ICD-9-CM Coordination and Maintenance Committee Meeting

Volumes 1 and 2, Diagnosis Presentations

December 6, 2002

SUMMARY

Below is a summary of the diagnosis presentations from the December 6, 2002 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 10, 2003. 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 for Thursday and Friday, April 3-4, 2003 at the Centers for Medicare and Medicaid Services (CMS) building, Baltimore, MD. Modification proposals for the April 2003 meeting must be received no later than February 3, 2003.

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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NCHS Classifications of Diseases 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, included in the proposal packet, was reviewed. Changes to ICD-9-CM resulting from the topics discussed today, if approved, would become effective on October 1, 2003. New proposals must be received at NCHS by February 3, 2003 to be considered for presentation at the April 2003 meeting.

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

Ms. Pickett also announced that the updated ICD-9-CM coding guidelines have been posted on the web site. These guidelines include coding changes, which became effective October 1, 2002. The four co-operating parties for ICD-9-CM are responsible for all guideline changes. Revisions to the guidelines content appear in bold print. The entire set of guidelines will also be published in the American Hospital Association's "Coding Clinic for ICD-9-CM".

Continuing Education certificates were not available at today's meeting, however, participants can request these by emailing Lizabeth Fisher at LFisher@CDC.GOV.

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SUMMARY OF COMMENTS AND DISCUSSION OF VOLUMES 1 AND 2 TOPICS
The following topics were presented at the meeting. (See attached topic packet):

Septic shock and Sepsis
Howard Levy, M.D. representing Eli Lilly and Company presented the background information for this topic. His PowerPoint presentation is available as <attachment1>.

On participant questioned how puerperal fever would be indexed. Another asked about the necessity of coding SIRS separately in patients with septicemia. Dr. Levy responded that the SIRS codes allow you to indicate whether or not the patient had organ dysfunction and whether it was caused by infection.

There were some comments that the proposed coding note, at category 038 and proposed new code 785.52 seem to be more appropriate to the coding guidelines rather than in the tabular. Some participants favored having the note appear in the tabular. If the note is to remain in the tabular it was suggested to reword the sequencing as "discretionary". It was felt this was too broad.

Dementia
John Hart, M.D. who represented the American Academy of Neurology presented background information about dementia with Lewy bodies and frontotemporal dementia (FTD). His PowerPoint presentations are available as <attachment2> and <attachment3>.

A question was asked whether frontal dementia is encompassed in frontotemporal dementia. Dr Hart responded that it is, and it was suggested that this term be added as an inclusion term and indexed to this new code.

Urologic topics
Jeffery Dann, M.D., representing the American Urological Association, presented the next topics. Each topic is listed below with the questions and comments raised following his presentation.

Scrotal transposition – One commenter questioned whether there are there health implications other than appearance if the condition is left untreated. Dr. Dann responded that this is usually treated surgically since there can be associated disorders with health implications other than appearance. One participant asked whether you should still code all other disorders separately if there is more than one, such as penile scrotal webbing. This will be reviewed further when considering this for the addenda.

Peyronie's disease - There were no comments about this proposal.

Penile injury - Some participants felt that a closer look should be given as to how these specific codes break out the trunk. One person questioned whether this much specificity should be given to a code that traditionally has been used when more information is not known about the specifics of the injury. It was suggested to look at the breakdown of other more specific trunk injury categories/sub-categories to see if they are as specific as this.

Urgency of urination - It was suggested to exclude urge incontinence (788.31) from this code.

Pre-operative insertion of ureteral stent for ureteral visualization – Clarification was given that this procedure is not routinely performed on every abdominal surgery patient. It is usually requested when the ureters are difficult to visualize during surgery due to being encased by tumor or scar tissue. If there were an abnormality with the ureters (such as hydronephrosis) then that would be coded. In many instances the stents can be removed non-operatively at the bedside.

There were many comments made suggesting that this code should not be in a disease chapter since the ureter is not diseased. It was suggested to add the new code to category 793, Nonspecific abnormal findings on radiological and other examination of body structure. Still others suggested trying to find or create a V code applicable to this.

Impaired fasting glucose -
Lavonne Berg, M.D. who represented the American Association of Clinical Endocrinologists, presented this topic. One participant questioned whether the prevalence of this condition has been overstated. Some questions were raised regarding how non-fasting impaired glucose tests should be coded. There was a suggestion to add an "other abnormal test" code to capture those other conditions indexed currently to code 790.2 such as pre-diabetes. There was also question raised as to whether the title should be "impaired" or "elevated" since both of these conditions involve elevated test results. One suggestion was to take the word "tolerance" and "test" out of the title for 790.2 leaving it just as "abnormal glucose". Some participants felt that the term "impaired" could refer to a diabetic or hypoglycemic who has an abnormal test result. Dr. Berg commented that using the word "impaired" in the proposed code titles came from the Expert Panel terminology that was used to describe these conditions. This should be the terminology currently used in practice.

