ICD-9-CM Coordination and Maintenance Committee Meeting
September 24-25, 2008
Diagnosis Agenda

The diagnosis portion of the meeting began on September 25th following the completion of the procedure topics. 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 that any written comments on topics presenter at this September meeting, all of which are being considered for October 1, 2009, must be received by NCHS staff by December 5, 2008. She requested that comments be sent via electronic mail since regular mail is often delayed due to security screening. The email addresses of all NCHS staff and the NCHS website are included in the topic packet. Attendees were also reminded that the full topic packet and PowerPoint presentations would be posted on the NCHS website shortly following the meeting.

Ms. Pickett also announced that continuing education (CE) credits would be available at the close of the meeting for both AHIMA credits and for AACC credits. 6 CE credits were awarded for Wednesday and 6 CE credits were awarded for Thursday. Attendees will receive 12 credits total for attending both full days.

Comments and discussion on the topics presented were as follows:

Traumatic Brain Injury (TBI) and related topics
It was reported at the beginning of the presentation of this topic that the Department of Defense (DoD) had agreed with the majority of the options supported by NCHS, which limit the changes to the addition of inclusion terms without changing existing code titles. There was still lack of consensus on proposals 1 and 3.

Following the presentation there were a number of questions and concerns raised. One commenter noted that in her experience the term TBI can also mean stroke.

Ted Miller and Dr. Linzer (from the American Academy of Pediatrics, AAP) both said mild and moderate do not have a standardized meaning. Dr. Dennis, the DoD representative, acknowledged the lack of consensus on the meaning of mild and moderate.

Renee Johnson, representing the National Center for Injury Control and Prevention, said that proposal 1 mixed axes and the ICD rubric and the case definition and surveillance definitions.

Dr. Laura Powers said the American Academy of Neurology (AAN) supports option 3. They want cognitive codes for all diagnoses, not just TBI, but agree that some may already be codable elsewhere, just not in chapter 5. Both Linzer and Miller also said that there is overlap with PTDS, but the DoD representative disagreed. There was a suggestion to revise the title of code V15.43, History of combat and operational stress reaction, to make it non-military.

One commenter expressed concern about equating moderate and severe TBI with the concussion codes, with particular time for loss of consciousness. Dr. Berglund, NCHS,

expressed his concern that TBI (NOS) would now be coded to 854 (where "brain injury" is an inclusion), and that it could be more appropriate to keep it there than move it to 850, particularly for moderate and severe TBI (although it may be OK for mild TBI). Moving it could affect data trends. If it were thought beneficial, we could consider title changes or new codes at the 854 category.

One commenter suggested that the excludes notes at 780.0 in proposal 6 be revised.

External cause status
There was a comment that this proposal was much improved since the version originally presented at the March C&M meeting. An issue was raised regarding which external cause status code would apply for children or multiple family members working together, such as on a farm, where the income is not individually received but is for the entire family or group. It was recommended that an inclusion term for this type of situation should be included under code E000.0, Civilian activity done for income or pay.

The definition of work was discussed. The term work can be interpreted more than one way, so the proposal specifically designates activity done for income or pay, not work.

Dr. Linzer, the representative in the audience from the American Academy of Pediatrics (AAP), stated that the AAP had hoped to discuss the proposal at greater length with the DoD prior to the meeting and still wishes to discuss it further during the comment period. He also asked that the status of the use of protective gear in relation to an injury be considered for a future proposal. He noted that information on seat belts and car seats would be of great value, and with the level of detail in this proposal, that would be even more important than what was presented.

Activity codes
The activity codes which were originally presented at the March 2008 C&M meeting were brought back to provide time for additional review and comment. The audience was informed that the DoD is conducting a pilot test of the codes, and the results will be known by the end of the year. It was also reported that all comments received thus far have been reviewed, but very few changes were made to the original proposal.

There was a comment that a default is needed for certain activity codes, such as running, when there are codes for more than one version of the activity. It was agreed that this would be provided.

It was asked whether the activity codes apply to all injuries including assaults and self-harm, not just unintentional injuries. The answer is yes, and this will be noted in the guidelines.

A member of the audience asked if the structure of the activity codes matched other E codes. The audience was told that they do match.

It was asked that fishing be added to the activity list if it is not already included. This will be reviewed.

Additional activity codes for jobs such as mining and tunneling were requested by an attendee. It was explained that the activity codes are independent of occupation codes, that an activity can be a component of many occupations. Activity codes for underground activities will be reviewed.

External cause codes for military operations
There were no comments on this proposal.

