ICD-9-CM Coordination and Maintenance Committee Meeting
September 28-29, 2006
Diagnosis Agenda

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ICD-9-CM TIMELINE

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

August 18, 2006	Hospital Inpatient Prospective Payment System final rule 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, 2006. This rule can be accessed at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp
August 2006	Tentative agenda for the Procedure part of the September 28 – 29, 2006 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage at - http://www.cms.hhs.gov/paymentsystems/icd9 Tentative agenda for the Diagnosis part of the September 28 – 29, 2006 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 28 – 29, 2006 ICD-9-CM Coordination and Maintenance Committee Meeting will be published. This will include the tentative agenda.
September 17, 2006	Because of increased security requirements, **those wishing to attend the September 28-29, 2006** ICD-9-CM Coordination and Maintenance Committee meeting must register for the meeting online at: http://www.cms.hhs.gov/events **Attendees must register online by September 17, 2006; failure to do so may result in lack of access to the meeting**.
Sept. 28-29, 2006	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 17, 2006.** You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building.
October 1, 2006	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/paymentsystems/icd9

October, 2006	Summary report of the Procedure part of the September 28-29, 2006 ICD-9-CM Coordination and Maintenance Committee meeting posted on CMS homepage at - http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Summary report of the Diagnosis part of the September 28-29, 2006 ICD-9-CM Coordination and Maintenance Committee meeting report posted on NCHS homepage at - http://www.cdc.gov/nchs/icd9.htm
October 13, 2006	Deadline for receipt of public comments on proposed code revisions discussed at the September 28 – 29, 2006 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on April 1, 2007 to capture new technology.
Early Nov., 2006	Any new ICD-9-CM codes required to capture new technology that will be implemented on April 1, 2007 will be announced. Information on any new codes to be implemented on April 1, 2007 will be posted on the following websites: Procedure at http://www.cms.hhs.gov/paymentsystems/icd9 Diagnosis addendum at http://www.cdc.gov/nchs/icd9.htm Code titles at http://www.cms.hhs.gov/medlearn/icd9code.asp
December 4, 2006	Deadline for receipt of public comments on proposed code revisions discussed at the March 23 - 24, 2006 and September 28 - 29, 2006 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2007.
January 22, 2007	Deadline for requestors: Those members of the public requesting topics for discussion at the March 22-23, 2007 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses by this date.
February 2007	Draft agenda for the Procedure part of the March 22, 2007 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 23, 2007 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 22 – March 23, 2007 ICD-9-CM Coordination and Maintenance Committee Meeting will be published.
February 22, 2007	On-line registration opens for the March 22 – 23, 2007 ICD-9-CM Coordination and Maintenance Committee meeting at: http://www.cms.hhs.gov/events
March 16, 2007	Because of increased security requirements, **those wishing to attend the March 22 – March 23, 2007** ICD-9-CM Coordination and Maintenance Committee meeting must register for the meeting online at: http://www.cms.hhs.gov/apps/events **Attendees must register online by March 16, 2007; failure to do so may result in lack of access to the meeting**.
March 22 –23, 2007	ICD-9-CM Coordination and Maintenance Committee meeting.
April 1, 2007	Any new ICD-9-CM codes required to capture new technology will be implemented. Information on any new codes implemented on April 1, 2007 previously posted in early October 2006 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 13, 2007	Deadline for receipt of public comments on proposed code revisions discussed at the March 22-23, 2007 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2007.
April 2007	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 2007	Summary report of the Procedure part of the March 22, 2007 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 23, 2007 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 2007	Final addendum 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
July 27, 2007	Those members of the public requesting that topics be discussed at the September 27 – 28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses.
August 1, 2007	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, 2007. This rule can be accessed at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp
August 16, 2007	On-line registration opens for the September 27-28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting at: http://www.cms.hhs.gov/events
August 2007	Tentative agenda for the Procedure part of the September 27 – 28, 2007 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 27 – 28, 2007 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 27 – 28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.
September 21, 2007	Because of increased security requirements, those wishing to attend the September 27 - 28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting must register for the meeting online at: http://www.cms.hhs.gov/apps/events **Attendees must register online by September 21, 2007; failure to do so may result in lack of access to the meeting.**

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 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 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 revisions discussed at September 27-28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting for implementation on April 1, 2008.
Early Nov. 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 September 27-28, 2007 ICD-9-CM Coordination and Maintenance Committee meetings for implementation of October 1, 2008.

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

Please consult this web page for updated information.

Topic: Hearing loss, speech, language, and swallowing disorders

Hearing loss is a common problem in modern society due to the combined effects of noise, aging, disease, and heredity. Hearing is a complex sense involving both the sensitivity of the ear as well as the ability to understand speech. Determining the prevalence of hearing loss depends on the type and degree of the loss, the area(s) of abnormality in the auditory system (middle ear, inner ear, brain, e.g.), noise exposure, and age.

The American Speech-Language-Hearing Association (ASHA) recommends additions and revisions to the ICD-9-CM so that diagnostic information can be coded that clarifies the lateral nature of all types of hearing loss.

Hearing loss

The proposed tabular modifications to category 389, Hearing loss build on new codes being implemented October 1, 2006 for sensorineural hearing loss. These include new codes for bilateral, unilateral and asymmetrical hearing loss for the other subcategories in this category which relate to hearing loss. Epidemiology, public policy (e.g. prevalence of hearing loss in children), and hearing loss research efforts could improve considerably if more specificity were available in ICD-9-CM, particularly differentiating bilateral and unilateral hearing loss.

Deaf, nonspeaking

It is proposed to revise the title to code 389.7 which is currently titled "Deaf mutism, not elsewhere classifiable". ASHA and the American Academy of Audiology (AAA) maintain that "deaf mutism" is an inaccurate and archaic term. Deaf and hard of hearing people can vocalize but have difficulty modulating their voices. People who are deaf and hard of hearing may use other means of communication rather than speech but they should not be identified as mute. The term "nonspeaking" is more descriptive of the diagnosis.

Auditory processing disorder

A new code is being proposed for auditory processing disorder. Auditory processing disorder (APD) refers to difficulties in the processing of auditory frequency, intensity, and temporal information in the central nervous system (CNS). In October 2005 "central auditory processing disorder" was added to the disease index to code 315.32, Mixed receptive-expressive language disorder. This code is in category 315, Specific delays in development. However, APD can also be acquired through neurological problems caused by tumors, head injury (postconcussive injury or traumatic brain injury), surgical mishaps, stroke or degenerative neurological conditions, bacterial or viral infections, or oxygen deficiency. It is proposed to create a unique code for acquired auditory processing disorder in Chapter 6, Diseases of Nervous System and Sense Organs.

Dual sensory impairment

Sometimes known as deaf-blindness or multi-sensory impairment, dual sensory impairment is more than a combination of visual and hearing impairment. An individual with dual sensory impairment can use neither their sight nor hearing to compensate for the impairment of the other sense and neither sense can be used as a primary source for accessing information. It is estimated that dual sensory impairment occurs in three of 100,000 births. However, dual sensory impairment can also be caused by many factors acquired later as an adult due to injury or illness. Coding blindness and hearing loss does not recognize that dual sensory impairment causes greater disability than either visual loss or hearing loss alone. A unique code would aid in health services research and treatment.

Hearing conservation

There is a need to differentiate hearing conservation and occupational hearing tests from ICD-9-CM V70.5, Health examination of defined subpopulations. The U.S. Department of Defense has a major hearing conservation mission. Hearing conservation is also required by the Occupational Safety and Health Administration for employees exposed to hazardous levels of noise. Hearing conservation involves hearing loss monitoring, employee education, acoustic analysis of noise risks, and prevention (hearing protection). There is no specific code that captures encounters for the purpose of hearing conservation. Code V70.5 (health examination for defined subpopulations) identifies armed forces personnel and occupational health screening). V72.11 and V72.19 (hearing examination following failed hearing screening and other examinations of ears and hearing) are not sufficiently detailed. This code would be used by to identify hearing conservation activities and to differentiate these activities from clinical audiology. The code would be used by audiologists, otolaryngologists, and other health care practitioners engaged in hearing conservation.

