ICD-9-CM Coordination and Maintenance Committee Meeting
Summary of Diagnosis Presentations
March 5, 2012

Donna Pickett, co-chair of the committee, welcomed the members of the audience to the diagnosis portion of the meeting. She reviewed the timeline included at the beginning of the topic packet informing the attendees of the deadline for written comments on topics presented at this meeting. All diagnosis topics presented during the meeting are being considered for October 1, 2014 implementation.

Written comments must be received by NCHS staff by May 11, 2012. Ms. Pickett requested that comments be sent via electronic mail to the following email address nchsicd9CM@cdc.gov since regular mail is often delayed. Telephone contact information for all NCHS staff and the NCHS website are included in the topic packet. Attendees were also reminded that the full topic packet is currently posted on the NCHS website. New proposals for the September 19-20, 2012 meeting must be received by July 19, 2012.

Ms. Pickett announced that the addenda, due to be posted by early June, in keeping with the long-established ICD-9-CM schedule for updating ICD-9-CM, will include much more than is being presented at this meeting. There are many revisions being made to correct errors that have been reported to CDC since the posting of the FY2012 ICD-10-CM files. The only addenda items being presented at today's meeting are those requests for reclassification or expansion of the existing classification.

Ms. Pickett also announced the following:

NCHS will no longer provide a hard copy continuing education (CE) certificate for this meeting. Attendees were instructed to contact the respective professional association for further information on CE reporting details. NCHS will continue to report, in this summary, the number of hours for each day of the meeting. The meeting was adjourned at 12:30 pm; attendees may be eligible for 3 CE hours for attending the Monday, March 5, 2012 meeting.

Reminder for those wishing to attend the September 19-20, 2012 ICD-9-CM Coordination and Maintenance Committee meeting, you must register for the meeting online at: http://www.cms.hhs.gov/apps/events by September 10, 2012. Failure to do so may result in lack of access to the meeting.

Today's call-in number was available for "listen only." No transcript will be available.

Comments and discussion on the topics presented on March 5, 2012 were as follows:

Atypical Femoral Fracture

Elizabeth Shane, MD, representing the American Society for Bone and Mineral Research (ASBMR) provided clinical background on this topic via telephone. Dr. Shane stated that ASBMR prefers option #2, as it has more detail and is more specific, and certain unique radiologic features, including MR imaging, suggest atypical femur fractures may differ from common stress fractures in some respects. Also, occurrence in patients who have not been on bisphosphonates suggests that the pathology may relate to abnormal bone remodeling and repair under normal loading rather than abnormal loading of normal or osteoporotic bone as occurs in stress fractures.

A commenter asked about clinical terminology use by orthopedists, and what terms would be used to describe these fractures. Dr. Shane responded that academic orthopedists will use the terms included, and do so in the medical literature; the term atypical femoral fracture is widely accepted in the academic community. She noted that some orthopedists use the term "Fosamax fracture," but this kind of fracture can also happen in some without exposure to bisphosphonates. Clinicians and researchers need to be able to track all such atypical femoral fractures, and find other risk factors. Dr. Shane expressed concern that if these are linked to bisphosphonate use, by calling them Fosamax fractures, then a population of patients may be missed since the fractures can occur in absence of taking these drugs.

In response to a question, Dr. Shane noted that the case definition for atypical femoral fracture was published in 2010. She acknowledged uncertainty about how widespread use of the term would be outside the academic community. Dr. Shane noted that there are usual and characteristic radiographic findings, which include for example thickened cortices.

A commenter asked if we could have bisphosphonate as a non-essential modifier at the proposed new code. It was noted that this had not been proposed as yet.

One commenter noted that the more detailed proposal at M84.7 loses the detail about laterality for the unspecified code, although this is present in most of the proposed codes, and asked if that would be a problem. Another commenter agreed, commenting that this was not a clinical issue, and noted that it takes time for terminology to move into regular clinical use from the academic setting. She wondered if it might be premature to introduce this concept as a code, with the further comment that radiologists often make statements about the atypical appearance of various findings. She also raised concern about the potential for overlap with osteoporosis, and potential for uncertainty on the cause of fractures, since those taking bisphosphonates would be expected to be at risk of osteoporosis.

Dr. Shane stated that she gone over and over the existing codes, and none of them fit for atypical femoral fracture. Therefore, she feels that it needs a unique code .

