ICD-9-CM Coordination and Maintenance Committee Meeting

Volumes 1 and 2, Diagnosis Presentations

September 29, 2006

SUMMARY

Below is a summary of the diagnosis presentations from the September 29, 2006 ICD-9-CM Coordination and Maintenance Committee (C&M) Meeting.

All proposals presented at this meeting are for consideration for implementation on October 1, 2007. Comments must be received in writing or via e-mail by December 4, 2006. Both the National Center for Health Statistics (NCHS) address and e-mail addresses of NCHS Classifications staff are listed below. The Centers for Medicare and Medicaid Services (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, March 22-23, 2007 at the CMS building, Baltimore, MD. Modification proposals for the March 23, 2007 meeting must be received no later than January 22, 2007.

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/. On-line registration for the March 22-23, 2007 meeting will open on February 22, 2007 and participants must register by March 16, 2007. The registration will allow participants to register once for both days of meetings. 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
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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 December 4, 2006, the deadline for receipt of public comments on proposed code revisions discussed at the March 24, 2006 meeting and those proposals presented today, that are being considered for October 1, 2007 implementation. It was strongly recommended, to ensure timely delivery, that comments be submitted via email or express mail. Proposals for consideration at the March 23, 2007 meeting must be received by January 22, 2007. Registration for the March 22-23, 2007 ICD-9-CM Coordination and Maintenance meeting will open on February 22, 2007 and close on March 16, 2007.

She announced that a summary of today's meeting, the full topic packet presented at the meeting, and related Power Point presentations 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 5 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 topic packet posted as a separate file):

Hearing loss, speech, language, and swallowing disorders
Kyle Dennis, Ph.D., CCC-A, FAAA and Dee Adams Nikjeh, Ph.D., CCC-SLP representing the American Speech-Language-Hearing Association presented a clinical overview of the topics in this proposal. Their PowerPoint presentation is available on the NCHS Classifications of Diseases and Functioning & Disability web site. The following comments were made.

- Carmela Tardo, M.D., representing the American Academy of Neurology (AAN), asked whether the proposed code 315.34, Speech and language developmental delay due to hearing loss, would apply to children with hearing loss due to otitis media. The issue as she framed it was whether the code would apply for both acquired and congenital hearing loss. She noted that in the past, this would have been coded to hearing loss. There could be issues of differentiating types of hearing loss. Dr. Dennis replied they applied to both. Dr. Tardo also suggested that a use additional code note for the type of hearing loss be added under proposed new code 315.34.
- It was suggested that an inclusion term be added at code 315.32 for "central auditory processing disorder."
- Dr. Tardo suggested considering subcategory 784.6, Other symbolic dysfunction, for the placement of the acquired auditory processing disorder rather than the proposed 349.8, Other and unspecified disorders of the nervous system. Dr. Dennis explained that the language component of this disorder is just a symptom of the underlying neuroprocessing disorder of the auditory system. He prefers it in the neurology chapter.
- Though the term "dual sensory impairment" is understood in the hearing loss, speech and language profession to mean a combined hearing and speech deficit, Dr. Tardo suggested adding "speech and hearing deficit" somewhere as an inclusion term to help clarify what is covered in the code.
- Another comment on "dual sensory impairment" suggested that it would be appropriate to call it by a more descriptive term such as "combined vision and hearing loss," or "deaf-blindness."
- It was further suggested to reconsider placement of the proposed dual sensory impairment code. Many felt that having that located in the V Codes may limit its use. It was suggested to consider somewhere in Chapter 16, Signs, Symptoms and Ill-Defined Conditions.
- In discussion of the proposed change to the title of the current code 387.9, Deaf mutism, not elsewhere classifiable, in response to a question, it was noted that mutism without deafness is coded to the symptom code 784.3, Aphasia.
- There were several comments concerning documentation of the phases of dysphagia and whether or not a speech therapist's specific diagnosis would be able to be coded if the provider did not follow through on this in their documentation.
- There was a suggestion to consider linking the proposed dysphagia codes with risk of aspiration.

