

Welcome to *California*



Identifying Healthcare-Associated Infections: Results of 2014 Validation and Review of Best Practices

Statewide Webinar
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Objectives

1. Review three-year validation plan
2. Describe 2014 validation findings from 345 California hospitals
3. Review commonly encountered gaps in case-finding
4. Identify best practices for case-finding
5. Review how to enhance SSI case finding using administrative codes

Validation of California Hospital HAI Data

Three-year validation plan, approved/endorsed by the CDPH HAI Advisory Committee

- Year 1 (2013) was to ensure hospitals were doing core surveillance practices
 - Each hospital was asked to attest to 6 surveillance/ review best practices
- Year 2 (2014) was to help hospitals assess and improve case-finding
- Year 3 (2015) will be a process to help hospitals evaluate/improve their SSI surveillance

Objectives of CDPH Validation, 2014

Onsite and internal validation was performed to:

- Gain a better understanding of how completely SSI, CLABSI, CDI, MRSA/VRE BSI surveillance is being performed
- Provide feedback and one-on-one coaching
- Provide education based on common errors, identified gaps, misinterpretations
- Identify hospitals that need additional assistance
 - CDPH will continue to work with hospitals until all hospitals are proficient in identifying and reporting HAI

Validation Process and Participation

Larger Volume Hospitals

- Onsite visit from HAI Program Liaison Infection Preventionist (IP) who independently validated hospitals' HAI data
- Infections Reviewed
 - Colon SSI, CLABSI, MRSA-VRE BSI, CDI

Smaller Volume Hospitals

- Led through an internal review of their HAI data using a toolkit developed by the HAI Program
- Infections Reviewed
 - Colon SSI, hysterectomy SSI, hip SSI, CLABSI, MRSA-VRE BSI, CDI

Validation Process in Smaller Volume Hospitals

- Self-directed validation process using a HAI Validation Workbook
 - Similar process to onsite validation; performed internally
- Training webinars conducted in early October 2014
- 46% reported the process took ≤ 4 hours to complete

Validation Process in Larger Volume Hospitals

- Onsite 1-day review by an HAI Program Liaison IP
- Liaison IP required to have access to all medical records
- Used standardized data collection tools
- Produced hospital-specific findings for presentation prior to exit
- Reviewed data from 1st quarter 2014
 - With the intent that gaps found in 1st quarter could be addressed by the hospital in quarters 2-4

Validation Process in Larger Volume Hospitals (continued)

For SSI validation

- Requested list of colon procedures
- Requested search of post-op diagnostic codes (from billing or medical records) to produce list of records “flagged” for validation review

For CLABSI and MRSA-VRE BSI validation

- Requested list of positive blood cultures
- Selected for pathogens more likely to represent CLABSI than BSI secondary to another site of infection

