

**ICD-9-CM Coordination and Maintenance Committee Meeting
Summary of Volumes 1 and 2, Diagnosis Presentations
March 19-20, 2008**

The diagnosis portion of the meeting began on March 19th following the completion of the procedure topics. Donna Pickett, co-chair of the committee, welcomed the members of the audience. She reviewed the timeline included at the beginning of the topic packet informing the attendees that any written comments on topics being considered for October 1, 2008 must be received by NCHS staff by April 11, 2008. She also announced that comments for all other topics presented at this meeting for consideration for October 1, 2009 would need to be submitted by June 20, 2008. NCHS has begun a new policy that comments for the Spring C&M meeting will no longer be accepted all year as has been the case in the past. She requested that comments be sent via electronic mail since regular mail is often delayed due to security screening. The email addresses of all NCHS staff and the NCHS website are included in the topic packet. Attendees were also reminded that the full topic packet and PowerPoint presentations would be posted on the NCHS website shortly following the meeting.

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

Comments and discussion on the topics presented were as follows:

Status of TPA for stroke –for October 1, 2008 consideration

Joseph P. Broderick, M.D., and Dawn Kleindorfer, M.D., representing the American Academy of Neurology (AAN), gave a PowerPoint presentation on the incidence of ischemic stroke and the data currently available on the number of stroke patients who receive t-PA treatment. The PowerPoint slides will be available in a separate file on the NCHS Classifications of Diseases and Functioning & Disability web site. The goal is to provide this beneficial treatment within 3 hours of onset on symptoms. They described the term “drip and ship” which is when a patient is started on t-PA in an emergency department then immediately transferred to a specialty stroke center for intensive care. What is being requested is a new code that identifies the status of a patient having received the t-PA and then being transferred. Dr. Kleindorfer explained that her research is hindered by the lack of data available on “drip and ship” incidence.

Dr. Broderick stated that the proposal in the topic packet does not include the definition that the AAN is requesting for the code title, which is, “history of receiving rt-PA for acute ischemic stroke in another hospital’s emergency department within the last 24 hours.”

A comment was made that it is often over 3 hours before stroke patients present to a hospital, and the question was asked whether there is any data on this. The answer was

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given that about 80 percent do not arrive quickly enough for treatment with tPA, and ultimately only about 8% are actually eligible.

A physician representing the stroke center at Johns Hopkins University Medical Center as well as the Maryland Stroke Alliance strongly supported the proposal. He assured the audience that documentation in the medical record at specialty stroke centers is required to be very detailed and would provide the information necessary to assign this new code. He noted that it was extremely important to have this data, and that it would help to make decisions.

A question was raised as to whether patients are transferred while receiving tPA, or afterward. The answer given was that either can occur, although usually giving tPA will be completed before transfer. It was noted that sometimes tPA does not work, and other treatments may be tried at a stroke center.

Several members of the audience expressed concern at the length and specificity of the code title proposed. There was support expressed for using the full definition in the code. It was also stated that the code should be broad enough to allow its use for t-PA treatment for other conditions as well, such as acute MI. There was a response that the neurologists would prefer to have a specific code that would enable unique identification of cases being treated for stroke. A comment was made that a specific definition is needed.

There was also concern expressed about the 24 hour timeframe, and how it was defined. There was a comment that this could be better handled as an aftercare code. The possibility was also raised of using a procedure code for tracking these cases.

The audience was reminded that this topic is being considered for implementation this October; comments are needed by April 11.

Other venous embolism and thrombosis

Patrick Romano, M.D., representing the Agency for Healthcare Research and Quality (AHRQ) gave a PowerPoint presentation on coding of venous embolism and thrombosis. He explained that the current ICD-9-CM codes are outdated from a terminology standpoint and that phlebitis is no longer considered an important component of thrombosis.

He also explained that it would be very helpful to be able to distinguish between patients who are being treated for an acute embolic or thrombotic event, and those who are on anticoagulation therapy for an extended period during what he described as the subacute or chronic period of treatment, which is generally 3 to 6 months. There is also a third category of patients who are at high risk for future clots and so are maintained on anticoagulants for a life time. At this time it is not possible to distinguish cases that resolved in the more distant past from cases still on treatment. He noted that the 5th digits for acute MI in the ICD-9-CM allow for the classification of initial versus subsequent episode of care, which is similar to the concept he is interested in capturing for embolism

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of thrombosis. He noted that the coding options included in the topic packet are a beginning framework and that alternative options will be considered.