Disability exam

Thousands of disability examinations are performed each year. In one year the Veterans Health Administration alone performs 300,000 to 400,000 disability exams to determine compensation and pension payments for disabling conditions incurred in or aggravated by military service. There is no specific code for disability examinations. The code V70.4, examination for medicolegal reasons, does not specifically cite disability examination, while code V70.5, health examination for defined subpopulations, identifies a wide array of subpopulations. Code V68.0, issue of medical certificates cites fitness and incapacity and code V68.2, request for expert evidence, includes an aspect of disability examinations. A unique code is needed for disability examinations and is being proposed as an expansion to current code V70.4, examination for medicolegal reasons.

Speech and language developmental delay due to hearing loss

There is consistent and substantial historical evidence that children born with hearing loss or deafness, whether permanent or intermittent, are at significantly greater risk for not acquiring normal, age-appropriate, language and speech abilities. A new unique code for speech and language developmental delay due to hearing loss will assist researchers

and epidemiologists to improve the accuracy of tracking, communicating, and allocating resources to those with this condition.

Dysphagia

Speech-language pathologists evaluate, diagnose and treat swallowing disorders. ASHA is requesting to expand the code for dysphagia, 787.2 to create unique codes specific to each phase of dysphagia which includes: oral, oropharyngeal, pharyngeal, pharyngoesophageal. Dysphagia is a dynamic disorder, and the symptoms vary significantly depending on the phase/phases of the swallow that are affected. Symptoms can be distinct to one phase or characteristic of the transition from one phase to the next.

TABULAR MODIFICATIONS

315 Specific delays in development

315.3 Developmental speech or language disorder

315.32 Mixed receptive-expressive language disorder

Add — Excludes: acquired auditory processing disorder (349.83)

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

349 Other and unspecified disorders of the nervous system

349.8 Other specified disorders of nervous system

New code — 349.83 Acquired auditory processing disorder

Excludes: central auditory processing disorder (315.32)

389 Hearing loss

389.0 Conductive hearing loss

New code — 389.05 Conductive hearing loss, unilateral

New code — 389.06 Conductive hearing loss, bilateral

389.1 Sensorineural hearing loss

New code — 389.13 Neural hearing loss, unilateral

Revise — 389.14 Central hearing loss~~, bilateral~~

New code		389.17	Sensory hearing loss, unilateral
Revise		389.18	Sensorineural hearing loss ~~of combined types~~, bilateral
	389.2		Mixed conductive and sensorineural hearing loss
New code		389.20	Mixed hearing loss, unspecified
New code		389.21	Mixed hearing loss, unilateral
New code		389.22	Mixed hearing loss, bilateral
Revise	389.7		Deaf ~~mutism~~, nonspeaking, not elsewhere classifiable
Delete			~~Deaf, nonspeaking~~
787			Symptoms involving digestive system
	787.2		Dysphagia
Delete			~~Difficulty in swallowing~~
New code		787.20	Dysphagia, unspecified Difficulty in swallowing
New code		787.21	Dysphagia, oral phase
New code		787.22	Dysphagia, oropharyngeal phase
New code		787.23	Dysphagia, pharyngeal phase
New code		787.24	Dysphagia, pharyngoesophageal phase
V49			Other conditions influencing health status
	V49.8		Other specified conditions influencing health status
New code		V49.85	Dual sensory impairment

V70 General medical examination

V70.4 Examination for medicolegal reasons

Delete ~~Blood-alcohol tests~~
Delete ~~Blood-drug tests~~
Delete ~~Paternity testing~~

New code V70.41 Disability examination

Use additional code(s) to identify:
specific examination(s), screening and testing performed (V72.0-V82.9)

New code V70.49 Other examination for medicolegal reasons
Blood-alcohol tests
Blood-drug tests
Paternity testing

V72 Special investigations and examinations

V72.1 Examination of ears and hearing

New code V72.12 Encounter for hearing conservation testing and treatment

Topic: Urinary risks factors for bladder cancer

According to the National Cancer Institute, each year in the United States, approximately 38,000 men and 15,000 women are diagnosed with bladder cancer.

Hematuria is a common presenting symptom of bladder cancer. This can be caused by a number of underlying urinary conditions, including urinary tract infection, benign prostatic hypertrophy, and kidney and ureteral calculi. In a specific subset of patients, however, hematuria is a cardinal sign of bladder cancer. These patients often require more intensive and more sensitive work-up than primary hematuria patients and may include, for example, diagnostic testing at the molecular level.

Patients presenting with hematuria, who are at high risk for bladder cancer, most commonly have other distinct risk factors which are suggestive to the experienced clinician. A number of these risk factors currently have unique codes in ICD-9-CM, including: currently smoking (305.1); voiding dysfunction (596.59); personal history of UTI (V13.02); personal history of urinary disorder (V13.09); personal history of irradiation (V15.3); and personal history of tobacco use (V15.82).

Although bladder cancer is generally associated with environmental factors and is not typically inherited, some individuals with family histories appear to inherit increased sensitivity to cancer-causing factors. Individuals with exposure to chemicals and dyes, such as benzenes or aromatic amines, are at higher risk of developing bladder cancer. This includes firefighters, hair stylists, truck drivers, and textile workers. Exposure to arsenic can occur from well water and drinking water near farms and mines and is linked to development of bladder cancer. These risk factors are indexed to non-specific ICD-9-CM codes. Family history of bladder cancer is indexed toV16.59, family history of malignant neoplasm in other urinary organs. Personal exposure to chemicals, dyes and arsenic are not indexed so they would likely be coded to V15.89, other specified personal history presenting hazards to health.

Abbott is requesting that new ICD-9-CM codes specific to these risk factors be created. This will aid in more precise identification and tracking of patients at high risk for developing bladder cancer. They will also allow these factors to be coded and identified in numerous other clinical situations where they present potential health hazards.

The requestor is also suggesting to add a coding note to code 599.7, Hematuria, to assign codes for any risk factors for bladder cancer that the patient may also have. NCHS welcomes input on this as at present ICD-9-CM does not address this concept.

TABULAR MODIFICATIONS

599 Other disorders of urethra and urinary tract

599.7 Hematuria

Add Use additional code, if applicable, to identify any risk factors for bladder cancer, such as:
Add exposure to lead and other potentially hazardous metals (V15.86)
Add exposure to potentially hazardous chemicals (V15.83)
Add family history of malignant neoplasm of bladder V16.52
Add functional disorder of bladder (596.59)
Add history of tobacco use (V15.82)
Add personal history of urinary tract infection (V13.02)
Add tobacco dependence (305.1)

V15 Other personal history presenting hazards to health

V15.8 Other specified personal history presenting hazards to health

New code V15.83 Exposure to potentially hazardous chemicals

Revise V15.86 Exposure to lead and other potentially hazardous metals
Add Exposure to arsenic

V16 Family history of malignant neoplasm

V16.5 Urinary organs
Revise Family history of condition classifiable to 188–189

New code V16.52 Bladder

Topic: Chronic Total Occlusion of Artery of Extremities

Chronic total occlusion of an artery in the extremities will generally develop over a long time period, with partial occlusion present initially. This can cause symptoms such as intermittent claudication (leg pain with exercise), when arteries to the lower extremities are involved. With worsening of a partial occlusion, rest pain may develop. On the other hand, presence of collateral blood supply may allow worsening of an occlusion with relatively less symptoms.

A more acute presentation of a total occlusion of a peripheral artery would usually result in an arterial thrombosis. This would be coded to category 444, Arterial embolism and thrombosis. These cases will involve sudden onset of severe pain. Treatment options include medical treatment with anticoagulation and thrombolytic therapy, and surgical treatment with thrombectomy, angioplasty, and bypass surgery.

A chronic total occlusion is typically composed of a hard fibrotic proximal cap, which may be calcified. This is followed by a segment of poorly organized fibrous and calcified plaque, ending with a firm distal cap. Symptoms for a chronic total occlusion may vary, particularly in relation to the significance of collateral blood supply. Treatment with stenting or angioplasty would be significantly more complex and difficult than for cases where there was only a partial occlusion, since the total occlusion is harder to cross. A chronic total occlusion of a native artery of the extremities would be coded to subcategory 440.2.

