

ICD-10 Coordination and Maintenance Committee Meeting
Summary of Diagnosis Presentations
March 19-20, 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, 2015.

Written comments for the diagnosis proposals must be received by NCHS by June 20, 2014; written comments on the procedure proposals are due to CMS by April 17, 2014. As noted in the timeline there will be no new diagnosis codes implemented on April 1, 2014. Ms. Pickett requested that comments be sent via electronic mail to the following email address nchsid9CM@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 September 23-24, 2014 meeting must be received by July 18, 2014.

Ms. Pickett also encouraged participants to comment on the timing of posting the October 1, 2015 (FY 2016) ICD-10-CM diagnosis addendum, since this is likely to be very large and we would like to know your concerns by June 20, 2014.

NCHS no longer provides 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 March 19, 2014 meeting was adjourned at 3:00 pm; attendees may be eligible for 5 CE hours. The March 20, 2014 meeting adjourned at 11:00 am; attendees may be eligible for 2 CE hours.

Comments and discussion on the topics presented on March 19-20, 2014 were as follows:

Opioid Induced Constipation

Lauren Buckley from Salix Pharmaceuticals supports the proposal and commented there is greater need for the codes since new treatments are becoming more available. The proposed changes will also be consistent with existing codes for other drug induced conditions.

Severity of coronary calcification

Linda Holtzman, Clarity Coding, asked if the requester provided the clinical definitions for mild, moderate and severe, and indicated concern that if such definitions were not available to health care providers, usage of the terms could be inconsistent, and the proposed codes could be premature. She indicated that she is not sure if clinicians would document this detail. Sue

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Bowman, representing the American Health Information Management Association (AHIMA), supported the comments made by Ms. Holtzman and also suggested that this proposal be sent out to relevant medical societies for their input. Ms. McConnell-Lamprey indicated that NCHS has contacted the American College of Cardiology and asked for their input regarding clinical relevance and universal terms of definitions.

Sesamoid Fractures

There were no comments on this proposal.

Familial Hypercholesterolemia

Dr. Josh Knowles, who is a cardiologist and researcher at Stanford, and serves as the Chief Medical Officer with the Familial Hypercholesterolemia Foundation, (FH Foundation), recognized the joint nature of the proposal being from FH Foundation and the National Lipid Association (NLA), and recognized Dr. Paul Hopkins of NLA. He also commented that the condition has been known for about 50 years and still only a fraction of those with the disorder have been identified; he has worked with the Centers for Disease Control and Prevention (CDC) to improve detection and screening. Also two other members of the FH Foundation, representing patients with this condition, provided comments in support of the proposed codes. They indicated that the codes would help raise awareness about patients with this condition. Dr. Jeffrey Linzer, representing the American Academy of Pediatrics (AAP), indicated that they support the proposed new codes and commented that the codes will be valuable.

Bacteriuria

Dr. Jeffrey Linzer (AAP) commented on the clinical importance of the proposed codes, and particularly the need to be able to differentiate bacteriuria from urinary tract infection (UTI), especially in children. The diagnosis of UTI in children can require significant further work up and evaluation with clinically relevant tests, such as ultrasound and voiding cystourethrogram. Bacteriuria in a child will lead to urine culture and potentially further evaluation, but diagnosis of UTI will generally require positive urine culture. Dr. Linzer also noted that bacteriuria could be essentially the only sign in a continent female child of a secondary hydronephrosis. Linda Holtzman commented that she doesn't oppose the proposal but asked for clarification of how the proposed new code for positive culture findings of urine would be used, and how this would differ from UTI. Dr. Linzer stated that positive urine culture would be definitive for UTI; however, bacteriuria differs. Dr. Berglund noted that the World Health Organization (WHO) included positive urine culture in the symptom codes at R82.7, and WHO indexed bacteriuria to N39.0, Urinary tract infection, although this is not the way that these issues would generally be handled clinically in the U.S. Dr. Berglund also noted other potential causes of positive urine culture, including contamination and colonization. Known contamination would generally not be coded, while colonization would be coded elsewhere, to a nonspecific code. Dr. Berglund added that NCHS will be seeking further input from urology experts, related to positive urine cultures, and whether these should be differentiated from UTIs, and based on this, may take information

