September 17, 2009
Diagnosis Agenda

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

Diagnosis Topics:

ICD-9-CM TIMELINE

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

September 16 – 17, 2009	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 10, 2009. You must bring an official form of picture identification (such as a drivers license) in order to be admitted to the building.
October 2009	Summary report of the Procedure part of the September 16 – 17, 2009 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Summary report of the Diagnosis part of the September 16–17, 2009 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd.htm
October 1, 2009	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/icd.htm Procedure addendum at - http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes
October 9, 2009	**Deadline for receipt of public comments on proposed code revisions discussed at the September 16-17, 2009 ICD-9-CM Coordination and Maintenance Committee meetings for implementation of April 1, 2010.**
November 2009	Any new ICD-9-CM codes required to capture new technology that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2010 will be posted on the following websites: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes http://www.cdc.gov/nchs/icd.htm

November 20, 2009	**Deadline for receipt of public comments on proposed code revisions discussed at the September 16-17, 2009 ICD-9-CM Coordination and Maintenance Committee meetings for implementation of October 1, 2010.**
January 8, 2010	**Deadline for requestors: Those members of the public requesting that topics be discussed at the March 9 – March 10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses by this date.**
February 2010	Draft agenda for the Procedure part of the March 9, 2010 ICD-9-CM Coordination and Maintenance Committee meeting posted on CMS homepage as follows: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Draft agenda for the Diagnosis part of the March 10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd.htm Federal Register notice of March 9 – March 10, 2010 ICD-9-CM Coordination and Maintenance Committee Meeting will be published.
February 12, 2010	**On-line registration opens for the March 9 – 10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting at: http://www.cms.hhs.gov/apps/events**
March 2010	Because of increased security requirements, **those wishing to attend the March 9 – March 10, 2010** ICD-9-CM Coordination and Maintenance Committee meeting must register for the meeting online at: http://www.cms.hhs.gov/apps/events **Attendees must register online by March 5, 2010 failure to do so may result in lack of access to the meeting**.
March 9 – March 10 2010	ICD-9-CM Coordination and Maintenance Committee meeting.
April 1, 2010	Any new ICD-9-CM codes required to capture new technology will be implemented. Information on any new codes implemented on April 1, 2010 previously posted in early November 2009 will be on the following websites:

	http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes http://www.cdc.gov/nchs/icd.htm http://www.cms.hhs.gov/MLNGenInfo
April 2, 2010	**Deadline for receipt of public comments on proposed code revisions discussed at the March 9-10, 2010 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2010.**
April 2010	Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This notice will include the final ICD-9-CM diagnosis and procedure codes for the upcoming fiscal year. It will also include proposed revisions to the DRG system on which the public may comment. The proposed rule can be accessed at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp
April 2010	Summary report of the Procedure part of the March 9, 2010 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Summary report of the Diagnosis part of the March 10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd.htm
May 21, 2010	**Deadline for receipt of public comments on proposed diagnosis code revisions discussed at the March 9-10, 2010 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2011.**
June 2010	Final addendum posted on web pages as follows: Diagnosis addendum at – http://www.cdc.gov/nchs/icd.htm Procedure addendum at – http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes
July 16, 2010	**Those members of the public requesting that topics be discussed at the September 15 – 16, 2010 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses.**

August 1, 2010	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, 2010. This rule can be accessed at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp
August 2010	Tentative agenda for the Procedure part of the September 15 – 16, 2010 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage at - http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Tentative agenda for the Diagnosis part of the September 15 – 16, 2010 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on NCHS homepage at - http://www.cdc.gov/nchs/icd.htm Federal Register notice for the September 15 –16, 2010 ICD-9-CM Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.
August 13, 2010	On-line registration opens for the September 15-16, 2010 ICD-9-CM Coordination and Maintenance Committee meeting at: **http://www.cms.hhs.gov/apps/events**
September 10, 2010	Because of increased security requirements, those wishing to attend the September 15 - 16, 2010 ICD-9-CM Coordination and Maintenance Committee meeting must register for the meeting online at: http://www.cms.hhs.gov/apps/events **Attendees must register online by September 10, 2010; failure to do so may result in lack of access to the meeting.**
September 15 – 16, 2010	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 10, 2010.** You must bring an official form of picture identification (such as a drivers license) in order to be admitted to the building.
October 2010	Summary report of the Procedure part of the September 15 – 16, 2010 ICD-9-CM Coordination and Maintenance

	Committee meeting will be posted on CMS homepage as follows: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Summary report of the Diagnosis part of the September 15–16, 2010 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd.htm
October 1, 2010	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/icd.htm Procedure addendum at - http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes
October 8, 2010	**Deadline for receipt of public comments on proposed code revisions discussed at the September 15-16, 2010 ICD-9-CM Coordination and Maintenance Committee meetings for implementation of April 1, 2011.**
November 2010	Any new ICD-9-CM codes required to capture new technology that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2011 will be posted on the following websites: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes http://www.cdc.gov/nchs/icd.htm
November 19, 2010	**Deadline for receipt of public comments on proposed code revisions discussed at the September 15-16, 2010 ICD-9-CM Coordination and Maintenance Committee meetings for implementation of October 1, 2011.**

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

Please consult this web page for updated information

Multiple gestation placenta status

The Society for Maternal and Fetal Medicine (SMFM) has requested new ICD-9-CM status codes for multiple gestations that indicate the number of placentas and amniotic sacs. Depending on the number the risk of complications is higher and the treatment plan differs.

Codes under category 651, Multiple gestation, cannot be expanded because all codes in the OB chapter of the ICD-9-CM have 5th digits for episode of care. A new V code category is being proposed to allow for the coding of the additional information requested by SMFM.

A corresponding issue is that of classifying the number of fetuses in a multiple gestation when one or more of the fetuses have died or there has been a selective reduction. Instructional notes can be added to the tabular and guidelines to inform coders on what code to assign in these situations.

This proposal has been endorsed by the American College of Obstetricians and Gynecologists (ACOG)

TABULAR MODIFICATIONS

651 Multiple gestation

Add Use additional code to specify placenta status (V91.00-V91.99)

New Section MULTIPLE GESTATION PLACENTA STATUS (V91)

New category V91 Multiple gestation placenta status

Code first multiple gestation (651.0-651.9)

New subcategory V91.0 Twin gestation placenta status

New code	V91.00	Twin gestation, unspecified number of placenta, unspecified number of amniotic sacs
New code	V91.01	Twin gestation, monochorionic/monoamniotic (one placenta, one amniotic sac)
New code	V91.02	Twin gestation, monochorionic/diamniotic (one placenta, two amniotic sacs)
New code	V91.03	Twin gestation, dichorionic/diamniotic (two placentae, two amniotic sacs)
New code	V91.09	Twin gestation, unable to determine number of placenta and number of amniotic sacs

New subcategory	V91.1	Triplet gestation placenta status	
New code		V91.10	Triplet gestation, unspecified number of placenta and unspecified number of amniotic sacs
New code		V91.11	Triplet gestation, with two or more monochorionic fetuses
New code		V91.12	Triplet gestation, with two or more monoamniotic fetuses
New code		V91.19	Triplet gestation, unable to determine number of placenta and number of amniotic sacs
New subcategory	V91.2	Quadruplet gestation placenta status	
New code		V91.20	Quadruplet gestation, unspecified number of placenta and unspecified number of amniotic sacs
New code		V91.21	Quadruplet gestation, with two or more monochorionic fetuses
New code		V91.22	Quadruplet gestation, with two or more monoamniotic fetuses
New code		V91.29	Quadruplet gestation, unable to determine number of placenta and unspecified number of amniotic sacs
New subcategory	V91.9	Other specified multiple gestation placenta status Placenta status for multiple gestations greater than quadruplets	
New code		V91.90	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs
New code		V91.91	Other specified multiple gestation, with two or more monochorionic fetuses
New code		V91.92	Other specified multiple gestation, with two or more monoamniotic fetuses
New code		V91.99	Other specified multiple gestation, unable to determine number of placenta and unspecified number of amniotic sacs

Hemolytic Transfusion Reactions (HTR)

A Hemolytic Transfusion Reaction (HTR) is a reaction of increased destruction of red blood cells due to incompatibility between blood donor and recipient. The reaction includes clinical and laboratory signs of increased destruction of red blood cells (e.g., fever, chills, rigors, hemoglobinuria, presence of antibodies to RBC antigens, and ABO or non-ABO incompatibility). Hemolytic transfusion reactions can be either acute or delayed depending on the timing of their occurrence and can be due to either ABO or non-ABO incompatibility.

