ICD-9-CM Coordination and Maintenance Committee Meeting
Summary of Volumes 1 and 2, Diagnosis Presentations
March 10, 2011

On March 10, Donna Pickett, co-chair of the committee, welcomed the members of the audience. 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, 2011 implementation.

Written comments must be received by NCHS staff by April 1, 2011. Ms. Pickett requested that comments be sent via electronic mail, since regular mail is often delayed. 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. The PowerPoint presentations from this meeting will be posted to the NCHS website shortly after the meeting, if they meet with the Federal Government's 508 compliance requirements. New proposals for the September 14-15, 2011 meeting must be received by July 15, 2011.

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 report, in this summary, the adjournment time for diagnosis portion of the meeting.

Reminder for those wishing to attend the September 14-15, 2011 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 9, 2011. 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 10 were as follows:

Seclusion status
General comments were in support for the new code. Additional inclusion terms of different terminology was suggested. A comment was made that the proposed code would enable tracking of patients that need to be protected from themselves, or those for whom it is necessary to protect others from them; the commenter noted they were wanting a way to track such cases. The AAP representative (Dr. Jeffrey Linzer) noted that the proposed code would be used for aggressive behavior and homicidal ideation, and asked whether it would also be used for suicidal ideation.

Vitreomacular adhesion
There were no comments on this proposal.

Partial Tear of Rotator Cuff
One commenter expressed support for the proposed code, but also noted that the Current Procedural Terminology (CPT) describes rotator cuff tears by numbers of muscles rather than thickness. In the description of repair of a complete rotator cuff tear CPT lists it involving three muscles rather than four (as described in the proposal). It was stated that AAOS had reviewed and supported the proposal, but also noted that it would be reviewed further.

Malnutrition
Comments included concern with the term "in," raising the question of how far does a coder go to establish a link, for cases in acute illness. It was suggested that "with" or "due to" might be better terms to use, or defining what was meant by "in." Jane White, representing the American Dietetic Association, commented that in cases of acute disease, resources are diverted to make proteins, and it takes time to restore body resources, so the provider must consider nutrition, or risk poor outcomes. Dr. Linzer, American Academy Pediatrics, (AAP), expressed appreciation for the proposed changes, but also said he could see the concern about the term "in." He said this can be interpreted as "due to", "associated with" or "present with". He thinks that in this case it should mean "present with" or "associated with" (that is, it need not be "due to"), and suggested a change to reflect that. Another participant also questioned the term "in" and asked how far coders should assume this when they see two conditions co-existing (for example - malnutrition and an acute injury). Another commenter expressed concern that first, second, and third degree malnutrition all go to unspecified, using a different system than mild, moderate, and severe malnutrition. A representative of American Society for Parenteral and Enteral Nutrition (ASPEN) said that dieticians will document, in their notes, malnutrition in a certain condition and then the physician should follow with documentation of this in the chart (progress notes or elsewhere).

Solitary Pulmonary Nodules
It was noted prior to the presentation that Option 2 has been withdrawn. Alexander Chen, MD, Washington University School of Medicine and Barnes Jewish Hospital, provided

clinical background on this topic. Nelly Leon-Chisen, American Hospital Association, (AHA) suggested that the title of proposed code 793.12 indicate that it is referring to "more than one nodule" and not "more than one finding" on radiological and other examination of lung field.

Wandering

Favorable comments for option 1 included that it is more specific to the problem described. If the intent is to assign a code for wandering, in addition to the underlying cause, it was recommended to add a use additional code note at the codes for the underlying disorders. It was also recommended to add a use additional code note at code 294.11, Dementia in conditions classified elsewhere with behavioral disturbance since wandering is listed as an inclusion term at that code. Dr. Linzer, AAP, stated a preference for option 2 and likens it to patients with a fall risk who need extra health resources for monitoring. He said he prefers locating the code in subcategory V49.8, perhaps at V49.80, although he said that the proposed V40.3 is OK. He also suggested including the terms Alzheimer's disease, dementia, and developmental delay in the code first list. The question was raised as to whether this code would apply to children who wander away from home, for example early in the morning before parents are up; it was suggested that was not the intent, so for such cases there should be a note to omit code. Another question was whether this code would apply to patients who escape from a lock down mental health unit. A question was also raised as to whether this code would apply for drug abuse, or whether that should be excluded; the issue should be considered. It was indicated that these examples were not included in the intent of the code as proposed by the requestor.

