ICD-9-CM Coordination & Maintenance Committee Meeting

Co-Chairman: Donna Pickett
March 10, 2010
9:00 a.m. EST

Donna Pickett: Welcome to the second day of the ICD-9-CM Coordination and Maintenance Committee. Today, we would be discussing proposals for the diagnosis section of ICD-9-CM.

A little housekeeping note, we will go to 4:00 today, possibly earlier, depending on how speedy our discussions are. And that is for the benefit of the people who are on the call in line where we lose their – we lose them at 4:00. Lunch today will be from 12:30 to 1:30, so for all of those who are sitting here anxiously waiting for lunch to start and not knowing what time, we thought we'd give you a heads up.

We have, from the NCHS staff, Amy Blum, David Berglund our Medical Officer, Beth Fisher, and the three of them will be presenting topics today. And then, we also have Traci Ramirez on our staff who is sitting in the front row and we have a new member of the NCHS classification staff, Charlotte Bowers. Charlotte will be observing all of you again today, so be on your best behavior, as you always are of course. But you will be seeing her at the podium for the September meeting.

Calendar information. I know it was reviewed quickly yesterday, but let me go through it again for – we have two proposals and several addenda items that are being considered for expedited implementation, which would be for October 1, 2010. Those things are marked in your topic package. Comments for those particular items would be needed by April 2nd, not April 3rd, not April 4th, but April 2nd. And also we continue to encourage you to send your

comments via e-mail, or if, you know, budget allows, Federal Express, but please, do not consider regular snail mail, U.S. Postal mail, as the way to get your comments to us because we can guarantee you that we will never get them on time.

And I know, you know, it's very disheartening when somebody says, "Well, I sent you the comments," then, you know, five weeks later and we still haven't gotten it through the door. So again, e-mail or any other expedited way of sending it, but please, no snail mails.

And also just going through the topic package, for those of you who are interested in submitting proposals for the September meeting, you have until July 15th to get those new proposals into us. As Pat mentioned yesterday, online registrations for the September meeting does not open until August 13. Do not call NCHS, do not call CMS, please do not call Mady Hue.

If you try to register prior to that date, if you go to the Web site, it will tell you that it's closed. It doesn't mean that you've missed the opportunity to register, it just means it's not open yet. So just a heads up because, boy, do we get phone calls, and Mady gets most of them, but the overflow sometimes hits us.

For the proposals that are being presented today that are for consideration for the October 2011 update, we would like to have your comments to us by June 11. And again, the reason we ask for the comments to come in by that time is to give us time to consider your comments on the proposal and also see if there are some that actually may have to come back to the September meeting. So this gives us time to do due diligence to make sure that we've got an ample opportunity to review every – all the comments and either follow-up with other groups as necessary. So again, the comment deadline for those is June 11.

OK. As noted yesterday, it's not clear whether we will have an opportunity to have call-in lines for the September meeting, but, you know, check the NCHS and CMS Web sites, and as soon as we know whether we'll be able to do it, we'll post that information to the Web site.

Yesterday, for those of you who weren't here, we did announce that an addenda is available for ICD-10-CM that's tabular addenda and also an alphabetic index. We're not able to post those files on our NCHS Web site at this time, but for those of you who are interested in receiving those files, we can send it to you electronically, so you can send us an e-mail, and again, in your topic package, you have all of our contact information. So if you would like the 10-CM addenda that coincides with what was posted at the end of 2009, feel free to e mail us and we can get those things out to you, and we do hope to be able to post the files on our Web site shortly.

Just as a reminder, CEU credits, we are no longer giving out certificates for that. You can use your topic package as a way of indicating your attendance at the meeting and work with your professional organizations in terms of how to report the credits for attendance at the meeting.

And lastly, as we start to do the presentations, and you have comments and of course, we know you'll have comments, please remember to go to the microphone. We do have people listening in on the call-in line and they cannot hear anyone unless you actually go to the microphone. I know everybody gets passionate and wants to speak from their seat but please go to the microphone.

And with that, I will now turn the podium over to Amy Blum who will do the first set of presentations. Amy?

Amy Blum: OK. Good morning. We are going to go to page – we're going to start with page 20, Exposure to Uranium. OK. So how do I make this thing change? No, that's not right. How do I – Oh, thank you. Page 20. And, whoever's out there, could you open the phone lines, please? We want to try to call New Mexico now. They're on. OK. Patrick, are you there?

Male: (They'll won't get in) until the operator opens up for questions.

Amy Blum: Operator?

Operator: Yes?

Amy Blum: Can you open the phone lines, please.

Operator: Certainly.

Amy Blum: Thank you. That's the one with (inaudible), page 20. That was the one. That one, right. Do you have to do that or can I do that myself? Oh, I have a – OK. Thank you. Patrick, are you out there?

Patrick Young: Good morning.

Amy Blum: Good morning. Are Parker or Heidi available also?

Patrick Young: I don't know. I don't believe so unless they respond?

Amy Blum: OK. Can more than one person respond at a time? OK. Very good. All right. So Patrick, we're going to just put your topic up first, since you are waiting and that way we don't have to keep you waiting this morning, is that all right?

Patrick Young: Fantastic.

Amy Blum: All right. Very good. OK, so the first topic we're going to have today is Exposure to Uranium. The person we have on the line is Patrick Young. He's with CDC out in New Mexico, and they're working with – well, the Environmental Protection Agency in conjunction with the Agency for Toxic Substances and Disease Registry, and the New Mexico Department of Health, is investigating uranium exposure, both occupational and non-occupational.

The NMDH now lists uranium exposure as a reportable disease if found in the urine at certain levels. Natural uranium mineral deposits are concentrated in northeastern Santa Fe County, the Grants-Gallup area, and other areas in the state of New Mexico. These mineral deposits can leach uranium into ground water. Other sources of exposure include contamination of sites from historical uranium mining and milling.

The ATSDR Regional Office in Dallas, Texas and the NMDH requested a new ICD-9 code for exposure to uranium to assist with tracking this exposure.

So what we are proposing is new code V87.02, contact with and suspected exposure to uranium. Patrick, did you want to add anything?

Patrick Young: No, you did a really good job.

Amy Blum: OK. Does anyone have any comments? Oh, here comes Dr. Linzer. Oh no, Dr. Linzer is just moving his feet, never mind. Dr. Linzer represents the American Pediatrics Association.

Jeffrey Linzer: Well, it's American Academy of Pediatrics.

Amy Blum: Oh, I'm sorry. American – that's true. AAP.

Jeffrey Linzer: Yes. That's another group. I was just asking Dr. Berglund, it seems to me we had gone through a list of new codes for contact with radioactive materials that I think is supposed to come out in the next edition.

Amy Blum: Yes.

Jeffrey Linzer: And this – the way this code is – falls out of that code set, so it should probably be placed in that same code set that we've already developed.

Amy Blum: OK. We'll look at that. I think that this particular request somehow fit better here, but we'll go look and see. We already have (leadiness) and arsenic in the V15. You know, we had already made codes for those so we'll have a look and see if it may be as better with some of the new codes that we've created.

Jeffrey Linzer: Which was something we developed with DOD.

Amy Blum: Yes, I remember those. Yes. OK, then. So I guess, that'll be that. There's no other comment. So Patrick, you can go back to sleep or whatever you're doing out in New Mexico with this time of the morning.

Patrick Young: I'm saving the day, thank you very much.

Amy Blum: Great. Thank you so much. Bye-bye. OK, then. Oh, operator, you can turn this off now. Let's keep this on, whichever.

We're going to go back up to – oh, are there any other comments from the phone line, on the uranium?

Male: We can go on mute, then.

Amy Blum: OK. All right, so we're going to go back to the beginning. The first topic is Influenza with Pneumonia. And this is one of the two topics that we are considering for implementation this October 1, so we do need to get your copies by April 2nd. Codes 488.0, influenza due to identified avian influenza virus and 488.1, influenza due to identified novel H1N1 influenza virus, do not provide the additional specification as the codes under category 487, influenza.

To allow for consistent coding of all forms of influenza with pneumonia, NCHS is proposing that codes 488.0 and 488.1 to be expanded to match the codes at 487. A review of all tabular instructional notes related to category 487 and 488 was done in conjunction with this proposal. Revisions to these notes are already – also being proposed at this time. This proposal is being considered for expedited review to allow implementation on October 1, 2010.

So what we've done is simply mirrored what's in 487 at the existing codes 488.0 and 488.1. So what we're proposing is that 488.0 to have a new code 488.01 influenza due to identified avian influenza virus with pneumonia, with the equivalent inclusion terms, a new code 488.02 influenza due to identified avian influenza virus with other respiratory manifestation, and 488.09 – not the best way of displaying it – influenza due to identified avian influenza virus with other manifestations. And then, we have an exactly equivalent extension at the 488.19.

So if you compare these codes to what is 487, you'll see they're exactly the same. But then, the remainder of the tabular would also need to be modified. So there's a lot of note that we would just need to update to show that we are expanding the range of wherever 488.0 and 488.1 are now identified in the tabular.

But one important thing to look at and decide upon, if we go down the proposal to 480, 484, 486, – right here. Right now, at 487, we have, at the

influenza with pneumonia code; we have a “Use additional code” note to specify the type of pneumonia. And then, up at these other codes, at 480, 484, and 486, we have excludes notes which say, "Viral pneumonia excludes influenza with pneumonia." A pneumonia infectious disease is classified elsewhere, excludes pneumonia with influenza. This 487 are excluded from all of the categories we're telling people to use as secondary code.