Embedded fragments status
The representative in the audience from the American Academy of Pediatrics (AAP) commented that this proposal would be beneficial. He asked that the term retained foreign body be added as an inclusion under the proposed category.

It was asked if this category would include such things as sponges and other materials inadvertently left in a patient following surgery. It was noted that this was not the intent. This will be reviewed. It may be necessary to have an exclusion between the relevant medical misadventure code and the proposed code, to clarify the intended use.

Venous thrombosis and embolism (VTE)-
The representative in the audience from the Agency for Healthcare Research and Quality (AHRQ) stated that AHRQ strongly supports option 1, creating codes for acute and chronic VTE, as well as distinguishing between chronic and resolved clots.

It was asked if codes for acute on chronic VTE are necessary and if it would be appropriate to use both a personal history code with a current VTE code. These questions will be considered. It was asked whether the default would be acute or chronic. It would be acute.

A member of the audience requested status codes for certain venous filters to accompany the chronic VTE codes. This will be considered for a future meeting. Another commented whether a V-code would be needed for the presence of "tulip" filters.

Epilepsy versus seizure
Dr. Barkley gave his presentation via telephone. He explained that seizures immediately following injuries, including those occurring within a 2 week timeframe, should be coded as non-epileptic seizures. Seizures that occur later than 2 weeks after head injury are considered epileptic. He also provided definitions for repetitive and recurrent seizures and requested a new code for psychogenic seizures. He requested that the term "breakthrough seizure" be indexed to code 345.1.

The representative in the audience from the American Academy of Pediatrics (AAP) stated that codes for seizures due to diabetes mellitus would be useful. Dr. Barkley

agreed. This will be considered for a future proposal. The AAP representative did approve of the inclusion of terms to define intractability.

The representative in the audience from the American Psychiatric Association (APA) stated that the APA would prefer that no decision be made on how to code psychogenic seizures until the APA and the epilepsy community have further discussion.

Insomnia, initiating versus maintaining sleep
The representative in the audience from the American Academy of Neurology (AAN) stated that both the AAN and the American Academy of Sleep Medicine oppose this proposal. Both organizations feel that it is premature due to a lack of clinical evidence to support a distinction between insomnia related to initiating and maintaining sleep. Another member of the audience asked if the two conditions are treated differently, and stated that if so, unique codes should be provided. The presenter, Dr. Ojile, responded that they are frequently treated differently. He also stated that the FDA is requiring different documentation to enable differentiating these in evaluating treatments.

Concern was expressed about the default for organic insomnia moving here from category 780, and whether that was intended. The response was yes, that was the intent.

Endometrial intraepithelial hyperplasia [EIN]
There was general support for this proposal. The only audience question was if a hysterectomy is done when EIN is present, and endometrial cancer is found, would the malignancy supercede the EIN? The response was yes, in that case, only the cancer code would be necessary.

Dysphonia
There were no comments on this proposal.

Fluency problems
There were objections from two members of the audience to this proposal. One comment was that we ought to be careful moving NOS codes to another chapter. A question was also raised about cases with stuttering when speaking but not when singing, with the response that such would be usual and expected, as stuttering does not generally affect singing.

The representative for the American Psychiatric Association (APA) expressed concerns about the proposal to creating new stuttering codes. He commented that stuttering has always been classified to a single code in the ICD-9-CM. He noted that similarities between stuttering and the tic disorders is strong. He stated that moving stuttering to nonspecific head and neck disorders was concerning, because it does not involve the larynx. It is the CNS, and strongly genetic. The APA representative acknowledged the stigma attached to mental health disorders, but stated moving stuttering out of chapter 5 would support the stigma rather than challenge it. He stated that similarities warrant keeping it with the mental disorders. In response, the presenter noted that category 784 does include at least one other CNS disorder. She stated that the facts are not clear on

whether there is a link between stuttering and the tic disorders, and stated that she still believes that stuttering does not belong where it now is in ICD-9-CM.

The representative in the audience from the American Academy of Pediatrics (AAP) supported the proposal, describing it as an elegant solution.

Wrong site, wrong surgery, wrong patient
There was a question that since CMS currently does not collect E code data whether it would collect these codes. A CMS staff member in the audience said that CMS will collect these E codes. There was also the question whether these codes are intended for a current encounter or for future encounters. The CMS staff member said they are intended for the current encounter.

A question was raised on what codes would apply if a mother was given the wrong baby to breast feed. It was stated that would be outside of the scope of ICD for coding.

