ICD-9-CM Coordination and Maintenance Committee Meeting

Volumes 1 and 2, Diagnosis Presentations

September 27-28, 2007

SUMMARY

Below is a summary of the diagnosis presentations from the September 27-28, 2007, ICD-9-CM Coordination and Maintenance Committee (C&M) Meeting.

All proposals presented at this meeting are for consideration for implementation on October 1, 2008. Comments for all proposals must be received in writing (either via U.S. mail or e-mail) by December 3, 2007. Both the National Center for Health Statistics (NCHS) mailing 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 Wednesday and Thursday, March 19-20, 2008, at the CMS building, Baltimore, MD. Modification proposals for the March 20, 2008, meeting must be received no later than January 18, 2008.

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: https://www.cms.hhs.gov/apps/events/. On-line registration for the March 19-20, 2008 meeting will open on February 15, 2008, and participants must register by March 12, 2008. 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
September 27-28, 2007

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NCHS Classifications of Diseases and Functioning & Disability web page:
http://www.cdc.gov/nchs/icd9.htm

NCHS ICD-9-CM Coordination and Maintenance Committee web page:
http://www.cdc.gov/nchs/about/otheract/icd9/maint/maint.htm

ICD-9-CM Coordination and Maintenance Committee Meeting
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Welcome and Announcements

Please note: The topics that were presented on Thursday, September 27, 2007 are so noted in this summary.

Donna Pickett welcomed all in attendance to the diagnosis portion of the ICD-9-CM Coordination and Maintenance (C&M) Committee meeting.

The time line for diagnosis changes, included in the proposal packet, was reviewed. Important dates of note are December 3, 2007, the deadline for receipt of public comments for all proposals that are being considered for October 1, 2008, implementation. It was strongly recommended, to ensure timely delivery, that comments be submitted via email or express mail. No updates to ICD-9-CM are to take effect April 1, 2008. Proposals for consideration at the March 20, 2008, meeting must be received by January 18, 2008. Registration for the March 19-20, 2008 ICD-9-CM Coordination and Maintenance Committee meeting will open on February 15, 2008, and close on March 12, 2008.

A summary of this meeting as well as related 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 7 hours of continuing education awarded for each day of the two day 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 separate topic packet):

RETROLENTAL FIBROPLASIA
Patrick Romano, M.D., M.P.H., Professor of Medicine and Pediatrics at the University of California Davis and speaking on behalf of the Agency for Healthcare Research and Quality (AHRQ) Quality Indicator Team, which includes Battelle Memorial Institute, University of California, and Stanford, presented the clinical background for this topic. The PowerPoint slides are available in a separate file on the NCHS Classifications of Diseases and Functioning & Disability web site. Following his presentation and the proposed coding changes the following questions and comments were made:

- Jeffrey Linzer, M.D., representing the American Academy of Pediatrics (AAP), stated that the AAP is in agreement with the proposal but did suggest that the affected zone be indicated for each stage. He acknowledged that ICD-9-CM is not robust enough for that additional information and requested that the affected zone be considered for ICD-10-CM.
- Koryn Rubin, a Health Policy Analyst representing the American Academy of Ophthalmology made a suggestion to change the title of code 362.21 from retrolental fibroplasia to cicatricial retinopathy of prematurity since the former term is outdated. Retrolental fibroplasia could be retained in the index and as an inclusion term at this code.
- One person asked whether or not this was only a developmental problem or if it could result from an adverse effect of oxygen use, and if so, could these be distinguished. Dr. Romano indicated that there is still a debate among neonatologists as to the effect of oxygen on retiniopathy of prematurity, and noted that it would not be feasible to distinguish cases that involved a potential adverse effect from cases that were developmental.
- One participant asked why these codes were being added to this category in chapter 6 and not to the perinatal chapter (chapter 15). Since the code for 362.21 already existed in chapter 6 it was felt best to build the additional codes around it.
- One person thought the code titles should indicate which conditions are acute vs. chronic. Dr. Linzer commented that physicians will document retinopathy of prematurity and not whether or not it is acute or chronic. The only chronic condition in this proposal is that of 362.21, retrolental fibroplasia, which is scarring as a result of stage 2 or higher of this disease.

