
ICD-9-CM Coordination and Maintenance Committee Meeting

Volumes 1 and 2, Diagnosis Presentations

April 1, 2005

SUMMARY

Below is a summary of the diagnosis presentations from the April 1, 2005 ICD-9-CM Coordination and Maintenance Committee (C&M) Meeting. Comments on this meeting's diagnosis topics, indicated as potential for October 1, 2005 implementation must be received in writing or via e-mail by April 15, 2005. Comments on the remaining diagnosis topics must be received in writing or via e-mail by December 2, 2005. 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, available from the following site: http://www.cms.hhs.gov/paymentsystems/icd9/default.asp.

The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled for Thursday and Friday, September 29-30, 2005 at the Centers for Medicare and Medicaid Services (CMS) building, Baltimore, MD. Modification proposals for the September 2005 meeting must be received no later than July 29, 2005.

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 register using the on-line events registration on the CMS website at: http://www.cms.hhs.gov/events/. Participants must register by September 23, 2005. A visitor list will be generated from this registration website and will be 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 register prior to each meeting you attend.

Thank you for your participation in these public forums on the ICD-9-CM. Your comments help insure a more timely and accurate classification.

**ICD-9-CM Coordination and Maintenance Committee Meeting**
**ICD-9-CM Volume 1 and 2, Diagnosis Presentations**
**April 1, 2005**


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NCHS Classification 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 ICD-9-CM C&M meeting.

The time line for diagnosis changes, included in the proposal packet, was reviewed. Important dates of note are April 15, 2005 for comments on proposals presented today that have potential to become effective on October 1, 2005. Comments for the remainder of today's meeting topics are due by December 2, 2005 and it was strongly recommended, to ensure timely delivery, that they be submitted via email or express mail. Proposals for consideration at the September 30, 2005 meeting must be received by July 29, 2005.

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

Continuing Education certificates were made available at the conclusion of the meeting. There were 6 hours of continuing education awarded for the diagnosis portion of the meeting.

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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):

Sleep disorders
Michael J. Sateia, M.D., representing the American Academy of Sleep Medicine (AASM) presented clinical background on the new codes proposed. Today's proposal included codes for conditions at the October 2004 meeting (with codes renumbered) as well as new codes proposed for circadian rhythm sleep disorders, parasomnias, and sleep related movement disorders. The proposal to move restless leg syndrome from current code 333.99 to a new code was withdrawn. The Academy is requesting that all codes be implemented at the same time, October 1, 2005, rather than staggered over two years. **Written comments regarding this topic must be received no later than April 15, 2005.**

Epilepsy
Gregory Barkley, M.D., representing the American Academy of Neurology, presented clinical information regarding this proposal. Comments included recommending adding an inclusion term to code 780.39 such as "seizure episode NOS" to help differentiate when to use this code vs. 345.9. It was observed that the current proposal does not move convulsive disorder from 780.39. It was recommended to drop the "s" from the code titles for 780.31 and 780.39. Jeffrey Linzer, M.D., representing the American Academy of Pediatrics, recommended having two codes for febrile seizures to differentiate between simple and complex. NCHS will look into the classification of febrile seizures in ICD-9-CM.

Cracked tooth
This proposal was submitted by Delta Dental. A representative of the American Dental Association (ADA) recommended that NCHS contact them to see if the terminology suggested in this proposal is in agreement with the ADA terminology.

Dental code modifications
There were no comments regarding this proposal.

Possible/Probable guideline
Donna Pickett presented results of an informal survey done by the America Health Information Management Association (AHIMA) and AHA (American Hospital Association). The survey sought input as to whether coding guidelines for coding possible and probable diagnoses should be the same. Currently inpatient guidelines dictate to code these diagnoses as if confirmed, while outpatient guidelines instruct to code only to the highest known condition (usually a symptom code). The PowerPoint file for this presentation will be available on line. Comments following her presentation included:

- Healthcare reimbursement programs are different in the U.S. than in Canada and Australia, so evaluating their policies vs. the U.S. should take that into consideration.
- If a modifier is to be used to indicate this, a change to the proposed UB-04 would be needed.

