

MMWR

*Recommendations
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MORBIDITY AND MORTALITY WEEKLY REPORT

1994 Revised Classification System for Human Immunodeficiency Virus Infection in Children Less Than 13 Years of Age

**Official Authorized Addenda:
Human Immunodeficiency Virus
Infection Codes
and Official Guidelines for
Coding and Reporting
ICD-9-CM**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
and Prevention (CDC)
Atlanta, Georgia 30333



The *MMWR* series of publications is published by the Epidemiology Program Office, Centers for Disease Control and Prevention (CDC), Public Health Service, U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION

Centers for Disease Control and Prevention. 1994 Revised classification system for human immunodeficiency virus infection in children less than 13 years of age; Official authorized addenda: human immunodeficiency virus infection codes and official guidelines for coding and reporting ICD-9-CM. *MMWR* 1994;43(No. RR-12):[inclusive page numbers].

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1994 Revised Classification System for Human Immunodeficiency Virus Infection in Children Less Than 13 Years of Age

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Acknowledgments

We thank the following persons/projects for contributing data used to establish the CD4+ percent categories: Stephane Blanche, the French Collaborative Study; Mary Glenn Fowler, the Women and Infants Transmission Study; Catherine Peckham, the European Collaborative Study; Margaret Heagarty, the New York City Perinatal HIV Transmission Collaborative Study; Savita Pahwa, North Shore University Hospital; and William Shearer and Celine Hanson, Baylor Medical Center.

1994 Revised Classification System for Human Immunodeficiency Virus Infection in Children Less Than 13 Years of Age

Summary

This revised classification system for human immunodeficiency virus (HIV) infection in children replaces the pediatric HIV classification system published in 1987 (1). This revision was prompted by additional knowledge about the progression of HIV disease among children.

In the new system, infected children are classified into mutually exclusive categories according to three parameters: a) infection status, b) clinical status, and c) immunologic status. The revised classification system reflects the stage of the child's disease, establishes mutually exclusive classification categories, and balances simplicity and medical accuracy in the classification process. This document also describes revised pediatric definitions for two acquired immunodeficiency syndrome-defining conditions.

INTRODUCTION

Following the initial report in 1982 of acquired immunodeficiency syndrome (AIDS) in children (2), it became evident that the clinical characteristics of AIDS in children were different from those in adults. In 1987, CDC published a classification system for children infected with human immunodeficiency virus (HIV) (1), the causative agent of AIDS. This classification system categorized clinical manifestations of HIV infection in children based on the limited data available early in the epidemic. New knowledge about the progression of HIV disease among children warranted revision of the 1987 classification system to better reflect the disease process.

In 1991, CDC convened a working group of Public Health Service and other consultants to discuss revision of the pediatric HIV classification system. The 1994 revised classification system was developed through ongoing collaborations with the consultants following the 1991 meeting. The goal of the working group was to construct a revised system that would:

- reflect the stage of disease for an HIV-infected child (i.e., the child's placement in the classification should have prognostic significance);
- establish mutually exclusive classification categories; and
- balance simplicity and medical accuracy in the classification process.

In the new system (Table 1), HIV-infected children are classified into mutually exclusive categories according to three parameters: a) infection status, b) clinical status, and c) immunologic status. Once classified, an HIV-infected child cannot be reclassified in a less severe category even if the child's clinical or immunologic status improves.

DIAGNOSING HIV INFECTION IN CHILDREN

Diagnosis of HIV infection in children born to HIV-infected mothers (Box 1) is complicated by the presence of maternal anti-HIV IgG antibody, which crosses the placenta to the fetus. Virtually all these children are HIV-antibody positive at birth, although only 15%–30% are actually infected. In uninfected children, this antibody usually becomes undetectable by 9 months of age but occasionally remains detectable until 18 months of age. Therefore, standard anti-HIV IgG antibody tests cannot be used to indicate reliably a child's infection status before 18 months of age (3). Polymerase chain reaction (PCR) and virus culture are probably the most sensitive and specific assays for detecting HIV infection in children born to infected mothers (4–6). Use of these assays can identify approximately 30%–50% of infected infants at birth and nearly 100% of infected infants by 3–6 months of age (7).

