

HISTORICAL DEVELOPMENT OF ICD-9-CM

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SOURCE: Scientific Data Documentation, International Classification of Diseases-9-CM, (1979) (http://wonder.cdc.gov/wonder/sci_data/codes/icd9/type_txt/icd9cm.asp).

The idea to develop the International Classification of Diseases (ICD) for use in hospital indexing was originally developed in response to a need for a more efficient basis for storage and retrieval of diagnostic data. In 1950, the U.S. Public Health Service and the Veterans Administration began independent tests of the International Classification of Diseases for hospital indexing purposes. In the following year, the Columbia Presbyterian Medical Center in New York City adopted the International Classification of Diseases, 6th Revision, with some modifications for use in its medical records department. A few years later, the Commission on Professional and Hospital Activities (CPHA) adopted ICD with similar modifications for use in hospitals participating in the Professional Activity Study (PAS).

The problem of adapting ICD for indexing hospital records was taken up by the U.S. National Committee on Vital and Health Statistics through its subcommittee on hospital statistics. The subcommittee reviewed the modifications made by the various users of ICD and proposed that uniform changes be made. This was done by a small working party. In view of the growing interest in the use of the ICD for hospital indexing, a study was undertaken in 1956 by the American Hospital Association and the American Association of Medical Record Librarians (now called the American Health Information Management Association) to determine the relative efficiencies of coding systems for diagnostic indexing. This study indicated that the ICD provided a suitable and efficient framework for indexing hospital records. The major users of ICD for hospital indexing purposes then consolidated their experiences, and an adaptation was first published in December 1959. A revision was issued in 1962, and the first "Classification of Operations and Treatments" was included.

In 1966, the international conference for the revision of the ICD noted that the eighth revision of ICD had been constructed with hospital indexing in mind and considered that the revised classification would be suitable, in itself, for hospital use in some countries. However, it was recognized that the basic classification might provide inadequate detail for diagnostic indexing in other countries. A group of consultants was asked to study the 8th revision of ICD (ICD-8) for its applicability to various users in the United States. This group recommended that further detail be provided for coding hospital and morbidity data. The American Hospital Association's "Advisory Committee to the Central Office on ICDA" developed the needed adaptation proposals, resulting in the publication of the International Classification of Diseases, Adapted (ICDA). In 1968, the United States Public Health Service published the International Classification of Diseases, Adapted, 8th Revision for use in the United States (ICDA-8). Beginning in 1968, ICDA-8 served as the basis for coding diagnostic data for both official morbidity [and mortality] statistics in the United States.

In 1968, the Commission on Professional and Hospital Activities (CPHA) of Ann Arbor, Michigan, published the Hospital Adaptation of ICDA (H-ICDA) based on both the

original ICD-8 and ICDA-8. In 1973, CPHA published the second revision of H-ICDA, called H-ICDA-2, but hospitals throughout the United States were divided in their use of either the H-ICDA or H-ICDA-2 classifications. Effective January 1979, ICD-9-CM was published as a single classification intended primarily for use in the United States, replacing the earlier related, but somewhat dissimilar, classifications. (ICD-10-CM and ICD-10-PCS are under consideration for future adoption in the United States.)

When ICD-9 was published by the World Health Organization (WHO), the International Classification of Procedures in Medicine (ICPM) was also developed (1975) and published (1978). The ICPM surgical procedures fascicle was originally created by the United States, based on its adaptations of ICD (called ICDA), which had contained a procedure classification since 1962. ICPM is published separately from the ICD disease classification as a series of supplementary documents called fascicles (bundles or groups of items). Each fascicle contains a classification of modes of laboratory, radiology, surgery, therapy, and other diagnostic procedures. (The publication of ICPM as individual fascicles allows WHO to revise each according to separate schedules.) The ICD-9-CM procedure classification is a modification of WHO's "Fascicle V, Surgical Procedures" and is published as Volume 3 of ICD-9-CM, which contains an alphabetic index and a tabular list. Greater detail was added to the ICD-9-CM procedure classification, necessitating the expansion of codes from three to four digits. Approximately 90% of the procedure coding rubrics (categories) refer to surgical procedures, with the remaining 10% accounting for other investigative and therapeutic procedures.