ICD-9-CM Coordination and Maintenance Committee Meeting
September 30, 2005
Diagnosis Agenda

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

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

August 12, 2005	Hospital Inpatient Prospective Payment System final rule published in the Federal Register as mandated by Public Law 99-509. The rule can be accessed at: http://www.cms.hhs.gov/providers/hipps/frnotices.asp
August 24, 2005	Tentative agenda for the Diagnosis part of the September 29 – 30, 2005 ICD-9-CM Coordination and Maintenance Committee meeting posted on NCHS homepage at - http://www.cdc.gov/nchs/icd9.htm
August 31, 2005	Federal Register notice for the September 29 – 30, 2005 ICD-9-CM Coordination and Maintenance Committee Meeting published.
September 23, 2005	Because of increased security requirements, **those wishing to attend the September 29-30, 2005** 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 23, 2005; failure to do so may result in lack of access to the meeting**.
Sept. 29-30, 2005	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 23, 2005.** 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, 2005	New and revised ICD-9-CM codes become effective 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/paymentsystems/icd9

October 2005	Summary report of the Procedure part of the Sept. 29-30, 2005 ICD-9-CM Coordination and Maintenance Committee meeting posted on CMS homepage at - http://www.cms.hhs.gov/paymentsystems/icd9 Summary report of the Diagnosis part of the Sept. 29-30, 2005 ICD-9-CM Coordination and Maintenance Committee meeting report posted on NCHS homepage at - http://www.cdc.gov/nchs/icd9.htm
October 15, 2005	Deadline for receipt of public comments on proposed code revisions discussed at the September 29-30, 2005 ICD-9-CM Coordination and Maintenance Committee meeting for implementation on April 1, 2006 to capture new technology.
Early Nov., 2005	Any new ICD-9-CM codes required to capture new technology that will be implemented on April 1, 2006 will be announced. Information on any new codes to be implemented on April 1, 2006 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 2, 2005	Deadline for receipt of public comments on proposed code revisions discussed at the March 31-April 1, 2005 and September 29-30, 2005 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2006.
January 3, 2006	On-line registration opens for the March 23 – 24, 2006 ICD-9- CM Coordination and Maintenance Committee meeting at: http://www.cms.hhs.gov/events/
January 23, 2006	Deadline for requestors: Those members of the public requesting that topics be discussed at the March 23 –March 24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses by this date.

February, 2006	Tentative agenda for the Procedure part of the March 23, 2006 ICD-9-CM Coordination and Maintenance Committee meeting posted on CMS homepage as follows: http://www.cms.hhs.gov/paymentsystems/icd9 Tentative agenda for the Diagnosis part of the March 24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm Federal Register notice announcing March 23 – March 24, 2006 ICD-9-CM Coordination and Maintenance Committee Meeting will be published. This will include the tentative agenda.
March 17, 2006	Because of increased security requirements, **those wishing to attend the March 23 – March 24, 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 March 17, 2006; failure to do so may result in lack of access to the meeting**.
March 23-24, 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 March 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.
April 1, 2006	Any new ICD-9-CM codes required to capture new technology will be implemented. Information on any new codes implemented on April 1, 2006 previously posted in early November 2005 on the following websites: Procedures at http://www.cms.hhs.gov/paymentsystems/icd9 Diagnoses at http://www.cdc.gov/nchs/icd9.htm Code titles at http://www.cms.hhs.gov/medlearn/icd9code.asp
April 2006	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/providers/hipps/frnotices.asp

April 2006	Summary report of the Procedure part of the March 23-24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.cms.hhs.gov/paymentsystems/icd9
	Summary report of the Diagnosis part of the March 23-24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
April 14, 2006	Deadline for receipt of public comments on proposed code revisions discussed at the March 28-29, 2006 ICD-9-CM Coordination and Maintenance Committee meeting for implementation on October 1, 2006 to capture new technology.
June 2006	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/paymentsystems/icd9
July 28, 2006	Deadline for requestors: Those members of the public requesting that topics be discussed at the September 28-29, 2006 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses by this date.
August, 2006	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, 2006. This rule can be accessed at: http://www.cms.hhs.gov/providers/hipps/frnotices.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 24, 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 24, 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 24, 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/paymentsystems/icd9 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 7, 2006	Deadline for receipt of public comments on proposed code revisions discussed at the September 29 – 30, 2006 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on April 1, 2006 to capture new technology.
October 2006	Summary report of the Procedure part of the September 29 – 30, 2005 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.cms.hhs.gov/paymentsystems/icd9 Summary report of the Diagnosis part of the September 29 – 30, 2006 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm

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 8, 2006	Deadline for receipt of public comments on proposed code revisions discussed at the March 31 - April 1, 2006 and September 29 -30, 2006 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2007.

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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: Mucositis

Mucositis is a frequent complication of anticancer treatment that causes redness and/or ulcerative sores in the soft tissues of the mucosal surfaces throughout the body, resulting in severe pain as well as difficulty in or lack of ability to eat, drink, and take oral medications. The rapidly dividing basal cells of the mucosal surfaces throughout the body are especially vulnerable to damage by chemotherapy and radiation therapies. While the oral mucosa is the most frequent site of mucosal toxicity, mucositis also is common along the entire alimentary tract, throughout the esophagus, stomach, duodenum, small intestine, colon, and rectum. Although less frequently reported in the literature, treatment of ovarian cancer and nasopharyngeal carcinoma may also result in vaginal and nasal mucositis, respectively.

Unique ICD-9-CM codes to describe mucositis currently do not exist. Currently the ICD-9-CM index entry for mucositis instructs coders to reference mucositis codes as follows: "Mucositis – see also inflammation by site", as well as a sub-entry of "necroticans agranulocytica 288.0". The codes that are used do not allow the condition to be identified readily or distinctly. Unique ICD-9-CM codes for mucositis are needed to enable accurate and consistent statistics on these patients as well as to be able to measure medical resource utilization and cost effectiveness of mucositis interventions.

Physicians at the Loyola University Medical Center have requested that unique codes be created for mucositis. Below are two code modification options:

OPTION 1: Create new codes for the different anatomic sites of mucositis, distributed through the Tabular by site placed within categories for inflammation as follows:

TABULAR MODIFICATIONS

478 Other diseases of upper respiratory tract

478.1 Other diseases of nasal cavity and sinuses

New Code 478.11 Nasal mucositis (ulcerative)

New Code 478.19 Other disease of nasal cavity and sinuses

528 Diseases of the oral soft tissues, excluding lesions specific for gingiva and tongue

528.0 Stomatitis

Add Mucositis (ulcerative) of mouth and oral soft tissues

Add Excludes: cellulitis and abscess of mouth (528.3)
gingivitis (523.0-523.1)

530 Diseases of esophagus

530.1 Esophagitis

New code 530.13 Mucositis (ulcerative) of esophagus

535 Gastritis and duodenitis

New code 535.7 Mucositis (ulcerative) of stomach

New code 535.8 Mucositis (ulcerative) of small intestine

558 Other and unspecified noninfectious gastroenteritis and colitis

New code 558.4 Mucositis (ulcerative) of large intestine

569 Other disorders of intestine

569.4 Other specified disorders of rectum and anus

New code 569.43 Mucositis (ulcerative) of rectum and anus

616 Inflammatory disease of cervix, vagina, and vulva

616.8 Other specified inflammatory diseases of cervix, vagina, and vulva

New Code 616.81 Mucositis (ulcerative) of cervix, vagina, and vulva

New Code 616.89 Other inflammatory disease of cervix, vagina and vulva

OPTION 2: Create a separate category with new codes for gastrointestinal mucositis sites, as well as new codes for vaginal and nasal mucositis.

TABULAR MODIFICATIONS

478 Other diseases of upper respiratory tract

478.1 Other diseases of nasal cavity and sinuses

New Code 478.11 Nasal mucositis (ulcerative)

New Code 478.19 Other disease of nasal cavity and sinuses

528 Diseases of the oral soft tissues, excluding lesions specific for gingiva and tongue

528.0 Stomatitis

Add Mucositis (ulcerative) of mouth and oral soft tissues

Add Excludes: cellulitis and abscess of mouth (528.3)
gingivitis (523.0-523.1)

New Category 538 Gastrointestinal mucositis
Mucositis:
NOS
ulcerative

Excludes: mucositis (ulcerative) of mouth and oral soft tissue (528.0)

New Code 538.2 Mucositis of esophagus

New Code 538.3 Mucositis of stomach

New Code 538.4 Mucositis of small intestine

New Code 538.5 Mucositis of large intestine

New Code 538.6 Mucositis of rectum and anus

New Code 538.9 Mucositis of other and unspecified

	616	Inflammatory disease of cervix, vagina, and vulva	
		616.8	Other specified inflammatory diseases of cervix, vagina, and vulva
New Code		616.81	Mucositis (ulcerative) of cervix, vagina, and vulva
New Code		616.89	Other inflammatory disease of cervix, vagina and vulva

Topic: Acute and chronic gingival disease

The current ICD-9-CM structure accurately reflects the broad classification of gingival disease but it does not provide subclassifications to identify whether the gingival disease is plaque-induced or not. There are many non-bacterial causes of gingivitis and the knowledge of the etiology permits precise therapies to intercept the gingival lesions and prevent their progression. The classification expansion proposed reflects the current disease classification system of the American Academy of Periodontology (AAP) as reported in the *Annals of Periodontology*, volume 4, number 1, 1999. The proposal is submitted by Delta Dental Plans Association.

