THE ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE MEETING
October 7-8, 2004

DIAGNOSIS AGENDA

Welcome and announcements
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Co-Chair, ICD-9-CM Coordination and Maintenance Committee

ICD-9-CM TIMELINE

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

October 1, 2004	New ICD-9-CM codes are implemented.
October 7-8, 2004	ICD-9-CM Coordination and Maintenance Committee Meeting.
October 2004	Summary report of the Procedure part of the October 7-8, 2004 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 October 7-8, 2004 ICD-9-CM Coordination and Maintenance Committee meeting report posted on NCHS website at- http://www.cdc.gov/nchs/icd9.htm
October 15, 2004	CMS will implement a new online registration process for future ICD-9-CM Coordination and Maintenance Committee (C&M) meetings. Information on future C&M meetings will be posted on the CMS events webpage at: http://www.cms.hhs.gov/events/ A link will be established from the ICD-9-CM web page at: http://www.cms.hhs.gov/paymentsystems/icd9
Early Nov. 2005	Any new ICD-9-CM codes required to capture new technology that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented on April 1, 2005 will be posted on the following websites. http://www.cms.hhs.gov/paymentsystems/icd9 http://www.cdc.gov/nchs/icd9.htm http://www.cms.hhs.gov/medlearn/icd9code.asp
January 3, 2005	On-line registration opens for the March 31-April 1, 2005 ICD-9-CM Coordination and Maintenance Committee meeting at: http://www.cms.hhs.gov/events/
January 12, 2005	Deadline for receipt of public comments on proposed code revisions discussed at the April 1-2, 2004 and October 7-8, 2004 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2005.
January 31, 2005	Deadline for requestors: Those members of the public requesting that topics be discussed at the March 31 –April 1, 2005 ICD-9-CM Coordination and Maintenance Committee meeting must have had

	their requests to CMS for procedures and NCHS for diagnoses by this date.
February 2005	Draft agenda for the Procedure part of the March 31, 2005 ICD-9-CM Coordination and Maintenance Committee meeting posted on CMS homepage as follows: http://www.cms.hhs.gov/paymentsystems/icd9
	Draft agenda for the Diagnosis part of the April 1, 2005 ICD-9-CM Coordination and Maintenance Committee meeting posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
	Federal Register notice of March 31 - April 1, 2005 ICD-9-CM Coordination and Maintenance Committee Meeting will be published.
March 25, 2005	Because of increased security requirements, **those wishing to attend the March 31 - April 1, 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 March 25, 2004; failure to do so may result in lack of access to the meeting.**
March 31-April 1 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 March 25, 2005. You must bring an official form of picture identification (such as a drivers license) in order to be admitted to the building
April 1, 2005	Any new ICD-9-CM codes required to capture new technology will be implemented. Information on any new codes implemented on April 1, 2005 previously posted in early November 2004 on the following websites: http://www.cms.hhs.gov/paymentsystems/icd9 http://www.cdc.gov/nchs/icd9.htm http://www.cms.hhs.gov/medlearn/icd9code.asp
April 2005	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 2005	Summary report of the Procedure part of the March 31, 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 April 1, 2005 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
June 2005	Final addendum posted 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 29, 2005	Those members of the public requesting that topics be discussed at the September 29 – 30, 2005 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses.
August 1, 2005	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, 2005. This rule can be accessed at: http://www.cms.hhs.gov/providers/hipps/frnotices.asp
August 2005	Tentative agenda for the Procedure part of the September 29 – 30, 2005 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 29 – 30, 2005 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 29 – 30, 2005 ICD-9-CM Coordination and Maintenance Committee Meeting will be published. This will include the tentative agenda.

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**.
September 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 drivers license) in order to be admitted to the building.
October 2005	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, 2005 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
October 1, 2005	New and revised ICD-9-CM codes go into effect along with DRG changes. Final addendum posted web pages as follows: Diagnosis addendum - http://www.cdc.gov/nchs/icd9.htm Procedure addendum at - http://www.cms.hhs.gov/paymentsystems/icd9

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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: Mechanical complication of joint prosthesis

ICD-9-CM diagnosis codes do not allow differentiation as to the specific cause of failed hip or knee replacements. Currently, the following codes are used to track the majority of failed hip and knee replacements: 996.4, Mechanical complication of an internal orthopedic device, implant, or graft, 996.66, Infection and inflammatory reaction due to internal joint prosthesis, or 996.77, Other complications of internal (biological) (synthetic) prosthetic device, implant and graft, joint prosthesis, due to internal joint prosthesis. These codes, particularly 996.4, capture a wide variety of diagnoses and causes of failed total joint replacements that have important and clinically relevant differences.

Total joint replacement (TJR) is one of the most commonly performed and successful operations in orthopedic surgery. In 2002, over 300,000 hip replacement and 350,000 knee replacement procedures were performed in the United States. As the population of the United States (U.S.) ages and advances in technology lead to expansion of the indications for TJR to include younger, more active patients, the prevalence of TJR is expected to continue to increase dramatically over the next several decades.

TJR operations have been shown to be highly cost-effective procedures, resulting in dramatic improvements in quality of life for patients who suffer from disabling arthritic conditions involving the hip or knee. Success rates of greater than 90% in terms of implant survivorship, reduction in pain, and improvement in function have been reported at 10 to 15 year follow-up. In most cases, hip or knee replacement surgery leads to dramatic improvements in health related quality of life by reducing pain and improving function for patients with arthritis.

The vast majority of hip and knee replacements last for up to 15 to 20 years or more, making total joint replacement surgery one of the most successful and cost-effective interventions in all of health care. However, after an extended period of *in vivo* use, hip and knee replacements can fail, necessitating revision surgery. Common reasons for revision joint replacement surgery include mechanical loosening of the prosthesis (also referred to as “aseptic loosening”); wear of the bearing surface, particularly common with polyethylene, causing (at times extensive) resorption of the bone around the prosthesis; infection; dislocation of the prosthetic joint; fracture of the bone around the implant (also referred to as “peri-prosthetic fracture”); implant fracture; technical error; and pain.

The American Joint Registry Project (AJRR) is an NIH-sponsored project that is intended to capture relevant information related to total joint replacement procedures that are performed in the U.S., including factors related to the patient, the surgeon, the hospital, the implants used, and the procedure. This information could be extremely valuable in evaluating the quality, clinical outcomes, and cost-effectiveness of TJR.

