ICD-9 Coding for Beginners  
MARCH 2006 EDITION

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Notes
ICD-9 Coding for Beginners

Audience
This manual is designed for new Part A and Part B medical coding and billing personnel.

Course Description
This course provides an introduction to the International Classification of Diseases, (Ninth Revision), Clinical Modification (ICD-9-CM) manual. Volumes 1 and 2 are discussed at length including discussion of the coding tables in Volume 2. Participants will learn the importance of coding to the “highest level of specificity” using practical examples and gain an understanding of the ICD-9 footnotes, symbols, instructional notes and conventions. Volume 3 is briefly discussed for Part A providers.

Required Materials
ICD-9-CM manual

Recommended Related Courses
- CMS-1500 Claims Filing
- CPT Coding for Beginners
- Electronic Media Claims Filing
- Inquiries, Appeals and Overpayments
- UB-92 Claims Filing
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History and Overview of ICD-9-CM

Background
The International Classification of Diseases, Ninth Revision, (ICD-9-CM) is a classification system developed by the World Health Organization (WHO) for classifying morbidity and mortality information for statistical purposes, for indexing hospital records by diseases and operations, and for storing and retrieving data.

In 1979, the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) was issued in the United States. Physicians have been required by law to submit diagnosis codes for Medicare reimbursement since the passage of the Medicare Catastrophic Coverage Act of 1988. This act requires physician offices to include the appropriate diagnosis codes when billing for services provided to Medicare beneficiaries on or after April 1, 1989. The Centers for Medicare and Medicaid Services (CMS) designated ICD-9-CM as the coding system physicians must use.

Characteristics of ICD-9-CM
ICD-9-CM is comprised of a three-volume set of codes. Volumes 1 and 2 are used primarily for physician billing and contain diagnosis codes and symptoms. Volume 3 is used for skilled nursing facility and hospital billing. Volume 3 also contains codes for surgical and non-surgical procedures.

- Volume 1 Diseases - Tabular or Numerical Codes (including V and E Codes)
- Volume 2 Diseases - Alphabetic Index to Diseases, Table of Drugs & Chemicals, and Alphabetic Index to Causes of Injury & Poisoning.
- Volume 3 Index to Procedures, Tabular List, Pharmacological Listings, Diagnosis Code/MDC/DRG List, and Complication & Cose morbidity (CC) List. ICD-10 International Classification of Diseases
10 Steps To Correct Coding

To code accurately, it is necessary to have a working knowledge of medical terminology and to understand the characteristics, terminology, and conventions of ICD-9. Providers should follow the steps below to ensure correct coding.

Step 1: Identify the reason for the visit (e.g., sign, symptom, diagnosis, condition to be coded).

Physicians describe the patient’s condition using the terminology that includes specific diagnoses as well as symptoms, problems or reasons for the encounter. If symptoms are present but a definitive diagnosis has not been determined, code the symptom. Do not code conditions that are referred to as “rule out,” “suspected,” “probable” or “questionable.”

Step 2: Always consult the Alphabetic Index, Volume 2, before turning to the tabular list.

The most critical rule is to begin a code search in the alphabetic index (volume 2). Never initially turn to the Tabular List (Volume 1), as this will lead to coding errors and less specificity in code assignments. To prevent coding errors, use both the Alphabetic Index and the tabular list when locating and assigning a code.

Step 3: Locate the main entry term

The Alphabetic Index is arranged by condition. Conditions may be expressed as nouns, adjectives and eponyms. Some conditions have multiple entries under their synonyms. Main terms are identified using **boldface** type.

Step 4: Read and interpret any notes listed with the main term.

Notes are identified using *italicized* type.

Step 5: Review entries for modifiers.

Nonessential modifiers are in parentheses. These parenthetical terms are supplementary words or explanatory information that may either be present or absent in the diagnostic statement and do not affect code assignment.

Step 6: Interpret abbreviations, cross-references, symbols and brackets.

Cross-references used are “see,” “see category” or “see also.” The abbreviation NEC (not elsewhere classified) may follow main terms or sub-terms. NEC indicates that there is no specific code for the condition even though the medical documentation may be very specific. The $^{5}_{th}$ box indicates the code requires a fifth digit. If the appropriate fifth digits are not found in the index, in a box beneath the main term, you **MUST** refer to the Tabular List. *Italicized Brackets* [ ] are used to enclose a second code number that must be used with the code immediately preceding it and in that sequence.
Step 7: Choose a tentative code and locate it in the tabular list.

Be guided by any inclusion or exclusion terms, notes or other instructions, such as “code first” and “use additional code” that would direct the use of a different or additional code from that selected in the index for a particular diagnosis, condition or disease.

Step 8: Determine whether the code is at the highest level of specificity.

Assign three-digit codes (category codes) if there are no four-digit codes within the code category. Assign four-digit codes (subcategory codes) if there are no five-digit codes for that category. Assign five-digit codes for those categories where they are available.