And number one, we think that's maybe confusing because, of course, the 9-CM, we don't have two different types of excludes notes like we have with 10 CM. But also we have the question that if you're supposed to use the secondary code, then we shouldn't have an excludes note here. But then, there's also the question that we really want to have a secondary code, or at 487, just like at the new codes 488.0 and 488.1, maybe, we shouldn't even have that “Use additional code note, because – or perhaps a different kind of instructional note because right now, if you've got influenza with pneumonia, the most likely probability is that the pneumonia is the viral pneumonia. And it's probably a rare case or an additional condition if you also have a superimposed bacterial pneumonia.

So we were thinking, just get rid of all the notes. In that way, if you use the influenza with pneumonia code, that code is telling you that the type of pneumonia that you have is the viral disease that's causing the influenza. If you want to use a secondary code for any other additional kind of pneumonia the person may have, fine, but there's no restrictions or instructions to do that with the – with the tabular.

So that's what we're proposing, to get rid of the “Use additional code note” at 487.0, not to include that use additional code note in the new codes that we're creating, and get rid of all those excludes notes up at the other pneumonia codes, in that way, there's sort of no limitations on how you code pneumonia or influenza with pneumonia. So it might take you all a little bit of time to go through this proposal, but if anybody has any comments right now – no? OK. Jeffrey Linzer:? (Linda) you better keep up.

Jeffrey Linzer: Thank you so much. We, actually, with the H1N1 this year saw quite a bit of staph pneumonia as an additional pneumonia. So I think that removing the

"Excludes notes" in the pneumonia section may make it clearer to the coder that it's OK to use both codes. And you may need – I'm not sure about the (leading) that use additional code, part of 487, because you should somehow be able to tell the coder it's OK, if the physician says there's influenza with pneumonia and a staph pneumonia for example, or an additional pneumonia. There should be some direction that is OK to code for both.

Amy Blum: OK. Yes. Well, we were thinking that maybe instead of a code first note some note or some instruction that would say, if there's another bacterial pneumonia also code that.

Jeffrey Linzer: Right. The other thing is this would be an opportune time at the 487.9 and the (488x9) that really covers a ton of territory. And it would be nice to see that split out into an encephalopathic condition, a gastrointestinal condition, and leave the 09 for a broader category. They're – this is very difficult for a physician to be able to document. And you know, they'll say "influenza with encephalopathy," and it gets bunched into the same code that could be gastrointestinal symptoms or some other – other than respiratory.

Amy Blum: Well, I think that's something we might need to bring back for September because we'll have to give it a little bit of thought, so we can put a proposal for expanding the 0.9 for next time and so right now, we can focus on the "With pneumonia" and go from there.

The next person that goes up to the mic, could you please make sure it's on? I can't – I just couldn't hear him very well. Maybe, you're just too tall for the microphone. OK. Any other comments on this proposal? Anybody out in the online world? Ma'am, could you open the lines again, please?

Operator: Yes. The lines are open.

Amy Blum: Are there any comments on the influenza with pneumonia proposal? All right then. Well then, I'm going to turn the podium over to Beth Fisher for our other topic that's being considered for this October, the fluency disorder.

Beth Fisher: Good morning. Moving along to page 10, we'll discuss Fluency Disorder. Putting the topic packet on screen here for anyone who didn't download it ahead of time but it is in our Web site, if you didn't get it before this meeting.

Fluency disorder. This topic has been presented a couple of times. It was presented once at September '08, and then we re-presented it last September. And there were still some concerns about some of the code titles especially. So we worked – it felt pretty hard, between the American Speech-Language-Hearing Association and the American Psychiatric Association and try to come to an agreement of how to place this. And I do have representatives from the American Speech-Language-Hearing Association here in the audience in case there are any further, especially clinical questions.

This proposal is being considered for implementation this October, so we will need comments by April 2nd, as it says there on the bottom of that first page of the proposal. If you want some details about the previous presentation there in – on our Web site in the previous CNM topic packet so you can review that there. What we're proposing, and this (could you go around?) is on page 11, to modify the existing code 307.0, which right now is titled "Stuttering" to be adult-onset fluency disorder. I think the previous presentation, we had a kind of a different title that was kind of hard to figure out, who, when, and where, and who didn't.

And with all of these revisions or new codes, we are trying to exclude where it would be classified elsewhere. If it's, for instance, the childhood-onset fluency disorder, we're proposing a new code 315.35. So under 307.0 we're proposing to exclude it from 307.0. As well as fluency disorder that's due to a late effect of CVA, which went into place, I think, a year or so ago, 438.14, and then fluency disorder and conditions classified elsewhere. So, basically, it kinds of separate out the adult-onset from the childhood-onset, which from our previous presentations is the more common presentation of this fluency disorder.

And we're also going to move the inclusion term cluttering and stuttering to – proposing to move them to 315.35. So that would default stuttering to the more common occurrence of this disorder. And further down, and we, again,

are proposing excludes notes under the new code. We are also proposing just a slight change to the inclusion term under 438.14 to be clear that it's stuttering due to the late effect of a CVA, not just stuttering NOS.

And then on the next page, 12 – just lay that there, the third new – second new code we're proposing is 784.52, which is the fluency disorder in conditions classified elsewhere, which was another concern brought up with this proposal was that there is – there is stuttering or fluency disorder that's caused by other diseases such as Parkinson's. So we're proposing a code, first note there to indicate you would code the underlying disease, and that is 784.52 also with it's appropriate excludes notes.

And at the bottom of that page, we just tried to show you some of the indexing changes that would take place mostly that we might try and show the default change. We got some other index entries centered. Thirty plus years old don't even ask me what the word "balbuties" mean, but it is indexed to 307.01 to be clear that we wanted people to look under the main term disorder, fluency before they, you know, went ahead, and just assign that code.

So after digesting that three pages, are there any comments here in the audience about this proposal? In the audience here at the auditorium? Dr. (Paulen).

(Paulen): We support the proposal, but I think – I think one of the things that I'm tasked with now, is to go back to the neurologist and say, “Well, don't use the term stuttering loosely.”

For instance, and you know, obviously, in Parkinson's, it's not really stuttering, it's palilalia whatever, but not to use the term loosely, because if you do, you – if a person comes in with a fluency disturbance or a speech disturbance, and you say it's stuttering, and you just say stuttering, it – and it’s (held on to) so it automatically goes to a psychiatric code. And so, unless you're pretty sure that that's the origin of the problem, then you should be using some other term or some less specified term. But basically, I support this.

Beth Fisher: OK.

(Paulen): That's fine – that's fine.

Beth Fisher: (Default is in) concern.

Jeanne Yoder: Hello. Hi, Jeanne Yoder, the Military Health System. I'm – I know you just explained why you have cluttering going to 307 instead of 315, where it's not otherwise specified, but could you explain that one more time. Why are you sending it to the cluttering, and you're sending it right to the mental health section instead of …

Beth Fisher: Well, right now, it is indexed to 307.0. And we're actually proposing to move it to 315.35.

Jeanne Yoder: Oh. OK.

Beth Fisher: Yes, sorry. Which I hope is – no, I'm sorry, you're right. I see on the index modifications, we needed to modify that it shouldn't go to 307.0. You're correct. We're proposing to send that to 315.35. Thank you for asking that.

Jeanne Yoder: Is that for the stammering, is that what you're saying, because that – because that one defaults to the adult code where the stuttering goes to the childhood code. But you said you intended that they both go to childhood?

Beth Fisher: We intended. Yes. Basically …

Jeanne Yoder: Oh, OK.

Beth Fisher: … where they have the stammering and stuttering default to the 315.35. And the cluttering.

Jeanne Yoder: OK. Because I have the same …

Beth Fisher: My intent was to show that we were going to send you to disorder fluency to see the various breakouts. So we didn't fully make those changes. But we'll fix that, put it online so you can see the proper breakout – proper indexing.

Any further comments here in the auditorium? OK then, operator, if you could open the phone lines for any comments?

Operator: Yes. The lines are open.

Darrell Regier: Yes. This is Darrell Regier and from American Psychiatric Association and we're happy to support the proposed – the proposed change as well.

Beth Fisher: Thank you, Dr. Regier. So, any further phone comments? OK, then, if not, we'll move on to the next proposal, which is the E. coli infection on page 13 – (you blocked the light up here). This is another request that we did present a year ago, March '09. It was really sort of just proposed to us. Can you just expand 041.4 so we can have a code for the O157:H7 strain of E. coli. So we presented that and there were a lot of comments we received about just the way E. coli is classified in general.

I was concerned about representing Shiga toxins producing appropriately. So there's a big narrative right up there on page 13 describing E. coli in very much detail and I can read it verbatim. So if you'll permit me then, just to go on to page 14, which is actually the proposal we're presenting here – we'll need to set up.

And this proposal originally did come from Jeffrey Linzer:'s group, the AAP. So I'm sure if there's anything you want to add at some point about the proposal, you'll provide that for us.

So what we're proposing here is to create a breakout – more breakouts at 041.4, which right now is just E. coli bacterial infection. To have 041.41, the – for Shiga toxin-producing E. coli with many inclusion terms there. We worked quite a bit also with our colleagues at CDC that work on recording of E. coli and Shiga toxin-producing E. coli, and these inclusion terms come, I think a lot, from their work. So you got many different ways of saying STEC, or Shiga toxin O157.

Then, we have 041.42, which is the other Shiga toxin producing that would be not the O157. And then, 041.43, which would be the unspecified Shiga toxin

producing, not classified either way, and then, other E. coli, the non-Shiga toxin-producing E. coli, 041.49.

And then, on page 15 – I think it's page 15, we are just representing the various "Use additional code" note or other coding instructions that has to be modified, but we're 041.49.

And then, on page 15 – I think it's page 15, we are just representing the various "Use additional code" notes or other coding instructions that has to be modified, but we're also proposing to add some "Use additional code" notes to 283.11, the hemolytic-uremic syndrome, which was something that can develop after you have the O157 E. coli infection, to just alert you to use those additional codes as well.