It is being proposed to create the following 5th digit expansion of code 996.4. Add a use additional code note, to use an appropriate code from subcategory V43.6, Organ or tissue replaced by other means, joint, to indicate which joint prosthesis has the complication. These proposed new codes would allow more detail in coding mechanical complications associated with these joint prostheses. Infections associated with a prosthetic joint would continue to be coded to 996.66, Infection and inflammatory reaction due to internal joint prosthesis.

TABULAR MODIFICATION

996 Complications peculiar to certain specified procedures

996.4 Mechanical complication of internal orthopedic device, implant, and graft

Add Use additional code to identify joint replaced by prosthesis (V43.60-V43.69)

New Code 996.40 Unspecified mechanical complication of internal orthopedic device, implant, and graft

New Code 996.41 Mechanical loosening of prosthetic joint
Aseptic loosening

New Code 996.42 Instability of prosthetic joint
Dislocation of prosthetic joint
Subluxation of prosthetic joint

New Code 996.43 Fracture of prosthetic joint
Breakage of prosthetic joint
Prosthetic joint implant failure

New Code 996.44 Peri-prosthetic fracture around prosthetic joint

New Code 996.45 Articular bearing surface wear of prosthetic joint

New Code 996.46 Other mechanical complication of prosthetic joint implant
Mechanical complication of prosthetic joint NOS

New Code 996.49 Other mechanical complication of other internal orthopedic device, implant, and graft

Excludes: mechanical complication of prosthetic joint implant (996.41-996.46)

Topic: Diabetic retinopathy, diabetic macular edema, and diabetic peripheral neuropathy

Diabetic retinopathy is a complication of diabetes that is caused by changes in the blood vessels of the eye. When the blood vessels in the retina are damaged, they may leak fluid or blood, and grow fragile, brush-like branches and scar tissue. This can blur or distort the images that the retina sends to the brain. Diabetic retinopathy is considered the leading cause of legal blindness among working-age Americans.

Diabetic retinopathy in its earliest stages is called nonproliferative diabetic retinopathy (NPDR) and is characterized by retinal vascular abnormalities including microaneurysms, intraretinal hemorrhages, and cotton-wool spots. As diabetic retinopathy progresses, there is a gradual closure of retinal vessels, which results in impaired perfusion and retinal ischemia. Signs of increasing ischemia include venous abnormalities and more severe vascular leakage. When these signs progress past certain defined levels, moderate or severe non-proliferative diabetic retinopathy is diagnosed. Progression of NPDR to the visually threatening level of Proliferative Diabetic Retinopathy is closely correlated with NPDR level. The more advanced stage, proliferative diabetic retinopathy (PDR), is characterized by the onset of neovascularization on the inner surface of the retina induced by retinal ischemia. New codes have been requested to identify the stages of NPDR.

Diabetic macular edema (DME) is swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula and cannot occur in the absence of diabetic retinopathy. The macula is the central portion of the retina, a small area rich in cones, the specialized nerve endings that detect color and upon which daytime vision depends. As macular edema develops, blurring occurs in the middle or just to the side of the central visual field. Visual loss from diabetic macular edema can progress over a period of months and make it impossible to focus clearly. A new code has been requested for diabetic macular edema.

Diabetic peripheral neuropathy is a serious and progressive complication of diabetes associated with significant morbidity, loss of quality of life, and increases in costs. Variations in diagnosis criteria and poor patient selection have resulted in the epidemiology and natural history of diabetic neuropathy remaining poorly defined.

There are not specific ICD-9-CM codes to categorize the different stages of diabetic peripheral neuropathy; a single code (357.2) is currently used to represent the entire spectrum of non-autonomic diabetic peripheral neuropathy. New codes have been requested to categorize the different stages of diabetic peripheral neuropathy.

Unique ICD-9-CM codes are needed to clearly identify the staging and severity of diabetic retinopathy, diabetic macular edema and diabetic peripheral neuropathy, for clinical management and epidemiological studies. There is a need within the medical community to differentiate the staging and severity of diabetic peripheral neuropathy and better understand the longitudinal progression of the disease state. Unique ICD-9-CM codes will facilitate reporting and data collection for these complications within the

diabetes patient population. The lack of unique codes results in the loss of valuable information on epidemiology, morbidity, utilization of services, and costs associated with different diabetes patient sub-groups.

TABULAR MODIFICATIONS

250 Diabetes mellitus

250.5 Diabetes with ophthalmic manifestations

Use additional code to identify manifestations, as:
Add diabetic macular edema (362.06)
Revise diabetic retinal edema (362.06)
Revise diabetic retinopathy (362.01-362.06)

250.6 Diabetes with neurological manifestations

Use additional code to identify manifestations, as:
Revise diabetic polyneuropathy (357.20-357.23)

357 Inflammatory and toxic neuropathy

357.2 Polyneuropathy in diabetes

New code 357.20 Unspecified polyneuropathy in diabetes
New code 357.21 Asymptomatic neuropathy in diabetes
New code 357.22 Symptomatic neuropathy in diabetes
New code 357.23 Disabling neuropathy in diabetes

362 Other retinal disorders

362.0 Diabetic retinopathy

362.01 Background diabetic retinopathy
Delete ~~Diabetic macular edema~~
Delete ~~Diabetic retinal edema~~
New code 362.03 Mild nonproliferative diabetic retinopathy
New code 362.04 Moderate nonproliferative diabetic retinopathy
New code 362.05 Severe nonproliferative diabetic retinopathy
New code 362.06 Diabetic macular edema
Diabetic retinal edema

Add Code first underlying diabetic retinopathy (362.01-362.06)

Topic: Acute Coronary Syndrome

A modification to category 410, Acute myocardial infarction, is being requested by Sieck HealthCare Consulting, to allow for the classification of ST-segment elevation myocardial infarction (STEMI) and non-ST-segment elevation myocardial infarction (NSTEMI). In the field of cardiology, large-scale clinical trials and registries have provided a wealth of data on hundreds of thousands of patients. This is especially true for the study of Acute coronary syndrome (ACS), which ranges from STEMI to NSTEMI to unstable angina (UA). These data have been used to define new therapies and to guide clinical care through evaluation of both the process and the quality of care for patients.

The area of research in ACS has seen a transformation of the classification of these syndromes over the past 5-7 years. The American College of Cardiology (ACC) and the American Heart Association (AHA) guidelines, which are the national standard, and all medical literature, classify patients with ACS into 3 groups: ST elevation MI (STEMI), Non-ST-elevation MI (NSTEMI), and unstable angina. The STEMI patients are managed quite differently, and now have a dedicated and separate ACC/AHA guideline. Within the UA/NSTEMI group, there are further treatment differences, with more aggressive medical and interventional treatment for those with NSTEMI than for those with UA.

