ICD-10 Coordination and Maintenance Committee Meeting
Summary of Diagnosis Presentations
September 23-24, 2014

Donna Pickett, co-chair of the committee, welcomed the members of the audience to the diagnosis portion of the meeting. Ms. Pickett 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 topics are being considered for implementation on October 1, 2016. There will not be any final decisions made at the meeting. The ICD-10-CM 2015 files have been posted to the CDC website: http://www.cdc.gov/nchs/icd/icd10cm.htm.

Written comments for the diagnosis proposals must be received by NCHS by November 21, 2014. Ms. Pickett requested that comments be sent via electronic mail to the following new email address: nchsicd10CM@cdc.gov. 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 March 18-19, 2015 meeting must be received by January 16, 2015.

NCHS no longer provides a hard copy continuing education (CE) certificate for this meeting. Attendees were instructed to contact their 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. On September 23, 2014 the meeting convened at 9:00 a.m. and adjourned at 3:00 p.m. There was a 1 hour lunch break that day. On September 24, 2014 the meeting convened at 9:00 a.m. and adjourned at 11:00 am; attendees may be eligible for CE hours.

Comments and discussion on the topics presented on September 23-24, 2014 were as follows:

Castleman Disease

David Fajgenbaum, MD, MSc, Co-Founder & Executive Director, Castleman Disease Collaborative Network provided clinical background of the topic. Frits van Rhee, MD, PhD, was also present for clinical questions. Linda Holtzman, Clarity Coding, asked if the condition was a neoplastic disorder because in ICD-9-CM it is coded to a nonspecific code. Dr. van Rhee responded that it is not, but made clear that it is not a nonspecific condition. Dr. Berglund also added that it was added to ICD-9-CM over twenty years ago and due to the freeze no changes to ICD-9-CM can be made. While Castleman disease is not a malignancy, it is a specific type of lymphoproliferative disease. Dr. Jeffrey Linzer, American Academy of Pediatrics (AAP), commented that it could be useful to add a code also note at HHV-8 positive Castleman disease, for Kaposi sarcoma, to differentiate these two codes. Dr. Fajgenbaum stated that HHV-8 virus

causes both Castleman disease and Kaposi sarcoma; while someone could have both, that would be unusual. Dr. Linzer (AAP) then commented that possibly an excludes 2 note would be more appropriate.

National Institutes of Health Stroke Scale

Aisha T. Liferidge, MD MPH, Assistant Professor, Director, Health Policy Fellowship Department of Emergency Medicine, The George Washington University provided clinical background of the topic. Jeanne Yoder, with the military health system, expressed concern about the NIHSS score being applied consistently by different users or providers. Her concern was based on other codes in ICD-10-CM that rely on scoring mechanisms that may or may not be applied consistently. Dr. Liferidge stated that landmark paper (in 1995) about use of tPA for stroke patients was based in part on the use of the NIH stroke scale. She also indicated that is really good inter-user reliability in being able to reproduce the same score each time without a lot of room for subjectivity. The score is intended to be used as an initial score for stroke severity and to be used when the patient presents to the emergency department. Though the score may be repeated later in the emergency department, to see if the patient has improved, the intent of the score is to measure initial stroke severity and the initial score is the most significant. Darlene Hyman, Auditing and Coding Experts (ACE), asked how many times the score is documented and who does the documentation? Dr. Liferidge again indicated that though it may be repeated in the emergency department it loses its relevance since the initial score is what is important. She indicated that the provider would be the one documenting the score. Laura Powers, MD, representing the American Academy of Neurology (AAN) stated that all of the studies for this have been based on initial score and that there is a tremendous amount of science behind this. She also indicated that their organization strongly supports addition of individual scores proposed in Option one over the ranges of Option two. She indicated that the concern with Option two is that there is not enough evidence behind the proposed ranges. She further indicated that if this scale is expanded for use with hemorrhagic strokes and subarachnoid hemorrhage there is not enough flexibility in the ranges proposed in Option two. Nelly Leon-Chisen, representing the American Hospital Association (AHA) commented that the concern on the part of coders about which score result to code, if there are multiple scores recorded, might be resolved by changing the code titles in Option one to "initial NIHSS Score" (as is reflected in "Option two"). She also suggested adding the "New note" proposed in Option two, at category I63, to Option one. She further indicated that future guideline changes as well as an article in "AHA Coding Clinic" about application of these codes would be helpful. Ms. Bullock indicated that it was intended to propose the "New note" to category I63, for each option.