NECROTIZING ENTEROCOLITIS (NEC)
Patrick Romano, M.D., M.P.H., Professor of Medicine and Pediatrics at the University of California Davis and speaking on behalf of the Agency for Healthcare Research and Quality (AHRQ) Quality Indicator Team, which includes Battelle Memorial Institute, University of California, and Stanford, presented the clinical background for this topic. The PowerPoint slides are available in a separate file on the NCHS Classifications of Diseases and Functioning & Disability web site. Following his presentation and the proposed coding changes the following questions and comments were made:

- Jeffrey Linzer, M.D., representing the American Academy of Pediatrics (AAP), stated that the AAP is not in total agreement with this proposal. He stated that the AAP feels that there is no need to indicate the presence of pneumatosis with NEC since it does not affect management or resource utilization. They would rather see codes for the stages mentioned in Dr. Romano's presentation. He stated that this is what is being taught in residency now. He also suggested that there be an excludes note added for 008.45, Clostridium difficile, pseudomembranous colitis, to direct the coder to that code when it applies. Additionally he suggested removing the word "fetus" from the subcategory and codes.
- There was concern raised that documentation may not use terms related to stages, while the terms perforation and pneumatosis would be found.
- It was suggested to add a code for unspecified, for those times when the documentation does not indicate either the stage or pneumatosis. It was pointed out that proposed code 777.50 should handle this situation.
- One person stated that if the codes are changed to stage or left as proposed that inclusion terms should be added to indicate what is included at each code. It was suggested that pneumatosis could be an inclusion for stage 2.
- One participant suggested adding the ability to code short bowel syndrome associated with this since that would indicate more severe cases. NCHS responded that could be an issue for further consideration.

DISRUPTION OF OPERATION WOUND

Patrick Romano, M.D., M.P.H., Professor of Medicine and Pediatrics at the University of California Davis and speaking on behalf of the Agency for Healthcare Research and Quality (AHRQ) Quality Indicator Team, which includes Battelle Memorial Institute, University of California, and Stanford, presented the clinical background for this topic. The PowerPoint slides are available in a separate file on the NCHS Classifications of Diseases and Functioning & Disability web site. Following his presentation and the proposed coding changes the following questions and comments were made:

- One person commented that they thought the intent of code 998.31, Disruption of internal operation wound, was to track disruption of an internal suture line.
- Another participant asked for clarification as to whether or not this subcategory is intended only for suturing of surgically created wounds or suturing of lacerations or wounds.
- There was agreement that proposed code 998.30, disruption of operation wound (to include the NOS) was a good idea.
- It was suggested to review past coding advice given regarding wound disruption to make sure this proposal is not in conflict with that advice.
- A question was asked as to whether the inclusion terms listed at each code represented all possible types of disruption. Other examples suggested included tendon, ligaments and multiple layers of "full-thickness".

- One person asked whether it would matter it if was sutures or staples that were used, or any device. Dr. Romano responded it would include any closure device.
- Jeffrey Linzer, M.D., representing the American Academy of Pediatrics (AAP), stated that the AAP is in agreement with this proposal and also commented that in Volume 3 of ICD-9-CM (procedures) there is not much differentiation as to type of device used for wound closure.

