

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 reasons 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 V99.09
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. Law 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 Cm Coding Guidelines With Examples

Faye Brown



Icd 9 Cm Coding Guidelines With Examples:

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

ICD-9-CM Coding Handbook, with Answers Faye Brown,2002 [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 **The Next Step: Advanced Medical Coding and Auditing, 2014 Edition - E-Book** Carol J. Buck,2013-12-13 Updated content includes the latest coding information available to promote accurate coding and success on the job [The Next Step: Advanced Medical Coding and Auditing, 2013 Edition](#) Carol J. Buck,2013 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, 2016 Edition - E-Book](#) Carol J. Buck,2015-12-03 Mastering advanced medical coding skills is easier with Carol J Buck s proven step by step method The Next Step Advanced Medical Coding and Auditing 2016 Edition uses real world patient cases to explain coding for services such as medical visits diagnostic testing and interpretation treatments surgeries and anesthesia Hands on practice with physician documentation helps you take the next step in coding proficiency With this guide from coding author

and educator Carol J Buck you will learn to confidently pull the right information from medical documents select the right codes determine the correct sequencing of those codes and then properly audit cases UNIQUE Evaluation and Management E M audit forms include clear coding instructions to help reduce errors in determining the correct level of service Real world patient cases cleared of any patient identifiers simulate the first year of coding on the job by using actual medical records More than 185 full color illustrations depict and clarify advanced coding concepts From the Trenches boxes highlight the real life experiences of professional medical coders and include photographs quotes practical tips and advice UPDATED content includes the latest coding information available for accurate coding and success on the job **The Next Step: Advanced Medical Coding and Auditing, 2016 Edition** Carol J. Buck,2015-12-22 Mastering advanced medical coding skills is easier with Carol J Buck s proven step by step method The Next Step Advanced Medical Coding and Auditing 2016 Edition uses real world patient cases to explain coding for services such as medical visits diagnostic testing and interpretation treatments surgeries and anesthesia Hands on practice with physician documentation helps you take the next step in coding proficiency With this guide from coding author and educator Carol J Buck you will learn to confidently pull the right information from medical documents select the right codes determine the correct sequencing of those codes and then properly audit cases UNIQUE Evaluation and Management E M audit forms include clear coding instructions to help reduce errors in determining the correct level of service Real world patient cases cleared of any patient identifiers simulate the first year of coding on the job by using actual medical records More than 185 full color illustrations depict and clarify advanced coding concepts From the Trenches boxes highlight the real life experiences of professional medical coders and include photographs quotes practical tips and advice UPDATED content includes the latest coding information available for accurate coding and success on the job *Buck's The Next Step: Advanced Medical Coding and Auditing, 2019/2020 Edition* Elsevier,2018-11-03 Master advanced coding skills Buck s The Next Step Advanced Medical Coding and Auditing shows how to code for services such as medical visits diagnostic testing and interpretation treatments surgeries and anesthesia Real world cases cleared of any patient identifiers takes your coding proficiency a step further by providing hands on practice with physician documentation With this guide you ll learn to pull the right information from medical documents select the right codes determine the correct sequencing of those codes and properly audit cases Real world patient cases cleared of any patient identifiers simulate the first year of coding on the job by using actual medical records allowing you to practice coding with advanced material UNIQUE From the Trenches boxes highlight the real life experiences of professional medical coders and include photographs quotes practical tips and advice UNIQUE Evaluation and Management E M audit forms include clear coding instructions to help reduce errors in determining the correct level of service Over 170 full color illustrations depict and clarify advanced coding concepts **The Next Step: Advanced Medical Coding and Auditing, 2015 Edition - E-Book** Carol J. Buck,2015-01-01 Moving on to advanced medical coding is easy with Carol J Buck s proven step by step method The Next

Step Advanced Medical Coding and Auditing 2015 Edition helps you master coding skills for services such as medical visits diagnostic testing and interpretation treatments surgeries and anesthesia Real world patient cases give you hands on practice with advanced physician based coding Enhance your decision making skills and learn to confidently pull the right information from medical documents select the right codes determine the correct sequencing of those codes properly audit cases and prepare for the transition to ICD 10 with the help of coding author and educator Carol Buck Dual coding addresses the transition to ICD 10 by providing practice as well as coding answers for both ICD 9 and ICD 10 UNIQUE Evaluation and Management E M audit forms developed to determine the correct E M codes simplify the coding process and help to ensure accuracy UNIQUE Netter anatomy illustrations in each chapter help you understand anatomy and how it affects coding Realistic patient cases simulate your first year of coding by using actual medical records with personal patient details changed or removed allowing you to practice coding with advanced material From the Trenches boxes highlight the experiences of real life professional medical coders and include photographs quotes practical tips and advice Auditing cases prepare you to assign correct codes to complicated records as well as audit records for accuracy More than 180 full color illustrations depict and clarify advanced coding concepts UPDATED content includes the latest coding information available to promote accurate coding and success on the job

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New York Court of Appeals. Records and Briefs. New York (State)., **ICD-9-CM Professional for Hospitals, Vol. 1, 2, 3, 2003 (Full Size Version)** Medicode, Anita C. Hart, Ingenix, 2002 **2002 ICD-9-CM Professional for Physicians, Volumes 1 and 2** Catherine A. Hopkins, 2001

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