TABULAR MODIFICATIONS

	523	Gingival and periodontal diseases	
		523.0 Acute gingivitis	
New code		523.01	Acute gingivitis, plaque induced
New code		523.09	Acute gingivitis, non-plaque induced
		523.1 Chronic gingivitis	
New code		523.11	Chronic gingivitis, plaque induced
New code		523.19	Chronic gingivitis, non-plaque induced

Topic: Acute and chronic periodontal disease

The current ICD-9-CM structure accurately reflects the broad classification of periodontal disease but it does not provide subclassifications to identify whether the periodontal disease is localized or generalized. It is important to distinguish between localized and generalized periodontal disease because different strategies may be applied to manage these patterns. These varied strategies may have varied health and economic outcomes and discrimination of the actual pattern may lead to better therapeutic regimen. The classification expansion proposed reflects the current disease classification system of the American Academy of Periodontology (AAP) as reported in the *Annals of Periodontology*, volume 4, number 1, 1999. The proposal is submitted by Delta Dental Plans Association.

TABULAR MODIFICATIONS

523 Gingival and periodontal diseases

523.3 Acute periodontitis

Add Aggressive periodontitis

New code 523.31 Acute periodontitis, localized

New code 523.32 Acute periodontitis, generalized

523.4 Chronic periodontitis

New code 523.41 Chronic periodontitis, localized

New code 523.42 Chronic periodontitis. generalized

Topic: Unsuccessful endodontic treatment

The ICD-9-CM classification does not provide a category to identify unsuccessful endodontic treatment. When it is unsuccessful the patient experiences the same symptoms associated with periradicular pathology. Current codes for pulpitis are not appropriate because there is no remaining pulp to be inflamed or to be the source of inflammation. Delta Dental Plans Association has submitted a proposal for a new subcategory and codes to classify unsuccessful endodontic treatment.

TABULAR MODIFICATIONS

526 Diseases of the jaws

New sub-category	526.6	Periradicular pathology associated with previous endodontic treatment Complications of root canal procedure
New code	526.61	Perforation of root canal space
New code	526.62	Endodontic overfill
New code	526.63	Endodontic underfill
New code	526.69	Other periradicular pathology associated with previous endodontic treatment

Topic: Unsatisfactory restoration

Current dental restorative materials are not permanent and suffer from failure. When damaged surfaces of the teeth are replaced with prosthetic materials, these materials become part of and act like tooth structure. Failure of these materials is then failure or pathology of the dentition. Failed restorations are considered to have a clinically significant loss of function, tissue inflammation, or pulp pathology. Delta Dental Plan Associations has submitted a proposal to create codes for unsatisfactory restoration.

TABULAR MODIFICATIONS

	525	Other diseases and conditions of the teeth and supporting structures	
New sub-Category		525.6	Unsatisfactory restoration of tooth
New code		525.61	Open restoration margins
New code		525.62	Unrepairable overhanging dental restorative materials
New code		525.63	Fractured restorative material without loss of material
New code		525.64	Fractured restorative material with loss of material
New code		525.65	Contour of existing restoration biologically incompatible with oral health
New code		525.66	Allergy to existing restorative material
New code		525.67	Poor aesthetics of existing restoration
New code		525.69	Other unsatisfactory restoration of tooth

Topic: Severe sepsis

At the April 2005 C&M meeting an open discussion was held on the coding of severe sepsis. After listening to the comments made during the discussion, as well as the presentation made on severe sepsis by a representative from Eli Lilly, a set of modifications have been developed that are being presented now. These modifications are designed to facilitate the correct use of the severe sepsis codes so that accurate and complete data on this serious condition can be collected.

This proposal provides several possible modifications. Each modification can be implemented independently of the others. For this reason, and to facilitate the review and discussion of each proposed change, they are presented here separately. A final decision as to which modifications to accept will be made following the comment period.

The guidelines would be updated should any of these modifications be approved and conflict with existing guidelines.

TABULAR MODIFICATIONS

Proposal 1: Instructional notes at codes 785.52, Septic shock, and 995.94, Systemic inflammatory response syndrome due to noninfectious process with organ dysfunction

Consensus was reached that though it is possible to develop septic shock following trauma, it is not possible to develop septic shock without severe sepsis, that is, without a systemic infection developing following the trauma. For this reason it is being proposed that the instructional note to code septic shock with code 995.94, Systemic inflammatory response syndrome due to noninfectious process with organ dysfunction, be deleted. The parallel note at code 995.94 to code septic shock would also be deleted.

785 Symptoms involving the cardiovascular system

785.52 Septic shock

Code first:

Delete ~~systemic inflammatory response syndrome due to noninfectious process with organ dysfunction (995.94)~~

995 Certain adverse effects not elsewhere classified

995.9 Systemic inflammatory response syndrome (SIRS)

995.94 Systemic inflammatory response syndrome due to noninfectious process with organ dysfunction

Use additional code to specify organ dysfunction, such as:

Delete ~~septic shock (785.52)~~

Proposal 2: Change the titles of the codes under subcategory 995.9, Systemic inflammatory response syndrome (SIRS)

The clinical indicators for SIRS, systemic inflammatory response syndrome, are present with all systemic inflammations and infections. The codes under subcategory 995.9, Systemic inflammatory response syndrome (SIRS), were created to allow for the classification of sepsis and severe sepsis and to allow for the identification of whether the SIRS was precipitated by infection or trauma. The current code titles do not clearly explain the meaning of the codes and their intended use. It is being proposed that code titles and inclusion terms be changed for the codes under subcategory 995.9 to make the codes easier to understand.

Additionally, a new inclusion term considered synonymous with severe sepsis, sepsis with multiple organ dysfunction (MOD), is being proposed to be added under code 995.92, and excludes notes are being added to better distinguish the codes.

TABULAR MODIFICATIONS

995 Certain adverse effects not elsewhere classified

995.9 Systemic inflammatory response syndrome (SIRS)

Revise	995.91	Sepsis ~~Systemic inflammatory response syndrome due to infectious process without organ dysfunction~~
		~~Sepsis NOS~~
Add		Systemic inflammatory response syndrome due to infectious process
Add	Excludes:	sepsis with acute organ dysfunction (sepsis with multiple organ dysfunction) (severe sepsis) (995.92)
Revise	995.92	Severe sepsis ~~Systemic inflammatory response syndrome due to infectious process with organ dysfunction~~
		~~Severe sepsis~~
Add		Sepsis with acute organ dysfunction
Add		Sepsis with multiple organ dysfunction (MOD)
Add		Systemic inflammatory response syndrome due to infectious process with organ dysfunction

Revise	995.93	Systemic inflammatory response syndrome due to noninfectious process ~~without organ dysfunction~~
Add		Systemic inflammatory response syndrome due to trauma
Add	Excludes:	systemic inflammatory response syndrome due to noninfectious process (trauma) with acute organ dysfunction (995.94)
Revise	995.94	Systemic inflammatory response syndrome due to noninfectious process with <u>acute</u> organ dysfunction
Add		Systemic inflammatory response syndrome due to trauma with acute organ dysfunction

Proposal 3: Revise current instructional notes

It is being proposed that the code first note under subcategory 995.9, Systemic inflammatory response syndrome (SIRS) be deleted since it does not properly apply to all codes under the subcategory. A code first note for the underlying condition would be added under each of the 995.9 codes.

Since SIRS due to a noninfectious process can lead to severe sepsis there was a question as to which code should be used in such a case, 995.92 or 995.94. The consensus was that if severe sepsis is present the trauma code should still be sequenced first, but the 995.92 code should be assigned to indicate that a systemic infection developed as a result of the trauma. It is being proposed that an instructional note for this rule be added under code 995.94.

