ICD-9-CM Coordination and Maintenance Committee Meeting

Volumes 1 and 2, Diagnosis Presentations

December 5, 2003

SUMMARY

Below is a summary of the diagnosis presentations from the December 5, 2003 ICD-9-CM Coordination and Maintenance Committee (C&M) Meeting. Comments on this meeting's diagnosis topics must be received in writing or via e-mail by January 9, 2004. 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 1-2, 2004 at the Centers for Medicare and Medicaid Services (CMS) building, Baltimore, MD. Modification proposals for the April 2004 meeting must be received no later than February 2, 2004.

C&M Visitor List Notice

Because of increased security requirements, those who wish to attend a specific ICD-9-CM Coordination and Maintenance Committee meeting in the CMS auditorium must submit their name and organization for addition to the meeting visitor list. Those wishing to attend the April 1-2, 2004 meeting must submit their name and organization by March 26, 2004 for inclusion on the visitor list. This visitor list will be maintained at the front desk of the Centers for Medicare and Medicaid Services (CMS) and used by the guards to admit visitors to the meeting. Those who attended previous ICD-9-CM Coordination and Maintenance Committee meetings will no longer be automatically added to the visitor list. You must request inclusion of your name prior to each meeting you attend.

Send your name and organization to one of the following by March 26, 2004 in order to attend the April 1-2, 2004 meeting.

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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

Please consult this web page for updated information.

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. It was noted that the December meeting date will be changed, and more information will be announced at a later date. Changes to ICD-9-CM resulting from the topics discussed today, if approved, would become effective on October 1, 2004. New proposals must be received at NCHS by February 2, 2004 to be considered for presentation at the April 2004 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.

It was noted that as part of the new Prescription Drug and Medicare Improvement Act of 2003, there was a provision to update the ICD-9-CM twice yearly. This came as a surprise to those who are involved in the ICD-9-CM update process. Comments from attendees on this were negative, with concerns raised on how feasible it would be to get software and other infrastructure updated twice yearly. The issue was also raised on where to address such concerns. It was stated that since this has now passed and become law, CMS and NCHS staff will work to meet the new requirements.

Attendees who missed the AHA/AHIMA presentation on the pilot test of ICD-10-CM on the first day of the meeting were encouraged to go to the aha.org or ahima.org web sites for the final report on the testing.

An updated version of the guidelines related to coding of sepsis is to be posted on the NCHS website shortly, and also published in Coding Clinic.

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

SUMMARY OF COMMENTS AND DISCUSSION OF VOLUMES 1 AND 2 TOPICS

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

Dental code expansion

This proposal was well received despite the large number of new codes proposed. There was agreement among audience members that an unspecified code for each new subcategory would be useful for those other than dentists who might use the codes.

The presenter was asked who would primarily be using these codes and how dentists would be educated in their use. His response was that the codes are primarily for use by the primary care dentist. The codes would be particularly useful in electronic patient records. However, the codes are needed first, and will be supported in such electronic records. Use of the new codes would be promoted among dentists.

Focal hyperhidrosis

There was general agreement on this proposal. A question raised was whether specific site codes should be provided. The presenter responded that most patients who have palmar hyperhidrosis also have plantar. Axillary is the most common type, and can also be present with other sites. Use of multiple codes would seem excessive, and should not be necessary. She added that at this point it is more important to be able to distinguish between focal and generalized.

There was a comment that the term focal may not be included in the record and that a default code needs to be provided in the index. The default would be the symptom code. It was also suggested that the term localized be indexed as an alternate term for focal.

It was also pointed out that Frey's syndrome is currently indexed to 350.8. It will need to be determined if this syndrome should remain where it is indexed, moved to a new code as proposed, or whether there are two types of Frey's syndrome.

West Nile virus with and without encephalitis

The audience supported this proposal. An audience member also requested an additional code or codes for West Nile with other neurological manifestations or disorders, to identify patients with polyradiculitis, optic neuritis and cranial nerve disorders related to West Nile virus. This could be created as a new code 066.42, West Nile Fever with other neurological manifestations, or as 066.48, West Nile Fever with other manifestations. A secondary code could be assigned to specify the type of

neurological manifestation; to show this, a code also note could be added.

Awaiting heart transplant status
There was general agreement with this new code, although the question was raised whether the code should apply to all transplant waiting lists, including kidney, and liver transplant. Options to address other organs could be specific codes for different organs, or a single code to apply to all organs. One audience member raised the issue that some patients may have multiple organs failing at once, and might be on more than one list. Also, a patient could receive one type of transplant, and yet remain on a list for a different organ. There would not be room at V49 to create multiple different organ codes, although a new V category could be considered. The question was also raised on whether this code would be used in patients who were in hospital for an extended period, but then received a transplant during the current stay. Pat Brooks of CMS explained to the audience that this code was requested by CMS for tracking purposes, specifically for left ventricular assist devices (LVADs).

Alpha-1-antitrypsin deficiency
There was general positive reaction on this topic.

Other metabolic disorders
The audience supported this proposal. A representative of the American Academy of Neurology strongly supported the proposal, and she explained that although there are not a large number of patients with these disorders, their care is complex and can involve repeated hospitalization, and it is important to be able to track them. Many states are now screening for these disorders, with tandem mass spectrometry. It was suggested that additional instructional notes and guidelines accompany these new codes, to make it clear how to code the disorder and any associated variable manifestations.

Autosomal deletion syndromes
There was overall support for this proposal. It was suggested that some syndromes that may be difficult to code could be better handled with the new codes. Further, it was recommended that other specific syndromes be reviewed for indexing or reindexing to one of these new codes.