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back to WHO. Linda Holtzman thought the proposal needed more development, particularly related to positive urine cultures, although based on Dr. Linzer's comments, she recognized the importance of bacteriuria. Nelly Leon-Chisen, speaking for the American Hospital Association, recommended that if further discussion was needed in deciding how to handle positive urine cultures, not identified as UTIs, that such discussion should not lead to delay in creating a code for bacteriuria.

Mast Cell Activation Syndromes

Sue Bowman, AHIMA, recommended adding "if known" to the D89.43 Code also note. Dr. Berglund commented that since D89.43 is a code for a secondary condition that the primary diagnosis should already be known. However, it could be possible for the physician to describe it as secondary, without recording the cause, so this could be considered.

Necrotizing Enterocolitis

Dr. Jeffrey Linzer, AAP, commented that these proposed new codes are similar to codes in category P77, but there is a need for codes for non-newborn patients. Currently there is no way of tracking this condition outside newborns.

Hypertensive Crisis, Urgency and Emergency

Dr. Linzer, AAP, indicated that the American College of Emergency Physicians (ACEP) also supports this coding proposal. He stated that the current issue with the hypertension codes is that you cannot tell if someone is getting ready to die due to their hypertension. Linda Holtzman asked if malignant hypertension is the same as hypertensive emergency. Dr. Linzer, AAP, responded that the two conditions are not the same, with malignant hypertension being an older and more broad based term that does not adequately describe the seriousness of the elevated hypertension, and is no longer in use. Dr. James Nagel, from Upper Chesapeake Medical Center, asked whether there could be a guideline, similar to urosepsis, that if "malignant hypertension" was documented one should query the provider if they really meant hypertensive crisis. Nelly Leon-Chisen, representing the American Hospital Association (AHA), indicated that NCHS should review the Excludes1 note at the beginning of section I10-I15 preventing use of these codes with those in Chapter 15 (Pregnancy, Childbirth and the Puerperium). She asked if the same would hold true for codes in this proposed new category, and whether eclampsia would be coded alone, or together with one of the proposed new codes. Dr. Berglund indicated that NCHS will review this further and if necessary query the American College of Obstetrics and Gynecology (ACOG).

Abnormal level of advanced glycation end products in tissues

Dr. Jeffrey Linzer, AAP, questioned the clinical significance of knowing this information and what it implies. Dr. James Nagel, Upper Chesapeake Medical Center, concurred with that comment, indicating that without a definite link to a biological condition, the creation of a new code seems premature. He also questioned the certainty of findings relating these to the aging process. Dr. Berglund expressed that a lot of research has been done on this, and noted that there has been a recent focus related to evaluating AGEs in the crystalline lens of the eye; even though the proposed code is not specific for that, it would be the most likely area of interest where this code would be anticipated to be used.

Cryopyrin-Associated Periodic Syndromes and Other Autoinflammatory Syndromes

There were several comments questioning the need for the codes, since the conditions are rare. Linda Holtzman asked what the frequency is for these disorders, and expressed concern about the detail proposed, with it being rare. She agreed with the proposal to move Familial Mediterranean Fever (FMF), if it is currently inappropriately placed in the classification. She further commented that if FMF is moved, that appropriate coding notes should be added to code also amyloidosis if it is present. Dr. Berglund stated that these are rare, but relatively recently understood, and may be more common than realized. Dr. Jeffrey Linzer, AAP, commented on these being rare, and expressed that despite seeing large numbers of children yearly, he has only seen one of these disorders, PFAPA syndrome, a handful of times. He further questioned why it was proposed to classify these at category M04, with arthritis, since these can be more generalized. Dr. Berglund responded that arthritis is a part of these disorders, and patients with the disorders are generally seen by rheumatologists. Sue Bowman, AHIMA, expressed agreement with Linda Holtzman on moving FMF, and recommended consulting with medical specialty societies before making final decisions about introducing these proposed new codes, given how extensive the proposed changes are. Dr. Berglund stated that medical specialty input would be sought from rheumatology.

