

# 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, 9<sup>th</sup> 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 Diagnosis 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

# Icd 9 Official Coding Guidelines

**Debra P. Ferenc**



## **Icd 9 Official Coding Guidelines:**

**ICD-9-CM Official Guidelines for Coding and Reporting ,1991      ICD-9-CM Inpatient Coding Reference and Study Guide** Ba Kobayashi,2010-07 If you need to have a strong understanding of how ICD 9 CM diagnosis and procedure codes are determined then you have chosen the right book ICD 9 CM Inpatient Coding Reference and Study Guide The author designed a book that goes beyond the fundamentals that gets into the details of ICD 9 CM diagnosis and procedure code assignment as would be experienced on the job This user friendly reference teaches coders how to handle many coding situations while also being comprehensive enough to teach someone with a basic knowledge of medical coding how to move to the next level of advanced inpatient coding Updated every year to reflect the annual ICD 9 CM coding changes the text enables HIM professionals to master the concepts of medical coding while also gaining critical knowledge to pass the CCS exam administered by AHIMA and the CPC H exam from the AAPC The book also serves as an excellent desk reference and resource for coders who need to refresh their ICD 9 CM coding skills Among the topics covered in Volume 1 are inpatient coding guidelines coding conventions coding tables and a drug reference However the heart of this manual is the body system analysis based on chapters 1 17 of the Tabular list in Volume I of the ICD 9 CM Official Coding Guidelines The chapters are categorized by body system such as respiratory digestive et al The chapters in this study guide follow the same sequence as the Official Coding Guidelines All chapters in addition to highlighting basic coding guidelines contain situation based coding tips and coding examples A quiz follows each chapter reinforcing concepts in a rigorous manner that applies directly to the professional coding environment The book also contains a selective discussion of invasive procedures that the coder will most likely encounter on the job and on the exam At the end of ICD 9 CM Inpatient Coding Reference and Study Guide are 15 case studies providing the reader with an opportunity to assess their ICD 9 CM coding skill set and speed at coding inpatient medical records Each record contains a face sheet history physical progress notes and answer sheet Some of the case studies contain ER reports consultations as well as operative and pathology reports The answer key at the end of this study guide contains a rationale for all code assignments 456 short answer questions 116 multiple choice questions 15 full medical record case studies Each question is highly relevant and reflects a coding situation most hospital based inpatient coders will face The text strives to ensure the reader understands every diagnosis and procedure discussed thorough discussion of symptoms standard treatment protocols and medications Coding examples and quizzes help clarify the information presented Linda Kobayashi BA RHIT CCS has been a coder and coding manager for almost 20 years Since 1998 Ms Kobayashi has owned and operated Codebusters Inc a nationwide coding consulting company Widely regarded as a medical coding and auditing expert she has conducted workshops on a variety of coding topics including CCS Exam preparation workshops Throughout her career the author has remained professionally active as an AHIMA member as well as a member of her state association CHIA California health Information Association Her formal training includes a teaching

credential from California State University Los Angeles a B A degree in English Literature from University of California Los Angeles an RHIT from AHIMA after completing the RHIT program at East Los Angeles College and a CCS certificate from AHIMA Extensive experience as a hands on coder auditor and educator and has given the author the expertise to help coders prepare for the professional coding environment **2015 ICD-9-CM for Physicians, Volumes 1 and 2, Standard Edition - E-Book** Carol J. Buck,2015-11-12

UPDATED Coding Clinic citations provide official ICD 9 CM coding advice ensuring accurate coding by identifying the year quarter and page number for information about specific codes in the AHA s Coding Clinic for ICD 9 CM **2014 ICD-9-CM for Physicians, Volumes 1 and 2, Standard Edition - E-Book** Carol J. Buck,2016-07-04

Codingupdates com companion website includes ICD 9 CM coding updates an ICD 9 CM to ICD 10 CM crosswalk and MS DRG information ICD-9-CM Coding: Theory and Practice with ICD-10, 2013/2014 Edition - E-Book