NEUROENDOCRINE TUMORS

James C. Yao, M.D., Associate Professor and Deputy Chairman of Gastrointestinal Medical Oncology at the University of Texas M.D. Anderson Cancer Center, presented the clinical background for this topic. The PowerPoint slides are available in a separate file on the NCHS Classifications of Diseases and Functioning & Disability web site. Following his presentation and the proposed coding changes the following questions and comments were made:

- One person asked whether or not these tumors are like a solid tumor, that can metastasize. Therefore, should the primary or secondary site be also coded? The answer given was that yes you would code a primary and secondary site for these tumors.
- It was suggested by a participant to carefully review where unspecified (NOS) codes are needed in new category 209, Neuroendocrine tumors. It was noted that while there is a very high level of detail, the proposed classification is missing cases involving the duodenum or colon, not otherwise specified.
- One individual asked whether there would be a new column added to the table of Neoplasms for neuroendocrine tumors for each site. NCHS responded that the table of Neoplasms would be updated, as well as other areas of the disease index, as appropriate, to reflect any new codes created.
- A comment was made that it might be helpful for this proposal to see proposed index changes associated with the new codes.
- It was suggested to provide education to coders to help them clarify what are foregut, midgut, and hindgut. This could be done through an article in AHA Coding Clinic.
- One person asked why there is a code first instruction note at category 209 to code any associated multiple endocrine neoplasia syndrome (codes 258.01-258.09). This note concurs with the instruction given at theses codes (subcategory 258.0) to use additional codes for malignancies associated with this syndrome.
- It was suggested to add the word “lung” to the title of proposed codes that have “bronchus” in them, such as 209.01, Malignant carcinoid tumor of the bronchus.
- While support was given overall to the proposal, it was suggested to review carefully what would be included in proposed subcategory 209.8, Neuroendocrine tumor of other sites. There may be overlap with other subcategories in this proposal, involving “other” sites. A question was raised about benign and malignant being included together at 209.8, and whether this would also include uncertain

behavior. It was noted that this was not intended.
- NCHS staff and Dr. Yao concurred that a revised proposal was in order.

EOSINOPHILIC GASTROINTESTINAL DISORDERS

Glenn Furuta, M.D. representing the American Partnership for Eosinophilic Disorders (APFED) presented the clinical background for this topic. The PowerPoint slides are available in a separate file on the NCHS Classifications of Diseases and Functioning & Disability web site. Following his presentation and the proposed coding changes the following questions and comments were made:

- Jeffrey Linzer, M.D., representing the American Academy of Pediatrics (AAP), expressed concern that these codes would overlap with allergic causes. It can be hard to differentiate allergic and eosinophilic cases. It might be better to consider eosinophilic gastroenteritis and colitis under code 558.3, Allergic gastroenteritis and colitis. It was suggested to use two codes, one for allergic type and one for eosinophilic type.
- It was observed that there is not a code for an allergic type of esophagitis, in contrast to the case for gastroenteritis and colitis.
- One participant asked whether or not hemorrhage is associated with these conditions and Dr. Furuta answered yes. The same participant then pointed out that currently category 535 uses fifth digits to show hemorrhage so the proposed codes at that category would need to be re-assessed to reflect this. To account for this, the proposed new code for eosinophilic gastritis could be placed at 535.7. See the revised version, developed following the meeting, which is posted on the NCHS Classifications of Diseases and Functioning & Disability web site as a separate document (http://www.cdc.gov/nchs/data/icd9/topic_EGID_Sep07.pdf).

HEPARIN-INDUCED THROMBOCYTOPENIA (HIT)

Lawrence Rice, M.D. of The Methodist Hospital presented the clinical background for this topic. The PowerPoint slides are available in a separate file on the NCHS Classifications of Diseases and Functioning & Disability web site. Following his presentation and the proposed coding changes the following questions and comments were made:

- One participant asked whether this can occur with use of heparin even if previously use did not cause any problem or reaction. Dr. Rice indicated that this could happen.
- It was suggested to add a use additional code note to indicate the appropriate external cause code (E Code) for the drug, E934.2.
- One person asked why this condition was not kept at 287.4, Secondary thrombocytopenia. In response, it was noted that HIT is a hypercoagulable state not a hemorrhagic condition, so it belongs at 289.8, Other specified diseases of blood and blood-forming organs as proposed. It was suggested, therefore, that since the ICD-9-CM index sends “decreased platelets” to thrombocytopenia that there be an educational article regarding this condition such as in AHA’s “Coding Clinic for ICD-9-CM”.

