ICD-9-CM Coordination and Maintenance Committee Meeting
September 27-28, 2007
Diagnosis Agenda

Welcome and announcements
Donna Pickett, MPH, RHIA
Co-Chair, ICD-9-CM Coordination and Maintenance Committee

ICD-9-CM TIMELINE

A timeline of important dates in the ICD-9-CM process is described below:

September 27 – 28, 2007	ICD-9-CM Coordination and Maintenance Committee meeting. Those who wish to attend the ICD-9-CM Coordination and Maintenance Committee meeting **must have registered for the meeting online by September 21, 2007.** You must bring an official form of picture identification (such as a drivers license) in order to be admitted to the building.
October 2007	Summary report of the Procedure part of the September 27 – 28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on the CMS homepage as follows: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Summary report of the Diagnosis part of the September 27 – 28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on the NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
October 1, 2007	New and revised ICD-9-CM codes go into effect along with DRG changes. Final addendum posted on web pages as follows: Diagnosis addendum - http://www.cdc.gov/nchs/icd9.htm Procedure addendum at - http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes
October 12, 2007	**Deadline for receipt of public comments on proposed code revisions discussed at the September 27-28, 2007 ICD-9-CM Coordination and Maintenance Committee meetings for implementation of April 1, 2008.**
Early November, 2007	Any new ICD-9-CM codes required to capture new technology that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2008 will be posted on the following websites: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes http://www.cdc.gov/nchs/icd9.htm

December 3, 2007	**Deadline for receipt of public comments on proposed code revisions discussed at the March 22-23, 2007 and September 27-28, 2007 ICD-9-CM Coordination and Maintenance Committee meetings for implementation of October 1, 2008.**
January 18, 2008	Deadline for requestors: Those members of the public requesting that topics be discussed at the March 19–March 20, 2008 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses by this date.
February 2008	Draft agenda for the Procedure part of the March 19, 2008 ICD-9-CM Coordination and Maintenance Committee meeting posted on CMS homepage as follows: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Draft agenda for the Diagnosis part of the March 20, 2008 ICD-9-CM Coordination and Maintenance Committee meeting posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm Federal Register notice of March 19 – March 20, 2008 ICD-9-CM Coordination and Maintenance Committee Meeting will be published.
February 15, 2008	**On-line registration opens for the March 19 – 20, 2008 ICD-9-CM Coordination and Maintenance Committee meeting at: http://www.cms.hhs.gov/events** Because of increased security requirements, **those wishing to attend the March 19 – March 20, 2008** ICD-9-CM Coordination and Maintenance Committee meeting must register for the meeting online **by March 12, 2008 failure to do so may result in lack of access to the meeting**.
March 19 – March 20 2008	ICD-9-CM Coordination and Maintenance Committee meeting.

April 1, 2008	Any new ICD-9-CM codes required to capture new technology will be implemented. Information on any new codes implemented on April 1, 2008 previously posted in early October 2007 will be on the following websites: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes http://www.cdc.gov/nchs/icd9.htm http://www.cms.hhs.gov/MLNGenInfo
April 11, 2008	Deadline for receipt of public comments on proposed code revisions discussed at the March 19-20, 2008 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on **October 1, 2008.**
April 2008	Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This notice will include the final ICD-9-CM diagnosis and procedure codes for the upcoming fiscal year. It will also include proposed revisions to the DRG system on which the public may comment. The proposed rule can be accessed at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp
April 2008	Summary report of the Procedure part of the March 19, 2008 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Summary report of the Diagnosis part of the March 20, 2008 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
June 2008	Final addendum for October 1, 2009 posted on web pages as follows: Diagnosis addendum at - http://www.cdc.gov/nchs/icd9.htm Procedure addendum at – http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes
June 20, 2008	Deadline for receipt of public comments on proposed code revisions discussed at the March 19-20, 2008 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on **October 1, 2009.**

July 25, 2008	Those members of the public requesting that topics be discussed at the September 24 – 25, 2008 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses.
August 1, 2008	Hospital Inpatient Prospective Payment System final rule to be published in the Federal Register as mandated by Public Law 99-509. This rule will also include all the final codes to be implemented on October 1, 2008. This rule can be accessed at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp
August 2008	Tentative agenda for the Procedure part of the September 24 – 25, 2008 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage at - http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Tentative agenda for the Diagnosis part of the September 24 – 25, 2008 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on NCHS homepage at - http://www.cdc.gov/nchs/icd9.htm Federal Register notice for the September 24 – 25, 2008 ICD-9-CM Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.
August 15, 2008	**On-line registration opens for the September 24-25, 2008 ICD-9-CM Coordination and Maintenance Committee meeting at: http://www.cms.hhs.gov/events** Because of increased security requirements, those wishing to attend the September 24 - 25, 2008 ICD-9-CM Coordination and Maintenance Committee meeting must **register for the meeting online by September 12, 2008; failure to do so may result in lack of access to the meeting.**

September 24 – 25, 2008	ICD-9-CM Coordination and Maintenance Committee meeting. Those who wish to attend the ICD-9-CM Coordination and Maintenance Committee meeting **must have registered for the meeting online by September 12, 2008.** You must bring an official form of picture identification (such as a drivers license) in order to be admitted to the building.
October 2008	Summary report of the Procedure part of the September 24 – 25, 2008 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Summary report of the Diagnosis part of the September 24–25, 2008 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
October 1, 2008	New and revised ICD-9-CM codes go into effect along with DRG changes. Final addendum posted on web pages as follows: Diagnosis addendum - http://www.cdc.gov/nchs/icd9.htm Procedure addendum at - http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes
October 10, 2008	**Deadline for receipt of public comments on proposed code revisions discussed at the September 24-25, 2008 ICD-9-CM Coordination and Maintenance Committee meetings for implementation of April 1, 2009.**
November 2008	Any new ICD-9-CM codes required to capture new technology that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2009 will be posted on the following websites: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes http://www.cdc.gov/nchs/icd9.htm
December 5, 2008	Deadline for receipt of public comments on proposed code revisions discussed at the September 24-25, 2008 ICD-9-CM Coordination and Maintenance Committee meetings for implementation of October 1, 2009.

Contact Information:

Mailing address:

National Center for Health Statistics
ICD-9-CM Coordination and Maintenance Committee
3311 Toledo Road, Room 2402
Hyattsville, Maryland 20782

Fax: (301) 458-4022

Donna Pickett: (301) 458-4434
E-mail: dfp4@cdc.gov

Amy Blum: (301) 458-4106
E-mail alb8@cdc.gov

David Berglund (301) 458-4095
E-mail zhc2@cdc.gov

Lizabeth Fisher (301) 458-4091
E-mail llw4@cdc.gov

NCHS Classifications of Diseases web page:
http://www.cdc.gov/nchs/icd9.htm

Please consult this web page for updated information.

Topic: Retrolental Fibroplasia

Retinopathy of prematurity (ROP) is a leading cause of blindness in children. It is a serious vasoproliferative disorder involving the developing retina in premature infants. While mild forms usually regress with little or no loss of visual function, more severe forms can lead to vision loss due to retinal scarring and damage. When ROP becomes severe it usually requires intervention, such as retinal photocoagulation. Advanced stage ROP can progress and result in blindness. Treatment, at the appropriate stage, can improve outcomes. Even with optimal management, however, many preterm infants, especially the smallest and most premature, will develop some level of ROP. Given the emphasis on interdiction as a potential preventative measure, separating early-stage or prethreshold ROP from threshold or severe ROP will allow more targeted interventions than under the current ICD-9-CM diagnosis code 362.2.

"Retrolental fibroplasia" is an older term which mainly applies to only cicatricial disease (i.e. when the retina is actually scarred). "Retinopathy of prematurity" is the disease name used to describe the acute retinal changes seen in premature infants.

The Agency for Health Research and Quality (AHRQ) is proposing the following new codes and tabular changes. The American Academy of Ophthalmology has been contacted and concurs with the proposed changes.

TABULAR MODIFICATIONS

362 Other retinal disorders

362.2 Other proliferative retinopathy

New code	362.20	Retinopathy of prematurity Retinopathy of prematurity NOS
	362.21	Retrolental fibroplasia
Add		Cicatricial retinopathy of prematurity
New code	362.22	Retinopathy of prematurity, stage 0-1
New code	362.23	Retinopathy of prematurity, stage 2
New code	362.24	Retinopathy of prematurity, stage 3
New code	362.25	Retinopathy of prematurity, stage 4
New code	362.26	Retinopathy of prematurity, stage 5

Topic: Necrotizing Enterocolitis

Necrotizing Enterocolitis (NEC) (777.5) is a major cause of morbidity and mortality in premature infants. It is a serious gastrointestinal illness seen mainly in very low birth weight (VLBW) infants, and is associated with bowel injury and intestinal mucosal disruption with enteric feedings, immature immune responses, and possibly infection by a pathogenic organism. Given the fragility of the patient population at risk, there will most likely be some baseline level of NEC expected, even with the best medical care. However, appropriate use of treatments such as antenatal steroids, standardized enteric feeding regimens with human milk, and probiotics, along with careful monitoring, could substantially reduce the incidence of this serious disease. The current code does not distinguish between severity of disease, which has significant implications for the morbidity and mortality of the infant. NEC without pneumatosis or perforation is a vague disorder, and may resolve with medical treatment. NEC with pneumatosis places the patient at higher risk for mortality and progression to serious complications, such as portal vein gas or perforation. When perforation or intestinal death occurs, surgery is usually required and emergent. Patients with perforation have high mortality rates.

The Agency for Health Research and Quality (AHRQ) is proposing the following new codes and tabular changes for necrotizing enterocolitis.

TABULAR MODIFICATIONS

777 Perinatal disorders of digestive system

777.5 Necrotizing enterocolitis in fetus or newborn

New code	777.50	Necrotizing enterocolitis in fetus or newborn Necrotizing enterocolitis in fetus or newborn, NOS
New code	777.51	Necrotizing enterocolitis in fetus or newborn with pneumatosis
New code	777.52	Necrotizing enterocolitis in fetus or newborn with perforation
New code	777.53	Necrotizing enterocolitis in fetus or newborn with pneumatosis and perforation

Topic: Disruption of Operation Wound

Disruption of operation wound ("wound dehiscence") is the physical separation of a surgical wound and is a potentially serious complication. Full thickness wound dehiscence places the patient at risk for evisceration, an emergent and life threatening complication. While dehiscence is of particular concern in abdominopelvic wounds, it can occur elsewhere. A superficial separation of the skin may cause little concern and simply be allowed to close by secondary intention without clinical consequence. By contrast, a deeper dehiscence may extend to the fascia and may or may not be treated surgically. These wounds may be monitored to ensure that they do not progress and require surgery. Finally, the most extensive cases of dehiscence require surgery in order to prevent evisceration. Currently, the diagnosis codes 998.31 and 998.32 separate "internal" and "external" disruptions, but these code titles are unclear as to disruption of which tissues constitutes "internal" or "external". Physicians are unlikely to document a dehiscence as either "internal" or "external" but rather would be more likely to denote the tissue that has separated. Guidance is needed to index specific adjectives that appear in surgeons' notes to the current ICD-9-CM descriptors "internal" and "external."

The Agency for Health Research and Quality (AHRQ) is requesting the following changes to the tabular. Related changes in the index would also be made.

TABULAR MODIFICATIONS

998 Other complications of procedures, not elsewhere classified

998.3 Disruption of operation wound

New code	998.30	Disruption of operation wound
		Disruption of operation wound NOS
	998.31	Disruption of internal operation wound
Add		Disruption or dehiscence of:
Add		fascia
Add		muscle or muscle flap
Add		ribs or rib cage
Add		skull or craniotomy
Add		sternum or sternotomy
Add		Full-thickness or deep disruption or dehiscence
	998.32	Disruption of external operation wound
Delete		~~Disruption of operation wound NOS~~
Add		Disruption or dehiscence of:
Add		cornea
Add		mucosa
Add		skin

Topic: Neuroendocrine tumors

Neuroendocrine tumors represent a spectrum of benign and malignant tumors that arise from endocrine or neuroendocrine cells scattered throughout the body. Neuroendocrine tumors are generally classified into two groups, carcinoid tumors and pancreatic endocrine tumors. Both tumor types arise from neuroendocrine tissue, and they are often histologically indistinguishable. Many of these tumors are associated with the multiple endocrine neoplasia syndromes, subcategory 258.0, that will become effective October 1, 2007.

For carcinoid tumors the most common sites are the bronchi, stomach, small intestine, appendix and rectum. They are commonly classified according to the presumed embryonic site of origin, the foregut (bronchi and stomach), the midgut (small intestine and appendix), and the hindgut (colon and rectum). Pancreatic endocrine tumors most often occur in the pancreas, but may also originate in extra-pancreatic tissue such as the stomach or autonomic nervous system.

These tumors are characterized by their ability to produce a variety of amine and peptides that can cause characteristic hormonal syndromes. It is the differences in these systemic syndromes, as well as differences in the location of the primary tumor, that accounts for the diverse clinical presentation of patients with these tumors. The most common systemic syndrome caused by carcinoid tumors is the carcinoid syndrome, code 259.2. Most of these tumors are indolent compared to other epithelial malignancies, but they can also be aggressive and resistant to conventional treatment.

