Breaking the Code: ICD-9-CM Coding in Details

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ICD-9-CM

- ICD-9-CM diagnosis codes are 3- to 5-digit codes used to describe the clinical reason for a patient's treatment. They do not describe the service performed, just the patient's medical condition.

- For any classification system to be reliable, the application of codes must be consistent across users. Therefore, CMS, the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), and the National Center for Health Statistics (NCHS) together have developed official coding guidelines. These guidelines are available on: **www.cdc.gov/nchs/data/icd9/icdguide.pdf**.

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- The diagnosis portion of ICD-9-CM consists of two volumes, the Disease Tabular and the Disease Index.
- The Disease Tabular (Numeric) is also known as Volume II of ICD-9-CM. It is a numeric listing of codes organized primarily by body system. The Disease Tabular provides much more detail than the Alphabetic Index on conditions included and excluded in the code selected. Another code in the same category may represent the diagnostic description better than the one indicated in the Disease Index.
- The Disease Index (Alphabetic) is also known as Volume I of ICD-9-CM. It is an index of all diseases and injuries categorized in ICD-9-CM. When a code is listed after the description, it means the reader should look up that code in the Disease Tabular section to determine if that is the most specific code to describe the diagnosis. The index is organized by main terms and subterms that further describe or specify the main term. In general, the main term is the condition, disease, symptom, or eponym (disease named after a person), not the organ or body system involved.

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Supplemental Classification and Tables:

Included in Volumes I and II are supplemental classifications and special tables that provide additional guidance in determining the most accurate code.

- **V codes** are a section of ICD-9-CM diagnosis codes that represent factors that influence health status or describe contact with health services. They are used to describe those circumstances or reasons for encounter other than for disease or injury.

- **E codes** are a supplemental classification included in ICD-9-CM used for reporting external causes of injuries and poisonings.

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Supplemental Classification and Tables:

- **Neoplasm Table** located in the Alphabetic Index (see ***Neoplasm*)** lists all cancer codes by site and nature of the disease (malignant primary or secondary, benign, or unspecified behavior).

- **Table of Drugs and Chemicals** is located at the end of the Alphabetic Index. It lists drug classifications as well as specific names of drugs, identifies the code for poisoning by that drug, and the associated E code to specify if the poisoning was accidental, an adverse effect (therapeutic use), suicide attempt, assault, or undetermined.

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Throughout ICD-9-CM, there are **notes** and **cross references** to assist the coder in arriving at the most accurate code according to the official guidelines. Examples include:

- ***Excludes* notes:** Informs the coder which diagnosis codes are not included in the code selected.

- ***Use Additional Code* note:** Informs the codes that more than one code is needed to fully describe the condition and gives examples of common associated conditions.

- ***Not otherwise specified (NOS)*** is an abbreviation frequently used in ICD-9-CM. Basically it means "unspecified". The documentation does not provide additional information to assign a more specific code in a particular category. In many (but not all) code categories, the fourth digit "9" signifies an unspecified code.

- ***Not elsewhere classified (NEC)*** also is present in ICD-9-CM. It is used when the medical record documents a condition to a level of specificity not identified by a specific ICD-9-CM code. In some cases the fifth digit "8" represents an NEC code.

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Includes and Excludes Notes and Inclusion terms:

Includes: This note appears immediately under a three-digit code title to further define, or give examples of, the content of the category.

Excludes: An excludes note under a code indicates that the term excluded from the code are to be coded elsewhere. In some cases the codes for the excluded terms should not be used in conjunction with the code from which it is excluded. An example of this is a congenital condition excluded from an acquired form of the same condition. The congenital and acquired codes should not be used together. In other cases, the excluded terms may be used together with an excluded code. An example of this is when fractures of different bones are coded to different codes. Both codes may be used together if both types of fractures are present.

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Includes and Excludes Notes and Inclusion terms:

Inclusion terms: List of terms are included under certain four and five digit codes. These terms are the conditions for which that code number is to be used. The terms may be synonyms of the code title, or in the case of “other specified” codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the index may also be assigned to a code.