A comment was made that the terms subacute and chronic are not used to describe embolism and thrombosis. The question was raised whether this would be more properly a “history of” rather than subacute or chronic. There was also a comment that there is the potential for overlap between these proposed codes and the personal history codes.

A comment was made about the iatrogenic code, and how it is used, and uncertainty on how often it is actually used. Another comment raised the issue of whether iatrogenic cases needed to be specifically identified at category 453. The question was also raised whether a catheter associated code was needed.

There was a comment that the term episode of care is too generic and that the terms initial and subsequent encounter are more descriptive and better understood. Another comment noted that using episode of care would be problematic, and unclear whether it would depend on the time and facility involved.

Dr. Jeffrey Linzer, representing the American Academy of Pediatrics (AAP), expressed support for the proposal, but noted a preference for the alternate option described. He also suggested that the proposed code 453.7 could be instead handled with fifth digits at the proposed subcategories 453.5 and 453.6, with modification.

Long term anticoagulation could also be coded. It could also be appropriate to consider coding for long term use of antibiotics, and of Total Parenteral Nutrition.

Venous complications in pregnancy and the puerperium

Patrick Romano, M.D., representing the Agency for Healthcare Research and Quality (AHRQ) also presented a proposal for coding of major puerperal infections and venous complications of pregnancy. Subcategory 670, Major puerperal infections, needs to be expanded to provide codes for the different types of infections included in the subcategory. And similar to the issues he presented for embolism and thrombosis, the concepts for acute and subacute and chronic would also be useful for the equivalent OB codes. He noted that the American College of Ob/Gyn supports this proposal.

There was support from the audience for the expansion of subcategory 670. There was a comment that most cases with 671.4 had septic pelvic thrombophlebitis. There were no additional comments for this proposal.

Methicillin-Resistant *Staphylococcus aureus* (MRSA) – for October 1, 2008 consideration

Rachel Gorwitz, M.D., of the Centers for Disease Control and Prevention’s Division of Healthcare Quality Promotion, gave an audio and PowerPoint presentation on the increasing problem of MRSA in the population and the difficulty in treating patients resistant to this class of antibiotics.

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There was extremely strong support from many members of the audience for this proposal. A further expansion of MRSA for other infections, such as staphylococcal meningitis (320.3), was also requested.

There was some question on the need for the V09 expansion, with the other expansions and particularly the 041 expansion. Concern was raised about whether V09 would need to be used with each of the new codes created, as this would not provide any additional information. It was explained that the V09 is a longstanding code to identify drug resistance and its continued use may be desired by some facilities.

There was a comment that coders should be permitted to assign a code for a MRSA infection from the lab report without having to seek approval from the primary provider. There was a question on whether a positive nasal culture would be the same as colonization, and how coding for that should be handled. It was noted that the expansion at V02 for carriers of infectious diseases would make coding for carriers of MRSA more specific. Adding the term colonization at the category level also would be an expansion. There is also another code for positive cultures (795.39), and instruction would be needed to differentiate use of the codes. It would also be important to differentiate cases with MRSA colonization and those with history of MRSA.

One commenter noted that other staphylococcus should still be included at the code V02.59, for carriers of other staphylococcus besides *S. aureus*.

One question asked why stop with pneumonia, and why not have codes for UTI (urinary tract infection) and cellulitis. It was noted that there are not specific codes for these, and expanding may not be feasible within the existing ICD structure. However, for such cases the existing codes can be used with an 041 code.

Another comment was that family history of MRSA and exposure to MRSA can be important reasons for screening or further testing. Thus, codes for these situations could be useful.

The audience was reminded that this topic is being considered for implementation this October; comments are needed by April 11.

Fever and other physiologic disturbances of temperature regulation – for October 1, 2008 consideration

There was general support for this proposal. It was suggested that the excludes note fever or chills due to confirmed infection –code to infection, be added at the subcategory level, since it applies to all of the codes in this subcategory. It was also suggested that the proposed code 780.60 have an excludes note for neonatal fever, to code 778.4.

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Disruption of operation wound – for October 1, 2008 consideration

Sue Bowman, representing the American Health Information Management Association (AHIMA), questioned the inclusion added at the 998.3 subcategory “disruption of any suture materials or method”. She specifically asked what a disruption of a “method” referred to.

Dr. Nagel asked how a disrupted wound due to trauma would be coded, trauma/injury code or disruption of wound code. That needs to be decided.

The audience was reminded that this topic is being considered for implementation this October; comments are needed by April 11.