Sleep disorders
Audience members supported this proposal. The issue of sleep related movement disorders was raised. Concern was raised that Restless leg syndrome, which was proposed as an inclusion under a

new code for sleep related movement disorders, is currently indexed to the neurology chapter (333.99). This proposal would move it to the symptom chapter. The presenter acknowledged that the pathophysiology of sleep related movement disorders is not fully understood. Category 333 is Other extrapyramidal disease and abnormal movement disorders. It was suggested that consideration be given to creating the new code for sleep related movement disorders at 333.9x, instead of at 780.58 as proposed. Also, it would be possible to create a specific code for Restless leg syndrome at 333.9x, as it is the most common sleep related movement disorder; it could be excluded from the other sleep related movement disorders, if that code is at 780.58 as proposed. Since these are related, there would be an advantage to having them together, as they also should be in ICD-10-CM.

An audience member suggested that the new code for Narcolepsy in conditions classified elsewhere have other common conditions causing it listed below the code first note. Some other conditions mentioned were head injury, and pontine tumors.

Nonspecific abnormal findings on neonatal screening
There was support for this proposal to improve data on neonatal screenings. Currently physicians may use the diagnosis code when an abnormal finding on a screening is found. This new code would provide an alternate code to use until the condition is definitively confirmed.

The presenter suggested removing "nonspecific" from the code title as proposed, to be consistent with other codes in the category. This will be considered.

Exposure to communicable diseases
There were no comments on this proposal.

Broken mechanical ventilator
There were no comments on this proposal.

Chondritis of ear
There were no comments on this proposal.

Decubitus ulcers
There was audience support for having the specific sites as proposed.

Deep vein thrombosis
The audience liked components of both the original proposal presented at the April 2003 C&M meeting and the revised proposal presented at this meeting. There was overall agreement that an

expansion for deep vein thrombosis would be beneficial.

There was a suggestion to change the proposed title of 453.44 to Venous embolism and thrombosis of distal lower extremity vein, with inclusion terms for tibial vein, peroneal vein, and calf vein. It was also suggested that indexing for the term "proximal" associated with venous embolism and thrombosis of lower extremity vein should refer the reader to code specific vein. These suggestions will be considered.

Endometrial hyperplasia with and without atypia
There was general agreement with this proposal but the question was raised as to whether the terms simple versus complex hyperplasia are terms that physicians routinely use. NCHS staff will follow up with the submitting organization on this issue, which is the American College of Obstetrics and Gynecology (ACOG).

Genital prolapse
There was support for this proposal. It was suggested that a similar expansion be made to code 618.5, Prolapse of vaginal vault after hysterectomy. NCHS staff will follow up with the submitting organization in considering this issue, which is ACOG.

Bethesda system
There were no comments on this proposal.

Female genital mutilation
There were no comments on this proposal. It was noted that the typographical error in the numbering of the second and third codes will be corrected, numbering them 629.21 and 629.22.

Long-term use of aspirin/insulin
Though there was support for these additions to the existing subcategory, the definition of "long-term" and guidelines for these codes was raised. It was suggested that "long-term" should include the relatively shorter term use of insulin in gestational diabetes, and prophylaxis in patients with DVT.

Diabetes mellitus
There were comments on the issue of different terminology used for adult patients and pediatric patients. Insulin dependent and non-insulin dependent diabetes mellitus (IDDM and NIDDM) are still commonly used among physicians who treat adults, while the newer terms type 1 and type 2 diabetes mellitus are more commonly used among pediatricians. The question was asked why the term adult onset diabetes is being proposed to be deleted but juvenile onset is not. The American Diabetic Association will be

contacted regarding these questions.

It was suggested by a member of the audience that the terms controlled and uncontrolled also be removed from the code titles. However, other audience members spoke out in opposition to this. They felt that such a change would remove the ability to distinguish between routine diabetic care, and cases where blood sugar levels need more specific attention.

Mental disorders addenda change

There was a lot of discussion on the extensive changes being proposed for the mental health chapter. The proposed moving of Rett's syndrome from the neurology chapter to the mental health chapter was opposed by the representative of the American Academy of Neurology (AAN). The Academy representative also questioned the removal of the term night terrors from the code 307.46, Somnambulism and night terrors, with proposed subsequent title to be Sleepwalking disorder. As this is not as general as the previous title, it was suggested that the title instead be "arousal disorder." Concern was also raised on the proposed title change at 310.1, from Organic personality syndrome, to Personality change due to conditions classified elsewhere. It was noted that mild memory disturbance is included here, and that it would be cognitive in nature rather than a personality change. It was suggested that this change would not be appropriate, unless certain of these inclusion terms were moved to a new code created to be more appropriate for representing these disorders. Such a code could be titled "mild cognitive disorder" and might be best classified elsewhere.

It was also suggested that it would not be appropriate to include Rett syndrome at 299.8, as it is now indexed to 330.8, Other specified cerebral degenerations in childhood.

It was questioned why autism is listed as a psychosis in the mental health chapter, since that is not what it is now clinically understood to be. This is where the ICD has it classified. It was suggested to change the title of category 299 to be broader and more representative of current clinical understanding of the included disorders.

It was also asked what "most recent episode" means for the bipolar disorder codes, and how to handle coding if this is not specified in the record. One suggestion was to change this to "current episode." One option would be to put this terminology in parentheses.

NCHS staff will consider all of these comments and discuss with

the American Psychiatric Association.

Addenda

There was comment on only a few addenda items. The change in the index for cerebral infarct was supported. The change of default for myasthenia was objected to by a member of the audience. She explained that myasthenia is synonymous with myasthenia gravis, and should default to 358.00. The term myasthenic can default to muscle weakness, 728.87. This change would require separating these terms in the index.