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- **Changes to Official Coding Guidelines**
- **Effective October 1, 2002**

Index Abbreviations:

NEC "Not elsewhere classifiable" – This abbreviation in the index represents "other specified". When a specific code is not available for a condition the index directs the coder to the "other specified" code in the tabular.

Tabular Abbreviations:

NEC "Not elsewhere classifiable" – This abbreviation in the tabular represents "other specified". When a specific code is not available for a condition the tabular includes an NEC entry under a code to identify the code as the "other specified" code. (see "Other codes)

NOS "Not otherwise specified" – This abbreviation is the equivalent of unspecified. (see "Unspecified" codes)

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- **Changes to Official Coding Guidelines**
- **Effective October 1, 2002**

“Other” codes

- **Codes titled “other” or “other specified” (usually a code with a 4th digit “8” or 5th digit “9” for diagnosis codes) are for use when the information in the medical record provides detail for which a specific code does not exist. Index entries with NEC in the line designate “other codes in the tabular. These index entries represent specific disease entities for which no specific code exists so the term is included within an “other” code.**

“Unspecified” codes

- **Codes (usually a code with a 4th digit “9” or 5th digit “0” for diagnosis codes) titled “un-specified” are for use when the information in the medical record is insufficient to assign a more specific code.**

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Punctuation

[ ] **Brackets** are used in the tabular list to enclose synonyms, alternative working or explanatory phrases. Brackets are used in the index to identify manifestation codes (e.g., “Etiology/Manifestation”).

( ) **Parentheses** are used in both the index and tabular to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.

: **Colons** are used in the Tabular list after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.

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General Coding Guidelines:

1. Use both the Alphabetic Index and the Tabular List when locating and assigning a code.
2. Locate each term in the Alphabetic Index and verify the code selected in the Tabular List after reading all instructional notations in both the Alphabetic Index and the Tabular List.
3. Diagnosis and procedure codes are to be used at their highest level of detail or their highest number of digits available for the specific code. A three-digit code is to be used only if it is not further subdivided. When fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.

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General Coding Guidelines:

4. The appropriate code or codes from 001.0 through V83.39 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.
5. The selection of codes 001.0 through 999.9 will frequently be used to describe the reason for the admission/encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g., infectious and parasitic diseases; neoplasms, symptoms, signs, and ill-defined condition, etc.).
6. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0-799.9) contain many, but not all codes for symptoms.

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General Coding Guidelines:

7. Signs and symptoms that are integral to the disease process should not be assigned as additional codes.
8. Conditions that are not an integral part of a disease process (I.e., additional signs and symptoms that may not be associated routinely with a disease process) should be coded when present.
9. Multiple coding for a single condition: In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. “Use additional code” notes are found in the tabular at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as the etiology/manifestation pair, “use additional code” indicates that a secondary code should be added.

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General Coding Guidelines:

9. Multiple coding for a single condition continued:

- “Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When a “code first” note is present and underlying condition is present the underlying condition should be sequenced first.
- “Code, if applicable, any causal condition first”, notes indicate that this code may be assigned as a principal diagnosis when the causal condition is known, then the code for that condition should be sequenced as the principal or first –listed diagnosis.
- Multiple codes may be needed for late effects, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

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General Coding Guidelines:

10. If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

11. A combination code is a single code used to classify:

    Two diagnoses, or

    A diagnosis with an associated secondary process (manifestation)

    A diagnosis with an associated complication

    Combination codes are identified by referring to subterm entries in

    the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

    Assign only the combination code when that code fully identifies the diagnostic condition involved or when the Alphabetic Index so directs. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.

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General Coding Guidelines:

12. A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a previous injury. Coding of late effects general requires tow codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second.

    An exception to the above guidelines are those instances where the code for the late effect is followed by a manifestation code identified in the Tabular List and title, or the late effect code has been expanded (at the fourth and fifth-digit levels) to include the manifestation(s). The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect.