An Acute Hemolytic Transfusion Reaction (AHTR) involves accelerated destruction of red blood cells immediately within 24 hours of a transfusion. Clinical and laboratory signs of hemolysis are present.

A Delayed Hemolytic Transfusion Reaction (DHTR) has accelerated destruction of red blood cells which usually manifests between 24 hours and 28 days (one month) after a transfusion and includes clinical or biological signs of hemolysis.

Some common antibodies associated with Hemolytic Transfusion Reactions (both AHTR and DHTR) include the following: Anti-A; Anti-B; Anti-A,B; Anti-K; Anti-k; Anti-Jka; Anti-Jkb; Anti-S; Anti-Fya; Anti-Fyb; and Anti-M; as well as others. Rh antibodies may also cause HTRs, including Anti-C; Anti-D; Anti-E; Anti-c; and Anti-e.

According to the Center for Biologics Evaluation and Research (CBER), of the Food and Drug Administration (FDA), in Fiscal Year 2008, HTRs were the leading cause of transfusion-related deaths reported to CBER, representing 37% of confirmed transfusion-related fatalities (22% for ABO mismatch and 15% for non-ABO mismatch). The increase in reported fatalities due to HTRs was due to an increase in fatality reports for both the ABO and non-ABO hemolytic reactions since FY 2007.

Currently, ICD-9-CM diagnosis coding does not distinguish between ABO and non-ABO HTRs, and between acute HTRs and delayed HTRs. A request that unique ICD-9-CM diagnosis codes be created for Hemolytic Transfusion Reactions (HTR) was received from FDA CBER.

References

U.S. Biovigilance Network (http://www.cdc.gov/nhsn/PDFs/hemovigModuleProtocol_current.pdf)
Canadian transfusion safety surveillance system
(http://www.phac-aspc.gc.ca/hcai-iamss/tti-it/index-eng.php)
Fatalities Report for FYs 2005 to 2008
(http://www.fda.gov/BiologicsBloodVaccines/SafetyAvailability/ReportaProblem/TransfusionDonationFatalities/ucm113649.htm)

TABULAR MODIFICATIONS

283 Acquired hemolytic anemias

Add Excludes: hemolytic transfusion reactions (999.61-999.63, 999.71-999.73, 999.76-999.78, 999.84-999.86)

999 Complications of medical care, not elsewhere classified

Revise 999.6 ABO incompatibility reaction due to transfusion of blood or blood products

Delete ~~Incompatible blood transfusion~~

Delete ~~Reaction to blood group incompatibility in infusion or transfusion~~

New code 999.60 ABO incompatibility reaction, unspecified
ABO incompatible blood transfusion NOS
Reaction to ABO incompatibility from transfusion NOS

New code 999.61 ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
Hemolytic transfusion reaction (HTR) due to ABO incompatibility
ABO incompatibility with hemolytic transfusion reaction at unspecified time after transfusion

New code 999.62 ABO incompatibility with acute hemolytic transfusion reaction
Acute hemolytic transfusion reaction (AHTR) due to ABO incompatibility
ABO incompatibility with hemolytic transfusion reaction less than 24 hours after transfusion

New code 999.63 ABO incompatibility with delayed hemolytic transfusion reaction
Delayed hemolytic transfusion reaction (DHTR) due to ABO incompatibility
ABO incompatibility with hemolytic transfusion reaction 24 hours or more after transfusion

New code 999.69 Other ABO incompatibility reaction
Other ABO incompatible blood transfusion
Other reaction to ABO incompatibility from transfusion
Delayed Serologic Transfusion Reaction (DSTR) from ABO incompatibility

Revise 999.7 Rh and other non-ABO incompatibility reaction due to transfusion of blood or blood products

Delete ~~Reactions due to Rh factor in infusion or transfusion~~

New code 999.70 Rh incompatibility reaction, unspecified
Rh incompatible blood transfusion NOS
Unspecified reaction to Rh incompatibility
Unspecified reaction due to incompatibility related to Rh antigens (C) (D) (E) (c) (e)
Reaction due to Rh factor in transfusion, NOS

New code 999.71 Rh incompatibility with hemolytic transfusion reaction not specified as acute or delayed
Hemolytic transfusion reaction (HTR) due to Rh incompatibility
HTR due to incompatibility related to Rh antigens (C) (D) (E) (c) (e), not specified as acute or delayed
Rh incompatibility with hemolytic transfusion reaction at unspecified time after transfusion

New code 999.72 Rh incompatibility with acute hemolytic transfusion reaction
Acute hemolytic transfusion reaction (AHTR) due to Rh incompatibility
AHTR due to incompatibility related to Rh antigens (C) (D) (E) (c) (e)
Rh incompatibility with hemolytic transfusion reaction less than 24 hours after transfusion

New code 999.73 Rh incompatibility with delayed hemolytic transfusion reaction
Delayed hemolytic transfusion reaction (DHTR) due to Rh incompatibility
DHTR due to incompatibility related to Rh antigens (C) (D) (E) (c) (e)
Rh incompatibility with hemolytic transfusion reaction 24 hours or more after transfusion

New code

999.74 Other Rh incompatibility reaction
Other reaction to Rh incompatible blood transfusion
Other reaction due to incompatibility related to Rh antigens (C) (D) (E) (c) (e)
Delayed Serologic Transfusion Reaction (DSTR) from Rh incompatibility

New code

999.75 Non-ABO incompatibility reaction, unspecified
Non-ABO incompatible blood transfusion NOS
Reaction to non-ABO antigen incompatibility from transfusion NOS
Unspecified reaction due to incompatibility related to minor antigens (Duffy) (Kell) (Kidd) (Lewis) (M) (N) (P) (S)

New code

999.76 Non-ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
Hemolytic transfusion reaction (HTR) due to non-ABO incompatibility
HTR from incompatibility related to minor antigens (Duffy) (Kell) (Kidd) (Lewis) (M) (N) (P) (S)
Non-ABO incompatibility with hemolytic transfusion reaction at unspecified time after transfusion

New code

999.77 Non-ABO incompatibility with acute hemolytic transfusion reaction
Acute hemolytic transfusion reaction (AHTR) due to non-ABO incompatibility
AHTR from incompatibility related to minor antigens (Duffy) (Kell) (Kidd) (Lewis) (M) (N) (P) (S)
Non-ABO incompatibility with hemolytic transfusion reaction less than 24 hours after transfusion

New code 999.78 Non-ABO incompatibility with delayed hemolytic transfusion reaction
Delayed hemolytic transfusion reaction (DHTR) due to non-ABO incompatibility
DHTR from incompatibility related to minor antigens (Duffy) (Kell) (Kidd) (Lewis) (M) (N) (P) (S)
Non-ABO incompatibility with hemolytic transfusion reaction 24 hours or more after transfusion

New code 999.79 Other non-ABO incompatibility reaction
Other non-ABO incompatible blood transfusion
Other reaction to non-ABO incompatibility from transfusion
Other reaction due to incompatibility related to minor antigens (Duffy) (Kell) (Kidd) (Lewis) (M) (N) (P) (S)
Delayed Serologic Transfusion Reaction (DSTR) from non-ABO incompatibility

999.8 Other infusion and transfusion reaction

New code 999.80 Transfusion reaction, unspecified
Add Incompatible blood transfusion NOS
Add Reaction to blood group incompatibility in infusion or transfusion NOS

