

Code Book for Developing Cardiovascular Risk Assessment Algorithm

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ICD-10 and CPT Codes

All codes are abstracted with the date to accurately see the timeline by which a patient attends their visit, is risk assessed, potentially attends any scheduled follow-up visits, and potentially is confirmed positive for cardiovascular disease.

Group A – Pregnancy Episode:

This episode determines how many patients are eligible for risk assessment during our study period. The patient must have at least 1 prenatal, L&D or postpartum visit during the data abstraction period.

Exclusion: Patients who have a positive pregnancy test during an office visit that is unrelated to pregnancy or maternity care.

Group B - Pregnant and Postpartum Office Visit

Denominator for Measure 1

These are CPT codes that distinguish when a patient has an eligible prenatal, L&D or postpartum office visit to do risk assessment at.

Group C – Exclusion Criteria for Risk Assessment

There are also exclusion criteria listed. These exclusion criteria are ICD-10 codes that can be abstracted to see if they pre-exist in the patient record and used along with the CPT office visit codes to see how many patients with pre-existing conditions were unnecessarily completed a risk assessment.

Group D: Toolkit Items

Algorithm items can be extracted from the algorithm Smartset in the EHR. This group of codes identifies items used to calculate the "positive at risk for CVD" score.

- SYMPTOMS: 1. Shortness of breath, 2. Orthopnea, 3. Tachypnea, 4. Asthma unresponsive to therapy, 5. Palpitations 6. Dizziness/syncope7. Chest pain
- VITAL SIGNS: 8. Resting heart rate >=110 bpm9. Systolic BP >=140 mm Hg10. Respiratory rate =>2411. Oxygen saturation <=96%
- RISK FACTORS: 12. age >=40, 13. African American, 14. Pre-pregnancy BMI >=35,15. Pre-existing Diabetes, 16. Hypertension, 17. Substance abuse, 18. History of chemotherapy
- Calculation of "positive for at risk for CVD" score:
 - >1 Symptoms + >1 vital sign+ >1 Risk factors or
 - ANY COMBINATION ADDING TO >4

Group E: Cardiovascular Risk Assessment Completed

Numerator for Measure 1

This is determined by algorithm completion. The algorithm is considered complete when it has a calculated risk and is signed by a clinician. These patients are counted if they were in Group B first.

Group F: Cardiovascular Risk Assessment Positive

Denominator for Measure 2

This is determined by an "at risk" algorithm output.

Group G – Cardiovascular Follow-up Visits

Numerator for Measure 2

This group distinguishes if a patient has completed their cardiovascular follow-up visits as scheduled. These codes are dated so that these patients are only counted if they were a part of Group D first (that a risk assessment was performed regardless of the result).

Group H – Cardiovascular Disease Confirmed

This group identifies which patients are true positives. This number includes all patients regardless of the risk assessment result. For Measure calculation: These patients are only counted if they were in Group E (risk assessment was positive for CVD risk).



CODES

Group A - Live birth

This episode determines how many patients are eligible for risk assessment during the data abstraction period. The patient must have at least 1 visit with a pregnancy or postpartum episode recorded in their medical record.

