ICD-9-CM Coordination and Maintenance Committee Meeting

Volumes 1 and 2, Diagnosis Presentations

May 18, 2001

SUMMARY

Below is a summary of the diagnosis presentations from the May 18, 2001 ICD-9-CM Coordination and Maintenance Committee Meeting. Comments on this meeting's topics must be received in writing or via e-mail by January 10, 2002. Both the NCHS address and e-mail addresses of C&M staff are listed below. HCFA prepares a separate summary of the meeting for procedures issues.

The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled to be held Thursday and Friday, November 1-2, 2001 at the Health Care Financing Administration building, Baltimore, MD. Modification proposals for the November 2001 meeting must be received no later than September 1, 2001.

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

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Welcome and Announcements

Donna Pickett welcomed all in attendance to the diagnosis portion of the C&M meeting.

Final changes are being made to the ICD-10-CM tabular and index.

The ICD-9-CM diagnosis addenda, effective October 1, 2001, will be made available to the American Hospital Association (AHA) next week. AHA will then send the addenda out to interested parties. It will also be posted on the NCHS web site.

A summary of today's meeting as well as the PowerPoint presentation made by Dr. Laura Powers will be posted to the NCHS web site within a few weeks.

Changes to ICD-9-CM resulting from the topics discussed today, if approved, would become affective with the October 1, 2002 addenda.

The proposal entitled "Encounter for high-dose interleukin-2 (IL-2)administration" has been withdrawn at the request of the originator.

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

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SUMMARY OF COMMENTS AND DISCUSSION OF VOLUMES 1 AND 2 TOPICS

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

Critical illness neuropathy

Laura Powers, M.D., representing the American Academy of Neurology, presented this topic. One participant asked whether one could make the assumption that if a patient was in a critical care unit and had a diagnosis of neuropathy they are suffering from critical illness neuropathy. No, usually a neurologist is consulted to evaluate a patient to determine if they have this condition.

Heart failure

There was much discussion following the presentation of this topic. Concerns were mostly that physicians will not document the specific type of heart failure and therefore the non-specific codes will be used most. Is it really worth new codes then? There would need to be education for physicians as to the coding change so they would be aware that more specific information can be collected about heart failure. One physician stated that this would be an example of ICD-9-CM being “ahead of the curve” because new internists are being instructed on how to determine which type of heart failure the patient has and how that specific diagnosis affects the treatment given to the patient. Documentation will improve as these new physicians enter the field and ICD-9-CM will be ready for that. A representative of Kaiser Permanente, one of the originators of this request, stated that they suggested this coding change to assist them in developing population based patient care. Their physicians want to document the specific type of heart failure but since it cannot be coded they do not. It was suggested that it would not be necessary to have acute vs. chronic since patients are not usually admitted to the hospital for congestive heart failure unless it is acute. Others pointed out that coding acute and chronic in the physician’s offices and outpatient clinics is useful to track the patient’s disease process and treatment. Additionally, if the patient has this diagnosis as a secondary diagnosis in the hospital it can be useful to know what type of heart failure the patient has and whether it is long standing or not. Participants were encouraged to review the proposal carefully and submit comments as to whether they thought the

number of codes could be reduced without losing the concept of the proposal.

Gene carrier status
Participants were concerned that the limited number of V codes still available for expansion in ICD-9-CM would be used up quickly if a carrier status code is assigned to every gene related disease. The codes in the new V83 category (Gene carrier status) are intended to be for those which show carrier status only and not those that a patient could subsequently develop. It is only intended to be used for diseases which have the potential to be passed on, genetically, to the next generation. Others were also concerned about the ramifications of giving this information to payers. Codes already exist which have the same potential privacy ramifications. This is being addressed separately as a privacy issue.

Coronary atherosclerosis in heart transplant patients
A suggestion was made to change the code title to read “Coronary atherosclerosis of coronary artery of transplanted heart” to eliminate confusion as to whether we are talking about a transplanted artery or heart. This same concept could be coded using V43.2 and the appropriate atherosclerosis code thus eliminating the need for a new code.

Ocular torticollis
There were no comments about this proposal.

Supplemental oxygen dependency
There were no comments about this proposal.

Personal history of pre-term labor
The need for the V13.21 code (for the non-pregnant woman)was questioned. Participants from physicians offices and clinics felt that the V13.21 code is necessary to track patients and help to provide pregnancy counseling. It was suggested to add an excludes note at V13.21 for pregnant patients (to use code V23.41).