Step 9: Consult the color-coding and reimbursement prompts, including the age, sex and Medicare as secondary payer edits.

Consult the official ICD-9-CM guidelines for coding and reporting, and refer to the AHA’s “Coding Clinic for ICD-9-CM” for coding guidelines governing the use of specific codes.

Step 10: Assign the code.

Diagnostic Coding and Reporting for Outpatient Services

Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

Selection

In the outpatient setting, the term “first-listed diagnosis” is used in lieu of principal diagnosis.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

Code Range

The appropriate code(s) from 001.0 – V83.89 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reasons for the encounter/visit.

Accurate Reporting

For accurate reporting of ICD-9-CM diagnosis codes, the documentation should describe the patient’s condition, using the terminology, which includes specific diagnoses as well as symptoms, problems or reasons for the encounter. There are ICD-9-CM codes to describe all of these.

Code Selection

The selection of codes 001.0 – 999.9 will frequently be used to describe the reason for the encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g., infectious & parasitic diseases; neoplasms; symptoms, signs and ill-defined conditions, etc.)
Symptoms, and Signs
Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the physician.

Circumstances Other Than Disease or Injury
The Supplementary Classification of Factors Influencing Health Status and Contact With Health Services (V01.0 –V83.89) is provided to deal with occasions when circumstances other than disease or injury are recorded as diagnoses or problems.

Code Specificity
ICD-9-CM is composed of codes with either 3, 4, or 5 digits. Codes with 3 digits are included in the heading of a category of codes that may be further subdivided by the use of fourth or fifth digits, which provide greater specificity. A code is invalid if it has not been coded to the full number of digits required for that code.

Code Sequence
List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions.

Uncertain Diagnosis
Do not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out”, or “working diagnosis.” Rather, code the condition(s) to the highest level of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Please Note: This differs from the coding practices used by hospital medical record departments for coding the diagnosis of acute care, short-term hospital inpatients.

Chronic Disease
Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

Coexisting Conditions
Code all documented conditions that exist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. History codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Diagnostic and Therapeutic Services
For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for the encounter/visit in the medical record to be
chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

For outpatient encounters for diagnosis tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Note: This differs from the coding practice in the hospital setting regarding abnormal findings on test results.

For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy, radiation therapy, or rehabilitation, the appropriate V code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

**Preoperative Evaluations**

For patients receiving preoperative evaluations only, sequence a code from category V72.8, Other Specified Examinations, to describe the preoperative consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the preoperative evaluation.

**Ambulatory Surgery**

For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

**Prenatal Visits**

For routine outpatient prenatal visits when no complications are present, codes V22.0, supervision of normal first pregnancy, and V22.1, supervision of other normal pregnancy, should be used as principal diagnoses. These codes should not be used in conjunction with Chapter 11 codes (Complications of Pregnancy, Childbirth, and the Puerperium (630-677)).

**Selection of Principal Diagnosis(es) for Inpatient, Short-Term, Acute Care, and Long-Term Care Hospital Records**

**General Inpatient Coding**

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”
The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985 Federal Register (Vol. 50, No. 147), pp. 31038-40.

In determining principal diagnosis the coding conventions in the ICD-9-CM, Volumes I and II take precedence over these official guidelines.

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

A. Code for symptoms, signs and ill-defined conditions. Codes, symptoms, signs and ill-defined conditions from chapter 16, are not to be used as principal diagnosis when a related definitive diagnosis has been established.

B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis. When there are two or more interrelated conditions potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

C. Two or more diagnoses that equally meet the definition for principal diagnosis. In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guideline does not provide sequencing direction, any one of the diagnoses may be sequenced first.

D. Two or more comparative or contrasting conditions. In those rare instances when two or more contrasting or comparative diagnoses are documented as “either/or”, they are coded as if the diagnosis was confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

E. When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as additional diagnoses.

F. Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment my not have been carried out due to unforeseen circumstances.

G. When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the 996–999 series, an additional code for the specific complication may be assigned.

H. If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out”, code the condition as if it existed or was established. The basis for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.
Reporting Additional Diagnoses for Inpatient, Short-Term, Acute Care and Long-Term Care Hospital Records

For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring clinical evaluation, or therapeutic treatment, or diagnostic procedures, or extended length of hospital stay, or increased nursing care and/or monitoring.

The following guidelines are to be applied in designating “other diagnoses” when neither the Alphabetic Index nor the Tabular List in ICD-9-CM provides direction. The listing of the diagnoses in the patient record is the responsibility of the attending physician.

Previous Conditions:

If the physician has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. However, history codes (V10 – V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Abnormal Findings:

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicates their critical significance.

Please note: This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a physician.