In addition to being better able to classify the different groups of ACS patients, the request to update the ICD-9-CM is being made to improve the monitoring of performance measures, as JCAHO has begun. Since the ICD-9-CM does not have a unique code for NSTEMI, there have been problems for hospitals, where JCAHO gives a hospital a poor score for time to angioplasty because the hospital data groups STEMI and NSTEMI patients together.

The project team that submitted this proposal consists of a multi-disciplinary team of individuals who are esteemed members of the medical community. Opinions solicited from cardiologist, ED physicians and consultants have been assimilated to develop a detailed and comprehensive approach to this code revision request. The project team is headed by Sandra Sieck of Sieck HealthCare Consulting

The modification proposal provides codes that distinguish between STEMI and NSTEMI patients, while adhering to the structure of the ICD-9-CM. This modification should not disrupt data trends, but enhance them.

TABULAR MODIFICATION

Revise 410 ST-elevation (STEMI) and non-ST-elevation (NSTEMI) ~~acute~~ m~~M~~yocardial infarction

Revise 410.0 ST-elevation myocardial infarction of anterolateral wall

Revise 410.1 ST-elevation myocardial infarction of other anterior wall

Revise 410.2 ST-elevation myocardial infarction of inferolateral wall

Revise 410.3 ST-elevation myocardial infarction of inferoposterior wall

Revise 410.4 ST-elevation myocardial infarction of other inferior wall

Revise 410.5 ST-elevation myocardial infarction of other lateral wall

Revise 410.6 ST-elevation true posterior wall myocardial infarction

Revise 410.7 Non-ST-elevation myocardial infarction ~~subendocardial infarction~~
Subendocardial infarction

Revise 410.8 ST-elevation myocardial infarction of other specified sites

Revise 410.9 Myocardial infarction, ~~U~~unspecified ~~site~~

Topic: Chronic kidney disease

NCHS received a comment from W. Kline Bolton, M.D., FACP, of the University of Virginia Health Services Foundation, on the proposed codes for chronic renal failure/end-stage renal disease, presented at the April 2004 C&M meeting. Dr. Bolton suggested that the ICD-9-CM incorporate the clinical practice guidelines for chronic kidney disease published by the National Kidney Foundation. These guidelines have been accepted by the National Institutes of Health (NIH) and are a major focus of the HHS Health People 2010.

Proper terminology to be used is chronic kidney disease (CKD), rather than imprecise terms such as chronic renal failure and chronic renal insufficiency. CKD has 5 stages, based on the glomerular filtration rate (GFR). The degree of time, effort and work that is involved in taking care of these various stages increases progressively. Care of stage 4 and 5 patients is intensive and complicated. The goal is to slow the progression of CKD, or possibly prevent it, or better prepare patients for renal replacement therapy. The determination of GFR is based on well established formulas. Primary care providers as well as nephrologists can determine the stage of CKD based on these formulas. The NIH has established the National Kidney Disease Education program (NKDEP) and has a website dedicated to it at http://www.nkdep.nih.gov.

Only patients on dialysis, or receiving kidney transplants may be considered as having end-stage renal disease. This terminology is mandated by Congress.

Another group of patients are classified in the clinical practice guidelines, those at risk for CKD. These are patients with contributing conditions, such as diabetes or hypertension, those having a single kidney, or those with a family history of kidney disease.

Based on the clinical practice guidelines for the evaluation and treatment of CKD, it is being proposed that code 585, Chronic renal failure, be modified to conform to this new standard.

Clinical practice guidelines for acute renal failure are being developed, but are not yet finalized.

TABULAR MODIFICATIONS

250 Diabetes mellitus

250.4 Diabetes with renal manifestations

Use additional code to identify manifestation, as:

Add chronic kidney disease (585.1-585.9)

403 Hypertensive renal disease

Use additional code to identify the stage of chronic kidney disease (585.1-585.9)

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

Revise 0 ~~without mention of renal failure~~ without chronic kidney disease

Revise 1 ~~with renal failure~~ with chronic kidney disease

404 Hypertensive heart and renal disease

Use additional code to identify the stage of chronic kidney disease (585.1-585.9)

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

Revise 0 ~~without mention of heart failure or renal failure~~ without heart failure or chronic kidney disease

Revise 2 ~~with renal failure~~ with chronic kidney disease

Revise 3 with heart failure and ~~renal failure~~ chronic kidney disease

Revise 585 ~~Chronic renal failure~~ Chronic kidney disease (CKD)

Add Note: These codes apply only to patients diagnosed with kidney disease for longer than 3 months.

Use additional code to identify kidney transplant status (V42.0)

New code 585.1 Stage I chronic kidney disease
Kidney damage with normal or increased glomerular filtration rate (GFR), greater than or equal to 90 ml/min/1.73m^2

New code 585.2 Stage II chronic kidney disease
Kidney damage with mild decrease in glomerular filtration rate (GFR), 60-89 ml/min/1.73m^2

New code 585.3 Stage III chronic kidney disease

		Kidney damage with moderate decrease in glomerular filtration rate (GFR), 30-59 ml/min/1.73m^2
New code	585.4	Stage IV chronic kidney disease
		Kidney damage with severe decrease in glomerular filtration rate (GFR), 15-29 ml/min/1.73m^2
New code	585.5	Stage V chronic kidney disease
		Kidney damage with glomerular filtration rate (GFR) of less than 15 ml/min/1.73m^2
		Kidney failure with GFR less than 15 ml/min/1.73m^2 not on dialysis
New code	585.6	End stage renal disease
		Stage V chronic kidney disease with patient on dialysis
New code	585.9	Chronic kidney disease, unspecified
		Chronic renal insufficiency
		Chronic renal failure NOS

Topic: History of fall

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Injury Prevention and Control at CDC are requesting a new code to show history of a fall.

Falls are an important public health problem affecting about one third of adults 65 and older each year. Approximately 20-30% of those who fall will suffer moderate to severe injuries, including hip fractures and head trauma. Fall-related injuries can reduce mobility and independence and often are serious enough to result in hospitalization and increased risk of premature death In 2001, over 1.6 million older adults were treated in emergency rooms for fall-related injuries, and 373,000 were hospitalized. Adults aged 75 and older who fall are more likely to be admitted to a long-term care facility for a year or longer. In this same population over 60% of deaths are from falls.

