ICD-10-CM PREFACE

2011

Introduction This 2011 update of the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) is being published by the United States Government in recognition of its responsibility to promulgate this classification throughout the United States for morbidity coding. The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), published by the World Health Organization (WHO), is the foundation of ICD-10-CM. ICD-10 continues to be the classification used in cause-of-death coding in the United States. The ICD-10-CM is comparable with the ICD-10. The WHO Collaborating Center for the Family of International Classifications in North America, housed at the National Center for Health Statistics (NCHS), has responsibility for the implementation of ICD and other WHO-FIC classifications and serves as a liaison with the WHO, fulfilling international obligations for comparable classifications and the national health data needs of the United States. The historical background of ICD and ICD-10 can be found in the Introduction to the International Classification, Geneva, Switzerland, 2005.

ICD-10-CM is the United States' clinical modification of the World Health Organization's ICD-10. The term clinical is used to emphasize the modification's intent: to serve as a useful tool in the area of classification of morbidity data for indexing of medical records, medical care review, and ambulatory and other medical care programs, as well as for basic health statistics. To describe the clinical picture of the patient the codes must be more precise than those needed only for statistical groupings and trend analysis.

Characteristics of ICD-10-CM

ICD-10-CM far exceeds its predecessors in the number of concepts and codes provided. The disease classification has been expanded to include health-related conditions and to provide greater specificity at the sixth digit level and with a seventh digit extension. The sixth and seventh characters are not optional; they are intended for use in recording the information documented in the clinical record.

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