Uncertain Diagnosis:

If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out”, code the condition as if it existed or was established. The basis for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.
**Volume 1 (Tabular-Numeric)**

- **Chapter headings** appear in BOLD CAPITALIZED letters and include the three digit category codes included in the chapter.
- **Subheadings** appear in BOLD CAPITALIZED letters and break out the specific conditions or diagnoses within a chapter. Subheadings contain the three digit category codes.
- **Categories** are three-digit diagnoses codes.
- **Sub-categories** are four-digit and five-digit assigned codes.
- Fifth digits can appear in a variety of places:
  - Beginning of a chapter
  - Beginning of a section
  - Beginning of a three digit category
  - Within a four digit sub-category

The Tabular List of Diseases (Volume 1) arranges the ICD-9-CM codes and descriptors numerically (001–999.9). Tabs divide this section into chapters, identified by the code range on the tab. The Tabular List includes two supplementary classifications:

- **V Codes** – Supplementary Classifications of Factors Influencing Health Status and Contact with Health Services (V01-V84).
- **E Codes** – Supplementary Classification of External Causes of Injury and Poisoning (E800-E999).

ICD-9-CM includes four official appendixes:

- Appendix A – Morphology of Neoplasms
- Appendix B – Deleted Effective October 1, 2004
- Appendix C – Classification of Drugs by AHFS List
- Appendix D – Classification of Industrial Accidents According to Agency
- Appendix E – List of Three-Digit Categories
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Chapter Heading</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
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<td>1</td>
<td>Infectious &amp; Parasitic Diseases</td>
<td>Codes 001-139</td>
</tr>
<tr>
<td>2</td>
<td>Neoplasms</td>
<td>Codes 140-239</td>
</tr>
<tr>
<td>3</td>
<td>Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders</td>
<td>Codes 240-279</td>
</tr>
<tr>
<td>4</td>
<td>Diseases of the Blood and Blood-Forming Organs</td>
<td>Codes 280-289</td>
</tr>
<tr>
<td>5</td>
<td>Mental Disorders</td>
<td>Codes 290-319</td>
</tr>
<tr>
<td>6</td>
<td>Diseases of the Nervous System and Sense Organs</td>
<td>Codes 320-389</td>
</tr>
<tr>
<td>7</td>
<td>Diseases of the Circulatory System</td>
<td>Codes 390-459</td>
</tr>
<tr>
<td>8</td>
<td>Diseases of the Respiratory System</td>
<td>Codes 460-519</td>
</tr>
<tr>
<td>9</td>
<td>Diseases of the Digestive System</td>
<td>Codes 520-579</td>
</tr>
<tr>
<td>10</td>
<td>Diseases of the Genitourinary System</td>
<td>Codes 580-629</td>
</tr>
<tr>
<td>11</td>
<td>Complications of Pregnancy, Childbirth and the Puerperium</td>
<td>Codes 630-677</td>
</tr>
<tr>
<td>12</td>
<td>Diseases of the Skin and Subcutaneous Tissue</td>
<td>Codes 680-709</td>
</tr>
<tr>
<td>13</td>
<td>Diseases of the Musculoskeletal System and Connective Tissue</td>
<td>Codes 710-739</td>
</tr>
<tr>
<td>14</td>
<td>Congenital Anomalies</td>
<td>Codes 740-759</td>
</tr>
<tr>
<td>15</td>
<td>Certain Conditions Originating in the Perinatal Period</td>
<td>Codes 760-779</td>
</tr>
<tr>
<td>16</td>
<td>Symptoms, Signs and ill-defined Conditions</td>
<td>Codes 780-799</td>
</tr>
<tr>
<td>17</td>
<td>Injury &amp; Poisoning</td>
<td>Codes 800-999</td>
</tr>
</tbody>
</table>

**Supplementary Classification Systems:**

- Supplementary Classification of Factors Influencing Health Status and Contact With Health Services | Codes V01-V84
- Supplementary Classification of External Causes of Injury and Poisoning | Codes E800-E999

**Appendices:**

- A. Morphology of Neoplasms
- B. Deleted Effective October 1, 2004
- C. Classification of Drugs by American Hospital Formulary Service (AHFS) List Number and Their ICD-9-CM Equivalents
- D. Industrial Accidents According to Agency
- E. List of Three-Digit Categories
## Volume 1 Footnotes, Symbols and Conventions