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General Coding Guidelines:

13. Impending or Threatened Condition:

Code any condition described at the time of discharge as "impending" or "threatened" as follows:

If it did occur, code as confirmed diagnosis.

If it did not occur, reference the Alphabetic Index to determined if the condition has a subentry term for "impending" or "threatened" and also reference main term entries for "Impending" and for "Threatened".

If the subterms are listed, assign the given code.

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Chapter-Specific Coding Guidelines:

- **Code only confirmed cases**

  Code only confirmed chases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H.

  In this context, “confirmation” does not require documentation of positive serology or culture for HIV; the provider’s diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

- **Patient with HIV disease admitted for unrelated condition**

  If a patient with HIV disease is admitted for an unrelated condition (such as traumatic injury), the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. Other diagnoses would be 042 followed by additional codes for all reported HIV-related conditions.

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Chapter-Specific Coding Guidelines:

- **Terms sepsis, severe sepsis, or SIRS**

  If the term sepsis, severe sepsis, or SIRS are used with an underlying infection other than septicemia, such as pneumonia, cellulitis or a nonspecified urinary tract infection, a code from category 038 should be assigned first, then code 995.91, followed by the code for the initial infection. The use of the terms sepsis or SIRS indicates that the patient's infection has advanced to the point of a systemic infection so the systemic infection should be sequenced before the localized infection. The instructional note under subcategory 995.9 instructs to assign the underlying systemic infection first.

  Note: The term urosepsis is a nonspecific term. If that is the only term documented then only code 599.0 should be assigned based on the default for the term in the ICD-9-CM index, in addition to the code for the causal organism if known.

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Chapter-Specific Coding Guidelines:

- **Septic Shock – Sequencing of septic shock**

  Septic shock is a form of organ dysfunction associated with severe sepsis. A code for the initiating underlying systemic infection followed by a code for SIRS (code 995.92) must be assigned before the code for septic shock. As noted in the sequencing instructions in the Tabular List, the code for septic shock cannot be assigned as a principal diagnosis.

- **Septic Shock without documentation of severe sepsis**

  Septic Shock cannot occur in the absence of severe sepsis. A code from subcategory 995.9 must be sequenced before the code for septic shock. The use additional code notes and the code first note provide sequencing instructions.

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Chapter-Specific Coding Guidelines:

- **Diabetes Mellitus**

  Codes under category 250, Diabetes mellitus, identify complications/manifestations associated with diabetes mellitus. A fifth-digit is required for all category 250 codes to identify the type of diabetes mellitus and whether the diabetes is controlled or uncontrolled.

  Fifth-digits for category 250:

  0 Type II or unspecified type, not stated as uncontrolled

  1 Type I, [juvenile type], not stated as uncontrolled

  2 Type II or unspecified type, uncontrolled

  3 Type I, [juvenile type], uncontrolled

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Chapter-Specific Coding Guidelines:

- **Diabetes Mellitus**

  The age of a patient is not the sole determining factor; though most type I diabetics develop the condition before reaching puberty. For this reason type I diabetes mellitus is also referred to as juvenile diabetes.

  Type of diabetes mellitus not documented:

  If the type of diabetes is not documented in the medical record the default is type II.

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Chapter-Specific Coding Guidelines:

- **Diabetes Mellitus**

  Diabetes mellitus and the use of insulin:

  All type I diabetics must use insulin to replace what their bodies do not produce. However, the use of insulin does not mean that a patient is a type I diabetic. Some patients with type II diabetes mellitus are unable to control their blood sugar through diet and oral medication alone and do require insulin. If the documentation in a medical record does not indicate the type of diabetes but does indicate that patient uses insulin, the appropriate fifth-digit for type II must be used. For type II patients who routine use insulin, code V58.67, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin. Code V58.67 should not be assigned if insulin is given temporarily to bring a type II patient's blood sugar under control during an encounter.