- The application of current guideline of "stated at the time of discharge" is often violated when some coders interpret that as "if seen in the chart". There should be a distinction.
- AHA survey was of a small group but not meant to be large survey. A more formal survey of all members could be done if necessary.
- Data researchers will see a downward trend right away; consider looking at how other countries worked this out.
- Consider applying the probable/possible rule only to the principle diagnosis and not secondary diagnoses.
- One should not use treatment of a condition as criteria of whether or not to code a diagnosis. Sometimes no treatment is the treatment.
- Is there a way to find out what percentage of discharges would be affected?
- Researchers would benefit from a sixth digit to show this.
- Would be helpful to know what diagnoses are difficult to diagnose, then perhaps modify guidelines for just those conditions.
- Would all cases where a symptom code would now be assigned instead of probable diagnosis be denied payment?
- A change to the inpatient guideline will have a bigger impact on facilities with largest differential diagnosis caseload.
- A more structured research on this was suggested, such as an evaluation study.
- Consider using modifier of "Q" (for questionable diagnosis), as in Canada.
- Look at expanding codes in the V71 category (Observation and evaluation code) to fifth digit to indicate probable/possible diagnosis.
- Have an additional modifier for conditions that get "ruled out".
- AHIMA has heard from patients who have difficulty getting these diagnoses expunged from their record after they have been coded. This sometimes takes years and affects insurance eligibility.
- This will be a bigger problem in the electronic record.
- What is the quality of data right now with these conditions being coded this way?
- Could an item be added to the UB-04 similar to the new item "present on admission"?

Sepsis coding

An open discussion was held to obtain feedback on the application of the codes for SIRS, sepsis and septic shock. Walter Linde-Zwirble of ZD Associates was available for questions from the audience, regarding these conditions.

Comments included the following:

- It is important to find out whether the organ dysfunction was due to the systemic inflammatory response.
- The presence of an infection does not always indicate that the 995.92 (SIRS due to infectious process) should be used. Sometimes a patient may have other underlying cause of the organ dysfunction (such as COPD causing respiratory failure) rather than the inflammatory response to infection.

- ICD-9-CM accommodated coding an infection well and coding organ dysfunction well; the reason for the need of codes for SIRS was to indicate when the systemic inflammatory response caused the organ dysfunction, and whether or not an infection was the precipitating event.
- A review of 2003 MEDPAR data showed that when code 995.92 was used, it corresponded to severely ill patients, with intensive need for resources, and thus was similar to the clinical picture intended for this code.
- Coders need clear guidelines on sequencing, especially when to apply the chapter specific guidelines vs. overarching guidelines for assignment of principal diagnosis. Newly released guidelines (for April 1, 2005) did not address this.
- There are many problems with how the terms sepsis, septicemia and severe sepsis and septic shock are used. They are not always used consistently. It is problematic to get physicians to document this correctly for coding purposes.
- Many different scenarios were presented as questions as to how to sequence these codes.
- One of the example scenarios was pneumonia, with subsequent respiratory failure. It was stated by Walter Linde-Zwirble that this would equate to severe sepsis. However, it was commented that it would not be appropriate for a coder to assign this diagnosis without it being documented in the record.
- Walter Linde-Zwirble also described an example scenario where multiple disorders were present, such as COPD, CHF, and pneumonia, potentially with sepsis, along with respiratory failure. In such a case, it may not be so clear which one caused the respiratory failure. It was commented that in such cases where the record was not clear, it would be appropriate to query the physician. Walter Linde-Zwirble commented that he would not want the default to be to assume severe sepsis in such cases.
- SIRS, inflammatory response, has many causes. If caused by infection that is sepsis. Organ failure associated with or due to an inflammatory response that was caused by an infection is severe sepsis. However, it is difficult to tell what the cause was sometimes, both for the physician, and subsequently for the coder.

This information will be reviewed by the cooperating parties.

Compartment syndrome

Jeffrey Linzer, M.D., representing the American Academy of Pediatrics recommended considering where compartment syndrome of the ankle should be indexed.

Hematology issues

Dr. Linzer offered several suggestions for slight modifications to this proposal. The topic packet has been updated to reflect this.

Psoas muscle abscess
Since this is currently indexed to tuberculosis of bones and joints, it was suggested to have an excludes note for this at proposed code 567.31, Psoas muscle abscess.