EXTRAVASATION OF VESICANT CHEMOTHERAPY

Lisa Schulmeister, representing TopoTarget USA, Inc., presented the clinical background for this topic. The PowerPoint slides are available in a separate file on the NCHS Classifications of Diseases and Functioning & Disability web site. Following her presentation and the proposed coding changes the following questions and comments were made:

- It was recommended that this code not be limited to just chemotherapy. It was noted that various hyperosmolar agents can also cause injury with extravasation, including contrast agents, calcium, and D50 dextrose.
- A question was raised by a participant as to what drugs are considered vesicants. Lisa Schulmeister indicated that there are 15 chemotherapy drugs considered vesicants.
- One person suggested adding a use additional code note to code the appropriate external cause of injury code (E Code), E933.1 for antineoplastic drugs.
- There were comments about the options for the proposed location of the new code, with expansion at 999.2, Other vascular complications, being problematic since this is not properly as vascular complication. Expansion at 999.8 is problematic since this would not have been expected to be coded there previously; the title at 999.8 could be changed to make it "Other complications of transfusions and infusions." It is likely that a variety of codes have been used previously, possibly including 996.1 for mechanical complication of vascular device, and 999.9 for complication related to an infusion. One comment favored expansion at 999.9, for complication related to infusions and injections.

PRESSURE (DECUBITUS) ULCER STAGING

Joanne Lynn, M.D., M.A., M.S. of the Office of Clinical Standards and Quality at the Centers for Medicare and Medicaid Services presented the clinical background for this topic. The PowerPoint slides are available in a separate file on the NCHS Classifications of Diseases and Functioning & Disability web site. Following her presentation and the proposed coding changes the following questions and comments were made:

- Representatives from the Wound, Ostomy and Continence Nurses Society pointed out that once an ulcer reaches stage 3 or stage 4 it remains as such. Even if the ulcer heals it is considered a "healed" stage 3 or stage 4 ulcer, since scar tissue will be present. If it re-opens then it is referred to as a "re-opened" stage 3 or stage 4 ulcer.
- Many questioned how the present on admission (POA) indicator would be recorded. This is something that will need to be addressed in the POA guidelines. Some comments noted the issue of deep tissue injury. When such tissue injury is present on admission, the stage of the ulcer may not be immediately apparent on admission.
- One participant pointed out that since ICD-9-CM does not have the structure to allow coding the site and the stages as one code it is possible to have multiple decubitus site codes and stage codes and not know which stage matches up to which site. ICD-10-CM has the site and stage combined into one code.

- One person pointed out that the staging information is often in the nursing notes and that coders should be able to code the stage from that without querying the provider.

VENTILATOR-ASSOCIATED PNEUMONIA

Chesley Richards, M.D., M.P.H., Deputy Director of the Division of Healthcare Quality Promotion at the National Center for Preparedness, Detection and Control of Infectious Diseases (NCPDCID), Centers for Disease Control and Prevention presented, via telephone, the clinical background for this topic. The PowerPoint slides are available in a separate file on the NCHS Classifications of Diseases and Functioning & Disability web site. Following his presentation and the proposed coding changes the following questions and comments were made:

- It was suggested by one participant to keep other complications associated with ventilator use at code 999.9, Other and unspecified complications of medical care, not elsewhere classified, and to add appropriate excludes at each code (999.9 and proposed code 997.31) reflecting that.
- One person asked whether postoperative pneumonitis should be coded here as it is currently indexed. Dr. Richards indicated agreement that this condition should be indexed to proposed code 997.31, Ventilator-associated pneumonia.

ACANTHAMOEBA KERATITIS/FUSARIUM KERATITIS

There were no comments following presentation of this topic.

LIPID RICH PLAQUE

This topic was presented on Thursday, September 27, 2007. There were no comments following presentation of this topic.

LONG TERM CURRENT USE METHADONE

This topic was presented on Thursday, September 27, 2007.