For CDI validation

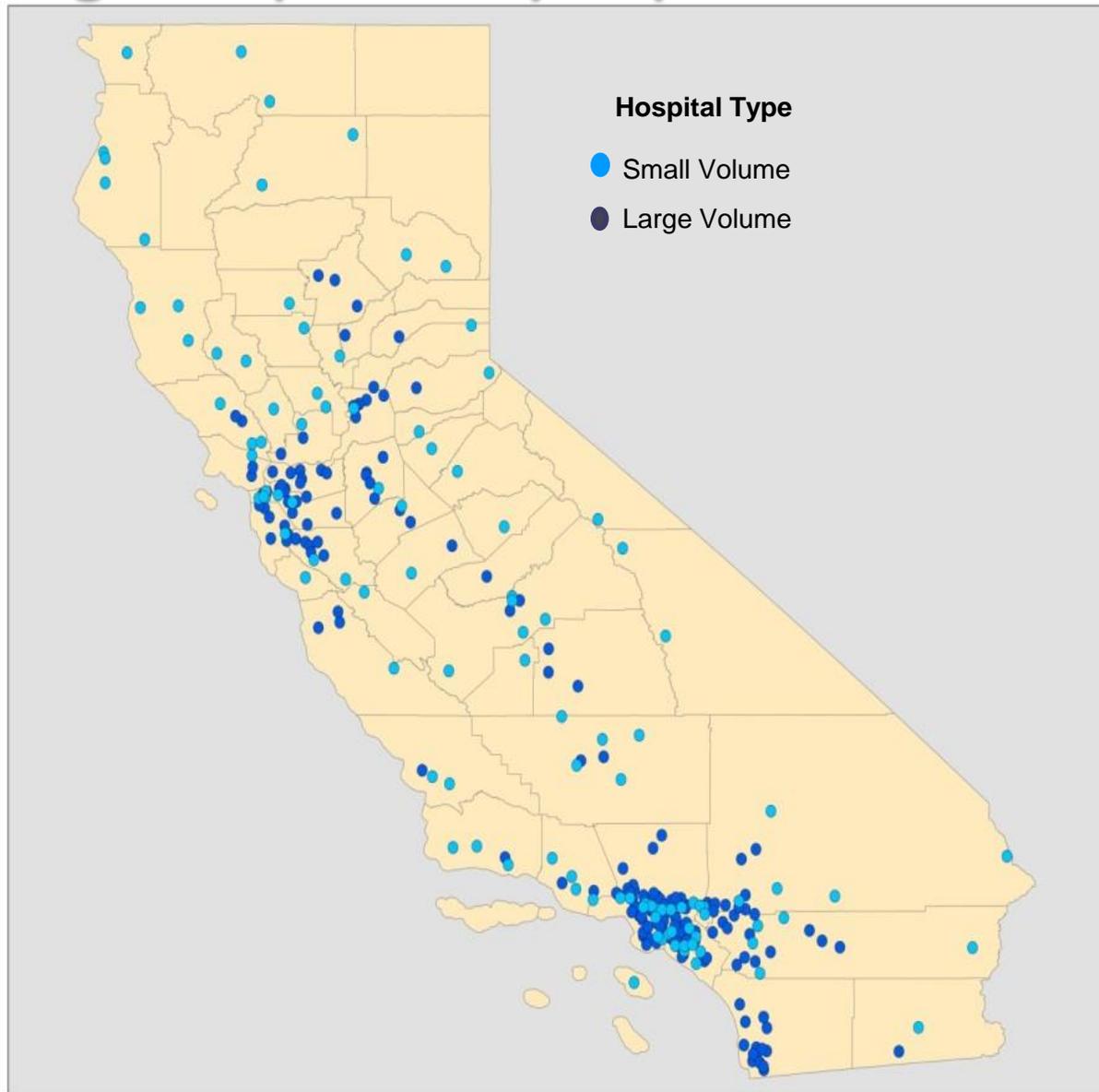
- Requested list of all positive CDI tests

Completing Validation Process

- Provided immediate results on sensitivity (case-finding percentage)
- Hospitals expected to correct data in NHSN based on validation findings
- Hospitals expected to incorporate ICD9/10-based surveillance to improve SSI case-finding moving forward

2014 Validation Findings

Participating Hospitals by Zip Code



Participating Hospital Characteristics

Larger Volume Hospitals N=234 (92%)

	Min	25%	Median	75%	Max
Beds	36	152	226.5	347	896
Patient Days	4,660	27,194	41,099	67,835	237,007

Smaller Volume Hospitals N=111 (81%)

	Min	25%	Median	75%	Max
Beds	4	25	50	96	226
Patient Days	52	2,629	6,899	13,079	39,274

SSI Validation Findings, 2014

Larger Volume Hospitals

$$\frac{204 \text{ Colon SSI Reported}}{295 \text{ Total Colon SSI}} = 69\%$$

Smaller Volume Hospitals

$$\frac{39 \text{ Colon SSI Reported}}{48 \text{ Total Colon SSI}} = 81\%$$

$$\frac{54 \text{ Hyst/Hip SSI Reported}}{58 \text{ Total Hyst/Hip SSI}} = 93\%$$

Common Reasons for Missed SSI, 2014

- Hospital did not know why SSI missed
- Review did not include evaluation of progress notes for documented signs and symptoms of infection
- No positive culture available
- Hospital was not reviewing post-op ICD-9 flag codes as part of surveillance

Common ICD post-op “flag” codes among missed SSI

- 567.22 Peritoneal abscess – 29% of missed colon SSI
- 998.59 Other postoperative infection - 38% of missed colon SSI