Coding of neuroendocrine tumors in the ICD-9-CM requires the topography code to identify the site and the behavior, and as the note at the beginning of chapter 2 instructs: "All neoplasms are classified in this chapter, whether or not functionally active. An additional code from Chapter 3 may be used to identify such functional activity associated with any neoplasm, e.g.: catecholamine-producing malignant pheochromocytoma of adrenal: code 194.0, additional code 255.6". It is the endocrine syndrome code that indicates a neuroendocrine tumor.

The M.D. Anderson Cancer Center has submitted a proposal for a new category in the ICD-9-CM that specifically identifies malignant and benign neuroendocrine tumors. These tumors are biologically different from adenocarcinomas, and other benign tumors, so it is felt that they should be separated from the other chapter 2 malignant topography codes. Though the fact that a tumor is a neuroendocrine tumor can be classified with a chapter 3 syndrome code as well as a morphology code, the ability to capture them through unique chapter 2 codes will improve data collection and quality for these types of tumors. There is a precedent in chapter 2 for indicating morphology with the malignant melanoma codes.

TABULAR MODIFICATONS

2. NEOPLASMS (140-239)

1. Content:

This chapter contains the following broad groups:

	140-195	Malignant neoplasms, stated or presumed to be primary, of specified sites, except of lymphatic and hematopoietic tissue
	196-198	Malignant neoplasms, stated or presumed to be secondary, of specified sites
	199	Malignant neoplasms, without specification of site
	200-208	Malignant neoplasms, stated or presumed to be primary, of lymphatic and hematopoietic tissue
Add	209	Neuroendocrine tumors

151 Malignant neoplasm of stomach

Add Excludes: carcinoid tumor of stomach (209.02)

152 Malignant neoplasm of small intestine, including duodenum

Add Excludes: carcinoid tumor of small intestine and duodenum (209.03, 209.11-209.19)

153 Malignant neoplasm of colon

Add Excludes: carcinoid tumor of colon (209.14, 209.15, 209.21, 209.22)

154 Malignant neoplasm of rectum, rectosigmoid junction, and anus

Add Excludes: carcinoid tumor of rectum (209.23)

162 Malignant neoplasm of trachea, bronchus, and lung

Add Excludes: carcinoid tumor of bronchus (209.01)

164 Malignant neoplasm of thymus, heart, and mediastinum

164.0 Thymus

Add Excludes: malignant carcinoid tumor of the thymus (209.04)

194 Malignant neoplasm of other endocrine glands and related structures

Delete ~~Use additional code to identify any functional activity~~
Add Excludes: neuroendocrine tumors (209.09-209.89)

New section NEUROENDOCRINE TUMORS (209)

New category 209 Neuroendocrine tumors

Code first any associated multiple endocrine neoplasia syndrome (258.01 -258.03)

Use additional code to identify associated endocrine syndrome, such as: Carcinoid syndrome (259.2)

Excludes: pancreatic islet cell tumors (157.4)

209.0 Malignant foregut carcinoid tumors

New code	209.01	Malignant carcinoid tumor of the bronchus Malignant carcinoid tumor of lung
New code	209.02	Malignant carcinoid tumor of the stomach
New code	209.03	Malignant carcinoid tumor of the proximal duodenum
New code	209.04	Malignant carcinoid tumor of the thymus
New code	209.09	Malignant carcinoid tumor of other sites of the foregut

209.1 Malignant midgut carcinoid tumors

New code	209.11	Malignant carcinoid tumor of mid (second portion) duodenum
New code	209.12	Malignant carcinoid tumor of the jejunum

New code	209.13	Malignant carcinoid tumor of the ileum
New code	209.14	Malignant carcinoid tumor of the cecum
New code	209.15	Malignant carcinoid tumor of the ascending colon
New code	209.16	Malignant carcinoid tumor of the appendix
New code	209.19	Malignant carcinoid tumor of other sites of the midgut

209.2 Malignant hindgut carcinoid tumors

New code	209.21	Malignant carcinoid tumor of the transverse colon
New code	209.22	Malignant carcinoid tumor of the descending colon
New code	209.22	Malignant carcinoid tumor of the sigmoid colon
New code	209.23	Malignant carcinoid tumor of the rectum
New code	209.29	Malignant carcinoid tumor of other sites of the hindgut

209.3 Benign foregut carcinoid tumors

New code	209.31	Benign carcinoid tumor of the bronchus Benign carcinoid tumor of lung
New code	209.32	Benign carcinoid tumor of the stomach
New code	209.33	Benign carcinoid tumor of the proximal duodenum
New code	209.34	Benign carcinoid tumor of the thymus
New code	209.39	Benign carcinoid tumor of other sites of the foregut

209.4 Benign midgut carcinoid tumors

New code	209.41	Benign carcinoid tumor of mid (second portion) duodenum
New code	209.42	Benign carcinoid tumor of the jejunum
New code	209.43	Benign carcinoid tumor of the ileum
New code	209.44	Benign carcinoid tumor of the cecum
New code	209.45	Benign carcinoid tumor of the ascending colon
New code	209.46	Benign carcinoid tumor of the appendix
New code	209.49	Benign carcinoid tumor of other sites of the midgut

209.5 Benign hindgut carcinoid tumors

New code	209.51	Benign carcinoid tumor of the transverse colon
New code	209.52	Benign carcinoid tumor of the descending colon
New code	209.52	Benign carcinoid tumor of the sigmoid colon
New code	209.53	Benign carcinoid tumor of the rectum
New code	209.59	Benign carcinoid tumor of other sites of the hindgut

209.8 Neuroendocrine tumor of other sites
Benign or malignant carcinoid tumors of other sites

New code	209.81	Neuroendocrine tumor of other respiratory system site
New code	209.82	Neuroendocrine tumor of other digestive system site
New code	209.83	Neuroendocrine tumor of other endocrine system site
New code	209.84	Neuroendocrine tumor of other genitourinary system site
New code	209.89	Neuroendocrine tumor of other site Carcinoid tumor NOS Neuroendocrine tumor NOS

V10 Personal history of malignant neoplasm

Add Code first any continuing functional activity, such as:
Carcinoid syndrome (259.2)

Topic: Eosinophilic Gastrointestinal Disorders

The eosinophilic gastrointestinal disorders (EGIDs) involve eosinophil accumulation in the tissues lining the gastrointestinal tract, in the absence of known causes for eosinophilia (such as drug reactions, parasitic infection, connective tissue disease, or malignancy). The EGIDs include eosinophilic esophagitis, eosinophilic gastritis, eosinophilic gastroenteritis, eosinophilic enteritis, and eosinophilic colitis. The EGIDs have some features of allergy and immune dysregulation, but do not clearly fit into the category of a true IgE mediated food allergy, cellular mediated hypersensitivity, immune disorder, or autoimmune disorder.

Eosinophilic esophagitis involves severe inflammation of the esophagus. It affects the ability to swallow, with subsequent malnutrition, and potential for failure to thrive in children.

Eosinophilic gastritis involves inflammation of the stomach, while eosinophilic enteritis involves inflammation of the small intestines. Eosinophilic gastroenteritis involves inflammation at multiple levels of the gastrointestinal tract. These forms of EGID can cause severe abdominal pain and vomiting.

Eosinophilic colitis involves inflammation of the colon. It can cause severe abdominal pain, with diarrhea, or blood in the stool. It may be misdiagnosed as irritable bowel disease or Crohn's disease.

Treatments for EGIDs can include limiting the diet (to avoid antigens that trigger disease symptoms), use of a feeding tube, treatment with steroids, and other specific therapy (such as treatment with anti-interleukin-5 antibody).

Creation of specific codes for EGIDs were proposed by the American Partnership for Eosinophilic Disease (Apfed).

As noted in the summary of the meeting, the proposed expansion at 535.4 would be invalid since fifth digits already exist. Please refer to the revised version posted on the NCHS website (http://www.cdc.gov/nchs/data/icd9/topic_EGID_Sep07.pdf)**.**

TABULAR MODIFICATIONS

530 Diseases of esophagus

530.1 Esophagitis

New code 530.13 Eosinophilic esophagitis

535 Gastritis and duodenitis

535.4 Other specified gastritis

New code 535.41 Eosinophilic gastritis

Excludes: eosinophilic gastroenteritis (558.41)

New code 535.49 Other specified gastritis

558 Other and unspecified noninfectious gastroenteritis and colitis

558.4 Eosinophilic gastroenteritis and colitis

New code 558.41 Eosinophilic gastroenteritis
Eosinophilic enteritis

New code 558.42 Eosinophilic colitis

Topic: Heparin-induced thrombocytopenia (HIT)

Heparin-induced thrombocytopenia (HIT) is a distinct and relatively common life-threatening clinical entity. Heparin is one of the most frequently prescribed medications with a trillion units used and with 12,000,000 patients having some heparin exposure in U.S. hospitals annually. Heparin usage can lead to one of the most important and devastating adverse reactions that can confront physicians. HIT will occur in 3%-5% of all patients receiving unfractionated heparin for at least 5 days (such as for treating deep vein thrombosis or unstable angina) and in about 0.5% of those receiving low molecular-weight heparin. A conservative estimate of the yearly incidence of HIT is 50,000 cases, or some estimate 5 times higher. It is one of the three most common causes of iatrogenic thrombocytopenia, along with sepsis (with or without DIC) and the adverse effects of other drugs. Fifty percent or more of those with HIT will have thrombotic complications. These thromboembolic events may be either arterial or venous and can lead to limb amputation, pulmonary emboli, strokes and myocardial infarction. Without prompt recognition and appropriate treatment, limb amputation may ensue in 10%-20%, and death in as many as 20%-30% of the cases.

DISTINCT DIAGNOSIS
HIT is a distinct and unique clinicopathologic syndrome. It is a humoral immune-mediated reaction causing an abrupt fall in platelet count and an extreme prothrombotic diathesis. The diagnosis is first clinically suspected based on a fall in platelet count by 50% or more, occurring 5-12 days after beginning heparin therapy. Although treatment should commence immediately if HIT is clinically suspected, the diagnosis must be confirmed by serologic tests for the pathogenic antibody. The serologic tests include commercially available ELISAs that detect the pathogenic antibodies to modified PF 4, or functional assays demonstrating the activation of platelets in the presence of patient serum and heparin.

COMPLICATIONS CLINICALLY DISTINGUISHABLE
Clinically, the thrombocytopenic syndrome that emerges is totally different from other drug-induced thrombocytopenias, such as those due to vancomycin, penicillin or quinine. The degree of thrombocytopenia is different (usually moderate), the timing different, the diagnostic tests different, but most particularly the complications and treatment are completely different. Bleeding, as seen with other iatrogenic thrombocytopenias, is not seen with HIT. Instead, half of all patients present with an arterial or venous thrombosis, sometimes devastating or fatal (DVT, PE, stroke, MI).

TREATMENT CLINICALLY DISTINGUISHABLE
Transfusing platelets is generally contraindicated with HIT, in contrast to other drug-induced thrombocytopenia. With HIT, the initiation of an alternative anticoagulant is strongly mandated, and the FDA has approved direct thrombin inhibitors for this indication. Even patients with “isolated HIT” (HIT without a new blood clot at the time of diagnosis) must promptly receive therapeutic doses of an alternative anticoagulant or else there is more than a 50% risk for new devastating blood clot. This risk of thrombosis

remains high for more than two weeks after stopping heparin and even after the platelet count recovers to normal. Prolonged anticoagulation after recovery is essential in order to prevent thromboembolic events. Clinically, HIT with or without an accompanying thrombotic complication leads to marked prolongation of patient hospitalizations and substantially greater costs.

ICD-9-CM CODING

The ICD-9-CM coding for HIT currently defaults to code 287.4, Secondary thrombocytopenia. This code includes not only thrombocytopenia due to drugs (the agent being identified by an additional E code) but also the non-drug causes of thrombocytopenia due to dilution, extracorporeal circulation of blood, platelet alloimmunization and post-transfusion purpura. For HIT, heparin is designated by the E-code E934.2, Anticoagulants, which also includes coumarin, phenindione, prothrombin synthesis inhibitor and warfarin. These other agents virtually never cause secondary thrombocytopenia but diminish the value of E934.2 as a designation for HIT.

Since there is no unique ICD-9-CM code for the HIT syndrome, patients diagnosed with HIT can be erroneously coded at discharge, based on ICD-9-CM codes that represent HIT thrombotic complications, such as DVT, VTE, CVA, limb amputation, acute MI and others. Therefore, retrospective analysis of the incidence of HIT becomes dependent on pharmacy records concerning the dispensing of anti-HIT medications. Underreporting will occur since patients with only early evidence of HIT, not requiring intervention by direct thrombin inhibitors or other therapeutic HIT agents, will not be found in the hospital pharmacy data banks. The lack of a unique code has hampered efforts to identify, study and to educate physicians about this syndrome and a climate of low awareness has contributed to delayed and missed diagnoses with corresponding tragic and poor patient outcomes.

HIT is such a catastrophic, potentially preventable, and highly treatable medical adverse event that two leading national medical organizations, the National Comprehensive Cancer Network and the American College of Chest Physicians, have developed guidelines for the early recognition, diagnosis, treatment and prevention of HIT.

In summary, HIT is more common and clinically unlike the other entities and the drug induced thrombocytopenias already coded to 287.4, and a unique code is requested to allow for more accurate and identifiable coding for this distinct thromboembolic disorder associated with profound morbidity and significant mortality.

Physicians at the Methodist Hospital/Weill Cornell Medical College, Houston, Texas have requested that a unique code be established for HIT. Below are the requested code modifications.