The standard p24-antigen assay is less sensitive than either virus culture or PCR, especially when anti-HIV antibody levels are high, because it fails to detect immune-complexed p24 antigen (8). However, modification of the p24-antigen assay to dissociate immune complexes has increased its sensitivity in diagnosing HIV infection among children exposed to HIV (9).

Other laboratory assays (e.g., anti-HIV IgA and ELISPOT/in vitro antibody production [IVAP]) have not been included in the algorithm for determining infection status because they are not commonly used. In addition, they are less sensitive than both PCR or virus culture. However, clinicians who determine a child's antiretroviral therapy on the basis of such assays may use them to classify the child as being infected.

Some children develop severe clinical conditions resulting from HIV infection before their infection status has been sufficiently established. For the purposes of classification, a child meeting the criteria for AIDS in the 1987 case definition (10) should be considered HIV-infected—even in the absence of definitive laboratory assays.

Children born to mothers with HIV infection are defined as seroreverters (SRs) and are considered uninfected with HIV if they a) become HIV-antibody negative after 6 months of age, b) have no other laboratory evidence of HIV infection, and c) have not met the AIDS surveillance case definition criteria (Box 1). Sufficient data are not

TABLE 1. Pediatric human immunodeficiency virus (HIV) classification*

Immunologic categories	Clinical categories			
	N: No signs/symptoms	A: Mild signs/symptoms	B:† Moderate signs/symptoms	C:† Severe signs/symptoms
1: No evidence of suppression	N1	A1	B1	C1
2: Evidence of moderate suppression	N2	A2	B2	C2
3: Severe suppression	N3	A3	B3	C3

*Children whose HIV infection status is not confirmed are classified by using the above grid with a letter E (for perinatally exposed) placed before the appropriate classification code (e.g., EN2).

†Both Category C and lymphoid interstitial pneumonitis in Category B are reportable to state and local health departments as acquired immunodeficiency syndrome.

BOX 1. Diagnosis of human immunodeficiency virus (HIV) infection in children***DIAGNOSIS: HIV INFECTED**

a) A child <18 months of age who is known to be HIV seropositive or born to an HIV-infected mother **and**:

- has positive results on two separate determinations (excluding cord blood) from one or more of the following HIV detection tests:
 - HIV culture,
 - HIV polymerase chain reaction,
 - HIV antigen (p24),

or

- meets criteria for acquired immunodeficiency syndrome (AIDS) diagnosis based on the 1987 AIDS surveillance case definition (10).

b) A child ≥18 months of age born to an HIV-infected mother or any child infected by blood, blood products, or other known modes of transmission (e.g., sexual contact) who:

- is HIV-antibody positive by repeatedly reactive enzyme immunoassay (EIA) and confirmatory test (e.g., Western blot or immunofluorescence assay [IFA]);

or

- meets any of the criteria in a) above.

DIAGNOSIS: PERINATALLY EXPOSED (PREFIX E)

A child who does not meet the criteria above who:

- is HIV seropositive by EIA and confirmatory test (e.g., Western blot or IFA) and is <18 months of age at the time of test;

or

- has unknown antibody status, but was born to a mother known to be infected with HIV.

DIAGNOSIS: SEROREVERTER (SR)

A child who is born to an HIV-infected mother and who:

- has been documented as HIV-antibody negative (i.e., two or more negative EIA tests performed at 6–18 months of age or one negative EIA test after 18 months of age);

and

- has had no other laboratory evidence of infection (has not had two positive viral detection tests, if performed);

and

- has not had an AIDS-defining condition.

*This definition of HIV infection replaces the definition published in the 1987 AIDS surveillance case definition (10).

available to conclusively define a child who is uninfected on the basis of viral detection tests. However, in certain situations (e.g., clinical trials), negative viral detection tests may be used presumptively to exclude infection.

