ICD-9-CM Coordination and Maintenance Committee Meeting

Volumes 1 and 2, Diagnosis Presentations

November 2, 2001

SUMMARY

Below is a summary of the diagnosis presentations from the November 2, 2001 ICD-9-CM Coordination and Maintenance Committee (C&M) Meeting. Comments on this meeting's topics must be received in writing or via e-mail by January 8, 2002. Both the NCHS address and e-mail addresses of NCHS C&M staff are listed below. CMS prepares a separate summary of the meeting for procedures issues.

The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled to be held Thursday and Friday, April 18-19, 2002 at the Centers for Medicare and Medicaid Services (CMS) building, Baltimore, MD. Modification proposals for the April 2002 meeting must be received no later than February 18, 2002.

Thank you for your participation in these public forums on the ICD-9-CM. Your comments help insure a more timely and accurate classification.

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ICD-9-CM Volume 1 and 2, Diagnosis Presentations
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Mailing Address:

National Center for Health Statistics
ICD-9-CM Coordination and Maintenance Committee
6525 Belcrest Road, Room 1100
Hyattsville, Maryland 20782

Fax: (301)458-4022

Donna Pickett:	Room 1100 (301) 458-4200	
	E-mail:	dfp4@cdc.gov
Amy Blum:	Room 1100 (301) 458-4200	
	E-mail:	alb8@cdc.gov
David Berglund:	Room 1100 (301)458-4200	
	E-mail:	zhc2@cdc.gov
Lizabeth Fisher:	Room 1100 (301)458-4200	
	E-mail:	llw4@cdc.gov

NCHS Classifications of Diseases and Functioning & Disability web page:
http://www.cdc.gov/nchs/icd9.htm

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Welcome and Announcements

Donna Pickett welcomed all in attendance to the diagnosis portion of the C&M meeting.

The time line for diagnosis changes is included in the proposal packet. Changes to ICD-9-CM resulting from the topics discussed today, if approved, would become effective on October 1, 2002. New proposals must be received at NCHS by February 18, 2002 to be considered for presentation at the April 2002 meeting.

A summary of today's meeting as well as related presentations and statements will be posted to the NCHS classification of diseases web site within a few weeks.

Ms. Pickett also announced a change to the NCHS Classifications of Diseases web site. The title is now "Classifications of Diseases and Functioning & Disability." In May 2001, the World Health Assembly approved the International Classification of Functioning, Disability and Health(ICF) as a member of the World Health Organization (WHO) Family of International Classifications. Information about this classification has been posted on the NCHS web site.

Continuing Education certificates were made available at the conclusion of the meeting.

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Discussion on use of V Codes for procedures

Prior to presenting the diagnosis topics Donna opened discussion on the use of V-codes for new technology procedures. This was included in comments received for the proposed changes to the hospital inpatient prospective payment systems (Federal Register May 4, 2001). Specifically the comments were made on the requirement to establish a mechanism to recognize the costs of new medical services and technologies, as specified in the Benefits Improvement and Protection Act of 2000. The comments were addressed in the September 7, 2001 of the Federal Register, "Medicare Program; Payments for New Medical Services and New Technologies Under the Acute Care Hospital Inpatient Prospective Payment System; Final Rule. One commenter proposed using V-codes, specifically V00.00-V00.99, as an alterative way to track new technology procedures.

Ms. Pickett introduced John Shaw, president of Next Wave, who presented his concept of this use of V-codes as a flag code. Mr. Shaw's presentation is available as Attachment A.

Comments, following his presentation, included concern with mixing procedure information in diagnosis codes.
ICD-9-CM procedure codes are not used on outpatient claims. Therefore data from both the inpatient and outpatient settings are not able to be combined. The outpatient setting is where follow-up is usually performed. Some questioned whether these flag codes would be used only during the interim from the time they become a new technology until they become "standard" for care.

One participant suggested the use of modifiers on procedure codes. Another suggestion was to use procedure code 00.00 to indicate or flag something as a new technology rather than a V-code. Both of these suggestions would need to be evaluated by CMS.

Another question raised was how to establish linking the procedure that is considered new technology with the flag code when there are multiple procedure codes on one record and bill.

Nelly Leon-Chisen, RHIA, representing the American Hospital Association, expressed disagreement to the use of V-codes for this purpose for many reasons including the limited remaining available new codes in the diagnosis portion of ICD-9-CM. The diagnosis codes need to be saved for future use for diagnoses rather than procedures. Additionally, the flag code concept does not provide any detail since these codes cannot be matched with the ICD-9-CM procedure code when there are multiple procedures performed. Also, coders should not be expected to identify a procedure as "new technology" without the physician specifying that in the medical record. It is doubtful that physicians will document that specifically. The entire statement is available as Attachment B.

