

**ICD-9-CM Coordination and Maintenance Committee Meeting
Summary of Volumes 1 and 2, Diagnosis Presentations
September 15-16, 2010**

On September 16, Donna Pickett, co-chair of the committee, welcomed the members of the audience. She reviewed the timeline included at the beginning of the topic packet informing the attendees of the deadline for written comments on topics presented at this meeting. Deadline for receipt of public comments on revisions to the General Equivalence Maps (GEMs) discussed at the September 15, 2010 ICD-9-CM Coordination and Maintenance Committee is November 12, 2010. On September 15, following completion of the procedure topics, some diagnosis topics were presented. Those topics are indicated as such in this document. All diagnosis topics presented during the meeting are being considered for October 1, 2011 implementation.

Written comments must be received by NCHS staff by November 19, 2010. Ms. Pickett requested that comments be sent via electronic mail, since regular mail is often delayed. Contact information for all NCHS staff and the NCHS website are included in the topic packet. Attendees were also reminded that the full topic packet is currently posted, in two parts, on the NCHS website. The PowerPoint presentations from this meeting will be posted to the NCHS website shortly after the meeting, if they meet with the Federal Government's 508 compliance requirements. New proposals for the March 10, 2011 meeting must be received by January 7, 2011.

Ms. Pickett also announced the following:

NCHS will no longer provide a hard copy continuing education (CE) certificate for this meeting. Attendees can print the agenda from this meeting for use in CE reporting. Attendees were instructed to contact the respective professional association for further information on CE reporting details. NCHS will continue to report, in this summary, the number of hours for each day of the meeting. Attendees are eligible for 6 CE hours for Wednesday, September 15 and 5 CE hours for Thursday, September 16.

- Reminder for those wishing to attend the March 9 – March 10, 2011 ICD-9-CM Coordination and Maintenance Committee meeting, you must register for the meeting online at: <http://www.cms.hhs.gov/apps/events> by March 4, 2011. Failure to do so may result in lack of access to the meeting.
- Today's call-in number was to be available until 3:15 pm; however, the meeting was adjourned before that time.

Comments and discussion on the topics presented on September 15 were as follows:

Dementia unspecified with and without behavioral disturbance

There was a comment made in favor of these codes.

Pseudobulbar Affect

Sue Bowman, representing the American Health Information Management Association (AHIMA), suggested changing the wording of the code first note to add “if applicable”. Dr. Laura Powers, representing the American Academy of Neurology (AAN), supports creation of the proposed new code.

Complications of stem cell transplant

There were no comments on this proposal. The audience was urged to submit written comments.

Pulmonary Arteriovenous Malformation and Pulmonary Atresia

Nelly Leon-Chisen, representing the American Hospital Association (AHA), and others commented in favor of the proposal. One commenter noted that a specific code may also be needed for arteriovenous malformation of the cerebral circulation. As noted at the meeting, there is an error in the topic packet and the line with the “use additional code” note for code 042 should be removed from this proposal, as it was not intended to be part of this proposal.

Acquired absence of joint

There were no comments on this proposal.

ICD-9-CM Proposed Addenda

The following comments were made regarding the ICD-9-CM tabular addenda:

Regarding the change to the chapter title for chapter 5, Linda Holtzman liked the idea of adding “and behavioral” to the title.

Regarding the revision of the code first note at the 536.3 Gastroparesis, it was suggested instead of “Code first, if applicable” to use “Code first, if known”. There were no other comments on the ICD-9-CM tabular addenda.

The following comments were made regarding the ICD-9-CM index addenda:

Regarding the addition of an index entry for “siderosis, CNS” to code 437.8, Other and ill-defined cerebrovascular disease, it was suggested to spell out the abbreviation CNS (as central nervous system). A commenter asked about the proposal to index “Tear, annular fibrosis,” to code 722.51, whether this disorder occurred only at the thoracic level, or could it involve other levels, which should also be indexed.

ICD-10-CM Proposed Addenda

The following comments were made regarding the ICD-10-CM tabular addenda:
Regarding the proposed deletion of inclusion term “circumscribed brain atrophy” at the G31.01 Pick’s disease, Sue Bowman, AHIMA, suggested instead to change the inclusion term wording to “frontotemporal circumscribed brain atrophy.” Dr. Powers, AAN, agreed and explained that this might be another alternative. There were no further comments on the ICD-10-CM index addenda.