Falls causing serious injury are preventable. Multi-factorial falls risk evaluation can predict who will fall. People who report they have fallen in the past year, or have a history of falls are much more likely to fall resulting in serious injury. Other factors also affect the risk of falling, such as unsteady gait, dizziness, or use of certain medications. However, knowing about a history of falling helps to identify some people not having these other conditions. Once patients with a history of falls or other risk factors are identified, interventions are effective in lowering the incidence of falls causing serious injury.

Currently there is no ICD-9-CM diagnosis code that conveys a history of falling. Introduction of such a code can be used to identify patients at risk, conduct epidemiological research, measure quality of care, and help justify a provider's decision to order preventive evaluation or services. The data on interventions is clearer for the elderly when a timeframe of the past 6-12 months is used. However, this code could also be used to identify associations between a history of falls and injuries in other age groups as well using different timeframes. External Cause of Injury codes (E codes) do not provide the same information since they are captured at the time of an acute injury. Many of the falls that elderly patients report, when asked, did not result in injury or a health care encounter.

The following new code is being proposed:

TABULAR MODIFICATION

V15 Other personal history presenting hazards to health

V15.8 Other specified personal history presenting hazards to health

New code V15.88 History of fall

Topic: Bed confinement status

The American Hospital Association (AHA) and the American Ambulance Association (AAA) are requesting a new code for bed confinement status.

Though the initial impetus for the request focused on claims, this code also may be useful in other settings such as long term care facilities, home health agencies and skilled nursing facilities to report the additional complexity involved with patients who are bed-confined.

The AHA and AAA have been working with the Centers for Medicare & Medicaid Services (CMS) as part of the negotiated rulemaking process for the ambulance fee schedule. One of the assumptions underlying the development of the Medicare ambulance fee schedule was that ambulance services were to be reimbursed based on the condition of the patient. With that in mind, the Negotiated Rulemaking Committee that advised CMS on the rule developed a comprehensive list of conditions and the corresponding service levels required to transport a patient in that condition.

This code would be used to describe patients who are bed-confined at the time of ambulance transport. These patients could also be described as "unable to get up without assistance," or "unable to sit in a chair or wheelchair." A unique ICD-9-CM describing this condition would allow ambulance providers and suppliers and others to provide information that supports the need for medical transport to a medically necessary test/treatment or long term care facility or as a means to more accurately describe the patient. Existing diagnosis codes, while specifying an illness or condition, do not adequately describe that the patient is unable to ambulate without assistance.

TABULAR MODIFICATION

V49 Other conditions influencing health status

V49.8 Other specified conditions influencing health status

New code V49.84Bed confinement status

Topic: Androgen insensitivity syndrome

Androgen insensitivity syndrome is the current preferred term for testicular feminization, also called Goldberg-Maxwell syndrome. Affected individuals generally develop as normal females through childhood, and to adult appearance. However, they actually have an XY chromosome genotype. Though a patient may have a vagina, she does not develop a uterus and she does not have menarche. This can be the first sign of this disorder. The patient does have undescended testicles, and is at risk for testicular cancer, so the testes must be surgically removed.

It is being proposed, at the request of the Androgen Insensitivity Syndrome Support Group, that a new code be created within category 259, Other endocrine disorders, for androgen insensitivity syndrome. This is consistent with the classification of this disorder in the ICD-10.

TABULAR MODIFICATION

257 Other testicular dysfunction

257.8 Other testicular dysfunction

Delete ~~Goldberg-Maxwell syndrome~~
~~Male pseudohermaphroditism with testicular feminization~~
~~Testicular feminization~~

Add Excludes: androgen insensitivity syndrome (259.5)

259 Other endocrine disorders

New code 259.5 Androgen insensitivity syndrome

Add Excludes: partial androgen insensitivity (Reifenstein syndrome) (257.2)

Topic: Volume depletion, dehydration, hypovolemia

Volume depletion may refer to depletion of total body water (dehydration), or depletion of the blood volume (hypovolemia). Blood volume may be maintained despite dehydration, with fluid being pulled from other tissues. Conversely, hypovolemia may occur without dehydration, when "third-spacing" of fluids occurs (e.g., with significant edema or ascites). Treatment of these conditions is different. Hypovolemia should be differentiated from dehydration.

The American Academy of Pediatrics has requested expansion of the code 276.5, Volume depletion, to create specific codes for dehydration and hypovolemia. This change corresponds to the code in the ICD-10-CM.

TABULAR MODIFICATION

276 Disorders of fluid, electrolytes, and acid-base balance

276.5 Volume depletion

Delete ~~Dehydration~~
~~Depletion of volume of plasma or extracellular fluid~~
~~Hypovolemia~~

New code 276.50 Volume depletion, unspecified

New code 276.51 Dehydration

New code 276.52 Hypovolemia
Depletion of volume of plasma

Topic: Asphyxia and hypoxemia

Asphyxia originally meant stopping of the pulse, but the term has come to be associated with hypoxia and hypercapnia. Hypoxia refers to a deficiency of oxygen reaching the tissues of the body, usually due to low inspired oxygen. Hypoxemia means deficient oxygenation of the blood. Hypercapnia refers to elevated levels of carbon dioxide in the arterial blood. Low oxygen levels can be present without asphyxiation. To differentiate these, the American Academy of Pediatrics has requested creation of new codes at 799.0 for asphyxia and hypoxemia.

Hypercapnia is indexed to code 786.09, Other dyspnea and respiratory abnormalities, so it will be excluded from subcategory 799.0.

TABULAR MODIFICATION

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

Revise 799.0 Asphyxia and hypoxemia

Add Excludes: hypercapnia (786.09)

New code 799.01 Asphyxia

New code 799.02 Hypoxemia

Topic: Teratogens

A number of substances are known to have effects on the development of the fetus, when the mother is exposed to the substance during pregnancy. Some of these teratogens have been known for many years, but others have become known since the original creation of the ICD-9-CM. The American College of Medical Genetics has requested new codes to enable tracking related to certain teratogens.

A number of anticonvulsants have teratogenic effects. In some cases, these may still be continued during pregnancy, since seizures also have significant potential for causing damage to the fetus. Some pharmaceuticals can be considered antimetabolic agents, and have teratogenic effects. These include retinoic acid, methotrexate, and the statins (cholesterol lowering drugs that are competitive inhibitors of HMG-CoA reductase). Other pharmaceutical agents also have known teratogenic effects. Some of these may be indexed or added as inclusion terms under code 760.79, Other noxious influences affecting fetus or newborn via placenta or breast milk.