This proposal gives options to create a specific code(s) for chronic total occlusion of native artery of the extremities, paralleling the codes at subcategory 440.2. The proposal is based on a request from Cordis that the ICD-9-CM diagnosis codes be revised to allow for more specific coding of chronic total occlusion of arteries of the extremities.

TABULAR MODIFICATIONS

Option 1

	440	Atherosclerosis
		440.2 Of native arteries of the extremities
Add		Use additional code for chronic total arterial occlusion of the extremities (440.4)
New code		440.4 Chronic total arterial occlusion of the extremities
		Code first atherosclerosis of native arteries of the extremities (440.20-440.29)

Option 2

440 Atherosclerosis

440.2 Of native arteries of the extremities

Add — Excludes: chronic total occlusion of native artery of the extremities (440.4)

New subcategory — 440.4 Chronic total occlusion of native artery of the extremities

Excludes: atherosclerosis of bypass graft of the extremities (440.30-440.32)

New code — 440.40 Chronic total occlusion of native artery of the extremities, unspecified

New code — 440.41 Chronic total occlusion of native artery of the extremities with intermittent claudication

New code — 440.42 Chronic total occlusion of native artery of the extremities with rest pain
Any condition classifiable to 440.41

New code — 440.43 Chronic total occlusion of native artery of the extremities with ulceration
Any condition classifiable to 440.21-440.22

Use additional code for any associated ulceration (707.10 - 707.9)

New code — 440.44 Chronic total occlusion of native artery of the extremities with gangrene
Any condition classifiable to 440.21, 440.22, and 440.23 with ischemic gangrene 785.4

Use additional code for any associated ulceration (707.10 - 707.9)

Excludes: gas gangrene 040.0

New code — 440.49 Other chronic total occlusion of native artery of the extremities

Topic: Osteonecrosis of jaw

A possible relationship between osteonecrosis of the jaw (ONJ) and the use of bisphosphonates and other medications is being studied in the oral and maxillofacial surgery (OMS) patient population. Without a specific reporting mechanism, the incidence of this occurrence is not being captured. The best code currently available in the ICD-9-CM manual is 733.49 (aseptic necrosis of bone, other) which is not specific enough for tracking such cases to allow for further research. Importantly, it should also be recognized that the current volume is lacking specific E codes describing both oral and intravenous bisphosphonate drugs. To properly track ONJ, it would also be significant to know the delivery route as well.

The American Association of Oral and Maxillofacial Surgeons' (AAOMS) case definition of osteonecrosis is "any patient who has not received radiation therapy to the oral cavity or neck, and who has exposed bone in the maxillofacial area that occurred spontaneously or following dental surgery and has no evidence of healing for more then 3 - 6 weeks after appropriate care". As noted in the definition, osteonecrosis differs from osteoradionecrosis which is caused by radiation therapy.

Due to the suspected increase in the incidence of bisphosphonate related ONJ, the AAOMS is requesting that creation of these codes be considered.

TABULAR MODIFICATIONS

733 Other disorders of bone and cartilage

733.4 Aseptic necrosis of bone

New code 733.45 Jaw

Use additional E code to identify drug, if drug-induced

Excludes: osteoradionecrosis of jaw (526.89)

E933 Primarily systemic agents

New code E933.6 Oral bisphosphonates

New code E933.7 Intravenous bisphosphonates

Topic: Intraoperative Floppy Iris Syndrome

Patients who have taken alpha-blockers (which may be given for urine retention, in particular that related to prostate hypertrophy) can have problems when undergoing cataract surgery. The iris is usually dilated using medication during cataract surgery. However, in those with a history of taking alpha-blockers, the iris does not stay properly dilated, but instead may flap or billow. This unexpected movement during surgery has the potential to lead to injury to the iris or other complications.

If this complication is considered, the ophthalmologic surgeon can keep the pupil open using stronger dilating medicine, or using miniature hooks. This can be an issue even if the patient has discontinued the alpha-blocker as much as five years before the cataract surgery.

Given how common cataracts are, and how common prostate hypertrophy is, with both of these being more common in the elderly, it will be useful to be able to specifically identify floppy iris syndrome. For these reasons, a specific code for this disorder was proposed by the American Society of Cataract and Refractive Surgery (ASCRS).

TABULAR MODIFICATIONS

364 Disorders of iris and ciliary body

364.8 Other disorders of iris and ciliary body

New code 364.81 Intraoperative floppy iris syndrome

Use additional E code to identify cause, such as:
Drugs primarily affecting the autonomic nervous system (E941.3)

New code 364.89 Other disorders of iris and ciliary body
Prolapse of iris NOS

Topic: Septic embolism

Septic emboli can be of two main types. A septic pulmonary embolus can originate from a localized infection such as a cellulitis or dental infection, with the embolic material traveling through the venous system to the heart, and then going into the pulmonary arterial system where it lodges in small vessels. A septic arterial embolus can originate from an infection in the heart (e.g., endocarditis) or lungs (e.g., lung abscess), and then the embolic material travels through the systemic arterial system to lodge in small vessels potentially anywhere in the body, such as the brain, the retina, or the digits.

There is no current entry for embolism, septic. Indexing for embolism, septicemic, refers to embolism, pyemic; that references specific codes for septicemia. Septic pulmonary embolism currently would be coded to 415.19, along with codes for septicemia and sepsis, as appropriate.

Septic pulmonary emboli may cause subsequent lung abscess or necrotizing pneumonia. A lung abscess involves localized pulmonary infection with necrosis, and a cavity at least 2 cm in diameter. Necrotizing pneumonia involves multiple localized pulmonary infections with necrosis and cavities smaller than 2 cm diameter. Both lung abscess and necrotizing pneumonia would be coded to 513.0, Abscess of lung.

Septic arterial emboli may originate from a central infection, such as in the heart or lungs (e.g., infective endocarditis (primarily left-sided) or lung abscess), or from right-sided sources in cases where there is a right to left shunt (e.g., patent ductus arteriosis).

While septic arterial emboli might be considered related to arterial embolism at category 444, the fourth and fifth digits at category 444 are currently used to identify the site of embolism. Thus, it would not be feasible to expand and include septic arterial emboli at category 444 without having a mixed axis, which is best to avoid. Thus, it appears best to create a new category 449, Septic arterial emboli.

TABULAR MODIFICATIONS

415 Acute pulmonary heart disease

415.1 Pulmonary embolism and infarction

New code 415.12 Septic pulmonary embolism
Septic embolism NOS

Code first underlying infection, such as:
septicemia (038.0 - 038.9)

Excludes: septic embolism following abortion (639.6)
septic embolism with ectopic or molar pregnancy (639.6)

444 Arterial embolism and thrombosis

Add Excludes: septic arterial embolism (449.0-449.9)

New Category 449 Septic arterial embolism

Code first underlying infection, such as:
infective endocarditis (421.0)
lung abscess (513.0)

New code 449.0 Septic arterial embolism of artery of brain

New code 449.1 Septic arterial embolism of artery of extremity

New code 449.2 Septic arterial embolism of artery of retina

New code 449.8 Septic arterial embolism of other artery

New code 449.9 Septic arterial embolism of unspecified artery

Topic: Parvovirus B19

The only parvovirus causing disease in humans may be referred to as human parvovirus, or parvovirus B19. The B19 came from the designation of the serum sample in which the virus was originally discovered, when it caused a false positive test for hepatitis B surface antigen; the sample had the designation of panel B and sample 19. To avoid confusion with other viruses, the official name assigned was parvovirus B19.

Parvovirus B19 is the cause of erythema infectiosum, also known as fifth disease (code 057.0). Parvovirus B19 also can cause an acute symmetrical polyarthropathy.

In some cases, parvovirus B19 can cause a transient aplastic crisis, with temporary failure of red blood cell production. In immune compromise, parvovirus B19 can be associated with a pure red cell aplasia and chronic anemia.

In the fetus, parvovirus B19 can lead to hydrops fetalis, congenital anemia, or fetal death in utero.