So that's what we have here. We also had worked a little bit on the code 008, with some concern about the breakout there also for E. coli, but we've decided to postpone that until September because it needs a little bit further review. But either way, these – both these – I mean, this proposal and then one that we will present in September would both be for October 1, 2011.

So we thought we would at least present this breakout that was originally submitted to us and get any comments that you might have, so that we can – if we have to, we could work on this further for September. So I would like the audience in the auditorium and we got Jeffrey Linzer.

Jeffrey Linzer: Well, the Academy wants to thank the contribution, the hard work from the enteric disease branch of the CDC on working with us on this proposal to make it as clear and straightforward as possible. It seems like there's a lot of inclusion terms, but these are terminology that are going to be commonly used through various parts of the medical record, and will make it much clear for the coder to be able to extract this information.

We know how devastating O157:H7 can be, especially in the pediatric population, and to be able to now separate out this particular organism, since this is normally identified in the microbiology screening, will be very helpful for tracking more closely the severity of this particular organism.

The only other comment, I know our colleagues at the CDC like the VTEC terminology and at the 041.41, you may just want to add that VTEC is an inclusion term.

Beth Fisher: OK. So what is the VTEC again.

Jeffrey Linzer: The VTEC …

Beth Fisher: Oh, the verotoxin.

Jeffrey Linzer: Right.

Beth Fisher: OK.

Jeffrey Linzer: OK. Don't go anywhere.

Beth Fisher: (Inaudible)

Female: I like the proposal, overall. I just have to say, I'm a little concerned about the documentation. I have to say, I myself have never seen these terms used in the medical record, and that includes coding at children's hospital and things like that. It may be that I'm just fortunate, and have never seen people who've had these devastating types of infection. But I guess I'm concerned too that what I might see in the progress notes is E. coli, and then, when I look on, you know, the microbiology report, it'll tell me, it's O157:H7 but I can't pick that up from the microbiology report. I have to go back to the physician and say, "I see the microbiology report as O157:H7. Do you wish to confirm that this was the type of E. coli? Yes or no?" You know, I can't – I can't just pick it up from there without a query.

So I guess my question to you is, are you going to ask every other physician in your Academy to document O157:H7, so I don't have to send a query on this?

Jeffrey Linzer: Actually, the Academy has a program to make it as difficult as possible for the coders to find the information. Yes. That's part of the educational program that the Academy carries on with these codes, we ask the pediatricians, the pediatric community to document this. Yes.

I tried to sit down. I tried.

Beth Fisher: Yes. If you're going to talk, would you just speak in the microphone, please.

Jeffrey Linzer: It's like Martin and Lewis.

Beth Fisher: Sidebar is to be taken out the hall.

Female: But much funnier. Actually, I just – I didn't really have a chance to quickly read through the clinical background paper. Can you just speak to that? What these organisms are and why they're different? You know, how they are more virulent or whatever than typical E. coli?

Jeffrey Linzer: Yes. It makes you really, really sick. Yes. And the EH1 – the O157:H7 is much more virulent and is more likely to lead to permanent renal damage with hemolytic-uremic syndrome as opposed to a cystitis or UTI, which is really generally going to be from a non-O157:H7 E. coli.

Female: OK.

Female: Now, I probably have the same question, as we fight for the microphone, where would unspecified go?

Beth Fisher: E. coli unspecified?

Female: Yes.

Female: Well, that's going to be assumed to be non …

Beth Fisher: It should probably go to the 49. Yes, you're right. We need to make sure we index that. Any other questions here in the auditorium? Hi, (Linda).

Linda Holtzman: Actually, if we're going to send unspecified to 041.49, maybe the title should say, other and unspecified.

Beth Fisher: Other and unspecified. OK. We can look at that. Yes.

Amy Blum: (If you have the convention that you don't have an unspecified…)

Beth Fisher: Well, Amy, we can't hear you unless you're in the microphone. But we will look at that. And the titling or whether we need to create a different code. OK, operator, are there any comment from the phone lines?

Operator: If you have a comment, just please speak up.

Beth Fisher: OK. Hearing none, we'll move on to page 16, acquired absence of joint – (see the day) of re-presentation. This one – we have also presented a couple of different ways and we're hoping (that their try) makes us – passes the test.

You know, this originally came up, how do you code somebody coming in that's had their joint prosthesis removed, usually because of an infection, now they're coming in to usually to have those joints – the new joint prosthesis put in. And we presented a number – a couple of different ways, March '08 and March '09. Again, those proposals are on our Web site for you to review to see the comparison.

So what we're proposing today is to – I think – first, the concern was we were just proposing, I think, awaiting joint prosthesis and people wanted to have a differentiation between you've – you had it out and you're coming back in with maybe you're not having this joint prosthesis surgery yet, we want to differentiate the person coming in for the replacement.

So last time, I think we had it just in the aftercare and there was concern about that. So today, what we're proposing is to keep the proposed V54.82 for aftercare following explantation of a joint prosthesis. And this would include, we've got including terms there, that it could be – it could be the person coming in to have the joint prosthesis re-inserted.

And then, the inclusion term saying aftercare following explantation of joint prosthesis staged procedure was suggested by the American Academy of Orthopedic Surgeons, who looked at this proposal and that included Dr. Bocek. I don't know if you remember, he was the one that initially proposed those codes for complications with joint prosthesis a few years back. So those inclusion terms are at that proposed code.

And then what we were proposing to do with the person which is to have an acquired absence of the joint or the joint prosthesis is to create the codes at V88.2, which I think V88 is where we've created newly acquired absence of some organ – I can't remember, but we have V88 now in the classification, I think, this October. And the V88.21 would be for acquired absence of hip, V88.22, acquired absence of the knee joint, and the V88.29 for acquired absence of other joint.

And I think that's it for that proposal. Are there any comments from the auditorium here on that?

Female: My one concern is about the first inclusion term under V54.82. I hope, you know, there won't be confusion and the people thinking that because it says this is a staged procedure that this code is supposed to be used for both stages. You know, you have the prosthesis taken out, and then, when we have a new one put in, because I'm not sure how the (term health) would be used of this particular code.

Beth Fisher: OK. We can think about that little bit. All right. Any other comments here in the auditorium? No? How about any comments from our phone participants? OK.

Then, we'll move on to page 17, Brain Death. This proposal came from the National Association of Children's Hospitals and Related Institutions, NACHRI, requesting a new unique code for brain death.

So currently, that term is indexed to 348.89, other conditions of the brain, and in their review of hospital data, children with brain injuries, they've identified a subset within that code that had a high mortality rate, and relatively short length of stay, and they reviewed charts revealing these children often had brain death declared early in the course of the hospital stay, and that once set was declared life support removed within a short period of time.

So they feel it will be helpful to recognize this patient population with a unique code and would like to be able to identify it for epidemiological studies. Currently, there are a lot of non-definable groups that this code, both recoverable and non-recoverable components. We also did have the

American Academy in Neurology review the proposal and they indicated their support.

There is one term currently indexed to 348.89, it's called "flat EEG," and they just requested that we leave that at 348.89, and not move it to brain death. We did have several additional letters of support from the organizations you see in this proposal, various organ donation organizations.

So we're proposing the new code, 348.82, title of "Brain Death," and move – and indicating the revision of a couple of index entries there for brain death. Are there any comments in the audience here, on the auditorium, on this proposal?

Female: I just want to comment a strong support for creating this code. I think it would be – oh, wait, I yield. I think it would be very helpful in analyzing mortality data, to have this code available.

Beth Fisher: OK, but you know, mortality is coded with ICD-10.

Female: Yes, I know.

Beth Fisher: OK.

Female: But I guess – I guess it's better to say …

Beth Fisher: Within the hospital.

Female: Right. And also, with – for example, there are media reports of mortality rates, you know, at local hospitals, and things like that, and it will be helpful to have this code available, so that there could be further analysis within those reports.

Beth Fisher: OK. Dr. Linzer:.

Jeffrey Linzer: I guess my question is how would this interplay – 599 on the V70.8, which are organ donor and examination for potential organ donor. Certainly, the specific code for showing utilization of resources is very important. We have not had the opportunity to review this through the Academy.

Beth Fisher: Well, so I'm sorry. I thought we have had sent it to you, as well as (inaudible), I think had been in contact with you. I'm sorry, we'll, of course, entertain your comments.

Jeffrey Linzer: And so, you know, we will take a closer look at this. It certainly – the other thing I would wonder is if a patient dies from cardiopulmonary arrest, for example or dies from some other medical complication, I know the intent of the code, but I'm worried whether the code might be misutilized. So, yes, they thought they were brain dead, so we're going to add the brain dead code. Where it's looking a specific type of patient, for example, someone with traumatic brain injury or asphyxia, who is not surviving and maybe utilizing hospital resources as a potential donor, or that is the reason for their passing, as opposed to just a subdural hematoma.

Beth Fisher: Right. Well would – yes, I would assume it wouldn't be of used on every person that expires.

Female: Dr. Linzer: …

Beth Fisher: The same way you don't use cardiopulmonary arrest on every single patient that expires. You know, I mean, you would think that it would be used specifically for those cases that it was intended. But I understand your concern. We'll probably need to get more comments from you as well.

Female: Well, fine. Let's ask Dr. Tardo for her comments.

Female: Is this thing on?

Beth Fisher: Were there further comments? Dr. Tardo, did you have a comment?

Carmela Tardo: Yes. Carmela Tardo from Child Neurology Society and the American Academy of Neurology. I've often been called to certify brain death, even in cases that are not transplant. This is cases with (inaudible) support. So I think examination for organ transplantation is a discreet thing, but certification of brain death is a different concept.

