ICD-9-CM Coordination and Maintenance Committee Meeting

Volumes 1 and 2, Diagnosis Presentations

September 30, 2005

SUMMARY

Below is a summary of the diagnosis presentations from the September 30, 2005 ICD-9-CM Coordination and Maintenance Committee (C&M) Meeting. All proposals presented at the meeting are for consideration for implementation on October 1, 2006. Comments on this meeting's topics must be received in writing or via e-mail by December 2, 2005. Both the National Center for Health Statistics (NCHS) address and e-mail addresses of NCHS C&M 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 23-24, 2006 at the CMS building, Baltimore, MD. Modification proposals for the March 2006 meeting must be received no later than January 23, 2006.

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 2006 meeting will open on January 3, 2006 and participants must register by March 17, 2006. The registration will allow participants to register for each individual day of the meeting. Therefore, participants who wish to attend both days will be required to register separately for each day of the meeting. 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 30, 2005

Mailing Address: National Center for Health Statistics
ICD-9-CM Coordination and Maintenance Committee
3311 Toledo Road, Room 2402
Hyattsville, Maryland 20782
Fax: (301)458-4022

Donna Pickett: Room 2402 (301) 458-4200
E-mail: dfp4@cdc.gov

Amy Blum: Room 2402 (301) 458-4200
E-mail: alb8@cdc.gov

David Berglund: Room 2402 (301)458-4200
E-mail: zhc2@cdc.gov

Lizabeth Fisher: Room 2402 (301)458-4200
E-mail: llw4@cdc.gov

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

ICD-9-CM Coordination and Maintenance Committee Meeting
ICD-9-CM Volume 1 and 2, Diagnosis Presentations
September 30, 2005

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 2, 2005, the deadline for comments on proposals presented at this meeting. It was strongly recommended, to ensure timely delivery, that they be submitted via email or express mail. Proposals for consideration at the March 24, 2006 meeting must be received by January 23, 2006.

A summary of this 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.

ICD-9-CM Coordination and Maintenance Committee Meeting
ICD-9-CM Volume 1 and 2, Diagnosis Presentations
September 30, 2005

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

Mucositis
Patrick J. Stiff, M.D., representing Loyola University Medical Center presented a clinical overview of mucositis. His PowerPoint presentation is provided as a separate attachment to this summary. During his presentation he covered how oral mucositis differs from stomatitis. Stomatitis is a more localized, superficial inflammation, and generally less severe than oral mucositis. In oral mucositis due to antineoplastic drugs or radiation therapy, there is frequently damage to cellular DNA. He emphasized that oral mucositis is a particularly serious problem for bone marrow transplant patients. It can be serious enough to force the discontinuation of treatment. He requested that a unique ICD-9-CM code be created for oral mucositis, as well as for mucositis of all sites.

Dr. Stiff was asked if the terms stomatitis and mucositis are used interchangeably. He responded that stomatitis is an older term and that the term mucositis is the currently recognized term. He was also asked if it is possible to determine the cause of the mucositis due to the fact that it can be present in any immunocompromised patient and that there are several different types. He responded that the different types are generally drug specific, so it is usually possible to determine the cause.

Finally, Dr. Stiff was asked, based on his slide that explained the different stages of mucositis, if the codes should reflect that severity. He said that though the stage is important, due to the subjectivity of how different physicians stage patients, it would not be useful to create codes for the stages of mucositis.

Following his presentation the comments were:
- Support for the need for these codes, including a unique code for oral mucositis.
- A request not to lump oral mucositis with stomatitis.
- A suggestion to combine Option 2 codes in proposed new category 538, gastrointestinal mucositis, into one code rather than by individual sites.
- A recommendation to use Option 1 to preserve data integrity.

Dr. Stiff's presentation is available on the NCHS Classification of Diseases web site.

Acute and chronic gingival disease
Following the discussion of the topic Dr. Mark Reynolds, representing the requestor Delta Dental Plan Association, was asked what would the default be for plaque induced and non plaque induced as well as for acute and chronic. His response was that plaque induced and chronic would be the defaults.