TABULAR MODIFICATIONS

057 Other viral exanthemata

057.0 Erythema infectiosum [fifth disease]

Add — Erythema infectiosum due to parvovirus B19

079 Viral and chlamydial infection in conditions classified elsewhere and of unspecified site

079.8 Other specified viral and chlamydial infections

New Code — 079.83 Parvovirus B19
Human parvovirus
Parvovirus NOS

Excludes: erythema infectiosum [fifth disease] (057.0)

INDEX MODIFICATIONS

Arthritis …
due to or associated with …

Add — human parvovirus 079.83 [711.5]
Add — parvovirus B19 079.83 [711.5]

Topic: Avian Influenza (Bird Flu)

Influenza is generally divided into three types, A, B, and C. Influenza type B and C viruses are specific to humans. Influenza type A affects a number of different animal species, with the largest variety found among birds. Waterfowl are considered a natural reservoir for influenza type A viruses. The influenza type A viruses are subtyped by hemagglutinin (H) and neuraminidase (N). There are 16 hemagglutinin subtypes and 9 neuraminidase subtypes, with many combinations possible (and with the most variety in birds). Influenza type A viruses have 8 segments of RNA, and thus there is considerable variation possible even for different subtypes with the same variety of hemagglutinin and neuraminidase. Only three subtypes of influenza type A are currently known to be circulating in humans, H1N1, H1N2, and H3N2.

The term avian influenza generally refers to influenza occurring in birds. Avian influenza can be divided into low pathogenic and highly pathogenic subtypes. Low pathogenic avian influenza strains have not been a human health concern. Highly pathogenic avian influenza spreads quickly among birds, and is often fatal in poultry. Only certain H5 and H7 subtypes have been found to cause highly pathogenic avian influenza. According to the USDA, there have been three outbreaks of highly pathogenic avian influenza affecting poultry in the US: an H7 variety on the east coast in 1924, an H5N2 subtype in Pennsylvania and Virginia in 1983-84, and an H5N2 subtype in Texas in 2004. There was also an outbreak of low pathogenic avian influenza subtype H7N2 in 2004 affecting poultry in Delaware, New Jersey, and Maryland. None of these outbreaks in birds led to any human cases of influenza.

A strain of highly pathogenic avian influenza subtype H5N1 was first reported to cause disease in humans in Asia in 1997. This Asian H5N1 has since spread among birds to Europe, Africa, and the Pacific. Human influenza due to H5N1 has generally been associated with close contact with birds. There has not been any wide human to human transmission, although it is not clear whether isolated instances may have occurred.

It should be noted that there have been cases of low pathogenic avian influenza subtype H5N1 in birds in North America. These are completely unrelated to the Asian H5N1, and do not pose a threat to humans. There is currently a ban on import of birds from countries affected by Asian H5N1. However, some experts have suggested that it is possible that migratory birds could spread Asian H5N1 to North America during the next year.

WHO has created a new code in ICD-10 to enable tracking avian influenza. In order to enable separate tracking of influenza type A in humans resulting from exposure to birds, a new ICD-9-CM code is being proposed for avian influenza.

TABULAR MODIFICATIONS

New code 488 Avian influenza

Note: Avian influenza is influenza caused by influenza viruses that normally infect only birds and, less commonly, pigs.

Topic: Myotonic disorders

Myotonia involves very slow relaxation of muscle after it contracts. This may be seen from any type of contraction, whether voluntary, or due to stretch reflex or electrical stimulation.

Myotonic muscular dystrophy (Steinart disease) is the second most common muscular dystrophy in North America, and the most common cause of myotonia. The course can be variable. At birth, infants may be almost normal, or may have facial muscle wasting and hypotonia. Weakness is mild in the first few years. Myotonia is usually not evident until about 5 years of age. Both striated muscle and smooth muscle is affected. Cardiac involvement may be present, usually with heart block, rather than cardiomyopathy. Endocrine abnormalities, immune deficiency, and cataracts may occur. Diagnosis may be made on a clinical basis, but muscle biopsy may be performed.

Myotonia congenita involves muscle stiffness and myotonia, with muscle hypertrophy. Muscle weakness may be present. However, the disease appears to be stable, and not progressive over many years. Myotonia congenita may be either autosomal dominant (Thomsen disease) or autosomal recessive (Becker disease, which is not the same as Becker muscular dystrophy). Both types involve the same genetic locus (7q35), affecting the skeletal muscle chloride channel-1 gene.

Paramyotonia congenita of von Eulenburg involves myotonia brought on by exposure to cold. It may also involve muscle weakness with temperature changes, and possibly potassium sensitivity in some cases. It affects the sodium channel.

Myotonic chondrodystrophy (Schwartz-Jampel disease) involves generalized muscle hypertrophy and weakness, with dysmorphic features and dwarfism. Schwartz-Jampel syndrome has been classified to 756.89, Other specified anomalies of muscle, tendon, fascia, and connective tissue. The term “myotonic chondrodystrophy” is not indexed, but chondrodystrophy is coded to 756.4, Chondrodystrophy. This proposal would move myotonic chondrodystrophy to subcategory 359.2, with other myotonic disorders.

Given the difference in severity between myotonic dystrophy, which is chronic, progressive, and often severe, compared with the milder course of myotonia congenita, specific codes for these conditions have been requested.

TABULAR MODIFICATIONS

359 Muscular dystrophies and other myopathies

359.2 Myotonic disorders

New code	359.21	Myotonic muscular dystrophy Dystrophia myotonica Myotonic dystrophy Steinert disease
New code	359.22	Myotonia congenita Thomsen disease
New code	359.23	Myotonic chondrodystrophy
New code	359.29	Other specified myotonic disorder Paramyotonia congenita of von Eulenburg

756 Other congenital musculoskeletal anomalies

Add Excludes: myotonic chondrodystrophy (359.23)

Topic: Cardiac tamponade

Cardiac tamponade is due to fluid accumulating in the pericardium, with increased pressure on the heart so that ventricular filling is impaired, and cardiac output is decreased. Symptoms can be similar to heart failure or cardiogenic shock, with tachycardia, dyspnea, and orthopnea.

Cardiac tamponade is generally accompanied by pulsus paradoxicus, with a marked decrease in the pulse (and systolic blood pressure) during inspiration. The diagnosis can be confirmed by echocardiogram.

Cardiac tamponade can be caused by a progressive effusion, which may be due to infection, or neoplasm, or follow cardiac surgery. It may also be caused by rupture of the heart, aortic dissection, or penetrating trauma. Treatment involves pericardiocentesis to remove the fluid. Depending on the cause, a catheter may be placed to enable drainage, a pericardial window may be created, or emergency cardiac surgery may be necessary for treating some conditions.

This issue of coding of cardiac tamponade was raised at the Editorial Advisory Board for Coding Clinic, leading to this proposal for a specific code for cardiac tamponade.

TABULAR MODIFICATIONS

	423	Other diseases of pericardium
New code		423.3 Cardiac tamponade
		Code first the underlying cause

Topic: Effects of Harmful Algal Bloom and Toxins

In April 2004 a proposal to create unique code for the effects of "red tide" was presented. Since that time NCHS has worked with the National Center for Environmental Health (Environmental Hazards and Health Effects Program) to refine the original proposal to be consistent with current knowledge.

Algae are vitally important to marine ecosystems and most species are not harmful. However, under certain environmental conditions, microscopic marine algae called Karennia brevis (K. brevis) grow quickly, creating blooms that can make the ocean appear red or brown. These blooms are sometimes referred to as tides.

K. brevis produces powerful toxins called brevetoxins, which have killed millions of fish and other marine organisms. Red tides have damaged the fishing industry, shoreline quality, and local economies in states such as Texas and Florida. Because K. brevis blooms move based on winds and tides, pinpointing a red tide at any given moment is difficult. Red tides occur throughout the world, affecting marine ecosystems in Scandinavia, Japan, the Caribbean, and the South Pacific.

In addition to killing fish, brevetoxins can become concentrated in the tissues of shellfish that feed on K. brevis. People who eat these shellfish may suffer from neurotoxic shellfish poisoning, a food poisoning that can cause severe gastrointestinal and neurologic symptoms, such as tingling fingers or toes.

The human health effects associated with eating brevetoxin-tainted shellfish are well documented. However, scientists are learning more about how other types of environmental exposures to brevetoxin, such as breathing the air near red tides or swimming in red tides, may affect humans. CDC studies suggests that people who swim among brevetoxins or inhale brevetoxins dispersed in the air may experience irritation of the eyes, nose, and throat, tingling of the lips and tongue, as well as coughing, wheezing, and shortness of breath. The effects will generally dissipate once they are removed from the environment. Additional evidence suggests that people with existing respiratory illness, such as asthma, may experience these symptoms more severely.