Aspiration syndrome, part 2
Dr. Linzer recommended implementing these proposed codes along with those previously proposed, effective October 1, 2005 (rather than some this year and some on October 1, 2006). **Written comments regarding this topic must be received no later than April 15, 2005.** It was also suggested to review the title proposed for new codes 779.85 and 779.86 as to whether it should be "aspiration of postnatal stomach contents" or "postnatal aspiration of stomach contents". It was also questioned as to whether these codes should be in the 770.1 subcategory rather than here. 770.8 was suggested as a possible location for these codes.

Torsion dystonia and athetoid cerebral palsy
Laura Powers, M.D., representing the American Academy of Neurology presented a list of conditions included in drug induced movement disorders (see separate file). She suggested re-titling proposed code 333.85 to read "Subacute dyskinesia due to drugs" and to include orofacial dyskinesia due to drugs in this code. This proposal has been updated in the topics packet, to reflect comments.

Myelitis
One person asked where acute myelitis would be indexed. Dr. Powers stated that it would be appropriate to code "acute myelitis" to the code for "acute transverse myelitis." A suggestion was made to exclude 060.41, West Nile virus with encephalitis, from proposed new code 323.01, Encephalitis and encephalomyelitis in viral diseases classified elsewhere. Another suggestion was made to revise the title of code 323.9, Unspecified cause of encephalitis.

Postnasal drip
A suggestion was made to index the various causes of postnasal drip to the main term "Drip" and cross reference "postnasal drip" to these entries. The topics package has been changed to reflect this comment.

Nonasthmatic bronchospasm
Dr. Linzer stated that this proposed new code would help track pediatric patients with a history of reactive airway disease that are not yet diagnosed with asthma.

Body Mass Index (BMI), pediatric
Dr. Linzer suggested that the inclusion term for the BMI codes also be added to code V65.3, Dietary surveillance and counseling. The topics package has been modified to reflect this comment.
One person suggested changing proposed codes for adult BMI range of 25-29 to match their actual BMI value (ex, change proposed code V85.21, Body Mass Index 25.0-25.9, adult to code V85.25). It was felt this would make it easier for coders and researchers to translate BMI value to BMI code.

Transfusion related acute lung injury (TRALI)
No comments were made regarding this proposal.

Genetic testing
It was recommended that these codes be implemented this October 1, 2005 along with the new codes in V26.3. **Written comments regarding this topic must be received no later than April 15, 2005.** In addition a comment was made that if these new codes are not implemented this October, there should be instructions as to how to code this in the interim until October 1, 2006.

Inconclusive imaging tests due to excess body fat
There was discussion about whether to place this diagnosis in proposed new code V72.51 or under the abnormal test results category of 793. This will be further reviewed by NCHS.

Encounter for hearing examination following failed hearing screening
No comments were made regarding this proposal.

Central pain syndrome, postoperative pain
Concern was raised as to when and for how long to apply post-op pain codes, especially in non-acute care settings such as home health. One comment raised the issue of potential use of a complication code for pain, and how this might affect pay for performance issues. Dr. Powers suggested that central pain syndrome be assigned to a code in the Neurology chapter and to also include thalamic pain syndrome (currently indexed to code 348.8) and myelopathic pain. Dr. Linzer suggested using 349.3 for both central pain syndrome and postoperative pain.

Sensorineural hearing loss
No comments were made regarding this proposal.

Encounter for pregnancy test, pregnancy confirmed
One commenter raised the question of having V codes that incorporate test results (positive and negative). Dr. Linzer supported this new code as it could be useful for referral of adolescent girls that present for pregnancy testing in hospital emergency departments. The requestor, the American College of Obstetrics and Gynecology has recommending that this code be considered for implementation effective October 1, 2005. **Written comments regarding this topic must be received no later than April 15, 2005.**

Other conditions or status of mother complicating pregnancy
No comments were made regarding this proposal.

Bariatric surgery status
No comments were made regarding this proposal.

Elevated tumor associated antigens [TAA]
No comments were made regarding this proposal.

Antepartum testing on father
One person commented that this will be useful for billing claims for father's testing.

Macrophage activation syndrome
No comments were made regarding this proposal.

Unspecified adverse effect of drug, medicinal and biological substance
No comments were made regarding this proposal.

Encounter for immunotherapy
It was suggested to exclude V07.3, Other prophylactic chemotherapy, from these codes. AHIMA recommended that this code be considered for implementation effective October 1, 2005. CMS concurred that this change would be useful to have as soon as possible. **Written comments regarding this topic must be received no later than April 15, 2005.**

Addenda
No comments were made regarding the addenda.