Delivery CPT Codes for Live Births

59400 Obstetrical care, vaginal delivery, global (including antepartum/postpartum care

59409 Obstetrical care, vaginal (delivery only)

59410 Obstetrical care, vaginal (including postpartum care only)

59412 Antepartum manipulation

59510 Cesarean delivery

59514 Cesarean delivery only

59515 Cesarean delivery including postpartum

59525 Remove uterus after cesarean

59610 Vbac delivery

59612 Vbac delivery only

59614 Vbac care after delivery

59618 Attempted vbac delivery

59620 Attempted vbac delivery only

Delivery ICD 10 Codes

Z37 Outcome of delivery

Z37.0 Single live birth

Z37.1 Single stillbirth

Z37.2 Twins, both liveborn

Z37.3 Twins, one liveborn and one stillborn

Z37.4 Twins, both stillborn

Z37.5 Other multiple births, all liveborn

Z37.50 Multiple births, unspecified, all liveborn

Z37.51 Triplets, all liveborn

Z37.52 Quadruplets, all liveborn

Z37.53 Quintuplets, all liveborn

Z37.54 Sextuplets, all liveborn

Z37.59 Other multiple births, all liveborn

Z37.6 Other multiple births, some liveborn

Z37.60 Multiple births, unspecified, some liveborn

Z37.61 Triplets, some liveborn

Z37.62 Quadruplets, some liveborn

Z37.63 Quintuplets, some liveborn

Z37.64 Sextuplets, some liveborn

Z37.69 Other multiple births, some liveborn

Z37.7 Other multiple births, all stillborn

Z37.9 Outcome unknown



Group B - Pregnant and Postpartum Office Visit

These determine what patients are eligible for CVD risk assessment at each site. *Notes, all codes indicated with antepartum are during the pregnancy, if not noted with antepartum, then the diagnosis is for the postpartum period.

CPT Codes for Pregnant and Postpartum Office Visit

These determine when the patients had an office visit when they could do the risk assessment.

99201 Office/outpatient visit new	99221	Initial hospital care
99202 Office/outpatient visit new	99222	Initial hospital care
99203 Office/outpatient visit new	99223	Initial hospital care
99204 Office/outpatient visit new	99224	Subsequent observation care
99205 Office/outpatient visit new	99225	Subsequent observation care
99211 Office/outpatient visit	99226	Subsequent observation care
99212 Office/outpatient visit	99231	Subsequent hospital care
99213 Office/outpatient visit	99232	Subsequent hospital care
99214 Office/outpatient visit	99233	Subsequent hospital care
99215 Office/outpatient visit	99234	Observation/hospital same date
99217 Observation care discharge	99235	Observation/hospital same date
99218 Initial observation care	99236	Observation/hospital same date
99219 Initial observation care	99238	Hospital discharge day
99220 Initial observation care	99239	Hospital discharge day

Group C ICD-10 Exclusion Codes for CVD Risk Assessment

In the tool, clinicians are directed to not complete risk assessments for patients if they have pre-existing cardiovascular disease or any red flags. If any of these codes are pre-existing in the patient record at the patient's first visit, they do not need to do a risk assessment. For measure 1 (percentage of patients who risk assessed for CVD risk) we exclude them from the denominator.

If a patient presents these conditions during subsequent prenatal or postpartum visits, she should be referred directly to follow-up, rather than completing another risk assessment.

CARDIOMYOPATHY

Of INDICINITION / (TITT	
I42.0 Dilated cardiomyopathy	I50.9 Heart failure, unspecified
I42.2 Obstructive hypertrophic cardiomyopathy	M30.3 Mucocutaneous lymph node syndrome
I42.8 Other cardiomyopathies	[Kawasaki]
I25.10 Atherosclerotic heart disease of native	O90.3 Peripartum cardiomyopathy
coronary artery without angina pectoris	Z82.49 Family history of ischemic heart disease
I50.30 Unspecified diastolic (congestive) heart	and other diseases of the circulatory system
failure	• •

CORONARY ARTERY DISEASE I24 Other acute ischemic heart diseases I24.0 Acute coronary thrombosis not resulting in myocardial infarction I24.1 Dressler's syndrome I24.81 Acute coronary microvascular dysfunction I24.89 Other forms of acute ischemic heart disease I24.9 Acute ischemic heart disease, unspecified I25.42 Coronary artery dissection I25.9 Chronic ischemic heart disease, unspecified I20.9 Angina pectoris, unspecified I21.B Myocardial infarction with coronary	involving other coronary artery of anterior wall I21.3 ST elevation (STEMI) myocardial infarction of unspecified site I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris I25.2 Old Myocardial Infarction I25.84 Coronary Atherosclerosis due to calcified Coronary Lesion I25.9 Chronic ischemic heart disease, unspecified O99.419 Diseases of the circulatory system complicating pregnancy, unspecified trimester
• • •	
microvascular dysfunction	Z86.79 Personal history of other diseases of the
I21.09 ST elevation (STEMI) myocardial infarction	circulatory system



