ICD-9-CM Changes for Fiscal Year 2006

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Every year ICD-9-CM is updated with new codes for diagnoses and procedures to reflect current medical practice and new technology. This year coders will find a number of significant changes in the new and revised codes for conditions coded on a daily basis in most healthcare settings. This article reviews some of the more significant new diagnosis and procedure codes.

Volume Depletion, Dehydration, and Hypovolemia

The American Academy of Pediatrics requested expansion of 276.5, Volume depletion, to create specific codes for dehydration and hypovolemia. Volume depletion may refer to total body water (276.51, Dehydration) or depletion of blood volume (276.52, Hypovolemia). Hypovolemia may occur with or without dehydration, and treatment of the two conditions is different.

Immune Thrombocytopenia Purpura

Code 287.3, primary thrombocytopenia, was expanded to include the more current terminology and to allow for identification of other various forms of primary thrombocytopenia now included under code 287.3. The new codes are 287.30, Primary thrombocytopenia, unspecified; 287.31, Immune thrombocytopenic purpura; 287.32, Evans' syndrome; 287.33, Congenital and hereditary thrombocytopenic purpura; and 287.39, Other primary thrombocytopenia.

Sleep Disorders

The American Academy of Sleep Medicine requested changes to describe the variety of sleep disorders and symptoms known to exist today. The new codes are 291.82, Alcohol-induced sleep disorders; 292.85, Drug-induced sleep disorders; 327.00–327.09, Organic disorders of initiating and maintaining sleep; 327.10–327.19, Organic disorder of excessive somnolence (organic hypersomnia); 327.20–327.29, Organic sleep apnea; 327.30–327.39, Circadian rhythm sleep disorders; 327.40–327.49, Organic parasomnia; 327.51–327.59, Organic sleep-related movement disorders; and 327.8, Other organic sleep disorders. As a result, the symptom codes for sleep disturbances (780.51–780.58) have been revised to be consistent with current terminology. Code V69.5 was added to reflect behavioral insomnia of childhood.

Diabetic Retinopathy and Diabetic Macular Edema

Unique codes were added to clearly identify the staging and severity of diabetic retinopathy and diabetic macular edema for clinical management and epidemiological studies to better understand the longitudinal progression of these diseases. The new codes for nonproliferative diabetic retinopathy are 362.03, NOS; 362.04, Mild; 362.05, Moderate; 326.06, Severe; and 362.07, Diabetic macular edema.

Acute Coronary Syndrome

A modification to category 410, acute myocardial infarction, was made to allow for the classification of ST-segment elevation myocardial infarction (STEMI) and non-ST segment elevation (NSTEMI). The American College of Cardiology and the American Heart Association classify patients with acute coronary syndrome into three groups: STEMI, NSTEMI, and unstable angina. The request was made to improve the monitoring of performance measures initiated (such as Joint Commission on Accreditation of Healthcare Organizations). The code for NSTEMI is now 410.7, with a fifth digit for the episode of care. All other codes within category 410 will be considered different locations of STEMIs.

Peritonitis and Peritoneal Abscess

New codes have been created to provide more specificity than code 567.2 allowed. The new codes are 567.21, Peritonitis (acute) generalized; 567.22, Peritoneal abscess, including subhepatic and subphrenic abscess; 567.23, Spontaneous bacterial peritonitis; and 567.29, Other suppurative peritonitis such as subphrenic peritonitis. Code 567.8 has also been expanded to codes 567.81, Choleperitonitis (also referred to as peritonitis due to bile); 567.82, Sclerosing mesenteritis (including fat necrosis of peritoneum); and 567.89, Other specified peritonitis.

Chronic Kidney Disease

Clinical practice guidelines for chronic kidney disease (CKD) were published by the National Kidney Foundation and have been accepted by the National Institutes of Health. CKD has five stages based on the glomerular filtration rate. Only patients on dialysis or receiving kidney transplants may be considered as having end-stage renal disease, which Congress, not the medical community, mandated.

Based on the clinical practice guidelines for the evaluation and treatment of CKD, category 585 codes have been retitled and expanded to the fourth digit level: 585.1, CKD, Stage I; 585.2, CKD, Stage II (mild); 585.3, CKD, Stage III (moderate); 585.4, CKD, Stage IV (severe); 585.5, CKD, Stage V; 585.6, End-stage renal disease; and 585.9, CKD, unspecified (to be used for incomplete terminology such as chronic renal disease, chronic renal failure NOS, and chronic renal insufficiency).