Comments and discussion on the topics presented on September 16 were as follows:

Mesh erosion/Mesh exposure

Sage Claydon, MD, American College of Obstetricians and Gynecologists (ACOG) was available via telephone and explained in detail the difference between the erosion and exposure and how these codes will help distinguish the two problems. Dr. Jeffrey Linzer, representing the American Academy of Pediatrics (AAP), also via telephone suggested that the code not be limited to just GYN procedures. Two options were discussed and while most favored the idea of codes for these complications, the language is problematic, and if approved additional inclusion terms would need to be added. There were concerns that this type of erosion may not mean the same as, for example, a pacemaker erosion through the skin. Inclusion terms and indexing will need to be carefully reviewed. Dr. Claydon was asked if the two conditions can exist at the same time or if they were mutually exclusive, and she responded that they can exist at the same time.

Infection Following Transfusion

Mikhail Menis, PharmD, MS of the Analytic Epidemiology Branch, Office of Biostatistics and Epidemiology, Center for Biologics Evaluation & Research (CBER) at the Food and Drug Administration (FDA) presented background on the topic via telephone. Nelly Leon-Chisen, AHA, asked if the intent is to identify patients that develop HIV after transfusion, and observed that this would take two codes. She further asked about HIV patients that develop any kind of infection, related to transfusion, when they are already HIV positive, thus raising the issue that the same codes would be used. Additionally, she asked for clarification as to whether the proposed code would be used for any type of infection in general. Dr. Menis, FDA, responded that the proposed code could be used for any infection that could occur after transfusion. One commenter suggested if HIV is present, you would use code V08. Dr. Berglund responded that the intent was to be able use the proposed code later once they came down with AIDS. Another commenter suggested using a late effect for complication code instead. There was also a suggestion to have one code for acute and another for chronic or late effect. Sue Bowman, AHIMA, indicated that this might confuse coders, and she also had concerns that the use of the code plus a status code would be linked with the patient forever. Dr. Menis, FDA, suggested an acute code could be useful for tracking purposes. Dr. Berglund urged all to submit comments in writing.

Anaphylactic Reaction, and Other Serum Reaction

Mikhail Menis, PharmD, MS of the Analytic Epidemiology Branch, Office of Biostatistics and Epidemiology, Center for Biologics Evaluation & Research (CBER) at the Food and Drug Administration (FDA) presented background on the topic via telephone. AHA commented that we should consider exclusion notes between the proposed codes and new codes in the 999.6 section. Jeffrey Linzer, MD, representing the American Academy of Pediatrics (AAP) via telephone commented that the terms were more appropriate and that the AAP favors the proposal. He also commented that it could be of assistance to have the term anaphylactoid reaction in the tabular, as well as in the index.

Malnutrition

Gordon L. Jensen, MD, PhD, Penn State University, Co-Chair American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) Task Force, was available via telephone and explained that certain of the codes for malnutrition are outdated and do not reflect the current standard of care. In addition, there is much misuse of these codes and this proposal attempts to correct that. This request is not to delete current codes, but to make sure the correct code is used. It was suggested that the term “frailty” be removed from the code first note at proposed new code 262.13, Severe malnutrition in chronic illness. Also a comment was made on the title of proposed new code 262.19, Severe malnutrition related to other disorders, that the title should be “Severe malnutrition in other disorders”. Additionally there were comments about need for instructions on sequencing codes for chronic conditions with codes for acute conditions. There was a concern raised regarding indexing both severe malnutrition and malnutrition NOS to the same default code of 263.9.

Lymphangiomyomatosis

Francis X. McCormack, MD, University of Cincinnati, representing the American Thoracic Society (ATS) presented background on this topic. Nelly Leon-Chisen, AHA, commented that if the condition was related to neoplasms why was the code not being added to the neoplasm chapter. Dr. Berglund indicated that clinically, it does not behave as a primary lung cancer, nor as metastatic lung cancers, and its not treated as a lung cancer.

Disorders Due to Intrinsic Circulating Anticoagulants, Antibodies, or Inhibitors

There were no comments on this proposal.

Interstitial Lung Diseases of Childhood

Lawrence M. Nogee, MD, Professor of Pediatrics, Division of Neonatology, The Johns Hopkins Hospital, described the clinical background for this topic. He described differences in the interstitial lung diseases found in children, in comparison with those described in adults. He gave an example of desquamative interstitial pneumonitis, that when it is seen in children, is due to surfactant mutations of the lung. One comment was that it was really hard to find an NOS for this. Another comment was that coders would look for physicians to document “childhood,” or they would not assign these codes,

despite the age. One commenter stated that most of these disorders seemed to affect newborns, so asked why these were not proposed to be in chapter 15. Dr. Noguee noted that this issue depends on the specific diseases, as some start right at birth, and others develop later. A few comments considered where these codes might be best placed.

Idiopathic Pulmonary Fibrosis

Francis McCormack, MD, University of Cincinnati, representing the American Thoracic Society (ATS) presented background on this topic. He described a number of idiopathic interstitial pneumonias, as well as comparing these with known causes of interstitial pneumonia. There were no comments on this proposal.