TABULAR MODIFICATION

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

760.7 Noxious influences affecting fetus or newborn via placenta or breast milk

760.74 Anti-infectives

Add
Antifungals

New code

760.77 Anticonvulsants
Carbamazepine
Phenobarbital

New code

760.78 Antimetabolic agents
Methotrexate
Retinoic acid
Statins

INDEX MODIFICATIONS

Noxious
substances transmitted through placenta or breast milk …

Add	acetretin 760.78
Add	aminopterin 760.78
Add	antiandrogens 760.79
Add	carbamazepine 760.77
Add	depakote 760.77
Add	dilantin 760.77
Add	endocrine disrupting chemicals 760.79
Add	estrogens 760.79
Add	etretinate 760.78
Add	fluconazole 760.74
Add	hormones 760.79
Add	lithium 760.79
Add	methotrexate 760.78
Add	misoprostil 760.79
Add	phenobarbital 760.77
Add	progestins 760.79
Add	retinoic acid 760.78
Add	solvents 760.79
Add	statins 760.78
Add	tetracycline 760.74
Add	thalidomide 760.79
Add	trimethadione 760.77
Add	vitamin A 760.78

Topic: Long Q-T syndrome

The long Q-T syndrome may be suspected in individuals with a prolonged Q-T interval on electrocardiogram. It is associated with recurrent syncope and sudden death. One form also involves congenital bilateral neural deafness (*correction*: Jervell-Lange-Nielsen syndrome). Another more common form does not involve deafness (Romano-Ward syndrome). A number of specified genetic defects have been identified as causes of the long Q-T syndrome, most of which involve genes for ion channels, that control repolarization of the heart.

Treatment of long Q-T syndrome can involve monitoring, and potentially replacement of an implantable cardioverter-defibrillator. A number of cases occur with susceptibility to syncope and sudden death, without the Q-T interval actually being prolonged on electrocardiogram. Thus, genetic testing of family members for disease is generally indicated.

The long Q-T syndrome is usually diagnosed in childhood. It has been more commonly found in Asians, but may be present in people of any genetic background. This request for a new code was submitted by the American Academy of Pediatrics.

TABULAR MODIFICATION

426 Conduction disorders

426.8 Other specified conduction disorders

New code 426.82 Long Q-T syndrome

INDEX MODIFICATION

Revise Romano-Ward syndrome (prolonged Q-T interval) ~~794.31~~ 426.82

Syndrome
Add Jervell-Lange-Nielsen 426.82
Revise Q-T interval prolongation ~~794.31~~ 426.82
Revise Romano-Ward (prolonged Q-T interval) ~~794.31~~ 426.82

Topic : Secondary diabetes mellitus

This topic is being represented. It was originally presented at the April 2004 C&M meeting.

Diabetes mellitus may occur due to certain other specified disorders. One example of this is cystic fibrosis. The American Academy of Pediatrics has requested a new code, to enable better tracking of these cases of secondary diabetes mellitus. Secondary diabetes mellitus should not be coded to category 250. In cases of secondary diabetes mellitus, the underlying disorder should be coded first.

TABULAR MODIFICATION

251 Other disorders of pancreatic internal secretion

New code 251.6 Secondary diabetes mellitus

Code first underlying disorder

Topic: Mechanical complication of ventilator

Effective October 1, 2004 a new code, V46.12 Encounter for respirator dependence during power failure, was implemented. However, there is no code which describes encounters or admissions due to general mechanical equipment failure. Because the failure of a mechanical ventilation system may result in death, and is classified as a life-critical system, precautions must be taken to ensure that they are highly reliable. Mechanical ventilators are carefully designed so that no single point of failure can endanger the patient. They usually have manual backup mechanisms to enable hand-driven respiration and some systems are equipped with methods to operate or call for help if their mechanisms or software fails. There are times when a ventilator dependent person must be go to a facility and be connected to another ventilator until their ventilator is fixed or replaced.

Unlike admissions/encounters due to power failure those due to mechanical failure of the ventilator are a complication of the device and should therefore have a code assignment in the complications category. It is being proposed to create a 5th digit expansion to code 997.3, Respiratory complications, for these encounters.

TABULAR MODIFICATION

997 Complications affecting specified body systems, not elsewhere classified

997.3 Respiratory complications

Delete ~~Mendelson's syndrome resulting from a procedure~~

Delete ~~Pneumonia (aspiration) resulting from a procedure~~

New code 997.31 Respiratory complications
Mendelson’s syndrome resulting from a procedure
Pneumonia (aspiration) resulting from a procedure

New code 997.32 Mechanical complication of respirator
Mechanical failure of respiratory ventilator

Excludes: encounter for respirator dependence during power failure (V46.12)

Topic: Suicidal ideation

Suicidal ideation, the thought of committing suicide, may be a problem even for people who have not been diagnosed with a mental or behavioral disorder. It includes all thoughts of suicide, whether or not the thoughts include a plan to commit suicide. Though most patients who voice or admit to suicidal thoughts do not go on to commit suicide, some of these patients will commit or attempt to commit suicide. Thus, suicidal ideation warrants thorough evaluation, both when the ideation is expressed as well as periodically thereafter.

A status code for this was requested in the comments from the ICD-10-CM pilot test. The American Psychiatric Association has approved the creation of such a code.

TABULAR MODIFICATION

V62 Other psychosocial circumstances

V62.8 Other psychological or physical stress, not elsewhere classified

New code V62.84 Suicidal ideation

Excludes: suicidal tendencies (300.9)

Topic: Excessive crying in child, adolescent, or adult

A unique code, 780.92, Excessive crying in an infant (baby), was created and became effective October 1, 2002. A new request has now been received from the American Hospital Association's Editorial Advisory Board and the National Association of Children's Hospitals and Related Institutions (NACHRI) to create a similar code for patients other than infants.

TABULAR MODIFICATION

780 General symptoms

780.9 Other general symptoms

New code 780.95 Excessive crying of child, adolescent, or adult

Topic: Urinary obstruction/retention

The code in the ICD-9-CM for urinary obstruction, code 599.6, Urinary obstruction, unspecified, must currently be used for urinary obstruction due to a specified cause. It is being proposed that 5th digits be added to code 599.6 to create unique codes for unspecified and other specified urinary obstruction.

It is also being proposed that index changes be added that provide instruction on the coding of urinary obstruction/retention due to benign prostatic hypertrophy.