IMMUNOLOGIC CATEGORIES

The three immunologic categories (Table 2) were established to categorize children by the severity of immunosuppression attributable to HIV infection. CD4+ T-lymphocyte depletion is a major consequence of HIV infection and is responsible for many of the severe manifestations of HIV infection in adults. For this reason, CD4+ counts are used in the adult HIV classification system (11). However, several findings complicate the use of CD4+ counts for assessing immunosuppression resulting from HIV infection in children. Normal CD4+ counts are higher in infants and young children than in adults and decline over the first few years of life (12–16). In addition, children may develop opportunistic infections at higher CD4+ levels than adults (17–19). Although insufficient data exist to correlate CD4+ levels with disease progression at all age groups, low age-specific CD4+ counts appear to correlate with conditions associated with immunosuppression in children (12,17,20,21). Therefore, despite these complications, classification based on age-specific CD4+ levels appears to be useful for describing the immunologic status of HIV-infected children.

Fewer data are available on age-specific values for CD4+ T-lymphocyte percent of total lymphocytes than for absolute counts. However, the CD4+ T-lymphocyte percent has less measurement variability than the absolute count (22). To establish the age-specific values of CD4+ percent that correlate with the CD4+ count thresholds, CDC compiled data from selected clinical projects in the United States and Europe. The data included >9,000 CD4+ counts, with the corresponding CD4+ percent determinations, from both HIV-infected and uninfected children <13 years of age. Nonparametric regression modeling was used to establish the CD4+ percent boundaries that best correlated with the CD4+ count boundaries in the classification system.

The immunologic category classification (Table 2) is based on either the CD4+ T-lymphocyte count or the CD4+ percent of total lymphocytes. If both the CD4+ count and the CD4+ percent indicate different classification categories, the child should be classified into the more severe category. Repeated or follow-up CD4+ values that result in a change in classification should be confirmed by a second determination. Values thought to be in error should not be used. A child should not be reclassified to a less severe category regardless of subsequent CD4+ determinations.

TABLE 2. Immunologic categories based on age-specific CD4+ T-lymphocyte counts and percent of total lymphocytes

Immunologic category	Age of child					
	<12 mos		1–5 yrs		6–12 yrs	
	μL	(%)	μL	(%)	μL	(%)
1: No evidence of suppression	≥1,500	(≥25)	≥1,000	(≥25)	≥500	(≥25)
2: Evidence of moderate suppression	750–1,499	(15–24)	500–999	(15–24)	200–499	(15–24)
3: Severe suppression	<750	(<15)	<500	(<15)	<200	(<15)

CLINICAL CATEGORIES

Children infected with HIV or perinatally exposed to HIV may be classified into one of four mutually exclusive clinical categories based on signs, symptoms, or diagnoses related to HIV infection (Box 2). As with the immunologic categories, the clinical categories have been defined to provide a staging classification (e.g., the prognosis for children in the second category would be less favorable than for those in the first category).

Category N, **not symptomatic**, includes children with no signs or symptoms considered to be the result of HIV infection or with only one of the conditions listed in Category A, **mildly symptomatic**. Category N was separated from Category A partly because of the substantial amount of time that can elapse before a child manifests the signs or symptoms defined in Category B, **moderately symptomatic**. Also, more staging information can be obtained during this early stage of disease by separating Categories N and A. In addition, for children who have uncertain HIV-infection status (prefix E), Categories N and A may help to distinguish those children who are more likely to be infected with HIV (23) (i.e., children in Category EA may be more likely to be infected than children in Category EN).

Category B includes all children with signs and symptoms thought to be caused by HIV infection but not specifically outlined under Category A or Category C, **severely symptomatic**. The conditions listed in Box 2 are examples only; any other HIV-related condition not included in Category A or C should be included in Category B. Anemia, thrombocytopenia, and lymphopenia have defined thresholds in the new classification system (23).

Category C includes all AIDS-defining conditions except lymphoid interstitial pneumonitis (LIP) (Box 3). Several reports indicate that the prognosis for children with LIP is substantially better than that for children who have other AIDS-defining conditions (21,24,25). Thus, LIP has been separated from the other AIDS-defining conditions in Category C and placed in Category B.