CLABSI Validation Findings, 2014

Larger Volume Hospitals

$$\frac{294 \text{ CLABSI Reported}}{402 \text{ Total CLABSI}} = 73\%$$

Smaller Volume Hospitals

$$\frac{67 \text{ CLABSI Reported}}{72 \text{ Total CLABSI}} = 93\%$$

Common Reasons for Missed CLABSI, 2014

- Hospital did not know why CLABSI missed
- Inaccurately attributed CLABSI as a secondary BSI to a primary infection site
 - Most common: GI pathogens in the blood determined to be secondary to GI infection or SSI although validation revealed surveillance definitions were not met
- Failure to monitor two or more blood cultures due to common commensal organisms as being from same patient and meeting CLABSI definition

Common Organisms Associated with Missed CLABSI

Larger Volume Hospital Validation

Organism	Missed CLABSI	
	#	(%)
<i>Enterococcus</i>	39	(36)
<i>Candida</i> species	24	(22)
Coagulase Negative <i>Staphylococcus</i>	19	(18)
<i>Klebsiella</i> species	13	(12)
<i>Staphylococcus aureus</i>	12	(11)
<i>Pseudomonas</i> species	4	(4)
Total*	111	

*Some CLABSI due to multiple organisms; results add to over 100%

MRSA-VRE BSI Validation Findings, 2014

Larger Volume Hospitals

$$\frac{1267 \text{ MRSA-VRE BSI Reported}}{1431 \text{ Total MRSA-VRE BSI}} = 88\%$$

Smaller Volume Hospitals

$$\frac{166 \text{ MRSA-VRE BSI Reported}}{184 \text{ Total MRSA-VRE BSI}} = 90\%$$