A new external cause code for effects resulting from environmental exposure to a harmful algal bloom and its toxins is now proposed.

TABULAR MODIFICATIONS

E928 Other and unspecified environmental and accidental causes

New code E928.6 Environmental exposure to harmful algae and toxins
Algae bloom NOS
Blue-green algae bloom
Brown tide
Cyanobacteria bloom
Florida red tide
Harmful algae bloom
Pfisteria piscicida
Red tide

INDEX MODIFICATIONS

Poisoning (acute) - see also Table of Drugs and Chemicals
Add Ciguatera 988.0
shellfish - see also Poisoning, food
Revise noxious (amnesic) (azaspiracid) (diarrheic) (neurotoxic) (paralytic) 988.0

Topic: Secondary diabetes mellitus

The American Association of Pediatrics (AAP) had 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. According to the "Report of the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus, 1997", secondary diabetes is considered neither type I or type II diabetes mellitus and are grouped as "other specific types".

Currently, the diabetes mellitus codes in category 250 provide fifth-digits for type I and type II diabetes, but there is no code or fifth-digit to indicate diabetes secondary to another condition. Previous advice given in AHA's Coding Clinic has been to code the underlying condition followed by 251.8, Other specified disorders of pancreatic internal secretion. Additionally, the advice stated that codes from category 250 are not to be used for secondary diabetes mellitus.

It was proposed at a previous C&M meeting to create two new fifth-digits at category 250, Diabetes mellitus, for secondary diabetes. This proposal was extremely unpopular with both attendees at the C&M meeting, and within CDC, so the proposal was not approved for implementation. However, the AAP, as well as others, would still like secondary diabetes mellitus to be included in the classification.

At this time a new proposal is being presented for a new category for secondary diabetes, category 249, that parallels category 250. All of the manifestation codes that apply to category 250 would also apply to 249. There would be sequencing differences with the new category, with appropriate instructional notes in the tabular.

This proposal does not include fifth-digits for the new codes, nor does it include the concept of controlled or uncontrolled. All corresponding index entries, such as the entry for steroid induced diabetes, would also be modified. Should this proposal be approved, the official coding guidelines would be updated to provide instruction on the coding of secondary diabetes mellitus.

This proposal was presented at the March 2006 C&M meeting in an abbreviated format. It was requested at that meeting that the full proposal be brought back to allow for a full review and discussion. This proposal also includes the concept of drug induced diabetes which was not a part of the original proposal.

TABULAR MODIFICATIONS

157 Malignant neoplasm of pancreas

Add — Use additional code to identify associated secondary diabetes mellitus, if applicable (249.0-249.9)

New Category

249 Diabetes mellitus due to underlying condition
Diabetes due to adverse effect of drug
Diabetes mellitus due to late effect of adverse effect of drug, disease, and poisoning
Secondary diabetes mellitus

Code first underlying condition, such as:
Cushing's syndrome (255.0)
Cystic fibrosis (277.00-277.09)
Malignant neoplasm of pancreas (157.0-157.9)
Poisoning – see Table of drugs and chemicals

Use additional code to identify:
Adverse effect of drug – see Table of drugs and chemicals
Any associated insulin use (V58.67)
Late effect of adverse effect of drug, poisoning and trauma (909.5, 909.0, 908.1)
Personal history of pancreatitis (V12.79)

New code

249.0 Diabetes mellitus due to underlying condition without mention of complication
Diabetes (mellitus) due to underlying condition without mention of complication or manifestation classifiable to 249.1-249.9
Diabetes (mellitus) due to underlying condition NOS

New code

249.1 Diabetes mellitus due to underlying condition with ketoacidosis
Diabetes mellitus due to underlying condition with diabetic acidosis without mention of coma
Diabetes mellitus due to underlying condition with diabetic ketosis without mention of coma

New code

249.2 Diabetes mellitus due to underlying condition with hyperosmolarity
Diabetes mellitus due to underlying condition with hyperosmolar (nonketotic) coma

New code

249.3 Diabetes mellitus due to underlying condition with other coma

Diabetes mellitus due to underlying condition with diabetic coma (with ketoacidosis)
Diabetes mellitus due to underlying condition with diabetic hypoglycemic coma
Diabetes mellitus due to underlying condition with insulin coma NOS

Excludes: diabetes mellitus due to underlying condition with hyperosmolar coma (249.2)

249.4 Diabetes mellitus due to underlying condition 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 Diabetes mellitus due to underlying condition 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 Diabetes mellitus due to underlying condition with neurological manifestations

Use additional code to identify manifestation, as:
diabetic amyotrophy (358.1)
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 Diabetes mellitus due to underlying condition with peripheral circulatory disorders

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

New code 249.8 Diabetes mellitus due to underlying condition with other specified manifestations
Diabetic hypoglycemia
Hypoglycemic shock

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

Use additional E code to identify drug, if due to therapeutic drug use (sequencing issue with this situation)

New code 249.9 Diabetes mellitus due to underlying condition with unspecified complication

250 Diabetes mellitus

Add Excludes: diabetes mellitus due to underlying condition (249.0-249.9)
secondary diabetes mellitus (249.0-249.9)

250.8 Diabetes with other specified manifestations

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 (<u>249.3,</u> 250.3)

251.1 Other specified hypoglycemia

Revise Excludes: hypoglycemia:
in diabetes mellitus (<u>249.8,</u> 250.8)

251.2 Hypoglycemia, unspecified

Revise Exclude: hypoglycemia in diabetes mellitus (<u>249.8,</u> 250.8)

255 Disorders of adrenal glands

255.0 Cushing's syndrome (should this be divided?)

Add — Use additional code to identify associated secondary diabetes mellitus, if applicable (249.0-249.9)

271 Disorders of carbohydrate transport and metabolism

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

277 Other and unspecified disorders of metabolism

277.0 Cystic fibrosis

Add — Use additional code to identify associated secondary diabetes mellitus, if applicable (249.0-249.9)

337 Disorders of the autonomic nervous system

337.1 Peripheral autonomic neuropathy in disorders classified elsewhere

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

357 Inflammatory and toxic neuropathy

357.2 Polyneuropathy in diabetes

Revise — Code first underlying disease (249.6, 250.6)

358 Myoneural disorders

358.1 Myasthenic syndromes in diseases classified elsewhere

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

577 Diseases of pancreas

577.0 Acute pancreatitis

Add Use additional code to identify associated secondary diabetes mellitus, if applicable (249.0-249.9)

577.1 Chronic pancreatitis

Add Use additional code to identify associated secondary diabetes mellitus, if applicable (249.0-249.9)

581 Nephrotic syndrome

581.8 With other specified pathological lesion in kidney

581.81 Nephrotic syndrome in diseases classified elsewhere

Revise Code first underlying disease, as:
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

Excludes: diabetes mellitus:
Revise congenital (249.0-249.9, 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)

INDEX MODIFICATIONS

Diabetes…
Add drug induced
correct substance properly administered - see category 249
overdose or wrong substance given or taken – see Table of drugs and chemicals
steroid induced
Revise correct substance properly administered - see category 249
Revise overdose or wrong substance given or taken – see Table of drugs and chemicals

Secondary diabetes draft guidelines

Sequencing instructions. The guidelines for 250 also apply as far as secondary manifestation/complication codes.

Diabetes mellitus due to underlying condition
Underlying condition, such as Cystic fibrosis
Applicable code(s) from 249
Appropriate complication/manifestation code(s)
V58.67, if applicable

Diabetes mellitus due to adverse effect of drug
Applicable code(s) from 249
Appropriate complication/manifestation code(s)
V58.67, if applicable
External cause code for adverse effect of drug

Diabetes mellitus due to late affect
Applicable code(s) from 249
Appropriate complication/manifestation code(s)
Applicable late effect code
V58.67, if applicable

Diabetes mellitus due to personal history of pancreatitis
Applicable code(s) from 249
Appropriate complication/manifestation code(s)
V12.79
V58.67, if applicable

Topic: Fetal medicine

Modern diagnostic techniques allow physicians to diagnose a number of fetal anomalies. Codes from category 655, Known or suspected fetal abnormalities affecting management of mother, have been used to indicate a fetal condition, but these codes do not provide a distinction between care provided to the mother and care provided directly to the fetus. Also, with the increased use of in utero surgery to correct fetal anomalies, it is necessary to be able to track the complications associated with this surgery, as well as the long term consequences.

