

**ICD-9-CM Coordination and Maintenance Committee Meeting
Summary of Volumes 1 and 2, Diagnosis Presentations
September 17, 2009**

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. All topics presented at this meeting are being considered for October 1, 2010 implementation. Written comments must be received by NCHS staff by November 20, 2009. Donna requested that comments be sent via electronic mail, since regular mail is often delayed due to security screening. 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 on the NCHS website. The PowerPoint presentations from this meeting will be posted to the NCHS website shortly after the meeting. New proposals for the March 10, 2010 meeting must be received by January 8, 2010.

Ms. Pickett also announced the following:

- There is a new code, effective October 1, 2009, for novel H1N1 influenza, commonly called “swine flu”. The code is 488.1, Influenza due to identified novel H1N1 influenza virus. This code was not presented at any previous ICD-9-CM Coordination and Maintenance (C&M) meetings. The urgent need and request for the new code came after the March 2009 ICD-9-CM C&M meeting. It was decided to implement it to allow the ability to collect information on people affected by this virus as the influenza season approaches again.
- There will be new ICD-10-CM files posted on the NCHS Classifications website, at the end of this calendar year. The new files will include updated tabular and index, reflecting ICD-9-CM changes through October 1, 2009 as well as WHO changes that have been made to ICD-10. In addition, the Table of Drugs and Chemicals, Table of Neoplasms, and External Cause of Injury Index will be posted.
- 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.
- NCHS has updated the Classification of Diseases, Functioning, and Disability website. The new address to bookmark is: <http://www.cdc.gov/nchs/icd.htm>.

Comments and discussion on the topics presented were as follows:

Multiple gestation placenta status

Pamela K. Kostantenaco, LPN, CPC, CMC representing the Society for Maternal and Fetal Medicine (SMFM) presented this topic. Amy Blum also requested comments on how to report multiple gestation pregnancy where there is a loss or reduction in number of fetuses. There were no further comments on this topic.

Hemolytic Transfusion Reactions (HTR)

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 this topic. The PowerPoint presentation is posted separately. One commenter suggested deleting the current coding notes (inclusion term and use additional code note) at 999.89, Other transfusion reaction, and moving them to proposed new code 999.80, Transfusion reaction, unspecified. Dr. Jeffrey Linzer, representing the American Association of Pediatrics, suggested adding an excludes note for these codes at 780.6, Fever and other physiologic disturbances of temperature regulation so as not to code post procedural fever in addition to these codes. He also suggesting looking at whether any changes to code 999.5, Other serum reaction, were needed since the proposed new codes are addressing all blood products.

Transfusion transmitted infections

Mikhail Menis, PharmD, MS of the FDA CBER presented background on this topic. A question was raised as to whether the term “blood” or “blood products” should be added to the title since this code is to capture infection transmitted that way, to be consistent with changes proposed at 999.6 and 999.7. There were several comments regarding the sequencing of this proposed new code first followed by the infection. Coding HIV (042) secondary would go against current coding guidelines about sequencing HIV. The coding guidelines also indicate that classification rules take precedent over the guidelines and this would need further review. This will also need to be reviewed further. There were comments made that suggested instead of this new code, you could code these infections using an infection code plus an external cause code for blood products, or a late effect code. Another person asked since these infections are likely to be diagnosed later, in another encounter, when would you see this diagnosis being used? An additional comment was made that some of these infections are curable, but some are not, and the question was raised as to whether the proposed code 999.32 should be used later.

Toby Silverman, MD, Chief, Clinical Review Branch, Division of Hematology, Office of Blood Research and Review, CBER, FDA, commented that not all of these infections will be diagnosed later. Some will be present acutely. It is important for the FDA CBER to be able to capture these transfusion transmitted infections to monitor the safety of the blood supply.

One person asked whether the code is intended to be used when the infection is recorded as suspected, or only when the infection is definite. Dr. Linzer subsequently noted that

since there are medicolegal implications of introducing this code, consideration should be made regarding whether or not to code probable/possible cases.

Febrile Nonhemolytic Transfusion Reaction (FNHTR)

Mikhail Menis, PharmD, MS of the FDA CBER presented background on this topic. Dr. Linzer suggested that this code would be better located in subcategory 780.6, Fever and other physiologic disturbances of temperature regulation. This is where postprocedural and postvaccination fever are both located. The other option would be to put an excludes note at 780.6, to send the coder to the new proposed code. Another commenter agreed with Dr. Linzer's suggestion, adding that since these reactions are common to chronic transfusions, and likely due to a difficulty in matching, it is not correct to locate this in the complication codes.

