines for Coding and Reporting

INGENIX

Effective October 1, 2009

Narrative changes appear in bold text. Items underlined have been moved within the guidelines since October 1, 2008.

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 instructions. 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 V89.09
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 Diagnostic Code More than Once
15. Admissions/Encounters for Rehabilitation
16. Documentation for BMI and Pressure Ulcer Stages
17. Syndromes

C. Chapter-Specific Coding Guidelines

1. Chapter 1: Infectious and Parasitic Diseases (001-139)
 - a. Human Immunodeficiency Virus (HIV) Infections

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Table of Contents Icd 9 Cm Official Guidelines For Coding And Reporting 2013

1. Understanding the eBook Icd 9 Cm Official Guidelines For Coding And Reporting 2013
 - The Rise of Digital Reading Icd 9 Cm Official Guidelines For Coding And Reporting 2013
 - Advantages of eBooks Over Traditional Books
2. Identifying Icd 9 Cm Official Guidelines For Coding And Reporting 2013
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Icd 9 Cm Official Guidelines For Coding And Reporting 2013
 - User-Friendly Interface

4. Exploring eBook Recommendations from Icd 9 Cm Official Guidelines For Coding And Reporting 2013
 - Personalized Recommendations
 - Icd 9 Cm Official Guidelines For Coding And Reporting 2013 User Reviews and Ratings
 - Icd 9 Cm Official Guidelines For Coding And Reporting 2013 and Bestseller Lists
5. Accessing Icd 9 Cm Official Guidelines For Coding And Reporting 2013 Free and Paid eBooks
 - Icd 9 Cm Official Guidelines For Coding And Reporting 2013 Public Domain eBooks
 - Icd 9 Cm Official Guidelines For Coding And Reporting 2013 eBook Subscription Services
 - Icd 9 Cm Official Guidelines For Coding And Reporting 2013 Budget-Friendly Options
6. Navigating Icd 9 Cm Official Guidelines For Coding And Reporting 2013 eBook Formats
 - ePub, PDF, MOBI, and More
 - Icd 9 Cm Official Guidelines For Coding And Reporting 2013 Compatibility with Devices
 - Icd 9 Cm Official Guidelines For Coding And Reporting 2013 Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Icd 9 Cm Official Guidelines For Coding And Reporting 2013
 - Highlighting and Note-Taking Icd 9 Cm Official Guidelines For Coding And Reporting 2013
 - Interactive Elements Icd 9 Cm Official Guidelines For Coding And Reporting 2013
8. Staying Engaged with Icd 9 Cm Official Guidelines For Coding And Reporting 2013
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Icd 9 Cm Official Guidelines For Coding And Reporting 2013
9. Balancing eBooks and Physical Books Icd 9 Cm Official Guidelines For Coding And Reporting 2013
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Icd 9 Cm Official Guidelines For Coding And Reporting 2013
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine Icd 9 Cm Official Guidelines For Coding And Reporting 2013
 - Setting Reading Goals Icd 9 Cm Official Guidelines For Coding And Reporting 2013
 - Carving Out Dedicated Reading Time

12. Sourcing Reliable Information of Icd 9 Cm Official Guidelines For Coding And Reporting 2013
 - Fact-Checking eBook Content of Icd 9 Cm Official Guidelines For Coding And Reporting 2013
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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