New code 999.84 Hemolytic transfusion reaction, incompatibility unspecified
Hemolytic transfusion reaction (HTR) with antigen incompatibility unspecified, not specified as acute or delayed
HTR with incompatibility unspecified at unspecified time after transfusion

New code 999.85 Acute hemolytic transfusion reaction, incompatibility unspecified
Acute hemolytic transfusion reaction (AHTR) with antigen incompatibility unspecified
AHTR, incompatibility unspecified

New code	999.86 Delayed hemolytic transfusion reaction, incompatibility unspecified. Delayed hemolytic transfusion reaction (DHTR) with antigen incompatibility unspecified DHTR, incompatibility unspecified.
	999.89 Other Transfusion Reaction
Add	Delayed Serologic Transfusion Reaction (DSTR), incompatibility unspecified

Transfusion transmitted infections

Transfusion-Transmitted Infections include any infectious organism (bacteria, virus, parasite, or other) transmitted through transfusion of blood or blood products (whole blood, RBCs, plasma, platelets, or other). Bacterial transfusion-transmitted infections include: gram-negative organisms (e.g. Yersinia enterocolitica, Pseudomonas spp , Serratia spp), gram-positive organisms (e.g., Staphylococcus aureus, Staphylococcus epidermidis), and others. Viral transfusion-transmitted infections include: HIV, hepatitis, parvovirus, cytomegalovirus, Epstein-Barr virus, West Nile virus, and others. Parasitic transfusion-transmitted infections include: malaria, Chagas, babesiosis, and others. Other transfusion-transmitted infections include infections due to prions, such as Creutzfeldt-Jakob Disease (CJD), and variant CJD, among others.

Currently there are no specific ICD-9-CM diagnosis codes for transfusion-transmitted infections. A request was received from FDA CBER that to create unique codes.

References

U.S. Biovigilance Network (http://www.cdc.gov/nhsn/PDFs/hemovigModuleProtocol_current.pdf)
Canadian transfusion safety surveillance system
(http://www.phac-aspc.gc.ca/hcai-iamss/tti-it/index-eng.php)

TABULAR MODIFICATIONS

999 Complications of medical care, not elsewhere classified

999.3 Other infection

Use additional code to identify the specified infection, such as:

Add hepatitis (070.00-070.93)
Add HIV (042)
Add malaria (084.0-084.9)
Add West Nile virus (066.40-066.49)

New code 999.32 Transfusion transmitted infection

Febrile Nonhemolytic Transfusion Reaction (FNHTR)

Febrile Nonhemolytic Transfusion Reaction (FNHTR) includes fever, chills, and rigors without hemolysis, occurring within 4 hours after transfusion. The two most commonly described mechanisms of the reaction are passively transfused cytokines and a reaction between recipient antibodies and transfused leukocytes.

Currently there is no specific ICD-9-CM diagnosis code for FNHTR. A recommendation was received from FDA CBER that a unique code be created for FNHTR.

References

U.S. Biovigilance Network (http://www.cdc.gov/nhsn/PDFs/hemovigModuleProtocol_current.pdf)
Canadian transfusion safety surveillance system
(http://www.phac-aspc.gc.ca/hcai-iamss/tti-it/index-eng.php)

TABULAR MODIFICATIONS

780 General symptoms

780.6 Fever and other physiologic disturbances of temperature regulation

Add — Excludes: febrile nonhemolytic transfusion reaction (FNHTR) (999.83)

999 Complications of medical care, not elsewhere classified

999.8 Other infusion and transfusion reaction

New code — 999.83 Febrile nonhemolytic transfusion reaction FNHTR

Post transfusion purpura (PTP)

Post Transfusion Purpura (PTP) is characterized by sudden severe thrombocytopenia (platelet count <10,000/µL) usually arising 5-12 days following transfusion of blood components (which may be whole blood, RBCs, plasma, or platelets). This reaction is associated with presence of antibodies directed against the Human Platelet Antigen (HPA) system.

Currently there is no specific ICD-9-CM diagnosis code for PTP. A recommendation has been received from FDA CBER, that a unique code be created for PTP.

References

U.S. Biovigilance Network (http://www.cdc.gov/nhsn/PDFs/hemovigModuleProtocol_current.pdf)
Canadian transfusion safety surveillance system
(http://www.phac-aspc.gc.ca/hcai-iamss/tti-it/index-eng.php)

TABULAR MODIFICATIONS

287 Purpura and other hemorrhagic conditions

287.4 Secondary thrombocytopenia

Delete ~~Posttransfusion purpura~~
Delete ~~Thrombocytopenia (due to):~~
Delete ~~dilutional~~
Delete ~~drugs~~
Delete ~~extracorporeal circulation of blood~~
Delete ~~massive blood transfusion~~
Delete ~~platelet alloimmunization~~

New code 287.41 Posttransfusion purpura
PTP

New code 287.49 Other secondary thrombocytopenia
Thrombocytopenia (due to):
dilutional
drugs
extracorporeal circulation of blood
massive blood transfusion
platelet alloimmunization

Transfusion Associated Circulatory Overload (TACO)

Transfusion-Associated Circulatory Overload (TACO) is a circulatory overload following transfusion of blood or blood components, which may be either due to the high rates and large volumes of infusion that cannot be effectively processed by the recipient, or underlying cardiac or pulmonary pathology. TACO is characterized by acute respiratory distress (e.g., dyspnea, orthopnea), increased blood pressure, pulmonary edema secondary to congestive heart failure, and positive fluid balance, during or within 6 hours of transfusion. Elderly and infants are at an increased risk for TACO occurrence even with small transfusion volumes. Occurrence of TACO is also very likely to be underreported due to a variety of differential diagnoses that present as acute respiratory distress in the transfused persons, including Transfusion Associated Lung Injury (TRALI) and anaphylaxis.

Currently there is no specific ICD-9-CM diagnosis code for TACO. A recommendation was received from FDA CBER that a unique code be created for TACO.

References
U.S. Biovigilance Network (http://www.cdc.gov/nhsn/PDFs/hemovigModuleProtocol_current.pdf)
Canadian transfusion safety surveillance system
(http://www.phac-aspc.gc.ca/hcai-iamss/tti-it/index-eng.php)

TABULAR MODIFICATIONS

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

276.6 Fluid overload

Delete ~~Fluid retention~~

New code 276.61 Transfusion associated circulatory overload
TACO

New code 276.69 Other fluid overload
Fluid retention

Transfusion-Associated Hemochromatosis (Iron Overload)

Transfusion-associated hemochromatosis or iron overload can result from repeated red blood cell transfusions. Hemochromatosis may result in organ damage, including heart, renal, and liver dysfunction.

Currently there is no specific ICD-9-CM diagnosis code for transfusion-associated hemochromatosis or iron overload. A request was received from FDA CBER to create a unique code for it.

References
U.S. Biovigilance Network (http://www.cdc.gov/nhsn/PDFs/hemovigModuleProtocol_current.pdf)
Canadian transfusion safety surveillance system
(http://www.phac-aspc.gc.ca/hcai-iamss/tti-it/index-eng.php)

TABULAR MODIFICATIONS

275 Disorders of mineral metabolism

275.0 Disorders of iron metabolism

Delete ~~Bronzed diabetes~~
Delete ~~Hemochromatosis~~
Delete ~~Pigmentary cirrhosis (of liver)~~

New code 275.01 Hemochromatosis due to repeated red blood cell transfusions
Iron overload due to repeated red blood cell transfusions

New code 275.09 Other disorders of iron metabolism
Bronzed diabetes
Hemochromatosis NOS
Pigmentary cirrhosis (of liver)

999 Complications of medical care, not elsewhere classified

999.8 Other infusion and transfusion reaction

Add Excludes: hemochromatosis due to repeated red blood cell transfusions (275.01)

Stuttering

The American Speech-Language-Hearing Association (ASHA) and the American Psychiatric Association (APA) recommend additions and revisions to the ICD-9-CM so that diagnostic information can be coded that clarifies and augments the nature and description of stuttering. Specifically this proposal is to allow the distinction between stuttering with onset in childhood vs. stuttering with onset after puberty

Stuttering is defined as a disruption in speech production characterized by primary behavioral symptoms that include sound and syllable repetitions, blocks (articulatory fixations that prevent the speaker from moving forward in his or her speech), and inappropriate prolongations of speech sounds. The speaker's inability to initiate or continue speaking may cause secondary reactions characterized by visible signs of awareness, tension and struggle.