Karla R. Lovaasen,Jennifer Schwerdtfeger,2012-08-20 Learn to code effectively with ICD 9 CM medical coding and gain a thorough introduction to ICD 10 CM PCS coding with one book ICD 9 CM Coding 2013 2014 Edition combines basic coding principles with proven practical insight and the ICD 9 CM and ICD 10 CM ICD 10 PCS Official Guidelines for Coding and Reporting to prepare you for the upcoming implementation of ICD 10 CM PCS Whether you re learning to code for the first time or making the transition from ICD 9 CM to ICD 10 CM PCS leading medical coding authors Karla Lovaasen and Jennifer Schwerdtfeger deliver the fundamental understanding you need to succeed in hospital and physician settings Both ICD 9 CM codes and ICD 10 CM ICD 10 PCS codes are shown in all coding exercises and examples including answer keys Emphasis on ICD 10 CM and ICD 10 PCS coding prepares you for the upcoming implementation of ICD 10 MS DRG documentation and reimbursement details guide you through this key component of the coding process Line coding exercises and activities challenge you to apply concepts to solve problems ICD 10 Official Guidelines for Coding and Reporting OGCR are included in each coding chapter immediately following the ICD 9 CM coding guidelines Full color A P content disease coverage procedure guidelines and drug data ensure that you re familiar with key topics affecting medical coding Medical record coverage introduces the records and documents you ll encounter on the job Updated Coding Clinic references direct you to the definitive coding resource from the American Hospital Association AHA A companion Evolve website provides convenient online access to the OGCR medical and surgical root operations definitions a MS DRG list partial answer keys and more

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OGCR with a format designed by coders for coders this handy spiral bound reference gives you easy access to the information you need to stay up to date and ensure the most accurate billing and optimal reimbursement in physician based coding Plus you can take this resource into certification exams for enhanced testing support Exclusive focus on ICD 9 CM Volumes 1 and 2 provides clear concise coverage of physician based coding essentials UNIQUE Full color Netter s Anatomy artwork clarifies complex anatomic information to help you appropriately code related procedures Use Additional Digit s symbol in the index identifies codes that require an additional digit to remind you to check the tabular The Official Guidelines for Coding and Reporting OGCR are listed within the lists of codes and in a separate index for fast easy access to the coding rules when you need them Items provide detailed information on common diseases and conditions helping you code more effectively Symbols throughout the text alert you to new revised and deleted codes and clearly identify codes that require special consideration before assigning symbols including Not First Listed Diagnosis Unspecified Code Includes and Excludes and Use Additional Additional hints tips and definitions within specific codes provide extra guidance in coding anatomy pathophysiology or other coding directions References to the American Hospital Association s Coding Clinics help you find expanded information about specific codes and their usage Age and Sex edits alert you to codes that are used only with patients of a specific age or sex helping to ensure accurate reporting Omit and Code Also codes highlight government text needing special attention Coding updates on the companion [codingupdates.com](http://codingupdates.com) website keep you informed of changes to ICD codes

**PROP - Coding Systems Custom E-Book** Anthem,2014-04-25 PROP Coding Systems Custom E Book

**Understanding Hospital Billing and Coding** Debra P. Ferenc,2013-02-26 Updated Claim Forms chapter covers the UB 04 claim form Updated information covers diagnosis and procedural coding with guidelines and applications Updated claim forms and names are used throughout

**The Next Step: Advanced Medical Coding and Auditing, 2013 Edition** Carol J. Buck,2012-12-11 Learning advanced medical coding concepts is easy with Carol J Buck s proven step by step method The Next Step Advanced Medical Coding and Auditing 2013 Edition provides an in depth understanding of physician based medical coding and coding services such as medical visits diagnostic testing and interpretation treatments surgeries and anesthesia Patient cases reflect actual medical records with personal details changed or removed and give you real world experience coding from physical documentation with advanced material Enhance your clinical decision making skills and learn to confidently pull the right information from documents select the right codes determine the correct sequencing of those codes properly audit cases and prepare for the transition to ICD 10 CM with the help of Carol J Buck Auditing cases in every chapter offer realistic experience with auditing coded reports UNIQUE Evaluation and Management E M Audit Forms developed to determine the correct E M codes simplify the coding process and help you ensure accuracy Dual Coding prepares you for the switch to ICD 10 by accompanying all ICD 9 answers with corresponding codes from ICD 10 CM Realistic patient cases simulate the professional coding experience by using actual medical records with personal patient

details changed or removed allowing you to practice coding with advanced material UNIQUE Netter anatomy plates in each chapter help you understand anatomy and how it affects coding From the Trenches boxes in each chapter highlight real life medical coders and provide practical tips advice and encouragement More than 175 illustrations and a full color design make advanced concepts more accessible and visually engaging Stronger focus on auditing cases prepares you to assign correct codes to complicated records as well as audit records for accuracy Updated content presents the latest coding information so you can practice with the most current information available *The Next Step: Advanced Medical Coding and Auditing,*