Beth Fisher: OK. All right.

Female: This code will not be used in replace of the diagnosis code. Those would also be coded on the record. Underlying cause of death would not be brain death. They'd have the traumatic brain injury code or whatever other problems. Those would be still the principal diagnosis and whatever other conditions the patient had, is that – was that what your concern was?

Jeffrey Linzer: Yes. I just hope that that would be the case. I don't know if a note – an excluded note would be required certainly, to what my colleague from Neurology Society is talking about is a very important concept, and we just want to make sure that this code would be appropriately applied.

Beth Fisher: Right. And we can look at that with the guidelines as well, so – if necessary. Thank you. Are there any comments from our phone participants?

OK. We'll move on to page 18 then, the Lambert-Eaton Myasthenic Syndrome. This request came to us from the American Academy of Neurology. Lambert-Eaton – actually it's in the classification right now, is Eaton-Lambert, and my understanding is that it's – the term is kind of used interchangeably, but, just recently, I think, in ICD-10, they changed it to Lambert-Eaton. So we were kind of trying to go along with their lead.

Right now, it's classified at 358.1, myasthenic syndromes in diseases classified elsewhere. And there was a request to have a unique code to be able to differentiate, well, actually, a couple of unique codes, to differentiate that one if – in neoplastic disease, and 100 and other diseases. It's got a long description of the disease process at the top of this page, which you can read at your leisure.

And so, what we're proposing to do is to create a new code or three new codes to delete it from 358.1, myasthenic syndromes in diseases classified elsewhere, and to have a new subcategory, 358.3 with 358.30 for unspecified Lambert-Eaton syndrome that when you don't know which is caused by neoplastic or other disease. 358.31, Lambert-Eaton syndrome in neoplastic disease and with a code first note to code first the underlying neoplastic disease, and then, 358.39, Lambert-Eaton syndrome in other diseases classified elsewhere to code first the underlying condition.

Do we have any comments from the audience here in the auditorium? OK. Do we have any comments from our phone participants?

Female: Amazing you can look into the muscle (inaudible) somehow associated with lung cancer.

Beth Fisher: OK. Then, we will move on. The next is on page 19, and I'm not sure is that your topic Amy, pelvic fracture?

Amy Blum: (Inaudible).

Beth Fisher: I think this is Amy's topic, pelvic fracture. Oh, we have the next topic by either David or Amy.

David Berglund: All right, we're skipping around a bit here. For those who printed their topics, we're skipping forward to page 21, saddle embolus of pulmonary artery. And let me just – let me see if I can use this keyboard to adjust where we are here. All right.

And if we can (go through just this here), I can look it up. We can – sorry, just (viewing things that way). Well, Charlie, how do I start that slide show? Well, take a quick look there. I was going to see if we can use this – well, all right. We'll let him do it and bring it back. There we go. Thank you. All right.

Saddle Embolus of Pulmonary Artery. These are one of the most severe types of embolism. Basically, a saddle embolus is where you have a very large blood clot that dislodges, and then, goes through the blood stream and lands in a big division of an artery and it can often be fatal. Now, in the aorta, you get this down in the iliac forking the bifurcation of the aorta, and this can be bad news and can cause loss of the lower limb.

The pulmonary artery is another site that's not uncommon and the pulmonary artery that can, of course, essentially block the blood flow into the lungs and be very severe. Whether a complete blockage or even a partial one, it can be very severe.

At this point in time, a saddle embolus, it was presumed was in the aorta. And we've noted on request on how to code this, that we didn't actually have an index entry for it. So rather than just providing an index entry, we are proposing to have a new code for a saddle embolus to the pulmonary artery and we would also provide specific code for a saddle embolus in the aorta, and that would remain the default as it has been in the past.

So the – again, saddle embolus to the aorta would currently just be an inclusion term at 444.0, arterial embolism and thrombosis of the abdominal aorta. Now, we certainly hope that a saddle embolus in the pulmonary artery wouldn't have been coded there in the past. I don't think that would happen. So, in any case, we're proposing the new codes here, the first one would be, a code at 415.13 for saddle embolus of the pulmonary artery, and this would go under 415.1, pulmonary embolism and infarction.

At the same time, we would also create a new code that's 444.01 for saddle embolus of abdominal aorta. We would, also, including the 444.0, we would provide a code 444.09 for other arterial embolism and thrombosis of abdominal aorta, and this would include aortic bifurcation syndrome, aortoiliac obstruction and Leriche syndrome.

These basically are thromboses involving the bifurcation of the aorta rather than an embolus, for those three inclusion terms, that is. And if you have a thrombosis and atherosclerotic disease that develops over time, that can be more likely to also allow for collateralization and collateral vessels to enlarge, and then, it may not be quite as immediately a problem, although it can certainly still be a problem but it's a bit different than the saddle embolus. So those would be at the other codes.

And then, at 444.8, the arterial emboli of other specified arteries, these – we would add an exclude note for pulmonary also. Sorry, we'd revised the note to reflect their range as shown there. All right, any questions about this?

Female: I'm assuming you'll change the index entries also since the saddle embolus can occur in other sites, because right now, saddle is the main term and aorta – I'm

sorry, the main term is embolus, and saddle is the – its index and then aorta is actually a non-essential modifier.

David Berglund: That would be something we will need to look at further, too.

Female: OK.

David Berglund: But, yes, certainly, we would be changing index entries related to this also, just considering that. Yes. OK. Other comments or questions, and can we see if there's any questions from the phone line?

Operator: The phone lines are open.

David Berglund: All right, hearing no questions, we will continue on. Thank you. We will next skip forward a bit further, just following along in the handouts, we would skip to page 26, and that is Personal History of Pulmonary Embolism and Anaphylactic Shock.

Now, with expansions of codes for venous embolism and thrombosis, we'd also noted that there is not an individual code for a personal history of a pulmonary embolism that's currently included V12.51, so that we would know that there was a venous thrombosis or embolism. So we're recommending creation of a unique code for a personal history of a pulmonary embolism.

And it had also been noted that there was not a unique code for a personal history of anaphylactic shock and a new code is being proposed for this, too. And both of these would be proposed as category V12.5, Personal History of Diseases of the Circulatory System. These basically would look like we see on screen here.

We would be – we would have new codes. We would still have V12.51 for venous thrombosis and embolism. We would now add an excludes note for pulmonary embolism that would go to V12.51, and we would add a new code V12. – that should have been changed to 0.55. It should be V12.55, pulmonary embolism, and then, V12.56 anaphylactic shock.

And this would allow us to capture things such as pulmonary emboli history, such that we would note someone had had that history, and then, also it would let us capture that someone had a history of anaphylactic shock. Related to anaphylactic shock, clearly, people with that usually have allergies also. At this point, we're not proposing any sequencing here, although ordinarily, we would probably expect the allergies to be the more important thing and be coded first. Comments, or questions, or thoughts on these?

Jeffrey Linzer: Yes. David, on the anaphylactic shock, the term is really archaic and out of date, and I think that the Allergy Society has now has settled more on just the terminology, anaphylaxis because the patient does not have to be in shock in order to have anaphylaxis. Anaphylactoid reaction is also an inclusion term that some people will use for non-IgE mediated anaphylaxis. So I would suggest changing your terminology.

This is something that we'll see where we will not know what the inciting agent is. The patient may come in with skin and respiratory symptoms. By definition, that's a two-organ systems and they can – that falls as anaphylaxis, and they'll never be in shock. Certainly, it puts them in a certain risk category where they should be having a home autoinjectors of epinephrine available and such. So our recommendation would be to only use anaphylactic shock as an inclusion term and use anaphylaxis as the current appropriate term.

David Berglund: OK, we will certainly be considering that, and thank you for the comment. Any other comments, questions, or concerns? Yes, you.

Female: Based on Jeffrey Linzer:'s comments, does this really belong in V12.5? It just doesn't seem like it's a circulatory disorder per se?

David Berglund: We can look at the possibility of putting that somewhere else. There's not – there is not necessarily other great places to put it under personal history, but we will look at that further and certainly take that under consideration also. I had taken something of a look at other places, but wasn't finding better locations, I'll have to admit. But if you have specific ideas on where else might be good, we'd be glad to hear that, too. Other comments?

Female: Just a minor point, but again, based on Jeffrey Linzer:'s comment, in the index, the main term is anaphylactic shock, and then, there are terms for anaphylactoid shock and anaphylaxis, but they refer you back that says, “See anaphylactic shock,” you may want to put that. And make anaphylaxis the main term.

Female: We may put that down for a September agenda item.

Female: Oh, OK.

David Berglund: That's something we’ll certainly take in under consideration, and thank you for the suggestion. Yes, certainly, the shock does imply certain other things involving the circulatory system, which may not always be the case, as Jeffrey Linzer: has indicated, OK. Other comments? And can we take some comments from the phone line, if any.

Operator: Certainly, the phone lines are open.

David Berglund: Hearing no further comments, we'll go on. Thank you very much.

The next topic we'll be looking at is Post-operative Aspiration Pneumonia, which is on page 28. For those who have been looking at the – let's see here, page 28 in the handout and I don't seem to be able to advance my slides now for some reason. But we can always just take a look at it here, that'll work, OK.

OK, there we are. Post-operative aspiration pneumonia, there has been some confusion about how this should properly be coded when you have aspiration pneumonia following a procedure. We have code 997.39 for other respiratory complications and that includes aspiration pneumonia complicating a procedure. But there's a “Use additional code” note at the beginning of the category to identify the complication.

So the question can be raised whether the code 507.0, pneumonitis due to inhalation of food or vomitus should be used along with the code 997.39. Or since the aspiration pneumonia would seem to be an inclusion term, whether you don't need any additional code at all. But that instructional note at

category 997, should be thought to or interpreted to require the use of a secondary code with the complication code.