Signs and symptoms related to causes other than HIV infection (e.g., inflammatory or drug-related causes) should not be used to classify children. For example, a child with drug-related hepatitis or anemia should not be classified in Category B solely because these conditions may be associated with HIV infection. In contrast, a child with anemia or hepatitis should be classified in Category B when the condition is thought to be related to HIV infection. The criteria for diagnosing some conditions and determining whether a child's signs, symptoms, or diagnoses are related to HIV infection may not be clear in all cases, and therefore may require judgment of the clinicians and researchers using the classification system.

Categories in the 1987 pediatric HIV classification system can be translated into categories in the 1994 system in most cases (Box 4). Class P0 is now designated by the prefix "E," and Class P1 is now Class N. Children previously classified as P2A are now classified in more than one category, reflecting the different prognoses for children with different conditions included in the P2A category (e.g., children who have wasting syndrome have a worse prognosis than those who have lymphadenopathy).

BOX 2. Clinical categories for children with human immunodeficiency virus (HIV) infection**CATEGORY N: NOT SYMPTOMATIC**

Children who have no signs or symptoms considered to be the result of HIV infection or who have only one of the conditions listed in Category A.

CATEGORY A: MILDLY SYMPTOMATIC

Children with two or more of the conditions listed below but none of the conditions listed in Categories B and C.

- Lymphadenopathy (≥ 0.5 cm at more than two sites; bilateral = one site)
- Hepatomegaly
- Splenomegaly
- Dermatitis
- Parotitis
- Recurrent or persistent upper respiratory infection, sinusitis, or otitis media

CATEGORY B: MODERATELY SYMPTOMATIC

Children who have symptomatic conditions other than those listed for Category A or C that are attributed to HIV infection. Examples of conditions in clinical Category B include but are not limited to:

- Anemia (< 8 gm/dL), neutropenia ($< 1,000/\text{mm}^3$), or thrombocytopenia ($< 100,000/\text{mm}^3$) persisting ≥ 30 days
- Bacterial meningitis, pneumonia, or sepsis (single episode)
- Candidiasis, oropharyngeal (thrush), persisting (> 2 months) in children > 6 months of age
- Cardiomyopathy
- Cytomegalovirus infection, with onset before 1 month of age
- Diarrhea, recurrent or chronic
- Hepatitis
- Herpes simplex virus (HSV) stomatitis, recurrent (more than two episodes within 1 year)
- HSV bronchitis, pneumonitis, or esophagitis with onset before 1 month of age
- Herpes zoster (shingles) involving at least two distinct episodes or more than one dermatome
- Leiomyosarcoma
- Lymphoid interstitial pneumonia (LIP) or pulmonary lymphoid hyperplasia complex
- Nephropathy
- Nocardiosis
- Persistent fever (lasting > 1 month)
- Toxoplasmosis, onset before 1 month of age
- Varicella, disseminated (complicated chickenpox)

CATEGORY C: SEVERELY SYMPTOMATIC

Children who have any condition listed in the 1987 surveillance case definition for acquired immunodeficiency syndrome (10), with the exception of LIP (Box 3).

EFFECT ON THE AIDS SURVEILLANCE CASE DEFINITION FOR CHILDREN

Because the classification system is used in conjunction with the AIDS case definition, the 1994 revision provided an opportunity to update certain features of the 1987 AIDS surveillance case definition for children <13 years of age (10). Although LIP is in Category B under the new pediatric HIV classification system, it will continue to be reportable to state and local health departments (along with the conditions in Category C) as an AIDS-defining condition in children. Two changes in the definitions for other conditions are summarized in the following bulleted text:

- The new definitions for HIV encephalopathy and HIV wasting syndrome reflect increased knowledge of these conditions in children and replace the definitions published in the 1987 AIDS surveillance case definition for children. The definition of HIV encephalopathy follows the recommendations of the American Academy of Neurology AIDS Task Force (26). Because this condition is complex, diagnosis may require neurologic consultation.
- The new definition of HIV infection (Box 1) replaces the definition for laboratory evidence of HIV infection in children used in the 1987 pediatric AIDS case definition. For children with an AIDS-defining condition that requires laboratory evidence of HIV infection, a single positive HIV-detection test (i.e., HIV culture, HIV PCR, or HIV antigen [p24]) is sufficient for a reportable AIDS diagnosis if the diagnosis is confirmed by a clinician.