Presently there are three major recognized forms of stuttering: stuttering with onset in early childhood, stuttering with onset after puberty and fluency disorder subsequent to brain lesion or disease, most typically as a result of cerebrovascular disease (sometimes called neurogenic stuttering).

The prevalence of stuttering in the general population, both in the United States and in other surveyed regions, is approximately 1% of the general population. There is a higher incidence, approximately 4%, with onset in early childhood that spontaneously resolves. It is not currently possible to predict which children will experience remission or become persistent stutterers. Persistent stuttering is a potentially handicapping and disabling condition with significant educational, social and vocational consequences

In contrast, stuttering with onset after puberty and neurogenic stuttering are much less frequently observed speech fluency disorders. Stuttering with onset after puberty, a form of conversion reaction, has been documented in relatively few published reports with virtually all reported cases showing onset in adulthood. The number of documented cases of stuttering secondary to central nervous system damage or disease is growing. Stuttering is most commonly observed subsequent to cerebrovascular events, but may be seen in neurodegenerative diseases, among a variety of causes.

New code 438.14, Late effects of cerebrovascular disease, fluency disorder takes effect on October 1, 2009. However, the only other code in ICD-9-CM for stuttering is 307.0, Stuttering. ASHA and APA recognize the appropriateness of this code for individuals showing post-childhood onset of stuttering symptoms secondary to emotional stress or trauma, but propose to add a new code for stuttering with onset in childhood. ASHA and APA propose to add this code to subcategory 315.3 Developmental speech or language disorder. Epidemiological, research and treatment efforts could improve considerably if this specificity were available in the ICD-9-CM to distinguish among types of fluency disturbances. In particular, it is timely and important to establish the proposed additional

code, especially that for the most typical presentation of stuttering, appropriately among other speech and language disorders.

According to the National Stuttering Association's 2002 survey findings (provided by ASHA) the typical profile for primary referral for diagnosis and treatment to speech-language pathologists are for childhood onset stuttering disorder. Only about 5% of cases appear to warrant treatment beyond that provided by speech-language pathologists.

TABULAR MODIFICATIONS

307 Special symptoms or syndromes, not elsewhere classified

Revise 307.0 Stuttering <u>with onset after puberty</u>

Add Excludes: childhood onset stuttering disorder (315.35)

315 Specific delays in development

315.3 Developmental speech or language disorder

New code 315.35 Childhood onset stuttering disorder

Excludes: stuttering (fluency disorder) due to late effect of cerebrovascular accident (438.14)
stuttering with onset after puberty (307.0)

Multiple sclerosis

Multiple sclerosis (MS) is a disease of the central nervous system characterized by the destruction of the myelin sheath surrounding neurons, resulting in the formation of "plaques." Because they involve the destruction of the myelin sheath that covers nerve tissue, diseases such as MS are known as "demyelinating" diseases.

MS is a progressive and usually fluctuating disease with exacerbations (patients feeling worse) and remissions (patients feeling better) over many decades. The cause of MS is unknown. The most widely held hypothesis is that MS occurs in patients with a genetic susceptibility and is "triggered" by certain environmental factors. MS is 3 times more common in women than men, with diagnosis usually made as young adults; however, it has been estimated that between 2 to 5% of cases begin before age 16. Although MS can occur at any age, it most often begins in people between the ages of 20 and 40. Women are more likely to develop MS than are men.

The National Institute of Neurological Disorders and Stroke information sheet "Multiple Sclerosis: Hope through Research" describes the various forms of the MS clinical course. Most commonly, MS first manifests itself as a series of attacks followed by complete or partial remissions as symptoms lessen, only to return later after a period of stability. This is called relapsing-remitting (RR) MS. Primary-progressive (PP) MS is characterized by a gradual clinical decline with no distinct remissions, although there may be temporary plateaus or minor relief from symptoms. Secondary-progressive (SP) MS begins with a relapsing-remitting course followed by a later primary-progressive course. Rarely, patients may have a progressive-relapsing (PR) course in which the disease takes a progressive path punctuated by acute attacks. PP, SP, and PR are sometimes lumped together and called "chronic progressive MS." It should be noted that the literature includes other terms used in describing the clinical course of MS that are not addressed in the NIH fact sheet. There is no internationally accepted classification for MS.

Currently, ICD-9-CM has a single code, 340, Multiple sclerosis, that represents all of the forms of MS. Expanded detail would allow better identification of a patient's current form of the disease and would be helpful to be able to identify subpopulations of patients with MS. It is noted that several drug treatments have been approved for specific MS indications by the U.S. Food and Drug Administration.

The BlueCross BlueShield Association is proposing the following new codes for multiple sclerosis.

TABULAR MODIFICATIONS

340 Multiple sclerosis

New subcategory 340.0 Relapsing multiple sclerosis

New code	340.01	Progressive relapsing multiple sclerosis
New code	340.02	Relapsing remitting multiple sclerosis
New code	340.09	Relapsing multiple sclerosis, not elsewhere classified

New subcategory 340.1 Progressive multiple sclerosis

Excludes: progressive relapsing multiple sclerosis (340.01)

New code	340.11	Primary progressive multiple sclerosis
New code	340.12	Secondary progressive multiple sclerosis
New code	340.19	Progressive multiple sclerosis, not elsewhere classified

New code 340.8 Other multiple sclerosis

New code 340.9 Multiple sclerosis, unspecified

Neurogenic claudication

Lumbar spinal stenosis is spinal canal narrowing. Neurogenic claudication is a commonly used term for a syndrome associated with significant lumbar spinal stenosis leading to compression of the cauda equina (lumbar nerves). Symptoms experienced are buttock and lower extremity cramping, pain, and fatigue. The symptoms are exacerbated by standing erect and extension of the lumbar spine and are typically relieved with sitting, squatting, and lumbar flexion of the lumbar spine. People compensate for these symptoms by flexing forward, leaning onto objects (e.g., over a shopping cart) and alternate sitting to rest when ambulating distances. Neurogenic claudication symptoms can be similar to vascular claudication symptoms but are instead due to multiple lumbar nerve root compression rather than vascular insufficiency.

Although there is a code for lumbar spinal stenosis, 724.02, Spinal stenosis, lumbar region, there currently is no unique ICD-9-CM (or ICD-10-CM) code for neurogenic claudication. Dr. Andelle Teng, a spine and orthopaedic surgeon, is requesting that a unique code be created. He indicates that one can have lumbar stenosis without having neurogenic claudication and therefore requests that we have a code be added that can allow differentiating between patients with and without neurogenic claudication, since lumbar stenosis is simply narrowing of the lumbar spinal canal. However, this does not imply a symptomatic or surgical condition. If the stenosis at a single level becomes severe enough, or if the nerves are being compressed by multiple levels of stenosis, then a patient can become symptomatic and then experience neurogenic claudication. Neurogenic claudication is a possible surgical condition.