TABULAR MODIFICATIONS

287 Purpura and other hemorrhagic conditions

287.4 Secondary thrombocytopenia

Revise — Excludes: heparin-induced thrombocytopenia (HIT) (289.84)

289 Other diseases of blood and blood-forming organs

289.8 Other specified diseases of blood and blood-forming organs

289.82 Secondary hypercoagulable state

Add — Excludes: heparin-induced thrombocytopenia (HIT) (289.84)

New Code — 289.84 Heparin-induced thrombocytopenia (HIT)

Topic: Extravasation of Vesicant Chemotherapy

Extravasation occurs when a substance passes out from a vessel or organ. This can occur for various substances, including for example blood, chyle, and urine. When a substance is given intravenously, it is possible for the substance to extravasate into tissue around the intravenous site.

Chemotherapy drugs can be classified as vesicants, with the potential to cause tissue necrosis if they extravasate, and non-vesicants, which do not cause tissue damage if they extravasate. While healthcare providers go to great care to avoid extravasation of vesicant chemotherapy, it can still sometimes occur. Some reasons may include intravenous (IV) catheters or devices moving and slipping out of veins, patients moving and dislodging their IV catheters, IV devices separating or breaking, and other causes.

Extravasation of vesicant chemotherapy can cause significant tissue damage. It can be one of the most injurious events that occurs in a physician office setting (as about 80% of these events do).

No current ICD-9-CM codes specifically capture vesicant chemotherapy extravasation. Thus, it has been proposed to create a new code to specifically capture extravasation of vesicant chemotherapy, by John L. Parsons, President of TopoTarget (manufacturer of Totect™, a drug for treating anthracycline extravasation). Two options are being presented.

TABULAR MODIFICATIONS

999 Complications of medical care, not elsewhere classified

Option 1:

999.2 Other vascular complications

Delete ~~Phlebitis following infusion, perfusion, or transfusion~~

Delete ~~Thromboembolism following infusion, perfusion, or transfusion~~

Delete ~~Thrombophlebitis following infusion, perfusion, or transfusion~~

New code 999.21 Extravasation of vesicant chemotherapy

New code 999.29 Other vascular complication
Phlebitis following infusion, perfusion, or transfusion
Thromboembolism following infusion, perfusion, or transfusion
Thrombophlebitis following infusion, perfusion, or transfusion

Option 2:

999 Complications of medical care, not elsewhere classified

999.8 Other transfusion reaction

Delete ~~Septic shock due to transfusion~~
~~Transfusion reaction NOS~~

New code 999.81 Extravasation of vesicant chemotherapy

New code 999.89 Other transfusion reaction
Septic shock due to transfusion
Transfusion reaction NOS

Topic: Pressure [Decubitus] Ulcer Staging

Pressure ulcers (also called "decubitus ulcers") are an especially dreaded complication of age and disability. JCAHO, CMS, CDC, nursing home provider initiatives, professional organizations, and others have aligned behind efforts to reduce the risk of onset and to accelerate healing and thereby to mitigate the suffering associated with pressure ulcers.

Clinicians ordinarily characterize pressure ulcers by location, shape, depth, and healing status. The most important element in quality measurement, workload, and clinical services is the depth of the lesion, using the following stages (for full description, see National Pressure Ulcer Advisory Panel at http://www.npuap.org/pr2.htm) :

- Stage I – non-blanching erythema (a reddened area on the skin)
- Stage II - abrasion, blister, shallow open crater, or other partial thickness skin loss
- Stage III - full thickness skin loss involving damage or necrosis into subcutaneous soft tissues
- Stage IV – full thickness skin loss with necrosis of soft tissues through to the muscle, tendons, or tissues around underlying bone
- Unstageable – due to being inaccessible for evaluation (non-removable dressings, eschar, sterile blister, suspected deep injury in evolution). Staging is usually possible within a few days.

Research and quality improvement work have shown that the rates of onset of serious pressure ulcers (through the skin – Stages III or IV) can be measured reliably, are sensitive to improved practices, and correlate with suffering and extensive treatment burden. In the way that the field has developed, discoloration in the skin without ulceration is categorized as a Stage I, although the lesion is not really an "ulcer." These superficial injuries are not so reliably measured, reducing their rates is not so clearly responsive to improved practices, and they indicate higher risk of serious pressure ulcers but do not directly cause suffering or much increased treatment burden. Stage II lesions are blisters or other superficial injuries that do not extend through the skin. Detection is reliable, burden of treatment is moderate, and suffering directly imposed is usually quite limited.

The current ICD-9-CM coding classifies all stages together. There are unique codes for pressure ulcers in ICD-9-CM for the more common sites (707.05 for buttock, for example). Especially since the superficial lesions (Stages I and II) are each an order of magnitude more common than the more serious lesions (Stage III and IV), having all of them grouped together makes it difficult to use coded records as part of any quality improvement endeavor.

Thus, CDC and CMS are jointly requesting that new codes be created to identify pressure ulcers by stage, including unstageable. CMS has guidelines for staging and recording these lesions; and reporting them has long been part of the Minimum Data Set for nursing homes and the OASIS data collection from home care agencies. Hospital quality reporting this year will include measures of pressure ulcers as well, so instructions on recording will be a matter for hospital coders' attention in the coming year.

The proposal is to create new codes as follows:

TABULAR MODIFICATIONS

707 Chronic ulcer of skin

707.0 Decubitus Ulcer

Add Use additional code to identify pressure ulcer stage (707.2)

New subcategory 707.2 Decubitus [pressure] ulcer stages

New code 707.20 Decubitus ulcer, unspecified
Decubitus [pressure] ulcer, NOS
Decubitus [pressure] ulcer, unstageable

New code 707.21 Stage I decubitus ulcer
Decubitus [pressure] pre-ulcer skin changes limited to persistent focal erythema

New code 707.22 Stage II decubitus ulcer
Decubitus [pressure] ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis

New code 707.23 Stage III decubitus ulcer
Decubitus [pressure] ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue

New code 707.24 Stage IV decubitus ulcer
Decubitus [pressure] ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone

Topic: Ventilator-associated pneumonia

The second most common hospital-associated infection after catheter-associated urinary tract infections, hospital-associated pneumonia accounts for 15% of all hospital-associated infections and 25% of all infections acquired in intensive care units (*1*). The primary risk factor for the development of hospital-associated bacterial pneumonia is mechanical ventilation (with its requisite endotracheal intubation) (*2*). Mechanical ventilators are indispensable in modern-day medical practice, particularly in intensive care units. Although mechanical ventilators provide necessary respiratory support for critically ill patients unable to breath on their own, their use puts patients at risk ventilator-associated pneumonia.

The CDC's National Nosocomial Infection Surveillance System (NNIS) reported that in 2002, the median rate of VAP per thousand ventilator-days in NNIS hospitals ranged from 2.2 in pediatric ICUs to 14.7 in trauma ICUs (*3*). In other reports, patients receiving continuous mechanical ventilation had 6-21 times the risk of developing hospital-associated pneumonia compared with patients who were not receiving mechanical ventilation (4-6). The fatality rates for hospital-associated pneumonia in general, and VAP in particular, are high. VAP accounts for 60% of all deaths due to hospital-associated infections (*1*). In studies in which invasive techniques were used to diagnose VAP, the crude mortality rates ranged from 4% in patients with VAP but without antecedent antimicrobial therapy (7) to 73% in patients with VAP caused by *Pseudomonas* or *Acinetobacter* spp. (*8*), and attributable mortality rates ranged from 5.8% to 13.5% (*9,10*). An estimate of the direct cost of excess hospital stay due to VAP is $40,000 per patient (*11*).
CDC and CMS are jointly requesting that a unique code be created to specifically identify ventilator-associated pneumonia. It has been noted that The CDC, the American Thoracic Society, and the Infectious Disease Society of America have guidelines related to aspects of prevention, diagnosis, and management of ventilator associated pneumonia (1, 12). However, a unique ICD-9-CM code that identifies ventilator associated pneumonia does not currently exist. The creation of a new code will both complement and enhance CDC's surveillance activities and facilitate monitoring of success in prevention efforts.

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TABULAR MODIFICATIONS

PNEUMONIA AND INFLUENZA (480-488)

Add

Excludes: pneumonia:
ventilator-associated (997.31)

997 Complications affecting specified body systems, not elsewhere classified

997.3 Respiratory complications

Delete

~~Mendelson's syndrome resulting from a procedure~~
~~Pneumonia (aspiration) resulting from a procedure~~

New code

997.31 Ventilator-associated pneumonia

Use additional code to identify organism

New code

997.39 Other respiratory complications
Mendelson's syndrome resulting from a procedure
Pneumonia (aspiration) resulting from a procedure

Topic: Acanthamoeba keratitis/Fusarium keratitis

Keratitis is an inflammation of the cornea, the front part of the eye. Keratitis has many causes including bacteria, viruses and fungi. Acanthamoeba keratitis is a rare but potentially blinding infection of the cornea, caused by a free-living ameba (Acanthamoeba) that is found commonly in the environment. It primarily affects otherwise healthy persons who wear contact lenses (including wearers who follow recommended contact lens-care practices). Increased risk for infection exists for persons who improperly store, handle, or disinfect their lenses (e.g., by using tap water or homemade solutions for cleaning); swim, use hot tubs, or shower while wearing lenses; come in contact with contaminated water; have minor damage to their corneas; or have previous corneal trauma. In May 2007 the U.S. Centers for Disease Control and Prevention (CDC) received reports of an increased number of cases of eye infections from Acanthamoeba possibly linked to a specific contact lens solution which was recalled while data was further assessed. No known cases of Acanthamoeba keratitis being spread from one person to another have been reported.

Symptoms of those affected by acanthamoeba keratitis may include eye pain, eye redness, blurred vision, sensitivity to light, sensation of something in the eye and excessive tearing. Because there are similarities with symptoms of other eye infections, early diagnosis is essential for effective treatment of Acanthamoeba keratitis. Several prescription eye medications are available for treatment.

Fusarium keratitis is a fungal keratitis more prevalent in warm climates. Risk factors for this infection include trauma (generally with plant material), chronic ocular surface diseases, immunodeficiencies, and rarely, contact lens use. Fusarium keratitis is not transmitted from person to person. In early 2006 CDC began receiving an increase in the number of cases of fusarium keratitis. Again, preliminary data showed a high proportion of cases attributable to use of a specific contact lens solution. The solution was voluntarily removed from the market worldwide. Signs and symptoms of this form of keratitis include unusual redness, eye pain, tearing, discharge, or sensitivity to light. It was recommended that prior to confirming diagnosis and initiating treatment that clinical specimens (e.g., corneal scrapings) should be obtained for culture.

Due to this recent increase in the number of cases noted for both of these conditions the American Academy of Ophthalmology concurred that the following tabular modifications should be proposed for proper coding of these two conditions. Neither of these conditions is currently specifically indexed in ICD-9-CM. The organism codes are indexed. Fusarium is indexed to code 118, Opportunistic mycoses. Acanthamoeba is not specifically indexed, however, code 136.2, Specific infections by free-living amebae would be appropriate.

The following changes to the tabular are proposed:

TABULAR MODIFICATIONS

006 Amebiasis

006.8 Amebic infection of other sites

Revise Excludes: specific infections by free-living amebae (136.21-136.29)

118 Opportunistic mycoses

Add Use additional code to identify manifestation such as:
keratitis (370.8)

136 Other and unspecified infectious and parasitic diseases

136.2 Specific infections by free-living amebae

Delete ~~Meningoencephalitis due to Naegleria~~

New code 136.21 Specific infection due to acanthamoeba

Use additional code to identify manifestation such as:
keratitis (370.8)

New code 136.29 Other specific infections by free-living amebae
Meningoencephalitis due to Naegleria

323 Encephalitis, myelitis, and encephalomyelitis

323.4 Other encephalitis, myelitis, and encephalomyelitis due to infection classified elsewhere

323.41 Other encephalitis and encephalomyelitis due to infection classified elsewhere

Revise Excludes: meningoencephalitis due to free-living ameba [Naegleria] (136.29)

370 Keratitis

370.8 Other forms of keratitis

Add Code first underlying condition, such as:
Add Acanthamoeba (136.21)
Add Fusarium (118)

Topic: Lipid rich plaque

A request has been received by InfraReDx for a unique code to identify lipid rich plaque. Real-time identification of plaque as being lipid-rich or non-lipid-rich represents important diagnostic information for the interventional cardiologist. Having this diagnostic information will help the cardiologist determine the most appropriate type of stent (drug eluting vs. bare metal) to utilize depending on the present location and amount of lipid-rich plaque.

The following modification to the tabular is proposed.

TABULAR MODIFICATIONS

	414	Other forms of chronic ischemic heart disease
New code		414.3 Coronary atherosclerosis due to lipid rich plaque
		Code first coronary atherosclerosis (414.00-414.07)

Topic: Long term current use methadone

Methadone is an opiate analgesic used to relieve moderate to severe pain that has not been relieved by non-narcotic pain relievers. It also is used to prevent withdrawal symptoms in patients who were addicted to opiate drugs and are enrolled in treatment programs in order to stop taking or continue not taking the drugs. A V code would capture this information on a person who is taking this drug for this specific long term use. If the chart documentation indicates addiction to this drug then the existing excludes note found at category V58 would direct the coder to use a code from sub-category 304.0, Opioid type dependence. Catholic Healthcare West is requesting a unique code for use of this drug.