Acute Kidney Diseases and Related Disorders

Lesley Stevens Inker, MD, MS, Tufts Medical Center, representing the National Kidney Foundation, provided clinical background on this topic. Comments included the need to educate the clinicians to use this correct new terminology. Many clinicians interchangeably use acute renal failure and acute renal insufficiency. A question was raised as to how prerenal azotemia would be coded, and it was noted that azotemia is indexed to 790.6, Other abnormal blood chemistry. It was stated that acute kidney injury (nontraumatic), NOS and acute renal insuffiency are not the same, and concern was raised about the proposal for "acute renal insufficiency" to be an inclusion term at the proposed 584.1. Concern was also raised that a small rise in creatinie (less than 0.3) should not be coded with AKI, as it could not be staged. It was suggested that index changes should have been presented for this proposal, since there are many that will need to be carefully reviewed, that may not currently be assigned to category 584.
A comment was made that toxin exposures such as contrast would be coded to 584.9 now, and the question was raised as to whether that would still go there; it was stated that it would be nice to have a separate code for contrast nephropathy.

A number of people asked how the term acute renal failure would be handled under this proposal. Dr. Jeffrey Linzer, representing the American Academy of Pediatrics, indicated that the common term used in emergency rooms and by surgeons is acute renal failure. He also expressed concern that the term "acute kidney injury" will be used in the E.R.

setting for traumatic injury. Such cases should be coded to the traumatic injury codes in chapter 17. This has been addressed in the diagnosis index, defaulting the term acute kidney injury to code 584.9 and indicating that for traumatic kidney injury coders should see injury, internal, kidney. Dr. Linzer also stated that since there are no definitions used in the classification; it is all dependent on providers documenting the proper terms. He also indicated that staging is not well published yet and residents do not document this well.

Dr. Hamburger representing the Renal Physician's Association (RPA) stated that they do not agree with the 5th digits proposed at 584.1. They support a new code 584.1 but without the 5th digits. They cited that the terms are not yet in use and there will be a mixture of information before proper education is completed.

Smoke inhalation
There were no comments on this proposal.

Positive finding for Interferon Gamma Release Assays (IGRA)
Comments included general support for the proposal. Dr. Linzer indicated a preference to expand current code 795.5 to the 5th digit for the two types of tests. It was pointed out that ICD-10-CM has a better capability of doing this and that to do that in 795.5 at this point would mean redefining a code that has been there for 30 years meaning "skin test". It was suggested to add inclusion terms for name of the test (similar to code 795.5). The requestor indicated that this would be "quantified tuberculosis gold test".

Atypical femoral fracture
One commenter expressed concern about use of the term "atypical," as the American Academy of Orthopaedic Surgeons (AAOS) had said that it may be used for other things. Some commenters suggested the need of more documentation and the clarification of the terms, especially whether the term "atypical" was a true diagnostic term. One commenter suggested looking at including the term "fragility fracture," as it is included in ICD-10-CM.

Severely calcified coronary lesions
Jeffrey Chambers, MD provided clinical background on this topic. Dr. Linzer, AAP suggested removing the word severely as coders may not see this in documentation. Nelly Leon- Chisen, AHA commented that the term "severe" is subjective. Dr. Chambers responded that the word severely was essential. Another commenter asked about the use of the term "lesion" versus "plaque" (as in the current code 414.3, Coronary atherosclerosis due to lipid rich plaque) and whether there were any other types of atherosclerosis. Dr. Chambers indiated that a third type called "fibro fatty" exists, but the term is not used much.

Hepatopulmonary Syndrome
There were no comments on this proposal.