The American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) has requested that a series of new codes be created for fetal medicine that includes codes for the anomalies, codes for the complications, and personal history codes for both the mother and fetus. These proposals have been presented separately at different C&M meetings. They are being brought back now to be presented as a full set of new codes.

The fifth-digits required for the other OB codes would not be used for the OB codes included in this proposal to allow for the possible future fifth-digit expansion of these codes. The 5th digits 0-4 would not be used to prevent any confusion with the existing OB 5th digits.

TABULAR MODIFICATIONS

651 Multiple gestation

Add Excludes: fetal conjoined twins (678.81)

653 Disproportion

653.7 Other fetal abnormality causing disproportion

Delete ~~Conjoined twins~~

Add Excludes: conjoined twins causing disproportion (678.81)

655 Known or suspected fetal abnormality affecting management of mother

Add Excludes: fetal anomalies and other fetal conditions (678.0-678.9)
suspected fetal anomalies not found (679.33)

656 Other fetal and placental problems affecting management of mother

Add Excludes: fetal hematologic conditions (678.7)
suspected placental problems not found (679.32)

657 Polyhydramnios

Add Excludes: suspected polyhyramnios not found (679.31)

658 Other problems associated with amniotic cavity and membranes

Add Excludes: suspected problems with amniotic cavity and membranes (679.31)

Add Other Maternal and Fetal Management (678-679)

New Category 678 Fetal anomalies and other fetal conditions

Excludes: current pregnancy with maternal history of in utero surgery during previous pregnancy (V23.85)

New code 678.0 Fetal facial anomalies

New code 678.1 Fetal central nervous system anomalies

New code 678.2 Fetal cardiovascular anomalies

New code 678.3 Fetal abdominal and gastrointestinal anomalies

New code 678.4 Fetal genitourinary anomalies

New code 678.5 Fetal limb anomalies

New sub-category 678.6 Other fetal anomalies

New code 678.61 Fetal aneuploidy

New code 678.69 Other fetal anomalies

New code 678.7 Fetal hematologic conditions
Fetal anemia
Fetal thrombocytopenia
Fetal twin to twin transfusion

New sub-category	678.8	Other fetal conditions	
New code		678.81	Fetal conjoined twins
New code		678.89	Other fetal conditions
New category	679	Other maternal and fetal management	
New subcategory	679.0	Maternal complications from in utero procedure	
New code		679.05	Maternal complications from in utero procedure, antepartum
New code		679.06	Maternal complications from in utero procedure, postpartum
New code category	679.1	Fetal complications from in utero procedure Excludes: newborn affected by in utero procedure (760.61)	
New code	679.2	Maternal in utero procedure status of current pregnancy	
New sub category	679.3	Suspected conditions during pregnancy not found	
New code		679.31	Suspected problems with amniotic cavity and membranes not found Suspected oligohydramnios not found Suspected polyhydramnios not found
New code		679.32	Suspected placental problems not found
New code		679.33	Suspected fetal anomalies not found
New code		679.39	Other suspected conditions during pregnancy not found

760 Fetus or newborn affected by maternal conditions which may be unrelated to present pregnancy

Revise 760.6 Surgical operations and other procedures on mother

New code 760.61 Newborn affected by in utero procedure

Excludes: fetal complications of in utero procedure (679.1)

New code 760.69 Newborn affected by other surgical operations and other procedures on mother

V15 Other personal history presenting hazards to health

V15.2 Surgery to other major organs

New code V15.21 Personal history of in utero procedure during pregnancy

New code V15.22 Personal history of in utero procedure while in utero

New code V15.29 Surgery to other major organs

V23 Supervision of high-risk pregnancy

V23.8 Other high-risk pregnancy

New code V23.85 Pregnancy with history of in utero procedure during previous pregnancy

Excludes: management of pregnancy affected by in utero procedure during current pregnancy (678.0-678.2)

Topic: Antenatal screening

Advances in antenatal screening requires the revision of the codes under category V28, Antenatal screening. Amniocentesis, for example, is no longer the state of the art test to detect chromosomal anomalies in utero. The American College of Obstetricians and Gynecologists (ACOG) has requested modifications to modernize category V28.

Additionally, excludes notes are being proposed at V26.3, Genetic counseling and testing, and V28, Antenatal screening, to indicate that codes under V26.3 are for a parent and those under V28 are for a fetus.

TABULAR MODIFICATIONS

V26 Procreative management

V26.3 Genetic counseling and testing

Add Excludes: genetic testing on fetus (V28.0 – V28.9)

V28 Antenatal screening

Add Excludes: antenatal screening of mother (V26.33- V26.39)

Revise V28.0 Screening for chromosomal anomalies ~~by amniocentesis~~
Amniocentesis
Chorionic villus sampling
Nuchal translucency testing

V28.3 Screening for malformations using ultrasonics
Add Fetal anatomic survey

V28.8 Other specified antenatal screening
Add Screening for genomic anomalies
Add Screening for proteomics
Add Screening for risk of pre-term labor

Topic: Personal history of cervical dysplasia

Once a patient has been treated for cervical dysplasia long term follow-up care is required to test for recurrence. The American College of Obstetricians and Gynecologists (ACOG) has requested a new code for personal history of cervical dysplasia to allow for the continued tracking of these patients.

TABULAR MODIFICATIONS

V13 Personal history of other diseases

V13.2 Other genital system and obstetric disorders

New code V13.22 Personal history of cervical dysplasia
Personal history of conditions classifiable to 622.10-622.12

Excludes: personal history of malignant neoplasm of cervix uteri (V10.41)

Topic: Acquired absence of cervix/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.

TABULAR MODIFICATIONS

629 Other disorders of female genital organs

629.8 Other specified disorders of female genital organs

New code 629.81 Acquired absence of uterus with cervix

New code 629.82 Acquired absence of uterus without cervix
Status post hysterectomy with remaining cervical stump

New code 629.89 Other specified disorders of female genital organs

V45 Other postprocedural states

V45.7 Acquired absence of organ

V45.77 Genital organs

Add Excludes: acquired absence of uterus and cervix (629.81, 629.89)

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~~ 629.81, 629.82)

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~~ 629.81, 629.82)

Topic: Screening for human papillomavirus (HPV) and sexually transmitted diseases (STD)

The role of Human papillomavirus (HPV) as the cause of cervical cancer is well known. There is now a routine screening exam that tests for HPV that is generally as accurate as a routine cervical cytologic smear. The American College of Obstetricians and Gynecologists (ACOG) has requested a unique code for encounters for HPV screening.

It is being proposed that a new code be created under subcategory V73.8, Other specified viral and chlamydial diseases, for screening for HPV. This new code would be excluded from code V76.2, Special screening for malignant neoplasm of cervix. V76.2 would be limited to standard Pap smear screenings for cervical cancer. The new code would be used in conjunction with V72.31, Routine gynecological examination, or V76.2 to indicate that the additional screening is planned.

Also, it has been noted that code V74.5, Special screening for venereal disease, is under a category limited to bacterial and spirochetal diseases. This, in effect, excludes the proper classification of non-bacterial sexually transmitted diseases. Additionally, the term sexually transmitted diseases (STD), is more current than venereal disease. It is being proposed that an excludes note be added at V74.5 to exclude screening for non-bacterial STDs and that the code title be modified.