Activity codes/Injuries and external cause codes for military operations – for October 1, 2008 consideration

Lt. Col. Steven Bullock gave a PowerPoint presentation on the Department of Defense’s need to identify the cause of injuries to military personnel. It is a major factor in determining military readiness. The military has been directed by the Office of the Secretary of Defense to reduce and prevent injuries, so collection of this data is essential to achieve this goal. His presentation covered the activity codes and also the military proposals related to injuries, family circumstances, psychosocial circumstances, and external cause codes.

In both Lt. Col. Bullock’s presentation and in the topic discussion that followed it was explained that the proposed activity codes are parallel to what is now in the ICD-10-CM and that there is no redundancy with the existing codes. Activity and transport accidents are mutually exclusive concepts in the ICD, and extensive guidelines would be provided for the use of activity codes.

There were many comments on these topics. Many expressed strong objection to implementing these proposals for this year due to their length and the lack of time to properly review them. One commenter stated that the injury community at large has not had an opportunity to review the proposals. It was noted that E codes are required by a number of states for various purposes, and these proposed expansions would be expected to impact them.

Concerns were raised about the activity codes particularly. Concern was raised about overlap with existing E codes, where activity may be implied in various codes (such as certain transport accident and accidental injury codes). Concern was raised about how well the proposed codes would cover all activities, with an example given of housework, not being leisure nor paid work, and thus not fitting well with the proposed codes at E000, Activity code status. A specific concern also was raised about mixing American tackle football and rugby. One commenter noted that it would be important to make clear that the proposed code for cell phone usage did not include usage while driving.

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Dr. Jeffrey Linzer, representing the American Academy of Pediatrics (AAP), expressed support for the parts of the proposal related to injuries, family circumstances, psychosocial circumstances, and external cause codes. However, he expressed concerns related to the activity codes. He noted concerns about whether some things may be missing. He stated he would like to take time to be sure the activity code expansion will be effective.

Concerns were raised about student activities, including fraternity sports, that it would be unclear how these should be coded in the current proposal. Also, a question was raised on how to code sports for military schools, and whether this would be leisure, student, work, or military related activity.

One commenter stated that she did not feel this proposal should be expedited. She noted that her organization creates tools for use with ICD-9-CM, and she stated that it would be difficult to do in the time frame required.

There was also concern that there are many states that require E codes and because they will need to update their reporting systems prior to October, if these are implemented this year, that notification will need to be published soon. The audience was also reminded that since E codes are not published in the IPSS Federal Register notice (Table 6), since they are not part of the PPS system, a separate Federal Register notice will need to be published by CDC to announce these codes.

The audience was reminded that these topics are being considered for implementation this October; comments are needed by April 11.

Exposure to harmful chemicals and other harmful substances – for October 1, 2008 consideration

One person asked why a new code was not included for exposure to mercury. It was suggested to exclude exposure to lead (V15.86) from exposure to metals (V87.0). There was a comment on proposed code V87.2, related to whether it was appropriate to include exposure to gas and hydrocarbons as potential inclusion terms. Other potential exposures were noted for which it could be useful to be able to code encounters, including exposures to chlorine gas, clay dust, coal dust, and meat packing.

It was suggested that the title at V87.3 be changed to reflect exposure to other potentially hazardous biological substances. This would be more specific, and would include mold. It was suggested that a code V87.8 also be created for exposure to other potentially hazardous substances (rather than using this title at the proposed code V87.39).

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Incidental Dural Tear – for October 1, 2008 consideration

John Shaw, President of NextWave, gave a PowerPoint presentation on dural tears, also referred to as incidental durotomies. Though they are most common during complex spinal cord procedures, and in these cases often referred to as incidental, they may also occur during other types of procedures. Regardless, they should always be coded, due to the complications they can produce, such as cerebrospinal fluid leak and the associated headache. Dural tears generally necessitate extending in-patient hospital stays.

There was strong support for this code. Concerning the placement of the code within the classification, support was expressed for creating a code within the nervous system chapter rather than the complications section of codes. It was felt that providers would be more likely to accept and use the code if it were in Chapter 6. There was also support for including the term incidental durotomy as an inclusion term, since it is a term frequently used to describe dural tears, although as it is labeled incidental, it may be overlooked. One concern was raised as to whether including the term “incidental” would lead to questions of whether to code other things referred to as incidental; this should not usually be the case.

One commenter expressed support for either option, and noted that if expansion was done at 998.2, that it would be possible to identify other major punctures and lacerations that occur during procedures.

There was some discussion about use of procedure codes for dural tear repair, and how tracking might be able to use a procedure code.