Infection Following Transfusion
One person expressed concern about use of the word "following," since it can just mean it occurred at a later time. He expressed that he would like to see cause and effect for this code. The question was also raised as to whether HIV disease or infection might be documented with transfusion, and that in acute cases, V08, Asymptomatic human immunodeficiency virus [HIV] infection status, might be used, so it should be considered whether to reference it, as well as AIDS. A question was also raised about how the proposed code might be used for cases of hepatitis.

Postoperative Respiratory Failure
One person suggested changing the title of proposed code 518.53 to read "acute on chronic respiratory failure…"

Postoperative Shock
Sue Bowman, representing the American Health Information Management Association (AHIMA), suggested changing the code first note at proposed new code 998.02 to a use additional code, if applicable, since SIRS cannot be a first listed code; an alternative would be to delete the note. Nelly Leon-Chisen, AHA, suggested a code first note for the infection. One commenter suggested moving the excludes for postoperative shock, currently at code 785.59, to the subcategory 785.5. Dr. Linzer, AAP, asked about hypovolemic shock after surgery, suggesting that the additions be reviewed, and consideration made of adding a separate code for it.

Drug-Induced Pancytopenia
There were questions about where to code chemotherapy induced pancytopenia and about the index using both the terms "toxin" and "drug" induced anemia. This can be confusing when it is a chemotherapy induced condition. Comments included breaking out the codes as done for the anemia codes.

Hypertrophic Cardiomyopathy
Comments included general support for the proposal.

Acute Interstitial Pneumonitis
Sue Bowman, AHIMA, expressed the need for more clarification on the terms pneumonitis and pneumonia citing that the terms are used interchangeably. There were others that expressed agreement with this. There was also a suggestion to add an entry for AIP meaning viral pneumonia. There were concerns that the indexing proposed here would lead to excessive querying of providers. Support was expressed for the changes.

Pneumothorax and Air Leak
Comments included general support for the proposal. Dr. Linzer, AAP, suggested that because of the resources required to care for someone with a chronic pneumothorax, it may be reasonable to create a separate code for it (at 512.84).

Thalassemia
Jeanne Boudreaux, MD, Medical Director & Director of the Thalassemia Program at the Aflac Center & Blood Disorders Service at Children's Healthcare of Atlanta, spoke via telephone, providing clinical background about the proposal. Comments included general support for the proposal. A question was raised about thalassemia trait. It was noted that thalassemia minor and thalassemia trait are the same, and that genetic counseling could be needed. It was also noted that thalassemia intermedia involves genotype abnormalities, and although it differs from thalassemia major in degree, people with it need ongoing clinical care.

Infection Due to Central Venous Catheter
Comments included general support for the proposal. The AHA representative, Nelly Leon-Chisen, stated that the proposal would change the meaning of 999.31, and suggested creating new separate codes for the bloodstream infection, and the local infection, and keeping the existing code as an unspecified infection due to central venous catheter. Dr. Linzer suggested adding the term cellulitis for local infections; he also questioned whether someone presenting with fever but not septic, in whom the catheter was removed and cultured positive, would be coded to the local infection code. A question was raised about coding septicemia with the proposed code, and it was noted that the existing note at 999.3 to use additional code for the infection would indicate this should be done. It was suggested to add the term pocket for local infection.

Atrial Fibrillation and Flutter
Comments included general support for the proposal. There were comments that rapid ventricular response could be a significant clinical concern, potentially requiring ICU admission for rate control. It was suggested that codes also be created to distinguish rate controlled from uncontrolled atrial fibrillation. A question was also raised as to whether atrial fibrillation codes should be still be used if it was corrected with ablation, or with medication, or if there would be a way of tracking for people that had a history of atrial fibrillation. Comments were made that "PAF" may often be used to mean paroxysmal atrial fibrillation, and that might be considered as an inclusion term, although it might be confused with persistent or permanent atrial fibrillation. It was suggested to add "de novo atrial fibrillation" as an inclusion term for the proposed codes for other atrial fibrillation.