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Chapter-Specific Coding Guidelines:

- **Diabetes Mellitus**

  Assigning and sequencing diabetes codes and associated conditions:

  When assigning codes for diabetes and its associated conditions, the code(s) from category 250 must be sequenced before the codes for the associated conditions. The diabetes codes and the secondary codes that correspond to them are paired codes that follow the etiology/manifestation convention of the classification (See Etiology/manifestation convention). Assign as many codes from category 250 as needed to identify all of the associated conditions that the patient has. The corresponding secondary codes are listed under each of the diabetes codes.

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Chapter-Specific Coding Guidelines:

- **Hypertension with Heart Disease**

  Heart conditions (425.8, 429.0-429.3, 429.8, 429.9) are assigned to a code from category 402 when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use additional code from category 428 to identify the type of heart failure in those patients with heart failure. More than one code from category 428 may be assigned if the patient has systolic or diastolic failure and congestive heart failure.

  The same heart conditions (425.8, 429.0-429.3, 429.8, 429.9) with hypertension, but without a stated casual relationship, are coded separately. Sequence according to the circumstances of the admission/encounter.

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Chapter-Specific Coding Guidelines:

- **Hypertension with Heart Disease**

  Certain heart conditions are assigned to category **402, Hypertensive heart disease,** when a causal relationship is stated (due to hypertension) or implied (hypertensive). Hypertensive heart disease includes cardiomegaly, cardiovascular disease, myocarditis, and degeneration of the myocardium. Category 402 includes a fifth-digit that indicates whether heart failure is present. However, and additional code is still required to specify the type of heart failure (428.0-428.43), if known.

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Chapter-Specific Coding Guidelines:

- **Hypertension with Heart Disease**

  A cause-and-effect relationship between hypertension and heart disease cannot be assumed, however, and careful attention must be given to the exact wording of the diagnostic statement. When the diagnostic statement mentions both conditions but does not indicate a causal relationship between them, separate codes are assigned. For example:

- Congestive heart failure due to hypertension 402.91 + 428.0
- Hypertensive heart disease with congestive heart failure 402.91 + 428.0
- Congestive heart failure with hypertension <u>428.0</u> + 401.9

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Chapter-Specific Coding Guidelines:
A causal relationship is presumed to exist for a cardiac condition when it Associated with another condition classified as hypertensive heart disease. For example:

- Hypertensive myocarditis with congestive heart failure 402.91 + 428.0
- Hypertensive cardiovascular disease with congestive heart failure 402.91 + 428.0

The coder should review the medical record for any reference to the presence of conditions such as coronary arteriosclerosis or chronic coronary insufficiency that could merit additional code assignments.

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Chapter-Specific Coding Guidelines:

- **Hypertension and Kidney Disease**

  When the diagnostic statement includes both hypertension and kidney disease, ICD-9-CM usually assumes that there is a cause-and-effect relationship. A code from code category 403, **Hypertensive Kidney disease,** is provided in the Alphabetic Index; a causal relationship need not be indicated in the diagnostic statement. A fifth digit is used with category 403 does not include acute renal failure, which is an entirely different condition from chronic kidney disease and is not caused by hypertension. Kidney conditions that are not indexed to hypertensive kidney disease may or may not be hypertensive; if the physician indicates a causal relationship, only the code for hypertensive kidney disease is assigned.

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Chapter-Specific Coding Guidelines:

- **Sample codes for cases of hypertensive kidney disease include the following:**

- **Hypertensive nephropathy, benign 403.10**
- **Hypertensive nephrosclerosis 403.90**
- **Accelerated hypertension with chronic kidney disease 403.01**
- **Acute renal failure with renal papillary necrosis and hypertension <u>584.7</u> + 401.9**

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Chapter-Specific Coding Guidelines:

Hypertension Heart and Kidney Disease

When a heart condition ordinarily coded to category 402 and a kidney condition coded to category 403 both exist, a combination code form category **404, Hypertensive heart and kidney** disease, is assigned. Fifth digits are provided to indicate whether congestive heart failure, chronic kidney disease, or both are present as follows:

- Either heart disease or chronic kidney disease
- With heart disease
- With heart disease and chronic kidney disease

When the diagnostic statement indicates that both hypertension and diabetes mellitus are responsible for chronic kidney disease, both the appropriate code from category 403 or 404 and code 250.4X, from the subcategory for diabetes with renal manifestations are assigned, with sequencing optional. An additional code is assigned for the stage of chronic kidney disease, if known.

