ICD (International Classification of Diseases) Codes

1. General Definition and Background Information:

The International Statistical Classification of Diseases and Related Health Problems (commonly referred to as ICD) is an extensive list of (alpha-numeric) codes used since 1900 to classify diseases and conditions and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease. The ICD is published by the World Health Organization (WHO). The ICD is used worldwide for morbidity and mortality statistics, reimbursement systems, and automated decision support in medicine.

2. Common Usage (Purposes) in Vital Statistics:

The United States is required to use the ICD for the classification of diseases and injuries that are reported on the death certificate under an agreement with WHO. By using the ICD, the U.S. and all vital records registration areas collect, process, and disseminate coded mortality data in a similar way to other countries around the world. This permits comparison of mortality (cause of death) data across and within countries. Periodically, new revisions are developed to reflect advances in medical science.

The latest version or ICD-10, as it is commonly known, was first used in 1999 to codify and report information from death certificates in the United States. ICD-11 is planned for 2015 and will be revised using Web 2.0 principles. Annual minor updates and three-yearly major updates are published by WHO.

ICD codes are assigned to all causes and conditions reported by the certifying physician, medical examiner or coroner on the death certificate. That information is then used to determine the underlying cause of death to report aggregate and comparable mortaility statistics.

See **Underlying Cause of Death** and **Major (Leading) Causes of Death** on this site for more information on these other commonly used vital statistics terms directly linked to the use of ICD codes.

3. Examples of Use (NCHS):

- **Data using ICD-10**
- **Statistical Notes for Health Planners. No. 6. Cause-of-Death Data. Woolsey, T. D. February 1978. 16 pp. (PHS) 78-1237.**

4. References and Links:

The **NCHS ICD-10** site provides numerous links, documents and data examples for ICD codes including *International Classification of Diseases - 10th Revision* (NCHS brochure) **View/download PDF** 209 KB and **A Guide to State Implementation of ICD-10 for Mortality, Part I**

An electronic version of ICD-10 and more detailed information on the ICD system is available at the **World Health Organization's** site.

Hardcopy versions of the three-volume set of ICD-10 are available from:
WHO Publications Center USA
49 Sheridan Avenue
Albany, NY 12210
Tel: 1-518-436-9686
Fax: 1-518-436-7433

5. Technical Notes:

- The process of converting to a new ICD revision affects many aspects of the mortality data system including revision of instruction manuals, medical software, and analyses. See the above link to the NCHS ICD-10 web site for more information on this issue.
- When revisions to the ICD occur, it is important to develop and use comparability ratios to understand and instruct data users about the differences. Of particular concern is the external cause of injury coding for 1999 and later, based on the ICD-10 classification system, which is notably different from external cause coding (E-codes) for 1998 and earlier years, based on the ICD-9 classification system. You may not be able to compare numbers of deaths and death rates computed for some external causes of injury based on 1999 and later data to those based on data from 1998 and earlier. Consequently, use caution when doing trend analysis of numbers of injury deaths and injury death rates across these years. Go to the NCHS **Comparability** web site for more information on this issue. A **comparability table** across all revisions for leading causes is also available.
- While the ICD is used for coding causes and conditions reported on the death certificate, the ICD-CM (Clinical Modification) which is a more detailed list of codes (six digits as opposed to the four digits used for ICD) is used primarily for coding of diagnoses and for reimbursement purposes by the medical professions/clinicians, healthcare facilities, and third party health insurance payors. More information on ICD-CM can be accessed at the NCHS web site separately for **ICD-9-CM** and **ICD-10-CM** (with an anticipated implementation date of October 1, 2013).
- In addition to ICD and ICD-CM, ICD-O (International Classification of Diseases for Oncology) is used by tumor or cancer registries for coding the site (topography) and the histology (morphology) of the neoplasm. The latest version is ICD-O-3 (third edition) and the coding structure is similar to ICD-10. In fact, the ICD-O topography codes or rubrics C00-C80 are based on the malignant neoplasm section of ICD-10. However, ICD-O includes morphology (M) codes to further define the kind of tumor that has developed and how it behaves. ICD-O codes are used for defining and reporting cancer incidence while ICD-10 codes are used for defining and reporting cancer mortality. Go to the National Cancer Institute's **SEER** (Surveillance Epidemiology and End Results) web site for more information on the ICD-O.
- The dates of use for the first ICD and all revisions are as follows:
    - ICD-1 (1900-1909)
    - ICD-2 (1910-1920)
    - ICD-3 (1921-1929)
    - ICD-4 (1930-1938)
    - ICD-5 (1939-1948)
    - ICD-6 (1949-1957)
    - ICD-7 (1958-1967)
    - ICD-8, adapted (1968-1978)

- ICD-9 (1979-1998)
- ICD-10 (1999 – present)