<table>
<thead>
<tr>
<th>Volume 1 (Tabular)</th>
<th>Example</th>
</tr>
</thead>
</table>
| :                  | 021.1 Enteric tularemia  
|                    | Tularemia:  
|                    | cryptogenic  
|                    | intestinal  
|                    | typhoidal   |
| []                 | 482.2 Pneumonia due to Hemophilus influenzae  
|                    | [H. influenzae] |
| //                 | Tachycardia  
|                    | ventricular (paroxysmal)  
|                    | psychogenic 316 [427.1] |
| ()                 | 198.4 Other parts of nervous system  
|                    | Meninges (cerebral) (spinal) |
| {}                 | 560.2 Volvulus  
|                    | Knotting}  
|                    | Strangulation}  
|                    | Torsion} of intestine, bowel, or colon  
|                    | Twist} |
| **NEC - Not elsewhere classifiable** | **Metabolism disorder 277.9**  
| This abbreviation (found in Volume 2) is used when the ICD-9-CM system does not provide a code specific for the patient’s condition. | specified type NEC 277.89 |
| **NOS – Not otherwise specified** | 047.9 Unspecified viral meningitis  
<p>| This abbreviation is the equivalent of ‘unspecified’ and is used only when the coder lacks the information necessary to code to a more specific four-digit subcategory (Volume 1). | Viral meningitis <strong>NOS</strong> |</p>
<table>
<thead>
<tr>
<th>Instructional Notes</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volume 1 notes define terms or clarify information. Other instructional notes include the words:</td>
<td>137 Late effects of tuberculosis</td>
</tr>
<tr>
<td>Includes</td>
<td>Note: This category is to be used to indicate conditions classifiable to 010-018 as the cause of late effects, which are themselves classified elsewhere . . . .</td>
</tr>
<tr>
<td>Excludes</td>
<td></td>
</tr>
<tr>
<td>Use Additional Code</td>
<td></td>
</tr>
<tr>
<td>Code First Underlying Disease</td>
<td></td>
</tr>
<tr>
<td>See Condition</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age and Sex Edit Symbols</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A, N, M, P:</td>
<td></td>
</tr>
<tr>
<td>These symbols reference age indicators:</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Adult Age: 15-124</td>
</tr>
<tr>
<td>N</td>
<td>Newborn Age: 0</td>
</tr>
<tr>
<td>M</td>
<td>Maternity Age: 12-55</td>
</tr>
<tr>
<td>P</td>
<td>Pediatric Age: 0-17</td>
</tr>
<tr>
<td>♀</td>
<td>Female diagnosis or procedure only. This appears to the right of the code description. This reference appears in the disease and procedure tabular list.</td>
</tr>
<tr>
<td>219</td>
<td>Other benign neoplasm of uterus</td>
</tr>
<tr>
<td>219.0</td>
<td>Cervix uteri</td>
</tr>
<tr>
<td>♂</td>
<td>Male diagnosis or procedure only. This symbol appears to the right of the code description. This reference appears in the disease and procedure tabular list.</td>
</tr>
<tr>
<td>222</td>
<td>Benign neoplasm of male genital organ</td>
</tr>
<tr>
<td>222.0</td>
<td>Testis</td>
</tr>
<tr>
<td>Use additional code to identify any functional activity</td>
<td></td>
</tr>
</tbody>
</table>

| 3 5th | This symbol indicates that a code requires a fifth digit. |
| 519.0 Tracheostomy complications |
| 519.00 Tracheostomy complications unspecified |
| 519.01 Infection of tracheostomy |

| DEF: This symbol indicates a definition of disease or procedure term. The definition will appear in blue type in the Disease and Procedure Tabular Lists. | 362.64 Senile reticular degeneration |
| DEF: Net-like appearance of retina; sign of degeneration. | |
**Volume 1 (Tabular)**

**Example**

**MSP:** This identifies specific trauma diagnoses that alert the carrier that another carrier should be billed first and Medicare billed second if payment from the first payer does not equal or exceed the amount Medicare would pay.

807.0 - Fracture of rib(s), closed

---

**Supplementary Classification of Factors Influencing Health Status and Contact With Health Services (V01-V84)**

This classification system is provided to deal with occasions when circumstances other than a disease or injury classifiable to categories 001-999 (the main part of ICD-9-CM) are recorded as “diagnoses” or “problems”. This can arise in three main ways:

- When a person who is not currently sick encounters the health services for some specific purpose, such as to act as a donor of an organ or tissue, to receive prophylactic vaccination, or to discuss a problem which is in itself not a disease or injury.

- When a person with a known disease or injury, whether it is current or resolving, encounters the health care system for a specific treatment of that disease or injury. (e.g. dialysis for renal disease, chemotherapy for malignancy, or a cast change).

- When some circumstance or problem is present which influences the person’s health status but is not in itself a current illness or injury. Such factors may be elicited during population surveys, when the person may or may not be currently sick, or be recorded as an additional factor to be borne in mind when the person is receiving care for some current illness or injury classifiable to categories 001-999.

---

**Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01 – V84)**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with Potential Health Hazards Related to Communicable Disease</td>
<td>V01 - V06</td>
</tr>
<tr>
<td>Persons with Need for Isolation, Other Potential Health Hazards and Prophylactic Measures</td>
<td>V07 - V09</td>
</tr>
<tr>
<td>Persons with Potential Health Hazards Related to Personal and Family History</td>
<td>V10 - V19</td>
</tr>
<tr>
<td>Persons Encountering Health Services in Circumstances Related to Reproduction and Development</td>
<td>V20 – V29</td>
</tr>
<tr>
<td>Liveborn Infants According to Type of Birth</td>
<td>V30 - V39</td>
</tr>
</tbody>
</table>
Persons with a Condition Influencing Their Health Status | V40 - V49
Persons Encountering Health Services for Specific Procedures and Aftercare | V50 - V59
Persons Encountering Health Services in Other Circumstances | V60 - V69
Persons without Reported Diagnosis Encountered during Examination and Investigation of Individuals and Populations | V70 - V84

Supplementary Classification of External Causes of Injury and Poisoning (E800-E999)

This section is provided to permit the classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse affects. Where a code from this section is applicable, it is intended that it shall be used in addition to a code from one of the main chapters of ICD-9-CM, indicating the nature of the condition. Certain other conditions which may be stated to be due to external causes are classified in Chapters 1-16 of ICD-9-CM. For these, the “E” code classification should be used as an additional code for more detailed analysis.