Pulsatile Tinnitus

Jeanne Yoder, Defense Health Agency, asked if there is a need to have codes for continuous and intermittent pulsatile tinnitus, or ways to identify a need for immediate action. Dr. Laura Powers, American Academy of Neurology (AAN), indicated that this condition is most often a symptom of intracranial intravenous hypertension, also known as pseudotumor cerebri, and most cases are not caused by an ear disorder. She agreed with the need to create stated that it would be great to have a code for this, but recommended placing it in the symptom chapter. Linda Holtzman, Clarity Coding, suggested adding an excludes note and also suggested that there was room for this at the H93.1 level rather than making a new subcategory. NCHS will further review placement of this.

In-Stent Restenosis of Coronary and Peripheral Stent

Dr. Jeffrey Linzer, AAP, questioned whether this would be better handled using the seventh character, in the complications section, for a sequelae code rather than introducing a new code. Nelly Leon-Chisen, AHA, indicated concern about whether the clinicians are clearly documenting the details such as “adjacent to stent” or “in stent stenosis”. Linda Holtzman, Clarity Coding, indicated that she assisted in writing this proposal and that it came from questions previously published in AHA’s “Coding Clinic”. She also indicated that there may be the need for a default code or index entry for stenosis of stent NOS.

Encounter for newborn, infant and child health examinations

Dr. Jeffrey Linzer, AAP, commented that this proposal is seeking to keep consistency with how encounters for newborns are currently coded using ICD-9-CM. Sometimes an encounter is just for developmental screening and is not part of a routine examination. Dr. James Nagel, Upper Chesapeake Medical Center, asked whether this is parallel to adult screening with abnormal findings. Dr Linzer responded that currently there are codes for an encounter for child health examination with and without abnormal findings. There was question raised whether there really needs to be a distinction between infant and child. The application of the terminology of infant vs. child would follow the classification guideline of newborn being under 28 days of life and infant being over 28 days old. Sue Bowman, AHIMA, commented that there may be confusion with using newborn and infant since they may currently be used interchangeably without regard to the age of the patient.

Prediabetes

There were no comments on this proposal.

Complications of urinary catheters, devices and implants

Linda Holtzman, Clarity Coding, supported the need for the changes, and stated that she agreed with having separate codes for stents and catheters. She noted that these had been grouped in ICD-9-CM, and there is a need for these to be differentiated.

Dr. Jonathan Rubenstein representing the American Urological Association (AUA) defined the difference between a catheter (a tube that drains to outside the body) and a stent (a tube draining within the body). Linda Holtzman recommended adding an Excludes2 note at subcategory T83.0 for coding of stents to be directed to codes in subcategory T83.1. A similar Excludes2 note at subcategory T83.1 should be added to direct coders back to subcategory T83.0 for catheter complications.

Complications of Nervous System Devices

It was pointed out that for proposed new code T85.123, the first inclusion term should read as follows: “Displacement of implanted electronic neurostimulator generator, brain, peripheral, gastric, spinal”.

Linda Holtzman, Clarity Coding, commented (as a participant in writing this proposal) that some things in this proposal were to restore detail that can be currently coded using ICD-9-CM. She also commented that the proposal had been shared with AAN, and with the North American Neurostimulator Society. Dr. Laura Powers, AAN, indicated that some neurostimulators are not “mechanical” but rather “electronic”. Stimulators to control epilepsy are an example of this in that they are a computer chip. She suggested that consideration be given, in the future, to reflect complications with these types of devices.

Stephanie Stinchomb, AUA, asked how one would distinguish the type of neurostimulator if multiple types of stimulators are coded using the same complication code. It was suggested that this detail could be obtained from either additional diagnoses coded or the procedure code used to describe the removal or replacement of the device.