CDI Validation Findings, 2014

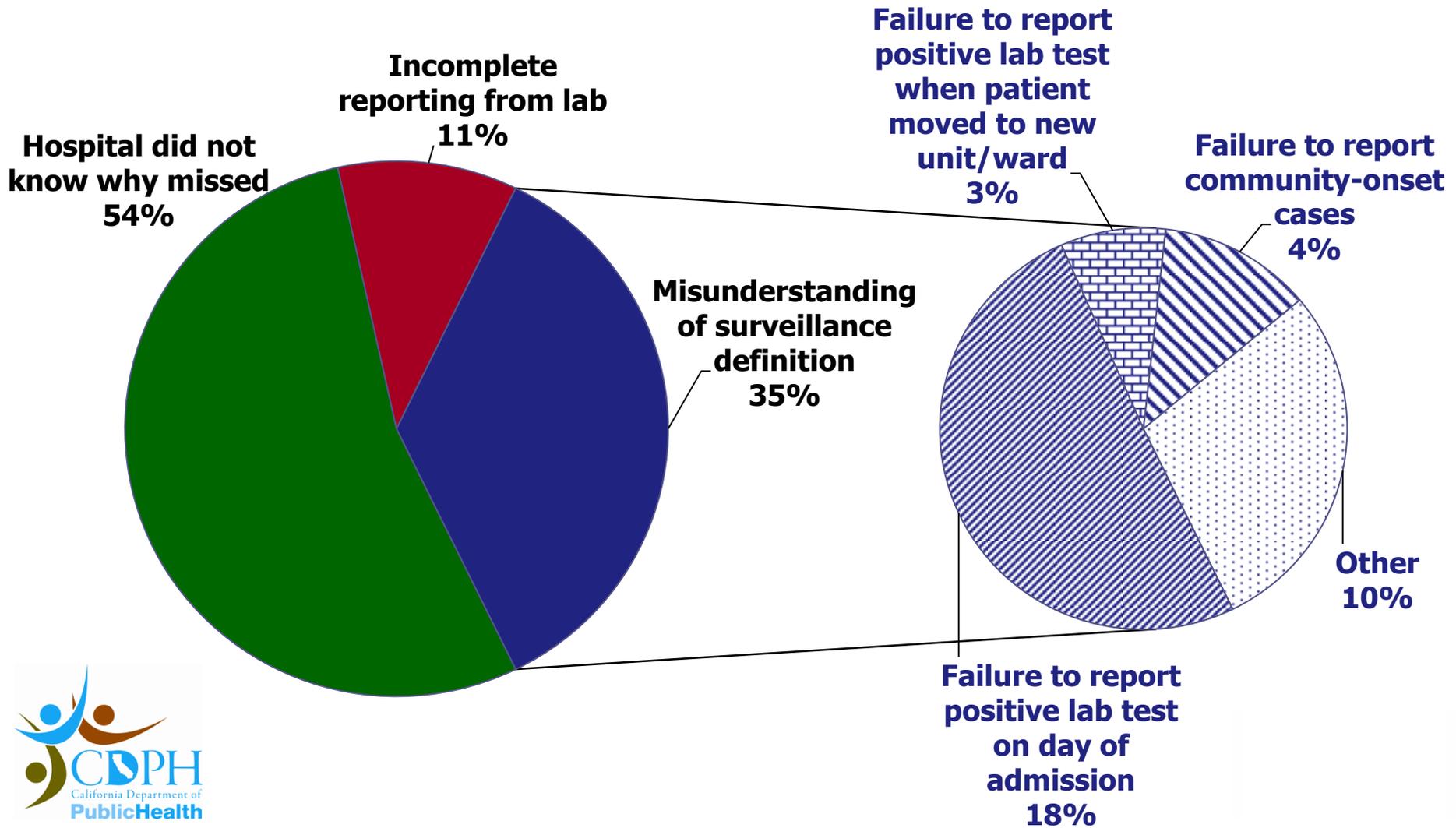
Larger Volume Hospitals

$$\frac{3460 \text{ CDI Reported}}{3731 \text{ Total CDI}} = 93\%$$

Smaller Volume Hospitals

$$\frac{578 \text{ CDI Reported}}{629 \text{ Total CDI}} = 92\%$$

Reasons for Missed CDI and MRSA-VRE BSI, 2014



Improving Surveillance

Quality HAI Surveillance

Requires

CONSISTENCY

COORDINATION

CONFIDENCE

COMPASSION

CONSISTENCY

Complete case-finding requires a comprehensive evaluation of a minimum clinical data set

	Always Step 1	Step 2
CLABSI	Review every positive blood culture	Review for presence of central line
SSI	Identify and review <ul style="list-style-type: none"> - ICD post-op diagnosis "flag" codes - Returns-to-OR - Post-op hospital re-admissions (30d or 90d) 	Realize that culture-based surveillance alone <u>misses</u> 50-60% of SSI Consider reviewing post-op imaging (CT or MRI) and discharge summaries
MRSA/VRE BSI	Review all final <i>S.aureus</i> and Enterococcal blood cultures	Include and report all positives from ER and 24-hour observation locations (<i>new in 2015</i>)
CDI	Review all <i>C.difficile</i> toxin positives tests (PCR or assay)	Include and report all positives from ER and 24-hour observation locations (<i>new in 2015</i>)

COORDINATION

- IP and Quality department staff can't do it alone
- HAI surveillance needs to be a shared responsibility across hospital units, services, and disciplines
- The more connection of relevant data points, the better the surveillance (e.g. **ICD9/10 post-op billing codes, imaging studies, new antimicrobial starts**)
- Ongoing collection of patient surgical risk factors (i.e. denominator data) requires data system solutions

CONFIDENCE

- ✓ Know the HAI surveillance definitions (refer to them often!)
- ✓ Apply definitions with confidence the same way every time
- ✓ Seek assistance for ambiguity*

Difference Between Clinical and Surveillance Definitions

- **Clinical criteria used by physicians for patient care and management may differ from surveillance criteria**
 - Clinical
 - Patient centered
 - Used for therapeutic decisions
 - Surveillance
 - Population based
 - Applied exactly the same way each time



Surveillance Definitions

CDC/NHSN Surveillance Definitions for Specific Types of Infections

INTRODUCTION

This chapter contains the CDC/NHSN surveillance definitions and criteria for all specific types of infections. Comments and reporting instructions that follow the site-specific criteria provide further explanation and are integral to the correct application of the criteria. This chapter also provides further required criteria for the specific infection types that constitute organ/space surgical site infections (SSI) (e.g., mediastinitis [MED] that may follow a coronary artery bypass graft, intra-abdominal abscess [IAB] after colon surgery).

Additionally, it is necessary to refer to the criteria in this chapter when determining whether a positive blood culture represents a primary bloodstream infection (BSI) or is secondary to a different type of HAI (see [Appendix 1 Secondary Bloodstream Infection \(BSI\) Guide](#)). A BSI that is identified as secondary to another site of HAI must meet one of the criteria of HAI detailed in this chapter. Secondary BSIs are not reported as separate events in NHSN, nor can they be associated with the use of a central line.