TABULAR MODIFICATION

599 Other disorders of urethra and urinary tract

Revise 599.6 Urinary obstruction~~, unspecified~~

New code 599.60 Urinary obstruction, unspecified

New code 599.69 Other urinary obstruction

INDEX MODIFICATIONS

Obstruction…
Revise urinary (moderate) 599.60
Revise organ or tract (lower) 599.60
Add specified NEC 599.69
Add due to
Add benign prostatic hypertrophy (BPH) – see category 600, Hyperplasia of prostate
Add specified NEC 599.69

Retention…
urine NEC 788.20
bladder, incomplete emptying 788.21
Add due to
Add benign prostatic hypertrophy (BPH) – see category 600, Hypertrophy of prostate
Add due to
Add benign prostatic hypertrophy (BPH) –see category 600, Hypertrophy of prostate

Topic: Insomnia, hypersomnia and sleep apnea

Sleep medicine is a new but growing medical subspecialty. The American Academy of Sleep Medicine has published "The International Classification of Sleep Disorders" that contains diagnostic, severity, and duration criteria to aid clinical diagnosis and treatment of sleep disorders. The Academy has been working with NCHS staff to bring the ICD up to date with the current classification of sleep disorders.

Below are proposals to expand the ICD-9-CM in the areas of insomnia, hypersomnia and sleep apnea. In future revision, additional modifications will be proposed for others sleep disorders.

TABULAR MODIFICATIONS

291 Alcohol-induced mental disorders

291.8 Other specified alcohol-induced mental disorders

New code 291.82 Alcohol-induced sleep disorders
Alcohol-induced hypersomnia
Alcohol-induced insomnia

292 Drug-induced mental disorders

292.8 Other specified drug-induced mental disorders

New code 292.85 Drug-induced sleep disorders
Drug-induced hypersomnia
Drug-induced insomnia

307 Special symptoms or syndromes, not elsewhere classified

307.4 Specific disorders of sleep of nonorganic origin

Add Excludes: organic hypersomnia (349.40-349.49)
organic insomnia (349.30-349.39)

307.41 Transient disorder of initiating or maintaining sleep
Add Adjustment insomnia

307.42 Persistent disorder of initiating or maintaining sleep

Add — Idiopathic insomnia
Add — Paradoxical insomnia
Add — Primary insomnia
Add — Psychophysiological insomnia

307.44 Persistent disorder of initiating or maintaining wakefulness

Add — Idiopathic hypersomnia with long sleep time
Add — Idiopathic hypersomnia without long sleep time
Add — Insufficient sleep syndrome
Primary hypersomnia

Add — Excludes: sleep deprivation (V69.4)

349 Other and unspecified disorders of the nervous system

New sub-category — 349.3 Organic disorders of initiating and maintaining sleep [Organic insomnia]

Excludes: insomnia NOS (780.52)
insomnia not due to a substance or known physiological condition (307.41-307.42)
insomnia with sleep apnea NOS (780.51)

New code — 349.30 Organic insomnia, unspecified
New code — 349.31 Insomnia due to non-mental health condition classified elsewhere
Code first underlying condition
New code — 349.32 Insomnia due to mental health condition
Code first mental health condition
Add — Excludes: alcohol-induced insomnia (291.82)
drug-induced insomnia (292.85)
New code — 349.39 Other organic insomnia

New sub-category — 349.4 Organic disorder of excessive somnolence [Organic hypersomnia]

Excludes: hypersomnia NOS (780.54)
hypersomnia not due to a substance or known physiological condition (307.43-307.44)
hypersomnia with sleep apnea NOS (780.53)

New code 349.40 Organic hypersomnia, unspecified
New code 349.41 Recurrent hypersomnia
Klein-Levin syndrome
Menstrual related hypersomnia
New code 349.42 Hypersomnia due to non-mental health condition classified elsewhere
Code first underlying condition
New code 349.43 Hypersomnia due to mental health condition
Code first mental health condition
Add Excludes: alcohol-induced hypersomnia (291.82)
drug-induced hypersomnia (292.85)
New code 349.49 Other organic hypersomnia

New sub-category 349.5 Organic sleep apnea

Excludes: Cheyne-Stokes breathing (786.04)
hypersomnia with sleep apnea NOS (780.53)
insomnia with sleep apnea NOS (780.51)
sleep apnea in newborn (770.81-770.82)
sleep apnea NOS (780.57)

New code 349.50 Organic sleep apnea, unspecified
New code 349.51 Primary central sleep apnea
New code 349.52 High-altitude periodic breathing
New code 349.53 Obstructive sleep apnea (adult) (pediatric)
New code 349.54 Idiopathic sleep-related non-obstructive alveolar hypoventilation
Sleep related hypoxia
New code 349.55 Sleep-related hypoventilation/hypoxemia in conditions classifiable elsewhere
Code first underlying condition
New code 349.56 Central sleep apnea in conditions classified elsewhere
Code first underlying condition
New code 349.59 Other organic sleep apnea

780 General symptoms

780.5 Sleep disturbances

Add — Excludes: organic hypersomnia (349.40-349.49)
organic insomnia (349.30-349.39)
organic sleep apnea (349.50-349.59)

Revise — 780.51 Insomnia with sleep apnea, unspecified
Revise — 780.52 ~~Other~~ Insomnia, unspecified
Delete — ~~Insomnia NOS~~
Revise — 780.53 Hypersomnia with sleep apnea, unspecified
Revise — 780.54 ~~Other~~ Hypersomnia, unspecified
Delete — ~~Hypersomnia NOS~~
Revise — 780.57 ~~Other and u~~Unspecified sleep apnea

V69 Problems related to lifestyle

New code — V69.5 Behavioral insomnia of childhood

Topic: Other specified peritonitis

In keeping with the modifications that we proposed in April 2004 for expanding the peritonitis codes to separate peritoneal and retroperitoneal infections, it is now being proposed that code 567.8, Other specified peritonitis, be expanded to allow for the specified classification of the multiple and varied conditions included in the code. An additional modification to subcategory 567.2, Other suppurative peritonitis, is also included with this proposal.

We propose to create a unique code for spontaneous bacterial peritonitis to distinguish it from other acute bacterial peritonitis, since treatment differs. Acute peritonitis may occur due to bile in the peritoneal cavity, referred to as choleperitonitis. Sclerosing mesenteritis is a broad category of inflammatory processes involving the mesenteric fat. It includes fat necrosis and fibrosis. Each of these conditions requires specific treatment.

