

ICD-9-CM Diagnostic Coding Guidelines for Outpatient Services

Audio Seminar/Webinar

June 12, 2008

Practical Tools for Seminar Learning

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Faculty

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Objectives

- ◆ **Review the ICD-9-CM Diagnostic Coding and Reporting Guidelines for Outpatient Services (Section IV)**
- ◆ **Provide guidance on the Chapter Specific Coding Guidelines for V codes.**
- ◆ **Discuss challenging coding areas: 1st listed diagnosis, signs and symptoms, and diagnostic/therapeutic encounters.**

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Objectives

- ◆ **Review the documentation requirements for coding outpatient encounters.**
- ◆ **Review challenging case scenarios that illustrate best coding practices**

2

Polling Question #1



Which of the following ICD-9-CM official coding and reporting guidelines differs between the outpatient and hospital inpatient setting?

- *1 Coding and reporting guidelines for inconclusive diagnoses (probable, suspected, etc.)
- *2 Coding and reporting guidelines for abnormal findings (x-ray, pathology, and other diagnostic tests)
- *3 Coding and reporting guidelines for conditions that are an integral part of a disease process (signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification)
- *4 Both 1 and 2

3

Coding Guidelines for Outpatient Services – Things to Remember

- ♦ The terms encounter and visit are synonymous when describing outpatient service contacts.
- ♦ Inconclusive diagnoses are not acceptable for outpatient reporting.
-Probable, Suspected, Rule out
- ♦ The term “first-listed” diagnosis is used in lieu of principal diagnosis.

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OP Coding Guidelines – Selection of First-listed Condition

- ◆ The coding conventions of ICD-9-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.
- ◆ Diagnosis may not be established at the time of an initial visit.
 - May take two or more visits before a diagnosis is confirmed.

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OP Coding Guidelines – Selection of First-listed Condition (cont.)

- ◆ **Outpatient Surgery**
 - Code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.
- ◆ **Observation Stay**
 - Assign a code for the medical condition as the first-listed diagnosis.
 - OP surgery complications requiring admit to OBS code reason for surgery followed by complication codes

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Polling Question #2



A patient had carcinoma of the descending colon which was resected one year prior to this outpatient encounter. Patient is now seen for colonoscopy to evaluate anastomosis and remaining colon. Colonoscopy showed a normal anastomosis and no evidence of cancer recurrence. However, a polyp was identified distal to anastomosis site and was removed. Pathologic evaluation showed benign polyp. No other abnormal conditions were found.

How should the reason for the encounter be coded?

- *1 Benign Polyp and personal history malignancy, large intestine.**
- *2 Suspected Malignant Polyp**
- *3 Benign Polyp**
- *4 Personal history malignancy, large intestine**

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OP Coding Guidelines – Codes from 001.0 – V84.8

- ♦ The appropriate code or codes from 001.0 through V84.8 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason (s) for the encounter/visit.**

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***OP Coding Guidelines –
Accurate Reporting ICD-9-CM Dx***

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

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***OP Coding Guidelines –
Selection of 001.0 – 999.9***

- ♦ The selection of codes 001.0 through 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 and parasitic diseases; neoplasms; symptoms, signs, and ill-defined conditions, etc).

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OP Coding Guidelines – Signs/Symptoms

- ◆ 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 provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined Conditions (codes 780.0–799.9), contains many, but not all, codes for symptoms.
 - Note: This rule is not to be ignored regarding payer specific medical necessity issues.

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OP Coding Guidelines –

Encounters for circumstances other than disease or injury

- ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01.0–V84.8) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

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OP Coding Guidelines – Level of Detail

- 1. Code to the highest level of specificity. ICD-9-CM is composed of codes with either 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater specificity.**
- 2. A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit sub classifications 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.**

*Note: See Section I.b.3., General Coding Guidelines ,
Level of Detail in Coding.*

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OP Coding Guidelines – ICD-9-CM code "chiefly responsible"

- ♦ List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.**

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***OP Coding Guidelines –
“Highest degree of certainty”***

- ◆ Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit. *This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.*

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***OP Coding Guidelines –
Chronic Diseases***

- ◆ 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)

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***OP Coding Guidelines –
Co-existing conditions***

- ◆ Code all documented conditions that coexist 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. 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.

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***OP Coding Guidelines –
Diagnostic Services Only***

- ◆ For patients receiving diagnostic 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.