- One person indicated preference for option 2 (do not create a new code) citing the need to preserve the last code in the V58.6 subcategory in case it is needed in the future.
- One participant suggested reviewing Coding Clinic coding advice and how dependence in remission is coded with this subcategory, which says that Methadone maintenance would generally be coded to category 304, Drug dependence.
- Another participant asked whether or not this code would include long term use of intrathecal pumps dispensing this drug.
- One participant noted that option 2 mixes this up with other drugs, so that it is difficult to follow these patients. Thus, a specific code would be useful.

WHEELCHAIR DEPENDENCE

This topic was presented on Thursday, September 27, 2007.

- There were some comments regarding whether this code could provide enough information to study wheelchair bound patients. There are many different levels of wheelchair bound people. Some are not as mobile as others. The level of mobility can be from those needing

total care, to those who are otherwise normal and able to care for themselves. More will be needed to document this fully.

NONTRAUMATIC HEMATOMA/POST-TRAUMATIC SEROMA

This topic was presented on Thursday, September 27, 2007.

- One person asked if this would include patients affected by long term current use of anticoagulants. The answer is yes. It was suggested that in such cases, it would be appropriate to also assign an E code for anticoagulants.
- The question was also raised as to how the terms contusion and bruise would be handled in relation to the proposed new codes.
- One participant asked why a post-traumatic seroma would not be coded to a late effect code.

ACQUIRED ABSENCE OF CERVIX AND UTERUS

This topic was presented on Thursday, September 27, 2007.

- There was general agreement expressed in favor of the proposed codes.

PROPHYLACTIC USE OF AGENTS AFFECTING ESTROGEN RECEPTORS AND ESTROGEN LEVELS

- It was noted that the proposal should be considered at a new subcategory V07.5, rather than V07.4, as written, since V07.4 already exists. The proposed new subcategory and codes, and the references to them in the accompanying text, have been updated to correct this in the version posted to the web.
- The question was raised whether cancer codes should also be listed at the use additional code note.

STAGED BREAST RECONSTRUCTION

Linda Holtzman, MHA, RHIA, of Clarity Coding, presented the background for this topic. The PowerPoint slides are available in a separate file on the NCHS Classifications of Diseases and Functioning & Disability web site. Following this presentation the following questions and comments were made:

- This proposal was well received and several people stated that they appreciated the detail of it.
- One comment suggested moving capsular contraction to proposed category 612, Deformity and disproportion of reconstructed breast.
- One person asked how to apply use of code V43.82, Breast transplant status.
- There were two comments favoring either proposed option 1 or option 2 since they remove the procedure language as well as their simplicity.
- It was suggested by one person to exclude code 778.7, Breast engorgement in newborn, from 611.1, Hypertrophy of breast. This same person suggested to leave the codes in new category 612 gender neutral and with no gender edits.
- It was suggested by a participant that the Society of Breast Reconstruction be contacted for comments on this proposal.

LEUKEMIA IN RELAPSE

There were no comments following presentation of this topic.

FEVER PRESENTING WITH CONDITIONS CLASSIFIED ELSEWHERE

- One person suggested that the title of subcategory 780.6, Fever, be changed to other disturbances of temperature and temperature regulation to accommodate patients who may have chills without fever (and also that chills be moved here, from 780.99). Chills can be important, as an individual may not be able to mount an immune response, to have fever. Additionally this person recommended excluding code 778.4, other disturbances of temperature regulation of newborn.
- Non-environmental hypothermia could also be included, possibly as another code.
- One person indicated she was in favor of the proposal.
- It was suggested to keep the coding of fever associated with vaccine separate at category 999, Complications of medical care, not elsewhere classified.
- Postoperative fever could also be included at proposed code 780.62.

ABNORMAL ANAL CYTOLOGIES AND ANAL INTRAEPITHELIAL NEOPLASIA (AIN)
There were no comments following presentation of this topic.

FUNCTIONAL URINARY INCONTINENCE AND FUNCTIONAL QUADRIPLEGIA
This topic was presented on Thursday, September 27, 2007.