- There was a suggestion regarding dysphagia that a combined type code also be created. However, another commenter suggested that having separate codes would be more appropriate, to better identify the specific types present.
- There was concern as to how the proposed dysphagia codes apply when the patient has had a stroke and is usually assigned code 438.82, Late effect of cerebrovascular disease, dysphagia. NCHS staff responded that a use additional code note at code 438.82 would be needed to identify the type of dysphagia.
- Laura Powers, M.D., also representing the AAN, commented that the different causes of dysphagia, specifically neurogenic and esophageal, should be assigned appropriately. She noted that these are the terms physicians use to describe the types of dysphagia. The esophageal cause should be assigned to a code in the gastrointestinal chapter of ICD-9-CM.
- During their presentation, the ASHA recommended an additional code for combined type dysphagia. It would represent two or more types of dysphagia. One audience member asked whether such a code is necessary since oropharyngeal includes oral and pharyngeal, and the only other remaining combination is pharyngoesophageal. She suggested it may be preferable to just use more than one dysphagia code if applicable.
- There were many comments regarding the placement of the proposed code for disability examination. Some felt V70.8, Other specified general medical examinations, was more appropriate. There are many codes in the V codes that represent aspects of this examination such as: V68.0, Issue of medical certificates (includes fitness); V68.2, Request for expert evidence; V70.3, Other medical examination for administrative purposes; and V70.5, health examination of defined subpopulations. Since there are many reasons one may seek a disability examination (pediatrics for developmental disability, veterans, etc.) it was suggested to carefully consider the placement of this code.
- Some participants also commented that present coding guidelines would need to be reviewed, since patients coming in for disability assessment do generally have known impairments and health problems, so these encounters would differ from screenings and encounters for examinations. It was suggested this code be considered equivalent to a pre-operative clearance examination for sequencing purposes.

Urinary risk factors for bladder cancer

Louis Liou, M.D., Ph.D., representing Abbott, presented a clinical background for this proposal. His PowerPoint presentation is available on the NCHS Classifications of Diseases and Functioning & Disability web site. Participants commented on the following:

- Following Dr. Liou's discussion on the important distinction between microscopic and gross hematuria, and their significance for bladder cancer, several participants commented that separate codes for gross hematuria and microscopic hematuria should be considered. Dr. Liou commented that there would a benefit to having these conditions in separate codes. One participant pointed out that the current draft version of ICD-10-CM has unique codes for these two conditions.

- Nelly Leon-Chisen, representing the American Hospital Association, commented that the proposed use additional code note at current code 599.7, Hematuria, would be a deviation for ICD-9-CM. Currently nothing precludes someone from coding the conditions listed in this note if they are documented. She suggested that NCHS carefully consider the implications of this type of note as it applies to all care settings.
- Several participants commented that for the current code V15.86, revising the title to include "other potentially hazardous metals" would change the meaning of the code. It was suggested to find another place for this code. Some suggested looking at the end of the V codes (beyond the currently used V86 category).
- One commenter questioned the likelihood that a person's occupation and exposure to hazardous substances would be documented in the medical record. Dr. Liou indicated that he does not assume chemical exposure based on an individual's occupation, but would likely question a patient about exposure if that person's occupation is more likely to involve exposure to these substances. He stated that these exposures are recorded in the chart by urologists.
- A question was raised regarding the difference between exposure and poisoning in regards to bladder cancer. It was suggested that this should be addressed in the coding guidelines.
- It was suggested that due to the importance of chemical exposure in disease development, perhaps more exposure codes are needed for separate levels.

Chronic Total Occlusion of Artery of Extremities

Matt Selmon, M.D., representing Cordis, presented the clinical background for this proposal. His PowerPoint presentation is available on the NCHS Classifications of Diseases and Functioning & Disability web site. The following comments were offered:

- Dr. Selmon was asked if the term chronic total occlusion is routinely documented and used by physicians. He responded yes, it is routinely used and understood to mean zero blood flow through a vessel. He was also asked if procedures for opening occlusion in bypass grafts are done. He responded that they are done on bypasses as well as native vessels, as bypasses often clot badly.
- The code first note, in Option 1, at proposed code 440.4 could also be applied to code 440.3, Atherosclerosis of bypass graft of the extremities.
- It was suggested to follow the same coding structure here that was presented for the chronic total occlusion of coronary artery in March 2006. It was further suggested to implement both of these changes at the same time.
- There was a comment regarding how "chronic" would be defined. No definition is included in the proposal.
- It was suggested to put the word "chronic" in parenthesis as a non-essential modifier. It was asked if the default for artery occlusion NOS should be acute or chronic. It was agreed that chronic would be the logical default for both coronary and peripheral occlusions, with an acute occlusion for a coronary artery generally involving a myocardial infarction.

- Some commented in favor of implementing Option 1 and at a later time expanding if the documentation in the medical record supports the need.