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***OP Coding Guidelines –
Diagnostic Services Only (cont.)***

- ◆ For encounters for routine laboratory/radiology testing in the absence of any signs/symptoms, or associated diagnosis, assign V72.5 and V72.6. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the V code and the code describing the reason for the non-routine test.

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***OP Coding Guidelines –
Diagnostic Services Only (cont.)***

- ◆ For outpatient encounters for diagnostic 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/symptoms as additional diagnoses.
This differs from the coding practices in the hospital inpatient setting regarding abnormal findings on test results.

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Polling Question #3



When coding outpatient diagnostic radiology services at your facility, what piece of documentation do you use to assign the primary diagnosis code?

- *1 Test order only (signs/symptoms)**
- *2 Radiology report – impression only**
- *3 Radiology report – impression and body of report only**
- *4 Radiology report and test order are reviewed prior to assigning the primary diagnosis**

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OP Coding Guidelines - Therapeutic Services

- ♦ 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.**

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OP Coding Guidelines – Pre-op Evaluations

- ♦ For patient's receiving preoperative evaluations only, sequence first a code from category V72.8, Other specified examinations, to describe the pre-op 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 pre-op evaluation.

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OP Coding Guidelines – 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.

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OP Coding Guidelines – Routine Prenatal Visits

- ◆ For routine prenatal visits when no complications are present, code V22.0 Supervision of normal first pregnancy, or V22.1 Supervision of other normal pregnancy, should be used as the principal diagnosis. These codes should not be used in conjunction with chapter 11 codes.

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CMS and Outpatient Coding Guidelines for Diagnostic Tests

CMS - Program Memoranda Carriers 2001
PM Rev. B-01-61, ICD-9-CM Coding for
Diagnostic Tests

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CMS - Coding Guidelines for Diagnostic Tests

- ◆ Use the ICD-9-CM code that describes the patient's diagnosis, symptom, complaint, condition, or problem. Do not code a suspected diagnosis.
- ◆ Use the ICD-9-CM code that is chiefly responsible for the item or service provided.
- ◆ Assign codes to the highest level of specificity.
- ◆ Code chronic conditions when they apply to the patient's treatment and code all documented conditions that affect treatment at the visit.
- ◆ Do not code conditions that no longer exist.

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ICD-9 Coding for Diagnostic Tests

- ◆ Determining the appropriate primary ICD-9 code to assign
- ◆ Determining the reason for the test
- ◆ Incidental findings
- ◆ Unrelated/co-existing Conditions
- ◆ No signs/symptoms given (screening)
- ◆ Coding to the highest degree of specificity and certainty

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CMS - Coding Guidelines for Diagnostic Tests (cont.)

- ◆ **Use the following guidelines to assign the primary diagnosis code**
 - Code a diagnosis confirmed by test results
 - Code signs/symptoms when findings are normal or when the findings are uncertain (ie. Probable, suspected, questionable)
 - Do not code incidental findings or unrelated co-existing conditions
 - For screening tests (those performed in the absence of signs/symptoms) assign the appropriate V code (findings are coded as secondary)

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Code Signs/Symptoms

- ◆ **Test performed and the results are back but the physician has not yet reviewed them to make a diagnosis, or there is no interpretation**
- ◆ **No report of the physician interpretation at the time of billing, code what is known at the time of billing.**

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Example

- ◆ **A patient is referred to a radiologist for an abdominal CT scan with a diagnosis of abdominal pain. The CT scan reveals the presence of an abscess.**
 - **What diagnosis should be reported?**

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Example

- ◆ **A patient is referred to a radiologist for a chest X-ray with a diagnosis of "cough." The chest X-ray reveals a 3 cm peripheral pulmonary nodule.**
 - **What diagnosis code should be reported?**

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Example

- ♦ **A patient is referred to a radiologist for a spine X-ray due to complaints of “back pain.” The radiologist performs the X-ray, and the results are normal.**
 - **What diagnosis code should be reported?**

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Example

- ♦ **A patient is referred to a radiologist for a gastrograffin enema to rule out appendicitis. However, the referring physician does not provide the reason for the referral and is unavailable at the time of the study. The patient is queried and indicates that he/she saw the physician for abdominal pain and was referred to rule out appendicitis. The radiologist performs the X-ray, and the results are normal.**
 - **What diagnosis code should be assigned?**