The following options are presented to code this condition:

Option 1:

TABULAR MODIFICATIONS

V58 Encounter for other and unspecified procedures and aftercare

V58.6 Long-term (current) drug use

New code V58.68 Long term (current) use of opiate analgesic
Long term current use of methadone

Option 2:

V58 Encounter for other and unspecified procedures and aftercare

V58.6 Long-term (current) drug use

V58.69 Long-term (current) use of other medications
Add Long term current use of methadone
Long term current use of opiate analgesic

INDEX MODIFICATION

Admission (encounter)
for
therapy
long-term (current) drug use NEC V58.69
Add methadone V58.69
Add opiate analgesic V58.69

Topic: Wheelchair dependence

People who are wheelchair bound are at greater risk for a variety of medical problems and issues including but not limited to decubitus ulcer and infections. Catholic Healthcare West is requesting a unique V code to capture this status condition. The following tabular modification has been proposed.

TABULAR MODIFICATIONS

V49 Other conditions influencing health status

V49.8 Other specified conditions influencing health status

New code V49.86 Wheelchair confinement status

Topic: Nontraumatic hematoma/post-traumatic seroma

Patients who suffer from a large traumatic hematoma may subsequently develop a seroma in the soft tissue of the affected area. A seroma is a small collection of fluid. ICD-9-CM currently indexes a seroma complicating a procedure but not one which develops post-traumatically. Recently the Editorial Advisory Board (EAB) for Coding Clinic for ICD-9-CM received a request for coding advice for a post-traumatic seroma. It was suggested that NCHS create a new code for this condition.

The EAB also received a request for coding advice for a nontraumatic hematoma of muscle. There are many index entries in ICD-9-CM for nontraumatic hematoma of other sites and they are, for the most part, assigned to "other disorders" of that given body system. There is no code for a nontraumatic hematoma of the muscle. It was requested by the EAB that NCHS create a unique code for this condition.

The following tabular changes are proposed:

728 Disorders of muscle, ligament, and fascia

728.3 Other specific muscle disorders

Delete
~~Arthrogryposis~~
~~Immobility syndrome (paraplegic)~~
~~Excludes: arthrogryposis multiplex congenita (754.89)~~
~~stiff-man syndrome (333.91)~~

New code 728.31 Nontraumatic hematoma of muscle

New code 728.39 Other specific muscle disorders
Arthrogryposis
Immobility syndrome (paraplegic)
Excludes: arthrogryposis multiplex congenita (754.89)
stiff-man syndrome (333.91)

729 Other disorders of soft tissues

729.9 Other and unspecified disorders of soft tissue

New code 729.90 Unspecified disorders of soft tissue

New code 729.91 Post-traumatic seroma
Excludes: Seroma complicating a procedure (998.13)

New code 729.99 Other disorders of soft tissue

Topic: Acquired absence of cervix and uterus

Code V45.77, Acquired absence of genital organs, groups all genital organs into a single code. There is no room for expansion since this is already a 5th digit code. The American College of Obstetricians and Gynecologists (ACOG) has requested a unique code for acquired absence of cervix. Such a code is important for tracking Pap smear necessity. Women who have had a full hysterectomy no longer need cervical Pap smears, but they do require vaginal smears to test for vaginal malignancies. Women with a cervical stump following a hysterectomy still require cervical Pap smears. Code V45.77 does not provide this information.

The new codes being proposed would be used in conjunction with codes V67.01, Follow-up vaginal pap smear, and V76.47, Special screening for malignant neoplasm of vagina, or simply as stand alone status codes.

This topic was first presented at the September 2006 C&M meeting, then again at the March 2007 meeting. It is being represented as a V code proposal.

TABULAR MODIFICATIONS

V45 Other postprocedural states

V45.7 Acquired absence of organ

V45.77 Genital organs

Add — Excludes: acquired absence of cervix and uterus (V88.0 - V88.2)

V67 Follow-up examination

V67.0 Following surgery

V67.01 Follow-up vaginal pap smear

Revise — Use additional code to identify acquired absence of uterus (~~V45.77~~ V88.0-V88.2)

V76 Special screening for malignant neoplasm

V76.4 Other sites

V76.47 Vagina

Revise

Use additional code to identify acquired absence of uterus (~~V45.77~~ V88.0-V88.2)

New category V88 Acquired absence of cervix and uterus

New code

V88.0 Acquired absence of both cervix and uterus
Acquired absence of uterus NOS
Status post total hysterectomy

New code

V88.1 Acquired absence of uterus with remaining cervical stump
Status post partial hysterectomy with remaining cervical stump

New code

V88.2 Acquired absence of cervix with remaining uterus

Topic: Prophylactic use of agents affecting estrogen receptors and estrogen levels

At the March 2006 ICD-9-CM Coordination and Maintenance Committee meeting a new code for long term use of antiestrogen agents, such as Tamoxifen and Raloxifene, was proposed to address the need to capture data on the many women who receive these drugs following breast cancer treatment. After review of comments received, and upon further research on this topic, it became apparent that new codes for other existing prophylactic agents used for treatment of estrogen receptor positive breast cancer should also be considered.

At the March 2007 ICD-9-CM Coordination and Maintenance Committee meeting the topic was brought back for reconsideration with an expanded proposal that provided new codes for the different classes of drugs that are used for this type of therapy. This proposal had a new subcategory titled prophylactic use of agents affecting estrogen receptors.

A comment from the American College of Obstetricians and Gynecologists (ACOG) pointed out that one of the classes of drugs included in the March 2007 proposal, aromatase inhibitors, do not affect estrogen receptors, but work to reduce estrogen levels. They are estrogen deprivators. For this reason, ACOG requested that the new subcategory be retitled to read, prophylactic use of agents affecting estrogen receptors and estrogen levels. This change makes the title of the subcategory not only more precise, it allows for the addition of new classes of drugs to be included in the future.

The discussions regarding the creation of new codes for the long term use of these types of agents have included their use in relationship to the coding of malignant neoplasms and the neoplasm guidelines. The ICD-9-CM distinguishes between current cases of cancer and personal history of cancer. The use of long term prophylactic agents to prevent recurrence of disease raises questions as to when treatment is actually complete. This issue was raised with Gyn-oncologists at ACOG. These agents are used to prevent recurrence and metastasis, so classifying their use as prophylactic is valid, regardless of whether a cancer code or a V code for history of cancer is used. The use additional code notes included on the proposal instruct that a personal history of cancer is allowed with a code from V07.5.

From a guideline perspective, the cancer code could be used with a code from proposed subcategory V07.5 throughout the course of treatment, including during routine chemotherapy and radiation therapy. A V07.5 code could also be used once the patient qualifies as having a history of cancer, a V10 code, that is, following completion of all treatment. The long term use of a drug that falls under subcategory V07.5 would not require the continued use of the cancer code. A code from subcategory V07.5 could also be used with a V67 follow-up code. These instructions would be added to the ICD-9-CM Official coding guidelines for neoplasm coding concurrent with the implementation of these new codes.

TABULAR MODIFICATIONS

V07 Need for isolation and other prophylactic measures

New subcategory V07.5 Prophylactic use of agents affecting estrogen receptors and estrogen levels

Use additional code to identify:
estrogen receptor positive status (V86.0)
family history of breast cancer (V16.3)
genetic susceptibility to cancer (V84.01-V84.09)
personal history of breast cancer (V10.3)
postmenopausal status (V49.81)

Excludes: hormone replacement therapy (postmenopausal) (V07.4)

New code V07.51 Prophylactic use of selective estrogen receptor modulators (SERMs)
Prophylactic use of:
raloxifene (Evista)
tamoxifen (Nolvadex)
toremifene (Fareston)

New code V07.52 Prophylactic use of aromatase inhibitors
Prophylactic use of:
anastrozole (Arimidex)
exemestar (Aromasin)
letrozole (Femara)

New code V07.59 Prophylactic use of other agents affecting estrogen receptors and estrogen levels
Prophylactic use of:
estrogen receptor downregulators
fulvestrant (Faslodex)
gonadotropin-releasing hormone (GnRH) agonist
goserelin acetate (Zoladex)
leuprolide acetate (leuprorelin) (Lupron)
megestrol acetate (Megace)

V58 Encounter for other and unspecified procedures and aftercare

V58.6 Long-term (current) drug use

Add Excludes: prophylactic use of agents affecting estrogen receptors and estrogen levels (V07.51-V07.59)

Topic: Staged breast reconstruction

Staged breast reconstruction following full or partial mastectomy for breast disease or breast trauma usually takes place over the course of months or years. In addition to tissue expanders, implants and grafts, revisions to the reconstructed breast may be needed to correct irregularities, the native breast may need to be balanced against the reconstructed breast, and the areola and nipple may need to be restored through grafting or tattooing. Some of the required procedures may be performed together during the same operative episode, and some may take place during separate encounters. For example, it is common to remove a tissue expander and replace it with a permanent implant in a single operation. Nipple reconstruction is sometimes performed with revision of the reconstructed breast or with a balancing procedure to the native breast, or it may be performed as a solo procedure.

Current diagnosis codes do not clearly identify the various stages for which a breast reconstruction encounter may occur, or between the disorders of reconstructed breasts and native breasts. Requests have been submitted to NCHS for new codes to properly identify the reason for an encounter involving breast reconstruction. Linda Holtzman, of Clarity Coding, submitted one of the proposals and will be presenting it today.

There are a few options to consider for this proposal. The first is to simply add various inclusion terms under code V45.71, Acquired absence of breast, that cover all components of the reconstruction process. Or, a new single code under V51, Aftercare involving the use of plastic surgery, could be created for encounter for breast reconstruction. These options do not provide any detail, but that detail could be provided with the procedure codes. Another option is to expand code V51 to provide codes for each possible stage of reconstruction. This option would allow for much greater detail, but the guidelines for the use of these codes, and their relationship to codes V50.1, Other plastic surgery for unacceptable cosmetic appearance, and V52.4, Fitting and adjustment of breast prosthesis and implant, would have to be determined. Historically, code V51 has had very limited applicability due to excludes notes that accompany it.

The tabular modifications proposed includes all options, as well as modifications that would be necessary to accompany any new encounter for reconstruction codes.

The official coding guidelines would need to be modified to include instruction on the proper coding of staged breast reconstruction. The modification option selected would determine how the guidelines are written. Should any changes to V51 be selected, the use of code V45.71 would have to de decided. Whichever option is selected, additional codes for history of breast cancer or breast trauma would also be required to explain the reason for the breast reconstruction. Instructional notes for these codes would need to be added to the modifications.

TABULAR MODIFICATIONS

Option 1:

V45 Other postprocedural states

V45.7 Acquired absence of organ

Revise V45.71 Acquired absence of breast and nipple
Add Encounter for exchange of tissue expander for staged breast reconstruction
Add Encounter for insertion of tissue expander for staged breast reconstruction
Add Encounter for nipple reconstruction
Add Encounter for reconstruction of breast mound
Add Encounter for tissue flaps or grafts for breast reconstruction

Add Excludes: cosmetic breast surgery (V50.1)
deformity and disproportion of reconstructed breast (612.0, 612.1)
fitting and adjustment of breast prosthesis and implant for cosmetic purposes (V52.4)

V51 Aftercare involving the use of plastic surgery
Plastic surgery following healed injury or operation

Add Excludes: breast reconstruction following mastectomy (V45.71)
cosmetic plastic surgery (V50.1)
Revise plastic surgery as treatment for current condition or injury - code to condition or injury
repair of scar tissue-code to scar

Options 2:

V51 Aftercare involving the use of plastic surgery

New code V51.0 Encounter for breast reconstruction following mastectomy

New code V51.8 Other aftercare involving the use of plastic surgery

Option 3:

V50 Elective surgery for purposes other than remedying health states

V50.1 Other plastic surgery for unacceptable cosmetic appearance

Revise

Excludes: plastic surgery following healed injury or operation (V51.01-V51.8)

V51 Aftercare involving the use of plastic surgery

New subcategory

V51.0 Encounter for breast reconstruction following mastectomy

Excludes: encounter for breast augmentation surgery (V50.1)
encounter for breast surgery for breast deformity of condition – code to deformity or condition
deformity and disproportion of reconstructed breast (612.0, 612.1)
fitting and adjustment of cosmetic breast prosthesis and implant (V52.4)

New code

V51.01 Encounter for tissue flaps or grafts for breast reconstruction following mastectomy
Encounter for reconstruction of breast mound

New code

V51.02 Encounter for insertion of tissue expander for staged breast reconstruction following mastectomy

Excludes: encounter for exchange of tissue expander for permanent breast implant for staged breast reconstruction following mastectomy (V51.03)

New code

V51.03 Encounter for exchange or removal of tissue expander for staged breast reconstruction following mastectomy
Encounter for exchange of tissue expander for permanent breast implant for staged breast reconstruction following mastectomy

New code

V51.04 Encounter for nipple reconstruction for staged breast reconstruction following mastectomy

New code V51.8 Other aftercare involving the use of plastic surgery

Other associated modifications:

611 Other disorders of breast

611.1 Hypertrophy of breast

Add Excludes: disproportion of reconstructed breast (612.1)

611.3 Fat necrosis of breast

Add Code first breast necrosis due to breast graft (996.79)

611.8 Other specified disorders of breast

Delete ~~Hematoma (nontraumatic) of breast~~
~~Infarction of breast~~
~~Occlusion of breast duct~~
~~Subinvolution of breast (postlactational) (postpartum)~~