Osteonecrosis of jaw

Vincent DiFabio, M.D., representing the American Association of Oral and Maxillofacial Surgeons, presented the clinical background for this proposal. His PowerPoint presentation is available on the NCHS Classifications of Diseases and Functioning & Disability web site. The following comments were offered:

- One commenter asked whether we needed both proposed new E codes, one for IV, and one for oral, due to the limited number of E codes available. Dr. DiFabio said it is important to be able to differentiate effects between these two types of use. He noted that side effects from IV usage occur sooner than those from oral usage. IV bisphosphonates are used in some cases for multiple myeloma and breast cancer patients. There is also concern about the long term use of the oral agent.
- Several other participants commented in favor of two E codes.
- There was also comment about the use of E933.1, Antineoplastic and immunosuppressive drugs, with the proposed new codes.

Intraoperative Floppy Iris Syndrome (IFIS)

Priscilla Arnold, M.D., representing the American Society of Cataract and Refractive Surgery, presented the clinical background for this proposal. Her PowerPoint presentation is available on the NCHS Classifications of Diseases and Functioning & Disability web site. Many comments were offered regarding this proposal.

- Dr. Arnold noted that this is a pharmacologic (drug related) neuropathy.
- Some asked whether this condition presents any symptoms if a patient is not having cataract surgery. Dr. Arnold stated that this is not likely and that even when evaluating patients for cataract surgery it cannot always be detected when dilating the pupil.
- Dr. Louis Liou commented that the American Urological Association (AUA) has done a mass email alerting urologists about this condition. This drug (tamsulosin, or Flomax) is widely prescribed for men with BPH with urinary retention, due to its few side effects. It is also prescribed to women with urinary retention, so this potential problem has widespread implications.
- IFIS may also occur with other alpha blockers, but that has been less common.
- The proposed code title reads as if this condition is a complication of cataract surgery. Dr. Arnold stated that it is not a complication of surgery, but a drug reaction that impacts surgery. It was suggested to add an excludes note at the beginning of section 996-999, Complications of Surgical and Medical care, NEC to exclude this new code, and to consider having the word “intraoperative” be a nonessential modifier rather than part of the code title.
- The use additional E code note could be changed to identify alpha blockers, or alpha adrenergic blocking agents.

Septic embolism

The following comments were offered regarding this proposal:

- It was asked why septic embolism NOS is included under proposed new code 415.12, Septic pulmonary embolism. Is it more prevalent or just more severe? NCHS staff commented that this was the most common site.
- It was suggested that the excludes notes at proposed new code 415.12, Septic pulmonary embolism, and proposed new category 449, Septic arterial embolism, be reviewed as they relate to the chapter 11, Complications of pregnancy, childbirth, and the puerperium.
- There needs to be similar excludes notes, as that at proposed new code 415.12, added to the pregnancy section codes.
- One commenter suggested using a structure similar to category 444, Arterial embolism and thrombosis, for proposed new category 449, Septic arterial embolism.
- It was asked if there is a real need for all of the codes in proposed new category 449, or if one code be sufficient. It was also asked why the sites specified in the new codes were selected. Are they more prevalent than others? NCHS staff explained that the codes represented the most prevalent sites identified in the literature on septic arterial embolism.
- One person inquired about the source of the request, specifically whether a medical society requested this code. NCHS staff responded that this request came through the Editorial Advisory Board for "Coding Clinic".
- There was a discussion on how these codes relate to the SIRS/sepsis codes, and the current index instructions to code the infection and the embolism separately. Many participants commented that there will be sequencing and index issues to review with these codes.

Parvovirus B19

NOTE: This topic was presented on Thursday, September 28, 2006. Following presentation of this topic there were no comments made.

Avian Influenza

Donna Pickett encouraged those wishing to comment on this topic to forward comments to her at NCHS by October 15, 2006. Donna and others at NCHS will be attending the 2006 Annual meeting of the World Health Organization (WHO) Network of Collaborating Centres for the Family of International Classifications, October 30 – November 4, 2006, and it will be useful for NCHS staff to have these comments with them since WHO has already implemented a code for avian influenza in ICD-10.

There were several comments made regarding this proposal, as follows:

- It was asked how two different H5N1 flu viruses can be classified the same way. NCHS staff responded that since the viruses have 8 RNA strands and only H and N are represented in the H5N1 classification, the other 6 RNA strands may be different, making it a different virus.
- Since there have been no cases of Avian flu in the United States, one commenter asked why devote an entire category to this condition rather than add it to existing category 487, Influenza. It was explained that this proposal duplicates that of a similar code implemented in ICD-10

by the WHO, and it leaves room for expansion and detail, if needed, at a later time. NCHS serves as the WHO Collaborating Center for the Family of International Classifications for North America and is, therefore, bound by WHO decisions regarding the ICD. It was noted that this would represent a different axis than the existing codes at category 487.