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CARE-ASSOCIATED

ssion (POA) or a healthcare-



*Contact NHSN@cdc.gov or HAIProgram@cdph.ca.gov

COMPASSION

- Patients want to feel safe
- Patient advocates want to be assured that providers are doing everything possible to prevent infections
- Identifying **every** HAI is necessary to
 1. understand what your patients are experiencing
 2. target prevention efforts
 3. measure HAI prevention progress

ConsumersUnion.org
Nonprofit Publisher of Consumer Reports



NHSN Recommended SSI Surveillance Methods

- Direct examination of wounds
 - Coordinate with surgical care colleagues
- Review medical records
 - CDPH recommends using ICD diagnosis codes to flag records for SSI review
- Surgeon surveys by mail or telephone
- Patient surveys by mail or telephone

Improving SSI Case-finding

Problem: SSI surveillance strategy that relies primarily on positive cultures, patients returning to surgery, and/or surgical patients being re-admitted to identify cases

Recommendations:

- Use post-operative ICD-9 (or 10) codes to “flag” cases to review for possible SSI
- Consider reviewing imaging results and discharge summaries

Example of ICD Post-Op Diagnosis Codes to Flag Record for SSI Review

Appendectomy: Identify patients with these codes within 40 days of surgery

ICD-9		ICD-10	
567.21	Peritonitis (acute) generalized	K63.0	Abscess of intestine
567.22	Peritoneal abscess	K63.2	Fistula of intestine
567.29	Other suppurative peritonitis	K65.0	Generalized (acute) peritonitis
567.38	Other retroperitoneal abscess	K65.1	Peritoneal abscess
569.5	Abscess of intestine	K68.19	Other retroperitoneal abscess
569.81	Fistula of intestine, excluding rectum and anus	L03.319	Cellulitis of trunk, unspecified
682.2	Cellulitis and abscess of trunk	T81.31XA	Disruption of external operation (surgical) wound, not elsewhere classified, initial encounter
998.31	Disruption of internal operation (surgical) wound	T81.32XA	Disruption of internal operation (surgical) wound, not elsewhere classified, initial encounter
998.32	Disruption of external operation (surgical) wound	T81.4XXA	Infection following a procedure, initial encounter
998.51	Infected postoperative seroma	T81.83XA	Persistent postprocedural fistula, initial encounter
998.59	Other postoperative infection		
998.6	Persistent postoperative fistula		

CDPH released sets of codes for each of the 29 reportable procedure categories in April 2015 (shown at end of slide set)

Improving SSI Surveillance - 1

Problem: Misunderstanding SSI surveillance requirements as related to 'dirty' cases

Recommendations:

- ALL of the 29 procedures required in California are required to be reported regardless of wound class
 - Entering the correct wound class of contaminated or dirty will result in a more accurate calculation of the "expected" number of SSI used to calculate your SIR
- All SSI must to be reported regardless of wound class

Improving SSI Surveillance - 2

Problem: Misunderstanding SSI surveillance definitions

Recommendations:

- Keep NHSN surveillance definitions handy. Refer to them often. Do not rely on memory!
- Use a “check sheet” to document SSI criteria

Improving CLABSI Case-finding

- Review every positive blood culture from inpatients - make sure you are receiving all final blood culture results
- Perform internal validation at least once/year
 - Ask to have retrospective line list of all positive blood culture results produced directly from your hospital's laboratory information system
 - Compare to positive blood culture list used for routine CLABSI surveillance
- Determine if patient had central line during hospitalization before ruling out CLABSI
 - Develop your own method based on available information systems

Know the CLABSI Surveillance Definition

- **Criterion 1:** Single blood culture if a pathogen, which means any organism other than a common commensal
 - Presence of central line and BSI not related to infection at another site
 - No other symptoms are needed to confirm CLABSI
- **Criterion 2:** 2 positive blood cultures with same common commensal organism, plus 1 of 3 symptoms: fever, chills, or hypotension
 - Cultures can be drawn on same or 2 consecutive days
 - Considered 2 separate blood draws if from 2 peripheral sites; 1 peripheral and 1 central line port; 2 different ports from the same central line; 2 different central lines
 - Same even if 1 at genus level (e.g. coag negative staph) and the other at species level (e.g. Staph epi)



Determine if Primary BSI (CLABSI) or Secondary BSI

- CLABSI can be ruled out if patient has a primary site of infection
- For many surveillance definitions, a positive blood culture is included in the criteria and can help define the infection
- To classify BSI as secondary to another site, you must ensure the primary site of infection meets the NHSN surveillance definition