Novel Influenza
Comments included general support for the ICD-9-CM proposal. Nelly Leon-Chisen, AHA, asked what code should be applied when the documentation just says "H1N1 flu". If it should be seasonal then it was recommended to put this in the index. For the ICD-10-CM changes commenters expressed concern about use of the X place holder, for ICD-10-CM, as it may confuse coders. This is because the "X" is also used to fill fields to get to the 7th character when they apply. One commenter also asked how novel influenza B would be handled if it occurred. NCHS will review this further with CDC experts. It was also suggested to review the indexing of seasonal influenza with pneumonia as it did not appear to be consistent. Another commenter expressed concern about the use of the term "origin" in the inclusion terms.

ICD-9-CM Tabular Addenda
Dr. Linzer, AAP, suggested adding an excludes note for developmental delay for the proposed revision to category 318, Other specified intellectual disabilities. For the proposed change to category 514, Pulmonary congestion and hypostasis, it was recommended to also consider deleting code 485 (bronchopneumonia, organism unspecified) from the list of codes.

ICD-9-CM Index Addenda
On the ICD-9-CM index addenda, a question was raised about Parkinsonism and how it differs from Parkinson's disease, and it was stated that it involved similar symptoms, occurring with another disease.

ICD-10-CM TOPICS

Place of Occurrence
Comments included general support for the proposal. One change on code Y92.002, delete the phrase "single family (private) house".

Other Chronic Pain
There were no comments on this proposal.

Migraines
There were no comments on this proposal.

Landau- Kleffner Syndrome
David Labiner, MD, Vice President National Association Epilepsy Centers
Arizona Comprehensive Epilepsy Program, University Medical Center provided clinical background on this topic. There were no comments on this proposal.

Epilepsy and recurrent seizures
David Labiner, MD, Vice President National Association Epilepsy Centers
Arizona Comprehensive Epilepsy Program, University Medical Center provided clinical background on this topic. There was a question raised about the terms intractable versus status epilepticus. It was stated that these are different, in that status implies seizures that last over 20 minutes, while intractable implies that seizures continue despite treatment. This was further clarified by pointing out index additions recently made for intractable include the term "pharmacoresistant". There was a question about febrile seizures in a child, with the response that febrile seizures are indexed to code 780.31, Febrile convulsions (simple), unspecified. Another question was asked if recurrent seizures are equivalent to epilepsy. Dr. Labiner responded that, in essence, recurrent seizures are equivalent to epilepsy

Epileptic Seizures Related to External Causes
David Labiner, MD, Vice President National Association Epilepsy Centers
Arizona Comprehensive Epilepsy Program, University Medical Center provided clinical background on this topic. There were no comments on this proposal.

Vascular Headaches
There were no comments on this proposal.

Post-traumatic Headache
There were no comments on this proposal.

Ventral hernia
Comments included general support for the proposal with the addition of an inclusion term of epigastric at the revisions to code K43.9.

Methicillin Resistant Staphylococcus Aureus (MRSA) and Drug Resistance
Dr. Linzer, AAP suggested that rather than having separate codes for MRSA and MSSA, in each of these areas, to leave resistance to be coded to category Z16, requiring use of two codes. He cited that vancomycin resistant enterococcus (VRE) is now prevalent and that there will continue to be other resistances developing in the future. This will get cumbersome to have codes in the specific chapters, as well as additional carrier and history of codes. Another comment made suggested to look further at the proposed new code Z16.4, Resistance to antineoplastic drugs. In particular he suggested looking at the actual drugs this may be referring to.

Underdosing
Dr. Jeffrey Linzer, AAP, recommended retaining the code for underdosing of morphine and fentanyl (currently indexed at code T40.2x6, Underdosing of other opioids). Nelly Leon-Chisen, AHA, recommended retaining the codes in subcategory Z91.12, Patient's intentional underdosing of medication regimen and code -Z91.14, Patient's other noncompliance with medication regimen. She and others felt it was important to have the ability to track this especially as it may relate to caregiver noncompliance and underdosing.

Orthopedic deformities
There were no comments on this proposal.

Hidden or buried penis
Comments included general support for the proposal with a recommendation to indicate a default in the index (congenital versus acquired). There was also a suggestion to include alternate terms.