There was the comment that non-surgical dural tears do occur and that the codes should distinguish this.

There were also comments regarding the use additional code notes in the proposals. The ICD generally has not included use additional code notes with lists of possible risk factors. Some felt that the proposal might be better without the use additional code note, for consistency in handling risk factors. One commenter stated he had no argument with the conditions listed, and stated that similar things could be added in other places.

Though this topic was not initially presented for consideration for October 1, 2008, the presenter asked that it might be considered for this due to the importance of tracking dural tears and because the subject has been discussed in the past. Dural tears was added to the ICD-9-CM as an index entry with the October 2007 addenda.

The audience was notified that this topic will be considered for implementation this October; comments are needed by April 11.

Hepatic coma and hepatic encephalopathy

There were a couple of comments that the term hepatic coma is generally not used. Common terminology is just hepatic encephalopathy. It was suggested that instead of

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expanding the code it be retitled to hepatic encephalopathy and the term hepatic coma be an inclusion term.

Premature birth status

There was a comment that these new codes would overlap with the codes from the perinatal chapter (at 765.2), since perinatal codes are to be used for the life of a patient. It was discussed that these codes would be used when there is no current health problem specifically associated with the prematurity, but the status is an important consideration to document, since there are risks associated, and it may impact future care. There may also be preventive treatments needed, or psychosocial issues, without a current physical diagnosis related to the prematurity. A comment was made that notes would be needed to clarify how the proposed codes should be used, as opposed to other existing codes.

There were comments that it would be preferable to have these codes in another section of the classification, since it is a personal history concept. There was also a comment that the code titles should read, "completed weeks of gestation".

A question was raised about whether similar codes would be needed for post mature deliveries, with the response that there are not the same long term issues.

Acute chemical conjunctivitis

It was asked whether this code overlaps with the poisoning codes. It does not overlap, since chemical conjunctivitis is not due to an overdose of a chemical which is the ICD definition of poisoning. But it was noted that it may be helpful for poisonings to be excluded from the proposed code. There was also a comment that it would be appropriate to add a use additional E code note for adverse effects under the code. A question was asked as to whether the proposed code would include conjunctivitis related to pepper spray, with the response being affirmative.

Acute heart failure

There was a discussion among the audience that this proposal deviates from the current coding of acute pulmonary edema associated with heart failure described as congestive, even though it matches cases not described as congestive. There were suggestions that instead of identifying the presence of pulmonary edema in the heart failure codes, it could be coded using a separate code, such as 514 for pulmonary edema or 518.4 for acute pulmonary edema, although if this were to be done, the excludes notes at these codes would need to be reviewed. There was also concern expressed that these proposed codes overlap with the codes for systolic and diastolic heart failure.

Nelly Leon-Chisen, Director of the Central Office on ICD-9-CM of the American Hospital Association (AHA), the organization that submitted the original proposal, commented that the proposal submitted by the AHA only asked for codes for acute and chronic forms of heart failure, and that this proposal as presented was more extensive than their initial request.

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A comment was also made that along with the proposed changes adding codes for acute and chronic rheumatic heart failure, there should also be a change to the title at the existing code 398.91, to add unspecified at the end of the code title.

Family circumstances

There was approval from the audience on this proposal. It was stated that a code for problems between parent and biological child would also be needed. There was no preference stated between the two options for foster care status. There were comments related to the proposed code for substance abuse in family, and potential ramifications of using such a code. It was also noted that there could be a need for a way to code problems due to death of a parent.

Autoimmune lymphoproliferative syndrome

There were no comments on this proposal.

Nursemaid's Elbow

Some commenters stated a preference that the title of the code be Nursemaid's elbow, since that is the commonly used term. The term subluxation of radial head is usually not documented. There was the question of whether a subluxation should be coded within the dislocation codes. It was confirmed that the ICD groups subluxation and dislocation together.

One person raised a concern that this will set a precedent to allow coding subluxation separately from dislocation. The issue was also raised as to what age group would be involved with this condition. It was stated that the diagnosis would not be made after 5 years of age. A concern was expressed that the term might be applied to adults, but it was stated that that would be inappropriate.

Dr. Linzer noted that the 5th digits for the other codes under category 832 are not applicable for this new code.

Awaiting joint prosthesis

There was extensive discussion on this proposal. The concept was liked, but most commenters felt that the title was unclear. There was a suggestion to title the code joint prosthesis explantation status.