BOX 3. Conditions included in clinical Category C for children infected with human immunodeficiency virus (HIV)

CATEGORY C: SEVERELY SYMPTOMATIC*

- Serious bacterial infections, multiple or recurrent (i.e., any combination of at least two culture-confirmed infections within a 2-year period), of the following types: septicemia, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media, superficial skin or mucosal abscesses, and indwelling catheter-related infections)
- Candidiasis, esophageal or pulmonary (bronchi, trachea, lungs)
- Coccidioidomycosis, disseminated (at site other than or in addition to lungs or cervical or hilar lymph nodes)
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis or isosporiasis with diarrhea persisting >1 month
- Cytomegalovirus disease with onset of symptoms at age >1 month (at a site other than liver, spleen, or lymph nodes)
- Encephalopathy (at least one of the following progressive findings present for at least 2 months in the absence of a concurrent illness other than HIV infection that could explain the findings): a) failure to attain or loss of developmental milestones or loss of intellectual ability, verified by standard developmental scale or neuropsychological tests; b) impaired brain growth or acquired microcephaly demonstrated by head circumference measurements or brain atrophy demonstrated by computerized tomography or magnetic resonance imaging (serial imaging is required for children <2 years of age); c) acquired symmetric motor deficit manifested by two or more of the following: paresis, pathologic reflexes, ataxia, or gait disturbance
- Herpes simplex virus infection causing a mucocutaneous ulcer that persists for >1 month; or bronchitis, pneumonitis, or esophagitis for any duration affecting a child >1 month of age
- Histoplasmosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)
- Kaposi's sarcoma
- Lymphoma, primary, in brain
- Lymphoma, small, noncleaved cell (Burkitt's), or immunoblastic or large cell lymphoma of B-cell or unknown immunologic phenotype
- *Mycobacterium tuberculosis*, disseminated or extrapulmonary
- *Mycobacterium*, other species or unidentified species, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
- *Mycobacterium avium* complex or *Mycobacterium kansasii*, disseminated (at site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
- *Pneumocystis carinii* pneumonia
- Progressive multifocal leukoencephalopathy
- Salmonella (nontyphoid) septicemia, recurrent
- Toxoplasmosis of the brain with onset at >1 month of age
- Wasting syndrome in the absence of a concurrent illness other than HIV infection that could explain the following findings: a) persistent weight loss >10% of baseline OR b) downward crossing of at least two of the following percentile lines on the weight-for-age chart (e.g., 95th, 75th, 50th, 25th, 5th) in a child ≥1 year of age OR c) <5th percentile on weight-for-height chart on two consecutive measurements, ≥30 days apart **PLUS** a) chronic diarrhea (i.e., at least two loose stools per day for ≥30 days) OR b) documented fever (for ≥30 days, intermittent or constant)

*See the 1987 AIDS surveillance case definition (10) for diagnosis criteria.

BOX 4. Comparison of the 1987 and 1994 pediatric human immunodeficiency virus classification systems

1987 Classification	1994 Classification
P-0	Prefix "E"
P-1	N
P-2A	A, B, and C
P-2B	C
P-2C	B
P-2D1	C
P-2D2	C
P-2D3	B
P-2E1	C
P-2E2	B
P-2F	B

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**ICD-9-CM
International Classification
of Diseases
9th Revision
Clinical Modification**

**Volume 1
Update**

**Official Authorized Addenda:
Human Immunodeficiency Virus
Infection Codes
and Official Guidelines for
Coding and Reporting
ICD-9-CM**

(Revision No. 3)

Effective October 1, 1994

Note: Replaces Previous Classification Effective October 1, 1991

FOR MORBIDITY PURPOSES ONLY

**Official Authorized Addenda:
Human Immunodeficiency Virus
Infection Codes
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Coding and Reporting
ICD-9-CM**

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Notice

Pages 16–19 of the following report are reprinted in the *MMWR* series of publications so that the material may be readily accessible to the public health community.