Modifications have also been made adding inclusion terms to code 593.9, Unspecified disorder of kidney and ureter. The phrases “acute renal disease,” “acute renal insufficiency,” and “renal disease NOS” will be indexed to code 593.9. Hopefully, this will clear up the confusion of the appropriate classification of imprecise terms such as acute or chronic renal insufficiency.

Teratogens

A number of substances called teratogens are known to have damaging effects on the development of a fetus when a mother is exposed to the substance during pregnancy. The American College of Medical Genetics requested new codes to track certain teratogens: 760.74, Noxious influences affecting fetus or newborn via placenta or breast milk, anti-infectives; 760.77, anticonvulsants; and 760.78, antimetabolic agents.

Meconium and Other Aspiration in Neonates

Based on input from the American Academy of Pediatrics, code changes have been made related to neonatal aspiration, meconium aspiration, meconium aspiration syndrome, and meconium staining. Meconium aspiration is defined as the presence of meconium (a baby’s first stool) below the vocal cords and occurs in up to 35 percent of live births with meconium staining. Meconium staining is not the same as meconium aspiration. Meconium in the amniotic fluid gives the fluid a greenish color. If the baby passes a meconium stool before birth, the amniotic fluid is stained, and the baby is covered with meconium. This is called meconium staining. This passage of meconium may be an indication of fetal distress. Meconium aspiration syndrome occurs when meconium is inhaled into the lungs by a newborn with his or her first breath, which invokes an inflammatory reaction.

ICD-9-CM previously had a single code for meconium aspiration syndrome, 770.1, which was inappropriate for meconium staining and meconium aspiration. The National Association of Children’s Hospitals and Related Institutions requested unique codes for these conditions. The new codes are:

- 763.84, Meconium passage during delivery
- 770.10, Fetal and newborn aspiration, unspecified
- 770.11, Meconium aspiration without respiratory symptoms
- 770.12, Meconium aspiration with respiratory symptoms
- 770.13, Aspiration of clear amniotic fluid without respiratory symptoms
- 770.14, Aspiration of clear amniotic fluid with respiratory symptoms
- 770.15, Aspiration of blood without respiratory symptoms
- 770.16, Aspiration of blood with respiratory symptoms
- 770.17, Other fetal and newborn aspiration without respiratory symptoms
- 770.18, Other fetal and newborn aspiration with respiratory symptoms
- 770.85, Aspiration of postnatal stomach contents without respiratory symptoms

- 770.86, Aspiration of postnatal stomach contents with respiratory symptoms
- 779.84, Meconium staining

Asphyxia and Hypoxemia

Asphyxia originally was defined as the absence of a pulse, but is now associated with hypoxia and hypercapnia. Hypoxia is a deficiency of oxygen reaching the body's tissue, usually due to low-inspired oxygen. Hypoxemia is a deficiency of oxygenation in the blood. Hypercapnia is elevated levels of carbon dioxide in the blood. A person may have low oxygen levels and not have asphyxia. To differentiate these clinical states, two new codes have been created: 799.01, asphyxia, and 799.02, hypoxemia.

Mechanical Complications of Joint Prosthesis

ICD-9-CM diagnosis codes do not differentiate between the specific causes of the failures of hip and knee replacements. New codes were created to specify:

- 996.40, Unspecified mechanical complication of internal orthopedic device, implant, and graft
- 996.41, Mechanical loosening of prosthetic joint
- 996.42, Dislocation of prosthetic joint
- 996.43, Prosthetic joint implant failure
- 996.44, Periprosthetic fracture around prosthetic joint
- 996.45, Periprosthetic osteolysis
- 996.46, Articular bearing surface wear of prosthetic joint
- 996.47, Other mechanical complication of prosthetic joint implant
- 996.49, Other mechanical complication

Encounter for Chemotherapy and Immunotherapy

Code V58.1, Chemotherapy, was expanded to the fifth digit level to create a code for immunotherapy. These new codes are designated specifically for encounters for treatment of neoplastic conditions. Immunotherapy, also called immune therapy or biologic therapy, is treatment that stimulates the body's immune defense system to fight infection and disease. Immunotherapy can stimulate the growth and activity of cancer-killing cells; for example, high-dose interleukin 2 used in the treatment of malignant melanoma and renal cell carcinoma. Specific codes now exist to describe the encounter when a patient receives either chemotherapy or immunotherapy, such as V58.11, Encounter for antineoplastic chemotherapy, and V58.12, Encounter for antineoplastic immunotherapy.