Improving CLABSI Surveillance - 1

Problem: A BSI due to a GI pathogen in a patient with a central line is incorrectly attributed as secondary to a Organ/Space SSI

Recommendations:

- To be an Organ/Space SSI, a **specific** infection site definition must also be met
 - Most commonly, gastrointestinal tract infection (GIT) and intra-abdominal infection (IAB)
 - If the criteria for both SSI and a specific site are not met, Organ/Space SSI is not the primary infection
- In a patient with a central line, if no primary infection site is identified, GI pathogens in the blood must be attributed as CLABSI

Improving CLABSI Surveillance - 2

Problem: Failure to report BSI due to a GI pathogen that meets the definition of a Mucosal Barrier Injury Laboratory-Confirmed Bloodstream Infection (MBI-CBI)

Recommendations:

- MBI-CBI are still CLABSI and must be reported

Improving CLABSI Surveillance - 3

Problem: A BSI due to a *Candida* species in a patient with a central line is incorrectly attributed as secondary to Pneumonia or UTI

Recommendations:

- *Candida* in the blood is included in HAI pneumonia definition for immunocompromised patients only
 - In most patients, *Candida* are not an etiologic agent of pneumonia
- UTI surveillance definitions now exclude *Candida*, yeasts, and other non-bacterial organisms from being the sole organism in urine cultures to determine primary infection
- In a patient with a central line, if no primary infection site is identified, *Candida* in the blood must be attributed as CLABSI

Improving CLABSI Surveillance - 4

Problem: Failure to identify CLABSI caused by common skin commensals, often due to missing the 2nd positive culture

Recommendations:

- Create a lab line list of all positive blood cultures for a month or quarter, then sort by patient name or MR# to identify multiple blood culture results for the same patient
- To meet CLABSI criteria when causative organism is a common commensal, must also verify clinical symptom of fever, chills, or hypotension

Difference Between CLABSI and MRSA-VRE BSI Surveillance and Reporting

CLABSI surveillance

- Requires positive blood culture in the presence of a central line
- Exclude if bloodstream infection secondary to another site of infection
- Report only hospital-onset infections

MRSA-VRE BSI surveillance

- Requires only the positive MRSA or VRE blood culture; patient may or may not have a line
- Report both primary and secondary bloodstream infections
- Report both community-onset and hospital-onset infections

When MRSA or VRE is the pathogen causing CLABSI, you must report the infection twice to capture in both your CLABSI surveillance and MRSA BSI surveillance

Improving LabID Surveillance - 1

Problem: Failure to report positive CDI test or MRSA-VRE blood cultures done in the emergency department

Recommendation:

- All positive CDI test results from your hospital lab are reported now
- Must now report all positive results for patients in emergency department and 24-hour observation units
 - entered and assigned to the outpatient location in which the specimen was collected

Improving LabID Surveillance - 2

Problem: Failure to report positive CDI test or MRSA-VRE blood cultures when patient moved to a new location

Recommendation:

- Must monitor movement of patients within the facility
- A positive test must be reported when a patient transfers to another location within the facility, even if less than 14 days since the previous positive test

Improving LabID Surveillance - 3

Problem: Failure to report positive CDI test or MRSA-VRE BSI when “community onset”

Recommendation:

- All positive CDI and MRSA-VRE BSI are included in surveillance and must be reported the LabID module

Improving Completeness of MRSA-VRE BSI Reporting

- Verify blood culture results you are receiving from your lab are complete and final
- Cases may be missed if unclear description of MDRO status on lab reports
 - Ask lab to report out as “MRSA” or “VRE” rather than relying on IP review of the susceptibility profile
 - Work with lab so positive specimen results are straightforward
 - An unclear MDRO status can affect not only surveillance and reporting but also treatment, isolation, and cleaning practices

Improving Completeness of CDI Reporting

Ensure you have identified and reported all CDI

- Ask your lab to run a retrospective line list positive CDI tests for a given time period
 - i.e. the previous month or quarter
 - Sort by patient name or ID
- Using NHSN Analysis, run a line list of all CDI LabID events you reported in the same time period
- Compare the lists

Resources for HAI Surveillance and Validation

www.cdph.ca.gov/HAI

Healthcare Providers



Information for Infection Prevention Programs

- ⇒ California Infection Control Guidelines
- ! Updated [Smaller Volume Hospitals Homepage](#)
- ⇒ HAI Information for Long-Term Care Facilities (LTCF)
- ⇒ HAI Liaison Program - IP Assignments by Hospital
- ! New Sustaining Infection Prevention Progress
- ⇒ AFLs, Legislation and Regulations