Now, since we had a question raised, we had a further review of these. We will need some future further review of these inclusion terms to sort out the best way of using them. But at this point in time, we'd like to improve the accuracy of coding for postoperative pneumonitis. One of these – one of the inclusion terms that we can use a lot here in ICD, which is an older term was Mendelson's syndrome.

Mendelson's syndrome indicates aspiration of stomach acid. It was originally from a study of obstetric anesthesia and involved, again, aspiration stomach acid during obstetric anesthesia in Mendelson's original study. But it has a broader meaning in essentially aspiration of the stomach acid at this time. They were proposing a new code to better capture that and modification of some of the other notes here. We would – let me roll down a little here just to show that.

We're proposing a new code, 997.32 for post procedural aspiration pneumonia. And this would include chemical pneumonitis resulting from a procedure and also Mendelson's syndrome resulting from a procedure. And we would also add an exclusion here to exclude aspiration pneumonia during labor and delivery to 668.0. And, in addition, at 997.39 here, we would add use additional code note to identify the complication. So questions or thoughts on these?

Female: Yes, a couple of questions. Right now, at the 997 level for the whole category, there's a note that says, "Use additional code to identify complication," are you suggesting to take out that note and then add it only at the specific subcategories where you would identify the separate complications? So, for example now, 997.32 would not require an additional code but you're only adding that note at 997.39, is that – am I reading that right? Or would you make the changes at each one of the 997 codes where you would allow a secondary code for that complication? It seems like, you know, you're making a change. (And want to knock the whole)…

David Berglund: We may want to keep that note just as a full – at the category level and that may make that additional note redundant. We'll review that.

Female: Yes, OK. That's what I'm trying to figure out, if this note is redundant or if the note stays at the category level that means it would apply to 997.32. But, technically, there it's all captured in a single code.

David Berglund: Yes, all right. Other comments? We got Jeffrey Linzer:.

Jeffrey Linzer: May, just for clarification, want to add an excludes note to 770.1X which is the aspiration of the newborn, so that somebody wouldn't think that the procedure of delivery and the baby having aspiration would fall into this complication code.

David Berglund: That would be a thought, certainly to add an exclusion here at this proposed new code to do that. That's a reasonable thought. We will be looking at it. Yes, (Linda).

(Linda): I just want to second (Nelly's) point. I don't think (this needs) additional code note, as necessary, since it's there for the entire category of 997. I'm also just concerned with removing the current inclusion note that says, "Pneumonia aspiration resulting from a procedure," because there's a “Use additional code” note at the 997 category level. It was always fairly clear to me that I would use 997.39 plus 5070, and I'm afraid that if we remove this inclusion note, people who haven't read these minutes might misunderstand what the intention is in removing the note, and might say, "Gee, does that mean I shouldn't use 997.39 anymore when someone has post-op aspiration pneumonia?" So, I'd like having the note there, but …

Amy Blum: (Linda), are you talking about the excludes note at 507? We are – we have on …

(Linda): (Inaudible).

Amy Blum: OK.

David Berglund: I think the issue is, we have a code title now that includes already the additional code. So perhaps, what we could consider is up at the category level, say, “Use additional code to identify the complication, if not already specified in the code title,” or something like that.

Amy Blum: Well, that's one of the global issue that we wanted to address as a topic in general. If we have, remembering that being – the ICD-9-CM is based on the ICD-9 and we were always limited to just using one code from the ICD-9. And so, a lot of inclusion terms were added under code, so that if you only use one code, they lumped a lot of things together.

But now that we have been telling people to use this secondary code in those cases, we were just – we would like some general comments about whether or not it's still a good idea to have some of these inclusion terms underneath this complication code. Or whether we should just have the title and either have a specific code identified or always have a secondary code for additional code note and not have these long list of things that are included in the complication code, so that you don't ever have the question, "Should I use the secondary code or not?"

I mean, if you look under digestive system complications, there's about five things that are included and about 20 things that are excluded. And I think, most of us follow along, “OK, well, we make use of the secondary code in some cases and not in other cases.” But we're thinking maybe we should clean it up and not have an instruction that you use the secondary code. You always use the secondary code to specify the complication, unless, there is a specific code with a complication there. That would be a lot of cleaning up, but I think it's something we might want to consider.

David Berglund: Yes. I think it's definitely an issue for the 99 series complication codes. We want to know two things, that it is a complication, it wasn't expected and that's a target for reducing complications and patient safety and so on. And plus, we also want to know what is the complication and it's not completely the same as the inclusion term, but sort of – just for that category.

I want to know what the complication that – it's a target. I want to know what it is, so that we can actually act on that to try to prevent it in the future. And the inclusion terms can just clarify some of that. But with having a modification up at the 99 series, maybe, a couple of sentences describe for the 99 series complication codes, we want to know that it's a complication and what the complication is. So use additional code to identify the specific complication if not already specified in the code title or something to that effect.

Amy Blum: OK. That's actually what I meant to say. Very good.

Male: All right. Nelly?

Nelly Leon-Chisen: Perhaps, Amy's suggestion is something that we could take up with guidelines because I think, if you're actually cleaning up the tabular and the index, it's a lot of work, and you know, we're working with the system that we're going to retire soon. So I would rather have you conserve your resources to deal with ICD-10 issues. And it seems like, you know, it would be pretty easy to handle with a guideline to say that you would – you know, you would code two things, the complication and the specific complication except in situations where a single code includes specifically both pieces, like this 997.32 code would.

Female: We are – I, certainly, am looking at this more towards the 10-CM as a big overhaul in just addressing these small things here in 9-CM, and of course, in 10-CM, because the complication code is so popular with physicians, we have been moving them out of the – faster and into the body systems to sort of mitigate their unpopularity. And so, we have a lot more specific complication code within the body chapters already in 10-CM, and now, I think we just need to look to make sure that we don't have a lot of these inclusion terms, but – as this would be a staged procedure.

Female: OK. Thank you.

David Berglund: OK, thank you for all the comments here. We do have a number of things we'll be looking at further, and certainly, as Amy's indicated, we've got a lot of things where we are somewhat trying to sort out what general principles we

should take in applying ICD-10-CM. We'd like to make everything perfectly clear, but also, make it as simple as possible to make it easy to understand. But we got to make sure we make it as simple as possible, but no simpler. Yes, we will not want to forget the online people.

Female: What did he say?

David Berglund: Donna was nodding at me and pointing upwards. So we will look upwards and we will see if there are any people on the phone line listening, if you have a comment or question to me. Are the phone line is open?

Operator: Yes, the phone lines are open.

David Berglund: And after everyone has looked upward and meditated briefly, we find that we are not hearing any further questions or comments there. So we will now proceed to the next question. Thank you for (thanks here).

We'll look and our next topic is just the next page on page 29 for those following along. We're next looking at Pilar Cyst and Trichilemmal Cyst. We have a couple of different kinds of cyst here.

Pilar cysts are epidermal cysts, they have an outer wall of keratinizing epithelium without a granular layer. They are similar to the normal epithelium of the hair follicle. We – these are quite common and they may occur in up to five to ten percent of the population and occur more where there is dense hair follicles and most of the time on the scalp. The pilar cysts are the second most common type of cyst that's found on the head and the neck. And they are almost always benign, although there can be malignant transformation, very, very rare.

In a very small percent of pilar cyst, there may be a single or multiple foci of proliferating cells with proliferating tumors and these can be called proliferating trichilemmal cysts. And these can grow quite rapidly. They can arise de novo also. They're biologically benign, but locally, can get very aggressive and become large and ulcerated even.

Pilar cysts may sometimes be called sebaceous cysts, although sebaceous cysts really are different kind of cysts, so that would be erroneous. We have not, in the past indexed pilar cysts or trichilemmal cysts, so at this time, we're proposing new codes for these and we want to be able to differentiate these from sebaceous cysts also.

So we are proposing the new codes at 704 diseases of hair and hair follicles. We propose a new subcategory 704.4 for pilar and trichilemmal cysts. (Anyway, we have) two new codes, 704.41 pilar cyst and 704.42 for trichilemmal cyst, which would include trichilemmal proliferating cyst. And then, at the existing code, 706.2 sebaceous cysts, we would add exclude notes for this new code also.

This is a relatively simple proposal. Any comments, questions or thoughts on these? All right, no. We don't seem to have any comments here at this time. Let's see if we have any questions or thoughts on these from people on the phone line. Are the phone lines open?

Operator: Yes, they are.

David Berglund: OK. Do we have any type of support for this, from the audience? Do people think this is a good idea in general? I see at least some people nodding their heads here. This is a good idea. And no negative comments, certainly. If anyone had a negative comment, I want you to come up and let me know what it was. I do at least think we have some support for this, so we do have some general audience support. And again, we'll ask you to put all comments in writing, if you have comments on these.

And next, we'd move on to our next topic, which is on page 30, for those following along, and it's, Retained Gallstones Following Cholecystectomy. Now, it can happen after cholecystectomy especially in a laparoscopic cholecystectomy to – in attempting to remove gallstones for it, not to be fully removed. This can be – this can remain in the bile duct or they can also be lost essentially when – during an attempt to retrieve them.

If – probably more if someone was trying to laparoscopically remove a stone and had more than one stone captured at once and was pulling it out. If more

than one stone was there, a smaller one might get left behind without knowledge.

I think that's actually quite rare and we'll certainly hope it remains rare, but in such a case, a stone could be left in the abdominal cavity or the abdominal wall even. And that could then later cause obstruction or infection or other problems.