Nonspecific Interstitial Pneumonitis

Francis X. McCormack, MD, University of Cincinnati, representing the American Thoracic Society (ATS), presented background on this topic. One person asked for clarification as to whether the term “nonspecific” was part of the diagnosis, and not a descriptive phrase. Dr. McCormack confirmed this, and indicated that this is a pathologic description. The term would be documented as such in the medical record.

Acute Interstitial Pneumonia

Francis X. McCormack, MD, University of Cincinnati, representing the American Thoracic Society provided clinical background on this topic. It was noted that this used to be called Hamman-Rich syndrome, but it was then thought to be a rapidly progressive form of idiopathic pulmonary fibrosis; now it is recognized to have a completely different histopathologic presentation. It was noted there may need to be some review of where Hamman-Rich syndrome would be added as an inclusion term. A question was raised about excluding those with pneumocystis, and it was noted that pneumocystis may rarely cause a similar histopathology. Dr Linzer, AAP, added that many radiologists may read an x-ray with an interstitial process, and some physicians may then describe it as an acute interstitial pneumonia, rather than an acute atypical pneumonia. Thus, there may be confusion as the these terms may be intermixed. He questioned what can be done to educate the physicians in proper terminology, so this will not be mixed up. Dr. McCormack acknowledged that lung biopsy is needed for diagnosis, and chest x-ray would not provide enough information for diagnosis. However, he stated that this term is well recognized in the interstitial lung disease community. Other commenters agreed clearer information is needed.

Respiratory Bronchiolitis-associated Interstitial Lung Disease

Francis X. McCormack, MD, University of Cincinnati, representing the American Thoracic Society, provided clinical background on this topic. One commenter asked for clarification as to whether physicians use these diagnoses empirically, or wait until they get the pathology finding before the diagnosis occurs. Dr. McCormack responded that the term is usually only used after a biopsy has been performed and the diagnosis has been confirmed. .

Lymphocytic Interstitial Pneumonia

Francis X. McCormack, MD, University of Cincinnati, representing the American Thoracic Society, provided clinical background on this topic. There were no comments on this proposal.

Cryptogenic Organizing Pneumonia

Francis X. McCormack, MD, University of Cincinnati, representing the American Thoracic Society, provided clinical background on this topic and also commented that this was one of the more common interstitial lung diseases that they see.

Desquamative Interstitial Pneumonia

Francis X. McCormack, MD, University of Cincinnati, representing the American Thoracic Society, provided clinical background on this topic. There were no comments on this proposal.

Elective C-sections prior to 39 weeks

Jon Hathaway, MD, American College of Obstetricians and Gynecologists (ACOG) was available for clinical discussion via telephone. Sue Bowman, AHIMA, commented that the proposed code title is confusing both because it uses “late” and “preterm” together and is included in the category for “early threatened labor.”. Dr Linzer agrees that there is a need to track this, but due to concerns with the semantics, stated it may be better to have a code with the number of weeks with active or without active labor. There was also a suggestion to consider addition of a V code to indicate the patient was in labor, versus not in labor.

Personal history of gestational diabetes

Jon Hathaway, MD, ACOG, spoke via telephone, providing clinical information about this, and expressing support for this proposal.

Encounter for fetal viability ultrasound/personal history of ectopic pregnancy

Jon Hathaway, MD, ACOG, spoke via telephone, providing clinical information about the proposal. Sue Bowman, AHIMA, questioned whether or not the proposed location of this code was appropriate and requested further review.

Adult Pulmonary Langerhans Cell Histiocytosis (PLCH)

Francis X. McCormack, MD, University of Cincinnati, representing the American Thoracic Society, provided clinical information on this topic. There were no comments on this proposal.

Glaucoma severity staging

Michael Repka, MD, and Cynthia Mattox, MD, from the American Academy of Ophthalmology were available to provide clinical background. Sue Bowman, AHIMA, commented that if the stage is not documented, there is a possible need for a separate code for indeterminate vs. unspecified stage. Other comments were made in favor of this proposal. A comment was made that in some places terms added seemed redundant, such as at 365.01, Open angle with borderline findings, low risk, then calling it Open angle, low risk. It was also noted that there is a typographical error at proposed new

subcategory 365.7, Glaucoma stage, with the code first note listing a code as 365.26, when it should read as 365.20.

Opioids expansion for ICD-10-CM

Sue Bowman, AHIMA, expressed several major concerns. She noted this is an enormous number of codes for one drug category, with concern about the precedence this would set. She noted that neither ICD-9-CM nor ICD-10-CM are intended to be a drug terminology. Also, she expressed concern about the change in the seventh character structure proposed for use to identify drugs.

Nelly Leon Chisen agreed this was way too much detail. She also questioned whether some of the codes were appropriate, acknowledging the attempt toward parallelism, but asking when do you ever get an underdosing of crack cocaine.