- There were general questions regarding the definition of these two conditions.
- Laura Powers, M.D., representing the American Academy of Neurology (AAN), provided clarification that functional incontinence refers to a person who cannot get to the bathroom perhaps due to staff not responding quickly to their call. Functional quadriplegia is not paresis. It is the inability to move due to another condition (severe contractures, arthritis, etc) and functionally you are the same as a paralyzed person.
- One person expressed being in favor of the proposed codes as it was felt they would help assessment of long term nursing care. This person also pointed out that the documentation of this condition would likely be in the nursing notes.
- In general the meeting participants expressed being in favor of this proposal but asked that the guidelines and code first notes be carefully reviewed. For example, at the proposed code 788.91, Functional urinary incontinence, it could be important that excludes notes be clear that it is for urinary incontinence due to a urinary physiologic condition.

VULVAR VESTIBULITIS AND OTHER VULVODYNIA
There were no comments following presentation of this topic.

EXTERNAL CAUSE FOR OVEREXERTION, STRENUOUS AND REPETITIVE MOVEMENTS
Lt. Col Steve Bullock presented an overview of this proposal. Following his presentation the following comments were offered:

- One participant said there were some subjective terms in the

proposed new codes. Additionally there are no NEC or NOS codes. This participant also suggested waiting until activity codes are proposed before finalizing these proposed changes.

- One person said the codes could have legal situations associated with them such as overexertion in school sports and the coach does not remove the player.
- These codes could be used with injuries related to various sports, including football and tennis.
- These codes also might be applicable in cases of rhabdomyolysis.
- There was some discussion of the possibility of providing examples of activities that could lead to the specific conditions represented at each of the codes. However, it was noted that many activities can potentially involve injury due either to repetitive effect or to a single event.
- Other participants expressed agreement with the proposal to expand E927, Overexertion and strenuous movements.

PERSONAL HISTORY OF ANTINEOPLASTIC CHEMOTHERAPY AND MONOCLONAL DRUG THERAPY

- Laura Powers, M.D., representing the American Academy of Neurology (AAN), suggested leaving out the term "antineoplastic" since some of these drugs are used for treatment of neurological disorders. There are some monoclonal antibody drugs that are currently approved only for treatment of neurological disorders.
- Other participants suggested having a code for antineoplastic chemotherapy but also a code for other chemotherapy.

CONTACT WITH AND EXPOSURE TO MOLD

This topic was presented on Thursday, September 27, 2007. It is posted on the NCHS Classifications of Diseases and Functioning & Disability web site as a separate document (http://www.cdc.gov/nchs/data/icd9/topic_Mold_Sep07.pdf).

- One person expressed support for this proposal since this would help address environmental health concerns for children, sick building syndromes, and allergies to mold in individuals. He felt the pediatric population data would be helped with this code.
- There was one comment made that was not in favor of the new code. He said that since there are mold spores everywhere, it will be difficult to determine when it is significant to code.
- Another participant expressed support of the code as clinically significant and indicated that coders will use their judgment of when to code this based on physician's documentation.

SUSPECTED FETAL CONDITIONS NOT FOUND AND ANTENATAL SCREENING

- Jeffrey Linzer, M.D., representing the American Academy of Pediatrics (AAP), expressed disagreement with the proposed new category V89, Suspected fetal conditions not found, and suggested using subcategory V28.3, Screening for malformation using ultrasonics.
- Pam Kostanza speaking on behalf of the Society for Maternal and Fetal Medicine expressed the need for these codes to show the reason for visit for a test when the condition is then not found. She cited the example of "rule out ectopic pregnancy", the test is

performed and no ectopic pregnancy is found. She said it would be useful to know what the suspected condition was that brought the patient in for the test.

- One person expressed disagreement with the need for the proposed codes citing that, in their opinion, OP coding guidelines already instruct coders to code the symptom when a diagnosis has not been established (from the test).

CERVICAL SHORTENING

There were no comments following presentation of this topic.

