

What is ICD-9-CM?

The International Classification of Diseases (ICD) is the oldest method of tracking diseases and mortality in the world. Developed in Europe, several versions have evolved over the years. The first edition, known as the International List of Causes of Death, was adopted by the International Statistical Institute in 1893.

The current version used in the United States was developed by the World Health Organization (WHO) and modified for use. ICD-9-CM (Clinically Modified) was adopted in this country in 1979. The code set is updated at least annually based on the input of providers, payers and others. A new generation and much larger code set, ICD-10-CM, will replace ICD-9 codes on October 1, 2015.

Already the standard for diagnostic coding and inpatient hospital coding in the U.S., ICD-9-CM was mandated in 2003 by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Covered entities required to use the ICD-9-CM code set include health plans, health care clearinghouses and health care providers who transmit any electronic health information in connection with a transaction for which a standard has been adopted by the U.S. Department of Health and Human Services (HHS). For this reason, knowledge of ICD-9-CM coding is essential to all medical coders and billers.

The ICD-9-CM code set consists of:

- **Volume 1:** The numeric listing of diseases, classified by etiology and anatomical system, as well as a classification of other reasons for encounters and causes of injury. This is called the tabular section of ICD-9-CM. Volume 1 is used by all health care providers and facilities.
- **Volume 2:** The alphabetic index used to locate the codes in Volume 1. Volume 2 is used by all health care providers and facilities.
- **Volume 3:** A procedural classification with a tabular section and an index. This set of procedure codes is used only by hospitals to report services.

The Centers for Disease Control (CDC), the National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS) are the U.S. governmental agencies responsible for overseeing all changes and modifications to ICD-9-CM.

To master the basics of ICD-9-CM coding, you must understand the foundation of coding in the home health environment. There are main competencies that coders and clinicians will be tested on. These competencies are listed below, with some main points that each encompasses or that you must understand to code correctly with diagnoses, V and E codes.

In general, the core competencies of ICD-9-CM coding involve understanding:

- Guidelines and Conventions
- Sequencing issues regarding signs and symptoms, acute diseases and V codes, late effects and complications and OASIS item rules
- V code use
- Manifestation coding
- Late effects and complications

This short guide highlights the main areas that you must understand – and be able to apply in your ICD-9 Manual – in order to find the correct code.

Official Guidelines and Conventions

The ICD-9-CM Official Guidelines for Coding and Reporting and conventions are specific guidelines and general rules that are applicable to all health care settings, unless otherwise indicated. They provide additional instruction and are based on the coding and sequencing instructions in Volumes 1, 2 and 3 of the ICD-9-CM. Adherence to these guidelines when assigning diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

There are 18 main guidelines to know and reference when coding. These guidelines cover dozens of pages and are available at:



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