Glasgow Coma Scale
Comments included general support for the proposal. In addition, since the minimum score for the Glasgow Coma Scale is 3, it was suggested that the title for proposed new

code R40.243 be "Glasgow coma scale score 4-8" (instead of 3-8) and the title for proposed new code R40.244 should be Glasgow Coma Scale score 3. Alternatively, the proposed code R40.244, Glasgow Coma Scale score less than 3, could be eliminated. Concern was also raised that the proposed code R40.245, Other coma, without documented Glasgow Coma Scale score, or with partial score reported, would overlap with code R40.20, Unspecified coma.

Femoroacetabular impingement
Linda Holtzman, Clarity Coding, commented that you can have more than one type of impingement and asked whether multiple codes would be used. The answer given, based on the intent of the requestor's proposal, is that you would use multiple codes. It was suggested to review a better way to number the codes.

Dehiscence of amputation stump
The only recommendation made for this proposal was to designate the excludes note as an Excludes1 note.

Benign Shuddering Attacks
One person commented that this condition is rarely seen and questioned the need for a code. Dr. Carmela Tardo, AAN, indicated that it is a condition that currently has a unique code in ICD-9-CM and feels it was overlooked. She indicated that it is a movement disorder, and the code needs to be carried over to ICD-10-CM. Other comments indicated general support for the proposal.

Pulmonary conditions
Comments included general support for the proposal.

Complications of genitourinary devices, implants and grafts
Comments included general support for the proposal. However, it was pointed out that the includes statements at proposed new codes T83.411, T83.422, and T83.492 are identical and should be reviewed. Additionally, the term "genital tract" at proposed new code T83.498 should be revised to "genitourinary tract." There was a question about what was meant by the term "breakdown." It was noted that this was a WHO term, and there are many ways that a device may stop functioning.

Posterior Reversible Encephalopathy Syndrome (PRES) and Cerebral Vasoconstriction
Comments included general support for the proposal.

Acute Necrotizing Hemorrhagic Encephalopathy
There were no comments on this proposal.

Acute disseminated encephalitis and encephalomyelitis (ADEM)
There were no comments on this proposal.

Cerebellar Ataxia in Diseases Classified Elsewhere
There were no comments on this proposal.

Reclassification of hemorrhoids in ICD-10
Comments for the proposal to delete the terms by the World Health Organization, WHO, were conflicting as these terms are still used here in the United States. One person commented that the terms they most see are internal, external and prolapsed, and that they should be retained in codes in ICD-10-CM.

Concussion Codes
Comments included general support for the proposal. Dr. Linzer, AAP, asked how you would show someone was unconscious for over 24 hours. Dr. Powers, AAN, stated this would be traumatic brain injury, and should be coded as such. Dr. Linzer suggested that a note be added to send this to the appropriate code. Sue Bowman, AHIMA, expressed agreement with use of the TBI code.

ICD-10-CM Tabular Addenda
The following comments were made regarding the ICD-10-CM tabular addenda:
Dr. Linzer, AAP, commented on the need to retain the note currently proposed to be deleted at section P00-P04, Newborn affected by maternal factors and by complications of pregnancy, labor and delivery. He finds the inclusion terms limiting and thinks the note helps broaden use of the category. The current note includes "potential morbidity," while the proposed change would limit use to confirmed morbidity; this needs more review. Sue Bowman, AHIMA, indicated that the term "condition that is ruled out" is conflicting with coding guidelines.

Nelly Leon-Chisen, AHA, commented on the addition of the excludes note at section T36-T50, Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances. She feels it would be better to consider a use additional code note for coding the effects of poisoning, and recommends review. It was indicated that this is how the notes currently read at section Poisoning by Drugs, Medicinal And Biological Substances (960-979), in ICD-9-CM, for coding poisonings versus adverse effects. This will be reviewed.

ICD-10-CM Index Addenda
There were no comments on the ICD-9-CM index addenda.

The audience was asked to carefully review the proposals following the meeting and reminded that the deadline for submitting written comments is close of business April 1, 2011.

The meeting was adjourned at 4:00 p.m.