There were also comments that in some cases an explanted joint is never replaced due to continuing infection or some other complication. Two codes were recommended, a code for explantation status, and a reason for encounter code for patients with an explanted joint being admitted for the placement of a new prosthetic joint.

Gastroschisis

There were no comments on this proposal.

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Underimmunized or lapsed immunization status

There was some discussion on the meaning of this code and how it relates to the codes for vaccinations not carried out, subcategory V64.0. Dr. Jeffrey Linzer, representing the American Academy of Pediatrics (AAP), the organization that submitted this proposal, explained that the term delinquent immunizations is the standard term used by pediatricians and family practitioners.

Dr. Linzer also explained that the AAP feels that the V64.0 codes should be used only when a vaccination is refused at the time of an office visit. The new code proposed would be used when a child is being seen, and it needs to be documented that the child has not previously received vaccinations that would be expected for age.

It was asked if it would be appropriate to use both a V64.0 code and the code being proposed. Dr. Linzer agreed it would be appropriate.

Encounter for serologic antibody testing

There was general agreement on this proposal, but there was a comment that the includes note could be confused with other types of lab tests not intended to be included with the proposed code. Immunity status testing could be interpreted to be such things as allergy testing. There was a comment that the code title and inclusion could also include HIV antibody testing as written.

Pre-procedural evaluations

There were many commenters in favor of this proposal, but there was lengthy discussion on the wording for the proposed code for laboratory examination as part of a general physical examination. Some felt the code title as presented was confusing. There was a suggestion to title the code "laboratory examination ordered as part of a general medical examination," to clarify use of the code.

There was also discussion on whether the guidelines should instruct coders to use both the V70.0, Routine general medical examination at a health care facility, and the proposed lab exam code. Wording of the instructional note at code V70.0 will be reconsidered. It was noted that V70.0 alone might be alright if all testing and examination was done at one facility, but would be difficult otherwise.

There were also comments that the proposed addition of includes notes under codes V72.6 and V72.83 should be expanded further from what was proposed to better explain the intent of the codes. It was generally agreed that expanded notes would be more useful.

Poisoning by antidepressants and psychostimulants

There was support for this topic. There was a statement that it is clinically common not to differentiate amphetamine and methamphetamine, with a question of how it would be handled if it is not clear which is involved.

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There was a suggestion to consider certain specific drugs including aminophylline and theophylline, as well as caffeine, which may be given to neonates to stimulate breathing based on a psychostimulant effect. Aminophylline is indexed elsewhere (975.7, Antiasthmatics), but can act as a psychostimulant.

Retinal and choroidal neoplasms of uncertain behavior

There was support for this proposal. There was a request to add an excludes note for the proposed new code 239.81 to code 190.5, Malignant neoplasm of retina, since this new code is for “suspected melanoma” of the retina. There was a comment that if the medical record said “suspected melanoma,” the coder would code melanoma (in the inpatient setting).

Inclusion body myositis (IBM)

There were no comments on this proposal.

Mesial temporal sclerosis

There was a question on the intent of the excludes note on the proposal excluding temporal sclerosis from the epilepsy codes. The comments were that the note might be interpreted that an epilepsy code and a temporal sclerosis code should not be used together, and both conditions are generally present together. There were suggestions to consider changing to a different type of note, or drop the note. There was a comment that it would generally be appropriate to code the epilepsy first.

There were comments related to the indexing of all recurrent seizures to epilepsy, with some objection to this default.

Exposure to algae

There were no comments on this proposal.

Addenda

There was a comment that the excludes note at 584.9 should include the entire range of category 866. At codes 996.62 and 999.31, it was suggested that the term Portacath should be consistently handled with capitalization. There were no additional comments on the tabular addenda items being considered for October 1, 2008. For the index entries being considered for October 1, 2008, it was asked that the entry for end of life for joint prosthesis not be approved, related to concerns about the terms, and coding it as a complication. The audience was reminded that any comments on these addenda items would be needed by April 11, 2008.

For the tabular addenda items for consideration for October 1, 2009, the only discussion was on the instructional note under the open wound section 870-897. It was agreed that there is a possible sequencing conflict between open wounds and infections such as wound botulism. No final decision was reached as to how to resolve the conflict.

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For the index addenda items for consideration for October 1, 2009 the only discussion was on the indexing of seizures. There was objection to the indexing of Seizure(s) disorder to epilepsy, and there was a response that this is a follow up to previous changes that have already been made. Also, it was requested that the term non-epileptic seizure be added to the index. The question of coding for alcohol withdrawal related seizures was raised as an example of non-epileptic seizures.