

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 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

Official Icd Cm Guidelines For Coding And Reporting

American Dental Association



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ICD-10-CM: Official Guidelines for Coding and Reporting - FY 2019 (October 1, 2018 - September 30, 2019) Centers for Medicare and Medicaid Services (CMS), National Center for Health Statistics (NCHS), U.S. Department of Health and Human Services (DHHS), 2018-08 These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD 10 CM the American Hospital Association AHA the American Health Information Management Association AHIMA CMS and NCHS These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD 10 CM itself The instructions and conventions of the classification take precedence over guidelines These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD 10 CM but provide additional instruction Adherence to these guidelines when assigning ICD 10 CM diagnosis codes is required under the Health Insurance Portability and Accountability Act HIPAA The diagnosis codes Tabular List and Alphabetic Index have been adopted under HIPAA for all healthcare settings [ICD-10-CM Official Guidelines for Coding and Reporting - FY 2020 \(October 1, 2019 - September 30, 2020\)](#) U.S. Department of Health and Human Services DHHS, 2019-11-19 These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD 10 CM itself The instructions and conventions of the classification take precedence over guidelines These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD 10 CM but provide additional instruction Adherence to these guidelines when assigning ICD 10 CM diagnosis codes is required under the Health Insurance Portability and Accountability Act HIPAA The diagnosis codes Tabular List and Alphabetic Index have been adopted under HIPAA for all healthcare settings 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 that are to be reported

Understanding Hospital Billing and Coding Debra P. Ferenc, 2013-02-26 A basic guide to hospital billing and reimbursement Understanding Hospital Billing and Coding 3rd Edition helps you understand complete and submit the UB 04 claim form that is used for all Medicare and privately insured patients It describes how hospitals are reimbursed for patient care and services showing how the UB 04 claim form reflects the flow of patient data from the time of admission to the time of discharge Written by coding expert Debra P Ferenc this book also ensures that you understand the essentials of ICD 10 CM and develop skills in both inpatient coding and outpatient ambulatory surgery coding UB 04 Claim Simulation on the companion Evolve website lets you practice entering information from source documents into the claim form Over 300 illustrations and graphics bring important concepts to life Detailed chapter objectives highlight what you are expected to learn Key terms acronyms and abbreviations with definitions are included in each chapter Concept Review boxes reinforce key concepts Test Your Knowledge exercises reinforce lessons as

you progress through the material Chapter summaries review key concepts Practice hospital cases let you apply concepts to real life scenarios Updated Claim Forms chapter covers the UB 04 claim form Updated information covers diagnosis and procedural coding with guidelines and applications Updated claim forms and names are used throughout **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 **Federal Register**, 2013-12 *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 **Understanding Pharmacy Reimbursement** F. Randy Vogenberg, 2006 Learn the fundamentals of reimbursement with this valuable guide Pharmacy Reimbursement examines current issues strategies requirements risk management consumer awareness and the evolution of pharmacy It provides practical instruction for a variety of practice settings including hospitals home care long term care and community retail Anticipating the transition to provider status Pharmacy Reimbursement helps managers practicing pharmacists and new graduates administer existing and emerging

reimbursement tasks for Medication Therapy Management Services in patient care settings This excellent resource provides pharmacists with a better understanding of reimbursement issues in order to best determine and establish future professional practices Current Catalog National Library of Medicine (U.S.),1993 First multi year cumulation covers six years 1965 70

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 Official Guidelines for Coding and Reporting** ,1991

HIPAA in Daily Practice Charles R. Dinkins,2003 The Health Insurance Portability and Accountability Act HIPAA impacts virtually every aspect of the healthcare industry This book is designed to answer questions about how to implement the HIPAA requirements into daily practice **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 **CDT 2025** American Dental Association,2024-09-13 The American Dental Association s CDT 2025 Current Dental Terminology provides the most current information required for consistent and accurate documentation of services delivered facilitating efficient processing of dental claims This book includes every code with its full descriptor Understanding the descriptor can help determine whether the procedure code accurately describes the service provided and can help resolve questions about the accuracy of claim submissions Dental practices can rely on the ADA the official and definitive source of CDT to help them submit accurate claims and streamline reimbursements and avoid rejections CDT 2025 Current Dental Terminology gives you the most current information needed to ensure your patient records are correct and maximize reimbursement CDT 2025 changes include 10 new codes 8 revisions 2 deleted codes 4 editorial changes Included are new and revised codes for the following administration of neuromodulators administration of dermal fillers removal of an indirect restoration on a natural tooth

replacement of an implant screw partial extraction for immediate implant placement placement of an interim direct restoration and repair of an implant abutment supported prosthesis In addition to providing the most up to date codes CDT 2025 also includes access to the CDT e book mobile app and web app providing digital access to the full suite of CDT codes and descriptors You will also find ICD 10 CM codes for dental procedures making CDT 2025 the most valuable resource to meet your coding needs *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 **CDT 2026 Book and App** American Dental Association,2025-09-17 The American Dental Association s CDT 2026 Current Dental Terminology provides the most current information required for consistent and accurate documentation of services delivered facilitating efficient processing of dental claims This book includes every code with its full descriptor Understanding the descriptor can help determine whether the procedure code accurately describes the service provided and can help resolve questions about the accuracy of claim submissions Dental practices can rely on the ADA the official and definitive source of CDT to help them submit accurate claims and streamline reimbursements and avoid rejections CDT 2026 Current Dental Terminology gives you the most current information needed to ensure your patient records are correct and maximize reimbursement CDT 2026 changes include 31 new codes 14 revisions 6 deleted codes and 9 editorial changes Included are new and revised codes that cover saliva testing prosthetics implant maintenance photobiomodulation anesthesia and more In addition to providing the most up to date codes CDT 2026 also includes access to the CDT e book mobile app and web app providing digital access to the full suite of CDT codes and descriptors You will also find ICD 10 CM codes for dental procedures making CDT 2026 the most valuable resource to meet your coding needs *The Definitive Guide to Complying with the HIPAA/HITECH Privacy and Security Rules* Jr. Trinckes,2012-12-03 The Definitive Guide to Complying with the HIPAA HITECH Privacy and Security Rules is a comprehensive manual to ensuring compliance with the implementation standards of the Privacy and Security

Rules of HIPAA and provides recommendations based on other related regulations and industry best practices The book is designed to assist you in reviewing the accessibility of electronic protected health information EPHI to make certain that it is not altered or destroyed in an unauthorized manner and that it is available as needed only by authorized individuals for authorized use It can also help those entities that may not be covered by HIPAA regulations but want to assure their customers they are doing their due diligence to protect their personal and private information Since HIPAA HITECH rules generally apply to covered entities business associates and their subcontractors these rules may soon become de facto standards for all companies to follow Even if you aren't required to comply at this time you may soon fall within the HIPAA HITECH purview So it is best to move your procedures in the right direction now The book covers administrative physical and technical safeguards organizational requirements and policies procedures and documentation requirements It provides sample documents and directions on using the policies and procedures to establish proof of compliance This is critical to help prepare entities for a HIPAA assessment or in the event of an HHS audit Chief information officers and security officers who master the principles in this book can be confident they have taken the proper steps to protect their clients information and strengthen their security posture This can provide a strategic advantage to their organization demonstrating to clients that they not only care about their health and well being but are also vigilant about protecting their clients privacy

The Code of Federal Regulations of the United States of America, 2005 The Code of Federal Regulations is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government

Code of Federal Regulations, 2009 Special edition of the Federal Register containing a codification of documents of general applicability and future effect with ancillaries

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