Acute and chronic periodontal disease

NCHS staff informed the audience that the proposal as submitted by Delta Dental Plans Association had requested that current code 523.3, Acute

periodontitis, be retitled to read "aggressive periodontitis" and that this new code be expanded for localized and generalized disease. It was explained to the audience that changing an existing code title that has been in use for so many years was not generally done for statistical integrity, but that the proposal being presented had aggressive periodontal disease as an inclusion term under the existing code.

Dr. Reynolds, representing Delta Dental Plans Association, stated they are asking that the code title and term "acute periodontitis" be retired since they do not recognize the term acute periodontitis as it is no longer used.

It was suggested by several members of the audience that the code title be modified to read "aggressive periodontitis", and that separate fifth digit codes for acute periodontitis, and localized and generalized aggressive periodontitis be proposed.

Dr. Reynolds was asked which of the codes for aggressive periodontal disease would serve as the default. He will discuss this with the American Academy of Periodontology, as this is a complex issue.

Unsuccessful endodontic treatment
There were no questions or comments regarding this request.

Unsatisfactory restoration
Following the presentation on this topic the following questions were asked:

- How does proposed code 525.63, Fractured restorative material without loss of material, fit with the proposed new code (presented in April 2005) for cracked tooth?
  Dr. Reynolds responded that two codes should be used. It was then suggested by an audience member to add code also notes at each code.

- What is the meaning of "biologically incompatible with oral health" in proposed code 525.65?
  Dr. Reynolds responded that this refers to unacceptable contours causing problems with brushing which can lead to development of chronic lesions and bone loss. He said that this is also referred to as unacceptable contours and unacceptable morphology.

Severe sepsis
When beginning this presentation NCHS staff explained that the proposal was a compilation of the comments and suggestions made at the April C&M meeting, when an open discussion on sepsis and severe sepsis was held. The proposal is divided into several sections to make it easier to review, with each section to be considered independently of the others. It was emphasized to the audience that this is only a proposal and that no decisions on any other sections would be made until after the comment period.

Comments were as follows:
Proposal 1: Instructional notes for septic shock and code 995.94
There were no questions or comments on this proposal.

Proposal 2: Code title changes for codes under subcategory 995.9

- Joe Kelly, M.D. of CMS commented that this appears to link SIRS to sepsis. He questioned the need for these codes, since SIRS can be a component of most inflammatory and traumatic conditions.
- A commenter who identified himself as an intensive care physician stated that he felt these codes were excellent and had enabled him to properly classify his severely sick patients.
- Dr. Walter Linde-Zwirble, who had made the sepsis presentation at the April C&M meeting, agreed that the codes have been very useful. He supported Proposal 2, changing the code titles for codes 995.91 and 995.92 to read sepsis and severe sepsis. He requested that the list of excluded terms under the proposed excludes note separate out each line, instead of having them combined as the proposal showed.
- Another comment was that physicians are not taught to separate SIRS from sepsis and the suggestion was to just have codes for sepsis and severe sepsis and not SIRS.

Proposal 3: Revision of current instructional notes
The comments were:

- Any solutions to coding sepsis and SIRS should be straight forward and consistent.
- Expand the proposed list at code 995.93, for underlying conditions.
- Severe sepsis could be caused by trauma and coding it first should be optional.
- Proposals #2 and #3 could act together and proposal #3 does not add increased coding clarification.
- It should be considered how this proposal could impact data.

Proposal 4: Sequencing of sepsis and the underlying condition
The comments were:

- Since this proposal will allow 995.9 codes to be coded first, there will be a data shift from code category 038.
- Year 2002 data showed that a code from category 038 was assigned as principal diagnosis in about 341,000 discharges. While nearly half of these were sepsis not otherwise specified, most do have some further information in the diagnosis. There were over 40,000 cases with staph aureus septicemia as principal diagnosis, and over 40,000 cases with gram negative sepsis as principal diagnosis. This information would be entirely lost in the principal diagnosis, if this were changed as shown.
- It is unclear if the statistics that reflect 038 codes having been coded as principal diagnosis reflect the true severity of patients with sepsis.
- Keep the code first note under infectious caused SIRS. Coding the underlying infection helps reflect the illness of the patient.
- For sepsis, 995.91, it would be reasonable to use the 038 code first. However, for severe sepsis, 995.92, it would be appropriate to be able to code it first.
- Code 995.91 should have its title changed to sepsis.
- These changes are good for quality improvement and resource management of treatment for this disease.