“E” codes are not required for Medicare Part B billing, but are encouraged for Part A billing and should be entered on the UB-92 CMS-1450 in field 77.
**Volume 2 (Alphabetic Index)**

The Alphabetic Index contains three sections.

Section 1: An alphabetic index of diseases and injuries

Section 2: Alphabetic Index to Poisoning and External Causes of Adverse Effects of Drugs and Other Chemical Substances (Table of Drugs and Chemicals)

Section 3: Alphabetic Index to External Causes of Injury and Poisoning (E Codes)

The Alphabetic Index has been placed before the Tabular List in both the disease and procedure classifications. This allows the user to locate the correct codes in a logical natural manner by locating the term in the index, then confirming the accuracy of the code in the tabular list. Reliance on only the Alphabetic Index or the Tabular List leads to errors in code assignments and less specificity in code selection.

When two codes are required to indicate etiology (cause) and manifestation, the Alphabetic Index (Volume 2) will indicate the required coding order. The second code will be italicized and listed in slanted brackets. The coder should assign the two codes in the same order as they appear in Volume 2.
## Volume 2 Footnotes, Symbols and Conventions

<table>
<thead>
<tr>
<th>Volume 2 (Index)</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SEE</strong></td>
<td>Fracture</td>
</tr>
<tr>
<td>Directs the coder to a more specific term under which the correct code can be found.</td>
<td>Bursting – see Fracture, phalanx, hand, distal</td>
</tr>
<tr>
<td><strong>SEE CATEGORY</strong></td>
<td>Infection….</td>
</tr>
<tr>
<td>Indicates the coder should review the category specified before assigning the code.</td>
<td>brain…..</td>
</tr>
<tr>
<td></td>
<td>late effect - see category 326</td>
</tr>
<tr>
<td><strong>SEE ALSO</strong></td>
<td>Bartholin’s ….</td>
</tr>
<tr>
<td>Indicates where supplemental information is available that may provide another code.</td>
<td>Adenitis (See also Bartholinitis) 616.</td>
</tr>
<tr>
<td><strong>NEC Not elsewhere classifiable</strong></td>
<td>Metabolism disorder 277.9</td>
</tr>
<tr>
<td>This abbreviation is used when the ICD-9-CM system does not provide a code specific for the patient’s condition.</td>
<td>specified type NEC 277.89</td>
</tr>
<tr>
<td>( )</td>
<td>198.4 Other parts of nervous system</td>
</tr>
<tr>
<td>Parentheses enclose supplementary words, called non-essential modifiers, which may be present in the narrative description of a disease without affecting the code assignment.</td>
<td>meninges (cerebral) (spinal)</td>
</tr>
<tr>
<td><strong>Italicized</strong></td>
<td>Foreign body</td>
</tr>
<tr>
<td><em>Italicized type</em> is used for all exclusion notes and to identify codes that should not be used for describing the primary diagnosis.</td>
<td>Note - For foreign body with open wound or other injury, see Wound, open, or the type of injury specified.</td>
</tr>
</tbody>
</table>
Volume 2 Coding Tables

Three main tables are presented in the Alphabetic Index as tables. The Hypertension and Neoplasm tables are found in their proper alphabetical place in the Index, but the Table of Drugs and Chemicals follows the alphabetic listing.

Hypertension Table

The hypertension table is found under the main heading “Hypertension/hypertensive” This table contains the complications, etiology (cause) and clinical manifestations of hypertension. There are three subcategories for each listing in this category.

<table>
<thead>
<tr>
<th>Malignant</th>
<th>Benign</th>
<th>Unspecified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant hypertension is usually defined as very high blood pressure with swelling of the optic nerve behind the eye, called papilledema. Malignant hypertension is usually accompanied by other organ damage like heart failure, kidney failure, and hypertensive encephalopathy. Malignant hypertension is a medical emergency.</td>
<td>In a benign (nonmalignant) hypertension, in which hypertensive neuroretinopathy is absent, a hypertensive crisis may occur based on the development of concomitant acute end-organ dysfunction.</td>
<td>This form indicates that the type of hypertension has not yet been determined by the physician.</td>
</tr>
</tbody>
</table>

Hypertension, Essential, or NOS:

- Assign hypertension arterial (essential)(primary)(systems)(NOS) to category code 401 with the appropriate fourth digit to indicate malignant (0.0), benign (0.1), or unspecified (0.9). Do not use either malignant (0.0) or benign (0.1) unless medical record documentation supports such a designation.