SECONDARY DIABETES MELLITUS

- One person suggested reviewing the includes note for endocrinopathy as to whether this belongs in proposed category 249 or existing category 250.
- Many expressed that this proposal was "cleaner" and easier to follow than previous proposals.
- The audience was asked to comment on the potential inclusion of 5th digits for controlled and uncontrolled.
- One person stated that the documentation will not improve and questions will still be raised on how to code things such as: "not well controlled" and "poorly controlled".
- The Endocrine Society will be contacted regarding these comments.

NEWBORN POST-DISCHARGE HEALTH CHECK

- Jeffrey Linzer, M.D., representing the American Academy of Pediatrics (AAP), said that these visits are different than routine health screening. There are additional things to check for on an infant that is between 0-4 days old such as jaundice, and dehydration. After the initial 96 hours of life the concern is more with feeding and growth. Then after 30 days of life the visits are mainly for immunizations.
- One person suggested to include "weight check" as this is often seen in charts of these infants.

ANDROGEN INSENSITIVITY SYNDROMES

NCHS asked if there was general agreement and the audience responded as being in favor of the proposed codes.

HUNGRY BONE SYNDROME

This topic was presented on Thursday, September 27, 2007. NCHS asked if there was general agreement and the audience responded as being in favor of the proposed code.

ISOLATED SYSTOLIC HYPERTENSION AND ISOLATED DIASTOLIC HYPERTENSION

This topic was presented on Thursday, September 27, 2007.

- One person asked whether hypertension, NOS would still be coded to 401.9 and the answer is yes.
- A participant cited that current physician documentation does not match what is in this proposal and said the codes should not be created if this is not what physicians are currently putting in the

charts.

- A question was raised as to whether "isolated" referred to isolated from other readings. It was noted that "isolated" refers to the fact that only either the systolic or the diastolic blood pressure was abnormal.
- Another participant asked how the proposed code 401.4, Mixed systolic/diastolic essential hypertension is different from 401.1, Benign essential hypertension. The response given was that patients with code 401.1 may not have mixed essential hypertension, although there could be overlap.
- One participant cited that this information could be collected using CPT "F" codes, however this would only apply to outpatient coding.
- Two participants expressed that it would be better to collect "controlled" and "uncontrolled" hypertension rather than what is proposed here.
- It was suggested to get input from other medical groups since this requestor is specifically representative of a hypertension organization.
- A comparison was given to the changes that were made for heart failure, and congestive heart failure, with concern related to the documentation of the condition.
- One participant made a recommendation to hold off of the proposed changes, due to concern about lack of documentation, and concern that coders might try to assign the proposed codes based on blood pressures reported on the chart.

ADDENDA

The following comments were made regarding proposed addenda changes:

- One person expressed being in favor or the changes at 337.2x, Reflex sympathetic dystrophy, as this adequately represents complex regional pain syndrome.
- Dr. Powers suggested holding off on changing any indexing to cognitive deficit. The AAN is currently working on a proposal related to this topic, and related to traumatic brain injury.
- There was a comment regarding the proposed addition of "end of life" in the index. It was suggested to also consider "premature" vs. "routine" end of life of some of the devices listed.
- The term "worn out" could also be used. There was also a question of why defibrillators and neurostimulators were not included.
- It was noted that the entry "Twiddler's" should read "Twiddler's syndrome."
- It was suggested that the entries for "Vaccination / delayed" and "Delay… / vaccination" should default to the V64.00 for unspecified, and that appropriate entries should be given for each of the codes V64.00-V64.7, as well as V64.09.

ICD-10-CM UPDATE

- Donna Pickett announced that updated ICD-10-CM files have been posted to the NCHS Classifications of Diseases and Functioning & Disability website. The new files include the Tabular, Index, Table of Drugs and Chemicals and the new General Equivalence Mapping (GEM)

files. Rhonda Butler, of 3M HIS, provided an overview of the GEM files. Her PowerPoint slides are available as a separate file on the NCHS Classification of Diseases and Functioning & Disability website.