TABULAR MODIFICATIONS

V72 Special investigations and examinations

V72.3 Gynecolgical examination

V72.31 Routine gynecological examination

Add — Use additional code to identify Human papillomavirus (HPV) screening (V73.81)

V73 Special screening examination for viral and chlamydial diseases

V73.8 Other specified viral and chlamydial diseases

New code — V73.81 Human papillomavirus (HPV)

V74 Special screening examinations for bacterial and spirochetal diseases

V74.5 Venereal disease

Add Bacterial and spirochetal sexually transmitted diseases

Add Excludes: special screening for nonbacterial sexually transmitted diseases (V73.81-V73.89, V75.4, V75.8)

V76 Special screening for malignant neoplasm

V76.2 Cervix

Add Excludes: special screening for human papillomavirus (V73.81)

INDEX MODIFICATION

Disease

Add sexually transmitted – see Disease, venereal

Topic: Vulvar intraepithelial neoplasia I, II and III [VIN I, II and II] and Vaginal intraepithelial neoplasia I, II, and III [VAIN I, II and III]

At the March 2006 C&M meeting a proposal for unique codes for vulvar intraepithelial neoplasia I and II [VIN I] and [VIN II] was presented at the request of the American College of Obstetricians and Gynecologists (ACOG) in keeping with the unique code that exist for cervical intraepithelial neoplasia I and II.

ACOG is now requesting that parallel codes for vaginal intraepithelial neoplasia [VAIN I and II] also be created. Additionally, it is being proposed that code 233.3, Carcinoma in situ of other and unspecified female genital organs, be expanded to create unique codes for VIN III and VAIN III that will parallel code 233.1, Carcinoma in situ of cervix uteri.

The VIN proposal as presented in March is included in this proposal so that those changes can be reviewed along with the new proposal.

TABULAR MODIFICATIONS

233 Carcinoma in situ of breast and genitourinary system

233.3 Other and unspecified female genital organs

New code	233.30	Unspecified female genital organ
New code	233.31	Vagina Severe dysplasia of vagina Vaginal intraepithelial neoplasia [VAIN III]
New code	233.32	Vulva Severe dysplasia of vulva Vulvar intraepithelial neoplasia [VIN III]
New code	233.39	Other female genital organ

624 Noninflammatory disorders of vulva and perineum

624.0 Dystrophy of vulva

Delete ~~Kraurosis of vulva~~
~~Leukoplakia of vulva~~

Excludes: carcinoma in situ of vulva (233.32)
Add severe dysplasia of vulva (233.32)
Add vulvar intraepithelial neoplasia III [VIN III] (233.32)

New code 624.01 Vulvar intraepithelial neoplasia I [VIN I]
Mild dysplasia of vulva

New code 624.02 Vulvar intraepithelial neoplasia II [VIN II]
Moderate dysplasia of vulva

New code 624.09 Other dystrophy of vulva
Kraurosis of vulva
Leukoplakia of vulva

Topic: Malignant ascites

Malignant ascites currently defaults to code 197.6, Secondary malignant neoplasm of retroperitoneum and peritoneum. While it is correct that malignant ascites may be the result of metastatic spread of a malignancy to the peritoneum, it may also be due to a primary ovarian malignancy. There is no code available to classify a malignant ascites due to an ovarian malignancy. The American College of Obstetricians and Gynecologists (ACOG) has requested that the default for malignant ascites be removed and a unique code be created for this symptom to allow it to be coded more accurately.

TABULAR MODIFICATION

789 Other symptoms involving the abdomen and pelvis

789.5 Ascites
Fluid in peritoneal cavity

New code 789.51 Malignant ascites

Code first malignancy:
Malignant neoplasm of ovary (183.0)
Secondary malignant neoplasm of retroperitoneum and peritoneum (197.6)

New code 789.59 Other ascites

Topic: Assisted reproductive fertility procedure status

Assisted reproductive fertility procedures are multistage. There are a number of pre-treatment diagnostic tests that are independent of the procedure itself. There is no way to identify patients who are undergoing a procedure from those still undergoing pre-treatment testing. The American College of Obstetricians and Gynecologists (ACOG) has requested a status code, to be used in conjunction with whichever infertility code is applicable, to be able to identify those patients undergoing this treatment.

TABULAR MODIFICATION

V26 Procreative management

V26.8 Other specified procreative management

New code	V26.81	Assisted reproductive fertility procedure status Patient undergoing assisted reproductive procedure (excluding pre-treatment diagnosis and testing)
New code	V26.89	Other specified procreative management

Topic: Personal history of sudden cardiac arrest and TIA/cerebral infarction without residual deficits

The term sudden cardiac death is used to describe cases when a person unexpectedly dies very suddenly, due to what is assumed to be cardiac arrest. A new code for family history of sudden cardiac death was approved for the October 1, 2006 update. Though this term may be used to describe a patient admitted to a medical facility and successfully resuscitated, its use should be limited to mortality. For morbidity purposes, when a patient survives sudden cardiac death the diagnosis is more specifically sudden cardiac arrest, and the underlying cause is usually determined to be some type of cardiac arrhythmia or previously undiagnosed cardiac anomaly or condition.

A request for a new code for sudden cardiac death and personal history of sudden cardiac death has been submitted. What is being proposed is a new code for personal history of sudden cardiac arrest with the inclusion term sudden cardiac death. There is currently an index entry for Death, cardiac that directs coders to Disease, heart. That entry could be modified to include the nonessential modifier sudden, and the instruction changed to code to condition.

Also, a new personal history code for transient ischemic attack (TIA) and cerebral infarction without residual deficit is being proposed. Patients with residual deficits are coded to category 438.

TABULAR MODIFICATIONS

438 Late effects of cerebrovascular disease

Add Excludes: personal history of:
cerebral infarction without residual deficits (V12.54)
PRIND (Prolonged reversible ischemic neurologic deficit) (V12.54)
RIND (Reversible ischemic neurological deficit) (V12.54)
transient ischemic attack (TIA) (V12.54)

V12 Personal history of certain other diseases

V12.5 Diseases of circulatory system

New code V12.53 Sudden cardiac arrest
Sudden cardiac death successfully resuscitated

New code V12.54 Transient ischemic attack (TIA), and cerebral infarction without residual deficits
Prolonged reversible ischemic neurological deficit (PRIND)
Reversible ischemic neurologic deficit (RIND)
Stroke NOS without residual deficits

Excludes: late effects of cerebrovascular disease (438.0-438.9)

INDEX MODIFICATIONS

Death
Revise cardiac (sudden) ~~– see Disease, heart~~ code to condition

Deficit
neurologic NEC 781.99
Add ischemic
Add reversible (RIND) 436
Add prolonged (PRIND) 436

Revise ~~P.R.I.N.D.~~ (Prolonged reversible ischemic neurologic deficit) 436

Add RIND (Reversible ischemic neurological deficit) 436

Topic: Acquired red cell aplasia

New codes for congenital red cell aplasia were created for the October 1, 2006 updates. The default code for red cell aplasia, however, is acquired. There is no unique code for acquired red cell aplasia. It is currently included under code 284.8, Other specified aplastic anemias. It is being proposed that code 284.8 be expanded to allow for a unique code for acquired red cell aplasia.

TABULAR MODIFICATONS

284 Aplastic anemia

284.8 Other specified aplastic anemias

Delete

~~Aplastic anemia (due to):~~
~~chronic systemic disease~~
~~drugs~~
~~infection~~
~~radiation~~
~~toxic (paralytic)~~
~~Red cell aplasia (acquired) (adult) (pure) (with thymoma)~~

~~Use additional E code to identify cause~~

New code 284.81 Red cell aplasia (acquired) (adult) (with thymoma)
Red cell aplasia NOS

New code 284.89 Other specified aplastic anemias
Aplastic anemia (due to):
chronic systemic disease
drugs
infection
radiation
toxic (paralytic)

Use additional E code to identify cause

ADDENDA

TABULAR

041 Bacterial infection in conditions classified elsewhere and of unspecified site

Revise Excludes: ~~bacteremia NOS (790.7)~~

250 Diabetes mellitus

Revise Excludes: hyperglycemia (790.29)

268 Vitamin D deficiency

268.1 Rickets, late effect

Revise ~~Use additional code to identify~~ Code first the nature of late effect

288 Diseases of white blood cells

288.0 Neutropenia

Add Use additional code for any associated mucositis (478.11, 528.00-528.09, 538, 616.81)

302 Sexual and gender identity disorders

302.5 Tran-sexualism

Add Sex reassignment surgery status

302.8 Other specified psychosexual disorders

302.85 Gender identity disorder in adolescents and adults

Add Use additional code to identify sex reassignment surgery status (302.5)

