

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. 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 Cm Coding Guidelines

Deborah J. Grider, Debra E. Hampton

Icd 9 Cm 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 Principles of ICD-9-CM Coding Deborah J. Grider, Debra E. Hampton, 2001 To help simplify and streamline learning the ICD 9 CM coding process the American Medical Association introduces Principles of ICD 9 CM Coding Principles is a textbook learning tool filled with explanations history practical tips examples exercises and self tests Written in an easy to understand format Principles is designed to guide new and veteran coders through all phases of ICD 9 CM from basic concepts to more detailed issues Principles of ICD 9 CM Coding is designed to help accomplish the following objectives Understand the purpose of ICD 9 CM and its relationship to the reimbursement process Understand and apply coding conventions Interpret basic coding guidelines for outpatient care Assign ICD 9 CM codes to the highest level of specificity Understand basic medical terminology to correctly assign ICD 9 CM codes **Basic ICD-9-CM Coding** Lou Ann Schraffenberger, 2003-08 **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 **Learning to Code with Icd-9-Cm for Health Information Management and Health Services Administration 2006** Thomas J. Falen, Aaron Liberman, 2005-12-01 Coding Clinic for ICD-9-CM American Hospital Association, 1990 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 Diagnostic Coding and Reimbursement for Physician Services, 2004** Anita C. Hazelwood, Carol A. Venable, 2003-08 Federal Register, 2013-08 Outpatient Coding Guidelines, 1988 *ICD-9-CM Professional for Physicians, Volumes 1 & 2, 2006 (in One Unit)* Anita C. Hart, Catherine A. Hopkins, 2004 ICD-9-CM Coding Handbook with Answers Nelly Leon-Chisen, Faye Brown, 2011-08 The Handbook conforms to the easy to use format and style established by Faye Brown and is the most popular textbook for hospital and physician office coder training Content reflects the latest official coding guidelines and presents examples in clear technically correct language that progresses from easy to more difficult The 2012 Handbook contains 269 case summary exercises as well as 100 plus in chapter exercises and review questions The case summary exercises are based on health records and require readers to consider the patient's condition as well as medical history reason for admission or encounter laboratory results procedures performed and the diagnoses listed Readers must apply pertinent coding principles and official coding guidelines in making code assignments and designating the principal diagnosis and procedure for each episode of care Each chapter includes an overview that highlights the important points a learning outcomes feature and a terms to know feature Both features are designed to help readers understand and absorb new information A Remember feature provides sidebar comment or facts that alert readers to additional information or perspectives that should not be forgotten when reading the chapter Major Content Areas Format and conventions and current coding practices for ICD 9 CM Use of supplementary classifications Coding of signs and symptoms Coding of infectious and parasitic diseases endocrine diseases and immunity disorders and mental disorders Coding of diseases of the blood and blood forming organs and diseases of the nervous system Coding of diseases of the respiratory digestive and genitourinary systems Coding of diseases of the skin and diseases of the musculoskeletal system Coding of pregnancy and childbirth complications abortion congenital anomalies and perinatal conditions Coding of circulatory system diseases and neoplastic diseases Coding of injuries burns poisoning and complications of care ICD 10 CM preview ICD 10 PCS preview POA requirements PLUS 260 case study exercises Index **Coding Clinic for ICD-9-CM**, 1998 New York Court of Appeals. Records and Briefs. New York (State)., *Faye Brown's ICD-9-CM Coding Handbook 2003, with Answers (Revised Edition)* Faye Brown, 2003 **ICD-9-CM Expert for Physicians, Volumes 1 and 2** Anita C. Hart, Catherine A. Hopkins, 2003 AHA Coding Clinic for ICD 9 CM references Definitions and illustrations New and revised code symbols and dated pages Check 4th and 5th digit alerts Color coded tabular alert coders to crucial coding and reimbursement issues Complete official coding guidelines Age and sex edits V code symbols *2004 ICD-9-CM Professional for Physicians, Volumes 1 and 2* Ingenix, 2003 These practical two volume ICD 9 CM Professional codebooks were designed with the coder in

mind Enhanced with crucial reimbursement indicators these codebooks are your guides to coding accurately The clinically oriented definitions and illustrations exclusive color coded tabular check fourth and fifth digit symbols and official coding guidelines are some of the hallmarks of these Professional editions of the ICD 9 CM code book Plus the latest revisions to the complete official coding guidelines are included **ICD-9-CM Professional for Hospitals, Vol. 1, 2, 3, 2003 (Full Size Version)** Medicode, Anita C. Hart, Ingenix, 2002 **ICD-9-CM Practice Management Information Corporation, Kathryn Swanson, 2003** ICD 9 CM is a statistical classification system that arranges diseases and injuries into groups according to established criteria Most ICD 9 CM codes are numeric and consist of three four or five numbers and a description P 1 of the introduction

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