- Category 995 codes need to be allowed as principal since it helps show the wide spectrum of this illness and how patients are being managed.
- Opposition to any change of sequencing for the SIRS / sepsis codes was expressed by multiple people.

Proposal 5: Sequencing of severe sepsis and the acute organ dysfunction

- There were many comments on this proposal, the majority of which were against sequencing organ dysfunction before the 995 codes.
- A specific comment was that implementing this proposal would not be in keeping with the definition of principal diagnosis.
- This proposal was based on sequencing an acute condition before the underlying cause, particularly in cases where it is life threatening.
- Several comments were made that the sequencing of acute respiratory failure has been the biggest problem with these codes due to the reimbursement factor.
- It was suggested that acute respiratory failure could be permitted as principal diagnosis, while leaving the other acute organ failures as secondary only codes. However, there was opposition from multiple people to making an exception for a single organ dysfunction.

Proposal 6: Sequencing of septic shock

The comments were:

- Resource audit contracts (RACs) are going to be focusing on review of Medicare data in areas of sepsis. If the C&M process changes these rules many times, it could affect this review since the data will be inconsistent, and the reviewers will not necessarily be familiar with Medicare data. It is important to keep rules consistent from year to year.
- Multiple people opposed sequencing a symptom before a definitive diagnosis. However, it was noted that septic shock is a definitive diagnosis.
- The question was raised as to why septic shock was a symptom code. The response to this from the NCHS staff was that the septic shock code was implemented only a few years ago, and it was added under the code in which it had previously been included, which was a symptom code.
- Coding septic shock is important, clinicians recognize this, and it is more likely to be documented.
- One comment was that the big issue is the lack of documentation from physicians in this area. A response to this was that it generally will be documented if it is present.
- Dr. Walter Linde-Zwirble explained that presence of septic shock implies severe sepsis, so that the severe sepsis code does not add additional information.
- Support for coding septic shock separately, without need for an additional severe sepsis code, was expressed.

<u>Major osseous defects</u>

- The one comment for this proposal was to consider adding periprosthetic fracture to the code first note, since it is known that it is a major cause of this defect.
- Support for this proposal was expressed by at least one attendee.

<u>Family history of colon polyps</u>

- It was suggested that this code be added at V18.5, Family history of digestive disorders, rather than V19.8, Family history of other condition.
- Support for this proposal was expressed by at least one attendee.

Takotsubo syndrome
There were no questions or comments regarding this request.

Familial Mediterranean Fever
There were no questions or comments regarding this request.

Central pain syndrome, postoperative pain
NCHS staff made this presentation, explaining that this was a revision to the pain proposal presented at the April C&M meeting. It brings together the suggestions made following the April presentation.
The following comments were made:

- There were many comments in support of a code for postoperative pain, though there were concerns expressed by many that the code could potentially be overused or misused.
- It was suggested a code for postoperative pain only be permitted as a reason for admission code. This was not viewed as workable by others, because postoperative pain is often the reason a patient remains in the hospital, so it may be needed as a secondary diagnosis.
- Instructions for the appropriate use of the code were requested.
- The question was asked, how long should pain be deemed postoperative?
- Dr. Laura Powers, representing the American Academy of Neurology, strongly supports the new proposed code for central pain syndrome. She agreed that a code for postoperative pain is needed, but another code for chronic pain is also necessary. She questioned whether these codes should be in the nervous system chapter, or in the symptom chapter. She prefers to keep available categories in the nervous system chapter for future use.
- There were several additional comments in favor of a code for chronic pain.
- It was suggested that 5th digits for site of pain be considered for the pain codes.
- There were several comments that generalized pain is probably better in the symptoms chapter because it is a nonspecific term.