NHSN Guidance Specific to California Hospitals

- ⇒ NHSN Guidance Specific to California Hospitals
- ⇒ Data Validation for Improving HAI Surveillance and Prevention
- ! Updated [NHSN Analysis for Prevention Guidance Series](#)

Influenza Information

- ⇒ Healthcare Personnel Influenza Vaccination
- ⇒ Influenza Vaccination Information for Consumers

Summary

- Quality HAI surveillance requires consistent methods, coordination of data collection, confidence in applying definitions, and compassion for patients in whom HAI must be prevented
- 2014 validation revealed that some hospitals need to improve CLABSI, LabID, and/or SSI case-finding
 - Hospitals that missed any CLABSI or >15% CDI/MRSA-VRE BSI will be re-evaluated in 2015
 - All hospitals are expected to incorporate the use of administrative flag codes into their SSI surveillance process
- 2015 validation will evaluate improvements in SSI case-finding and assess accuracy of select surgical risk factors

2015 SSI Validation Workbook Preview

- 3rd part of HAI Program validation plan
- HAI Validation Workbook
 - Self-directed review, with online reporting of results
 - Review of SSI surveillance process only
 - Will include select surgical denominator data elements
 - Will require use of ICD-9/10 flag codes to identify patient records to review for SSI
- Webinar to announce details coming in September 2015
- Results will be due in early December
 - To allow sufficient time to correct 2015 SSI data if gaps/problems are identified

California Department of Public Health
Healthcare-Associated Infections (HAI) Program

Use of ICD-CM Diagnosis Codes to “Flag” Post-operative Patients for Further Evaluation of Possible SSI

Beginning in 2015, diagnosis “flag” codes should be used as an adjunct to every California hospital’s SSI surveillance program. Use of these codes for identifying patient records for further review has demonstrated as much as a 50% improvement in SSI case finding, especially in the identification of SSI that occur during the index surgical admission and may not be picked up by other surveillance methods. Using ICD-CM9 or ICD-CM10 diagnosis codes help detect SSI when a culture is not done or there is no return to surgery. Remember when using these codes, they flag cases that may indicate infection. They help to identify which medical records to review to confirm or rule out SSI.

Use of these flag codes should not replace all other SSI surveillance methods already in place. You should continue your existing SSI surveillance efforts, especially those aimed to identify post-operative patients who are readmitted to the hospital and to identify SSI that occur post-discharge.

INSTRUCTIONS for using post-operative ICD-CM9 or ICD-CM10 codes for enhancing SSI surveillance:

1. Ask your billing or medical records department to generate lists for each of the 29 NHSN procedures that your hospital is required to report. Be sure to produce a separate list for each specific surgery type (i.e. one list for colon, one for abdominal hysterectomy, etc.)
2. Ask your billing or medical records department to use these lists to further screen each surgical patient record to identify ICD-CM 9 or ICD-10 diagnostic codes that might be indicative of a post-operative infection. Screen for these codes during the index surgical admission and any readmission up to
 - 40 days after surgery for those procedures requiring 30 day surveillance, per NHSN protocol
 - 100 days after surgery for those procedures requiring 90 day surveillance, per NHSN protocol
3. The list generated will serve to “flag” patient records for chart review to look for SSI. To assist you in chart review, the generated list of “flagged” patient records should include:
 - Patient name
 - ICD-CM9 or ICD-CM10 diagnosis code that flagged the record
 - Original procedure date
 - Discharge date
 - Date of re-admission

For questions, please contact your designated HAI Program Liaison IP or email HAIProgram@cdph.ca.gov

ICD Post-Op Codes to Flag Records for Review

CDC Proc Code	ICD-9 Code	ICD-10 Code
AAA	996.6	T81.4XXA
	996.62	T82.7XXA
	998.51	T85.79XA
	998.59	
APPY	567.21	K63.0
	567.22	K63.2
	567.29	K65.0
	567.38	K65.1
	569.5	K68.19
	569.81	L03.319
	682.2	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.32	T81.83XA
	998.51	
	998.59	
BILI	567.21	K65.0
	567.22	K65.1
	567.29	K68.19
	568.38	L03.319
	682.2	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.32	T81.83XA
	998.51	
	998.59	
998.6		