- A member of the audience commented that the H and N antigen results would not likely be immediately available, so this diagnosis will probably be made by suspicion; therefore, how specific should this code be? NCHS staff stated that typing would likely be done if it was suspected bird flu. It is not done in other cases. The code would be useful should a pandemic occur.
- The text of the note was discussed with some wanting the word "only" removed. One person commented that the use of the word "influenza" three times in the note should be reviewed for possible rewording. It was reiterated that the code and the instructional note are intended to mirror the new code in the ICD-10, but that the wording of the note will be reviewed.

Myotonic disorders

Several comments were offered following presentation of this topic. Laura Powers, M.D., representing the American Academy of Neurology (AAN) offered the following comments and offered to work with NCHS to further refine this proposed change to the classification:

- She requested a new code for drug induced myotonia, with a use additional E code note to identify the drug.
- She also requested that Becker disease be added as a sub-term under code 359.22, Myotonia congenita, and to also consider adding "acetazolamide responsive."

Other comments offered included:

- Congenital anomalies usually are classified in chapter 14, Congenital Anomalies (categories 740-759), and it was asked if this code should be excluded from chapter 14, Congenital anomalies.
- Consider adding the word "congenital" to the proposed excludes note at category 756, Other congenital musculoskeletal anomalies.
- There was discussion about the fact that many congenital conditions are located outside of chapter 14 as years ago when this classification was developed it was not known that certain conditions were only congenital. It is doubtful that chapter 14 could hold all of the congenital conditions.
- It was suggested to consider whether proposed code 359.22, Myotonia congenita, should be excluded from category 756.

Cardiac tamponade

NOTE: This topic was presented on Thursday, September 28, 2006. There were no comments made following presentation of this proposal.

Effects of Harmful Algal Bloom and Toxins

- It was suggested that since there are other problems associated with these blooms, other than ingesting fish that have been exposed to these

toxins (such as respiratory problems), there may be a need for other codes in addition to code 988.0, Toxic effect of fish and shellfish, eaten as food.

- It was suggested that there may be a need for index entries for ingestion of fish exposed to algae bloom, other than just Ciguatera (trout was an example given).
- It was recommended to check whether this is indexed under the term "Poisoning/food".

Secondary diabetes mellitus

Following presentation of this topic, which was also presented at the March 2006 meeting, comments were as follows:

- One person suggested changing the title of the category and codes from "Diabetes mellitus due to underlying condition" to "Secondary diabetes mellitus".
- One person asked if there would be codes for controlled vs. uncontrolled in this category. It was suggested that if there were no codes for controlled/uncontrolled that a note or a Coding Clinic article be written to clarify this further.
- One participant asked whether this proposal had been shown to an endocrinology group for comment. The proposal has been shown to several groups and one common element was that it was suggested that no 5th digits be included in this proposal (as in category 250).
- A point was raised as to how quickly one would develop secondary diabetes as a result of a poisoning. It would more likely be a late effect and that is one reason why the use additional code notes proposed included to code late effect of adverse effect of drug, poisoning and trauma.
- Many commented on the confusion that might be caused by the conflicting notes in the includes, code first and use additional code notes. A suggestion was made to add an instructional note that helps with these sequencing issues. It was pointed out that a similar precedent exists at category 639, Complications following abortion and ectopic and molar pregnancies, for this type of note.
- One participant wanted to know if there would be changes to the index for steroid induced diabetes, currently indexed to code 251.8, Other specified disorders of pancreatic internal secretion. NCHS staff stated that this index entry would be changed.
- There was a comment that the index should be reviewed for gastroparesis due to secondary diabetes mellitus.

Fetal medicine

The following comments were offered regarding this proposal:

- One commenter asked what is considered a "major organ" in regards to the subcategory V15.2, Surgery to other major organs. NCHS responded that there is no formal definition of major organ.
- There were conflicting comments regarding what was meant to be included in each of the proposed codes V15.21, Personal history of in utero procedure during pregnancy vs. V15.22, Personal history of in utero procedure while in utero. It was therefore suggested to review the

code titles to provide clarity that one is intended to apply to the mother who had the surgery (V15.21), while the other is intended to apply to the person who was operated on, in utero, as a fetus (V15.22).