Now, that is again a rare thing to occur. It's a kind of thing that we sometimes get questions about, that people send to (Nelly) to help us try to answer and we then scratched our heads about for a while because they weren't quite very clear. There hasn't really been a clear way to code that, let me just say.

So we are proposing some new codes that will let us capture that. So that's 997 – 997.4 digestive system complication, we're proposing a new code 997.41 for retained cholelithiasis following cholecystectomy. And at the same time, we would – in expanding, create an additional new code, 997.49, for other digestive system complication. And additionally, we would create some other notes in order to make it more clear how these were to be used. At 574 cholelithiasis, we would add an exclusion for routine cholelithiasis following cholecystectomy to the 997.41.

We would add an excludes note at 996 – the – well, the existing note there for excluding from the complications peculiar to certain specified procedures, we would exclude complications of internal anastomosis of the gastrointestinal tract now to that new code 997.49 instead of the 997.4 that it had been. And similarly, at 998.3, disruption of wound and 998.31 disruption of internal operation surgical wound, we would change the exclusion to go to complications of internal anastomosis of the gastrointestinal tract to go the new 997.49. So those are just the updates to allow us to be properly coded in the right place.

Comments or questions or thoughts on this proposed new code? You people think that it looks like a good idea, I see a thumbs up and I see people nodding. Yes, this looks likes a good idea. All right, thank you. And again,

we'll ask for comments in writing. Let's check and see if there's anyone on the phone line also. Are the phone lines open?

Operator: Yes, the phone lines are open.

David Berglund: Any comments on this from the phone line? Hearing none, we will proceed onward. And at this point, I've completed the topics I was addressing and I will be passing it back to Amy Blum and we'll be moving onward. Amy, I'll leave it up to you to move back to where you want this.

Amy Blum: And we're making very good time, OK. Back to page 19, Pelvic Fracture without Disruption of Pelvic Circles. Is (Pat Reilly) here? There's (Pat), this is for her. Oh, the keyboard's up here now, OK

(Pat Reilly): Yesterday, we had 3.5 hours in the morning and two-point – 2.25 hours in the afternoon, and I said …

Amy Blum: OK.

(Pat Reilly): we're going to count that (insurance) said, "Let's just kind of fix that…

Amy Blum: At the last meeting, we proposed the modification to the index. It's an addenda change, because we had "with disruption of pelvic circle" as a non-essential modifier and we were going to just take that off and make the index entry "multiple pelvic fractures with disruption of pelvic circle" because it's not non-essential, it's part of the co-title. But then, of course, we realized that we didn't have a code for "without disruption of the pelvic circle."

So we put this proposal together to create new codes for multiple pelvic fractures with disruption of pelvic circle and without disruption of pelvic circle. So that was the first step in making a new code, and then, we sent this off to the orthopedics community who said that, "Well, now you know, we use the word ring, not the word circle."

So we decided to just, instead of changing the co-title at this point, to just adding the inclusion term, "multiple pelvic fractures with disruption of pelvic ring and multiple pelvic fractures without disruption of the pelvic ring."

Then we also got a note back. It's rather the eleventh hour from the orthopedist who said, "Oh, by the way, the pelvic ring actually has a left and a right side, so you didn't know that did you? That a ring has a left and a right side." But it does, so we didn't have time actually at this point to add that to this proposal. But I'm not sure at this late date with the way the codes are in 9-CM whether we're going to go ahead and try to modify the codes.

But for right now, we're going to propose this – the new codes for multiple pelvic fractures without disruption of pelvic circle, open and closed, with the inclusion terms for with pelvic ring. Any comment? Well, OK. Does anyone watch "The Office"? (Mary) just had a slight pelvic fracture.

Jeffrey Linzer: Just a comment on your index modification code, you have indicated where you're going to remove the non-essential modifier and make it part of the term for multiple with disruption of pelvic ring for closed. But, you need to add the other three in the index as well.

Amy Blum: That's – we always add the, whatever changes we made in the tabular we do add to the index. We don't always show them all. This is the index modification that we're showing here independent of the tally changes. All of the new codes will be added to the index also.

OK, then on page 22, cystostomy complication. The classification has specific codes for complications of many artificial stoma, but not for cystostomy. A question was submitted as to how the code an infection of a cystostomy. In the current options, 997.5, urinary complications – oh, one moment, let me just change this, so you can see this. Here we go.

And, let's see and our 996.39 mechanical complications of other genitourinary device, implant, graft, don't really provide you with an accurate code. So, this question did come to us from (3M), I haven't noted that here, it was from (Aurora).

So we are proposing to create some new codes an infection of the cystostomy with the "Use additional code" note to specify the type of infection, a mechanical complication in cystostomy, and then, other complications. And because this is already within another specified subcategory, we would then

have to have another code of 596.89 for other specified disorder of the bladder.

Female: (Inaudible)

Amy Blum: And then if you look on page 23, you'll see where within the rest of the classification 996.39 where we have our mechanical complication of cystostomy, we would exclude this new code, oops. And then, at 997.5, we would also exclude the new code for complications of cystostomy, and then, down at attention to artificial openings, we would just add the new range of new codes and delete the old 997.5 from that excludes note.

Oh, I didn't ask the people in the audience if they had any, I mean, in the – if they had any questions about the pelvic fracture. So if anyone listening online has any comments about pelvic fractures or cystostomy, please let me know. And anyone in the audience have any? OK, so, all right. The bladder gets now equal attention (as to the colon). OK, very good.

Now, our next one, hopefully, we'll get some comments on this next one, Smoke Inhalation. NCHS has received questions regarding the correct coding for smoke inhalation and how it relates to the coding of acute respiratory failure. The default code for the term smoke inhalation is 987.9, toxic effect of unspecified gas fume or vapor.

OK, I have a critical update that we're going to ignore. Oh, I just love words, OK. However, at the tabular section 980 to 989, toxic effects of substances chiefly non-medicinal as to source, there's an exclude note for respiratory conditions due to external agents. So if you see here at this main heading, 988 to 989, there’s the excludes notes there.

Based on that excludes note, the default for smoke inhalation NOS should be changed to a code within category 506, respiratory conditions due to chemical fumes and vapors, or category 508, respiratory conditions due to other and unspecified external agents. The axis of classification for these categories aren't consistent. Categories 506 includes codes for specific types of respiratory conditions and category 508 is a broken out based on the external agent. Both categories require an E code to identify the cause.

We're asking for comments on which category you all feel would be best to assign the default for smoke inhalation NOS, 506 or 508, or another one if you feel there's another one that's even better and whether or not we should create a specific code for smoke inhalation NOS.

Additionally, there's also the question of sequencing of these codes in conjunction with the associated specific respiratory condition. To be consistent with the sequencing rules for other poisoning and toxic effect code, a “Use additional code” note should be added under category 506 and 508. This note would apply to all secondary respiratory codes including acute respiratory failure.

Finally, the term asphyxia is indexed to the same default as the term smoke inhalation and comments are requested as to whether or not the term asphyxia is equivalent to smoke inhalation NOS. And if you go to page 25, you'll see the different – these are the different index entries that now all go to the same default code for smoke inhalation 987.9. And we wanted your opinion on whether or not such things as asphyxia and gas asphyxia and vapor asphyxia should be considered synonymous with just smoke inhalation NOS.

But more importantly, we were just wanting to know whether or not we should create a new code for the term and whether we should exclude smoke inhalation from the 980 to 989. Now, this might take some thoughts. You might want to look this up and think about it, and get back to us with comments. This isn't being fast tracked. This is something that we're considering for October 2011 and you might think it's perfectly fine to leave everything as it is and perhaps change the excludes note at that section title.

So whatever comments you have, let us know when you have some time to think about it. And people in the phone-in line, does anyone have any thoughts on this now? OK, well, this is an important one. We hope to get some comments on that. No, all right then.

Next one on page 27, Complications of Weight Loss Procedures. And again, after we put this comment together, we got some additional comments from or someone I'm trying to remember, but in any case, I'll discuss those in just a

moment. Bariatric surgery and gastric band procedures, while very successful in most cases for weight reduction do have associated complications such as infections and device malfunction.

Complications of bariatric surgery are now indexed to code 997.4, digestive system complications. NCHS is proposing that a new set of codes for the complications of these procedures be created. This is a case where we simply index the complication to a generic code titled, "digestive system complication," and we actually don't have any secondary code to use. So what we're proposing and that one of the questions is, “The term bariatric surgery, should that be the umbrella term with sub-terms for gastric banding, gastric bypass?”

So we do have to look at some of the terminology, but the fundamental idea is that we would have some specific code for infections due to the, actually, invasive bariatric surgeries where they do the Roux-en-Y, and actually, it's an open procedure and complication codes for the Lap-Bands, they just – those – the devices that they put in laparoscopically or, however, it's just a band and they don't actually cut. We'd make two separate sub-categories with specific codes for infections due to those procedures or other complications of those procedures. And these new codes would be excluded from code 997.4.

Any comment? No, OK. Anyone online have a comment? Oh, I have a little announcement, (Brenda McRae) you dropped your ID badge in the ladies' bathroom. It's at the guard's desk. Maybe she has even left the building. No, OK, so. So, no comments about this, all right. We are moving along. Is that a blip? No, OK, then.

On to page 31, Biochemical Pregnancy. OK, fertility clinics and physicians who specialize in assisted reproductive technologies have asked for a code to identify patients who have, what I refer to imprecisely as a false-positive pregnancy or a chemical pregnancy – biochemical pregnancy. These terms are not indicating that the pregnancy was conceived using hormonal stimulation or other such chemical method. This is for cases where a woman's pregnancy test comes back as positive indicating serum hCG level but when followed up with ultrasound, no fetus is present.