331 Other cerebral degenerations

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

331.0 Alzheimer's disease

331.1 Frontotemporal dementia

Delete ~~Use additional code for associated behavioral disturbances (294.10-294.11)~~

331.8 Other cerebral degeneration

331.82 Dementia with Lewy bodies

Delete ~~Use additional code for associated behavioral disturbances (294.10-294.11)~~

572 Liver abscess and sequelae of chronic liver disease

572.2 Hepatic coma

Add Excludes: hepatic coma associated with viral hepatitis – see category 070

585 Chronic kidney disease (CKD)

Revise Code first hypertensive chronic kidney disease, if applicable, (403.00 - 403.91, 404.00-404.93)

608 Other disorders of male genital organs

608.2 Torsion of testis

608.22 Intravaginal torsion of spermatic cord
Add Torsion of spermatic cord NOS

622 Noninflammatory disorders of cervix

622.1 Dysplasia of cervix (uteri)

Revise Excludes: abnormal results from cervical cytologic examination without histologic confirmation (795.00-795.09)
carcinoma in situ of cervix (233.1)
cervical intraepithelial neoplasia III [CIN III] (233.1)
~~without histologic confirmation (795.00-795.09)~~

656 Other fetal and placental problems affecting management of mother

656.8 Other specified fetal and placental problems
Add Subchorionic hematoma

661 Abnormality of forces of labor

661.2 Other and unspecified uterine inertia
Add Atony of uterus without hemorrhage

Add Excludes: atony of uterus with hemorrhage (666.1)
Add postpartum atony of uterus without hemorrhage (669.8)

666 Postpartum hemorrhage

666.1 Other immediate postpartum hemorrhage

Revise Excludes: atony of uterus without hemorrhage (661.2)
Add postpartum atony of uterus without hemorrhage (669.8)

731 Osteitis deformans and osteopathies associated with other disorders classified elsewhere

731.3 Major osseous defects

Code first underlying disease, if known, such as:
Revise osteoporosis (730.00- 730.09)

780 General symptoms

780.3 Convulsions

780.39 Other convulsions
Revise Seizure(s) NOS

996 Complications peculiar to certain specified procedures

996.7 Other complications of internal (biological) (synthetic) prosthetic device, implant, and graft

996.77 Due to internal joint prosthesis

Add Use additional code to identify prosthetic joint (V43.60 - V43.69)

999 Complications of medical care, not elsewhere classified

Add Use additional code, where applicable, to identify specific complication

V82 Special screening for other conditions

V82.7 Genetic screening

Revise Excludes: genetic testing for procreative management (V26.29, V26.31, V26.32, V26.34)

ADDENDA

INDEX

Admission (encounter)
for
vaccination, prophylactic (against)
Add human papillomavirus (HPV) V04.89

Accident…
cerebrovascular…
Add aborted 434.91

Allergy, allergic (reaction) 995.3
dandruff 477.8
Delete ~~existing dental restorative material 525.66~~
dermatitis (venenata) - see Dermatitis
epidermal (animal) 477.8
Add existing dental restorative material 525.66
feathers 477.8

Revise Anhedonia 780.99

Aphthae, aphthous - see also condition
ulcer (oral) (recurrent) 528.2
genital organ(s) NEC
Revise female 616.50

Atonia…
Revise uterus 661.2
Revise without hemorrhage ~~669.8~~
Add intrapartum 661.2
Add postpartum 669.8

Caries (bone) (see also Tuberculosis, bone) 015.9 [730.8]
primary
pit and fissure origin 521.06
Revise root surface 521.08

Cholesterol
Add elevated (high) 272.0
Add with elevated (high) triglycerides 272.2

Add CIDP (Chronic inflammatory demyelinating polyneuropathy) 357.81

Crush, crushed, crushing (injury) 929.9
Delete ~~with~~
Delete ~~fracture - see Fracture, by site~~

Revise Cystocele ~~(- rectocele)~~

Defect
coagulation
Revise specified type 286.9

Deficiency, deficient
Add methylenetetrahydrofolate reductase (MTHFR) 270.4
Add short stature homeobox gene (SHOX)
Add with
Add short stature (idiopathic) 783.43

Delivery
cesarean…
Revise atony, uterus, ~~with hemorrhage 666.1~~ 661.2
Add with hemorrhage 666.1
complicated (by) NEC 669.9
Revise cervical dystocia 661.2
dystocia
Revise cervical 661.2
laceration 664.9
Revise periurethral tissue 664.8
prolonged labor
due to
Revise cervical dystocia 661.2

Disease…
cervix (uteri)
Revise inflammatory 616.0
Delete ~~specified NEC 616.89~~
labia
Revise inflammatory 616.10
Delete ~~specified NEC 616.89~~
vagina, vaginal
Revise inflammatory 616.10
Delete ~~specified NEC 616.89~~
vulva
Revise inflammatory 616.10
Delete ~~specified NEC 616.89~~

Dystocia
Revise cervical 661.2

Ectasia, ectasis
Add gastric antral vascular (GAVE)
Add with hemorrhage 537.83
Add without hemorrhage 537.82

Elevation
Add cholesterol 272.0
Add with triglycerides 272.2
Add triglycerides 272.1
Add with cholesterol 272.2

Add Endosalpingiosis 629.89

Encounter for…
Add vaccination, prophylactic (against)
Add human papillomavirus (HPV) V04.89

Enteritis…
Add radiation 558.1

Add Erythrodysesthesia, palmar plantar (PPE) 693.0

Findings
cholesterol 292.9
Add high 272.0
Add with high triglycerides 272.2
triglycerides 292.9
Add high 272.1
Add with high cholesterol 272.2

Fracture…
vertebra…
Add chronic 733.13

Revise Hand-foot syndrome <u>693.0</u>

Hallux 735.9
Add limitus 735.8

Revise HGSIL (high grade squamous intraepithelial lesion) <u>(cytologic finding)</u> 795.04
Add biopsy finding – code to CIN II or CIN III

High
Add cholesterol 272.0
Add with high triglycerides 272.2
Add triglycerides 272.1
Add with high cholesterol 272.2

Hypertension
cardiorenal (disease) 404.00 404.10 404.90
with
heart failure 404.01 404.11 404.91
Revise and chronic kidney disease 404.01 404.11 404.91
Revise stage I through stage IV or unspecified 404.01 404.11 404.91

Inadequate, inadequacy
Revise aesthetics of dental restoration 525.67

Infarct, infarction
cerebral …
Add aborted 434.91
myocardium…
Add intraoperative 997.1
Add postprocedural 997.1

Insensitivity
Add adrenocorticotropin hormone (ACTH) 255.4

Myelitis…
due to
Revise infection classified elsewhere 136.9 [323.42]
Revise postinfectious 136.9 [323.63]
Revise toxic 989.9 [323.72]

Open, opening
Revise bite ~~(anterior) (posterior) 524.29~~
Add anterior 524.24
Add posterior 524.25

Revise Pain(s) (see also Painful) 780.96

Painful…
Add total hip replacement 996.77
Add total knee replacement 996.77

Pneumonia…
Add ventilator associated 999.9

Polyneuritis, polyneuritic (see also Polyneuropathy) 356.9
Revise demyelinating, chronic inflammatory (CIDP) 357.81

Polyneuropathy…
Add demyelinating, chronic inflammatory (CIDP) 357.81
Add specified NEC 356.8

Poor
Revise aesthetics of existing restoration of tooth 525.67

Pregnancy…
complicated (by) 646.9
Revise endometritis …670

Revise Seizure(s) 780.39

Stroke
Revise in evolution 434.91

Syndrome
Revise hand-foot 693.0
Delete ~~ovarian vein 593.4~~
Add patella clunk 719.66
Revise Schwachman's ~~288.02~~ – see Shwachman's
Add Shwachman's 288.02

Tachycardia 785.0
Add junctional ectopic 427.0

Ulcer, ulcerated, ulcerating, ulceration, ulcerative 707.9
aphthous (oral) (recurrent) 528.2
genital organ(s)
Revise female 616.50

Revise Vulvitis (acute) (allergic) (aphthous) (chronic) (gangrenous) (hypertrophic) (intertriginous) 616.50

Revise Vulvodynia 625.8

Add Watermelon stomach
Add With hemorrhage 537.83
Add Without hemorrhage 537.82