TABULAR MODIFICATIONS

995 Certain adverse effects not elsewhere classified

995.9 Systemic inflammatory response syndrome (SIRS)

Delete ~~Code first underlying systemic infection~~

995.91 Systemic inflammatory response syndrome due to infectious process without organ dysfunction

Add Code first underlying systemic infection

995.92 Systemic inflammatory response syndrome due to infectious process with organ dysfunction

Add Code first underlying systemic infection

995.93 Systemic inflammatory response syndrome due to noninfectious process without organ dysfunction

Add Code first underlying condition, such as:
acute pancreatitis (577.0)
trauma

	995.94 Systemic inflammatory response syndrome due to noninfectious process with organ dysfunction
Add	Code first underlying condition, such as: acute pancreatitis (577.0) trauma
Add	Note: when both SIRS due to noninfectious process and severe sepsis are present and the underlying cause is trauma, the trauma code should be sequenced first followed by code 995.92 with additional codes for all acute organ dysfunction

Proposal 4: Sequencing of sepsis and severe sepsis and the underlying systemic infection

The sequencing of sepsis and severe sepsis as they relate to the underlying systemic infection has been an area of significant discussion. The current sequencing rules require that the underlying systemic infection be sequenced first, followed by either 995.91 or 995.92. The official coding guidelines provide instruction that should a localized infection such as pneumonia be present on admission, and the systemic infection with resulting sepsis or severe sepsis develop following admission, it is acceptable to assign the local infection first. This proposal does not conflict with that guideline. It is being proposed for sepsis or severe sepsis that is present at any time during a hospital admission. These sequencing rules would apply whether being assigned as principal diagnoses or secondary diagnoses.

It is being proposed that a use additional code note for the underlying systemic infection be added under codes 995.91 and 995.92. With this note the sequencing of the sepsis and the severe sepsis would be first, following by the underlying systemic condition. This would be a reversal to the current sequencing requirement. This proposal is based on the fact that the sepsis and severe sepsis codes do indicate an infection, but it would make data more consistent, and hopefully, easier for the coder.

This sequencing rule would not be applicable to codes 995.93 and 995.94 since it is a noninfectious process that causes the SIRS for these codes. For both these codes a code first note would still be correct since the noninfectious process (trauma) is to be sequenced first.

TABULAR MODIFICATIONS

995 Certain adverse effects not elsewhere classified

995.9 Systemic inflammatory response syndrome (SIRS)

Delete ~~Code first underlying systemic infection~~

995.91 Systemic inflammatory response syndrome due to infectious process without organ dysfunction

Add Use additional code to identify systemic infection

995.92 Systemic inflammatory response syndrome due to infectious process with organ dysfunction

Add Use additional code to identify systemic infection

Proposal 5: Sequencing of codes 995.92 and 995.94 and the associated acute organ dysfunctions, and the addition of disseminated intravascular coagulopathy (DIC) syndrome to the acute organ dysfunction list.

Use of codes 995.92, Systemic inflammatory response syndrome due to infectious process with organ dysfunction, and 995.94, Systemic inflammatory response syndrome due to noninfectious process with organ dysfunction, require the use of additional codes to identify the acute organ dysfunctions. Certain acute conditions, such as septic shock and disseminated intravascular coagulopathy (DIC) syndrome, are sentinel indicators that a patient has severe sepsis and multiple organ dysfunction.

The sequencing of underlying condition versus acute manifestation is continually debated for many conditions, and has been an issue with severe sepsis as well. Interpreting the definition of principal diagnosis, the condition after study chiefly responsible for necessitating the admission, leads some to support the acute manifestation and others to support the underlying condition. From an epidemiologic standpoint it is the underlying condition that ultimately necessitates the admission as none of the acute manifestations would have occurred otherwise.

From a resource management and clinical perspective it is often the acute manifestation that seems most appropriate to sequence first. The difficulty here is which acute manifestation takes precedence over the other.

To allow the acute organ dysfunction to be sequenced before the systemic underlying infection or condition is not being formally proposed at this time, but it was submitted as a comment so it being included now for consideration. Such a change would reverse the reason for the creation of the severe sepsis codes, which was to be able to gather specific data on severe sepsis. Additionally, the decision over which acute organ dysfunction to sequence first in the case of multiple organ dysfunction would be difficult.

Regardless of the final sequencing decision made for severe sepsis, a request has been made to add disseminated intravascular coagulopathy (DIC) syndrome to the list of acute organ dysfunctions. DIC syndrome is commonly associated with infection, and it may occur following severe trauma or shock from other causes. For this reason it is being included under both code 995.92 and 995.94. The proposed modification is shown below.

TABULAR MODIFICATIONS

995 Certain adverse effects not elsewhere classified

995.9 Systemic inflammatory response syndrome (SIRS)

995.92 Systemic inflammatory response syndrome due to infectious process with organ dysfunction

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

Add disseminated intravascular coagulopathy (DIC) syndrome (286.6)

995.94 Systemic inflammatory response syndrome due to noninfectious process with organ dysfunction

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

Add disseminated intravascular coagulopathy (DIC) syndrome (286.6)

Proposal 6: Severe sepsis and septic shock

Septic shock is only present in association with end stage severe sepsis. It indicates an infectious process so it is equivalent to assigning severe sepsis, but indicates an additional severity. It is being proposed that septic shock be excluded from severe sepsis. If septic shock is coded the code for severe sepsis would not be needed. This proposal could apply regardless of the sequencing of any of the sepsis, infection, or acute organ dysfunction codes.

TABULAR MODIFICATIONS

785 Symptoms involving cardiovascular system

785.5 Shock without mention of trauma

785.52 Septic shock

Delete

~~Code first:~~
~~systemic inflammatory response syndrome due to infectious process with organ dysfunction (995.92)~~
~~systemic inflammatory response syndrome due to noninfectious process with organ dysfunction (995.94)~~

Add

Use additional code to identify any other associated acute organ dysfunction, such as:
acute renal failure (584.5-584.9)
acute respiratory failure (518.81)
critical illness myopathy (359.81)
critical illness polyneuropathy (357.82)
disseminated intravascular coagulopathy (DIC) syndrome (286.6)
encephalopathy (348.31)
hepatic failure (570)

Add

Excludes: severe sepsis (995.92)
systemic inflammatory response syndrome due to infectious process with organ dysfunction (995.92)

995 Certain adverse effects not elsewhere classified

995.9 Systemic inflammatory response syndrome (SIRS)

995.92 Systemic inflammatory response syndrome due to infectious process with organ dysfunction

Use additional code to identify any other associated acute organ dysfunction, such as:

Delete ~~septic shock (785.52)~~

Add Excludes: septic shock (785.52)

Topic: Major osseous defects

Osseous defects are the result of extensive bone loss, typically in the area of the hip joint. The most common cause of this bone loss is peri-prosthetic osteolysis from a previous joint replacement, contributing to implant failure and need for revision. Other causes include osteomyelitis, aseptic or osteonecrosis, benign or malignant neoplasms, pathological fractures, severe osteoporosis, or trauma - with or without a previous joint replacement. Osseous defects can also be caused by combinations of these factors, for example, osteolysis could cause a joint implant to become loose, and repeated impact of the loose implant on bone weakened by osteoporosis could in turn create a cavity/defect. While some bone loss is common and treated incidentally in joint replacement, major defects are clinically meaningful, since the surrounding bone structure into which the joint implants are placed is not strong enough to mechanically support the implants without prior structural repair.

Knowledge of these defects and any causal and/or co-morbid conditions has important implications regarding diagnosis and treatment options for the orthopedic surgeon, as well as risks for future implant failure. Treatment for major osseous defects of the hip and knee may involve primary or revision hip or knee arthroplasty, often in conjunction with filling the defect with morcelized or structural autogenous or allogenic bone graft and providing added mechanical support for the graft itself using wires, cables, acetabular roof rings, cages, metal wedges, augments, screws, etc. Combined, these devices provide additional structural support for the hip and knee implants.

A number of clinical studies have identified these major defects as the most significant risk factor when predicting outcomes and resource utilization for revision total joint replacement surgery. While most common for hip replacement, major osseous defects affect knee replacements as well.

Kevin J. Bozic, M.D., M.B.A., from the University of California at San Francisco has requested that a unique code for major osseous defects be created. This code could be used independently or in addition to a mechanical complication code, such as 996.4x to show cause of a joint prosthesis failure. The underlying cause, if known, should be coded first.

TABULAR MODIFICATIONS

731 Osteitis deformans and osteopathies associated with other disorders classified elsewhere

New code 731.3 Major osseous defects

Code first underlying disease, if known, such as:
malignant neoplasm of bone (170.0-170.9)

Topic: Family history of colon polyps

Colon polyps are frequently found and removed during colonoscopies. Though most colon polyps are not dangerous and most are benign, over time, some types of polyps especially those larger in size, can become cancerous. Certain people have a greater risk of developing colon polyps especially if they are over 50 years old; have had colon polyps before; have had a family member diagnosed with colon polyps or have had a family member diagnosed with cancer of the large intestine.

Physicians at the King's Daughters Hospital in Temple, TX have suggested that a unique code be created for "family history of colon polyps" since this may prompt screening colonoscopies at earlier ages or with more frequency than average risk individuals. Additionally an individual with this family history may seek medical advice to initiate lifestyle prevention methods. It is not currently uniquely represented in an ICD-9-CM history code, nor is it specifically indexed.