Post transfusion purpura (PTP)

Mikhail Menis, PharmD, MS of the FDA CBER presented background on this topic. One person asked for clarification of the inclusion term "massive blood transfusion". Dr. Silverman indicated that the term "massive" may be used in trauma settings and usually refers to transfusion of greater than 10 units of packed red blood cells in a 24 hour period. She indicated that this condition is related to packed cell transfusion because there are no platelets. Dr. Linzer commented that in trauma centers there may be massive transfusion protocol and this should not lead the coder to use the code 287.49. The term "massive" is usually documented in the record for trauma cases. It does not have to be assumed from looking at the number of transfusions a person receives. It was also commented that the amount of blood involved for massive transfusion may vary based on the size of the patient. Another person commented that since PTP is going to be located in subcategory 287.4, it supports locating the febrile related code in subcategory 780.6. One person suggested adding an inclusion term for whole blood, since the topic narrative indicates this can be caused by whole blood transfusions. It was clarified that PTP does not usually occur with whole blood transfusion since platelets are in it, as long as it is fresh. It was also suggested to review whether to move the E code instruction currently at code 287.4, down to the proposed specific codes. An E code for blood transfusion could be used with the proposed code 287.41, and E codes for drugs could apply to proposed code 287.49. This will be considered further.

Transfusion Associated Circulatory Overload (TACO)

Mikhail Menis, PharmD, MS of the FDA CBER presented background on this topic. One person commented that this is a paradigm shift because TACO is not encountered as much, but rather TRALI (transfusion related acute lung injury). He also asked whether both TACO and TRALI can co-exist. Dr. Menis clarified that TRALI involves noncardiogenic pulmonary edema, whereas TACO is heart related. Dr. Silverman commented that TACO vs. TRALI involves differential diagnosis criteria to determine which condition exists. TACO is a new term, but the concept is not new, and she indicated that it will continue to be seen in the future. She indicated that both TRALI and TACO should be seen as a specific diagnosis written in the chart. One other comment was made suggesting that there will need to be clarification of sequencing this code with heart failure codes.

Transfusion-Associated Hemochromatosis (Iron Overload)

Mikhail Menis, PharmD, MS of the FDA CBER presented background on this topic. Dr. Linzer commented that this condition affects sickle cell anemia patients who have chronic transfusion. It is reasonable for this code to be added because many times chelation is required to clear the system. He also suggested adding sequencing notes about using this code with sickle cell anemia codes.

Additionally, Dr. David Berglund presented an alternative option to adding this condition to the classification along with other causes for iron overload. This additional PowerPoint presentation is posted separate from this summary. Specific concepts involved include primary hereditary hemochromatosis, hemochromatosis due to multiple blood transfusions, iron overload due to conditions classified elsewhere, unspecified hemochromatosis, and other iron overload.

One person suggested adding frequently used terms as inclusions at proposed code 275.01. Otherwise diagnoses such as “transfusion associated hemochromatosis” will be coded to unspecified. It was also pointed out, by Dr. Silverman, that you may not always see the proposed code title recorded as a diagnosis, but it will be useful to have the code if the condition is documented. Dr. Linzer suggested adding an inclusion term for “iron overload due to chronic transfusions” since that is likely to be documented.

Another person asked the FDA CBER staff whether they are considering blood substitute products. They responded that yes, these are being considered, but at the present time there are no such products currently on the market in the United States

Stuttering

Nan Bernstein-Ratner, EdD, representing the American Speech-Language-Hearing Association (ASHA) presented background on this topic. The PowerPoint presentation is posted separately. Dr. Linzer stated that the AAP strongly supports adding this code and related changes but suggested changing the revision to code 307.0 to read “adult onset” rather than “onset after puberty”. It was noted that onset is not usually between 8 and 16 years of age. He also suggested that there is a fourth type of stuttering, and that is when it is due to traumatic brain injury (TBI), or other neurological conditions, and suggested there be an instruction to follow late effect coding for this condition. It was pointed out, however, that there is no symptom code for stuttering that could be used with the late effect code, and you would have to use the 307.0 code. Dr. Laura Powers, representing the American Academy of Neurology (AAN), indicated that there are many neurologic conditions that can cause stuttering, such as Parkinson’s disease. She commented that it is wrong to have to assign code 307.0 for these cases. She suggested that these types of stuttering cases should be coded by adding it to symptom code 784.59, Other speech disturbance. These conditions involving stuttering are not mental health related.

Multiple sclerosis

A proposal, submitted by the Blue Cross Blue Shield Association (BCBSA), to expand the code for multiple sclerosis was presented. Following the presentation, a

representative of Blue Cross and Blue Shield commented that treatments are often specific for relapsing remitting multiple sclerosis, and now they have to request charts to verify this. The intent of this code expansion proposal was to ease electronic claims processing by reducing requests for further documentation regarding relapsing and remitting multiple sclerosis.