Newborn post discharge check
The comments were:

- Consider adding “newborn 48 hour post discharge exam” as inclusion to distinguish it from the routine child/infant check. Dr. Linzer, representing the American Academy of Pediatrics, commented that the immediate post discharge period varies in number of days post discharge, so it would be inappropriate to limit it to 48 hours.
- Following Dr. Linzer’s remarks there was the comment that some type of limit on the code would be helpful, even if it wasn’t as specific as a set timeframe.

Attention to surgical dressings and sutures
The comments were:

- Add clarification to the code first note since this code is already in the aftercare category.
- Would removal of packing fall in these codes? What about removal of drains? The audience agreed that removal of packing would be appropriate here (V58.31), but not removal of drains.
- AHIMA representative Sue Bowman stated that AHIMA supports these proposed codes. She added that current code V58.3 is misused. She asked if the inclusion term "nonsurgical dressing change" could be added to proposed code V58.30. She was asked if she feels the code title for the code could be "nonsurgical dressing change," and allow this to be the default code. She agreed that that would be an acceptable idea, because it should be the case that the coder is aware of the type of dressing change.

Intrauterine hypoxia and asphyxia

Proposal 1:

- Dr. Linzer, representing the American Association of Pediatrics, commented that the purpose of the proposal was to bring the terminology in the classification up to date. The old terms would remain in the index.

Proposal 2: Dr. Linzer spoke in favor of this, and all of the Intrauterine hypoxia and asphyxia proposals. There were no other comments.

Proposal 3: There were no additional comments or questions on this proposal.

Proposal 4:

- Option 1:
  - In response to a question on whether the term "birth asphyxia" would still be indexed, NCHS staff responded that yes, it would remain indexed.
  - Regarding what to do if the documentation does not say mild, moderate, or severe, and what is the most common, Dr. Linzer responded that mild is more common.
  - When queried about creation of a default or an NOS code, Dr. Linzer recommended an unspecified code, but he will check with neonatology specialists.
  - Dr. Linzer spoke in favor of option 1.
- Option 2:
  - Concern was expressed that this would create a code with an overlap in meaning with the existing birth asphyxia codes. However, it was noted that the meaning is not exactly the same.

Proposal 5: There were no additional comments or questions on this proposal.

Proposal 6:

NCHS staff advised the audience that the background statement for this proposal was incorrect. The proposal is to revise the code title for 775.7 and add an inclusion term, not create a new code.
The background statement has been corrected in the topic packet.

There were no comments on this proposal.

Proposal 7:
At the end of the discussion on the topic Dr. Linzer stated that the AAP recommends changing existing code titles.

Mild cognitive impairment
John Hart Jr., M.D., representing the American Academy of Neurology, presented an overview of the clinical aspects of mild cognitive impairment. His PowerPoint presentation is provided as a separate attachment to this summary. Comments regarding the proposal included:

- Most diseases that have "mild" in the name also have a "moderate" and "severe" form of the disease; regarding whether that would be the case for cognitive impairment, Dr. Hart responded that no, moderate and severe forms of cognitive impairment would be considered dementia and Alzheimer's disease.
- Following Dr. Hart's response there were many comments expressing concern about the use of the term cognitive impairment to mean many different things. There was concern expressed that this condition may not be coded accurately due to this terminology problem.
- Dr. Hart acknowledged that the term mild cognitive impairment is not the most precise, but it is the term that has been established in the neurologic community for a specific clinical entity, so that is what the code does need to be titled.
- The question was asked whether mild cognitive impairment would be considered a late effect of CVA.
- Dr. Hart explained that it is not a vascular condition, so it should be excluded from category 438. He did add that it is often found in combination with vascular disease and mental health disorders.
- It was suggested to change the title of the proposed code to "mild cognitive impairment, so stated" to take care of the "cognitive impairment" issue.
- Dr. Hart also added that 780.93 is different, since you don't have to have memory loss to have mild cognitive impairment, and that it is not a type of amnesia.

Dr. Hart's presentation is available on the NCHS Classification of Diseases web site.

