

Official ICD-9-CM Guidelines for Coding and Reporting

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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. 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

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Carol J. Buck



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Hazelwood,Carol A. Venable,2003-08 *Principles of ICD-9-CM Coding* Deborah J. Grider,American Medical
Association,Debra E. Hampton,2003 This revised training and educational tool helps to simplify learning the ICD 9 CM
coding process Chapters include all areas of ICD 9 CM from an introduction to the content format and coding process to an
in depth analysis for identifying and locating the most appropriate codes ICD-9-CM Professional for Hospitals, Vol. 1, 2,
3, 2003 (Full Size Version) Medicode,Anita C. Hart,Ingenix,2002 *2004 ICD-9-CM Professional for Physicians, Volumes 1
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1. Understanding the eBook Icd 9 Cm Coding Guidelines For Outpatient Services
 - The Rise of Digital Reading Icd 9 Cm Coding Guidelines For Outpatient Services
 - Advantages of eBooks Over Traditional Books
2. Identifying Icd 9 Cm Coding Guidelines For Outpatient Services
 - 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 Coding Guidelines For Outpatient Services
 - User-Friendly Interface
4. Exploring eBook Recommendations from Icd 9 Cm Coding Guidelines For Outpatient Services

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

- Fact-Checking eBook Content of Icd 9 Cm Coding Guidelines For Outpatient Services
 - 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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