Carnitine deficiency -
One participant suggested indexing the NOS to the secondary code. Another commenter raised the question about whether five new codes are needed for this condition. It was suggested to create one new code at this time with an assessment later as to the need for additional codes.

Primary carnitine deficiency is rare. Secondary carnitine deficiency is more common. Some participants suggested that codes for primary and secondary carnitine deficiency should be created. A separate suggestion was made to create a code for carnitine deficiency due to hemodialysis.

A representative of the Sigma Tau Pharmaceuticals was present and commented that all of these conditions are rare and he favored giving difference to primary and secondary only. He did not know the volume of patients with this condition.

Another participant suggested leaving room here for mitochondrial diseases in the classification and also suggested creating only two new codes here for

primary and secondary.

Rhabdomyolysis -
There was one suggestion to indicate traumatic as an inclusion term and index it to this new code.

Hypercoagulable states -
Dr. Powers made a comment that it could help, for consistency with clinical use of the terms, to change the inclusion term "activated protein C resistance" to "Factor V Leiden mutation". She also suggested adding "prothrombin gene mutation" as an inclusion term.

Hyperaldosteronism -
One person asked about the prevalence of and having a separate code for Conn's syndrome. Another commenter stated that it would seem a patient either has primary or secondary hyperaldosteronism and the other conditions would fall into one or the other of these. It was suggested that rather than create the additional three codes the conditions should be included within primary, secondary and an "other" code.

Barrett's esophagus -
A suggestion was made to look at indexing of metaplasia of other organs and add esophagus in the same way. This is currently not indexed.

Early satiety –
One comment was made as to how this would be indexed, under early or under satiety or both?

Encounter for emergency contraception –
It was suggested to clarify in the code title and in the index that this is post-coital emergency contraception.

Thoracoscopic procedure converted to open procedure –
A suggestion was made that rather than creating another unique code (as proposed) to make the existing code, or a new code that addresses the conversion of a procedure from endoscopic to open.

Subaponeurotic hemorrhage (Subgaleal hemorrhage) –
There were no comments about this proposal.

Postpartum cardiomyopathy –
One person commented whether "peripartum" cardiomyopathy has a code as they are seeing some patients who develop this during pregnancy.

Late infant –
There were no comments regarding this proposal.

Loss of consciousness in mild traumatic brain injury –
A suggestion was made to change the time periods to read as "30 minutes or less" and "31-59 minutes" to include the patient who has loss of consciousness of exactly 30 minutes.

Cerebral infarct of unknown vessel –

There were many comments about this proposal. The changes that are being proposed are not always documented this way in the chart.
A question was raised whether to use the 5th digit "2" or "0" when coding a case where the occlusion and infarct are on opposite sides.
There were many comments about terminology currently in use including: hemorrhagic vs. embolic stroke; lacunar CVA vs. lacunar infarct; whether carotid occlusion is the same as a CVA, and whether a CVA is the same as an infarction.
The term "mild stroke" has been used on some charts of patients who did not have a long length of stay but the physician determined that the patient had an infarction and not a TIA.
One commenter stated that the code 436, Acute but ill-defined cerebrovascular disease (CVA), is used frequently by hospitals that do not have the technology to diagnose any further detail.
The participants were encouraged to send all comments to NCHS by 1/10/03 to assist in reviewing this proposal for inclusion into the 10/1/03 addenda.

Hair tourniquet syndrome –
There were no comments regarding this proposal.

Addenda -
There was a suggestion to retitle 491.21 to say "With (acute) exacerbation.

There were many comments against removing the Code first any associated underlying condition note from 785.4. Participants were encouraged to submit comments in writing to NCHS.

It was suggested to add the term "cardiac" to the new index entry for stress test 794.39 (Findings, abnormal, without diagnosis), if that is what it is referring to.

Fitz-Hugh and Curtis syndrome – A suggestion was made to add an NOS entry, which would default to 099.56 (peritonitis)

One comment was made regarding the thrombosis, vein, deep index change. It was suggested to read as follows:

Thrombosis
vein (deep) 453.8

Aspirin – It was suggested to have an NOS entry since the coder may not have the purpose of the use of aspirin clearly documented. Since this change has the potential to affect entries for other drugs, that also have multiple uses, it was requested that careful review be given to this while weighing the burden to the coder of determining the use of the drug.