TABULAR MODIFICATIONS

V19 Family history of other conditions

V19.8 Other condition

New Code V19.81 Family history of colon polyps

Excludes: family history of malignant neoplasm of gastrointestinal tract (V16.0)

New Code V19.89 Family history of other condition

Topic: Takotsubo syndrome
(Reversible left ventricular dysfunction following sudden emotional stress)

Takotsubo syndrome is a reversible left ventricular dysfunction in patients without coronary disease precipitated by emotional or physiological stress and has been recently reported in medical literature with more frequency. The syndrome was initially recognized and reported in the Japanese population, however, in the past three years it has been reported more in the white U.S. population as well as in Europe. It was initially given the name "tako-tsubo-like left ventricular dysfunction". More recently, the condition has been called "transient left ventricular apical ballooning syndrome". Both names make reference to the associated left ventricular morphologic features including transient wall-motion abnormalities involving the left ventricular apex and mid-ventricle that accompany the syndrome. The word "tako-tsubo" refers to the round-bottomed narrow-necked Japanese fishing pot used for trapping octopus.

Despite the absence of obstructive epicardial coronary artery disease patients commonly present with ST-segment elevation in the precordial leads, chest pain, relatively minor elevation of cardiac enzyme and biomarker levels, and transient apical systolic left ventricular dysfunction. Patients with the syndrome are usually monitored and treated for left heart failure, dynamic intraventricular obstruction, arrhythmias, and mechanical complications, should they develop. The inpatient mortality rate seems to be low, with rapid resolution after the sudden onset, as does the risk for recurrence. Though the possibility of simultaneous multivessel coronary spasm may contribute to the onset of the syndrome the exact cause of the syndrome is not yet known.

Effective October 1, 2005 this condition, as well as the equivalent term "apical ballooning syndrome" was indexed to code 429.89, Other ill-defined heart diseases. Due to the recent increase in occurrence of this condition NCHS recommends creating a unique code for this syndrome as follows:

TABULAR MODIFICATIONS

429 Ill-defined descriptions and complications of heart disease

Revise 429.8 Other ill-defined heart diseases

New Code 429.83 Takotsubo syndrome
Reversible left ventricular dysfunction following sudden emotional stress
Stress induced cardiomyopathy
Transient left ventricular apical ballooning syndrome

Topic: Familial Mediterranean Fever

Familial Mediterranean fever (FMF) is a rare inherited disorder characterized by regular attacks of inflammation in the lining of the abdominal cavity, chest cavity, skin or joints along with recurrent high fevers. It usually affects people of Mediterranean ancestry, most commonly people of non-Ashkenazi Jewish, Armenian, Arab, and Turkish background. The gene for FMF was identified in 1997. There is no diagnostic laboratory test, therefore, diagnosis is usually made based upon clinical findings. Treatment using prophylactic colchicine usually provides remission or improvement in most patients though they are subject to further acute attacks. Currently this condition is indexed to code 277.3, Amyloidosis. A request was received from the Israel Ministry of Health to create a unique code for Familial Mediterranean fever.

TABULAR MODIFICATIONS

277 Other and unspecified disorders of metabolism

277.3 Amyloidosis

Delete ~~Amyloidosis:~~
Delete ~~NOS~~
Delete ~~inherited systemic~~
Delete ~~nephropathic~~
Delete ~~neuropathic (Portuguese) (Swiss)~~
Delete ~~secondary~~
Delete ~~Benign paroxysmal peritonitis~~
Delete ~~Familial Mediterranean fever~~
Delete ~~Hereditary cardiac amyloidosis~~

New Code 277.30 Amyloidosis, unspecified
Amyloidosis NOS

New Code 277.31 Familial Mediterranean fever
Benign paroxysmal peritonitis
Hereditary amyloid nephropathy
Periodic familial polyserositis
Recurrent polyserositis

New Code 277.39 Other amyloidsosis
Hereditary cardiac amyloidosis
Inherited systemic amyloidosis
Neuropathic (Portuguese) (Swiss) amyloidosis
Secondary amyloidosis

Topic: Central pain syndrome, postoperative pain

At the April 2005 ICD-9-CM Coordination and Maintenance Meeting there were several options presented to create unique codes for encounters for pain management. Following that meeting several comments were received and we are again presenting this topic with those suggestions included.

Central pain syndrome can be caused by damage to the central nervous system. This can be traumatic or brain-related (such as stroke, multiple sclerosis, tumors, epilepsy or Parkinson's disease). The character and extent of the pain differs widely depending partly on the variety of causes. These patients are treated with pain medications and sometimes antidepressants and anticonvulsants.

There have been questions raised to the Editorial Advisory Board for the "AHA Coding Clinic for ICD-9-CM" regarding how to code "post-thoracotomy pain". Postoperative pain is currently indexed to "see Pain, by site". Coding only the site of the pain does not give any additional information that it is postoperative. In the past, published coding advice has instructed coders to code the underlying cause of the pain (such as diabetic neuropathy), or the site of the pain, and to not code any postoperative complication code, such as 998.89, Other specified complications.

Currently there are codes for pain found both in the body system chapters and Chapter 16, Signs and symptoms.

TABULAR MODIFICATIONS

780 General symptoms

780.9 Other general symptoms

780.99 Other general symptoms

Delete ~~Generalized pain~~

New category 338 Pain

Excludes: localized pain- code to site
psychogenic pain (307.80)

Use additional code for any associated pain disorder (307.89)

New code 338.1 Generalized pain

New code 338.2 Central pain syndrome
Myelopathic pain syndrome
Thalamic pain syndrome (hyperesthetic)

New code 338.3 Postoperative pain
Postthoracotomy pain

New code 338.8 Other pain

Complications of Surgical and Medical Care, Not Elsewhere Classified (996-999)

Add Excludes: postoperative pain (338.3)

Index entries:

Pain
Add axillary 729.5
Add musculoskeletal 729.1 (see also – Pain, by site)

Topic: Newborn post discharge check

The American Academy of Pediatrics (AAP) is requesting that a unique code be established for encounters for newborn discharge follow examination. It is recommended by the AAP that this type of visit occur within 48 hours of discharge when a healthy newborn is discharged from the hospital less then 48 hours following delivery. (Committee on Fetus and Newborn, American Academy of Pediatrics. *Hospital Stay for Healthy Term Newborns.* Pediatrics 2004;113:1434 –1436).

Currently, there is no code to describe this specific encounter. Codes such as V20.2, Routine infant or child health check; V29.8, Observation for other specified suspected condition, and V58.89, Other specified aftercare do not sufficiently describe the reason for this type of encounter.

The purpose of the follow-up visit is to:

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

TABULAR MODIFICATIONS

V20 Health supervision of infant or child

V20.2 Routine infant or child health check

New code	V20.20	Routine infant or child health check
New code	V20.21	Newborn post-discharge follow up visit Newborn post-discharge health check

Topic: Attention to surgical dressings and sutures

The Medicare Home Health comprehensive patient assessment form known as the OASIS was modified in 2003 to comply with ICD-9-CM coding guidelines and use of V Codes. The home health industry has received letters and suggestions related to the intent of ICD-9-CM code V58.3, Attention to surgical dressings and sutures, which has included changes of dressings and removal of sutures. They have requested to have separate codes for attention to surgical wound dressings, attention to non-surgical dressings and suture or staple removal.

TABULAR MODIFICATIONS

V58 Encounter for other and unspecified procedures and aftercare

Revise V58.3 Attention to (surgical) dressings and sutures
Delete ~~Change of dressings~~
Delete ~~Removal of sutures~~

Add Code first any associated aftercare

Add Excludes: planned postoperative wound closure (V58.41)

New code V58.30 Encounter for change or removal of dressing NOS

New code V58.31 Encounter for change or removal of surgical wound dressing

New code V58.32 Encounter for removal of sutures
Encounter for removal of staples

V58.4 Other aftercare following surgery

V58.41 Encounter for planned postoperative wound closure

Add Excludes: encounter for (surgical) dressings and suture aftercare (V58.3)

Topic: Intrauterine hypoxia and asphyxia

Traditional theories of the etiology of neonatal neurologic injury have focused on the hospital portion of the labor and delivery because it is available for careful and minute by minute observation. This represents a limited portion of the complete gestation and has inappropriately led to a series of conclusions on the etiology of brain injury in the newborn and young child that focused almost strictly on the intrapartum period.

The nomenclature associated with these "diagnoses" has also been problematic, with traditional terminology applied that are technically incorrect descriptors of the fetal/neonatal condition and establishing an accepted "etiology" of the later injury that assumed a cause and effect relationship.

For example the terminology currently used to describe fetal encephalopathic injury and death is antiquated and imprecise. The term "hypoxia" actually refers to a deficiency of oxygen reaching the tissues of the body usually due to low inspired oxygen while "hypoxemia" means deficient oxygenation of the blood. Asphyxia, from the Greek, actually means stopping of the pulse but has come to be associated with hypoxia and hypercapnia.

As our understanding of perinatal cerebral injury has become clearer, it is obvious that the older terminology can no longer apply. The actual cause of the morbidity and mortality in this condition is due to ischemic injury from hypoxemia, hypercapnia and acidosis. While it is normal for these conditions to occur during the normal birth process, when it leads to brain damage the result is hypoxic-ischemic encephalopathy (HIE).