The following tabular modifications are proposed:

TABULAR MODIFICATIONS

724 Other and unspecified disorders of back

724.0 Spinal stenosis, other than cervical

Revise	724.02	Lumbar region<u>, without neurogenic claudication</u> Lumbar region NOS
New code	724.03	Lumbar region, with neurogenic claudication

Acquired absence of pancreas

There is currently no unique ICD-9-CM diagnosis code for acquired absence of the pancreas. It is indexed to code V45.79, Other acquired absence of organ. It has been suggested to create new unique code for this condition so as to provide additional information about patients with code 251.3, Postsurgical hypoinsulinemia assigned. Since there is no more room in category V45, or subcategory V45.7 it is being proposed to create this new code in category V88, Acquired absence of other organs and tissue. NCHS proposes the following changes:

TABULAR MODIFICATIONS

251 Other disorders of pancreatic internal secretion

251.3 Postsurgical hypoinsulinemia

Use additional code to identify (any associated):

Revise acquired absence of pancreas (V88.11-V88.12)

V45 Other postprocedural states

V45.7 Acquired absence of organ

V45.79 Other acquired absence of organ

Add Excludes: acquired absence of pancreas (V88.11-V88.12)

V88 Acquired absence of other organs and tissue

New subcategory V88.1 Acquired absence of pancreas

Use additional code to identify (any associated):
insulin use (V58.67)
secondary diabetes mellitus (249.00-249.91)

New code V88.11 Acquired total absence of pancreas
Acquired absence of pancreas NOS

New code V88.12 Acquired partial absence of pancreas

Do not resuscitate

A request has been received from Jeanne Yoder to add a code to ICD-9-CM for do not resuscitate status. Currently there is no unique code for this in ICD-9-CM. In ICD-10-CM there is a code for this which is Z66, Do not resuscitate.

Patient care services during an encounter may change when a patient has a "do not resuscitate" order in the chart. This code will assist in identifying records for review if this status can be identified.

It would be recommended to code this only when there is an order, in the current encounter, for do not resuscitate.

TABULAR MODIFICATIONS

V49 Other conditions influencing health status

V49.8 Other specified conditions influencing health status

New code V49.86 Do not resuscitate status

Physical restraints

A request has been received from Jeanne Yoder to add a code to ICD-9-CM for physical restraint status.

Patients must be evaluated and monitored more closely when restraints are used. A health care facility must be able to easily identify patients who had restraints used during the encounter. The services provided during an encounter change when a patient is physically restrained. It is a high risk situation which requires special training and patient care. This new code will assist in giving better description of the episode of care.
The following tabular modifications are requested:

TABULAR MODIFICATIONS

V49 Other conditions influencing health status

V49.8 Other specified conditions influencing health status

New code V49.87 Physical restraints status

Excludes: restraint due to a procedure – omit code

Combat Operational Stress Reaction (COSR)

At the September 12, 2008 meeting of the ICD-9-CM Coordination and Maintenance Committee, the Department of Defense (DoD) proposed a new code for history of combat and operational stress reaction (COSR). The proposal was deferred pending further review and discussion with the American Psychiatric Association (APA) as there was concern about introducing this history code for a condition that had no equivalent code in Chapter 5, Mental Disorders. Following recommendations made by the National Center for Health Statistics (NCHS) and review by Army Behavioral Health a recommendation was made that COSR be treated as a variant of acute reaction to stress which is currently coded to ICD-9-CM category 308, Acute reaction to stress. This category already has an inclusion term for combat fatigue.

The changes proposed are to add an inclusion term for combat and operational stress reaction in category 308, Acute reaction to stress and to add a new V code for personal history of combat and operational stress reaction. The personal history code would provide the capability of tracking patients who later have symptoms related to having had COSR. The APA has reviewed and is in concurrence with the proposed changes.

TABULAR MODIFICATIONS

308 Acute reaction to stress

Add Includes: combat and operational stress reaction

V11 Personal history of mental disorder

New code V11.4 Combat and operational stress reaction

Neurofibromatosis - Schwannomatosis

Neurofibromatosis (NF) encompasses a set of distinct genetic disorders that cause tumors to grow along various types of nerves and, in addition, can affect the development of non-nervous tissues such as bones and skin. Neurofibromatosis causes tumors to grow anywhere on or in the body. It has been classified in the past into two major forms, type 1 and type 2. Recently a third major type has been recognized, called schwannomatosis. This is a rare type of NF that may vary between patients. These patients have multiple Schwannomas on cranial, spinal and peripheral nerves, however, they do not develop vestibular tumors and do not go deaf as in the type 2 NF.

Neurofibromatosis is currently recognized in ICD-9-CM at subcategory 237.7, Neurofibromatosis. There is 5th digit specification for type 1 (von Recklinghausen's disease) and type 2 (acoustic neurofibromatosis). The American Academy of Neurology is requesting a new code to capture schwannomatosis. Additionally they recommend adding a code to allow capturing other neurofibromatosis.

The following tabular modifications are proposed:

TABULAR MODIFICATION

237 Neoplasm of uncertain behavior of endocrine glands and nervous system

237.7 Neurofibromatosis

Delete ~~von Recklinghausen's disease~~

New code 237.73 Schwannomatosis

New code 237.78 Other neurofibromatosis

Mesh erosion/Mesh exposure

One of the most effective surgeries for vaginal vault prolapse is abdominal sacral colpopexy. In this procedure, a graft is used to suspend the upper vagina to the anterior longitudinal ligament of the sacrum. Synthetic graft material used to suspend the apex of the vagina to the anterior longitudinal ligament of the sacrum has been associated with mesh erosion and subsequent pelvic infection (due to the erosion into internal organs). Treatment for this usually requires excision of the mesh. Exposure of the mesh into the vagina can also occur but is a less severe condition.

Mesh and mesh patches are also used to repair ventral (incisional) hernias caused by thinning or stretching of scar tissue that forms after surgery. Mesh erosion is a known complication that results in bowel perforations and/or, chronic intestinal fistulae.

Previous coding advice has been to assign code 996.76, Other complications due to genitourinary device, implant, and graft for the erosion and/or code 996.65, Infection and inflammatory reaction due to other genitourinary device, implant and graft if an infection occurred from the mesh.

The American College of Obstetricians and Gynecologists (ACOG) is requesting unique codes for mesh erosion and mesh exposure. They are especially concerned about a clear delineation between the two conditions. The following tabular modifications are proposed:

TABULAR MODIFICATIONS

996 Complications peculiar to certain specified procedures

Add Excludes: mesh erosion (998.84)
Add mesh exposure (998.85)

998 Other complications of procedures, NEC

998.8 Other specified complications of procedures, not elsewhere classified

New code 998.84 Mesh erosion

New code 998.85 Mesh exposure

Obesity hypoventilation syndrome (Pickwickian syndrome)

In obesity hypoventilation syndrome (OHS), breathing problems cause chronic hypoventilation, that manifests with decreased oxygen levels and elevated carbon dioxide levels. OHS is also called Pickwickian syndrome. It involves sleep disordered breathing. The breathing problems may be related to both obesity and to neurological issues. Weight loss is beneficial.

While other codes may be assigned for the sleep disordered breathing, notes to require a particular code ordering are not being proposed.

TABULAR MODIFICATIONS

278 Overweight, obesity and other hyperalimentation

278.0 Overweight and obesity

New code 278.03 Obesity hypoventilation syndrome
Pickwickian syndrome

Heart failure terms related to systolic function

It is proposed to add inclusion terms related to systolic function, for systolic heart failure, diastolic heart failure, and combined systolic and diastolic heart failure subcategories.

In diastolic heart failure, or combined heart failure with a diastolic component, there is diastolic dysfunction. This generally involves a stiff left ventricle and problems with the ventricle filling during the diastolic phase. Inclusion terms are proposed to clarify the presence of diastolic dysfunction in these cases.

Parts of this proposal may be considered as alternative or replacement to the proposal in March 2009, titled "Heart Failure with Reduced Ejection Fraction, and with Normal Ejection Fraction." The ejection fraction is the usual measure of left ventricular systolic function. While terms related to reduced and preserved ejection fraction are widely used in the literature, and related guidelines, concerns were raised about how such terms might be interpreted in the context of ICD coding. This proposal was developed in consultation with Dr. Andy Hedberg of the American College of Physicians-American Society of Internal Medicine. Previous proposals presented in March are under independent consideration from the current proposals.