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Chapter-Specific Coding Guidelines:

- **Hypertension with Other Conditions**

  Although hypertension is often associated with other conditions and may accelerate their development, ICD-9-CM does not provide combination codes. Codes for each condition must be assigned to fully describe the condition.

  For example:

- Atherosclerosis of aorta with benign essential hypertension 440.0 + 401.0
- Coronary atherosclerosis with systemic benign hypertension 414.00 + 401.0
- Arteriosclerotic heart disease 414.00
- Arteriosclerotic heart disease with essential hypertension 414.00 + 401.9

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Chapter-Specific Coding Guidelines:

- **Cerebral infarction/stroke/cerebrovascular accident (CVA)**

  The terms stroke and CVA are often used interchangeably to refer to a cerebral infarction. The terms stroke, CVA, and cerebral infarction NOS are all indexed to the default code 434.91, Cerebral artery occlusion, unspecified, with infarction. Code 436, Acute, but ill-defined, cerebrovascular disease, should not be used when the documentation states stroke or CVA

- **Code V12.59**

  Assign code V12.59 (and not a code from category 438) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.

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Chapter-Specific Coding Guidelines:

- **Chronic Obstructive Pulmonary Disease [COPD] and Asthma**

  The conditions that comprise COPD are obstructive chronic bronchitis, subcategory 491.2, and emphysema, category 492. All asthma cods are under category 493, Asthma. Code 496, Chronic airway obstruction, not elsewhere classified, is a nonspecific code that should only be used when the documentation in a medical record does not specify the type of COPD being treated.

- **Overlapping nature of the conditions that comprise COPD and asthma**

  Due to the overlapping nature of the conditions that make up COPD and asthma, there are many variations in the way these conditions are documented. Code selection must be based on the terms as documented. When selecting the correct code for the documented type of COPD and asthma, it is essential to first review the index, and then verify the code in the tabular list. There are many instructional notes under the different COPD subcategories and codes. It is important that all such notes be reviewed to assure correct code assignment.

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Chapter-Specific Coding Guidelines:

- **Acute exacerbation of asthma and status asthmaticus**

  An acute exacerbation of asthma is an increased severity of the asthma symptoms, such as wheezing and shortness of breath. Status asthmaticus refers to a patient's failure to respond to therapy administered during an asthmatic episode and is a life threatening complication that requires emergency care. If status asthmaticus is documented by the provider with any type of COPD or with acute bronchitis, the status asthmaticus is sequenced first. It supersedes any type of COPD including that with acute exacerbation or acute bronchitis. It is inappropriate to assign an athma code with 5th digit 2, with acute exacerbation, together with an asthma code with 5th digit 21, with status asthmatics. Only the 5th digit 1 should be assigned.

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Chapter-Specific Coding Guidelines:

- **Acute bronchitis with COPD**

  Acute bronchitis, code 466.0, is due to an infectious organism. When acute bronchitis is documented with COPD, code 491.22, Obstructive chronic bronchitis with acute bronchitis, should be assigned. It is not necessary to also assign code 466.0. If a medical record documents acute bronchitis with COPD with acute exacerbation, only code 491.22 should be assigned. The acute bronchitis included in code 491.22 supersedes the acute exacerbation. If a medical record documents COPD with acute exacerbation without mention of acute bronchitis, only code 491.21 should be assigned.

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Brown, Faye (2005), *ICD-9-CM Coding Handbook 2006 with Answers*. (2006 Ed., pp. 414 – 439 and 266-267). Chicago:AHA Press, Health Forum, Inc.