New code 611.81 Ptosis of breast

Excludes: ptosis of native breast in relation to reconstructed breast (612.1)

New code 611.82 Hypoplasia of breast
Micromastia

Excludes: hypoplasia of native breast in relation to reconstructed breast (612.1)

New code 611.83 Capsular contracture of breast implant

New code 611.89 Other specified disorders of breast
Hematoma (nontraumatic) of breast
Infarction of breast
Occlusion of breast duct
Subinvolution of breast (postlactational) (postpartum)

New category 612 Deformity and disproportion of reconstructed breast

New code 612.0 Deformity of reconstructed breast
Contour irregularity in reconstructed breast
Excess tissue in reconstructed breast
Misshapen reconstructed breast

New code 612.1 Disproportion of reconstructed breast
Breast asymmetry between native breast and reconstructed breast
Disproportion between native breast and reconstructed breast

757 Congenital anomalies of the integument

757.6 Specified anomalies of breast

Delete ~~Hypoplasia of breast~~

Add Excludes: hypoplasia of breast (611.82)

996 Complications peculiar to certain specified procedures

Add Excludes: capsular contracture of breast implant (611.83)

V45 Other postprocedural states

V45.7 Acquired absence of organ

V45.71 Acquired absence of breast

Add Acquired absence of breast and nipple
(will add regardless of which option selected)

V50 Elective surgery for purposes other than remedying health states

V50.1 Other plastic surgery for unacceptable cosmetic appearance

Add Excludes: encounter for breast reduction (611.1)

V52 Fitting and adjustment of prosthetic device and implant

V52.4 Breast prosthesis and implant

Add — Elective implant exchange (different material) (different size)

Add — Removal of tissue expander without synchronous insertion of permanent implant

Revise — Excludes: admission for initial breast implant insertion for breast augmentation (V50.1)

Add — complications of breast implant (996.54, 996.69, 996.79)

Add — encounter for staged breast reconstruction following mastectomy (V45.71 or V51.0x) (depending on which option selected)

Topic: Leukemia in relapse

Despite the best efforts of clinicians, patients with leukemia may have a relapse of their disease. Relapse is different than the primary disease that is not in remission, and may require a whole new set of interventions and treatments that may be similar to the initial induction therapy or more aggressive therapy, with greater risk of additional morbidity and mortality. Currently, there is no way to identify these patients in the ICD-9-CM. The American Academy of Pediatrics (AAP) proposes that a new fifth digit be added to the hematopoietic neoplasm code categories 203-208 that will allow for the classification of leukemia in relapse. It is also being proposed that the title of fifth digit 0 for these categories be modified to make the intent of the digit clearer. These fifth digits will result in 20 new codes.

TABULAR MODIFICATIONS

203 Multiple myeloma and immunoproliferative neoplasms

The following fifth-digit subclassification is for use with category 203:

Revise
0 without mention of having achieved remission
1 in remission
Add
2 in relapse

204 Lymphoid leukemia

The following fifth-digit subclassification is for use with category 204:

Revise
0 without mention of having achieved remission
1 in remission
Add
2 in relapse

205 Myeloid leukemia

The following fifth-digit subclassification is for use with category 205:

Revise
0 without mention of having achieved remission
1 in remission
Add
2 in relapse

206 Monocytic leukemia

The following fifth-digit subclassification is for use with category 206:

Revise
0 without mention of having achieved remission
1 in remission
Add
2 in relapse

207 Other specified leukemia

The following fifth-digit subclassification is for use with category 207:

Revise
0 without mention of <u>having achieved</u> remission
1 in remission

Add
2 in relapse

208 Leukemia of unspecified cell type

The following fifth-digit subclassification is for use with category 208:

Revise
0 without mention of <u>having achieved</u> remission
1 in remission

Add
2 in relapse

Topic: Fever presenting with conditions classified elsewhere

While inherent in a number of conditions, fever is considered a significant complication when associated with many chronic conditions, such as leukemia and sickle cell disease. The current generic fever code does not convey well that fever may be a presenting complication that requires specific evaluation. The code first note now under code 780.6, Fever, is not considered sufficient to show the connection between the underlying condition and the fever. The American Academy of Pediatrics (AAP) is requesting a new code for fever presenting with other conditions.

A new code is also being proposed for postprocedural fever.

TABULAR MODIFICATIONS

288 Diseases of white blood cells

288.0 Neutropenia

Revise Use additional code for any associated fever (780.61)

780 General symptoms

780.6 Fever

Delete
~~Chills with fever~~
~~Fever NOS~~
~~Fever of unknown origin (FUO)~~
~~Hyperpyrexia NOS~~
~~Pyrexia NOS~~
~~Pyrexia of unknown origin~~

Delete ~~Code first underlying condition when associated fever is present, such as with:~~
~~leukemia (codes from categories 204, 205, 206, 207, 208)~~
~~neutropenia (288.00-288.09)~~
~~sickle-cell disease (282.60-282.69)~~

New code 780.60 Fever, unspecified
Chills with fever
Fever NOS
Fever of unknown origin (FUO)
Hyperpyrexia NOS
Pyrexia NOS
Pyrexia of unknown origin

New code	780.61	Fever presenting with conditions classified elsewhere

Code first underlying condition when associated fever is present, such as with:
- leukemia (codes from categories 204, 205, 206, 207, 208)
- neutropenia (288.00-288.09)
- sickle-cell disease (282.60-282.69)

New code	780.62	Postprocedural fever

Excludes: fever associated with confirmed infection – code to infection (exclude 998.59 also?)

Topic: Abnormal anal cytologies and anal intraepithelial neoplasia (AIN)

Since the creation of new codes for abnormal cytologic smears of the cervix, and the presentation of proposed new codes for abnormal cytologic smears of the vagina and vaginal intraepithelial neoplasia (VAIN) at the March 2007 C&M meeting, a new request has been submitted by Nora Laver, M.D., of Tufts New England Medical Center for similar codes for the anus. Anal cytologic smears are reported exactly the same way as those for the cervix. The correlation between abnormal cytologic smears and the risk of dysplasia and carcinoma is the same for the anus as it is for the cervix.

There are only two subcategories left, 795.1, and 795.9, under category 795, Other and nonspecific abnormal cytological, histological, immunological and DNA test findings, the category under which abnormal cervix Pap smears are classified. For the March proposal for abnormal vaginal smears, the use of 795.1 was proposed. Generally, a code with a 4th character 9 is used as an unspecified code, so code 795.9 is not ideal for expansion. For this reason, a new set of codes for abnormal cytologies of the anus is being proposed under category 796, Other nonspecific abnormal findings.

In creating this new set of codes it is also necessary to make modifications to the existing abnormal cervical cytology codes, as well to the abnormal vaginal cytology codes as presented in March. The cervix and the anus both have transformation zones where the mucosa becomes squamous. Preferably, a cytologic sample will contain cells from this transitional zone. A sample may be considered satisfactory, (for example, a postmenopausal woman may lack endocervical cells present in the transformation zone because of normal physiologic changes), but a code is needed to indicate that a sample is lacking the transitional zone. There is no such code for the cervical smear subcategory. It is included with this proposal. The vagina and vulva do not have a transitional zone, they are only composed of a squamous cell lining. Due to the lack of available codes, and the similarity in the histology of the vagina and vulva, the proposed new subcategory 795.1 is being re-presented as abnormal smear of the vagina and vulva.

TABULAR MODIFICATIONS

569 Other disorders of intestines

569.4 Other specified disorders of rectum and anus

New code

569.44 Dysplasia of anus
Anal intraepithelial neoplasia I and II (AIN I and II) (histologically confirmed)
Dysplasia of anus NOS
Mild and moderate dysplasia of anus (histologically confirmed)

Excludes: abnormal results from anal cytologic examination without histologic confirmation (796.70-796.79)
anal intraepithelial neoplasia III (230.5, 230.6)
carcinoma in-situ of anus (230.5, 230.6)
HGSIL of anus (796.74)
severe dysplasia of anus (230.5, 230.6)

622 Noninflammatory disorders of cervix

622.1 Dysplasia of cervix (uteri)

Add

Excludes: HGSIL of cervix (795.04)

623 Noninflammatory disorders of vagina

623.0 Dysplasia of vagina

Add

Mild and moderate dysplasia of vagina

Add

Excludes: abnormal results from vaginal cytological examination without histologic confirmation (795.10-795.19)
HGSIL of vagina (795.14)

624 Noninflammatory disorders of vulva and perineum

624.0 Dystrophy of vulva

Add

Excludes: abnormal results from vulva cytological examination without histologic confirmation (795.10-795.19)
HGSIL of vulva (795.14)

795 Other and nonspecific abnormal cytological, histological, immunological and DNA test findings

Add Excludes: abnormal cytologic smear of anus and anal HPV (796.70-796.79)

795.0 Abnormal Papanicolaou smear of cervix and cervical HPV

Add Excludes: abnormal cytologic smear of vagina and vulva and vaginal and vulvar HPV (795.10- 795.19)
Revise mild cervical dysplasia (histologically confirmed) (622.11)
Revise moderate cervical dysplasia (histologically confirmed) (622.12)
Revise severe cervical dysplasia (histologically confirmed) (233.1)

795.00 Abnormal glandular Papanicolaou smear of cervix
Revise Atypical cervical glandular cells NOS

New code 795.07 Satisfactory cervical smear but lacking transformation zone

Revise 795.08 Unsatisfactory cervical cytology smear
Revise Inadequate cervical cytology sample

Revise 795.1 Abnormal Papanicolaou smear of vagina and vulva and vaginal and vulvar HPV

Add Use additional code to identify acquired absence of uterus and cervix, if applicable (V88.0-V88.2)

Add Excludes: abnormal cytologic smear of cervix and cervical HPV (795.00-795.09)
carcinoma in-situ of vagina (233.31)
carcinoma in-situ of vulva (233.32)
dysplasia (histologically confirmed) of vagina NOS (623.0, 233.31)
dysplasia (histologically confirmed) of vulva NOS (624.01, 624.02, 233.32)
mild vaginal dysplasia (histologically confirmed) (623.0)
mild vulvar dysplasia (histologically confirmed) (624.01)

moderate vaginal dysplasia (histologically confirmed) (623.0)
moderate vulvar dysplasia (histologically confirmed) (624.02)
severe vaginal dysplasia (histologically confirmed) (233.31)
severe vulvar dysplasia (histologically confirmed) (233.32)
vaginal intraepithelial neoplasia I (VAIN I) (623.0)
vaginal intraepithelial neoplasia II (VAIN II) (623.0)
vaginal intraepithelial neoplasia III (VAIN III) (233.31)
vulvar intraepithelial neoplasia I (VIN I) (624.01)
vulvar intraepithelial neoplasia II (VIN II) (624.02)
vulvar intraepithelial neoplasia III (VIN III) (233.32)

New code	795.10	Abnormal glandular Papanicolaou smear of vagina and vulva Abnormal thin preparation smear of vagina NOS Abnormal thin preparation smear of vulva NOS Abnormal vaginal cytology NOS Abnormal vulvar cytology NOS Atypical vaginal glandular cells NOS Atypical vulvar glandular cells NOS
New code	795.11	Papanicolaou smear of vagina and vulva with atypical squamous cells of undetermined significance (ASC-US)
New code	795.12	Papanicolaou smear of vagina and vulva with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)
New code	795.13	Papanicolaou smear of vagina and vulva with low grade squamous intraepithelial lesion (LGSIL)
New code	795.14	Papanicolaou smear of vagina and vulva with high grade squamous intraepithelial lesion (HGSIL)
New code	795.15	Vaginal and vulva high risk human papillomavirus (HPV) DNA test positive

New code 795.16 Papanicolaou smear of vagina and vulva with cytologic evidence of malignancy

New code 795.18 Unsatisfactory vaginal and vulvar smear
Inadequate vaginal vulvar sample

New code 795.19 Other abnormal Papanicolaou smear of vagina and vulva and vaginal and vulvar HPV
Vaginal low risk human papillomavirus (HPV) DNA test positive
Vulvar low risk human papillomavirus (HPV) DNA test positive

Use additional code for associated human papillomavirus (079.4)

796 Other nonspecific abnormal findings

New subcategory 796.7 Abnormal cytologic smear of anus and anal HPV

Excludes: abnormal cytologic smear of cervix and cervical HPV (795.00-795.09)
abnormal cytologic smear of vagina and vulva and vaginal and vulvar HPV (795.10-795.19)
anal intraepithelial neoplasia I (AIN I) (569.43)
anal intraepithelial neoplasia II (AIN II) (569.43)
anal intraepithelial neoplasia III (AIN III) (230.5, 230.6)
carcinoma in-situ of anus (230.5, 230.6)
dysplasia (histologically confirmed) of anus NOS (569.43)
mild anal dysplasia (histologically confirmed) (569.43)
moderate anal dysplasia (histologically confirmed) (569.43)
severe anal dysplasia (histologically confirmed) (569.43)

New code 796.70 Abnormal glandular Papanicolaou smear of anus
Atypical anal glandular cells NOS

New code 796.71 Papanicolaou smear of anus with atypical squamous cells of undetermined significance (ASC-US)

New code	796.72	Papanicolaou smear of anus with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)
New code	796.73	Papanicolaou smear of anus with low grade squamous intraepithelial lesion (LGSIL)
New code	796.74	Papanicolaou smear of anus with high grade squamous intraepithelial lesion (HGSIL)
New code	796.75	Anal high risk human papillomavirus (HPV) DNA test positive
New code	796.76	Papanicolaou smear of anus with cytologic evidence of malignancy
New code	796.77	Satisfactory anal smear but lacking transformation zone
New code	796.78	Unsatisfactory anal cytology smear Inadequate anal cytology sample
New code	796.79	Other abnormal Papanicolaou smear of anus and anal HPV Anal low risk human papillomavirus (HPV) DNA test positive Use additional code for associated human papillomavirus (079.4)

Topic: Functional urinary incontinence and functional quadriplegia

Functional urinary incontinence is defined as leakage of urine related to an irreversible impairment in cognitive functioning which leads to an impairment in the individual's ability to exercise volitional control over bladder function. This type of urinary incontinence is most common in settings which provide care for older adults suffering from dementia. This type of incontinence is unique in terms of its progression, approaches to treatment, and expected outcomes. Management strategies revolve around controlling the complications, such as urinary tract infections, and skin breakdown. The ability to classify this condition is important due to its increasing prevalence.