CDC Proc Code	ICD-9 Code	ICD-10 Code
CARD	513.1	J85.3
	682.2	L03.319
	730.08	M86.18
	996.61	M86.28
	996.62	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.32	T82.6XXA
	998.51	T82.7XXA
	998.59	
CBGB & CBGC	513.1	J85.3
	682.2	L03.319
	730.08	M86.18
	996.61	M86.28
	996.62	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.32	T82.6XXA
	998.51	T82.7XXA
	998.59	
CHOL	567.21	K65.0
	567.22	K65.1
	567.29	K68.19
	567.38	L03.319
	682.2	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.32	T81.83XA
	998.51	
	998.59	
998.6		

CDC Proc Code	ICD-9 Code	ICD-10 Code
COLO	567.21	K63.0
	567.22	K63.2
	567.29	K65.0
	567.38	K65.1
	569.5	K68.19
	569.61	K94.02
	569.81	K94.12
	682.2	L03.319
	998.31	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.51	T81.83XA
	998.59	
	998.6	
CSEC	567.21	K65.0
	567.22	K65.1
	567.29	L03.319
	682.2	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.51	
	998.59	
FUSN	996.6	T81.4XXA
	996.69	T85.79XA
	998.51	
	998.59	

CDC Proc Code	ICD-9 Code	ICD-10 Code
FX	996.6	T81.4XXA
	996.66	T84.50XA
	996.67	T84.60XA
	996.69	T84.7XXA
	998.51	T85.79XA
	998.59	
GAST	567.21	K65.0
	567.22	K65.1
	567.29	K68.19
	567.38	L03.319
	682.2	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.32	T81.83XA
	998.51	
	998.59	
998.6		
HPRO	996.6	T81.4XXA
	996.66	T84.50XA
	996.67	T84.60XA
	996.69	T84.7XXA
	998.51	T85.79XA
	998.59	
HTP	998.51	T81.4XXA
	998.59	

ICD Post-Op Codes to Flag Records for Review

CDC Proc Code	ICD-9 Code	ICD-10 Code
HYST	567.21	K65.0
	567.22	K65.1
	567.29	L03.319
	682.2	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.51	
	998.59	
KPRO	996.6	T81.4XXA
	996.66	T84.50XA
	996.67	T84.60XA
	996.69	T84.7XXA
	998.51	T85.79XA
	998.59	
KTP	998.51	T81.4XXA
	998.59	
LAM	998.51	T81.4XXA
	998.59	
LTP	998.51	T81.4XXA
	998.59	
NEPH	998.51	T81.4XXA
	998.59	

CDC Proc Code	ICD-9 Code	ICD-10 Code
OVRY	567.21	K65.0
	567.22	K65.1
	567.29	L03.319
	682.2	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.51	
	998.59	
PACE	682.2	L03.319
	996.61	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.51	T82.6XXA
	998.59	T82.7XXA
REC	567.21	K63.0
	567.22	K63.2
	567.29	K65.0
	567.38	K65.1
	569.5	K68.19
	569.61	K94.02
	569.81	K94.12
	569.81	L03.319
	682.2	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.51	T81.83XA
998.59		
998.6		

CDC Proc Code	ICD-9 Code	ICD-10 Code
RFUSN	996.6	T81.4XXA
	996.69	T85.79XA
	998.51	
	998.59	
SB	567.21	K63.0
	567.22	K63.2
	567.29	K65.0
	567.38	K65.1
	569.5	K68.19
	569.61	K94.02
	569.81	K94.12
	682.2	L03.319
	998.31	T81.31XA
	998.32	T81.32XA
	998.32	T81.4XXA
	998.51	T81.83XA
998.59		
998.6		
SPLE	567.21	K65.0
	567.22	K65.1
	567.29	K68.19
	567.38	L03.319
	682.2	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.51	T81.83XA
998.59		
998.6		
THOR	998.51	T81.4XXA
	998.59	

CDC Proc Code	ICD-9 Code	ICD-10 Code
VHYS	567.21	K65.0
	567.22	K65.1
	567.29	L03.319
	682.2	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
XLAP	567.21	K65.0
	567.22	K65.1
	567.29	K68.19
	567.38	L03.319
	682.2	T81.31XA
	998.31	T81.32XA
	998.32	T81.4XXA
	998.32	T81.83XA
	998.51	
	998.59	
998.6		

Questions?

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