ARRHYTHMIA

Z86.79 Personal history of other diseases of the circulatory system

148.91 Unspecified atrial fibrillation

148.92 Unspecified atrial flutter

149.1 Atrial premature depolarization

149.3 Ventricular premature depolarization

149.8 Other specified cardiac arrhythmias

149.9 Cardiac arrhythmia, unspecified

145 Other conduction disorders

145.10 Unspecified right bundle-branch block

145.0 Right fascicular block

145.19 Other right bundle-branch block

145.2 Bifascicular block

145.3 Trifascicular block

145.4 Nonspecific intraventricular block

145.5 Other specified heart block

145.6 Pre-excitation syndrome

145.81 Long QT syndrome

145.89 Other specified conduction disorders

145.9 Conduction disorder, unspecified

O99.412 Diseases of the circulatory system

unspecified

stated

complicating pregnancy, second trimester O99.413 Diseases of the circulatory system complicating pregnancy, third trimester 197.190 Other postprocedural cardiac

147.1 Supraventricular tachycardia

127.0 Primary pulmonary hypertension

147.11 Inappropriate sinus tachycardia, so

147.19 Other supraventricular tachycardia

147.20 Ventricular tachycardia, unspecified

O99.411 Diseases of the circulatory system

147.10 Supraventricular tachycardia,

147.29 Other ventricular tachycardia

complicating pregnancy, first trimester

147.2 Ventricular tachycardia

147.21 Torsades de pointes

functional disturbances following cardiac surgery

PULMONARY HYPERTENSION

127 Primary pulmonary hypertension

127.1 Kyphoscoliotic heart disease

127.21 Secondary pulmonary arterial hypertension

127.22 Pulmonary hypertension due to left heart disease

127.23 Pulmonary hypertension due to lung diseases and hypoxia

127.24 Chronic thromboembolic pulmonary

CONGENITAL HEART DISEASE

105.2 Mitral stenosis and regurgitation

127.83 Eisenmengers

134 Valve regurgitation

134.0 Nonrheumatic mitral (valve) insufficiency

134.1 Nonrheumatic mitral (valve) prolapse

134.2 Valve disease

134.81 Nonrheumatic mitral (valve) annulus calcification

134.89 Other nonrheumatic mitral valve disorders

134.9 Nonrheumatic mitral valve disorder. unspecified

135 Valve disease

135.0 Nonrheumatic aortic (valve) stenosis

135.1 Valve regurgitation

135.2 Nonrheumatic aortic (valve) stenosis with insufficiency

135.8 Other nonrheumatic aortic valve disorders

135.9 Nonrheumatic aortic valve disorder. unspecified

136 Valve disease

hypertension

127.20 Pulmonary hypertension, unspecified

127.29 Other secondary pulmonary hypertension

I27.81 Cor pulmonale (chronic)

127.82 Chronic pulmonary embolism

127.89 Other specified pulmonary heart diseases

127.9 Pulmonary heart disease, unspecified

136.0 Nonrheumatic tricuspid (valve) stenosis

136.1 Nonrheumatic tricuspid (valve) insufficiency

136.2 Nonrheumatic tricuspid (valve) stenosis with insufficiency

136.8 Other nonrheumatic tricuspid valve disorders

136.9 Nonrheumatic tricuspid valve disorder, unspecified

137 Valve disease

137.0 Nonrheumatic pulmonary valve stenosis

137.1 Valve regurgitation

137.2 Nonrheumatic pulmonary valve stenosis with insufficiency

137.8 Other nonrheumatic pulmonary valve disorders

137.9 Nonrheumatic pulmonary valve disorder, unspecified

138 Valve regurgitation

177.810 Aortic root dilation

O99.411 Mitral stenosis



O99.412 Mitral stenosis

O99.413 Mitral stenosis

Q20.0 Truncus arteriosus

Q20.1 Double outlet right ventricle

Q21.0 VSD

Q21.10 ASD

Q21.20 Atrioventricular canal defect

Q21.3 TOF

Q22.1 Valve disease

Q23.0 Valve disease

Q23.2 Valve disease

Q24.5 ALCAPA

Q25.0 PDA

Q25.1 Coarctation of aorta

Q25.44 Dilated ascending aorta

Q25.5 Pulmonary atresia

Q25.6 Pulmonary stenosis

Q26. 3 Anomalous pulmonary vein

Q87.40 Marfan syndrome

Q87.89 Loeys-Dietz

Z87.74 Sudden death

Z86.79 History of aortic pulmonary mitral stenosis

Z87.74 Fontan

Q20.3 TGA

Q20.4 Single ventricle

Q20.8 Fontan



Group D – Toolkit Items

The algorithm items can be extracted directly from the EHR Smartset, or manually using the following code.