TABULAR MODIFICATIONS

428 Heart failure

428.2 Systolic heart failure

Revise	428.20	Systolic heart failure, unspecified
Add		Heart failure with reduced left ventricular systolic function (not specified as acute or chronic)
Revise	428.21	Acute systolic heart failure
Add		Acute heart failure with reduced left ventricular systolic function
Revise	428.22	Chronic systolic heart failure
Add		Chronic heart failure with reduced left ventricular systolic function
Revise	428.23	Acute on chronic systolic heart failure
Add		Acute on chronic heart failure with reduced left ventricular systolic function

428.3 Diastolic heart failure

Revise	428.30	Diastolic heart failure, unspecified
Add		Heart failure with diastolic dysfunction (not specified as acute or chronic)
Add		Heart failure with preserved left ventricular systolic function (not specified as acute or chronic)
Revise	428.31	Acute diastolic heart failure
Add		Acute heart failure with diastolic dysfunction
Add		Acute heart failure with preserved left ventricular systolic function
Revise	428.32	Chronic diastolic heart failure
Add		Chronic heart failure with diastolic dysfunction
Add		Chronic heart failure with preserved left ventricular systolic function
Revise	428.33	Acute on chronic diastolic heart failure
Add		Acute on chronic heart failure with diastolic dysfunction
Add		Acute on chronic heart failure with preserved left ventricular systolic function

428.4 Combined systolic and diastolic heart failure

Revise	428.40	Combined systolic and diastolic heart failure, unspecified
Add		Heart failure with reduced left ventricular systolic function combined with diastolic dysfunction (not specified as acute or chronic)
Revise	428.41	Acute combined systolic and diastolic heart failure
Add		Acute heart failure with reduced left ventricular systolic function combined with diastolic dysfunction
Revise	428.42	Chronic combined systolic and diastolic heart failure

Add		Chronic heart failure with reduced left ventricular systolic function combined with diastolic dysfunction
Revise	428.43	Acute on chronic combined systolic and diastolic heart failure
Add		Acute on chronic heart failure with reduced left ventricular systolic function combined with diastolic dysfunction

High Cardiac Output Heart Failure

High cardiac output heart failure occurs secondary to a number of other conditions. It has not been possible to identify it explicitly in ICD-9-CM, and it is now coded to 428.9, Heart failure, unspecified. It is proposed to create a new code for high cardiac output heart failure.

This proposal is similar to part of a presentation from March 2009, titled "Acute Heart Failure Classification, and Related Heart Failure Issues," specifically, Part 2, High Output Failure. This may be considered a replacement for that previous proposal. This proposal was developed in consultation with Dr. Andy Hedberg of the American College of Physicians-American Society of Internal Medicine.

TABULAR MODIFICATIONS

428 Heart failure

New code 428.6 High cardiac output heart failure
High cardiac output failure
High output cardiac failure
High output heart failure

Encounters for the insertion, checking or removal of an intrauterine contraceptive device

Currently, an encounter for the insertion of an intrauterine contraceptive device (IUD) is coded to V25.1. The routine checking, removal and any subsequent reinsertion of an IUD is code V25.42. The American College of Obstetricians and Gynecologists (ACOG) has asked that these codes be modified to allow for better classifying encounters for IUD insertion and maintenance. The College specifically wants the ability to capture both the removal and immediate reinsertion of an IUD.

It is being proposed that code V25.11 be expanded to include both insertion and removal of an IUD. Both of these codes could be used together on a record. Also, code V25.42 would be limited to routine surveillance of an existing device.

TABULAR MODIFICATIONS

V25 Encounter for contraceptive management

Revise — V25.1 Encounter for insertion or removal of intrauterine contraceptive device

Add — Excludes: encounter for routine checking of intrauterine contraceptive device (V25.42)

New code — V25.11 Encounter for insertion of intrauterine contraceptive device

New code — V25.12 Encounter for removal of intrauterine contraceptive device

V25.4 Surveillance of previously prescribed contraceptive methods

Delete — ~~Excludes: presence of intrauterine contraceptive device as incidental finding (V45.5)~~

Revise — V25.42 Intrauterine contraceptive device Checking~~, reinsertion, or removal~~ of intrauterine device

Add — Excludes: presence of intrauterine contraceptive device as incidental finding (V45.5)

Add — insertion or removal of intrauterine contraceptive device (V25.11-V25.12)

V45 Other postprocedural states

V45.5 Presence of contraceptive device

Delete ~~Excludes: checking, reinsertion, or removal of device (V25.42)~~
~~complication from device (996.32)~~
~~insertion of device (V25.1)~~

V45.51 Intrauterine contraceptive device

Add Excludes: checking of device (V25.42)
Add complication from device (996.32)
Add insertion of device (V25.11)
Add removal of device (V25.12)

External cause status

The new codes for external cause status have been well received and many questions have come in regarding their use. A new code for volunteer activity was requested by the Bureau of Labor Statistics so that is being proposed.

The issue of a child doing work for communal family employment, such as a child assisting in the fields in migrant worker families, was discussed. The decision was to continue to include this under E000.8, Other external cause status. This was decided because the child is not independently compensated. Any injuries the child may sustain would not qualify under workers compensation laws. A child who is injured while doing compensated work, such as on a newspaper delivery route would be included under code E000.0 if the child receives a salary from an employer. Babysitting should be coded to E000.8 unless the babysitter is a contractor for a babysitting service in which case code E000.0 would be appropriate.

A question was submitted asking if such activities as bank robbery should be considered civilian activity done for income or pay. The answer is no, only legally reimbursed activities should be considered when using code E000.0. For this reason, it is being proposed that the inclusion term under E000.0 be modified to indicate only legal compensation is included.

TABULAR MODIFICATIONS

	E000	External cause status
	E000.0	Civilian activity done for income or pay
Revise		Civilian activity done for financial or other <u>legal</u> compensation
New code	E000.2	Volunteer activity
	Excludes:	activity of child or other family member assisting in compensated work of other family member (E000.8)
	E000.8	Other external cause status
Add		Activity of child or other family member assisting in compensated work of other family member
Delete		~~Volunteer activity~~

Heat illness (heat exhaustion, heat injury and heat stroke)

Heat exhaustion (HE) is defined as a syndrome of hyperthermia with physical collapse or debilitation occurring during or immediately following exertion in the heat, with no more than minor central nervous system dysfunction (e.g. headache, dizziness). HE resolves rapidly with minimal cooling intervention.

Heat injury (HI) is defined as HE with clinical evidence of organ (e.g. liver, kidney, stomach) and/or muscle (e.g. rhabdomyolysis, compartment syndrome) damage, but without sufficient neurological symptoms to be diagnosed as heat stroke.

Heat stroke (HS) is defined as a syndrome of hyperthermia, physical collapse or debilitation, and encephalopathy as evidenced by delirium, stupor, or coma occurring during or immediately following exertion or significant heat exposure. HS can be complicated by organ and/or tissue damage, systemic inflammatory activation, and disseminated intravascular coagulation. HS is a life-threatening condition and a medical emergency.

The ICD-9-CM has codes for heat exhaustion, 992.3-992.5 and for heat stroke, 992.0. There is no specified code for heat injury nor is it indexed. The U.S. Army has a medical policy for evaluating and treatment of soldiers suffering from heat illness. The Army has requested that a new code for heat injury be created.

It is also being proposed that instructional notes be added under code 992.0 to instruct coders to code any complications of heat stroke, such as coma or SIRS. It is also being proposed that instructional notes be added under the SIRS codes, 995.93 and 995.94 to indicate that these conditions may be a result of heat injury or heat stroke.

TABULAR MODIFICATIONS

992 Effects of heat and light

992.0 Heat stroke and sunstroke

Add Use additional code(s) to identify any associated complication of heat stroke, such as:
Add alterations of consciousness (780.01-780.09)
Add systemic inflammatory response syndrome (995.93-995.94)

992.8 Other specified heat effects

New code 992.81 Heat injury

Use additional code(s) to identify any associated complication of heat injury, such as:
compartment syndrome (traumatic) (958.90-958.99)
rhabdomyolysis (728.88)
systemic inflammatory response syndrome (995.93-993.94)

New code 992.89 Other specified heat effects

995 Certain adverse effects not elsewhere classified

995.9 Systemic inflammatory response syndrome (SIRS)

995.93 Systemic inflammatory response syndrome due to non-infectious process without acute organ dysfunction

Code first underlying conditions, such as:
Add heat injury (992.81)

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

Code first underlying conditions, such as:
Add heat stroke (992.0)

Retained foreign bodies

Injuries from explosions often include fragments or splinters from the explosive device embedding in the injured person. In some cases the fragments can be removed. In other cases they are too difficult to remove because of their number or their location in the body. Any embedded object has the potential to cause infection due to the object itself or any organism present on it when it entered the body. An embedded magnetic object is a relative contraindication to an MRI exam. Some types of embedded fragments, such as those composed of lead, pose long-term health risks. Certain metal alloys, including some containing tungsten, may also be long-term toxicological hazards.