Fussy infant\excessive crying of infant
Participants asked if there were definitions for “fussy”, “excessive crying” and “infant”. According to the requestor, the

American Academy of Pediatrics, this diagnosis is used by physicians when no cause is found for the symptoms. Infant is usually defined to be patients less than 12 months old but the AAP will be consulted for a definition.

Aqueous misdirection
There were no comments about this proposal.

Disruption of operation wound
A question was asked whether external wound would be assumed if it were not documented in the record. This would be set up in the index that way, however, it's more likely that there would be documentation as to the type of wound. It was also suggested to review codes which exist for disruption to surgical wounds of specific organs, for possible overlap and need for exclusion notes.

Dieulafoy lesion
It was suggested to have separate codes for the lesion with vs. without hemorrhage. Since hemorrhage is the presenting symptom for this diagnosis it will be added as a non-essential modifier. Additionally, it was asked whether you would code both the lesion and the hemorrhage or whether the hemorrhage is included in the code. The hemorrhage would be included in the code. It was also suggested to have an excludes note at the intestine code for duodenum (sending the coder to the stomach and duodenum site).

Scooter external cause code
There were no comments about this proposal.

Perinatal conditions
Five separate proposals for code changes for perinatal conditions were presented.

Persistent fetal circulation
There were no comments regarding this proposal.

Other respiratory conditions of fetus and newborn
A question was asked regarding the difference between respiratory failure and transient tachypnea of newborn (TTN). TTN is a more serious condition that does resolve. The respiratory failure is

a hyaline membrane disease. John Muldoon, representing the National Association of Children's Hospitals and Related Institutions (NACHRI), stated that these are different conditions with TTN being the more serious of the two.

Other infections specific to the perinatal period
It was suggested to change the code title for the proposed code 771.82 to be similar to the rest of the subcategory. It was also pointed out that some neonatologists use septicemia and bacteremia interchangeably.

Neonatal cardiac dysrhythmia
There is no way to code these conditions now. It was suggested to add excludes notes at their equivalent adult codes. It was also suggested to create a code 779.89 for other conditions currently in the 779.8 code.

Weeks of gestation
A question was asked whether you could use more than one code in the 765 category on the same chart. Yes, because one code describes the birth weight information while the other describes the gestational age information. Some participants were not sure if the proposed code 765.3 Nonviability of newborn due to extreme immaturity was necessary. It was suggested to use the extreme immaturity codes only. It was pointed out that you cannot base information only on gestational age. Some premature newborns are developed enough to survive while others have the gestational age but are not fully developed and cannot survive. Weeks of gestation is very important information which helps predict the probability of developmental problems later.

Torus fractures
There were no comments regarding this proposal.

Aftercare codes
Roslyn Laakso, R.H.I.T., CCS-P, representing the Long-Term Care Section of the American Health Information Management Association (AHIMA) presented this proposal. Discussion centered around defining convalescence vs. aftercare and whether to expand either V54 (other orthopedic aftercare)or V66 (convalescence and palliative care) or both. Participants felt it was important to have more detail as to the location of the healing fracture

(maybe upper leg, lower leg, upper arm and lower arm). Most felt that the V54 category should be expanded now and continue to work on the definition of V66. Additionally, changing the titles in the V66 category will help everyone to understand that only V66.7 is to be used for palliative care. It was suggested that the aftercare concept for conditions besides fractures needs to be addressed also, especially for open wound care. One participant stated that currently the home health industry PPS regulations state that for open wound care they are to use the acute care diagnosis code which led to the open wound (such as appendicitis if it is an appendectomy wound). Also, currently V codes are not allowed in the OASIS database. These issues are being addressed separately and should not affect the proposed changes to V54 or V66. Participants were encouraged to review this proposal carefully and provide their comments as it will greatly impact data collection. The comments will be reviewed and a revised proposal will most likely be presented at the November C&M meeting.

Excludes notes for ICD-10-CM

Most attendees agreed that there is more than one meaning to the excludes notes depending on what code they are in and what they are excluding. Participants suggested having a different name for “excludes 2" because it still leaves two meanings to one word. Suggestions included “does not include”, “assign separate code if present”, “condition to code when present”. It was noted that care must be used to avoid overlapping existing concepts such as “use additional code” and “code first” notes. Again the participants were encouraged to submit comments regarding this concept.

Addenda

There were no comments regarding the proposed addenda changes.