Altered mental status

- There was agreement from the audience that this would be a useful code.
- It was requested that an inclusion term "change in mental status" be added to the code. This has been added to the proposal in the topic packet.
- Dr. Laura Powers, representing the American Academy of Neurology, clarified why there is an excludes note for altered level of consciousness in the proposal. Altered mental status is a common reason for neurology consultation, and it is not related to the level of consciousness. That is why level of consciousness (codes from subcategory 780.0) were excluded from the proposed new code.

Hematology/Aplastic anemia/Myelofibrosis

- Following the presentation of the topic by NCHS staff, Dr. Linzer expressed support for the changes, but asked that Monocytosis and Plasmacytosis be given unique codes as the AAP had requested in a

comment letter for the April 2005 C&M meeting. He also asked for an excludes note, excluding the 288.5 codes from the 288.8 codes, to require coders to select a more specific code.

Complex febrile seizure

- Dr. Laura Powers, representing the American Academy of Neurology stated the Academy agrees there is a need to have proposed code 780.32, Complex febrile seizure. However, she did not think it would be appropriate to use it as a secondary code with an epilepsy code, only for cases where the epilepsy code would not apply. She did not agree with the code first note to code first any form of epilepsy. She explained that if epilepsy is present, a code for febrile seizures is not necessary.
- In response to the question, when is a patient a complex febrile convulsion patient and when does a patient become an epilepsy patient, Dr. Linzer explained that complex febrile seizure patients are admitted and usually have a neurology consultation. It is an acute presentation, not a long term diagnosis. Epilepsy is a chronic condition.
- Dr. Linzer was also asked if it is possible to have a febrile seizure after the age of 5. He said it would be atypical with no other etiology.

Torsion of appendix testis

- Stephanie Stitchcomb, representing the American Urologic Association (AUA) requested that the proposed codes be reordered, placing torsion of epididymis last at 608.24, as it is the least common of the conditions.
- There were several requests to add an inclusion term for tunica vaginalis to distinguish these codes from female specific codes.

Lower urinary tract symptoms

- It was requested that the term Lower urinary tract symptoms (LUTS) NOS be added to the classification. This is a term frequently seen in urology records now.

Cervical stump prolapse

- There were no questions or comments for this proposal.

Cytologic evidence of malignancy

- There were no questions or comments for this proposal.

Encounter for testing of male partner of habitual aborter
The comments were:

- Make sure there is a code for other genetic testing for nonprocreative management, such as testing children, and add appropriate excludes notes between the two. The audience was reminded that codes for nonprocreative genetic testing were presented in April and the appropriate excludes notes were part of that proposal.
- A request that the code titles be modified to read more logically.

Estrogen receptor status

- There were no questions or comments on this proposal.

Complications and personal history of in utero surgery

When presenting this proposal NCHS staff explained that code V15.21 is to be used for the mother, and code V15.22 is to be used to indicate that the patient was the fetus operated on in utero. The audience was asked for suggestions on better code titles for this. A suggestion offered was "history of surgery as fetus".

Fifth digit title changes for categories 403 and 404

The comments were:

- Get rid of the 5th digit codes since category 585, chronic kidney disease (CKD), gives the stage of CKD. Keep it simple.
- For data studies information is lost for the principal diagnosis when a secondary code is needed.

Inflammation of post-procedural bleb

There was a question on which code would be the default if the stage is not known.

Optic nerve hypoplasia

Dr. Laura Powers stated that since the optic disc is the end of the optic nerve, the code could potentially be placed in either subcategory 377.4 or subcategory 377.2. Since the term is "optic nerve hypoplasia," subcategory 377.4 might be considered.

Addenda comments:

- How do you code neutropenic fever with pancytopenia? See April 2005 proposal.
- Are tachygastria and gastroperesis the same? Dr. Linzer said they are not the same.
- For code 780.6 take out "such as with" in the code first note. Instead, suggested phrasing was "code first the underlying conditions when present"
- On body mass index, Dr. Jeffrey Linzer, representing the American Academy of Pediatrics, emphasized their support for pediatric BMI codes which were proposed at the April 2005 meeting.
- Regarding "crying, constant" vs. "crying, excessive," the code for child should be 780.95, not 780.92. An error on this was corrected on the topic packet addenda.
- Concern was expressed regarding the proposal to index mild hyaline membrane disease to code 770.6.