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International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

ICD-9-CM

ICD-9-CM is a clinical modification of the World Health Organization's 9th Revision and was designed for the classification of morbidity and mortality information to be used for statistical purposes, for indexing of hospital records by disease and for data storage and retrieval. Annual modifications are made through the Coordination and Maintenance Committee (C&M), which holds biannual meetings that are open to the public. Proposals submitted to the Committee are presented at the meetings for discussion. The approved modifications are incorporated into the official government version and become effective for use October1 of the following year.

ICD-9-CM exceeds its predecessors in the number of codes provided. The disease classification has been expanded to include health-related conditions and to provide greater specificity to the fifth-digit level of detail. The fifth digits are not optional; they are intended for use in recording the information substantiated in the clinical record.

Volume I of the ICD-9-CM system contains five appendices:

Appendix A Morphology of Neoplasms

Appendix B Glossary of Mental Disorders (deleted 10/1/04)

Appendix C Classifications of Drugs by American Hospital Formulary Service List Number and Their ICD-9-CM Equivalents

Appendix D Classification of Industrial Accidents According to Agency

Appendix E List of Three-Digit Categories

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These appendices are included as a reference to the user in order to provide further information about the patient's clinical picture, to further define a diagnostic statement, to aid in classifying new drugs, or to reference three-digit categories.

CODING

Translating verbal descriptions of diseases, injuries, conditions, and procedures into numerical designations is a complex activity. In order to accurately code one should have a working knowledge of medical terminology in order to understand the characteristics, terminology, and conventions of the ICD-9-CM. Originally coding was used to provide access to medical records by diagnoses and operations through retrieval for medical research, education and administration. Today medical codes are used to facilitate payment of health services, evaluate utilization patterns and to study the appropriateness of healthcare costs. Coding provides the bases for epidemiological studies and research into the quality of healthcare.

BASIC STEPS TO CODING DIAGNOSES

Consult Volume 2, Alphabetic Index to ICD-9-CM. Locate the main entry term. The Alphabetic Index is arranged by condition. Some conditions have multiple entries under their synonyms. Select the most appropriate code.

Refer to Volume 1 of the ICD-9-CM locating the selected code. Use exclusion notes or other instructions that would direct the use of a different code from the selected in the Index for a particular diagnosis, condition or disease.

Utilize the conventions in the Tabular List (Volume 1, ICD-9-CM) as a reference and to maintain comparability with its parent, the ICD-9, a list of 3 digit ICD-9-CM categories is given in Appendix E.

MEDICAL NECESSITY

Many payers only pay for services considered medically necessary, which means that items and services must have been established as safe and effective. Therefore the items or services must be:

- consistent with the symptoms or diagnosis of the illness or injury under treatment
- necessary and consistent with generally accepted professional medical standards

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- not furnished primarily for the convenience of the patient, the attending physician, or other physician or supplier
- furnished at the most appropriate level which can be provided safely and effectively to the patient.

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