Sue Prophet, RHIA, representing the American Health Information Management Association (AHIMA), expressed opposition to this type of use of V-codes to track procedures. Ms. Prophet indicated this use would violate the HIPAA designation of code sets for electronic transactions diagnoses and procedures. The ICD-9-CM diagnosis classification system was designated to be used for reporting diagnoses and ICD-9-CM, Volume 3, Procedures was designated to be used for classification of procedures. Additionally, Ms. Prophet indicated that there is increasing need to capture data about healthcare provided in the non-acute care setting and using V-codes to track new technology procedures will reduce the number codes available for these data needs. The entire statement is available as Attachment C.

Ms. Pickett reminded the participants that they can submit written comments on this subject.

SUMMARY OF COMMENTS AND DISCUSSION OF VOLUMES 1 AND 2 TOPICS

The following topics were presented at the meeting. (See attached topic packet):

Heart failure

This topic was previously presented at the May 2001 meeting. Based on comments at that meeting as well as input later from representatives of Kaiser Permanente Mid-Atlantic States, the

proposal was modified and presented today for further consideration and comment. Some suggested returning (from the original proposal) separate codes for acute and chronic congestive heart failure at code 428.0. Others commented that not having this designation could help encourage documentation and use of the new codes. Patricia Casey, from Kaiser Permanente, commented that the current documentation in the chart is not matching what is being treated. Congestive heart failure, whether acute or chronic is still an unspecified term with regard to actual cardiac function. Ms. Casey indicated that she does not see the need for separate codes for acute and chronic congestive heart failure. Some questioned whether the concept "acute ON chronic" should be added to the new diastolic and systolic codes which is different than acute. Ms. Casey agreed that such codes could be useful.

Another comment was that depending on the type of hospital the patient is treated in you will not always see documentation for anything other than 428.0. Teaching hospitals may have specific documentation but smaller community hospitals will probably not. It was suggested to add acute and chronic as non-essential modifiers to 428.0 so acute CHF is included in this code.

Severe sepsis

Peter Morris,MD, from Wake Forest University presented an overview of systemic inflammatory response syndrome (SIRS) and severe sepsis. His PowerPoint presentation is available as Attachment D. Following his presentation and the presentation of the proposed new codes there were several comments and questions discussed.

One participant asked whether a patient who enters the hospital with sepsis always develop SIRS. Dr. Morris responded that this is not always the case and that SIRS can occur for reasons other than infection (trauma, burns, other insults to the body). There were several questions regarding the use of multiple codes to describe the patient with SIRS with an infection and organ failure (severe sepsis). This would require use of separate codes for the infection, severe sepsis and the organ failure. Severe sepsis and SIRS would usually not be the principal diagnosis since the patient typically is admitted the underlying infection or trauma and develops this while in the ICU. It is

the body's response to the severe insult or infection. It was suggested to separate severe sepsis from SIRS and to have separate codes for that with an infection vs. without an infection. An example of the use of proposed code 995.92 could be a burn patient without infection but having organ failure.

There was concern whether severe sepsis is documented in the medical record or if it is criteria driven and how clear this will be to the coder. It is criteria driven and the documentation is more clear in the ICU where it is treated. There was concern that physicians would document a "real bad case of septicemia" as severe sepsis. There has been much PRO (peer review organization) and OIG (Office of Inspector General) review centered on the use of the septicemia codes and there was concern that these new codes could fall under similar scrutiny if the documentation and guideline for use is not clear to coders. Sequencing issues need to be addressed in the use of these codes.

Vascular disease

Jeffrey Kaufman,MD, a physician from Vascular Services of Western New England, presented clinical background for the proposals in this topic.

Atheroembolism:

Some participants indicated they have seen this term documented in the medical records. Participants indicated general agreement that the proposed codes are needed.

Venous disease:

It was suggested to add chronic venous hypertension with deep vein thrombosis as an inclusion at 459.1. Also, it was suggested to change the proposed title of code 454.9 to say "uncomplicated" rather than "asymptomatic." Asymptomatic could be an inclusion term for this code. Some participants questioned whether physicians will document postphlebetic syndrome with ulcer or an ulcer of the lower limbs with a history of phlebitis and assume it to be the same. Dr Kaufman indicated the physician documentation should be specific to link the postphlebetic syndrome to the ulcer.