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Example

- ◆ Patient has multiple EKGs for complaints of chest pain, however the final diagnosis is a gastritis problem causing the chest pain
 - Therefore based on coding and Medicare payer rules, the sign and symptom (chest pain) should not be coded, as it is integral to the disease process

Note: Chest Pain may be coded as the admitting diagnosis

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Radiology Coding FAQs

- ◆ Can I code from the header of the radiology report?
 - Must the body of the report support the exam stated in the header?
- ◆ If a radiologist uses the phrase “consistent with” in his report can I code the condition as a definitive diagnosis?
 - *Coding Clinic*, 3rd Quarter 2005

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Order for Radiology Dx Coding

- ◆ **Radiology Report**
 - **Impression vs. Findings?**
 - **Indications**
- ◆ **Test orders**

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Classification of Factors Influencing Health Status

- ◆ **A V code table defining whether the V code should be reported as first listed, first or additional or additional only is found in the same publication on page 86**

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Primary Circumstances for V Code Use

- 1. A person is not currently sick but has a health care encounter for a specific reason, i.e. inoculations, screening, etc.**
- 2. Aftercare for resolving condition or long term condition requiring continuous care, i.e. dialysis**
- 3. Health status influenced by other than current illness or injury**
- 4. Birth status for newborns**

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V Code Guidelines

- ♦ May be used in any setting, but generally more applicable to outpatient settings**
- ♦ Have designations to list first, list only as an additional diagnosis, or list as either (see V code list, pg 86, CC 4Qtr 2002)**

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V Code Categories

- ◆ **Contact/Exposure (V01)**
 - Exposure to communicable disease
 - No signs/symptoms
 - May be primary or secondary
- ◆ **Vaccinations (V03-V06)**
 - Encounter for prophylactic inoculation against a disease
 - Use as secondary if given as part of routine preventive care

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Influenza and PPV Vaccines



Effective for dates of service on or after
October 1, 2006:

- ◆ Report diagnosis code V06.6 on claims that contain Influenza Virus and/or PPV vaccines and their administration when the purpose of the visit was to receive both vaccines
- ◆ Continue reporting diagnosis code V03.82 on claims that contain only PPV vaccine and its administration
- ◆ Continue reporting diagnosis code V04.81 on claims that contain only Influenza Virus vaccine and its administration

<http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM5037.pdf>

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V Code Categories (cont.)

◆ Status

- Patient is either a carrier or has the sequelae or residual of a past disease or condition
- Status affects course of treatment and outcome
- Status vs. history – history patient no longer has condition

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V Code Categories (cont.)

◆ History of (Personal)

- No longer exists, no treatment but has potential for recurrence and may require monitoring
 - Exceptions V14 & V15.0
- May be used w/ follow-up codes

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Neoplasm Guidelines

- ◆ **V10XX, Personal History of Malignant Neoplasm is reported if the primary malignancy has been excised or eradicated and there is not further treatment directed to the site nor evidence of any existing primary malignancy.**

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V Code Categories (cont.)

- ◆ **History of (Family)**
 - Patient family member has had a disease that causes patient to be at higher risk for the disease
 - May be used w/ screening codes

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V Code Categories (cont.)

- ◆ **Screening (V28, V73-V82)**
 - Testing for disease or indicators in seemingly well individuals for early detection and treatment for those who test positive
 - May use as additional code if done during visit for other reason
 - Findings of screening reported as secondary

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Screening Mammography – V76.11 vs. V76.12

- ◆ What constitutes “high risk”?
- ◆ CMS considers the following patients to be high risk:
 - Has a personal history of breast cancer (V10.3)
 - Has family history of breast cancer (V16.3)
 - Mother
 - Sister
 - Daughter
 - Had her first baby after age 30 (V15.89)
 - Has never had a baby (V15.89)
- ◆ Assign V76.11 as primary, above as secondary

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Screening Colonoscopy – V76.41 & V76.51

- ◆ **High Risk Factors Colorectal Ca**
 - Sibling, parent, or child w/ colon ca or adenomatous polyp (V16.0 & **V15.81**)
 - Family history
 - Familial adenomatous polyposis (**V15.81**)
 - Hereditary nonpolyposis colorectal cancer (V16.0)
 - Personal history
 - Adenomatous polyps (V12.72)
 - Colorectal cancer (V10.05)
 - Inflammatory bowel disease
 - Crohn's
 - Ulcerative colitis

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V Code Categories (cont.)