Skilled nursing facilities are a current focus of Centers for Medicare and Medicaid Services (CMS) continence management, and a comprehensive continence care program in any long term care facility must include appropriate management of incontinence caused by advancing dementia.

The International Continence Society's Nursing Education Subcommittee submitted a request for a unique ICD-9-CM code for functional urinary incontinence. This proposal is supported by the American Urological Association.

Additionally, a new ICD-9-CM code for functional quadriplegia is also being proposed. A code for this condition has been included in the ICD-10-CM at the request of the long term care community. It is felt that a similar code in ICD-9-CM would also be useful.

TABULAR MODIFICATIONS

780 General symptoms

780.7 Malaise and fatigue

New code 780.72 Functional quadriplegia

Excludes: hysterical paralysis (300.11)
immobility syndrome (728.3)
neurologic quadriplegia (344.00-344.09)

788 Symptoms involving urinary system

788.3 Urinary incontinence

Add Excludes: functional urinary incontinence (788.91)
Add urinary incontinence associated with cognitive impairment (788.91)

	788.9	Other symptoms involving urinary system
Delete		~~Extrarenal uremia~~ ~~Vesical:~~ ~~pain~~ ~~tenesmus~~
New code	788.91	Functional urinary incontinence Urinary incontinence due to cognitive impairment
	Excludes:	urinary incontinence due to physiologic condition (788.30-788.39)
New code	788.99	Other symptoms involving urinary system Extrarenal uremia Vesical: pain tenesmus

Topic: Vulvar vestibulitis and other vulvodynia

At the March 2007 C&M meeting a proposal for a new code for vulvodynia was presented. Comments received at NCHS from the American College of Obstetricians and Gynecologists (ACOG) on this proposal indicated that it did not provide sufficient detail for the different types of vulvodynia, specifically, that no new code for vulvar vestibulitis was include with the proposal. A more detailed proposal for vulvodynia is now being proposed.

Vulvodynia is a syndrome of unexplained vulvar pain that is frequently accompanied by physical and psychological disability, limitation of daily activities, and sexual dysfunction. Vulvar vestibulitis is a subtype of vulvodynia characterized by distinct tenderness, and at times, erythema in the vestibule. The cause of vulvar vestibulitis and other vulvodynia is unknown, but it has been determined not to be associated with human papillomavirus or other sexually transmitted infections, and is generally not associated with vulvar malignancies. Vulvodynia is distinct from vulvar pain due to specific conditions such as yeast infections. Treatment varies, and includes topical anesthetic agents, antidepressants and anticonvulsants.

TABULAR MODIFICATIONS

	616	Inflammatory disease of cervix, vagina, and vulva
	616.1	Vaginitis and vulvovaginitis
Add		Excludes: vulvar vestibulitis (625.71)
	625	Pain and other symptoms associated with female genital organs
New subcategory	625.7	Vulvodynia
New code	625.71	Vulvar vestibulitis
New code	625.79	Other vulvodynia Vulvodynia NOS

Topic: External cause for overexertion, strenuous and repetitive movements

The U.S. Department of Defense (DOD) would like to better capture the cause of common injuries of military personnel. Military physical training and combat duties can be very rigorous and lead to injuries. The DOD has requested that external cause category E927 Overexertion and strenuous movements, be expanded to allow for the identification of the type of movement (mechanism) associated with an injury. It may be possible for more than one of the new codes to be used together if the injury is the result of multiple causes within the category.

At the March 2008 C&M meeting an accompanying proposal for activities codes will be presented.

TABULAR MODIFICATIONS

994 Effects of other external causes

994.5 Exhaustion due to excessive exertion

Revise Exhaustion due to overexertion

Revise E927 Overexertion and strenuous and repetitive movements or loads

Delete ~~Excessive physical exercise~~
~~Overexertion (from):~~
~~lifting~~
~~pulling~~
~~pushing~~
~~Strenuous movements in:~~
~~recreational activities~~
~~other activities~~

New code E927.0 Overexertion from sudden strenuous movement
Sudden trauma from strenuous movement

New code E927.1 Overexertion from prolonged static position
Overexertion from maintaining prolonged positions, such as:
Holding
Sitting
Standing

New code E927.2 Excessive physical exertion

New code E927.3 Cumulative trauma from repetitive motion
Cumulative trauma from repetitive movements

New code E927.4 Cumulative trauma from repetitive impact

Topic: Personal history of antineoplastic chemotherapy and monoclonal drug therapy

Exposure to potent medicinal agents, such as antineoplastic chemotherapies, especially at a young age, increases the risk of developing other malignancies and other serious conditions at a later age. This is particularly true for patients who have been treated for childhood leukemias. A personal history code for this exposure has been requested. Use of such a personal history code, along with a personal history code for the condition treated, would be helpful in collecting data on the incidence of future disease due to previous treatment.

At the March 2007 C&M meeting a proposal for a new category for exposure to potentially hazardous substances was presented, V87. Additional codes for personal history of antineoplastic chemotherapy and monoclonal drugs are being proposed within this possible new category, the title of which would be modified to allow for a broader range of codes.

TABULAR MODIFICATIONS

	V15	Other personal history presenting hazards to health
Add		Excludes: other specified personal exposures and history presenting hazards to health (V87)
New Category	V87	Other specified personal exposures and history presenting hazards to health
New subcategory	V87.1	Personal history of antineoplastic therapy
New code	V87.11	Personal history of antineoplastic chemotherapy
New code	V87.12	Personal history of antineoplastic monoclonal drug therapy

Topic: Contact with and exposure to mold

See separate handout posted on the NCHS Classifications of Diseases and Functioning & Disability web site (http://www.cdc.gov/nchs/data/icd9/topic_Mold_Sep07.pdf).

Topic: Suspected fetal conditions not found and antenatal screening

At both the September 2006 and the March 2007 C&M meetings proposals for fetal medicine were presented. Two of the proposals, codes for suspected fetal conditions not found, and modifications to the antenatal screening codes are being brought back for additional discussion.

Pregnant patients are referred to maternal-fetal specialists for detailed ultrasounds when an initial screening ultrasound indicates a possible abnormality. In many cases the detailed exam shows no abnormality. There has been support for codes to identify suspected conditions not found, but previous proposals have suggested codes within the OB chapter. Comments received have recommended that such codes be placed in the V code section. That suggestion is being presented at this time.

Concurrent with the need to identify suspected fetal conditions not found is the need to add instructional notes to the tabular and the guidelines for the use of codes from category V28, Encounter for antenatal screening of mother.

TABULAR MODIFICATIONS

Revise	656	Other <u>known or suspected</u> fetal and placental problems affecting management of mother
New Section		SUSPECTED FETAL CONDITIONS NOT FOUND V89
New Category	V89	Suspected fetal conditions not found Excludes: known or suspected fetal anomalies affecting management of mother, not ruled out (655.00-655.93) newborn and perinatal conditions – code to condition
New code	V89.0	Suspected problem with amniotic cavity and membrane not found Suspected oligohydramnios not found Suspected polyhydramnios not found
New code	V89.1	Suspected placental problem not found
New code	V89.2	Suspected fetal anomaly not found
New code	V89.3	Suspected problem with fetal growth not found
New code	V89.4	Other suspected fetal condition not found

V28 Encounter for antenatal screening of mother

Add Excludes: suspected fetal conditions affecting management of pregnancy (655.00-655.93, 656.00-656.93, 653, 658.00-658.93)

Add suspected fetal conditions not found (V89.0-V89.4)

Revise V28.3 Encounter for routine screening for malformation using ultrasonics

Add Encounter for routine fetal ultrasound NOS

Topic: Cervical shortening

A short cervix in the second trimester of pregnancy appears to be a warning sign of impending premature birth among woman who have previously given birth prematurely. Research has found that women whose cervixes have shortened to less than 25 millimeters in length by the 16th week of pregnancy are 3 times more likely to deliver prematurely.

Classic cervical insufficiency is a diagnosis bases on an obstetric history of recurrent second or early third trimester fetal loss, following painless cervical dilatation, prolapse or rupture of the membranes, and expulsion of a live fetus despite minimal uterine activity. In the absence of recurrence of second or early third trimester fetal loss, it is incorrect to use the term cervical insufficiency in connection with a short or traumatized cervix alone.

The term cervical shortening is not indexed in the ICD-9-CM. Though there are a number of other codes that may be used to represent cervical shortening, such as 654.5, Cervical incompetence complicating pregnancy, 654.6, Other congenital or acquired abnormality of cervix, and 644.1 Other threatened labor, none of these codes is precise in classifying cervical shortening. Cervical shortening may cause pre-term labor, but not absolutely, and it may be due to several factors.

The term cervical incompetence may also be used for non-pregnant patients. It is a general term that can represent a number of different conditions and may impact on a woman's future ability to conceive and carry a fetus to term. There is an ICD-9-CM code for this, 622.5.

A unique code for cervical shortening complicating pregnancy is being proposed. The American College of Obstetrician and Gynecologists supports this proposal. It is also being proposed that the term cervical shortening for non-pregnant patients be indexed to 622.5 for acquired cases, and 752.49, Other anomalies of cervix, vagina, and external female genitalia, for congenital cases.

TABULAR MODIFICATIONS

649 Other conditions or status of the mother complicating pregnancy, childbirth, or the puerperium

New code 649.7 Cervical shortening
[0,1,3]

654 Abnormality of organs and soft tissues of pelvis

654.5 Cervical incompetence

Add Excludes: cervical shortening (649.7)

654.6 Other congenital or acquired abnormality of cervix

Add Excludes: cervical shortening (649.7)

Sample index modifications:

Short, shortening, shortness
Add cervical, cervix 649.7
Add gravid uterus 649.7
Add non-gravid uterus 622.5
Add acquired 622.5
Add congenital 752.49

Topic: Secondary diabetes mellitus

In April 2004, the American Association of Pediatrics (AAP) requested a code to identify secondary diabetes mellitus specifically for cystic fibrosis (CF) patients who develop diabetes mellitus as a result of the CF. Diabetes mellitus can also result from other specific disease processes (such as Cushing's syndrome, malignant neoplasm, and certain genetic disorders) or be a late effect of poisoning. Three additional proposals to create new codes have been presented over the past few years, none of which achieved consensus.

Since the March 2007 meeting, NCHS has consulted with the Endocrine Society regarding new codes for secondary diabetes. The Endocrine Society supports the creation of separate codes for secondary diabetes, codes that clinicians will find straightforward and easy to use. They have recommended adding one new category, 249.xx.

The Endocrine Society also noted that while previous proposals did not include use of fifth digits, they have recommended that fifth digits for controlled and uncontrolled be required for the new codes. They noted that physicians should continue to be allowed, as they are now, to use their professional judgment to determine a patient's level of control, as control differs from patient to patient. Further, they believe it would be inappropriate to use a specific measure, such as the hemoglobin A1C to classify level of control.

At this time a revised proposal is being presented for a new category for secondary diabetes which takes into consideration the recommendations of the Endocrine Society and those from prior meetings. Category 249 parallels category 250 and all of the manifestation codes that apply to category 250 would also apply to 249. Code first notes have been dropped.

Sequencing of code 249 will be dependent on the documentation in the medical record and the official coding guidelines.