These are in effect very early miscarriages. The positive test confirms that conception occurred, but when the ultrasound indicates no uterine pregnancy, an ectopic pregnancy must be ruled out. When no ectopic pregnancy is noted, then miscarriage is confirmed.

At the request of the American College of Obstetrics and Gynecology, the following expansion of code 631 is being proposed to address this situation. So we're just proposing to create one new code and this is a long title, "Inappropriate rise or decline of quantitative human chorionic gonadotropin in early pregnancy," which is a biochemical pregnancy. And then another 631.8 other abnormal products of conception.

Any comments or questions? No, OK. Anyone online have a question? Nelly.

Nelly Leon Chisen: Do you know how this would be documented in the record because I'm a little confused, you know, how people would find this because it says that these patients has been referred to imprecisely as a false-positive pregnancy? Is that how you will be documenting on record a false-positive pregnancy?

Amy Blum: I do think that in some cases, yes, it is referred to as a false-positive and I think we would have to have that in the index thing, false-positive meaning this or…

Nelly Leon-Chisen: OK.

Amy Blum: Because we do have the V22 or 23 codes that are pregnancy test positive, negative, unspecified and so we want to exclude them from those codes.

Nelly Leon-Chisen: So, they should not be going to those codes.

Amy Blum: No, exactly.

Nelly Leon-Chisen: They will be going to this new one instead.

Amy Blum: Right, yes.

Nelly Leon-Chisen: OK.

Amy Blum: Anything else? If you look on page 32, these are the other changes that we would make and if you can see that, it's a V0 – it's a V72.4 pregnancy examination or test. This new code would be excluded.

Male: Amy, while, it may be, stating the obvious, I'm just wondering if you need an excludes note for increase in hCG and non-pregnancy related conditions?

Amy Blum: OK, probably it couldn't hurt. They would have to figure out what codes we are sending you to. We have to ask them about that. OK, very good. And we're on to the addenda. We are almost done. Wow. OK.

On page 33, these first entries on page 33 are all just cosmetic changes to the tabular that we are going to implement this October 1st at 225, 365, 737, 742 and 759, all of these entries. We expanded the code at 237.7 last year of the neurofibromatosis code and we did not update these ranges on the CD-ROM. So all this is – all we're saying is that we're just going to go back into the tabular and just make these updated changes in those places where we referenced a code, 237.7. We're going to take care of that this year. And that's everything that there is on page 33.

On page 34, a D15.89 on the CD-ROM at the excludes note, we just have a typographical error. We're going to correct that this year on the CD. At V55, the excludes note, 997.4 was supposed to have been deleted when we created the new codes, 569.60 to 569.69. We just forgot to do that, so we're going to just take that off now.

At V76.51, we had been asked by our own survey branch in NCHS to just have the inclusion term, screening colonoscopy, NOS, be added under the special screenings for malignant neoplasm so that in case they just see the term, screening neoplasm, they know which default code to use. So we're going to do that this year as well.

And at V90, we are creating this October 1, we're going to have some new codes for retained foreign body and there was just one more excludes note we meant to add to that topic that we've omitted and so we're going to add that

now. So at V90, we're just going to have one more excludes note, a foreign body accidentally left during the procedure and this will be part of the full V90 proposal that's going to be implemented this October 1.

So those are all of the changes that we're considering to the tabular of – for this October that we will need comments on by April 2nd, but there's really not too much, it's just mostly a cleaning up thing.

So now, at the bottom of page 34, we are looking at tabular changes being considered for October 1, 2001. And the very first one, we were, excuse me, yes, 2011. I remember 2001 just like yesterday. I am getting old, OK.

We had a number of proposals at our last meeting having to do with complications of blood transfusions. And one of things that we've discussed was whether you – if you have an infection due to a blood transfusion – we talked about creating some codes for that. That proposal wasn't quite ready and we're still working on it a little bit, but one of the issues that was raised was, "If you have a blood transfusion and you know that you have gotten an infection, it's documented that you have an infection, the complication code should come first and the infection second."

But then the question was raised, "So what if you get HIV from a blood transfusion?" Now, you hope that doesn't happen, but it certainly can and we have in our guidelines that the 042 must always be first listed and all manifestations of HIV should come after. But there is that one exception that if it's a HIV infection that is because of a blood transfusion, coding guidelines do require and the instructional notes do require that the blood transfusion complication code come first.

So we're just proposing – I'm adding a code first note at HIV, a code first HIV disease due to blood transfusion, code the 999.39, first and the 042, second. And when we go further through the addenda changes that 999.39, there is a use additional code note where we would have use additional code to specify the infection and we'd add HIV.

Yes, Sue?

Sue Bowman: Well, I would just suggest that you add, if applicable, because the way it's worded now, it sounds like you always put HIV due to blood transfusion first.

Amy Blum: Yes, that's a good idea. Yes, Tine?

Tine: Yes, I have to disagree with this instruction because oftentimes, the patient come back, basically treat for (AIDS) and this particular do not reflect the treatment of patients putting in 99 first, so I – that's great instructions.

Amy Blum: Do you say that that is correct even if they know that the infection is due to the transfusion?

Tine: Yes, but the transfusion – but that 99 was not to be treated, the AIDS would be treated.

Amy Blum: But the standard coding guidelines do require that a poisoning or a toxic effect does have to be sequenced before the infection, so, you were saying that you'd want this to be an exception?

Tine: That is correct.

Amy Blum: OK.

Sue Bowman: This type of thing ends up in questions where people ask which guideline is more important than another guideline. And, I think, in the past, the – our HIV guidelines is sort of been one of the more important guidelines that, you know, the 042 would always go first. And so, what you're doing here, you're really changing the data that, you know, where the 042 has always come first. So it's a – you know, I'm not sure people really want to do that. I need to sort of think about what it means because I have a feeling that we probably would not want to change the data for the last 30 some years on HIV.

Amy Blum: OK. Well, first of all, we are fortunate to be able to say that HIV infections from blood transfusions are very rare, and hopefully, we would never have the actual situation where the guidelines are being questioned that's the first thing to think about. And then I'd think we do have to think overall for continuity; if you want consistency, if you have your complication or your late effect

first, whether or not you want to have an exception, so that's something to consider.

But again, you know, I've made note of all this and I think we do – we'll probably go back to this again when we revisit the whole transfusion-transmitted infections. But this is something we wanted people to think about that there is this one situation where HIV can be transmitted and how we wanted to sequence that. OK. Any comments on this particular entry from those folks on line?

OK. At – just moving on down at 236.1, there's just a typo that we want to correct. We want to revise the line under 236.1. It's not actually a typo, but the computer system doesn't really like words that are truncated like that. So we're going to just get rid of those parentheses and write the word out. Yes, right there. OK?

Moving on to page 35, at 323.0, one of the questions that came to us was, "How do you code HIV-associated encephalitis?" So to assist coders in knowing which is the correct HIV code to use, we are proposing, under 323.0, a code-first note to code first the underlying disease such as HIV. But then, we were also noticing when we were working on this proposal that the title of 323.4, 323.41 and 323.42, were not proper code titles, we didn't have due to other infections classified elsewhere and this is in other category. So we're just modifying the code titles to match the structure of other subcategory.

At the 346 migraine, we had a request, we went ahead and made all these six digits for with and without intractable migraine. And we now, we had been told that intractable is not the term that they use anymore, now, they use refractory. So instead of changing all of the existing titles, we are just proposing to add some inclusion terms for – under each one of these six digits for with and without mention of intractable migraine to add with and without refractory migraine. So we would just index the term refractory to be equivalent to intractable in (intensium), we can't update the terminology.

OK. At 646.7, we just want to modify the existing title. Let's see. Here's migraine and here's 646.7. In the digestive system chapter, some conditions

are listed as problems of the liver and some conditions are listed as problems of the biliary tract. In the OB chapter, a lot of those were lumped together and just liver disorders in pregnancy. And people have questioned, "Well, it's in the digestive system chapter, something is listed as a biliary tract problem, why are we coding it to a liver disorder in pregnancy?" So we're just going to modify the title as 646.7 to include liver and biliary tract and then we've got this all taken care of. OK?

At 968.5, I believe this came to us from (Tine). We had a question, "What is the difference between the cocaine that is mentioned at code 968.5, poisoning by surface and infiltrative anesthetics and the other poisoning code we have for cocaine use is a central nervous system stimulant?"

So what we are proposing to do to help people understand the difference is that code 968.5 that the inclusion term, cocaine, just put in brackets a – an instructional note, shall we say of the word topical and exclude poisoning by cocaine use as a central nervous system stimulant and excluding the 970.81 from the 968.5. So the 968.5 is for those kind of things that the dentist uses and that the 970.81 are those other uses of cocaine, off-label uses of cocaine, which is probably, the most – more likely place – more likely code that you'll be ending up using.

OK. On page 36, going back to what we were talking about at the 042. We do have the corresponding use additional code note to specify the infection of HIV at the 999.3, so, I do have your comment already about that sequencing. At V58.69, the – just – people wanted a little bit more clarification that the V58.69, the long-term current use of methadone is for pain control. But the default that we decided on last year was just the term methadone use, NOS, or methadone maintenance, NOS would default to the 304.00 abuse or dependence, I can't remember.

OK. At D84, genetic susceptibility disease, we're trying to make sure people understand the difference between genetic susceptibility and chromosome anomalies. We're proposing an exclude note here, but this is just a suggestion that might not be the best way of handling it. We just want people to let us

know how they think best that we explain the best use of the V84 code, the genetic susceptibility code.

Likewise, that V84.81, where we have the code, genetic susceptibility to the multiple endocrine neoplasia, we're proposing to exclude the actual MEN codes themselves because if you've already got the multiple endocrine neoplasia, it's obvious that you have the genetic susceptibility and you don't need to use both codes together.