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). The same heart conditions with hypertension, but without a stated casual relationship are coded separately.

Hypertensive Renal Disease with Chronic Renal Failure:

- Assign category code 403, hypertensive renal disease, when conditions classified to categories (585-587) are present. Unlike hypertension with heart disease, ICD-9-CM presumes a cause-and-effect relationship and classifies renal failure with hypertension as hypertensive renal disease.
Hypertensive Heart and Renal Disease:

- Assign codes from combination category 404 when both hypertensive heart and hypertensive renal disease are stated in the diagnosis.

Hypertensive Cerebrovascular Disease:

- First assign category codes from 430-438 (cerebrovascular disease) and then the appropriate hypertension code from categories (401-405).

- Hypertensive Retinopathy: Two codes are necessary to identify the condition. First assign the code from the subcategory 362.11 (hypertensive retinopathy), then the appropriate code from categories 401-405 to indicate the type of hypertension.

Hypertension, Secondary:

- Two codes are required: One to identify the underlying etiology and one from category 405 to identify the hypertension.

Hypertension, Transient or Elevated Blood Pressure:

- Assign code 796.2, elevated blood pressure reading without diagnosis of hypertension. Use codes 642.3X for transient hypertension of pregnancy.

Hypertension, Controlled/Uncontrolled:

- Assign appropriate code from categories (401-405). Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to the current therapeutic regimen.

**Neoplasm Table**

The neoplasm table is found under the main term Neoplasm, neoplastic. The table gives the code numbers for neoplasm by anatomical site. For each site, there are six possible code numbers according to whether the neoplasm in question is malignant, benign, in situ, of uncertain behavior or of unspecified nature. The description of the neoplasm will often indicate which of the six columns is appropriate.

The word neoplasm simply means new growth. Neoplasm may remain benign (non-cancerous), become cancerous (malignant), spread to other areas (metastasis) or, remain in one designated area (ca in situ). It should be noted, the term mass is not synonymous with neoplasm, as it is often used to describe cysts and thickenings such as those occurring with hematoma or infection.

<table>
<thead>
<tr>
<th>Malignant</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Secondary</td>
</tr>
</tbody>
</table>

First Coast Service Options, Inc. - Medicare Communication and Education
To properly code a neoplasm it is necessary to determine from the record if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior. If malignant, any secondary (metastatic) sites should also be determined.

The neoplasm table in the Alphabetic Index should be referenced first. If the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate. For example, if the documentation indicates “adenoma”, refer to the term in the Alphabetic Index to review the entries under this term and the instructional note to “see also neoplasm, by site, benign.” The table provides the proper code based on the type of neoplasm and the site. It is important to select the proper column in the table that corresponds to the type of neoplasm. The tabular list should then be referenced to verify that the correct code has been selected from the table and that a more specific site code does not exist.

- If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis.

- When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

- Coding and sequencing of complications associated with the malignant neoplasm or with the therapy thereof are subject to the following guidelines:
  - When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the anemia is designated as the principal diagnosis and is followed by the appropriate code(s) for the malignancy.
  - When the admission/encounter is for management of an anemia associated with chemotherapy or radiotherapy and the only treatment is for the anemia, the anemia is sequenced first followed by the appropriate code(s) for the malignancy.
  - When the admission/encounter is for management of dehydration due to the malignancy or the therapy, or a combination of both, and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.
  - When the admission/encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of an intestinal malignancy, designate the complication as the principal or first-listed diagnosis if treatment is directed at resolving the complication.

- When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category V10, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the V10 code used as a secondary code.
ICD-9 Coding for Beginners

March 2006

• Admissions/Encounters involving chemotherapy and radiation therapy:
  
  o When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by chemotherapy or radiation treatment, the neoplasm code should be assigned as principal or first-listed diagnosis. When an episode of inpatient care involves surgical removal of a primary or secondary site malignancy followed by adjunct chemotherapy or radiotherapy, code the malignancy as the principal or first-listed diagnosis, using codes in the 140-198 series or where appropriate in the 200-203 series.

  o If a patient admission/encounter is solely for the administration of chemotherapy or radiation therapy code V58.0, Encounter for radiation therapy, this should be the first-listed or principal diagnosis. If a patient receives both chemotherapy and radiation therapy, both codes should be listed, in either order of sequence.

  o When a patient is admitted for the purpose of radiotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is V58.0, Encounter for radiotherapy, or V58.1, Encounter for chemotherapy.

• When the reason for admission/encounter is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal or first-listed diagnosis, even though chemotherapy or radiotherapy is administered.