Mechanical Complications of Other Nervous System Devices

There were no comments on this proposal.

Infection and Inflammatory Reaction

Dr. Rubenstein, AUA, commented that inclusion terms for the sacral nerve stimulator, similar to those proposed in the mechanical complication sections previously proposed, could also be added to proposed new code T85.732.

Other Specified Complications

There were no comments on this proposal.

Mechanical complication of graft of urinary organ

There were no comments on this proposal.

Mechanical complication of devices, prosthetics, implants and grafts of genital tract

There were no comments on this proposal.

Infection and inflammatory reaction due to device, prosthetic, implant and graft in urinary system

Dr. Rubenstein, AUA, commented that proposed new code T83.518 is a duplicate concept that only belongs at proposed new code T83.593. The proposed new code T83.518 as listed in the proposal should be deleted. The proposed code T83.517 should be reassigned with the code T83.518.

Complications due to implanted mesh and other prosthetic material to surrounding organ or tissue

There were no comments on this proposal.

Malignant neoplasm of prostate

Dr. Rubenstein, AUA, provided additional clinical background to the management of malignant neoplasm of the prostate specific to the proposed tabular changes for this proposal. There were no further comments on this proposal.

Neoplasm of unspecified behavior kidney

There were no comments on this proposal.

Acquired ureteropelvic junction (UPJ) obstruction

Dr. Rubenstein, AUA, further commented on the need for code N13.0 to be reactivated, adding that this is related to narrowing of the ureteropelvic junction. Linda Holtzman, Clarity Coding, indicated that if this is due to a calculus, that an excludes note should be considered to direct the coder to code N13.2, Hydronephrosis with renal and ureteral calculous obstruction.

Atypical small acinar proliferation

There were no comments on this proposal.

Testicular pain/Scrotal pain

There were no comments on this proposal.

Erectile Dysfunction (ED) due to radiation therapy and ablative therapies

There were no comments on this proposal.

Postprocedural urethral stricture

There were no comments on this proposal.

Complications of stoma of urinary tract

There were no comments on this proposal.

Asymptomatic microscopic hematuria

There were no comments on this proposal.

Chronic bladder pain

Dr. Rubenstein, AUA, indicated that some patients may be diagnosed with interstitial cystitis when it is actually chronic bladder pain.

Abnormal radiologic finding kidney

There were no comments on this proposal.

Urology related addenda items

There were no comments on this proposal.

Diabetes mellitus controlled using oral medication

There were no comments on this proposal.

Chapter 5 Addenda

Dr. Darrel A. Regier, representing the American Psychiatric Association (APA) gave a brief overview regarding the proposed addenda changes. Linda Holtzman, Clarity Coding, asked for clarification that the existing codes for alcohol abuse and alcohol dependence will be retained, but that these terms will be added as inclusion terms. Ms. Fisher confirmed that.

It was pointed out that the key difference in coding alcohol use and codes in this section is the use of the word “disorder”. Ms. Holtzman further commented that often it is documented in the record that a patient is “positive for alcohol use,” and that this should not be coded to the abuse codes but rather to code F10.99, Alcohol use, unspecified. There was also discussion about the recent legal changes for use of cannabis and how that could have an impact on the use of the substance use disorder codes. Dr. William Narrow, APA, responded that currently DSM criteria does not address legal issues when considering diagnosis of substance use disorders. NCHS will

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further evaluate indexing of “use” vs. “abuse” and “dependence” for the various substance disorders.

Dr. Laura Powers, AAN, asked that consideration be given to adding a code also note at G31.2, Degeneration of nervous system due to alcohol. NCHS will consider these comments in their review.

ICD-10-CM TABULAR OF DISEASES - PROPOSED ADDENDA

There were no comments on the proposed tabular addenda.

ICD-10-CM INDEX OF DISEASES - PROPOSED ADDENDA

There were no comments on the proposed index addenda.