Cryopyrin-Associated Periodic Syndromes and Other Autoinflammatory Syndromes

Darlene Hyman, ACE, asked for clarification regarding when the Familial Mediterranean fever is associated with amyloidosis is there an implied sequencing. Dr. Berglund replied that the proposal intended one to be able to apply two codes for that scenario and that we would not be implying sequencing at this point and it could depend on the circumstances of the admission or encounter (what brought them in). Either condition could be the reason they presented.

Dental Terms

There were no comments on this proposal.

Mastocytosis and Certain Other Mast Cell Disorders

Linda Holtzman, Clarity Coding, asked Dr. Berglund if mastocytosis was a neoplastic condition. Dr. Berglund confirmed that it is a neoplastic disorder. Linda also asked for clarification on the term newborn onset, and Dr. Berglund noted that the term neonatal onset was also included, and that this does imply onset within the first 28 days of life. Ms. Holtzman also expressed concern about the number of codes, and asked how common these disorders are. Dr. Berglund noted that the cutaneous types of mastocytosis are more common than the systemic types. Ms. Holtzman also expressed concern that she may not see that level of detail.

Dyspareunia

Jonathan Rubenstein, MD, representing the American Urological Association (AUA) was available via telephone for clinical questions. Dr. Darrel A. Regier, representing the American Psychiatric Association (APA) suggested that there should be some clarification about use of the dyspareunia (N94) codes vs. code F52.6, psychogenic dyspareunia was needed. Dr. Rubenstein (AUA) stated that the decision about whether to use an N94 code vs. a F52 code should be made by the reviewing the documentation of the clinician. He did not feel there was anything one could do in the classification to make that decision other than to clarify with an excludes note which already exists at current code N94.1. Linda Holtzman, Clarity Coding, concurred that the F52.6 code would only be used if the physician specifically noted psychogenic dyspareunia otherwise the N94 code would be used. Linda also commented that the existing exclusion note for psychogenic dyspareunia should remain.

Incontinence

Jonathan Rubenstein, MD, representing the American Urological Association (AUA) was available via telephone for clinical questions. Nelly Leon-Chisen (AHA) commented that the term urinary should not be in parenthesis, since this is not a non-essential modifier. Dr. Linzer, (AAP) expressed concern about how this might be applied to a child who is late in toilet training. Dr. Rubenstein, (AUA) stated that the code should not be misinterpreted for a pediatric patient that has not achieved continence. Dr. Darrel A. Regier, (APA) suggested that code F98.0 have an excludes note.

Difficulties with micturition

There were no comments on this proposal.

Irritable Bowel Syndrome with Constipation

Dr. Steve Shiff, Forest Laboratories, LLC., provided clinical background of the topic. Dr. Jeffrey Linzer (AAP) commented on why there was not a new code proposed for irritable bowel syndrome, mixed. Dr. Linzer also asked why there were no medical specialties supporters. Ms. McConnell-Lamptey stated that letters of support were received from both the American Gastroenterological Association (AGA) and the Rome Foundation. They indicated support for the proposed codes including a new code for the mixed type. Nelly Leon-Chisen (AHA) commented that as proposed it would not be clear that mixed would be coded in other. She also supports adding a new code for mixed. Linda Holtzman, Clarity Coding, supports this, and suggests that mixed should be at the code K58.8, and code K58.9 should be other irritable bowel syndrome.

Chronic Idiopathic Constipation

Ms. McConnell-Lamptey stated that the American Gastroenterological Association, (AGA) did submit a letter of support for these proposed codes. Linda Holtzman, Clarity Coding, commented that if chronic idiopathic constipation and functional constipation are clinically the same then functional constipation should be added as an inclusion term.

Observation and evaluation of newborns for suspected conditions ruled out

Dr. Jeffrey Linzer (AAP) stated that adding and expanding the proposed codes would be very helpful especially in representing cases where parents present with newborns suspicious of conditions that might require detailed work up and services that are later ruled out. Nelly Leon-Chisen, (AHA) commented on the need to review changes previously proposed to the P00-P04 section and how it relates to this change. She does agree that the proposed codes are needed and that category P00 needs to be revised. Linda Holtzman, Clarity Coding, asked for clarification on use of codes from both categories on the same encounter. Dr. Linzer stated that if two different body systems were involved then he feels that it would be appropriate to use both types of codes. It was suggested that instructional notes or revised guidelines for P00-P04 would probably be needed to help clarify the use of codes from these separate sections together on the same encounter.

Gestational Carrier

There were no comments on this proposal.