HIE also has well defined clinical definitions (mild, moderate, and severe) based on clinical presentation and imaging findings.

Since some of these conditions can exist during the perinatal period but are unrelated to the birthing process, additional changes were recommended to accommodate these conditions, unrelated to the birth process.

Because of the need to correctly identify these potentially devastating conditions accurately, the American Academy of Pediatrics recommended the following changes to ICD-9-CM.

TABULAR MODIFICATIONS

Proposal 1

Category 768, and code 768.9 title changes are proposed, with some changes to inclusion terms. Also note that a later proposal moves "hypoxia NOS, in liveborn infant" to a new proposed code.

Revise	768	~~Intrauterine hypoxia and birth asphyxia~~ Fetal distress, intrauterine hypoxemia, anoxia, cerebral ischemia, and hypoxic-ischemic encephalopathy (HIE)
Revise	768.9	Unspecified birth ~~asphyxia~~ hypoxemia, anoxia, and cerebral ischemia in liveborn infant
Revise		~~Hypoxia~~ Hypoxemia NOS, in liveborn infant
Add		Cerebral ischemia NOS, in liveborn infant

Proposal 2

Since the acidemia associated with fetal distress and these related conditions may be either metabolic or mixed metabolic-respiratory, the term "fetal metabolic acidemia" associated with this code set should be changed to reflect this.

	768	Intrauterine hypoxia and birth asphyxia
	768.2	Fetal distress before onset of labor, in liveborn infant
Revise		Fetal ~~metabolic~~ acidemia before onset of labor, in liveborn infant
	768.3	Fetal distress first noted during labor, in liveborn infant
Revise		Fetal ~~metabolic~~ acidemia first noted during labor, in liveborn infant
	768.4	Fetal distress, unspecified as to time of onset, in liveborn infant
Revise		Fetal ~~metabolic~~ acidemia unspecified as to time of onset in liveborn infant

Proposal 3

Since fetal distress and these related conditions may be noted during the delivery process, it is proposed that the code titles should be changed to reflect this.

768 Intrauterine hypoxia and birth asphyxia

Revise 768.3 Fetal distress first noted during labor and delivery, in liveborn infant

Revise Fetal metabolic acidemia first noted during labor and delivery, in liveborn infant

Proposal 4

Proposed addition of the concept hypoxic-ischemic encephalopathy.

Option 1

Revise the existing titles at 768.5 and 768.6 as shown. However, the terms related to birth asphyxia would remain in the index.

768 Intrauterine hypoxia and birth asphyxia

Revise 768.5 Severe ~~birth asphyxia~~ hypoxic-ischemic encephalopathy (HIE)

Delete ~~Birth asphyxia with neurologic involvement~~

Revise 768.6 Mild or moderate birth ~~asphyxia~~ hypoxic-ischemic encephalopathy (HIE)

Delete ~~Other specified birth asphyxia (without mention of neurologic involvement)~~

New code 768.60 Mild hypoxic-ischemic encephalopathy (HIE)

New code 768.61 Moderate hypoxic-ischemic encephalopathy (HIE)

Option 2

Create a new subcategory for the concept of hypoxic-ischemic encephalopathy. Exclude this from the existing code for severe birth asphyxia.

	768	Intrauterine hypoxia and birth asphyxia	
	768.5	Severe birth asphyxia	
Add	Excludes: hypoxic-ischemic encephalopathy (768.7)		
New subcategory	768.7	Hypoxic-ischemic encephalopathy	
New code		768.70	Mild hypoxic-ischemic encephalopathy (HIE)
New code		768.71	Moderate hypoxic-ischemic encephalopathy (HIE)
New code		768.72	Severe hypoxic-ischemic encephalopathy (HIE)

Proposal 5

Create a new code for respiratory arrest of newborn. Create a new code for hypoxemia of newborn unrelated to labor and delivery, with hypoxia NOS in newborn to be coded here, moving it from code 768.9.

	770	Other respiratory conditions of fetus and newborn	
	770.8	Other respiratory problems after birth	
New code		770.87	Respiratory arrest of newborn
New code		770.88	Hypoxemia of newborn unrelated to labor and delivery Hypoxia NOS in newborn

Proposal 6

Revise the code title for code 775.7 and add an inclusion term for acidosis NOS of newborn. Note: this text has been corrected from the original to properly reflect the changes proposed.

775 Endocrine and metabolic disturbances specific to the fetus and newborn

Revise 775.7 ~~Late metabolic acidosis of newborn~~ Acidemia of the newborn unrelated to labor and delivery
Acidosis NOS in newborn

Proposal 7

Add an inclusion term at 779.2 for cerebral ischemia unrelated to labor and delivery. Add a new code for cardiac arrest of newborn unrelated to birth.

779 Other and ill-defined conditions originating in the perinatal period

779.2 Cerebral depression, coma and other abnormal cerebral signs
Add Cerebral ischemia unrelated to labor and delivery

779.8 Other specified conditions originating in the perinatal period

New code 779.85 Cardiac arrest of newborn unrelated to birth

Topic: Mild cognitive impairment

Mild cognitive impairment is a disease entity defined by an impairment in memory (or any other cognitive domain) that is beyond what is normal for age, with relatively intact function in the other cognitive domains.

One of the more standard set of criteria for diagnosis of mild cognitive impairment is as follows: (1) memory complaint, preferably corroborated, (2) objective memory impairment for age, (3) relatively preserved general cognition for age, (4) essentially intact activities of daily living, and (5) not demented. Using these criteria, patients progress to dementia at a rate of approximately 12% per year. This is in distinction to an incidence rates from a similar community population with a documented progression rate of 1 to 2% per year. When a group of these subjects were followed up at 6 years, approximately 80% of them will have converted to dementia.

The American Academy of Neurology (AAN) requested a new code for mild cognitive impairment.

TABULAR MODIFICATIONS

331 Other cerebral degenerations

331.8 Other cerebral degeneration

New code 331.83 Mild cognitive impairment

Topic: Altered mental status

An altered mental status may frequently be described, as a symptom of a number of different types of illness. Some of the potential underlying etiologies include trauma, infection, neoplasm, alcohol, and drugs, as well as endocrine disorders, neurological disorders, psychiatric disorders, and renal disorders.

Altered mental status may be based on reports of family or caregivers. Acute changes from baseline mental function are important, which requires knowledge of the baseline.

Mental status examination includes assessment of orientation, affect and mood, language, memory, judgment and insight, as well as abnormal thought content, and perception abnormalities. Level of consciousness is also assessed, and there are existing codes for altered levels of consciousness at subcategory 780.0. Delirium not otherwise specified is coded to 780.09, Other, Alteration of consciousness. If a specific cause of altered mental status is known, that should be coded, rather than the symptom code being used.

Several requests were received for a new code for altered mental status.

TABULAR MODIFICATIONS

780.9 Other general symptoms

New code 780.96 Altered mental status

Excludes: altered level of consciousness (780.01- 780.09)
delirium NOS (780.09)

Topic: Hematology / Aplastic Anemia / Myelofibrosis

Myelofibrosis involves fibrous tissue replacing normal bone marrow. It usually is accompanied by leukoerythroblastic anemia. It can be a primary hematologic disease, or a secondary process. The primary form may be called by a number of names, including primary myelofibrosis, and myeloid metaplasia. In April 2005 a new code was proposed at 238.73, Myelofibrosis with myeloid metaplasia, with an inclusion term "primary myelofibrosis."

The secondary process may be called myelophthisis. Myelophthisis may occur in a number of other disorders, including malignancies, infections (particularly fungi and mycoplasma), lipid storage disease (e.g., Gaucher's disease), sarcoidosis, and osteoporosis.

The marrow fibrosis usually is accompanied by leukoerythroblastosis, or leukoerythroblastic anemia. This might also be referred to as myelopathic anemia or myelophthisis anemia.

There are a number of index entries for terms related to myelofibrosis, which do not reflect current understanding, and the current modifications. Thus, it is proposed that these index entries be modified to make coding more consistent.

The proposal for elevated white blood cell count and decreased white blood cell count was changed based on comments following the April 2005 meeting. These codes are presented to show the current proposed form of the changes.

TABULAR MODIFICATIONS

284 Aplastic anemia <u>and other bone marrow failure syndromes</u>

New code 284.2 Myelophthisis
Secondary myelofibrosis

Code first the underlying disorder

INDEX MODIFICATIONS

Anemia
Revise leukoerythroblastic ~~285.8~~ 284.8
Revise myelopathic ~~285.8~~ 284.8
Revise myelophthisic (normocytic) ~~285.8~~ 284.8

Revise Leukoerythroblastosis ~~289.0~~ 289.9

Myelofibrosis (osteosclerosis) 289.89
Add with myeloid metaplasia 238.73
Add idiopathic 238.73
Add primary 238.73
Add secondary 284.2

Osteosclerosis
Revise myelofibrosis (see also Myelofibrosis) 289.89

TABULAR MODIFICATIONS

Changed from April 2005.