TABULAR MODIFICATIONS

New Category

249 Secondary diabetes mellitus

Includes: diabetes mellitus (due to) (in) (secondary) (with):
drug-induced or chemical induced
endocrinopathy
infection

Excludes: gestational diabetes (648.8)
hyperglycemia NOS (790.29)
neonatal diabetes mellitus (775.1)
nonclinical diabetes (790.29)
Type I diabetes – see category 250
Type II diabetes – see category 250

Note: Codes 249.0-249.9 do not require a fifth-digit

Use additional code to identify any associated insulin use (V58.67)

Use additional E code to identify cause, if drug or chemical induced

New code

249.0 Secondary diabetes mellitus without mention of complication
Secondary diabetes mellitus without mention of complication or manifestation classifiable to 249.1-249.9
Secondary diabetes mellitus NOS

New code

249.1 Secondary diabetes mellitus with ketoacidosis
Secondary diabetes mellitus with diabetic acidosis without mention of coma
Secondary diabetes mellitus with diabetic ketosis without mention of coma

New code

249.2 Secondary diabetes mellitus with hyperosmolarity
Secondary diabetes mellitus with hyperosmolar (nonketotic) coma

New code

249.3 Secondary diabetes mellitus with other coma
Secondary diabetes mellitus with diabetic coma (with ketoacidosis)
Secondary diabetes mellitus with diabetic hypoglycemic coma
Secondary diabetes mellitus with insulin coma NOS

Excludes: secondary diabetes mellitus with hyperosmolar coma (249.2)

249.4 Secondary diabetes mellitus with renal manifestations

Use additional code to identify manifestation, as:
chronic kidney disease (585.1-585.9)
diabetic nephropathy NOS (583.81)
diabetic nephrosis (581.81)
intercapillary glomerulosclerosis (581.81)
Kimmelstiel-Wilson syndrome (581.81)

New code 249.5 Secondary mellitus with ophthalmic manifestations

Use additional code to identify manifestation, as:
diabetic blindness (369.00-369.9)
diabetic cataract (366.41)
diabetic glaucoma (365.44)
diabetic macular edema (362.07)
diabetic retinal edema (362.07)
diabetic retinopathy (362.01-362.07)

New code 249.6 Secondary diabetes mellitus with neurological manifestations

Use additional code to identify manifestation, as:
diabetic amyotrophy (353.1)
diabetic gastroparalysis (536.3)
diabetic gastroparesis (536.3)
diabetic mononeuropathy (354.0-355.9)
diabetic neurogenic arthopathy (713.5)
diabetic peripheral autonomic neuropathy (337.1)
diabetic polyneuropathy (357.2)

New code 249.7 Secondary diabetes mellitus with peripheral circulatory disorders

Use additional code to identify manifestation, as:
diabetic gangrene (785.4)
diabetic peripheral angiopathy (443.81)

New code 249.8 Secondary diabetes mellitus with other specified manifestations
Secondary diabetic hypoglycemia in diabetes mellitus
Secondary hypoglycemic shock in diabetes mellitus

Use additional code to identify manifestation, as:
any associated ulceration (707.10-707.9)
diabetic bone changes (731.8)

New code 249.9 Secondary diabetes mellitus with unspecified complication

250 Diabetes mellitus

Add Excludes: secondary diabetes (249.0-249.9)

250.8 Diabetes with other specified manifestations
Revise Diabetic hypoglycemia NOS
Revise Hypoglycemic shock NOS

Delete ~~Use additional E code to identify cause, if drug-induced~~

251 Other disorders of pancreatic internal secretion

251.0 Hypoglycemic coma

Revise Excludes: hypoglycemic coma in diabetes mellitus (249.3, 250.3)

251.1 Other specified hypoglycemia

Excludes: hypoglycemia:
Revise in diabetes mellitus (249.8, 250.8)

251.2 Hypoglycemia, unspecified

Revise Exclude: hypoglycemia in diabetes mellitus (249.8, 250.8)

271 Disorders of carbohydrate transport and metabolism

Revise Excludes: diabetes mellitus (249.0-249.9, 250.0-250.9)

337 Disorders of the autonomic nervous system

337.1 Peripheral autonomic neuropathy in disorders classified elsewhere

Code first underlying disease, as:
Revise diabetes (249.6, 250.6)

353 Nerve root and plexus disorders

353.5 Neuralgic amyotrophy

Add — Code first any associated underlying disease, such as:
diabetes mellitus (249.6, 250.6)

357 Inflammatory and toxic neuropathy

357.2 Polyneuropathy in diabetes

Revise — Code first underlying disease (249.6, 250.6)

362 Other retinal disorders

362.0 Diabetic retinopathy

Revise — Code first diabetes (249.5, 250.5)

366 Cataract

366.4 Cataract associated with other disorders

366.41 Diabetic cataract

Revise — Code first diabetes (249.5, 250.5)

443 Other peripheral vascular disease

443.8 Other specified peripheral vascular diseases

443.81 Peripheral angiopathy in diseases classified elsewhere

Revise — Code first underlying disease, as:
diabetes mellitus (249.7, 250.7)

536 Disorders of function of stomach

536.3 Gastroparesis

Revise — Code first underlying disease, such as:
diabetes mellitus (249.6, 250.6)

581 Nephrotic syndrome

581.8 With other specified pathological lesion in kidney

581.81 Nephrotic syndrome in diseases classified elsewhere

Code first underlying disease, as:

Revise diabetes mellitus (249.4, 250.4)

583 Nephritis and nephropathy, not specified as acute or chronic

583.8 With other specified pathological lesion in kidney

583.81 Nephritis and nephropathy, not specified as acute or chronic, in diseases classified elsewhere

Code first underlying disease, as:

Revise diabetes mellitus (249.4, 250.4)

648 Other current conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium

648.0 Diabetes mellitus

Revise Conditions classifiable to 249, 250

707 Chronic ulcer of skin

707.1 Ulcer of lower limbs, except decubitus

Code, if applicable, any causal condition first:

Revise diabetes mellitus (249.8, 250.80-250.83)

713 Arthropathy associated with other disorders classified elsewhere

713.5 Arthropathy associated with neurologic disorders

Code first underlying disease as:
neuropathic joint disease [Charcots's joints]:

Revise diabetic (249.6, 250.6)

731 Osteitis deformans and osteopathies associated with other disorders classified elsewhere

731.8 Other bone involvement in diseases classified elsewhere

Code first underlying disease as:

Revise diabetes mellitus (249.8, 250.8)

751 Other congenital anomalies of digestive system

751.7 Anomalies of pancreas

Revise Excludes: diabetes mellitus: (250.0-250.9)

Delete ~~congenital (250.0-250.9)~~

790 Nonspecific findings on examination of blood

790.2 Abnormal glucose

Revise Excludes: diabetes mellitus (249.0-249.9, 250.00-250.93)

Topic: Newborn Post-discharge Health Check

The American Academy of Pediatrics (AAP) recommends that all otherwise healthy newborns that are discharged from the hospital less then 48 hours from delivery should be examined by their primary care provider within 2 days of that discharge.

The purpose of the follow-up visit is to:
• Weigh the infant; assess the infant's general health, hydration, and degree of jaundice; identify any new problems; review feeding pattern and technique, including observation of breastfeeding for adequacy of position, latch-on, and swallowing; and obtain historical evidence of adequate urination and defecation patterns for the infant.
• Assess quality of mother-infant interaction and details of infant behavior.
• Reinforce maternal or family education in infant care, particularly regarding infant feeding.
• Review the outstanding results of laboratory tests performed before discharge.
• Perform screening tests in accordance with state regulations and other tests that are clinically indicated, such as serum bilirubin.
• Verify the plan for health care maintenance, including a method for obtaining emergency services, preventive care and immunizations, periodic evaluations and physical examinations, and necessary screenings.

AAP raised the concern that existing codes do not adequately describe the reason for the encounter, including codes for the well child exam (V20.2), observation for other specified condition (V29.8) and other specified aftercare (V58.89). Therefore, AAP has asked that a new specific code be established for this type of visit.

TABULAR MODIFICATIONS

	V20	Health supervision of infant or child	
Revise	V20.2	Routine infant or child health check<u>s</u>	
New code	V20.21	Routine health check for newborn under 72 hours old	
New code	V20.22	Routine health check for newborn over 72 hours old through 28 days old	
New code	V20.29	Other routine infant or child health check	

Topic: Androgen insensitivity syndromes

The androgen insensitivity syndromes (AIS) are the most common reasons for male pseudohermaphroditism. All cases have an XY chromosome genotype. The range of presentation is from phenotypic female, to cases with ambiguous genitalia, incomplete virilization with hypospadias, and cases with small phallus and testes and infertility.

Complete androgen insensitivity syndrome has also been called testicular feminization, or Goldberg-Maxwell syndrome. Affected individuals frequently develop as normal females through childhood, and to adult appearance. In general, a vagina is present, but no uterus, and there is no menarche. This may be the first sign of this disorder. The testes may be undescended, or may descend to the inguinal area and be detected there. There is risk for testicular cancer, so the testes must be surgically removed.

In partial AIS there can be wide variety in presentation, ranging from severe hypospadias, and bifid scrotum, to essentially normal male phenotype with infertility, or there can be extreme undervirilization with apparently female phenotype, but potentially with appearance of clitoromegaly and labial fusion. Reifenstein syndrome is one form of partial AIS, with hypospadias, gynecomastia, and hypogonadism, along with post-puberty testicular atrophy and azoospermia.

This topic was proposed by the American Academy of Pediatrics. The current code for androgen insensitivity syndrome became effective October 2005. However, since the lack of androgen response may be partial or complete, AAP noted that it would be of value to further expand this code, to differentiate these conditions.

TABULAR MODIFICATIONS

257 Testicular dysfunction

257.8 Other testicular dysfunction

Revise — Excludes: androgen insensitivity syndrome<u>s</u> (259.5<u>0-259.52</u>)

259 Other endocrine disorders

259.5 Androgen insensitivity syndrome

Delete — ~~Partial androgen insensitivity~~
~~Reifenstein syndrome~~

New code — 259.50 Androgen insensitivity, unspecified

New code — 259.51 Androgen insensitivity syndrome
Complete androgen insensitivity
de Quervain's syndrome
Goldberg-Maxwell Syndrome

New code — 259.52 Partial androgen insensitivity
Partial androgen insensitivity syndrome
Reifenstein syndrome

752 Congenital anomalies of genital organs

Delete — Excludes: ~~testicular feminization syndrome (259.5)~~

752.7 Indeterminate sex and pseudohermaphroditism

Add — Excludes: androgen insensitivity (259.50-259.52)
pseudohermaphroditism:
Revise — testicular feminization syndrome (<u>259.50-259.52</u>)

Topic: Hungry bone syndrome

Hungry bone syndrome occurs commonly after parathyroidectomy, for either primary or secondary hyperparathyroidism. It is characterized by hypocalcemia, and may also have hypophosphatemia and hypomagnesemia. The hypocalcemia usually resolves within 3 weeks, but in some cases can last for much longer, even years.

The pathophysiology of hungry bone syndrome is thought to usually involve an extended history of previously elevated levels of parathyroid hormone, with some related bone demineralization, potentially with osteoporosis. The subsequent change in parathyroid hormone levels to low or normal then result in the bone sequestering calcium ("hungry bone"), with resulting increased density of bone. The hungry bone syndrome may also occur after treatment for thyrotoxicosis.

This topic was raised subsequent to questions that came to the Editorial Advisory Board for Coding Clinic.

TABULAR MODIFICATIONS

252 Disorders of parathyroid gland

Add Excludes: hungry bone syndrome (275.5)

275 Disorders of mineral metabolism

New code 275.5 Hungry bone syndrome

Topic: Isolated Systolic Hypertension and Isolated Diastolic Hypertension

Isolated systolic hypertension has been recognized to be critically important to treat and control. It is the leading cause of uncontrolled hypertension in people over 50 years old. The systolic blood pressure is the most significant predictor of cardiovascular mortality.

Essential hypertension commonly is the mixed systolic/diastolic form, where both the systolic and diastolic blood pressure is elevated. It could be helpful to explicitly identify where mixed systolic/diastolic essential hypertension occurs, and to differentiate it from cases with isolated systolic or isolated diastolic hypertension.

It can also be important to identify isolated diastolic hypertension. More recent studies have found it to relate to lower risk of cardiac disease.

The proposal to be able to identify isolated systolic hypertension, isolated diastolic hypertension, and mixed systolic/diastolic hypertension was from Steven A. Yarows, MD, FACP, the president elect of the Midwest chapter of the American Society of Hypertension. He also raised concerns about the misleading nature of code 401.1, Benign, essential hypertension, on the basis that it can have significant contribution to cardiac mortality.

Specific codes would make it much easier to determine the rate of control for hypertension, in its various different guises. It would increase the effectiveness of societies that work to teach practicing physicians the importance of controlling this deadly disease. Two options are being proposed.