The Department of Defense requested new codes for embedded fragment status to identify the type of embedded material. Though this category would be useful primarily for the military, the codes would also be applicable to any injury resulting in embedded fragments. These new codes would not be applicable to or overlap with internal medical devices.

This topic was originally presented at the September 08 C&M meeting when a proposal for a new category for embedded fragments status was proposed. These codes would be used as secondary status codes for cases such as injury codes that include the presence of a foreign body, or with toxic effect codes. A new code was also being proposed for personal history of embedded fragment removal. This would be a status code that would be used to identify potential health hazards associated with having had retained foreign bodies.

There was agreement that such a set of codes would be useful, but the consensus was that it should be re-titled retained foreign bodies and that certain additional codes should be added. This revised proposed is now being presented.

TABULAR MODIFICATIONS

360 Disorders of the globe

360.5 Retained (old) intraocular foreign body, magnetic

Add Use additional code to identify foreign body (V90.01-V90.9)

360.6 Retained (old) intraocular foreign body, nonmagnetic

Add Use additional code to identify foreign body (V90.01-V90.9)

374 Other disorder of eyelids

374.8 Other disorders of eyelid

374.86 Retained foreign body of eyelid

Add Use additional code to identify foreign body (V90.01-V90.9)

376 Disorder of the orbit

376.6 Retained (old) foreign body following penetrating wound of orbit

Add Use additional code to identify foreign body (V90.01-V90.9)

385 Other disorders of middle ear and mastoid

385.8 Other disorders of middle ear and mastoid

385.83 Retained foreign body of middle ear

Add Use additional code to identify foreign body (V90.01-V90.9)

709 Other disorders of skin and subcutaneous tissue

709.4 Foreign body granuloma of skin and subcutaneous tissue

Add Use additional code to identify foreign body (V90.01-V90.9)

728 Disorders of muscle, ligament, and fascia

728.8 Other disorders of muscle, ligament, and fascia

728.82 Foreign body granuloma of muscle

Add Use additional code to identify foreign body (V90.01-V90.9)

729 Other disorders of soft tissues

729.6 Residual foreign body in soft tissue

Add Use additional code to identify foreign body (V90.01-V90.9)

796 Other nonspecific abnormal findings

796.0 Nonspecific abnormal toxicological findings

Add Use additional code for retained foreign body, if applicable, (V90.01-V90.9)

17. INJURY AND POISONING (800-999)

Add Use additional code for retained foreign body, if applicable, V90.01-V90.9)

TOXIC EFFECTS OF SUBSTANCES CHIEFLY NONMEDICINAL AS TO SOURCE (980-989)

Add Use additional code to identify:
Add retained foreign body status, if applicable, (V90.01-V90.9)
Add personal history of retained foreign body removed (V87.32)

V87 Other specified personal exposures and history presenting hazards to health

V87.3 Contact with and (suspected) exposure to other potentially hazardous substances

New code V87.32 Personal history of retained foreign body fully removed

New Category V90 Retained foreign body status
Embedded fragment status
Embedded splinter status

Excludes: artificial joint prosthesis status (V43.60-V43.69)
in situ cardiac devices (V45.00-V45.09)
personal history of retained foreign body removed (V87.32)

New subcategory V90.0 Retained radioactive and depleted isotope fragment status
New code V90.01 Retained radioactive fragments
New code V90.02 Retained depleted uranium fragments
New code V90.09 Other retained depleted isotope fragments

New code V90.1 Retained metal fragments

Excludes: retained radioactive and depleted isotope metal fragments (V90.01-V90.09)

New code V90.2 Retained plastic fragments
Acrylics fragments
Diethylhexylphthalates fragments
Isocyanate fragments

New subcategory V90.8 Other specified retained foreign body status
New code V90.81 Retained glass fragments
New code V90.82 Retained wood fragments
New code V90.84 Retained stone or crystalline fragments
Retained concrete or cement fragments
New code V90.85 Retained animal quills or spines
New code V90.89 Other specified retained foreign body status

New code V90.9 Retained foreign body status, unspecified material

Homicidal ideations

Homicidal ideation is a common medical term for thoughts about homicide. Homicidal ideation is not a disease itself, but results from other illnesses such as psychosis and delirium. Homicidal ideation is an important risk factor when trying to identify a person's risk for violence. Co-existing suicidal and homicidal ideations present jointly in many patients.

An ICD-9-CM code now exists for suicidal ideations, V62.84. A code for homicidal ideations has been requested by Darlene Hyman. The American Psychiatric Association (APA) has approved of this proposal.

TABULAR MODIFICATION

V62 Other psychosocial circumstances

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

New code V62.85 Homicidal ideations

Long term use versus prophylactic use of medications

The indexing of administration for antibiotics is inconsistent. Code V58.62, Long-term (current) use of antibiotics, is the appropriate code for all long term uses of antibiotics, including prophylactic use for the prevention of infection. Short term use of antibiotics, or any other drug, is not specifically classified in the ICD. Prophylactic use of antibiotics is indexed to V07.39, Other prophylactic chemotherapy. This is a nonspecific code which provides no information.

Category V07, Need for isolation and other prophylactic measures, includes subcategory V07.5 Prophylactic use of agents affecting estrogen receptors and estrogen levels. Codes under subcategory V07.5 may be used for any long term use of the agents classified under the subcategory, including their uses during active treatment for malignancies. This category was created due to a lack of available codes under subcategory V58.6. Creating the subcategory under V07 was approved by the American College of Obstetricians and Gynecologists (ACOG), the organization that had requested the new codes.

Having certain codes for long term use under a prophylactic use subcategory has created confusion as to the difference between long term use and prophylactic use. In fact, the subcategories are equivalent. The long term use of any drug can be for both treatment as well as prevention (prophylaxis). It is not possible for a coder to make such a distinction. The concepts are included together in a single category in the ICD-10-CM.

To correct these problems certain changes to the tabular and index are being proposed. These include changing the title of category V07 and the code titles for the codes under subcategory V07.5, and revising the index entries for prophylactic use of antibiotics. Modifications to the index to correct the inconsistency of antibiotic administration were presented at the March 09 C&M meeting, but a full proposal is being brought back now to assure full understanding prior to possible approval.

TABULAR MODIFICATIONS

Revise	V07	Need for isolation and other prophylactic <u>or treatment</u> measures
Add	Excludes:	long-term (current) (prophylactic) use of certain specific drugs (V58.61-V58.69)
Revise	V07.5	~~Prophylactic u~~<u>U</u>se of agents affecting estrogen receptors and estrogen levels
Revise	V07.51	~~Prophylactic u~~<u>U</u>se of selective estrogen receptor modulators (SERMs)
Revise		~~Prophylactic u~~<u>U</u>se of:

Revise V07.52 ~~Prophylactic u~~Use of aromatase inhibitors
Revise ~~Prophylactic u~~Use of:

Revise V07.59 ~~Prophylactic u~~Use of other agents affecting estrogen receptors and estrogen levels
Revise ~~Prophylactic u~~Use of:

Revise V07.8 Other specified prophylactic or treatment measure

Revise V07.9 Unspecified prophylactic or treatment measure

V58 Encounter for other and unspecified procedures and aftercare

V58.6 Long-term (current) drug use
Add Long-term (current) prophylactic drug use

INDEX MODIFICATIONS

Administration, prophylactic
Revise antibiotics (long-term) V58.62

Admission (encounter)
for
prophylactic
administration of
Revise antibiotics (long-term) V58.62
therapy
Revise long-term (current) (prophylactic) drug use NEC V58.69

Drug…
therapy (maintenance) status NEC
Revise long-term (current) (prophylactic) use V58.69

Revise Long-term (current) (prophylactic) drug use V58.69

Prophylactic
administration of
Revise antibiotics (long-term) V58.62

Jaw pain

A request was received to reindex the term jaw pain from code 526.9, Unspecified disease of the jaws, to code 784.99, Other symptoms involving head and neck. This request was made because jaw pain may be a symptom of a myocardial infarction and code 526.9 does not provide any information. NCHS staff agreed with the importance of this symptom, so a new code for this symptom is being proposed.