Now, for the E codes – did anybody have any comments on this before we move on, any comments about any of the addenda items? Online? No.

OK. Then moving to the E codes, at E917, we are proposing to strike out at the excludes note at E917, Injury Caused by Assault. The E967.0 through E967.9 are only the perpetrator codes and they're not supposed to really be used with the assault codes and even though we're excluding them so that we've been confusing people that, "Well, are you supposed to use the perpetrator code for any kind of assault?" And no.

So in addition to excluding the perpetrator code from the E917 at the E967 perpetrator of child and adult abuse, we are proposing to add a note, codes from category E967, correspond only to codes under category 995, Child Maltreatment Syndrome and codes 995.80 through 995.85, Adult Maltreatment and Abuse. They are not to be used to identify the perpetrator of other types of assault that's just a long instructional note that we're thinking of adding there. OK?

And so that's everything that we have for our tabular addenda. Now, for our index addenda. So for anyone who doesn't have the pages, here's what the note looks like, at E967.

And then, the index changes that we're going to consider for this October 1, we just have in our neoplasm table, the one line neoplasm colon, see also neoplasm, intestine, large and rectum. That line got put together. And it's really supposed to be two separate lines for "See also neoplasm, intestine, large," and then another sub-line with rectum. So we're just going to add that – correct that on the neoplasm table now.

We are still debating – we made the – some pain codes, a jaw pain, NOS and we were defaulting it to – I do not recall at this time, something within – where the rest of the jaw things are. But then we still have the question of what to do with pain in the maxilla. And that currently goes to the same default code that we had for pain in the jaw, but most of the things that referred to pain in the maxilla are going – are defaulting to problems of the temporomandibular joint.

That's what we're proposing here, but we're not sure that everybody would agree with that, and so, we just want to know what you think would be the best default for pain, maxilla, NOS.

We are also going to add to the pneumonia line, under pneumonia, basal, basic basilar, see pneumonia by type, because right now, it says, “See pneumonia, lobar” or something like that. And so that we want people to just basal pneumonia or basilar pneumonia is just a generic term for pneumonia, and so, we want you to code it to type.

We are going to change the entry for puerperal fever to 672 that was a change that we were supposed to have made – we've made some new codes for major puerperal infections a while back and this is one entry that we didn't update.

Adding an entry for screening colonoscopy and that goes along with the entry we're making in the tabular to include the term, screening colonoscopy under V76.51.

And we traded in a lot of new codes for stromal tumor a few years ago, and we indexed them, but the site endometrium wasn't added and the group that asked for those – I can't remember who asked for it, but they also wanted endometrium, Andy Anderson asked for the stromal tumor (combs), but someone asked us to, please also add endometrium to the stromal tumor entry, so we’re proposing that now.

And the last couple of changes that we're proposing for this October are to the table of drugs and chemicals and they are basically just two typographical errors. We have a line for DeKalin, where the "K" should be lower case, not

upper case. And we have the word utility, spelled wrong on the table of drugs and chemicals. So that's everything we're proposing for the index for this October 1. Any comments? Online?

OK, then. The – they were considering the following changes for October 1, 2011 for the index, adding the term acroangiodermatitis to code 448.9, adding an entry for chronic anemia. We had the question on, "How you code chronic anemia?" We had simple chronic, but we don't have just plain chronic.

Yes, Linda?

Linda Holtzman: And just a quick comment on the chronic. I'm just wondering – I mean – I know that'll send people to 285.9, I know there's an exclusion there on 285.9 for like chronic blood loss anemia and things like that. But I'm wondering if we need some additional exclusion notes elsewhere, like, I assume what you're trying to do is to make sure that chronic anemia so stated go to 285.9 as opposed to 285.29, which is anemia of unspecified chronic disease.

So maybe we need an exclusion note on 285.29 for – excludes anemia, chronic, not otherwise specified. And that – and then, send people to 285.9 and maybe some other notes on 285.9 to remind people that, you know, of the reverse.

Amy Blum: OK. I've made note of that. And we're also proposing – let's see, to add the term, "borderline" to high blood pressure and diabetes. So under all of the entries for high blood pressure, we would default the term, borderline high blood pressure to 796.2, which is Elevation of Blood Pressure without Diagnosis. So where we would not send the term borderline to 401.9, we would send it to the symptom code for elevated blood pressure.

And for borderline diabetes, again, we wouldn't send it to a diabetes mellitus code, we'd send it to the abnormal blood glucose. So the term borderline would not be equivalent to the condition that would be considered equivalent to the symptom code. So under borderline, we'd add these sub-terms diabetes mellitus and hypertension. Under diabetes, we'd add this sub-term borderline.

And then, we had a question about, "How to code, X-linked lymphoproliferative disease?" And we're going to index that to 759.89, add under – we have all the entries for methadone use, NOS. We're going to add them also under drugs, therapy, maintenance status, methadone to go to the default for methadone use.

Under encephalitis, we will add an entry for – due to HIV, to show people how that it to be – what the secondary code is that you would use with HIV to code encephalitis. And we do have a corresponding – we had those changed in the tabular also that correspond to this.

We have a request to index encephaloduroangiomyosynangiosis, EDAMS, which I'm sure you see all the time, right, to 437.5. We have a request to index eosinophilia with (angiomyeloid) hyperplasia and we're proposing to send that to 228.01.

Most of these index changes have come from the editorial advisory board, questions that have come into the central office. And these are the suggested the codes that the EAB has recommended for these terms.

Under aortic intramural hematoma, would have a "See dissection, aorta." Down here. OK. And then another entry for the borderline high blood pressure, another entry for the amyloid – hyperplastic (amyloid) with eosinophilia. Another entry for hypertensive borderline.

We had a request to index the term, Interrogation of a Cardiac Pacemaker. And so, we would add that and we'll send that to the term – to the code for Fitting and Adjustment.

Female: Two comments. First, I like this. I think it's a good idea to add interrogation of the – a term. But of course, you can also interrogate an ICD, a defibrillator as well. So it seems you should also have an entry – a sub-entry for defibrillator to V53.32.

Amy Blum: OK.

Female: Also, (Dr. Paller), pardon me. Am I correct you can also interrogate a neurostimulator? So maybe we should have neurostimulator as well. And I think that's V53.02.

Amy Blum: OK. Very good. Since, we're adding the main term interrogation, we can add whatever sub-term that work. We have another question coming up?

Female: Actually, we've just had a conversation.

Amy Blum: OK.

Female: You can also interrogate a loop recorder, which would be V53.09, I guess, or V53.39, other cardiac device loop recorder. Thanks.

Amy Blum: OK. I don't think we have it indexed as loop recorder, do we?

Female: (Inaudible)

Amy Blum: OK, I'll have to look that up. OK. All right. Also, we're proposing to index the term IRIS, Immune Reconstitution Inflammatory Syndrome and that's – we're saying it's basically the same thing as (SARS) to just code that to 995.90.

Another entry for methadone maintenance, and I don't know if anyone has noticed, but when you go to the main term pneumonia, there are a very large number of non-essential modifiers, which have been in the classification since I think ICD-01 and – or ICD-1. We are proposing to get rid of the bulk of them because we think most of them are not valid.

So we have struck out quite a few of them that we think are no longer necessary, leaving in some. We're happy to strike out any others or keep some that may be considered important. But what we are proposing is that for October 1, 2011, the main term, pneumonia, will have a much cleaner look. So if anybody has any particular other thing that – if you think we are not removing some appropriate ones, so that there are some we should leave, let us know. And of course, the default would still be 46.

We are proposing a few new entries under pregnancy or complicated by cholestasis and insulin resistance. And then another entry for resistant insulin complicated pregnancy. If you go up to the Pregnancy Complicated by Cholestasis, the 646.7, if you remember on the tabular changes, we wanted to change the title of 646.7 to Liver and Bile Duct because that right now, cholestasis in the digestive system is a disorder of the bile duct, not of the liver, but they go to the same place in the pregnancy chapter. So that's why we are modifying the title in the tabular, so that this entry works in the index.

We're proposing and entering an index term for saddle injury and just saying, "See contusion by site." And here comes Dr. Linzer.

Dr. Linzer: Problem is saddle injury can also be a laceration or open wound. It doesn't always imply a contusion.

Amy Blum: So we should just see, "See injury by type?"

Dr. Linder: Yes.

Amy Blum: OK. We had the question of, "How to code localized or intra-abdominal sepsis?" So we're proposing adding a couple of new entries under the index entry for sepsis that intra-abdominal sepsis would go to 567.22 Peritonitis and Localized Sepsis. If you happen to see that term, you would code that to the specific localized infection and move that up here.

Stent Jail would be indexed to 996.72 that's a complication of a – you have that device in you and the – it gets clogged or something.

And finally, under syndrome, we would add Immune Reconstitution Inflammatory Syndrome and Post Chemoembolization Syndrome. And that is it. If anyone have any comments about any of these addenda items. Anyone online? Are the lines open?

Operator: Yes, they are.

Amy Blum: Great. So we are done. I think we might actually beat the traffic today. So any other comment? Oh, wait, (Donna) has some – OK. And …

Donna Pickett: Just a few closing remarks. Thank you for coming. We do expect lots of letters and e-mails from you since we didn't get a lot of comments here during the meeting today.

Again, for proposals that are being considered for this coming October 2010, we'd like those comments in by April 2nd, for the other proposals, by June 11th and if you're dying to submit a proposal for the September meeting that's July 16th.

Also, if all of you, you know, are still kind of hungry, we can go down to the cafeteria early. You don't have to wait until 12:30, so that is a good thing. For those of you who want to rush to the airport and catch a flight, we thank you for attending and we look forward to seeing you at the September meeting.

Thank to those of you who are also online, have a good day.

END