A question was raised about slow release preparations, such as via a patch, as opposed to long acting, and the terminology used to describe these.

Dr. Linzer, AAP, expressed concern about the level of detail clinical records would need to support the proposed codes. He also asked whether FDA had requested this, and it was noted that this was proposed by Covidien Pharmaceuticals.

Lisa Saake of Covidien commented that previous FDA initiatives have raised concerns about lack of specificity of the opioid category in ICD-9-CM for tracking abuse, misuse, and overdose. This proposal was an attempt to provide such specificity. She agreed that no one would underdose on crack cocaine, but stated that they were limited in suggesting that such codes be removed from ICD-10-CM. She expressed hope that comments could be worked through to develop specificity for improved tracking in future.

It was noted that things may be done to improve this proposal. Comments were requested in writing.

Reportable malignant skin cancers

General support was received on this proposal. Dr. Berglund expressed support for the option of creating separate codes for basal cell and squamous cell carcinomas, as well as unspecified skin cancer.

ICD-10-CM Weeks of gestation of pregnancy

General support was received on this proposal. Nelly Leon-Chisen, AHA, commented that the approach used in the proposed note for chapter 15, giving an example range for second trimester of 14 weeks 0 days to less than 28 weeks 0 days, should be used in the proposed Z codes as well. Dr. Jeffrey Linzer, AAP, suggested further review to determine whether this concept could all be placed in one subcategory (Z35.1) to conserve space for future coding needs. It was noted that this may or may not be possible, since the intent is to leave room to expand this in the future with codes tracking the days within the weeks of gestation. There was a comment to review the potential conflict of the definition of third trimester in chapter 15 (which starts at 28 weeks 0 days) and proposed new code Z35.37, Second trimester, week 28. Another comment raised the

issue of whether this would be an additional code on every patient visit into the clinic not just hospital, and it was noted there is a potential for that.

ICD-10-CM Weeks of gestation for newborn

General comments included the need for possible additional changes in the weeks from 23 weeks to even lower, for potential future medical advances. Dr. Jeffrey Linzer, AAP, indicated that current science does not support lowering this threshold. Nelly Leon-Chisen, AHA, suggested having beginning and end limits for the codes, and she will submit proposed language with her written comments. Sue Bowman, AHIMA, suggested adding NOS to the title of existing code P07.20, Extreme immaturity of newborn, unspecified weeks.

Benign neoplasm of genitourinary organs

One commenter asked about NOS for the proposed new codes for Benign lipomatous neoplasms, and whether the proposed code D17.79 would include both other and unspecified. It could be considered whether to create a separate NOS code, or to make it explicit that NOS is included with other.

Urethral False Passage

There were no comments on this proposal.

Nodular prostate

There were no comments on this proposal.

Inflammatory disease of the prostate

There were no comments on this proposal.

Cyst of the prostate

There were no comments on this proposal.

Acquired and congenital torsion of the penis

Linda Holtzman suggested a minor change to the title of proposed new code N48.82 Acquired torsion of penis, acquired. The repeated term “acquired” needs to be removed. She also suggested removing the term “acquired” in the inclusion term of acquired torsion of penis NOS. This would make clear that the default should be acquired.

Cyst of the epididymis

A commenter asked how commonly this condition happens, and Jonathan Rubenstein, M.D., American Urological Association, responded that this is very common and the treatment is usually surgical removal if it is severe.

Hidden penis

There were no comments on this proposal. A separate proposal for acquired hidden penis may be brought to the March 2011 C&M meeting.

Personal history of malignant neoplasm of ureter

There were no comments on this proposal.

Corticobasal degeneration

John Hart, Jr., M.D., Medical Science Director, The University of Texas at Dallas, representing the American Academy of Neurology (AAN), presented clinical background on this proposal. There were no comments on this proposal.

Visual agnosia and related conditions (ICD-10-CM only)

John Hart, Jr., M.D., Medical Science Director, The University of Texas at Dallas, representing the American Academy of Neurology (AAN), presented clinical background on this proposal and explained in detail visual agnosia and subtypes including prosopagnosia and simultanagnosia, and how this is different from someone with Alzheimer's disease not recognizing family members. General support for this proposal was received. There was a suggestion that if these symptoms have an etiology, instructional notes should be considered.

Displacement/dislocation of internal hip prosthesis titles (ICD-10-CM Only)

There were no comments on this proposal.

Gastroparesis

Linda Holtzman, representing Clarity Coding, presented this topic. Nelly Leon-Chisen, AHA, commented that the "Excludes 2" note was redundant. Sue Bowman, AHIMA, commented that having both code first and excludes notes could cause confusion and suggests further review.

The audience was asked to carefully review the proposals following the meeting and to submit written comments by the November 19, 2010 deadline.