288 Diseases of white blood cells

New subcategory 288.4 Decreased white blood cell count

Excludes: neutropenia (288.01-288.09)

New code 288.40 Leukocytopenia, unspecified
Decreased leukocytes, unspecified
Decreased white blood cell count
Leukopenia

New code 288.41 Lymphocytopenia
Decreased lymphocytes

New code 288.49 Other decreased leukocytes
Monocytopenia
Other decreased white blood cell count
Plasmacytopenia

New subcategory 288.5 Elevated white blood cell count

Excludes: eosinophilia (288.3)

New code 288.50 Leukocytosis, unspecified
Elevated leukocytes, unspecified
Elevated white blood cell count
Leukemoid reaction, unspecified

New code 288.51 Lymphocytosis (symptomatic)
Elevated lymphocytes
Lymphocytic leukemoid reaction

New code 288.59 Other elevated leukocytes
Leukemoid reaction
monocytic
myelocytic
Monocytosis (symptomatic)
Other elevated white blood cell count
Plasmacytosis

Topic: Complex febrile seizure

Complex febrile seizures are defined as fever associated seizures that are focal, prolonged (greater than 15 minutes), or reoccur within 24 hours in children between 6 months and 5 years of age. They may also be referred to as atypical or complicated febrile seizures. Fever associated seizures that do not meet these criteria may be referred to as simple febrile seizures.

There are significant differences in morbidity between simple and complex febrile seizures. Long term risk of epilepsy can range from 6-8% in children who have a single feature of a complex seizure all the way to 49% in those who have had all three A child with a complex febrile seizure may need neuroimaging and/or long-term anticonvulsant therapy.

There has been no good way of tracking these at risk children. Current ICD-9-CM coding directions for the category containing febrile seizure directs the coder to the epilepsy codes (345.10-.91) if the patient was in status epilepticus. Also lost are children who may have had one of the other features of this condition.

To help better track these at risk children, the American Academy of Pediatrics recommended that the febrile seizure code be revised and a new code be added for complex febrile seizures.

TABULAR MODIFICATIONS

345 Epilepsy

345.1 Generalized convulsive epilepsy

Excludes: convulsions:

Revise NOS (780.39)

Revise infantile (780.39)

345.9 Epilepsy, unspecified

Revise Excludes: convulsive seizure or fit NOS (780.39)

780 General symptoms

Revise 780.3 Convulsions

Excludes: convulsions:

Delete ~~epileptic (345.10-345.91)~~
in newborn (779.0)

Revise 780.31 Febrile convulsions <u>(simple), unspecified</u>

Add Excludes: convulsions, epileptic (345.10-345.91)

New code 780.32 Complex febrile convulsions
Febrile seizure:
atypical
complex
complicated

Code first any epileptic convulsion, if present (345.10 -345.91)

780.39 Other convulsions

Add Excludes: convulsions, epileptic (345.10-345.91)

Topic: Torsion of appendix testis

The conditions included under code 608.2, Torsion of testis, do not include the appendix testis, a small solid projection of tissue on the outer surface of the testis which is a remnant of the embryologic mullerian duct. The American Urological Association (AUA) has requested that the appendix testis be added to 608.2 and that the code be expanded to create unique codes for the different conditions currently grouped together under 608.2

TABULAR MODIFICATIONS

608 Other disorders of male genital organs

608.2 Torsion of testis

Delete ~~Torsion of:~~
~~epididymis~~
~~spermatic cord~~
~~testicle~~

New code	608.20	Torsion of testis, unspecified
New code	608.21	Torsion of appendix epididymis
New code	608.22	Extravaginal torsion of spermatic cord
New code	608.23	Intravaginal torsion of spermatic cord
New code	608.24	Torsion of appendix testis

Topic: Lower urinary tract symptoms

The term enlarged prostate is becoming more commonly used for benign prostatic hyperplasia and hypertrophy of prostate. The American Urological Association (AUA) has requested that the term enlarged prostate be added as an inclusion term under category 600, Hyperplasia of prostate, and that new codes for the symptoms of enlarged prostate that currently do not have specific codes, urinary hesitancy and straining on urination be created.

TABULAR MODIFICATIONS

600 Hyperplasia of prostate

Add Enlarged prostate

788 Symptoms involving urinary system

788.6 Other abnormality of urination

New code 788.64 Urinary hesitancy

New code 788.65 Straining on urination

Topic: Cervical stump prolapse

Currently prolapse of the cervical stump is indexed to code 618.1, Uterine prolapse without mention of vaginal wall prolapse. The American College of Obstetricians and Gynecologists (ACOG) has requested a unique code for cervical stump prolapse, but not under code 618.1 which is an incorrect classification for this condition. The uterus is no longer present with cervical stump prolapse.

TABULAR MODIFICATIONS

618 Genital prolapse

618.8 Other specified genital prolapse

New code 618.84 Cervical stump prolapse

Topic: Cytologic evidence of malignancy

When the codes for abnormal cytologic smears of the cervix were created the term cytologic evidence of malignancy was included under code 795.04, Papanicolaou smear of cervix with high grade squamous intraepithelial lesion (HGSIL). Physicians at the American College of Obstetricians and Gynecologists (ACOG) request that a unique code for cytologic evidence of malignancy be created.

TABULAR MODIFICATIONS

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

795.0 Abnormal Papanicolaou smear of cervix and cervical HPV

795.04 Papanicolaou smear of cervix with high grade squamous intraepithelial lesion (HGSIL)

Delete ~~Cytologic evidence of malignancy~~

New code 795.06 Papanicolaou smear of cervix with cytologic evidence of malignancy

Topic: Encounter for testing of male partner of habitual aborter

October 1, 2005 new codes become effective for genetic testing and counseling. At the April 2005 C&M meeting an expansion on those new codes were presented which creates codes that distinguish between male and female. The American College of Obstetricians and Gynecologists (ACOG) has requested that a further expansion to the codes presented in April be made to create a unique code for a male encounter for a female partner who is a habitual aborter. Having a female partner who is a habitual aborter is a common reason for a male to be tested. A parallel unique code of female habitual aborter not currently pregnant would also be created.

The proposal as shown below includes the portion that was presented in April.

TABULAR MODIFICATIONS

629 Other disorders of female genital organs

629.8 Other specified disorders of female genital organs

New code 629.81 Habitual aborter without current pregnancy

Excludes: habitual aborter with current pregnancy (646.3)

New code 629.89 Other specified disorders of female genital organs

629.9 Unspecified disorder of female genital organs

Delete ~~Habitual aborter without current pregnancy~~

Revised from April 2005 C&M proposal

V26 Procreative management

V26.3 Genetic counseling and testing

New code	V26.31	Testing for genetic disease carrier status <u>of female</u>
New code	V26.32	Other genetic testing <u>of female</u>
Add	Use additional code to identify habitual aborter (629.81)	
New code	V26.34	Testing for genetic disease carrier status <u>of male</u>
New code	V26.35	Encounter for testing of male partner of habitual aborter
New code	V26.39	<u>Other genetic testing of male</u>

Topic: Estrogen receptor status

About two-thirds of breast cancer patients have an estrogen receptor positive (ER+) tumor. The incidence of ER+ tumors is greater among postmenopausal than among premenopausal woman. Patients with estrogen receptors have a somewhat better prognosis and are more likely to benefit from endocrine therapy. Knowledge of receptor status at the time of diagnosis may be useful in the selection of adjuvent therapy (after excision or radiation therapy) and palliative therapy if metastatic disease develops.

Estrogen ablation (by oopherectomy) provides palliation in advanced breast cancer. Tamoxifen, an oral hormone, can bind to estrogen receptors on breast cancer cells and is as effective for palliation as is oopherectomy. It is a particularly effective therapy for metastatic breast cancer in the postmenopausal woman. As an adjuvant therapy in breast cancer, it prolongs the duration of disease free survival, improves cure rate in receptor positive patients by 20-30%, and reduces the risk of contralateral breast cancer by about 60%.

Though the estrogen receptor status of a patient is routinely on the medical record, there is no ICD-9-CM code that allows for its classification. The American College of Obstetricians and Gynecologists (ACOG) has requested a new code that will permit the identification of the estrogen receptor status of a patient. The status code would be used in conjunction with the code for malignant neoplasm of breast.