Some members of the audience expressed concern that too many E codes could be required, and there is insufficient room on both hospital and physician bills to accommodate them. Ms. Pickett, who was presenting the topic, explained that the 5010 has been revised and will be able to accommodate three E codes and that more could overflow to other fields used for the diagnosis portion of the bill. There were comments that some hospitals can capture more than 9 diagnoses, but have to choose which of these to report. Providers may need more leeway in reporting, and may need prioritization of E code reporting.

Tumor lysis syndrome
The representative in the audience from the American Academy of Pediatrics (AAP) stated that he was happy to see this code. He explained that tumor lysis syndrome is common in children with leukemia and it is a very severe complication. He stated that it often occurs with first presentation of disease, when a high white count is present, and there has been difficulty tracking it in the past. He stated that this appears to be a good placement for it. The audience was told that the proposed new code is equivalent to its placement in the ICD-10.

There was some discussion on previous advice in Coding Clinic that tumor lysis syndrome should be coded to acute renal failure, with a statement of concern about moving something that has been in one place for years. It was explained that acute renal failure is just one of the possible manifestations of this syndrome, and the advice in Coding Clinic was based on a particular case, and no unique code is currently available. It may be reasonable to consider a note at 584.8, Acute renal failure, With other specified pathological lesion in kidney, to code first tumor lysis syndrome if present.

Fertility preservation prior to antineoplastic therapy
There were no comments on this proposal

Fitting/adjustment of gastric lap band
There was audience support for this proposal. There was agreement that the subcategory title should be revised to better reflect the codes under it.

Failed sedation
The representative in the audience from the American Academy of Pediatrics (AAP) had concerns about this proposal. He commented that the term conscious sedation is used less now. He commented that there can be various levels of sedation, including mild, moderate, deep, and general. Health care providers do not generally use the term, "failed anesthesia" or "history of failed anesthesia." Without identifying the level of anesthesia, he stated that it did not seem this would provide much benefit to most practitioners.

Transfusion reaction
Following the presentation of the proposal as presented in the topic packet another option was proposed. Rather than creating a new code, the minor antigen reaction terms can be re-indexed to existing code 999.89, Other transfusion reaction. They are currently indexed to code 999.6, ABO incompatibility reaction. The goal of the proposal is to limit code 999.6 to only ABO incompatibility reaction. The Agency for Healthcare Research and Quality (AHRQ), the organization that submitted the proposal, reviewed this second option just prior to the meeting and agreed that either option would accomplish their goal.

There were no audience comments on the proposal

Hypoxic-ischemic encephalopathy (HIE)
The representative in the audience from the American Academy of Pediatrics (AAP) commented that the terms mild, moderate and severe in regards to HIE are clinically and radiographically defined and distinguishable. There were no other comments.

Antineoplastic chemotherapy induced anemia
There was general audience support for this proposal though there was one comment that it may be difficult to get providers to document this as stated, just as it is difficult to get providers to document common conditions like blood loss anemia. Another commenter stated that they saw this in documentation. There was a request to exclude this proposed code from code 285.22, Anemia in neoplastic disease. There was also a question about coding for immunotherapy induced anemia; this will be reviewed. The representative from the American Academy of Pediatrics (AAP) expressed support for this proposal.

Family circumstances
There was general support for this proposal. The representative from the American Academy of Pediatrics (AAP) expressed support for this proposal. Some concern was expressed that the inclusion term proposed at V61.20, Concern about behavior of child, could cover every parent; the code title is Counseling for parent-child problem, unspecified, which more clearly shows this to be used for cases involving counseling.

Personal history of immunosuppression, estrogen, and steroid therapy
The representative in the audience from the American Academy of Pediatrics (AAP) expressed support for this proposal. He noted that the risk of systemic vs. inhaled steroids is very different. He asked that consideration be given to creating codes to distinguish personal history of systemic steroid use and inhaled steroid use.

Apparent Life Threatening Event (ALTE) in an Infant
Though there was general support for a new code for this condition, there was discussion on how to use the code in relationship to the manifestations and when a confirmed diagnosis is determined for the symptoms. A member of the audience felt it would be better as a secondary diagnosis. The presenter, representing the American Academy of Pediatrics (AAP), prefers that it be the principal or first listed diagnosis on a record with additional codes assigned for the accompanying signs and symptoms. It might not be necessary to assign the code when a confirmed diagnosis is made, although it might still be of use for tracking.

It was stated that it can be considered to add notes, to code first the underlying cause, if known, and to use additional code for associated manifestations.