ICD-10 Codes for Attributes in Tool:

11 of the 18 items can be found with codes, the other 7 items can be found directly in the patient's EMR.

SYMPTOMS

1. Dyspnea/shortness of breath R06 Abnormalities of breathing R06.0 Dyspnea

2. Orthopnea

R06.01 Orthopnea (included in the Dyspnea category already

3. Tachypnea R06.82 Tachypnea

4. Asthma J45 Asthma

R06.2 wheezing NOS

J.44.9 obstructive bronchitis, chronic obstructive asthma

5. Palpitations **R00.2 Palpitations**

R00 Abnormalities of heartbeat

6. Dizziness/syncope

R42 Dizziness and giddiness R55 Syncope and collapse

(G90.01) carotid sinus syncope

(T67.1) heat syncope

(F45.8) neurocirculatory asthenia

(G90.3) neurogenic orthostatic hypotension

(195.1) orthostatic hypotension (T81.1-) postprocedural shock

(F48.8) psychogenic syncope

7. Chest pain

R07.9 Chest pain, unspecified R07 Pain in throat and chest

(R68.84) jaw pain (N64.4) pain in breast

RISK FACTORS

15. Pre-existing diabetes

E11.65 Diabetes Mellitus, II with

Hyperglycemia

E11.9 Diabetes Mellitus, II

Controlled

E88.81 Dysmetabolic Syndrome

E88.81 Insulin Resistance

E88.81 Metabolic Syndrome

R73.01 Elevated Fasting Glucose

R73.01 Impaired Fasting Glucose

R73.09 Prediabetes

R73.09 Abnormal Glucose

R73.9 Hyperglycemia

16. Hypertension

110-I16 Essential hypertension

(I60-I69) essential (primary) hypertension involving

vessels of brain

(H35.0-) essential (primary) hypertension involving

vessels of eye

17. Substance abuse

F19.20 other psychoactive substance abuse,

uncomplicated

F10.1 alcohol abuse, uncomplicated

F11 Opioid related disorders

F16 Hallucinogen related disorders

F17 Nicotine dependence

Z72.0 Tobacco use

F18 Inhalant related disorders

F19 Other psychoactive substance related

disorders

18. Chemotherapy

Z92.21 History of Chemotherapy

VARIABLES FROM THE EMR

VITAL SIGNS

8. Resting heart rate >=110 bpm

9. Systolic BP >=140 mm Hg

10. Respiratory rate =>24

11. Oxygen saturation <=96%

RISK FACTORS

12. age >=40

13. African American

14. Pre-pregnancy

BMI >=35



Group E - Cardiovascular Risk Assessment Completed

This is determined by a completed algorithm in the EHR. A complete algorithm will have a calculated risk score and is signed by a clinician.

Group F: - Cardiovascular Risk Assessment Positive

This is determined by an "at risk" algorithm output.

Group G- Cardiovascular Follow-up Procedure

These determine which patients completed their follow-up cardiovascular tests or cardiology or MFM consults as documented in the Smartset that occurred within 60 days after a positive risk assessment.

CPT Codes for CVD Tests

Electrocardiogram = 93000, 93005, 93010

Brain natriuretic peptide test (BNP) = 37386

Echocardiogram = 93303, 93304, 93306, 93307, 93308, 93320, 93321, 93325, 93326, 93350, 93351

Holter monitor = 93224, 93225, 93226, 93227, 93230, 93231, 93233, 93235, 93236, 93237

Complete blood count (CBC) = 85025, 85027, G0306, H0307

Basic metabolic panel = 80048

Comprehensive metabolic panel = 80053

Arterial blood gas = 82803

Drug screen = 80307 (10 panel)

Thyroid stimulating hormone = 84439; 84443

<u>CPT Codes for MFM/Cardiologist Evaluation and Management following a referral documented in the Smartset that occurred within 60 days after a positive risk assessment.</u>

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Group H - Cardiovascular Disease Confirmed

These determine the patients diagnosed with CVD.