TABULAR MODIFICATIONS

174 Malignant neoplasm of female breast

Add Use additional code to identify estrogen receptor status (V86.0, V86.1)

175 Malignant neoplasm of male breast

Add Use additional code to identify estrogen receptor status (V86.0, V86.1)

Revise SUPPLEMENTARY CLASSIFICIATION OF FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES (V01-V86)

Add ESTROGEN RECEPTOR STATUS (V86)

New Category V86 Estrogen receptor status

Code first malignant neoplasm of breast (174.0-174.9, 175.0-175.9)

New code V86.0 Estrogen receptor positive status [ER+]

New code V86.1 Estrogen receptor negative status [ER-]

Topic: Complications and personal history of in utero surgery

With the increased use of in utero surgery to correct anomalies a fetus it is necessary to be able to track the complications associated with this surgery as well as the long term consequences. It is being proposed that a complication code for complications to the mother, a complication code for complications to the baby, as well as personal history codes for both the mother and baby be created to provide a full range of codes to track in utero procedures.

There is a question of whether the fifth-digits for the OB codes should be use for these codes, and if so, which fifth-digits?

TABULAR MODIFICATIONS

655 Known or suspected fetal abnormality affecting management of mother

Add — Excludes: management of pregnancy affected by in utero surgery (678.0-678.2)

Add — IN UTERO SURGERY (678)

New Category — 678 Management of pregnancy affected by in utero surgery

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

New code — 678.0 Maternal complications of in utero surgery

New code — 678.1 Fetal complications of in utero surgery

Excludes: newborn affected by in utero surgery (760.61)

New code — 678.2 Maternal in utero surgery status of current pregnancy

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

760.6 Surgical operation on mother

New code 760.61 Newborn affected by in utero surgery

Excludes: fetal complications of in utero surgery (678.1)

New code 760.69 Newborn affected by other surgical operation on mother

V15 Other personal history presenting hazards to health

V15.2 Surgery to other major organs

New code V15.21 Maternal personal history of in utero surgery

New code V15.22 Personal history of fetal in utero surgery

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 surgery during previous pregnancy

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

Topic: Fifth digit title changes for categories 403 and 404

With the modifications for category 585, Chronic kidney disease, that occurred with the October 1, 2005 addenda changes were made to the titles for the 5th digits for category 403, Hypertensive kidney disease, and category 404, Hypertensive heart and kidney disease. The new titles were based on the structure of the previous titles. It became evident after the new titles were finalized that they were not valid due to the changes made to category 585. Coders have been advised to use only 5th digit 1 for these categories until the new titles become effective.

The problem is that the title of 5th digit 0 is without chronic kidney disease. It is not possible to have hypertensive kidney disease or hypertensive heart and kidney disease without having chronic kidney disease. The distinction between the 5th digits for categories 403 and 404 in the past had been whether the patient had chronic renal failure. Now, based on the changes made to category 585 that specifies the stage of chronic kidney disease, the 5th digits for these categories need to distinguish between the less severe stages of chronic kidney disease, and severe kidney disease and end stage renal disease. New titles are being proposed.

TABULAR MODIFICATIONS

Revise 403 Hypertensive chronic kidney disease

Delete ~~Use additional code to identify the stage of chronic kidney disease (585.1 -585.6), if known~~

The following fifth-digit subclassification is for use with category 403:

Revise 0 ~~without chronic kidney disease~~ with chronic kidney disease stage I though stage III, or unspecified

Add Use additional code to identify the stage of chronic kidney disease (585.1-585.3)

Revise 1 with chronic kidney disease stage IV through end stage renal disease

Add Use additional code to identify the stage of chronic kidney disease (585.4-585.6)

Revise 404 Hypertensive heart and chronic kidney disease

Delete ~~Use additional code to identify the stage of chronic kidney disease (585.1 -585.6), if known~~

The following fifth-digit subclassification is for use with category 404:

Revise 0 without heart failure ~~or chronic kidney disease~~ with chronic kidney disease stage I through stage III, or unspecified

Add Use additional code to identify the stage of chronic kidney disease (585.1-585.3)

Revise 2 with chronic kidney disease stage IV through end stage renal disease

Add Use additional code to identify the stage of chronic kidney disease (585.4-585.6)

Revise 3 with heart failure and chronic kidney disease stage I through stage III, or unspecified

Add Use additional code to identify the stage of chronic kidney disease (585.1-585.3)

New fifth-digit 4 with heart failure and chronic kidney disease stage IV through end stage renal disease

Add Use additional code to identify the stage of chronic kidney disease (585.4-585.6)

585 Chronic kidney disease

Add Excludes: hypertensive chronic kidney disease (403.00-403.91, 404.00-404.94)

585.5 Chronic kidney disease, stage V

Add Excludes: chronic kidney disease, stage V on dialysis (585.6)

585.6 End stage renal disease

Add Stage V chronic kidney disease on dialysis

Topic: Inflammation of post-procedural bleb

Following ophthalmologic procedures that create a filtering bleb (an auxiliary drain on the outside of the eyeball) inflammation, usually infectious, can occur. The bleb is extremely thin-walled that bacteria can easily invade. Filtering blebs are most commonly associated with trabeculectomy for the treatment of glaucoma, but they may also be created with other ophthalmologic procedures. The occurrence of this post-procedural complication is more common now that anti-metabolites are used during the procedure.

The post-procedural bleb inflammation has stages of severity. Stage 1 is characterized by bleb purulence with or without a mild anterior segment inflammation. Stage 2 includes bleb purulence and moderate anterior segment inflammation. Stage 3 includes marked anterior chamber reaction, vitritis, and severe pain. Stage 3 may lead to bleb-related endophthalmitis and acute visual loss.

Topical antibiotics may resolve stage 1 infection. Topical drugs and oral antibiotics are needed for stage 2. Patients must be evaluated frequently. A subconjunctival antibiotic injection is generally recommended for patients who do not improve within 24 to 48 hours. Repeat injections may be needed for stage 3. After resolution of the infection, surgical revision of the bleb may be needed. Patients with avascular, thin blebs, and recurrent bleb leaks are at risk for repeat infection.

The American Academy of Ophthalmology has requested a unique code for inflammation of post-procedural bleb.

TABULAR MODIFICATIONS

360 Disorders of the globe

360.0 Purulent endophthalmitis

Add Excludes: bleb associated endophthalmitis (379.63)

360.1 Other endophthalmitis

Add Excludes: bleb associated endophthalmitis (379.63)

379 Other disorders of eye

New sub-Category
379.6 Inflammation (infection) of postprocedural bleb
Postprocedural blebitis

New code
379.61 Inflammation (infection) of postprocedural bleb, stage 1

New code
379.62 Inflammation (infection) of postprocedural bleb, stage 2

New code
379.63 Inflammation (infection) of postprocedural bleb, stage 3
Bleb associated endophthalmitis

998 Other complications of procedures, not elsewhere classified

998.5 Postoperative infection

Add
Excludes: bleb associated endophthalmitis (379.63)

Topic: Optic nerve hypoplasia

Optic nerve hypoplasia is a congenital abnormality of the optic disc which can impair vision. It manifests as a small optic nerve, which may be accompanied by a peripapillary ring (the double ring sign). Optic nerve hypoplasia can be unilateral or bilateral and impair visual function mildly or severely. Children with poor vision resulting from this condition should be treated for refractive errors. Occlusion therapy may be required in some cases, and optimizing conditions at home and at school is necessary so that impaired vision does not impede development or education.

Optic nerve hypoplasia is being more frequently diagnosed due to improvements in neuroimaging. There is no specific ICD-9-CM code that identifies this condition. The American Academy of Ophthalmology has requested a specific code for optic nerve hypoplasia.

TABULAR MODIFICATION

377 Disorders of optic nerve and visual pathways

377.2 Other disorders of optic disc

New code 377.25 Optic nerve hypoplasia

743 Congenital anomalies of eye

743.8 Other specified anomalies of eye

Add Excludes: optic disc hypoplasia (377.25)

ADDENDA

TABULAR

151 Malignant neoplasm of stomach

Add Excludes: malignant stromal tumor of stomach (171.5)

152 Malignant neoplasm of small intestine, including duodenum

Add Excludes: malignant stromal tumor of small intestine (171.5)

171 Malignant neoplasm of connective and other soft tissue

Add Includes: malignant stromal tumors

Excludes: connective tissue:

Revise internal organs <u>(except stromal tumors)</u> – code to malignant neoplasm of the site [e.g., leiomyosarcoma of stomach, 151.9]

211 Benign neoplasm of other parts of digestive system

Add Excludes: benign stromal tumors of digestive system (215.5)

215 Other benign neoplasm of connective and other soft tissue

215.5 Abdomen

Add Benign stromal tumors of abdomen

235 Neoplasm of uncertain behavior of digestive and respiratory systems

235.2 Stomach, intestines, and rectum

Add Excludes: stromal tumors of uncertain behavior of digestive system (238.1)

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

238.1 Connective and other soft tissue

Add Stromal tumors of digestive system

255 Disorders of adrenal glands

255.1 Hyperaldosteronism

Revise 255.10 ~~Primary aldosteronism~~ Hyperaldosteronism, unspecified

Delete ~~Hyperaldosteronism, unspecified~~

Add Primary aldosteronism, unspecified

285 Other and unspecified anemias

Revise 285.2 Anemia ~~in~~ of chronic ~~illness~~ disease

Add Anemia in chronic illness

Revise 285.29 Anemia of other chronic ~~illness~~ disease

Add Anemia in other chronic illness

288 Diseases of white blood cells

288.0 Agranulocytosis

Add Use additional code for any associated fever (780.6)