TABULAR MODIFICATIONS

Option 1 :	401	Essential hypertension	
Revise		401.0	Malignant <u>essential hypertension</u>
Revise		401.1	Benign <u>essential hypertension</u>
New code		401.2	Isolated systolic essential hypertension Isolated systolic hypertension
New code		401.3	Isolated diastolic essential hypertension Isolated diastolic hypertension
New code		401.4	Mixed systolic/diastolic essential hypertension Mixed systolic/diastolic hypertension
Revise		401.9	Unspecified <u>essential hypertension</u>

Option 2:

New category	406	Isolated and mixed hypertension

Code first the type of hypertension,
essential hypertension (401.0-401.9)
hypertensive heart disease (402-00-402.91)
hypertensive heart and chronic kidney disease (404.00-404.90)
secondary hypertension (405.01-405.99)

New code	406.1	Isolated systolic hypertension
New code	406.2	Isolated diastolic hypertension
New code	406.3	Mixed systolic/diastolic hypertension

Addenda

Tabular

151 Malignant neoplasm of stomach

Delete ~~Excludes: malignant stromal tumor of stomach (171.5)~~

152 Malignant neoplasm of small intestine, including duodenum

Delete ~~Excludes: malignant stromal tumor of small intestine (171.5)~~

171 Malignant neoplasm of connective and other soft tissue
Includes: blood vessel
Delete ~~malignant stromal tumors~~

Excludes:…
Revise internal organs ~~(except stromal tumors)~~ - code to malignant neoplasm of the site [e.g., leiomyosarcoma of stomach, 151.9]

233 Carcinoma in situ of breast and genitourinary system

233.1 Cervix uteri
Revise Cervical intraepithelial glandular neoplasia grade III

238 Neoplasm of uncertain behavior of other and unspecified sites and tissues

238.7 Other lymphatic and hematopoietic tissues

Delete Excludes: ~~myelofibrosis (289.83)~~

250 Diabetes mellitus

250.6 Diabetes with neurological manifestations

Use additional code to identify manifestation, as:
diabetic
Revise amyotrophy (353.5)

289 Other diseases of blood and blood-forming organs

289.8 Other specified diseases of blood and blood-forming organs

289.83 Myelofibrosis

Add — Use additional code for associated therapy-related myelodysplastic syndrome, if applicable (238.72, 238.73)

Add — Use additional external cause code if due to anti-neoplastic chemotherapy (E933.1)

302 Sexual and gender identity disorders

Revise — 302.5 Trans-sexualism (errata for CD)

315 Specific delays in development

315.3 Developmental speech or language disorder

New code — 315.34 Speech and language developmental delay due to hearing loss

Delete — ~~Use additional code to identify type of hearing loss (389.00-389.9)~~

331 Other cerebral degenerations

Use additional code, where applicable, to identify:
Revise — dementia with behavioral disturbance (294.11)
Revise — dementia without behavioral disturbance (294.10)

337 Disorders of the autonomic nervous system

337.2 Reflex sympathetic dystrophy

337.20 Reflex sympathetic dystrophy, unspecified
Add — Complex regional pain syndrome type I, unspecified

337.21 Reflex sympathetic dystrophy of the upper limb
Add — Complex regional pain syndrome type I of the upper limb

337.22 Reflex sympathetic dystrophy of the lower limb

Add — Complex regional pain syndrome type I of the lower limb

337.29 Reflex sympathetic dystrophy of other specified site

Add — Complex regional pain syndrome type I of other specified site

353 Nerve root and plexus disorders

353.1 Lumbosacral plexus lesions

Delete — ~~Code first, if applicable, associated diabetes mellitus (250.6)~~

353.5 Neuralgic amyotrophy

Add — Code first, if applicable, associated diabetes mellitus (250.6)

354 Mononeuritis of upper limb and mononeuritis multiplex

354.4 Causalgia of upper limb

Add — Complex regional pain syndrome type II of the upper limb

Add — Excludes: complex regional pain syndrome type II of the lower limb (355.71)

355 Mononeuritis of lower limb

355.7 Other mononeuritis of lower limb

355.71 Causalgia of lower limb

Add — Excludes: complex regional pain syndrome of upper limb (354.4)

355.9 Mononeuritis of unspecified site

Add — Complex regional pain syndrome NOS

Add — Excludes: complex regional pain syndrome
Add — lower limb (355.71)
Add — upper limb (354.4)

358 Myoneural disorders

358.1 Myasthenic syndromes in diseases classified elsewhere

Code first underlying disease, as:
Revise botulism (005.1, 040.41, 040.42)

365 Glaucoma

365.4 Glaucoma associated with congenital anomalies, dystrophies, and systemic syndromes

365.41 Glaucoma associated with chamber angle anomalies

Delete ~~Code first associated disorder, as:~~
~~Axenfeld's anomaly (743.44)~~
~~Rieger's anomaly or syndrome (743.44)~~

365.42 Glaucoma associated with anomalies of iris

Delete ~~Code first associated disorder, as:~~
~~aniridia (743.45)~~
~~essential iris atrophy (364.51)~~

365.43 Glaucoma associated with other anterior segment anomalies

Delete ~~Code first associated disorder, as:~~
~~microcornea (743.41)~~

365.5 Glaucoma associated with disorders of the lens

365.51 Phacolytic glaucoma

Delete ~~Use additional code for associated hypermature cataract (366.18)~~

365.52 Pseudoexfoliation glaucoma

Delete ~~Use additional code for associated pseudoexfoliation of capsule (366.11)~~

365.59 Glaucoma associated with other lens disorders

Delete ~~Use additional code for associated disorder, as:~~
~~dislocation of lens (379.33-379.34)~~
~~spherophakia (743.36)~~

365.6 Glaucoma associated with other ocular disorders

365.61 Glaucoma associated with pupillary block

Delete ~~Use additional code for associated disorder, as:~~
~~seclusion of pupil [iris bombé] (364.74)~~

365.62 Glaucoma associated with ocular inflammations

Delete ~~Use additional code for associated disorder, as:~~
~~glaucomatocyclitic crises (364.22)~~
~~iridocyclitis (364.0-364.3)~~

365.63 Glaucoma associated with vascular disorders

Delete ~~Use additional code for associated disorder, as:~~
~~central retinal vein occlusion (362.35)~~
~~hyphema (364.41)~~

365.64 Glaucoma associated with tumors or cysts

Delete ~~Use additional code for associated disorder, as:~~
~~benign neoplasm (224.0-224.9)~~
~~epithelial down-growth (364.61)~~
~~malignant neoplasm (190.0-190.9)~~

365.65 Glaucoma associated with ocular trauma

Delete ~~Use additional code for associated condition, as:~~
~~contusion of globe (921.3)~~
~~recession of chamber angle (364.77)~~

366 Cataract

366.4 Cataract associated with other disorders

366.43 Myotonic cataract

Revise Code first underlying disorder (359.21~~-359.29~~)

386 Vertiginous syndromes and other disorders of vestibular system

Revise 386.0 Ménière's disease
Revise Ménière's syndrome or vertigo

Revise 386.00 Ménière's disease, unspecified
Revise Ménière's disease (active)

Revise 386.01 Active Ménière's disease, cochleovestibular

Revise 386.02 Active Ménière's disease, cochlear

Revise 386.03 Active Ménière's disease, vestibular

Revise 386.04 Inactive Ménière's disease
Revise Ménière's disease in remission

415 Acute pulmonary heart disease

415.11 Iatrogenic pulmonary embolism and infarction

Add Use additional code for associated septic pulmonary embolism, if applicable, 415.12

525 Other diseases and conditions of the teeth and supporting structures

525.7 Endosseous dental implant failure

525.71 Osseointegration failure of dental implant
Add Failure of dental implant due to infection
Add Failure of dental implant due to unintentional loading
Add Failure of dental implant osseointegration due to premature loading
Add Failure of dental implant to osseointegrate prior to intentional prosthetic loading

525.72 Post-osseointegration biological failure of dental implant
Add Failure of dental implant to osseointegrate prior to intentional prosthetic loading

525.73 Post-osseointegration mechanical failure of dental implant
Add Mechanical failure of dental implant NOS

584 Acute renal failure

Revise 584.9 Acute renal failure, with unspecified type of lesion

640 Hemorrhage in early pregnancy

Revise Requires fifth digit; valid digits are in [brackets] under each code. See beginning of section 640-649 for definitions.

641 Antepartum hemorrhage, abruptio placentae, and placenta previa

Revise Requires fifth digit; valid digits are in [brackets] under each code. See beginning of section 640-649 for definitions.

642 Hypertension complicating pregnancy, childbirth, and the puerperium

Revise Requires fifth digit; valid digits are in [brackets] under each code. See beginning of section 640-649 for definitions.

643 Excessive vomiting in pregnancy

Revise Requires fifth digit; valid digits are in [brackets] under each code. See beginning of section 640-649 for definitions.

644 Early or threatened labor

Revise Requires fifth digit; valid digits are in [brackets] under each code. See beginning of section 640-649 for definitions.

645 Late pregnancy

Revise Requires fifth digit; valid digits are in [brackets] under each code. See beginning of section 640-649 for definitions.

646 Other complications of pregnancy, not elsewhere classified

Revise Requires fifth digit; valid digits are in [brackets] under each code. See beginning of section 640-649 for definitions.

647 Infectious and parasitic conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium

Revise Requires fifth digit; valid digits are in [brackets] under each code. See beginning of section 640-649 for definitions.

648 Other current conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium

Revise Requires fifth digit; valid digits are in [brackets] under each code. See beginning of section 640-649 for definitions.

649 Other conditions or status of the mother complicating pregnancy, childbirth, or the puerperium

Add Requires fifth digit; valid digits are in [brackets] under each code. See beginning of section 640-649 for definitions.

746 Other congenital anomalies of heart

746.8 Other specified anomalies of heart

746.84 Obstructive anomalies of heart, NEC

Add Shone's syndrome

Add Use additional code for associated anomalies, such as:
Add coarctation of aorta (747.10)
Add congenital mitral stenosis (746.5)
Add subaortic stenosis (746.81)

771 Infections specific to the perinatal period

771.8 Other infections specific to the perinatal period

771.81 Septicemia [sepsis] of newborn

Add Use additional codes to identify severe sepsis (995.92) and any associated acute organ dysfunction

797 Senility without mention of psychosis

Add Frailty

995 Certain adverse effects not elsewhere classified

995.9 Systemic inflammatory response syndrome (SIRS)

995.92 Severe sepsis

Use additional code to specify acute organ dysfunction, such as:

Add acute respiratory insufficiency (518.82)
Add acute vascular insufficiency of intestine (557.0)
Add necrosis of intestines (557.0)

995.94 Systemic inflammatory response syndrome due to non-infectious process with acute organ dysfunction

Use additional code to specify acute organ dysfunction, such as:

Add acute respiratory insufficiency (518.82)
Add acute vascular insufficiency of intestine (557.0)
Add necrosis of intestines (557.0)

996 Complications peculiar to certain specified procedures

996.6 Infection and inflammatory reaction due to internal prosthetic device, implant, and graft

996.62 Due to vascular device, implant and graft

Excludes: infection due to:

Add umbilical venous catheter (999.31)

998 Other complications of procedures, NEC

998.3 Disruption of operation wound

Add Disruption of postprocedural wound closure or post-traumatic wound repair

999 Complications of medical care, not elsewhere classified

999.3 Other infection

999.31 Infection due to central venous catheter

Revise Catheter-related bloodstream infection (CRBSI) NOS

Add Umbilical venous catheter

Revise PERSONS WITH POTENTIAL HEALTH HAZARDS RELATED TO PERSONAL AND FAMILY HISTORY (V10-V19)

V15 Other personal history presenting hazards to health

Revise V15.2 Surgery to other ~~major~~ organs

V64 Persons encountering health services for specific procedures, not carried out

V64.0 Vaccination not carried out

V64.05 Vaccination not carried out because of caregiver refusal

Add Excludes: vaccination not carried out because of caregiver refusal for religious reasons (V64.07)

General tabular modifications:

Common fifth digit subclassification- identify each code affected, for example:

The following fifth-digit subclassification is for use with categories 010-018:

0 unspecified
1 bacteriological or histological examination not done
2 bacteriological or histological examination unknown (at present)
3 tubercle bacilli found (in sputum) by microscopy
4 tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
5 tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
6 tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods [inoculation of animals]

010 Primary tuberculous infection
Requires fifth digit. See beginning of section 010-018 for codes and definitions.

010.0 Primary tuberculous infection
Add [0-6]

Categories affected (not every code in every category affected):
010-018, 045, 070, 115, 200-208, 242, 250, 295, 296, 299, 303-305, 312, 342, 345, 346, 403,404, 410, 433, 434, 493, 531-535, 550, 574, 634-637, 741, 764, 765, 789, 800, 801, 803-805, 807, 810, 811, 814-816, 823, 831-835, 838, 851-854, 864-866, 868, 880-881, 941-945 (there are notes and brackets in the OB chapter and certain 700 codes, and 948), V30

This can be done with the external cause codes are well, transport accidents. 4th digit subdivisions.

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Add due to antineoplastic chemotherapy 284.89
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Add hereditary 285.0
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Add hereditary 285.0
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Add vitamin B_6 responsive 285.0

Add Bedbugs bite(s)- see Injury, superficial, by site

Add Birt-Hogg-Dube syndrome 759.89

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Add bedbug - see Injury, superficial, by site

Add BOOP (bronchiolitis obliterans-organized pneumonia) 516.8

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Add with organizing pneumonia (BOOP) 516.8

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Add Leukoencephalopathy, reversible, posterior 348.5

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Add Twiddler's syndrome (due to)
Add automatic implantable defibrillator 996.04
Add pacemaker 996.01

Vaccination
Add delayed V64.09

Worn out
Add artificial heart valve 996.02
Add pacemaker lead or battery V53.31
Add joint prosthesis 996.47

EXTERNAL CAUSE TABULAR

SUPPLEMENTARY CLASSIFICATION OF EXTERNAL CAUSES OF INJURY AND POISONING (E800-E999)

(q) A pedestrian conveyance is any human powered device by which a pedestrian may move other than by walking or by which a walking person may move another pedestrian.

Add Includes: heelies, wheelies

E885 Fall on same level from slipping, tripping, or stumbling

E885.1 Fall from roller skates
Add Heelies
Add Wheelies

E928 Other and unspecified environmental and accidental causes

E928.6 Environmental exposure to harmful algae and toxins

Revise Pfiesteria piscicida (errata)

EXTERNAL CAUSE INDEX

Electric shock, electrocution…

Add electroshock gun (taser) (stun gun) E925.8

Add caused by other person E968.8

Add legal intervention E975

Add stated as accidental E925.8

Add stated as intentional E968.8

Add stated as intentional self-harm (suicidal (attempt)) E958.4

Add stated as undetermined whether accidental or intentional E988.4

Add suicide (attempt) E958.4

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Add heelies, wheelies E885.1

TABLE OF DRUGS AND CHEMICALS

Add	Hand sanitizer	976.0	E858.7	E946.0	E950.4	E962.0	E980.4