Minimally Invasive Surgical Procedures Converted to Open

Stephanie Stinchcomb, representing AUA, commented that the ICD-9-CM equivalent code is used frequently. She favors Option 2 but suggested that the term "minimally invasive" might mean something different depending on your specialty. In urology this might mean endoscopic. She also suggested that the proposed code for "unspecified" may not be needed. Nelly Leon-Chisen, representing AHA also indicated support for Option 2 especially since it does not convey any complication. She raised concern that with Option 3, the codes would be located where intraoperative complications are and that those doing data mining might misunderstand the meaning of the codes. Also, placing them as proposed in Option 2 is similar to where they are currently located in ICD-9-CM. Linda Holtzman also supports Option 2 but would prefer a term other than "minimally invasive". Its meaning over time could change for a procedure. She would prefer if the title somehow indicated conversion from one approach to another. She also indicated that these changes might require review of the procedure codes and guidelines since presently one is instructed to code the procedure that was started (such as inspection) and follow that with a code for the procedure that was completed.

3rd Degree Laceration during delivery

Linda Holtzman, Clarity Coding, asked if there could be an indexing or an inclusion note for a partial third degree tear. Ms. Holtzman stated there is some confusion in the field on whether it should be coded as second or third degree. There is need to review the inclusion and exclusion notes regarding this.

Ectopic Pregnancy

There were no comments on this proposal.

Contraceptive Initial Encounter and Surveillance Codes

There were no comments on this proposal.

Ovarian Cyst Laterality

Dr. Jeffrey Linzer, representing AAP, recommended adding codes for bilateral citing the example of seeing patients for bilateral ovarian torsion. This would circumvent the need to return to propose these in the future. Stephanie Stinchomb, representing AUA, also indicated support for the proposed codes.

Supervision of Pregnancy with History of Ectopic or Molar Pregnancy

There were no comments on this proposal.

Sarcopenia

Laura Powers, MD, AAN, commented that she is a little skeptical about this. The term sarcopenia is not one that she uses as a neurologist. The major players in the science of muscle disease include the neurologists, the physiatrists, and the rheumatologists, and she did not see any of those groups listed with the coalition. The term sarcopenia implies a separate condition, but this does not exclude muscle loss due to some other condition, such as stroke in Parkinsonism. Dr. Powers said that they seem to be implying nutrition was related, although the information given does not say. She asked whether it should be senile sarcopenia, to limit it to the elderly. She expressed concern that the definition may not be clear enough, such that this might just applied to anybody with muscle loss.

Nelly Leon-Chisen, AHA, expressed concern about using an Excludes1 type of note, as that implies you could not have other causes of muscle weakness, together with sarcopenia. This will be reviewed further.

Linda Holtzman, Clarity Coding, noted that she worked with the Alliance for Aging on this issue. She noted that they had hoped to have a clinical expert present to answer clinical questions, Stephanie Studenski, MD, MPH, with the National Institutes on Aging, at NIH, and with the Baltimore Longitudinal Study on Aging. However, the timing had not worked out for this.

Cynthia Bens, Vice President of Public Policy, of the Alliance for Aging Research, part of the Aging In Motion Coalition, noted the importance of making clear that sarcopenia is separate from other conditions that people may be suffering from. People who have sarcopenia tend to be older. Whether this can be limited to the elderly is worth considering. The population is fairly small. It is not intended that this code would apply to a large swath of the population, nor to everyone that is elderly. However, there are people that suffer from this condition that may have more difficulty recovering from hip fractures, and may be more likely to die from these conditions. This is important to the geriatrics community, who are a part of our coalition. We will look to some of the other specialty societies and see if we can work together on this.

Linda Holtzman noted that the intent of the proposed excludes notes was to avoid using this for everyone with weakness, although the type of note could be an issue to consider.

Further input will be sought from Dr. Powers, with AAN, and from others with an interest in this.

ICD-10-CM TABULAR OF DISEASES - PROPOSED ADDENDA

There were no comments on the tabular addenda.

ICD-10-CM INDEX OF DISEASES - PROPOSED ADDENDA

Nelly Leon-Chisen, (AHA) indicated support for the proposed index changes and also asked whether the NCHS had received questions about when it is appropriate to code “alcohol use". She noted that the code the addenda change proposes to send it to is titled “Problems related to lifestyle” and that she is concerned that this is very generic. She indicated that though this is

being moved out of Chapter 5 it may still be unclear when to use the code. The phrase "alcohol use" might refer to one having a glass of wine at the end of the day or it may refer to more use of alcohol in a patient who has an undiagnosed problem with alcohol use. Ms. Fisher responded that NCHS welcomes comments on this especially as it may relate to the current guidelines of when to apply a secondary diagnosis code (how relevant it is to the patient's treatment for conditions in the inpatient stay or outpatient encounter).