Add ORGANIC SLEEP DISORDERS (327)

333 Other extrapyramidal disease and abnormal movement disorders

333.9 Other and unspecified extrapyramidal and abnormal movement disorders

333.92 Neuroleptic malignant syndrome

Add Excludes: neuroleptic induced parkinsonism (332.1)

348 Other conditions of brain

348.3 Encephalopathy

348.31 Metabolic encephalopathy

Add Excludes: toxic metabolic encephalopathy (349.82)

349 Other and unspecified disorders of the nervous system

349.8 Other specified disorders of nervous system

349.82 Toxic encephalopathy
Add Toxic metabolic encephalopathy

357 Inflammatory and toxic neuropathy

357.4 Polyneuropathy in other diseases classified elsewhere

Code first underlying disease, as:
Add chronic uremia (585.9)
Revise uremia NOS (586)

420 Acute pericarditis

420.0 Acute pericarditis in diseases classified elsewhere

Code first underlying disease, as:
Add chronic uremia (585.9)
Revise uremia NOS (586)

496 Chronic airway obstruction, not elsewhere classified

Excludes: chronic obstructive lung disease [COPD] specified (as) (with):
Add decompensated (491.21)

514 Pulmonary congestion and hypostasis

Add Excludes: hypostatic pneumonia due to or specified as a specific type of pneumonia – code to the type of pneumonia (480.0-480.9, 481, 482.0-482.49, 483.0-483.8, 485, 486, 487.0)

520 Disorders of tooth development and eruption

520.6 Disturbances in tooth eruption
Teeth:
Add prenatal

536 Disorders of function of stomach

536.3 Gastroparesis
Add Tachygastria

567 Peritonitis and retroperitoneal infections

567.2 Other suppurative peritonitis

567.23 Spontaneous bacterial peritonitis

Add Excludes: bacterial peritonitis NOS (567.29)

NEPHRITIS, NEPHROTIC SYNDROME, AND NEPHROSIS (580-589)

Revise Excludes: hypertensive ~~renal~~ chronic kidney disease (403.00-403.91, 404.00-404.94)

642 Hypertension complicating pregnancy, childbirth, and the puerperium

642.2 Other pre-existing hypertension complicating pregnancy, childbirth, and the puerperium
Hypertensive:

Revise heart and ~~renal~~ chronic kidney disease specified as complicating, or as a reason for obstetric care during pregnancy, childbirth, or the puerperium

Revise ~~renal~~ chronic kidney disease specified as complicating, or as a reason for obstetric care during pregnancy, childbirth, or the puerperium

666 Postpartum hemorrhage

666.1 Other immediate postpartum hemorrhage

Revise Atony of uterus with hemorrhage

Add Excludes: atony of uterus without hemorrhage (669.8)

780 General symptoms

780.6 Fever

Add Code first underlying condition when associated fever is present, such as with:
leukemia (codes from categories 204, 205, 206, 207, 208)
neutropenia 288.0
sickle cell disease (282.60-282.69)

780.9 Other general symptoms

Revise 780.95 ~~Other e~~Excessive crying of child, adolescent, or adult

793 Nonspecific abnormal findings on radiological and other examination of body structures

793.8 Breast

793.81 Mammographic microcalcification

Add Mammographic calcification of breast

Add Mammographic calculus of breast

799 Other ill-defined and unknown causes of morbidity and mortality

799.4 Cachexia

Add Code first associated condition, if known

Delete ~~Excludes: nutritional marasmus (261)~~

V07 Need for isolation and other prophylactic measures

V07.39 Other prophylactic chemotherapy

Revise Excludes: maintenance chemotherapy following disease (V58.11)

V54 Other orthopedic aftercare

V54.1 Aftercare for healing traumatic fracture

Add Excludes: aftercare for amputation stump (V54.89)

PERSONS WITHOUT REPORTED DIAGNOSIS ENCOUNTERED DURING EXAMINATION AND INVESTIGATION OF INDIVIDUALS AND POPULATIONS

Revise (V70-V82)

Add GENETICS (V83-V84)

Add BODY MASS INDEX (V85)

ADDENDA

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retroperitoneal 567.38
Add postprocedural 998.59

Admission (encounter)
for
blood typing V72.86
Add Rh typing V72.86
Add Rh typing V72.86

Aftercare V58.9
Add amputation stump V54.89
Add stump, amputation V54.89

Aneurysm
Mycotic, any site 421.0
Add without endocarditis – see Aneurysm, by site

Anteversion
Revise cervix ~~(see also~~ – see, Anteversion, uterus~~) 621.6~~

Atonia, atony, atonic
uterus 666.1
Add with hemorrhage 666.1
Add without hemorrhage 669.8

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Add wound – see Wound, open, by site, complicated

Cachexia
Revise cancerous ~~(M8000/3) 199.1~~ 799.4 (see also Neoplasm, by site, malignant)
Revise due to malnutrition 799.4
Revise malignant ~~(M8000/3) 199.1~~ 799.4 (see also Neoplasm, by site, malignant)

Calcification
Add breast 793.81

Add Calciphylaxis (see also Calcification, by site) 275.49

Calculus
Add breast 793.81

Cellulitis
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Revise male ~~(see also Abscess, peritoneum)~~ 567.21

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Add due to total parenteral nutrition (TPN) 573.8

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Add atrial appendage 429.89
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Add without myocardial infarction 429.89

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Revise prosthetic joint ~~(see also Complications, mechanical, device, orthopedic, prosthetic joint)~~ 996.47

Add Crying
Add constant, continuous
Add adolescent 780.95
Add adult 780.95
Add baby 780.92
Add child 780.95
Add infant 780.92
Add newborn 780.92

Crying
Add excessive
Add adolescent 780.95
Add adult 780.95
Add baby 780.92
Add child 780.95 (Note: this has been corrected from the original)
Add infant 780.92
Add newborn 780.92

Disease
hyaline (diffuse) (generalized) 728.9
membrane (lung) (newborn) 769
Add mild 770.6
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Add decompensated 491.21
Add with exacerbation 491.21
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Add decompensated 491.21
Add with exacerbation 491.21

Displacement
Revise cervix ~~(see also Malposition,~~ - see Displacement, uterus~~) 621.6~~

Encephalitis…
Add Rasmussen 323.8

Encephalopathy
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Add Endotoxemia – code to condition

Revise Fibromatosis 728.79
Add congenital generalized (CGF) 759.89

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Revise cervix ~~(see also Malposition,~~ - see Flexion, uterus~~) 621.6~~

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Add erythematous 535.5

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viral…
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Add in remission 070.54

Add Hypoaldosteronism 255.4

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Revise with sleep apnea, unspecified 780.51

Insufficiency
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Malfunction
colostomy 569.62
Add valve 569.62
Add ileostomy
Add valve 569.62
Add valve
Add colostomy 569.62
Add ileostomy 569.62

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Revise uterus ~~or cervix~~ (acquired) (acute) (adherent)…621.6

Add Myofibromatosis
Add infantile 759.89

		1 malignant	4 benign	5 uncertain
	Neoplasm, neoplastic			
	gastrointestinal			
Add	stromal	171.5	215.5	238.1
	intestine			
Add	stromal	171.5	215.5	238.1
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Add	stromal	171.5	215.5	238.1

Revise Pannus (corneal) 370.62
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Add appendicitis 648.9

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Revise Retroperitonitis ~~(see also Peritonitis)~~ 567.39

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Add thyroid hormone 246.8

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Revise cervix ~~(see also Retroversion,~~ - see Retraction, uterus~~)~~ ~~621.6~~
Revise uterus ~~(see also Retroversion, uterus)~~ 621.6

Retroversion
Revise cervix ~~(see also~~ – see , Retroversion, uterus~~)~~ ~~621.6~~

Add STEMI 410.9 (see also – Infarct, myocardium, ST elevation)

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Revise — aspiration, of newborn (massive) ~~or (meconium)~~ 770.18
Add — Borjeson-Forssman-Lehmann 759.89
Add — fish odor 270.8
Add — posterior reversible encephalopathy (PRES) 348.39
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Add — type II 770.6
Add — retroviral seroconversion (acute) V08
Add — seroconversion, retroviral (acute) V08

Add — Tachygastria 536.3

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Add — natal 520.6
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Add — Rh typing V72.86

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Add — hormone resistance 246.8

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Add — aorta – see Aneursym

Add Vasospasm 443.9
Add coronary 413.1

Version
Revise cervix ~~(see also Malposition,~~ - see Version, uterus~~)~~ ~~621.6~~

Revise VIN I (vulvar intraepithelial neoplasia I) 624.0

Revise VIN II (vulvar intraepithelial neoplasia I) 624.0