Choking Game

Patricia Russell, MD, of Tacoma, WA, provided clinical background on this topic via telephone. Comments included a question to Dr Russell on ages of people affected, if this is done by children and adolescents only, or does it involve adults also? She indicated that it usually occurs in that age group, but it can also include young adults in college or around college age. Dr. Russell also indicated that the peak age was 13 and 14, and it can involve both males and females.

One commenter asked if this was associated with a sexual deviation, described as autoerotic asphyxiation. However, Dr. Russell responded that it differs in demographics and intent. Autoerotic asphyxiation usually involves a solitary adult male with sexual intent. In contrast, the choking game involves younger people participating in a game, often in groups. It is not sexual in nature. There can be variation in the intent. Some want to pass out, while some think it is funny. Some want to see who is the toughest, or who can go the longest without passing out. These show a marked difference in the intent. Behavioral surveys have found the choking game in girls slightly more, but close to 50-50 split on gender, which differs from the autoerotic asphyxia mostly found in males. Dr. Russell noted that the death rate is higher in boys for the choking game.

Another commenter acknowledged the differences, with the different demographics, and then stated that nothing in the proposal would preclude using the proposed new code for autoerotic asphyxia. Thus, she raised the issue of whether it would be worthwhile to exclude autoerotic asphyxia from the proposed new code, so that it would only be used for pediatric and adolescents involved with the choking game. Surprise was expressed that there had not been any previous request to create a new separate ICD-10-CM activity code for autoerotic asphyxia; such may be considered in the future.

Dr. Russell stated that the choking game is a significant public health issue, and that the proposed new code would help with tracking it. Jeffrey Linzer, MD, via telephone, representing the American Academy of Pediatrics, commented that it would be appropriate to have a means of tracking the choking game, and that the Academy supports this proposal.

Cognitive Sequelae of Cerebrovascular Diseases

Laura Powers, MD, representing the American Academy of Neurology, spoke in favor of this proposal, and noted that it would be beneficial to have the cognitive deficit and the cause as a cognitive sequela of cerebrovascular disease all in one code for these problems.

There was general support of this proposal.

Family History of SIDS

Jeffrey Linzer, MD, representing the American Academy of Pediatrics, stated that the Academy supports being able to track this. However, there are concerns with the proposal as written. He stated that family history is very broad. The greatest risk is among siblings of one who dies of SIDS. A cousin dying of SIDS would not change the risk. We need to narrow it to biological siblings. There are additional risks, such as from co-sleeping. It would be helpful if the proposal was modified, to be specific for a history in a biological sibling. It would also be good to have a risk factor code, to show a risk of SIDS.

There was a question about how the proposed code would be used, and whether it would go on the mother's chart or an infant's chart. The commenter said it would make more sense to have a personal history of a sibling that died of SIDS. It was noted that family history codes would be appropriate to use for a sibling death related to SIDS.

There was general support for this proposal with modifications discussed and an addition to include a code for risk factor.

ICD-10-CM Tabular Addenda

The following comments were made regarding the tabular addenda:
Regarding the change proposed to category I70.23 related to severity, one comment was made that the severity and location both are involved in coding, so the Use additional code should be revised to refer to the location as well as the severity, to properly include all codes under L97.

Regarding the proposed change in the note at Chapter 16, section P00-P04, Nelly Leon-Chisen, American Hospital Association (AHA), agreed that the note as it currently reads conflicts with the current guidelines. She stated that when a condition is ruled out, we would not want to mix such cases with those that have the condition. Thus, she thoroughly supported the change. Another commenter expressed agreement, and stated she was concerned when she first saw this note. She added that while she recognized that significant resources may be used caring for patients that subsequently are found not to have a suspected disorder, it would not be appropriate to mix such cases with those that are found to have the disorder. Jeffrey Linzer, MD, representing the American Academy of Pediatrics, acknowledged the concern and agreed that if the proposal is accepted that further revisions to the classification would be needed.

Regarding codes related to personal history of primary and secondary neoplasms, Nelly Leon-Chisen, AHA, stated that there seemed to be two axes of classification involved at code Z85.8, with a mixture of things included, with some primary, and some secondary, and some by site. She stated that she recognized this came from WHO in ICD-10, and suggested that there needs to be review and decisions made on potential changes and whether to distinguish by site, by type of neoplasm, or some other approach, and how to best represent these in the codes. She also suggested that NCHS contact the World Health Organization on such modifications, to include by site at code Z85.8.

ICD-10-CM Index Addenda

There were no comments on this proposal.