- ◆ **Observation (V29, V71)**
 - Used when a person is being observed for a suspected condition that is ruled out and the patient does not have sign/symptoms related to the suspected condition
 - Used as principal only
 - Exception V30 – V29 is sequenced after V30
 - Additional codes for conditions unrelated to obs may be sequenced as additional codes

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V Code Categories (cont.)

- ◆ **Aftercare (V51-V58)**
 - The initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase or long-term consequences of the disease
 - Generally listed first, but may be additional code
 - Certain aftercare codes require secondary dx code
 - Status and aftercare codes may be used together
 - Do not use if treatment is directed at current, acute disease or injury
 - Exceptions V58.0, V58.1, V56.x

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Fracture Aftercare

- ◆ **V54.1 Aftercare for healing traumatic fracture**
- ◆ ***Coding Clinic 4thQ 2003 p.8***
 - "Coding guidelines require that an aftercare code be used for all subsequent encounters after the initial encounter for care of a fracture. For statistical purposes, a fracture should only be coded once."

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V Code Categories (cont.)

♦ Follow-up (V24, V67)

- Explain continuing surveillance following completed treatment of a disease, condition or injury
- Infer that the condition has been fully treated and no longer exists
- If the condition recurs then the diagnosis code should be used in place of the follow-up code
- Can be used w/history codes
 - Code follow-up as first

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Case Study

- ♦ A patient who had a coronary bypass two years ago is seeing the physician for a follow-up stress test and subsequent evaluation. The patient has no complaints. This is:
 1. aftercare
 2. a follow-up visit
 3. a routine exam

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V Code Categories (cont.)

- ◆ **Donor**
 - for use with individuals donating for others, not for self donations and not for cadaveric donations.
- ◆ **Counseling**
 - patient or family receives assistance in the aftermath of an illness or injury and support is required for coping.
 - Not necessary with a diagnosis code when counseling component is integral to treatment

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V Code Categories (cont.)

- ◆ **Obstetrics and Related Conditions**
 - Use when no problems or complications
 - V22.0 & V22.1 always primary, do not use with codes from OB chapter
 - V27 outcome of delivery – secondary code on all maternal records

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V Code Categories (cont.)

◆ Routine and Administrative Exams

- describe routine encounters, e.g. school or pre-employment exams
- if exam is for a suspected condition or treatment, report the condition code
- a diagnosis or condition discovered during a routine exam may be reported as an additional code
- pre-op exam is used only for surgical clearance, when no treatment is given.

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V Code Categories (cont.)

◆ Special Investigations and Examinations (V72)

- Diagnostic service only
- No problem, diagnosis or condition is identified
- Pre-op Exams
 - V72.81, V72.82, V72.83
 - Assign as primary, followed by reason for surgery

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Resource/Reference List

- **International Classification of Diseases, 9th Revision, Clinical Modification : ICD-9-CM, 4th ed.; US Health Care Financing Administration, DHHS publication**
- ***AHA Coding Clinic for ICD-9-CM*, Effective, October 1, 2007 discharges, Fourth Quarter 2007, pg 192**
- ***AHA Coding Clinic for ICD-9-CM*, Vol 12, Number 4, Fourth Quarter 1995**
- **<http://www.cdc.gov/nchs/about/otheract/icd9/maint/maint.htm>**

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Resource/Reference List

- ♦ **ICD-9-CM Official Guidelines for Coding and Reporting Effective October 1, 2007**
- ♦ **Program Memoranda Rev. B-01-61, ICD-9-CM Coding for Diagnostic Tests**
- ♦ ***AHA Coding Clinic for ICD-9 CM* Volume 20 Third Quarter - Number 3 2003**
- ♦ ***AHA Coding Clinic for ICD-9 CM* Volume 17 Third Quarter - Number 3 2000**

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Audience Questions



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July 24, 2008

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Appendix

Resource/Reference List	35
CE Certificate Instructions	

Resource/Reference List

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- ♦ ***AHA Coding Clinic for ICD-9 CM* Volume 20 Third Quarter - Number 3 2003**
- ♦ ***AHA Coding Clinic for ICD-9 CM* Volume 17 Third Quarter - Number 3 2000**

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