

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 reason 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 V89.09
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 Diagnostic 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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**U.S. Department of Health and Human
Services DHHS**

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Table of Contents Official Icd Cm Guidelines For Coding And Reporting

1. Understanding the eBook Official Icd Cm Guidelines For Coding And Reporting
 - The Rise of Digital Reading Official Icd Cm Guidelines For Coding And Reporting
 - Advantages of eBooks Over Traditional Books
2. Identifying Official Icd Cm Guidelines For Coding And Reporting
 - 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 Official Icd Cm Guidelines For Coding And Reporting
 - User-Friendly Interface
4. Exploring eBook Recommendations from Official Icd Cm Guidelines For Coding And Reporting
 - Personalized Recommendations
 - Official Icd Cm Guidelines For Coding And Reporting User Reviews and Ratings
 - Official Icd Cm Guidelines For Coding And Reporting and Bestseller Lists
5. Accessing Official Icd Cm Guidelines For Coding And Reporting Free and Paid eBooks
 - Official Icd Cm Guidelines For Coding And Reporting Public Domain eBooks
 - Official Icd Cm Guidelines For Coding And Reporting eBook Subscription Services
 - Official Icd Cm Guidelines For Coding And Reporting Budget-Friendly Options
6. Navigating Official Icd Cm Guidelines For Coding And Reporting eBook Formats

- ePub, PDF, MOBI, and More
- Official Icd Cm Guidelines For Coding And Reporting Compatibility with Devices
- Official Icd Cm Guidelines For Coding And Reporting Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Official Icd Cm Guidelines For Coding And Reporting
 - Highlighting and Note-Taking Official Icd Cm Guidelines For Coding And Reporting
 - Interactive Elements Official Icd Cm Guidelines For Coding And Reporting
- 8. Staying Engaged with Official Icd Cm Guidelines For Coding And Reporting
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Official Icd Cm Guidelines For Coding And Reporting
- 9. Balancing eBooks and Physical Books Official Icd Cm Guidelines For Coding And Reporting
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Official Icd Cm Guidelines For Coding And Reporting
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Official Icd Cm Guidelines For Coding And Reporting
 - Setting Reading Goals Official Icd Cm Guidelines For Coding And Reporting
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Official Icd Cm Guidelines For Coding And Reporting
 - Fact-Checking eBook Content of Official Icd Cm Guidelines For Coding And Reporting
 - 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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