It was suggested to add the proposed new codes 459.13 and 459.33 to the code first list for subcategory 707.1, Ulcer of lower

limbs, except decubitus, since they also indicate presence of an ulcer.

Arterial dissection:
Dr. Kaufman stated that this diagnosis is usually coded as aneurysm which he feels is incorrect. Laura Powers, MD, representing the American Academy of Neurologists, commented that this condition is also seen in the vertebral arteries as much as carotid arteries and that this could be indexed to 443.29, Dissection of other artery.

Another comment was made regarding adding dissection to the codes in subcategory 414.1, Coronary atherosclerosis. In this code it is the vessel rather than heart that is dissecting. In considering other sites to include a question was asked whether the pulmonary artery should be included somewhere. Dr. Kaufman stated that this artery does not dissect.

Facial droop following cerebrovascular accident
The proposal for a new code for facial droop was presented as listed originally in the topic packet. Dr. Powers suggested revising the code title to read facial weakness instead of facial droop. Dr. Powers also suggested other late effect conditions of CVA which might benefit from having individual codes in the 438 category. These additional suggestions are as Attachment E.

Ectopic pregnancy with uterine pregnancy
Some participants preferred option #1 while most favored option #2 of this proposal. Option #2 expands each existing ectopic pregnancy code, to the fifth digit level, to indicate whether or not the patient also had an intrauterine pregnancy.

Pulmonary complications of cystic fibrosis
Suzanne Pattee, JD, representing the Cystic Fibrosis Foundation, spoke briefly in support of the proposal for the new codes. Patients with CF and pneumonia are different than those CF patients that have underlying pulmonary manifestations. There was discussion regarding whether the term “manifestation” should be used or “complication”. It was felt that in this case the pulmonary condition is a manifestation of the underlying CF. Some questioned whether documentation in the medical record would be clear enough to warrant using the proposed code 277.02 (CF

with pulmonary manifestations). It was asked whether a coder should assume a CF patient presenting with pneumonia means that they have CF with pulmonary manifestations? This is not always the case. There was a question about whether to use multiple codes in the 277 category if the patient has multiple manifestations of the disease, or whether a code should be created for "multiple" manifestations. It was felt better to code the manifestations individually so you do not lose the specificity of what the patient has.

Symptomatic menopause

Questions arose regarding how to code the patient who has had her ovaries removed and presents for bone density testing. The code 256.2, Postablative ovarian failure should be used for these cases. You could also add the code V45.77, Acquired absence of genital organ(ovary). There were no other comments on this proposal.

Paintball gun injury

There were no comments on this proposal. The participants favored adding these codes to the classification.

Aftercare codes

This topic had been presented in May 2001 and was revised following comments expressed at and after that meeting and presented at this meeting for further consideration.
Aileen Gergley, representing the Long Term Care section of AHIMA, stated there is a strong need for an expansion of the V-codes for this purpose. Ann Meadow, from CMS also expressed support for this proposal and added that they are interested in the expansion of codes for aftercare following surgery presented in the original AHIMA proposal. She stated that the OASIS system drives the grouper for home health prospective payment. These proposed V-codes could be cross walked to work with that grouper. Rehabilitation and other long term care settings could also use this expansion. Another commenter indicated that many acute care hospitals have long term care facilities attached to them. The coders in those facilities are responsible for all of the coding. It would be helpful to have the same codes used for all settings. Additionally, using the same coding guidelines and specificity of codes on assessments as well as the billing forms would be helpful.

Toxic shock syndrome
There were no comments on this proposal other than general agreement to add a code for this syndrome.

West Nile Virus
There was agreement that a separate code should be added for this condition. It was suggested to add an excludes note under code 066.3, Other mosquito-borne fever, since the new code being added falls in sequence after an "other" code.

Abnormal findings on cervical pap smear
It was recommended to change the title of proposed code 795.00 to read "Nonspecific abnormal Papanicolaou smear of cervix, NOS".

Exposure to and observation for suspected contact with anthrax
Participants supported these proposed new codes. There was some discussion regarding how to code a population being screened for anthrax. It was recommended to use the V01 code since they would probably be screening due a suspected exposure to anthrax.

Addenda
There was discussion as to how best to word the "code also" note at the 707.1 subcategory so as not to imply that an underlying cause is always required (like the other code first notes which are a fallback from the dagger/asterisk coding convention). You can use this code without coding an underlying condition. Some software programs default the "code also" codes to be secondary diagnosis and never principal diagnosis.

There were no other comments regarding the proposed addenda items.