TABULAR MODIFICATION

567 Peritonitis

567.2 Other suppurative peritonitis

New code 567.23 Spontaneous bacterial peritonitis

567.8 Other specified peritonitis

Delete ~~Chronic proliferative peritonitis~~
~~Fat necrosis of peritonitis~~
~~Mesenteric saponification~~
~~Peritonitis due to bile~~
~~Peritonitis due to urine~~

New code 567.81 Choleperitonitis
Peritonitis due to bile

New code 567.82 Sclerosing mesenteritis
Fat necrosis of peritoneum
(Idiopathic) sclerosing mesenteric fibrosis
Mesenteric liopdystrophy
Mesenteric panniculitis
Retractile mesenteritis

New code 567.89 Other specified peritonitis
Chronic proliferative peritonitis
Peritonitis due to urine
Mesenteric saponification

Topic: Refractory anemia/Myelodysplastic syndrome

The ICD-9-CM classifies refractory anemia as aplastic anemia. The ICD-10 and the ICD-O-3 classify refractory anemia as myelodysplastic syndrome. With the ICD-O-3, myelodysplastic syndrome is classified as a malignancy. This discrepancy between the classifications creates a problem for statistical classification for both morbidity and mortality.

Additionally, Cancer Registries in the United States are maintaining records on patients with myelodysplastic syndrome. Registry data and hospital data on refractory anemia do not correlate.

NCHS is proposing that the ICD-9-CM be modified to reflect the classification of refractory anemia to correspond to its classification in the ICD-10 and the ICD-O-3. Though this is strictly an addenda type change, it is being presented as a topic due to its significance.

TABULAR MODIFICATIONS

202 Other malignant neoplasms of lymphoid and histiocytic tissue

202.9 Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue

Add Myelodysplastic syndrome
Add Refractory anemia

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

238.7 Other lymphatic and hematopoietic tissues

Delete ~~Myelodysplastic syndrome~~

281 Other deficiency anemias

281.3 Other specified megaloblastic anemias. not elsewhere classified

Delete ~~Refractory megaloblastic anemia~~

284 Aplastic anemia

284.9 Aplastic anemia, unspecified

Delete ~~Anemia, refractory~~

285 Other and unspecified anemias

285.0 Sideroblastic anemia
Anemia
Delete ~~sideroblastic~~
Delete ~~refractory~~

INDEX MODIFICATIONS

Anemia
Revise refractory (primary) 202.9
Revise with hemachromatosis 202.9
Revise megaloblastic 202.9
Revise sideroblastic 202.9
Revise sideropenic 202.9

Syndrome
Revise myelodysplastic ~~238.7~~ 202.9

Topic: Meconium staining

The passage of meconium before birth is an indication of fetal distress. It is seen most commonly in infants small for gestational age, post dates, or those with cord complications, or other factors compromising placental circulation. Meconium aspiration is commonly defined as the presence of meconium below the vocal cords and occurs in up to 35% of live births with meconium staining.

Meconium aspiration syndrome occurs in about 4% of deliveries complicated by meconium stained fluid. Meconium aspiration syndrome occurs when meconium from amniotic fluid in the upper airway is inhaled into the lungs by the newborn with his /her first breath and it invokes an inflammatory reaction in the lungs.

There are misconceptions about meconium staining. Meconium staining is not meconium aspiration, and meconium aspiration is not meconium aspiration syndrome. The ICD-9-CM has a single code for meconium aspiration syndrome, 770.1. The use of this code for meconium staining and meconium aspiration is inappropriate.

The National Association of Children's Hospitals and Related Institutions (NACHRI), has requested unique codes for meconium staining and meconium aspiration, to allow for the distinct coding of these three conditions.

TABULAR MODIFICATIONS

770 Other respiratory conditions of fetus and newborn

770.1 Meconium aspiration syndrome

Add — Excludes: meconium aspiration (779.85)
meconium passage (779.84)
meconium staining (779.84)

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

779.8 Other specified conditions originating in the perinatal period

New code — 779.84 Meconium staining
Meconium passage

New code — 779.85 Meconium aspiration

Add — Excludes: meconium aspiration syndrome (770.1)

ADDENDA

TABULAR

282 Hereditary hemolytic anemias

282.4 Thalassemia

282.49 Other thalassemia

Add — Hb-Bart's disease

282.7 Other hemoglobinopathies

Delete — ~~Hb-Bart's disease~~

323 Encephalitis, myelitis, and encephalomyelitis

323.6 Postinfectious encephalitis

Add — Infectious acute disseminated encephalomyelitis (ADEM)

323.8 Other causes of encephalitis

Add — Noninfectious acute disseminated encephalomyelitis (ADEM)

332 Parkinson's disease

332.1 Secondary Parkinsonism

Add — Neuroleptic-induced Parkinsonism

333 Other extrapyramidal disease and abnormal movement disorders

333.1 Essential and other specified forms of tremor

Add Medication-induced postural tremor

333.7 Symptomatic torsion dystonia

Add Neuroleptic-induced acute dystonia

333.8 Fragments of torsion dystonia

333.82 Orofacial dyskinesia

Add Neuroleptic-induced tardive dyskinesia

333.9 Other and unspecified extrapyramidal diseases and abnormal movement disorders

333.90 Unspecified extrapyramidal diseases and abnormal movement disorders

Add Medication-induced movement disorders NOS

333.99 Other

Add Neuroleptic-induced acute akathisia

402 Hypertensive heart disease

Revise Use additional code to specify type of heart failure ~~(428.0, 428.20-428.23, 428.30-428.33, 428.40-428.43)~~ (428.0-428.9)

487 Influenza

Excludes: Hemophilus influenzae [H. influenzae]:

Delete ~~pneumonia (482.2)~~

487.0 With pneumonia

Add Use additional code to identify the type of pneumonia (480.0-480.9, 481, 482.0-482.9, 483.0-483.8, 485)

607 Disorders of penis

607.84 Impotence of organic origin

Revise Excludes: nonorganic ~~or unspecified~~ (302.72)

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

648.8 Abnormal glucose tolerance

Add Use additional code, if applicable, to identify long-term [current] use of insulin (V58.67)

660 Obstructed labor

660.8 Other causes of obstructed labor

Add Use additional code to identify condition

728 Disorders of muscle, ligament, and fascia

728.8 Other disorders of muscle, ligament, and fascia

Revise 728.87 Muscle weakness (generalized)

CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD

Revise Includes: conditions which have their origin in the perinatal period, before birth until the first 28 days after birth, even though death or morbidity occurs later