Official Authorized Addenda: Human Immunodeficiency Virus Infection Codes and Official Guidelines for Coding and Reporting ICD-9-CM

Summary

This document contains changes to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes for HIV infection and disease and includes guidelines for coding and reporting these conditions. The ICD-9-CM is the diagnosis classification system used for morbidity coding in U.S. health-care facilities. The simplification of the classification structure and the addition of guidelines should facilitate greater coding accuracy.

INTRODUCTION

This addendum for Volume 1 of the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) is reported by the World Health Organization Collaborating Center for Classification of Diseases for North America and the Morbidity Classification Branch, Division of Health Care Statistics, at CDC's National Center for Health Statistics.

This addendum replaces the addendum containing the codes for human immunodeficiency virus (HIV) infection (042.0–044.9) that became effective October 1, 1991. This addendum is effective October 1, 1994, and is the third revision of codes for the classification of HIV infection. This addendum reflects the evolving conceptual framework for HIV-related illnesses and presents a simplified coding structure for these conditions. **These changes will be effective only for morbidity purposes; the cause of death codes are unchanged.*** Modifications to these ICD-9-CM codes do not affect the CDC surveillance definitions for HIV disease.

This revised addendum contains the following changes:

- The current 042–044 series of codes has been replaced with a single code, 042, for HIV disease.
- A new code, V08, has been created for asymptomatic HIV infection.
- Code 795.8 has been deleted and a new code, 795.71, Inconclusive serological findings for Human Immunodeficiency Virus [HIV], has been created. This code will include inconclusive HIV test findings in infants.
- Additional instructional notes have been added to assist in proper code sequencing.
- HIV-specific official coding guidelines have been created to assist persons who assign codes in the selection and sequencing of codes for HIV infection, disease, and related conditions.

*Cause-of-death coding is done using the *International Classification of Diseases, Ninth Revision* (ICD-9), which is not modified between revisions. The ICD-9-CM, which is used for morbidity purposes, is updated annually.

BACKGROUND

The increasing incidence of HIV infection and advances in medical knowledge about the spectrum of illnesses caused by this virus have created demand for continued modifications to the classification. The current modifications will simplify the coding of HIV-related illnesses and should improve the accuracy of reporting, allowing public health officials, clinical researchers, and agencies that finance health care to monitor more reliably the diagnoses of acquired immunodeficiency syndrome (AIDS) and other manifestations of HIV infection.

When the original interim classification was issued on October 1, 1986, periodic revisions were anticipated. The first such revision occurred in 1987 and reflected the change in terminology from HTLV-III/LAV to HIV, characterizing the causative agent of AIDS. In the 1991 revision, several HIV-related conditions were added to the lists of inclusions under the 042-044 series of categories.

The 042, 043, and 044 categories were originally created to distinguish AIDS (042) from AIDS-related complex (ARC) (043) and other HIV disease (044). These distinctions among the ICD-9-CM categories are no longer clear-cut, and the three-digit categories no longer denote separate clinical entities. Also, demands for additions to the lists of inclusion terms continue to grow, and it has become impossible for these lists to remain as current as medical reports. In addition, both the lack of clear guidelines for the sequencing of the HIV and manifestation codes and the restrictions on persons who assign codes to use only a single code from the 042-044 series have created confusion and inconsistent coding practices in the field.

Codes 795.8 and 044.9 have also caused confusion. Code 795.8 was intended for inconclusive HIV test results, whereas code 044.9 was intended for asymptomatic HIV infection (or a statement of "HIV positive"). However, both of these codes have been widely misused because of the lack of clear instructions and guidelines.