Vaccination Not Given

The American Academy of Pediatrics also requested additional codes to identify the multiple reasons why a patient did not receive a routine immunization or vaccination. Tracking why an immunization was not given can be as important as tracking those that are given. Subcategory V64.0, Vaccination not carried out, has been expanded to:

- V64.00, Unspecified reason
- V64.01, Acute illness
- V64.02, Chronic illness or condition
- V64.03, Immune compromised state
- V64.04, Allergy to vaccine or component
- V64.05, Caregiver refusal
- V64.06, Patient refusal
- V64.07, Religious reasons
- V64.08, Patient had disease being vaccinated against
- V64.09, Other reason

Changes to Volume 3, ICD-9-CM Procedures

Percutaneous Transluminal Coronary Angioplasty and Adjunct Vascular System Procedures

One of the most dramatic changes to volume 3 of ICD-9-CM for October 1, 2005, is the replacement of the previous codes for percutaneous transluminal coronary angioplasties with one new code, 00.66, Procedures on blood vessels (within the subcategory 00.6). The previous codes to describe the number of vessels treated and the number of stents placed were deleted (36.01, 36.02, and 36.05).

A new series of codes was added to describe the number of vessels involved and the number of stents inserted. These codes will apply to both coronary and peripheral vessels and will be coded in addition to the therapeutic procedure to provide detailed information about the total procedure. Codes 00.40–00.43 describe the number of vessels treated. Codes 00.45–00.48 describe the number of stents placed in the vessels. As appropriate, the coder will assign a code in the range of 00.40–00.43 and 00.45–00.48 for the patient having this type of procedure. The code-also notes included under subcategory 00.4 remind the coder to assign the angioplasty or atherectomy code (00.61–00.62, 00.66, 39.50), endarterectomy code (38.10–38.18), insertion of vascular stents (00.55, 00.63–00.65, 36.06–36.07, 39.90), or other removal of coronary artery obstruction (36.09) as appropriate for each individual patient.

Hip and Knee Replacement Revision Procedures

In the past, code 81.53 was used to capture all partial and total revision hip replacements, and code 81.55 captured all revision knee replacements. Revision procedures may include replacing any or all of the implants, including the femoral component, the acetabular component, and the bearing surface for hip procedures or the tibial insert, femoral component, or patellar component for knee procedures.

New codes were added to describe the revision of a hip replacement, both total and partial. Codes 00.70–00.73 describe the component of the hip replacement that is being removed and replaced or whether a total revision of the previous hip replacement was performed. A code-also note appears under the hip replacement and hip revision codes to identify the type of bearing surface, if known (00.74–00.76). Finally, if the hip replacement or revision surgery included the removal of a joint (cement) spacer, an additional code (84.57) would be required.

New codes were added to describe the revision of a knee replacement. The coder will report up to two components using 00.81–00.83 to describe revision of knee replacement (tibial, femoral, or patellar components). Code 00.80, Revision of knee replacement, total (all components), would be used for all components. Another option during knee replacement revision is the replacement of the tibial insert or liner, reported with 00.84.

The code titles for both 81.53 and 81.55 were revised to include “not otherwise specified.” These codes are to be used if the coder is unable to determine the components that were replaced in the knee or hip joint. Codes (00.70–00.73, 00.80–00.84) are used instead if documentation supports their assignment.

Adjunct Codes for External Fixator Devices

Previously ICD-9-CM did not distinguish between different types of fracture fixation devices. A new subcategory with codes 84.71–84.73 was added to identify the various types of external devices designed to secure bone fragments with temporary percutaneous implants.

Insertion or Replacement of Single or Dual Array Rechargeable Neurostimulator Pulse Generator

New codes were added to identify the rechargeable neurostimulators. Neurostimulator therapy treats chronic pain using a pulse generator with leads placed either in the epidural space of the spinal column or at a targeted peripheral nerve.

For Further Review

Equally important is a review of the entire addendum for volumes 1, 2, and 3. In these documents, the coder can see all details of additions, revisions, and deletions made to the tabular list and alphabetic index that go into effect October 1, 2005. These are found at www.cdc.gov/nchs/data/ icd9/icdidx_addenda06.pdf, www.cdc.gov/nchs/data/icd9/icdtab_addenda06.pdf, and www.cms.hhs.gov/paymentsystems/icd9/icd9addendafy06.pdf.

Numerous significant changes were made in ICD-9-CM this year. The new codes must be used starting October 1, 2005, and will add valuable information for reimbursement, quality management, and public health research.

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Article citation:
Schraffenberger, Lou Ann. "ICD-9-CM Changes for Fiscal Year 2006." *Journal of AHIMA* 76, no.8 (September 2005): 70-72,74,76.

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