771 Infections specific to the perinatal period

Revise Includes: infections acquired before or during birth via the umbilicus or during the first 28 days after birth

924 Contusion of lower limb and of other and unspecified sites

924.0 Hip and thigh

Revise 924.00 Thigh (with hip)

Revise 924.01 Hip (without thigh)

924.1 Knee and lower leg

Revise 924.10 Lower leg (with knee)

Revise 924.11 Knee (without lower leg)

V45 Other postprocedural states

V45.1 Renal dialysis status
Add Hemodialysis status
Add Peritoneal dialysis status

Revise Persons Encountering Health Services In Other Circumstances (V60- V69)

V61 Other family circumstances

V61.1 Counseling for marital and partner problems

V61.10 Counseling for marital and partner problems, unspecified
Add Marital relationship problem
Add Partner relationship problem

V61.2 Parent-child problem

V61.20 Counseling for parent-child problem, unspecified
Add Parent-child relationship problem

V61.8 Other specified family circumstances
Add Sibling relationship problem

V62 Other psychosocial circumstances

V62.2 Other occupational circumstances or maladjustment
Add Occupational problem

V62.3 Educational circumstances
Add Academic problem

V62.4 Social maladjustment
Add Acculturation problem

V62.8 Other psychological or physical stress, not elsewhere classified

V62.81 Interpersonal problems, not elsewhere classified
Add Relational problem NOS

V62.89 Other
Add Borderline intellectual functioning
Add Religious or spiritual problem

ADDENDA

INDEX

Acrocyanosis 443.89
newborn 770.83
Add — meaning transient blue hands and feet – omit code

Antritis 473.0
Delete — ~~acute 461.0~~
Add — maxilla 473.0
Add — acute 461.0
Add — stomach 535.4

Breathing
mouth 784.9
Add — causing malocclusion 524.59

Cardiomyopathy
Add — newborn 425.4
Add — congenital 425.3
Add — takotsubo 429.89

Complications
Add — esophagostomy 530.87

Cyst
Revise — Gartner's duct ~~752.11~~ 752.41

Delivery
complicated by
Add — female genital mutilation 660.8

Disorder
Add — central auditory processing 315.32
Revise — male erectile ~~307.72~~ 607.84
Add — nonorganic origin 302.72

Dysfunction
Add — erectile 607.84
Add — nonorganic origin 302.72
Add — systolic 429.9
Add — with heart failure – see Failure, heart

Dysplasia
Add colon 211.3
Add high grade, focal 211.3

Elevation
Add lipoprotein a level 272.8
Add liver function
Add study 794.8
Add test (LFT) 790.6

Findings
Add liver function test 790.6

Revise Gastropathy, ~~exudative~~ ~~579.8~~ 537.89
Add exudative 579.8

Revise Hyperglycemia 790.29

Revise Impotence (sexual) ~~(psychogenic) 302.72~~ 607.84
Add psychogenic 302.72

Infection
Revise Ebola ~~065.8~~ 078.89

Injury
Add transfusion-related lung injury (TRALI) 997.3

Intoxication
Revise drug 292.89

Hepatitis
Add history of
Add B V12.09
Add C V12.09

History of
Add hepatitis B V12.09
Add hepatitis C V12.09

Hyperkeratosis
Revise cervix ~~622.1~~ 622.2

Labor
obstructed…
Add due to female genital mutilation 660.8

Neoplasm
Revise posterior fossa (cranial) ~~191.6~~ 191.9

Newborn
Add cardiomyopathy 425.4
Add congenital 425.3

Paralysis
stomach 536.3
Add diabetic 250.6 [536.3]
Revise nerve (nondiabetic) 352.3

Pregnancy
complicated by
current disease or condition (nonobstetrical)
Add female genital mutilation 648.9
Add female genital mutilation 648.9

Seizure
febrile 780.31
Add with status epilepticus 345.3

Sepsis (generalized) 995.91
Add due to
Add noninfectious process 995.93
Add trauma 995.93
severe 995.92
Add due to
Add noninfectious process 995.94
Add trauma 995.94

Status
Revise dialysis (peritoneal) V45.1

Stroke
Add hemorrhagic – see Hemorrhage, brain

Syndrome
Add — Alagille 759.89
Add — apical ballooning 429.89
Add — Gianotti Crosti 057.8
Add — due to known virus- see Infection, virus
Add — due to unknown virus 057.8
Add — Goldberg 759.89

Tachycardia
Add — AV nodal re-entry (re-entrant) 427.89

Talc granuloma
Add — in operation wound 998.7

Thrombosis
Add — tumor – see Neoplasm, by site
vein
Revise — deep ~~453.8~~ 453.40

Add — Transfusion-related lung injury (TRALI) 997.3

Ulcer
stasis
Add — with varicose veins 454.0

TABLE OF DRUGS AND CHEMICALS

Add	Namenda	969.8	E854.8	E939.8	E950.3	E962.0	E980.3

Chapter 5- Mental Disorders (290-319)

Delete the following:

~~In the International Classification of Diseases, 9th Revision (ICD-9), the corresponding Chapter V, "Mental Disorders," includes a glossary which defines the contents of each category. The introduction to Chapter V in ICD-9 indicates that the glossary is intended so that psychiatrists can make the diagnosis based on the descriptions provided rather than from the category titles. Lay coders are instructed to code whatever diagnosis the physician records.~~

~~Chapter 5, "Mental Disorders," in ICD-9-CM uses the standard classification format with inclusion and exclusion terms, omitting the glossary as part of the main text.~~

~~The mental disorders section of ICD-9-CM has been expanded to incorporate additional psychiatric disorders not listed in ICD-9. The glossary from ICD-9 does not contain all these terms. It now appears in Appendix B, which also contains descriptions and definitions for the terms added in ICD-9-CM. Some of these were provided by the American Psychiatric Association's Task Force on Nomenclature and Statistics who are preparing the Diagnostic and Statistical Manual, Third Edition (DSM-III), and others from A Psychiatric Glossary.~~

~~The American Psychiatric Association provided invaluable assistance in modifying Chapter 5 of ICD-9-CM to incorporate detail useful to American clinicians and gave permission to use material from the aforementioned sources.~~

~~1. Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, 9th Revision, World Health Organization, Geneva, Switzerland, 1975.~~

~~2. American Psychiatric Association, Task Force on Nomenclature and Statistics, Robert L. Spitzer, M.D., Chairman.~~

~~3. A Psychiatric Glossary, Fourth Edition, American Psychiatric Association, Washington, D.C., 1975.~~