One person asked whether the information, proposed in the new codes, is in the documentation being received when it is requested from the provider.

Dr. Powers, representing AAN, commented that while they understand the proposal and that these terms may be used as indications for medication, there currently is not consensus on these categories presented today. There is still much work being done to better classify multiple sclerosis including inflammatory vs. noninflammatory. In the next few years medication response may be based on genetic make up. She recommended waiting until further classification recommendations are made, which may be in the next 3-4 years.

There were comments noting the need for a code for acute exacerbation of multiple sclerosis, citing that multiple sclerosis patients may present to the emergency room for this reason.

Neurogenic claudication

It was suggested to have the American Academy of Orthopaedic Surgeons (AAOS) review this request prior to making a final decision.

Acquired absence of pancreas

There were no comments regarding this proposal.

Do not resuscitate

There were no comments regarding this proposal.

Physical restraints

There were comments in favor of the request, citing the need to track this and that increased patient care is required in cases where physical restraints are applied. Another person asked whether it might also be a good idea to include other methods of “restraint” including bed alarms and beside sitters. The requester noted that it would help to have this code, because at present it is a JCAHO requirement to be able to identify these patients, and currently most facilities do this using manual logging methods. One person asked what was meant by “restraint due to a procedure”. This was referring to use of restraints during administration of anesthesia. One person mentioned that there is a difference in use of restraints in a dementia patient versus other restraint needs, such as concerns for safety of the patient or others; the diagnosis will show these differences. Dr. Linzer commented that while he understands the importance of these issues perhaps this could be handled using a procedure code in Volume 3 rather than creating a diagnosis code.

Combat Operational Stress Reaction (COSR)

There were no comments regarding this proposal.

Neurofibromatosis – Schwannomatosis

There were no comments regarding this proposal.

Mesh erosion/Mesh exposure

There was a comment that the terms may not always be used outside of the gynecological surgery field. Additionally some discussion was held on what was meant by exposure versus erosion. Some felt exposure involved the mesh being exposed through a wall where erosion involved going into another organ. Others felt that erosion might mean the mesh has gone through a wall and is now exposed to the outside (such as in abdominal hernia surgery repair). There was a suggestion to locate this code in chapter 10, Diseases of the Genitourinary System, such as at category 629, Other disorders of female genital organs, so that it can be specifically used for vaginal mesh erosion. There was a comment expressing concern about using two available codes at category 998.8, and a suggestion that this could be located at category 997, Complications affecting specified body systems, not elsewhere classified, so that it can be applied to other areas as well. There was a comment that other devices can erode, too.

Obesity hypoventilation syndrome (Pickwickian syndrome)

There were comments in favor of the location of this proposed new code. One person also added that he was in favor of having it located here rather than in other hyperalimantation. There was one comment raised regarding sequencing of codes when respiratory failure occurs with this condition.

Heart failure terms related to systolic function

One person commented that it would be good to see mention of diastolic ejection fraction mentioned in this change. There were concerns that adding this would cause coders to go looking for this in echocardiogram reports, and if any mention of this is added it should have “so stated” attached. Additionally it would be important to have guidelines reflect proper coding of this term. One person commented that the diagnosis “preserved function” is used in charts. This was included in a proposal at a previous C&M, and the commenter wanted to be sure that this had not been dropped.

High Cardiac Output Heart Failure

One participant stated seeing the diagnosis “high output septic shock” and wanted to know how that would be coded using this coding change. The issue of whether septic shock should be excluded from the proposed new code was raised. Another person commented that septic shock and high output cardiac failure are not inherent and are managed differently, so it is important that they not be excluded from each other.

Encounters for the insertion, checking or removal of an intrauterine contraceptive device

There was one comment suggesting to remove, from the proposed excludes note at V25.42, “incidental finding”. This term may cause coders to think they should code

incidental findings. Dr. Jeffrey Linzer suggested an additional new code of V25.13 with a suggested title of “removal with immediate reinsertion of an IUD”.

External cause status

There were comments regarding using the word “legal” in the proposed inclusion term revision for code E000.0, Civilian activity done for income or pay. There are many distinctions of legal, and this may make the use of this code more complicated than it needs to be. It was suggested that it would be necessary to exclude anything related to criminal activity from this code. It was also noted that treatment related to injuries while babysitting may be covered by a person’s homeowner’s insurance policy, and this may vary by state, and not be universal. It was noted that babysitting is not a part of the proposal itself (in the code revisions). It was only used as an example. There were comments related to work related injuries, noting that many things are work related, and sometimes billing can be held up until it is shown whether or not it was work related.