Therefore, the current 042-044 series of codes has been replaced with a single code, 042, Human Immunodeficiency Virus [HIV] Disease, to be used for all symptomatic (or previously symptomatic) HIV infections. This code includes all cases of physician-diagnosed AIDS, whether asymptomatic (e.g., a diagnosis based on CD4+ T-lymphocyte criteria alone) or symptomatic. In addition, a new code, V08, has been created for asymptomatic HIV infection. The new code, 795.71, is applicable only to those patients who test positive on a preliminary screening test, but whose HIV infection status is not yet confirmed. Infants who test positive on certain serologic tests that may also reflect the serostatus of the mother should be coded as 795.71. In addition, a set of HIV-specific official coding guidelines has been developed to help ensure proper code selection and sequencing.

STRUCTURE OF THE CLASSIFICATION

The classification for symptomatic HIV infection consists of a single, three-digit ICD-9-CM code—code 042, found in Chapter 1, *Infectious and Parasitic Diseases*, of the ICD-9-CM. This classification places HIV infection at the beginning of the section on viral diseases. Multiple coding of all listed manifestations of HIV infection is required. The new code for asymptomatic HIV infection, V08, is found in the *Supplementary Classification of Factors Influencing Health Status and Contact with Health Services*;

the code for inconclusive serologic tests for HIV, 795.71, is found in Chapter 16, *Signs, Symptoms, and Ill-Defined Conditions*.

HOW TO USE THIS CLASSIFICATION

The following instructions for persons who assign codes will help to ensure more accurate coding practices:

- To use these codes correctly, the physician must provide complete information about the manifestations of the HIV-related illnesses and their relationship to HIV. Persons who assign codes should not assume that conditions are HIV related unless the physician so indicates.
- All manifestations of HIV infection must be coded. The person who assigns codes should refer to Volume 2 of the ICD-9-CM, the *Alphabetic Index*, to determine the proper codes for these conditions.
- Selection of the principal diagnosis should be based on the information contained in the individual patient record. The 042 code should be listed as the principal diagnosis when a patient is admitted to a health-care facility for an HIV-related condition. Additional codes for all HIV-related conditions should be assigned as other diagnoses.
- A patient with HIV disease may be admitted to a health-care facility for an unrelated condition. In these cases, the unrelated condition should be the principal diagnosis, with the 042 code listed as an additional diagnosis, followed by the codes for the manifestations of the HIV disease.
- Asymptomatic HIV infection should be coded as V08 and not as 042. However, patients who have a history of symptomatic HIV infection, but who are currently asymptomatic, should be coded as 042.

HIV-2 ILLNESS

The classification assumes that conditions classified as code 042 are the result of infection with HIV-1 unless an additional code for HIV-2 is included in the record. Therefore, in cases of illness resulting from infection with HIV-2, the physician must specify that HIV-2 is the causative agent, and the coder must list the code for the HIV-2 infection, 079.53, as an additional diagnosis.

**ICD-9-CM OFFICIAL AUTHORIZED ADDENDA FOR HUMAN
IMMUNODEFICIENCY VIRUS INFECTION CODES****Volume 1****042 Human Immunodeficiency Virus [HIV] Disease**

Acquired immune deficiency syndrome
Acquired immunodeficiency syndrome
AIDS
AIDS-like syndrome
AIDS-related complex
ARC
HIV infection, symptomatic

Use additional codes to identify *all* manifestations of HIV disease.

Use additional code to identify HIV-2 infection (079.53), if present.

Excludes: asymptomatic human immunodeficiency virus [HIV] infection (V08)
inconclusive serologic findings for human immunodeficiency virus [HIV] infection (795.71)

795.71 Inconclusive serological findings for human immunodeficiency virus [HIV]

Excludes: asymptomatic human immunodeficiency virus [HIV] infection status (V08)
human immunodeficiency virus [HIV] disease (042)

V08 Asymptomatic human immunodeficiency virus [HIV] status

human immunodeficiency virus [HIV] positive (status)
human immunodeficiency virus [HIV] infection (asymptomatic)

Excludes: human immunodeficiency virus [HIV] disease (042)
inconclusive serological findings for human immunodeficiency virus [HIV] (without diagnosis) (795.8)
symptomatic human immunodeficiency virus [HIV] infection (042)

OFFICIAL GUIDELINES FOR CODING AND REPORTING*

10. HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTIONS

10.1 Code only confirmed cases of HIV infection/illness.

This is an exception to guideline 1.8 which states "If the diagnosis documented at the time of discharge is qualified as 'probable,' 'suspected,' 'likely,' 'questionable,' 'possible,' or 'still to be ruled out,' code the condition as if it existed or was established..."