TABULAR MODIFICATION

784 Symptoms involving head and neck

784.9 Other symptoms involving head and neck

New code 784.92 Jaw pain

INDEX MODIFICATIONS

Pain…
Revise jaw 784.92
Revise maxilla 784.92

Addenda

Tabular

189 Malignant neoplasm of kidney and other and unspecified urinary organs

Revise Excludes: malignant carcinoid tumor of kidney (209.24)

285 Other and unspecified anemias

285.2 Anemia of chronic disease

285.22 Anemia in neoplastic disease

Add Excludes: aplastic anemia due to antineoplastic chemotherapy (284.89)

345 Epilepsy and recurrent seizures

Delete Excludes: ~~progressive myoclonic epilepsy (333.2)~~

403 Hypertensive chronic kidney disease

Revise any condition classifiable to 585 and 587 with any condition classifiable to 401

416 Chronic pulmonary heart disease

416.0 Primary pulmonary hypertension

Add Excludes: pulmonary hypertension NOS (416.8)

Add secondary pulmonary hypertension (416.8)

416.8 Other chronic pulmonary heart diseases

Add Pulmonary hypertension NOS

487 Influenza

487.1 With other respiratory manifestations

Add Influenza NEC

572 Liver abscess and sequelae of chronic liver disease

572.3 Portal hypertension

Add Use additional code for any associated complications, such as:
portal hypertensive gastropathy (537.89)

552 Other hernia of abdominal cavity, with obstruction, but without mention of gangrene

552.8 Hernia of other specified sites, with obstruction

Delete ~~Excludes: hernia due to adhesion with obstruction (560.81)~~

583 Nephritis and nephropathy, not specified as acute or chronic

583.6 With lesion of renal cortical necrosis
Revise Nephropathy NOS with (renal) cortical <u>necrosis</u>

629 Other disorders of female genital organs

629.8 Other specified disorders of female genital organs

Revise 629.81 ~~Habitual aborter~~ <u>Recurrent pregnancy loss without current pregnancy</u>

Revise Excludes: ~~habitual aborter~~ <u>recurrent pregnancy loss</u> with current pregnancy (646.3)

646 Other complications of pregnancy, not elsewhere classified

Revise 646.3 ~~Habitual aborter~~ <u>Recurrent pregnancy loss</u>

721 Spondylosis and allied disorders

721.4 Thoracic or lumbar spondylosis with myelopathy

721.42 Lumbar region
Delete ~~Spondylogenic compression of lumbar spinal cord~~

748 Congenital anomalies of respiratory system

748.1 Other anomalies of nose
Congenital:
Revise perforation of wall of nasal sinus

751 Other congenital anomalies of digestive system

751.2 Atresia and stenosis of large intestine, rectum, and anal canal
Absence:
Revise large intestine, congenital

751.3 Hirschsprung's disease and other congenital functional disorders of colon
Revise Macrocolon

753 Congenital anomalies of urinary system

753.4 Other specified anomalies of ureter
Revise Deviation of ureter

763 Fetus or newborn affected by other complications of labor and delivery

763.5 Maternal anesthesia and analgesia
Revise Reactions and intoxications from maternal opiates and tranquilizers during labor and delivery

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

799.8 Other ill-defined conditions

799.82 Apparent life threatening event in infant

Add Code first confirmed diagnosis, if known
Use additional code(s) for associated signs and symptoms
Delete ~~Excludes: signs and symptoms associated with a confirmed diagnosis code to confirmed diagnosis~~

836 Dislocation of knee

836.5 Other dislocation of knee, closed

836.51 Anterior dislocation of tibia, proximal end

Revise Posterior dislocation of femur, distal end, closed

836.52 Posterior dislocation of tibia, proximal end

Revise Anterior dislocation of femur, distal end, closed

836.6 Other dislocation of knee, open

836.61 Anterior dislocation of tibia, proximal end

Add Posterior dislocation of femur, distal end, open

836.62 Posterior dislocation of tibia, proximal end

Add Anterior dislocation of femur, distal end, open

SPRAINS AND STRAINS OF JOINTS AND ADJACENT MUSCLES (840-848)

Revise Includes: avulsion of joint capsule, ligament, muscle, tendon
Revise hemarthrosis of joint capsule, ligament, muscle, tendon
Revise laceration of joint capsule, ligament, muscle, tendon
Revise rupture of joint capsule, ligament, muscle, tendon
Revise sprain of joint capsule, ligament, muscle, tendon
Revise strain of joint capsule, ligament, muscle, tendon
Revise tear of joint capsule, ligament, muscle, tendon

995 Certain adverse effects not elsewhere classified

Revise 995.2 Other and unspecified adverse effect of drug, medicinal and biological substance ~~(due) to correct medicinal substance properly administered~~

Delete ~~Adverse effect to correct medicinal substance properly administered~~

Delete ~~Allergic reaction to correct medicinal substance properly administered~~

Delete ~~Hypersensitivity to correct medicinal substance properly administered~~

Delete ~~Idiosyncrasy due to correct medicinal substance~~

~~properly administered~~

Delete ~~Drug:~~

Delete ~~hypersensitivity NOS~~

Delete ~~reaction NOS~~

995.20 Unspecified adverse effect of unspecified drug, medicinal and biological substance

Add Unspecified adverse effect of unspecified medicinal substance properly administered

995.27 Other drug allergy

Add Allergic reaction NEC (due) to correct medical substance properly administered

Add Hypersensitivity (due) to correct medical substance properly administered

995.29 Unspecified adverse effect of other drug, medicinal and biological substance

Add Unspecified adverse effect of medicinal substance NEC properly administered

V10 Personal history of malignant neoplasm

V10.5 Urinary organs

Add Excludes: personal history of malignant carcinoid tumor (V10.91)

Add personal history of malignant neuroendocrine tumor (V10.91)

V13 Personal history of other diseases

V13.2 Other genital system and obstetric disorders

Revise Excludes: ~~habitual aborter~~ recurrent pregnancy loss (646.3)

V23 Supervision of high-risk pregnancy

V23.2 Pregnancy with history of abortion

Revise Excludes: ~~habitual aborter~~ recurrent pregnancy loss:

V26 Procreative management

V26.3 Genetic counseling and testing

V26.32 Other genetic testing of female

Revise Use additional code to identify ~~habitual aborter~~ recurrent pregnancy loss (629.81, 646.3)

Revise V26.35 Encounter for testing of male partner of ~~habitual aborter~~ female with recurrent pregnancy loss

TRANSPORT ACCIDENTS (E800-E848)

Definitions and examples related to transport accidents

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

Add Includes: motorized mobility scooter
Revise wheelchair (electric)

E017 Activities involving roller coasters and other types of external Motion

Revise E017.0 Roller coaster riding

Revise PLACE OF OCCURRENCE (E849)

E865 Accidental poisoning from poisonous foodstuffs and poisonous

Revise Excludes: anaphylactic shock due to adverse food reaction (995.60-995.69)

E884 Other fall from one level to another

E884.3 Fall from wheelchair

Add Fall from motorized mobility scooter

Add Fall from motorized wheelchair

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

E885.0 Fall from (nonmotorized) scooter

Add Excludes: fall from motorized mobility scooter (E884.3)

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