Heat illness (heat exhaustion, heat injury and heat stroke)

Dr. Linzer commented that heat injury as described by the U.S. Army, in this proposal, is not consistent with what is in use in the civilian environment. For “heat injury,” he declared that it would usually be called heat exhaustion. He described an example of a football player collapsing during summer practice, that would likely be diagnosed as heat exhaustion. He also felt that for heat stroke loss of consciousness would be inherent. He stated that is it unclear whether the term “heat injury” is being taught or used widely. In response to this, it was noted that the U.S. Army uses these definitions. There was one comment suggesting including the definition as an inclusion term to proposed new code 992.81, Heat injury. However, another commenter indicated concern about adding a definition to the classification that is not universally accepted. There was also a suggestion to add a use additional code note for any organ dysfunction. It was suggested to follow up with input from other specialty societies, including the American Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), the Endocrine Society, and the American Academy of Neurology (AAN).

Retained foreign bodies

Following presentation of this topic there was a comment that subcategory V87.3, for personal history, does not seem to fit for the proposed new code, with the subcategory also including concepts such as exposure to algae. It was suggested to use V15.5, Personal history of injury, instead (such as V15.53). It was also suggested to add the word “nontherapeutic” to the title of proposed subcategory V90.0. This was because it was felt that it is important to differentiate the purpose of the use of the radioactive substance. There was some discussion about other embedded objects such as retained radioactive beads, retained tooth and an insect in the ear. There was a comment that the current definition is not consistent. Some are using retained foreign bodies to describe those that cannot be removed, and others use it to mean those accidentally left in during a procedure. There needs to be a distinction between retained versus current foreign body. There was a comment that the proposed Use additional code note at 360.5 should only include those that can be magnetic, so for example should not include plastic (the proposed new code V90.2), and should not just list the full range V90.01-V90.9. There

was a subsequent comment that it can be hard to tell whether a substance will be magnetic, noting as an example that gold is not magnetic.

Homicidal ideations

Dr. Linzer commented that this condition is seen often in emergency rooms. He suggested that this be considered to be used as a principal or primary as well as a secondary diagnosis code.

Long term use versus prophylactic use of medications

Dr. Linzer wanted it to be clear that this would not introduce coding treatment regimes that involve use of antibiotics. It was suggested that the term long term should not be a nonessential modifier when indexing V58.62. If it is a nonessential modifier, it as felt that then people would code drug use any time it is stated rather than just long term use. A comment was also made to consider expanding the term “drug” to include biological agents, such as coagulation factor. Currently subcategory V58.6 is only for drugs.

Jaw pain

There were favorable comments received for adding a code for this condition. One person said that jaw pain is seen as an outpatient diagnosis for temporomandibular joint arthroscopy, and it was suggested to somehow differentiate temporomandibular joint disorders and this code, perhaps using an excludes note. There was a suggestion to locate the new code at category 526, Diseases of the jaws, since it is currently indexed to code 526.9. This could be done at 526.8 or by expanding 526.9. It was suggested to index pain in the mandible to this code also.

Addenda

The following comments were made regarding the tabular addenda:

Regarding the change proposed to category 403 one comment was made that it is more of a concern about which fifth digit to use when the chronic kidney disease is unspecified. Without the code from category 587 you do lose information.

A comment was made to help clarify the intent of the change at code 799.82, Acute life threatening event (ALTE). It is important to code the ALTE whether or not signs and symptoms are due to a confirmed diagnosis. Coding ALTE helps clarify why the patient presented for treatment, and is needed for tracking purposes. A comment was made that the note to Code first confirmed diagnosis, together with the note to Use additional code for signs and symptoms, may appear to imply that the signs and symptoms should also be coded along with a confirmed diagnosis and the ALTE code. This could be handled by revising the proposed note to Use additional code for signs and symptoms, with an addition such as, “if confirmed diagnosis is not known.”

It was suggested to add the term “human power” as a nonessential modifier to the change proposed at the transport accidents section.

The following comments were made regarding the index addenda:

A commenter suggested adding the term “ring” as a nonessential modifier to the change for fracture/pelvis/multiple.

Regarding the change to indexing of two codes for one condition (gastropathy/congestive portal) it was suggested to consider where else this concept might apply. A comment was made that this could be done widely and could be helpful. Another commenter recommended to not do this type of indexing change in ICD-9-CM.

It was recommended to add the term “straddle injury” to indexing of periurethral injury, referring to genitourinary injury (add “straddle” at the term Injury).

Additional comment:

One person asked what the status of the V code table was in the coding guidelines which take effect on October 1, 2009. She wanted to know why there are no longer secondary only codes and what the intent of the change was. She said mixing the terms principal (an inpatient term) with first listed (an outpatient term) was a little confusing since many of the V codes are outpatient related. The response was that the intent was to simplify this guideline and identify only the principal/first listed V codes. The intent was not to match it to any payer’s specific use of the V codes (e.g., listing V codes that are only going to be accepted for inpatient billing use).