Official ICD-9-CM INGENIX. Guidelines for Coding and Reporting

Effective October 1, 2009

Narrative changes appear in bold text, Items underlined have been moved within the guidelines since October 1, 2008.

The Geners for Medicare and Medicard Services-(CMS) and the National Center for Health Statistics (NGHS), two departments within the U.S. Federal Government Department of Health and Human Services (DHHS) provide the following gradelines for coding and reporting using the International Classification of Diseases, 9th Revision, Clinical Medification (ICD-9-CM). These gradelines should be used as a companion document to the official version of the ICD-9-CM as published on CD-8-OM by the U.S. Government Princing Office (GPO).

These guidelines have been approved by the four organizations that make up the Cooperating Factors for the ICD-9-CM: the American Hospital Association (AHIMA), the American Health Information Management Association (AHIMA), CMS, and NCHS. These guidelines are recluded on the official government version of the ICD-9-CM, and also appear in "Goding Clinic for ICD-9-CM" published by the AHA.

These guidelines are a set of rules thus have been developed toaccompany 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 goodelines are based on the coding and sequencing instructions in Violumes I, II and III of ICD-9-CM, but provide additional instruction. 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 FIENA for all healthcare settings. Volume 3procedure codes have been adopted for impatient procedures reported by haspitals. A joint effort between the healthcare provider and the coder is essential to achieve contribute and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to must 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 oversmphasized. 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 cornest 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 Gooperating Pantes, is official.

The guidelines are organized into socitoes. Section I includes the structure and consentitions 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 recludes guidelines for selection of principal diagnosts for

non-curpation settings. Section III includes guidelines for reporting additional diagnosts in non-curpations settings. Section IV is for outpations coding and reporting.

Section I. Conventions, general coding guidelines and chapter specific guidelines

- A. Conventions for the ICD-9-CM.
 - T. Foreman
 - 2. Abbreviations.
 - a. Index abbreviations.
 - b. Tabular abbreviances.
 - Promotionation.
 - 4. Includes and Excludes Notes and Inclusion sensa-
 - 5. Other and Unspectful codes
 - ia. "Other" codes
 - b. "Unspecified" codes
 - Enology/manifestation convention ("code line", "use additional code" and "in diseases classified risewhere" notes)
 - T. "And"
 - St. State of the second
 - 9. "See" and "See Also".
- General Coding Guidelines.
 - 1. Use of Both Alphabets: Index and Tabular List.
 - 2. Locate each term in the Alphabetic Index.
 - 3. Level of Detail in Coding
 - 4. Code or codes from (NTLO shrough V89.09)
 - Selection of codes OOL 0 through 999.9
 - 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 Chromic Conditions
 - 11. Combination Code
 - 12. Lose Effects
 - 13. Impending or Threatened Condition
 - 14. Reporting Same Diagnosts Code More than Once.
 - 15. Admissions/Encounters for Rehabilitation
 - 16. Documentation for BMI and Pressure Ulcer States
 - 3.7. Symdisymen-
- C. Chapter-Specific Coding Guidelines
 - Chapter 1: Infectious and Parasitic Diseases (001-139).
 - Human Immunodeliciency Virus (HIV) Infections

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