ICD-10 Codes for General Cardiovascular and Ischaemic Disease

Cardiovascular and Ischaemic Disease

125.10 Cardiovascular Disease, Unspecified

I48.91 Atrial Fibrillation

150.9 Congestive Heart Failure

Circulatory System Diseases

120.9 Angina Pectoris, NOS

121.09 Myocardial Infarction, Acute, Anterior (Initial episode of care)

121.3 Myocardial Infraction, Acute, Unspecified (initial episode of care)

I25.10 ASHD Coronary Artery

125.10 ASHD Unspecified

125.10 CAD (Coronary Artery Disease)/ASHD

125.2 Old Myocardial Infarction

125.84 Coronary Atherosclerosis due to calcified Coronary Lesion

125.85 Chronic coronary microvascular dysfunction

125.9 Chronic Ischaemic Heart Disease

Hypertensive Disease

I11.0 Malignant Hypertension Heart Disease with Heart Failure

I11.0 Benign Hypertension Heart Disease with Heart Failure

I11.0 Unspecified Hypertension Heart Disease with Heart Failure

111.9 Benign Hypertension Heart Disease without Heart Failure

111.9 Malignant Hypertension Heart Disease without Heart Failure

I11.9 Unspecified Hypertension Heart Disease without Heart Failure

ICD-10 codes for Pregnant and Postpartum Specific Cardiovascular and Ischaemic Disease

O90.3 Cardiomyopathy in the puerperium

O99.4 Diseases of the circulatory system complicating pregnancy, childbirth and the puerperium Conditions in I00-I99 Excludes1:

O90.3 peripartum cardiomyopathy

Excludes 2: (O10-O16) hypertensive disorders (O88.-) obstetric embolism (O87.-) venous complications and cerebrovenous sinus thrombosis in labor, childbirth, and the puerperium (O22.-) venous complications and cerebrovenous sinus thrombosis in pregnancy

O99.41 Diseases of the circulatory system complicating pregnancy

O99.411 Diseases of the circulatory system complicating pregnancy, first trimester, (antepartum)

O99.412 Diseases of the circulatory system complicating pregnancy, second trimester, (antepartum)

O99.413 Diseases of the circulatory system complicating pregnancy, third trimester, (antepartum)

O99.419 Diseases of the circulatory system complicating pregnancy, unspecified trimester, (antepartum)

O99.42 Diseases of the circulatory system complicating childbirth

O99.43 Diseases of the circulatory system complicating the puerperium

Additional Pregnancy Outcome ICD-10 Codes

Maternal:

O10.011, O10.012, O10.013 Chronic hypertension

O13.1, O13.2, O13.3 Gestational hypertension O14.02, O14.03 Mild-moderate preeclampsia O14.12, O14.13 Severe Preeclampsia



O15.02, O15.03 Eclampsia O14.22, O14.23 HELLP syndrome O24.414 Gestational DM (diet or medication) O36.5920. O36.5930 Fetal growth restriction O60.12X0, O60.13X0, O60.14X0 Premature rupture of membranes O60.02, O60.03 Preterm labor/delivery/birth O82 Cesarean Birth O75.82 Early elective delivery O41.1210, O41.1220, O41.1230 Chorioamnionitis Z39.2 Postpartum care following Cesarean Z39.2 Postpartum care following vaginal delivery Z39.9 Induction of labor O42 Premature rupture of membranes O60 Preterm delivery/birth O75.4 Severe obstetric complications O99.011, O99.012, O99.013 Anemia P05.10 gestational age at delivery P07.00 birth weight O14.00 development of preeclampsia O10.019 hypertensive complications O24.111, O24.112, O24.113 Diabetes frequency O24.011, O24.012, O24.012 Diabetes frequency TYPE I DM O22.31, O22.32, O22.33 DVT prophylaxis in women undergoing PR30233, 30240, 30243 Severe maternal morbidity (SMM) including transfusion Length of stay after Cesarean Codes: Admission, Discharge, Date of Delivery, Type of Delivery Length of stay after vaginal delivery: Admission, Discharge, Date of Delivery, Type of Delivery Induction rate: Code for Delivery Induced I21.xx, I22.x Acute Myocardial Infarction 171.xx, 179.0 Aneurysm N17.x. O90.4 Acute Renal Failure Acute Respiratory Distress Syndrome: J80, J95.1, J95.2, J95.3, J95.82x, J96.0x, J96.2x, J96.9x, R06.03, R09.2 Amniotic Fluid Embolism: O88.112, O88.113, O88.119, O88.12, O88.13 Cardiac Arrest / Ventricular Fibrillation: I46.x, I49.0x Puerperal Cerebrovascular Disorders: A81.2, G45.x, G46.x, G93.49, H34.0x, I60.xx, I61.xx, 162.xx, 163.00, 163.01x, 163.1xx, 163.2xx, 163.3xx, 163.4xx, 163.5xx, 163.6, 163.8x, 163.9, 165.xx, 166.xx,