  “V” Codes Associated with Neoplasms

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V10</td>
<td>Personal history of malignant neoplasm</td>
</tr>
<tr>
<td>V16</td>
<td>Family history of malignant neoplasm</td>
</tr>
<tr>
<td>V71</td>
<td>Observation and evaluation for suspected conditions not found</td>
</tr>
<tr>
<td>V76</td>
<td>Special screening for malignant neoplasms</td>
</tr>
</tbody>
</table>

Table of Drugs and Chemicals

The Table of Drugs and Chemicals contains an extensive list of drugs, and other chemical substances to identify poisoning states and other external causes of adverse effects set in a six-column format. The first column is used to code the substance involved in the poisoning situation. The next five columns are grouped under the heading “External Cause (E Code)” and identify the circumstances involved.

The E codes in the five columns in this table are defined as:

Accidental Poisoning Codes (E850-E869) identify accidental overdose of drug, wrong substance given or taken inadvertently, accidents in the usage of drugs and biologicals in medical and surgical procedures, and to show external causes of poisoning classifiable to 980 – 989. Therapeutic Uses
Codes (E930-E949) indicates a correct substance properly administered in therapeutic or prophylactic dosage as the external cause of adverse effects.

Suicide Attempt Codes (E950-E952) identify instances in which self-inflicted injuries or poisonings are involved.

Assault Codes (E961-E962) indicate injury or poisoning inflicted by another person with the intent to injure or kill.

Undetermined Codes (E980-E982) are to be used when the intent of the poisoning or injury cannot be determined (i.e., whether it was intentional or accidental).
Coding Burns

Current burns (940 – 948) are classified by depth, extent and by agent (E code). Burns are classified by depth as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement).

- Sequence first the code that reflects the highest degree of burn when more than one burn is present.
- Classify burns of the same local site three-digit category level, (940-947) but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis.
- Non-healing burns are coded as acute burns. Necrosis of burned skin should be coded as non-healed burn.
- Assign code 958.3, Post-traumatic wound infection, not elsewhere classified, as an additional code for any documented burn site.
- When coding burns, assign separate codes for each burn site. Category 946, burns of multiple specified sites, should only be used if the locations of the burns are not documented. Category 949, burns, unspecified, is extremely vague and should rarely be used.
- Assign codes from category 948, Burns classified according to extent of body surface involved, when the site of the burn is not specified or when there is a need for additional data. It is advisable to use category 948 as additional coding when needed to provide data for evaluating burn mortality, such as that needed by burn units. It is also advisable to use category 948 as an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface.
- In assigning a code from category 948: Fourth-digit codes are used to identify the percentage of total body surface involved in a burn (all degree).
- Fifth-digits are assigned to identify the percentage of body surface involved in third-degree burn.
- Fifth-digit zero (0) is assigned when less than 10 percent or when no body surface is involved in a third-degree burn.
- Category 948 is based on the classic “Rule of Nines” in estimating body surface involved: head and neck are assigned nine percent, each arm nine percent, each leg 18 percent, the anterior trunk 18 percent, posterior trunk 18 percent, and genitalia one percent. Physicians may change these percentage assignments where necessary to accommodate infants and children who have proportionately larger heads than adults and patients who have large buttocks, thighs, or abdomens that involve burns.
- Encounters for the treatment of the late effects of burns (i.e., scars or joint contractures) should be coded to the residual condition (sequelae) followed by the appropriate late effect code (906.5-906.9). A late effect E code may also be used if desired.
- When appropriate, both a sequelae with a late effect code, and a current burn code may be assigned on the same record.
The body is divided into eight areas:

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head and Neck</td>
<td>9%</td>
</tr>
<tr>
<td>Posterior Trunk</td>
<td>18%</td>
</tr>
<tr>
<td>Anterior Trunk</td>
<td>18%</td>
</tr>
<tr>
<td>Left Arm</td>
<td>9%</td>
</tr>
<tr>
<td>Right Arm</td>
<td>9%</td>
</tr>
<tr>
<td>Posterior Leg</td>
<td>18%</td>
</tr>
<tr>
<td>Anterior Leg</td>
<td>18%</td>
</tr>
<tr>
<td>Genitalia</td>
<td>1%</td>
</tr>
</tbody>
</table>

Total body: 100%

**Rule of Nines**

Estimation of Total Body Surface Burned

- Head and neck 9%
- Each arm 9%
- Anterior trunk 18%
- Posterior trunk 18%
- Genitalia 1%
- Anterior leg 9%
- Posterior leg 9%
Coding Multiple Injuries and/or Multiple Fractures

When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Multiple injury codes are provided in ICD-9-CM, but should not be assigned unless information for a more specific code is not available. These codes are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.

The code for the most serious injury, as determined by the physician, is sequenced first.

- Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.
- When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) from categories 950-957, Injury to nerves and spinal cord, and/or 900-604, Injury to blood vessels. When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

The principles of multiple coding of injuries should be followed in coding fractures. Fractures of specified sites are coded individually by site in accordance with both the provisions within categories 800-829 and the level of detail furnished by medical record content. Combination categories for multiple fractures are provided for use when there is sufficient detail in the medical record (such as trauma cases transferred to another hospital), when the reporting form limits the number of codes that can be used in reporting pertinent clinical data, or when there is insufficient specificity at the fourth-digit or fifth-digit level. More specific guidelines are as follows:

- Multiple fractures of same limb classifiable to the same three-digit or four-digit category are coded to that category.
- Multiple unilateral or bilateral fractures of same bone(s) but classified to different fourth-digit subdivisions (bone part) within the same three-digit category are coded individually by site.
- Multiple fracture categories 819 and 828 classify bilateral fractures of both upper limbs (819) and both lower limbs (828), but without any detail at the fourth-digit level other than open and closed type of fractures.
- Multiple fractures are sequenced in accordance with the severity of the fracture and the physician should be asked to list the fracture diagnoses in the order of severity.
Volume 3 (Procedures – Tabular & Alphabetic Index)

Volume 3, which is updated annually by CMS, is used for hospital and skilled nursing facility billing.

Volume 3 begins with an Alphabetical Index to Procedures. The index is followed by the Tabular List of procedure descriptors (i.e., thoracentesis (34.91), laparotomy (54.1)) and corresponding 3 or 4-digit numerical codes).

Chapters 1-15 contain surgical procedures and are organized anatomically. Chapter 16 contains miscellaneous diagnostic and therapeutic procedures.

Listed below are the exclusive resources found ONLY in the ICD-9-CM Expert for Hospitals, Volume 1, 2, and 3 books.

Pharmacological Listings
The most common generic and brand name of drugs are linked with the disease processes to assist in the identification of complications and cormorbidities (CC) thereby improving Diagnosis Related Groups (DRG) assignment practices.

Diagnosis Code/Major Diagnostic Categories (MDC) Diagnosis Related Groups (DRG) List
Provides the complete list of principal diagnosis codes and the MDC and the DRG to which they belong, with the exception of a combination of principal and secondary diagnoses.

Complication & Cormorbidity (CC) Code List
A complete list of all codes considered Complication and Cormorbidities (CC) that will affect DRG assignment. This is an essential auditing tool for assigning the most appropriate DRG.

Valid Three-digit ICD-9-CM Codes
ICD-9-CM is composed of codes with either 3, 4, or 5 digits. A code is invalid if it has not been coded to the full number of digits required for that code. There are a certain number of codes that are valid for reporting as three-digit codes. A list of the valid three-digit codes is included as a convenient reference when auditing claims.
The following table is an index listing the chapter, chapter heading, and procedure codes within Volume 3.

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Chapter Heading</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Operations on the Nervous System</td>
<td>01-05</td>
</tr>
<tr>
<td>2</td>
<td>Operations on the Endocrine System</td>
<td>06-07</td>
</tr>
<tr>
<td>3</td>
<td>Operations on the Eye</td>
<td>08-16</td>
</tr>
<tr>
<td>4</td>
<td>Operations on the Ear</td>
<td>18-20</td>
</tr>
<tr>
<td>5</td>
<td>Operations on the Nose, Mouth, and Pharynx</td>
<td>21-29</td>
</tr>
<tr>
<td>6</td>
<td>Operations on the Respiratory System</td>
<td>30-34</td>
</tr>
<tr>
<td>7</td>
<td>Operations on the Cardiovascular System</td>
<td>35-39</td>
</tr>
<tr>
<td>8</td>
<td>Operations on the Hemic and Lymphatic System</td>
<td>40-41</td>
</tr>
<tr>
<td>9</td>
<td>Operations on the Digestive System</td>
<td>42-54</td>
</tr>
<tr>
<td>10</td>
<td>Operations on the Urinary System</td>
<td>55-59</td>
</tr>
<tr>
<td>11</td>
<td>Operations on the Male Genital Organs</td>
<td>60-64</td>
</tr>
<tr>
<td>12</td>
<td>Operations on the Female Genital Organs</td>
<td>65-71</td>
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<tr>
<td>13</td>
<td>Obstetrical Procedures</td>
<td>72-75</td>
</tr>
<tr>
<td>14</td>
<td>Operations on the Musculoskeletal System</td>
<td>76-84</td>
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<tr>
<td>15</td>
<td>Operations on the Integumentary System</td>
<td>85-86</td>
</tr>
<tr>
<td>16</td>
<td>Miscellaneous Diagnostic and Therapeutic Procedures</td>
<td>87-99</td>
</tr>
</tbody>
</table>
## Resources

<table>
<thead>
<tr>
<th>WEBSITES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Medicare &amp; Medicare Services (CMS)</td>
<td><a href="http://new.cms.hhs.gov/ICD9ProviderDiagnosticCodes/">http://new.cms.hhs.gov/ICD9ProviderDiagnosticCodes/</a></td>
</tr>
<tr>
<td>First Coast Service Options, Inc.</td>
<td><a href="http://www.floridamedicare.com">www.floridamedicare.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER PUBLICATIONS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM Professional, Volume 1, 2 &amp; 3</td>
<td>Ingenix/St.Anthony Publishing/Medicode</td>
</tr>
</tbody>
</table>