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

10.2 Selection of HIV code

042 Human Immunodeficiency Virus [HIV] Disease

Patients with an HIV-related illness should be coded to 042, Human Immunodeficiency Virus [HIV] Disease.

V08 Asymptomatic Human Immunodeficiency Virus [HIV] infection

Patients with physician-documented asymptomatic HIV infections who have never had an HIV-related illness should be coded to V08, Asymptomatic Human Immunodeficiency Virus [HIV] Infection.

795.71 Nonspecific Serologic Evidence of Human Immunodeficiency Virus [HIV]

Code 795.71, Nonspecific serologic evidence of human immunodeficiency virus [HIV], should be used for patients (including infants) with inconclusive HIV test results.

10.3 Previously diagnosed HIV-related illness

Patients with any known prior diagnosis of an HIV-related illness should be coded to 042. Once a patient had developed an HIV-related illness, the patient should always be assigned code 042 on every subsequent admission. Patients previously diagnosed with any HIV illness (042) should never be assigned to 795.71 or V08.

10.4 Sequencing

The sequencing of diagnoses for patients with HIV-related illnesses follows guideline 2 for selection of principal diagnosis. That is, the circumstances of admission govern the selection of principal diagnosis, "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

*The ICD-9-CM *Official Guidelines for Coding and Reporting* is a separate document published by the Government Printing Office. It contains nine previous sets of coding guidelines that are not specific to HIV infection. The *Official Guidelines* are updated periodically and the following changes are part of the 1994 update.

Patients who are admitted for an HIV-related illness should be assigned a minimum of two codes: first assign code 042 to identify the HIV disease and then sequence additional codes to identify the other diagnoses. If a patient is admitted for an HIV-related condition, the principal diagnosis should be 042, followed by additional diagnosis codes for all reported HIV-related conditions.

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

Whether the patient is newly diagnosed or has had previous admissions for HIV conditions (or has expired) is irrelevant to the sequencing decision.

10.5 HIV Infection in Pregnancy, Childbirth and the Puerperium

During pregnancy, childbirth or the puerperium, a patient admitted because of an HIV-related illness should receive a principal diagnosis of 647.8X, Other specified infectious and parasitic diseases in the mother classifiable elsewhere, but complicating the pregnancy, childbirth or the puerperium, followed by 042 and the code(s) for the HIV-related illness(es). This is an exception to the sequencing rule found in 10.4 above.

Patients with asymptomatic HIV infection status admitted during pregnancy, childbirth, or the puerperium should receive codes of 647.8X and V08.

10.6 Asymptomatic HIV Infection

V08 Asymptomatic human immunodeficiency virus [HIV] infection, is to be applied when the patient without any documentation of symptoms is listed as being "HIV positive," "known HIV," "HIV test positive," or similar terminology. Do not use this code if the term "AIDS" is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use 042 in these cases.

10.7 Inconclusive Laboratory Test for HIV

795.71 Inconclusive serologic test for Human Immunodeficiency Virus [HIV]

Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness may be assigned code 795.71.

10.8 Testing for HIV

Code V72.6 Laboratory examination, should be assigned for patients seen only for HIV testing. This code does *not* include any counseling given during the encounter for the laboratory test; an additional code of

V65.44, HIV counseling, should be used to indicate that counseling was given. (Test results are not available during these encounters.)

When the patient returns to be informed of his/her HIV test results, V72.6 is not used. If the results are negative, use code **V65.44, HIV counseling**. If the results are positive, code **V08, Asymptomatic HIV infection**, should be used unless the patient has symptoms of HIV disease. If the test result is positive and the patient has an HIV-related illness, code **042, HIV disease**, should be used.

MMWR

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