*2013 Edition - E-Book* Carol J. Buck,2012-12-14 Stronger focus on auditing cases prepares you to assign correct codes to complicated records as well as audit records for accuracy Updated content presents the latest coding information so you can practice with the most current information available 2015 ICD-9-CM for Hospitals, Volumes 1, 2 and 3 Standard Edition - E-Book

Carol J. Buck,2015-01-22 UPDATED Coding Clinic citations provide official ICD 9 CM coding advice ensuring accurate coding by identifying the year quarter and page number for information about specific codes in the AHA s Coding Clinic for ICD 9 CM **The Comprehensive Review Guide for Health Information** Carla Tyson-Howard,Shirlyn C. Thomas,2009-10-07 Perfect for preparing for the RHIA and RHIT exams the Comprehensive Review Guide for Health Information serves as a personal tutor for HIM students to review the major learning competencies that will be tested on the exams the workbook section divided by knowledge clusters contains short answer fill in the blank and matching questions to assess the students understanding of the competency after using the comprehensive review book section and listening to audio recordings At the end of every knowledge cluster a multiple choice test simulates the questions on the national RHIA and RHIT **2013 ICD-9-CM for Hospitals, Volumes 1, 2 and 3 Professional Edition -- E-Book** Carol J.

Buck,2012-08-28 Elsevier and the American Medical Association have partnered to co publish this ICD 9 CM reference by Carol J Buck Maximize your efficiency and effectiveness with Carol J Buck s 2013 ICD 9 CM for Hospitals Volumes 1 2 3 Professional Edition Combining Netter s Anatomy artwork and the Official Guidelines for Coding and Reporting OGCR with a format designed by coders for coders this handy spiral bound reference gives you easy access to the information you need to stay up to date and ensure the most accurate billing and optimal reimbursement in both physician based and inpatient coding Plus you can take this resource into certification exams for enhanced testing support Coverage of all three ICD 9 CM volumes includes both inpatient and outpatient codes UNIQUE Full color Netter s Anatomy artwork clarifies complex anatomic information to help you appropriately code related procedures Use Additional Digit s symbol in the index identifies codes that require an additional digit to remind you to check the tabular The Official Guidelines for Coding and Reporting OGCR are listed within the lists of codes and in a separate index for fast easy access to the coding rules when you need them Items provide detailed information on common diseases and conditions helping you code more effectively Symbols throughout the text alert you to new revised and deleted codes and clearly identify codes that require special consideration before assigning

symbols including Unacceptable Principal Diagnosis Use Additional Includes and Excludes Non OR Procedure Code First Present on Admission Hospital Acquired Condition and CC and MCC Additional hints tips and definitions within specific codes provide extra guidance in coding anatomy pathophysiology or other coding directions References to the American Hospital Association's Coding Clinics help you find expanded information about specific codes and their usage Age and Sex edits alert you to codes that are used only with patients of a specific age or sex helping to ensure accurate reporting Omit and Code Also codes highlight government text needing special attention Coding updates on the companion codingupdates.com website keep you informed of changes to ICD codes

Medical Coding ICD-9 (Speedy Study Guides) Speedy Publishing, 2014-07-03 A medical coding ICD 9 book or software program contains detailed information concerning a variety of health conditions along with a numerical set of numbers Each disease or health condition is assigned a specialized code that is used for identification purposes when submitting documents to insurance carriers for reimbursement Health care employees such as medical coders and secretaries require a medical coding ICD 9 as part of their job while working in medical facilities including physician's offices hospitals and nursing homes

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## Whispering the Techniques of Language: An Psychological Journey through **Icd 9 Official Coding Guidelines**

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