Newborn Post-discharge Health Check, re-presentation
The representative in the audience from the American Academy of Pediatrics (AAP) explained that the AAP has requested a further change to the proposal. The AAP would prefer that new codes for newborn health check be created under a new subcategory V20.3, and that the subcategory be titled "Newborn health supervision." The code titles and inclusion term would be the same as shown for the proposed codes V20.21 and V20.22

The audience supported this proposal, but the question was asked whether all newborns would be included under the new subcategory, or if some newborns should still be assigned to code V20.2. The AAP wants all newborns to be assigned the code from the new subcategory and to be excluded from code V20.2. There was also a question about coding for routine health check for teens or adolescents, and it was stated that they would be coded to V20.2.

Torus fracture
There were no comments on this proposal.

Pouchitis
The audience liked this proposal. One commenter noted that this often requires outpatient follow up. It was asked that "inflammation of pouch" be indexed to this new code.

Gout
There was general support for this proposal. There were two questions from the audience. The first was whether new codes for hyperuricemia are needed that specify the range, and whether such a code should be assigned with a code for gout. Dr. Croft, the

presenter, said he would leave that decision up to the coding community. It was also asked what percentage of patients who have gout fall above and below what is considered the normal range for uric acid. Dr. Croft said that many patients with gout do have normal uric acid levels, so studies are still on going to determine the best tests to predict or prevent gout.

Colic
There was support for the proposal, but some members of the audience felt that the code title should be infantile colic, so that the new code is not used for adults. Some felt that adult colic should remain indexed to abdominal pain. Another option mentioned by Dr. Linzer was to separate colic as in the proposal, but add fifth digit codes for infantile colic and adult colic. There was an audience recommendation that renal colic be excluded from this code.

Vomiting expansion
The representative in the audience from the American Academy of Pediatrics (AAP), the organization that submitted the proposal request, stated that there are significant implications for bilious vomiting in newborns and that the AAP strongly supports this proposal.

There was a question on whether the codes for vomiting are better in the symptom chapter or the digestive system chapter. Vomiting is a symptom of many conditions, so these codes were considered best placed in the symptom chapter under subcategory 787.0, Nausea and vomiting. Then the question was asked how the codes under subcategory 787.0 relate to code 536.2, Persistent vomiting. Code 536.2 can be used with any other vomiting code.

The audience wanted confirmation if the proposed codes under code 779.3 would be limited to patients under 28 days old. That is the intent of the proposal. There was also a recommendation to exclude hematemesis from the proposed code 779.33, Other vomiting in newborn.

Merkel cell carcinoma
The audience approved of the proposal but there was a question of whether code 209.30, Malignant poorly differentiated neuroendocrine carcinoma, any site, would be the default for Merkel cell carcinoma of unknown site. The audience was told that code 209.30 is distinct from Merkel cell carcinoma, but that both carcinomas are correctly grouped under subcategory 209.3. A default code for Merkel cell NOS will be needed if the codes are approved.

Secondary neuroendocrine tumors and personal history of neuroendocrine tumors
The audience supported this proposal. There was a question about the proposed code V10.91, and whether it would only be for personal history of malignant neuroendocrine tumors. Since V10 is Personal history of malignant neoplasm, that would be appropriate, so the title should be modified by adding malignant. This will be further reviewed, to consider a potential need for more than a single code for personal history of

neuroendcocrine tumors to allow for the coding of different sites, and for additional codes to distinguish benign versus malignant tumors.

Inconclusive mammogram
The audience liked this proposal. There was a comment that women with dense breasts are statistically more likely to develop breast cancer, so it is important to be able to track.

Addenda
There were three suggested changes to the tabular portion of the addenda. It was suggested that the inclusion term being proposed under code 244.2 read hypothyroidism resulting from administration or ingestion of radioactive iodine. It was suggested that the wording of the code titles for codes under subcategory V15.8 be reordered, and it was recommended that code V65.11 be changed to pediatric pre-birth visit for expecting parent.

There was some discussion about the intent of the proposed excludes notes at the various aftercare codes, whether only a single aftercare code is better than using multiple. It was explained that the intent had been to instruct coders that only a single excludes note is required, but based on comments received the excludes note could be changed to a use additional code note if the preference is to use multiple aftercare codes for a single episode of care.

On the index portion of the addenda it is being proposed that the term atypical ductal hyperplasia of breast be indexed. It was requested that the term ductal hyperplasia also be indexed. There was discussion about the proposed index entries for worn out devices and if some additional devices should be added to the index besides what is being proposed. There was discussion about the proposed re-indexing of prophylactic and long-term use of antibiotics and whether a unique code for a single or short term dose of antibiotics also needs to be classifiable (as it would now be indexed to V07.39, but the proposed addenda would change).