Newborn:

P03.4 5-minute APGAR <7
P05. 09 <2500 g rate
P05.10 Late preterm birth rate
P03.9 Unexpected newborn complications overall
P07.16 VLBW <1500 g
O02.1 Fetal demise >20 weeks, IUFD

167.xx, 168.xx, O22.50, O22.52, O22.53, 197.810, 197.811, 197.820, 197.821, O87.3 Pulmonary Edema / Acute Heart Failure: I50.1, 150.20, 150.21, 150.23, 150.30, 150.31, 150.33, 150.40, 150.41, 150.43, 150.810, 150.811, 150.813, 150.814, 150.82, 150.83, 150.84, 150.89, 150.9, J81.0 Sepsis: A32.7, A40.x, A41.x, I76, O85, O86.04, R65.20, R65.21, T81.12XA, T81.44XA Shock: O75.1, R57.x, T78.2XXA, T81.10XA, T81.11XA, T81.19XA, T88.6XXA Air and Thrombotic Embolism: I26.x, O88.012-O88.03, O88.212-O88.23, O88.312-O88.33, O88.812-O88.83, T80.0XXA Severe maternal morbidity (SMM) including transfusion: 30230H0, 30230K0, 30230L0, 30230M0, 30230N0, 30230P0, 30230R0, 30230T0, 30230H1, 30230K1, 30230L1, 30230M1, 30230N1, 30230P1, 30230R1, 30230T1, 30233H0, 30233K0, 30233L0, 30233M0, 30233N0, 30233P0, 30233R0, 30233T0, 30233H1, 30233K1, 30233L1, 30233M1, 30233N1, 30233P1, 30233R1, 30233T1, 30240H0, 30240K0, 30240L0, 30240M0, 30240N0, 30240P0, 30240R0, 30240T0, 30240H1, 30240K1, 30240L1, 30240M1, 30240N1, 30240P1, 30240R1, 30240T1, 30243H0, 30243K0, 30243L0, 30243M0, 30243N0, 30243P0, 30243R0, 30243T0, 30243H1, 30243K1, 30243L1, 30243M1, 30243N1, 30243P1, 30243R1, 30243T1

Severe obstetric complications excluding transfusion-only cases: O88.0 - Amniotic fluid embolism; O88.1 - Other embolism of obstetric pulmonary vessels; O75.1 - Shock during or following labor and delivery; O67.4 - Obstructed labor due to shoulder dystocia; Uterine rupture: O71.0 - Rupture of uterus during labor; O71.1 - Rupture of uterus before onset of labor; O72.0 - Third-stage hemorrhage; O72.1 - Other immediate postpartum;

O85 - Puerperal sepsis; O88.8 - Other specified obstetric embolism, not elsewhere classified Z52.0 - Blood transfusion associated with delivery z51.3 - Transfusion: all RBC transfusions Length of hospital stay (any stay during pregnancy) Codes for Any type of stay, admission, discharge up to 12 months

Hospital Readmission
Any Code for Readmission

O45.91, O45.92, O45.93 Placenta abruption Z3A.01 Total preterm birth rate P10.0 - Injury to scalp of newborn due to extraction with vacuum extractor P12.0 - Birth injury to scalp P14.0 - Injury to facial nerve due to birth trauma



P20.0 - Hypoxemic-ischemic encephalopathy [HIE] of newborn

P21.9 - Birth asphyxia, unspecified

P36.9 - Sepsis of newborn, unspecified

P50.9 - Neonatal jaundice from unspecified cause

P22.0 - Respiratory distress of newborn

P24.0 - Meconium aspiration syndrome in newborn

P36.9 - Sepsis of newborn, unspecified

P39.0 - Neonatal urinary tract infection

P91.0 - Neonatal seizure

P91.6 - Hypoxic-ischemic encephalopathy [HIE] of

newborn