- One person commented that many times there are complications of in utero operations, especially in multiple gestation pregnancies, and this may need to be addressed.
- A question was raised regarding multiple gestations and how often a procedure would be done on only one fetus, as well as how these would be handled in the classification.
- There was a question raised whether there would be overlap between proposed code 679.33, Suspected fetal anomalies not found, and codes in category 655, Known or suspected fetal abnormality affecting management of mother.
- One person stated that proposed code 679.06, Maternal complications from in utero procedure, postpartum, might be confusing in comparison to late effect codes.
- There were comments about the fifth digits for the proposed new categories 678 and 679 being different from those used in other obstetrics sections of the classification.
- A question was raised about suspected preterm labor, where a patient comes in to the hospital, but then does not deliver, and how this would be classified.

Antenatal screening

- One comment was made regarding revising code titles in category V28, Antenatal screening, to remove procedures from the titles (for example V28.3, to remove the words “using ultrasonics” from the title).
- It was suggested to add the words “of parents” to category V26, Procreative management, so there is a clear distinction between this category and category V28, Antenatal screening.
- There was a comment that it might also be helpful to change the title at V28.1, Screening for raised alpha-fetoprotein levels in amniotic fluid, to remove the phrase “in amniotic fluid.” This would allow the code to also be used for raised alpha-fetoprotein levels in serum. However, there was concern this would change the meaning of the code.

Personal history of cervical dysplasia

There were no comments made following presentation of this proposal.

Acquired absence of cervix/uterus

- One person suggested checking whether the term “partial hysterectomy” means the same as “retained stump”. It was suggested to have an NOS code for this. NCHS will check with the American College of Obstetricians and Gynecologists regarding the definition of partial hysterectomy and this default.
- A question was raised about where the default would be for someone who was status post hysterectomy NOS (uterus absent, but absence or presence of cervix not specified).

Screening for human papillomavirus (HPV) and sexually transmitted diseases (STD)

There were no comments made following presentation of this proposal.

Vulvar intraepithelial neoplasia I, II and III [VIN I, II and III] and Vaginal intraepithelial neoplasia I, II and III [VAIN I, II and III]
It was noted that the VIN proposal that was presented in March is included with this additional VAIN proposal so that the full set of changes can be reviewed together. There were no comments from the participants on this proposal.

Malignant ascites
Following presentation of this topic the following comments were made:

- There was a strong feeling expressed by many that this code should be in Chapter 2, Neoplasms, and not in Chapter 16, Signs, symptoms and ill-defined conditions.
- Additionally, it was asked whether it would still be necessary to code the malignancy. NCHS staff pointed out the code first note on the proposal. This note instructs that a malignancy code would always be required with the malignant ascites code.
- Some commented that the documentation may just say “malignant ascites” (especially on outpatient medical records), and there is no known malignancy site specified.
- One suggestion was to consider using code 199.1, if no other malignancy code was known.
- One person commented that this new code would shift data from 197.6 to the proposed code in the signs and symptoms chapter.

Assisted reproductive fertility procedure status
One person commented that it would be useful to include “in vitro fertilization (IVF)” as an inclusion term for proposed code V26.81, Assisted reproductive fertility procedure status.

Personal history of sudden cardiac arrest and TIA/cerebral infarction without residual deficits
NOTE: This topic was presented on Thursday, September 28, 2006. The following comments were offered:

- Dr. Laura Powers indicated that the acronym RIND is not used very often anymore.
- Dr. Powers also offered to check with the AAN regarding the correct code assignment for PRIND and RIND, whether it should be 436 or 434.91.
- One person suggested adding the word “underlying” to the proposed revision to the index entry for Death/cardiac, so it would read “code to underlying condition.”
- Another person recommended, at the index entry for Death/cardiac, to add entries for personal history and family history.

Acquired red cell aplasia
NOTE: This topic was presented on Thursday, September 28, 2006. There were no comments regarding this proposal.

Addenda comments:
NOTE: The proposed addenda changes were presented on Thursday, September 28,

2006 and the following comments were made:

- At tabular code 666.1, Other immediate postpartum hemorrhage, it was suggested to add “postpartum atony of uterus with hemorrhage” as an includes note.
- A default code was suggested at the proposed revision to the index entries for gastric antral vascular ectasia and watermelon stomach.
- At the proposed revision to the index entry for HGSIL, it was suggested to add the term “pap smear finding” as a nonessential modifier.
- There was a question regarding the proposed new entry for aborted cerebral infarction. Dr. Powers concurred that the index entry for aborted cerebrovascular accident should be 434.91 as presented on the addenda. She explained that these are patients admitted with a stroke, who get TPA. These patients have come in with signs of a cerebrovascular accident, but following intervention they usually have no symptoms.