ICD-9-CM Coordination and Maintenance Committee Meeting

Volumes 1 and 2, Diagnosis Presentations

October 8, 2004

SUMMARY

Below is a summary of the diagnosis presentations from the October 8, 2004 ICD-9-CM Coordination and Maintenance Committee (C&M) Meeting. Comments on this meeting's diagnosis topics must be received in writing or via e-mail by January 12, 2005. Both the NCHS address and e-mail addresses of NCHS C&M staff are listed below. CMS prepares a separate summary of the meeting for procedures issues.

The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled for Thursday and Friday, March 31-April 1, 2005 at the Centers for Medicare and Medicaid Services (CMS) building, Baltimore, MD. Modification proposals for the March-April 2005 meeting must be received no later than January 31, 2005.

C&M Visitor List Notice

Because of increased security requirements, those who wish to attend a specific ICD-9-CM Coordination and Maintenance Committee meeting in the CMS auditorium must register using the on-line events registration on the CMS website at: http://www.cms.hhs.gov/events/. This will be open for registration beginning January 3, 2005. Participants must register by March 25, 2005. A visitor list will be generated from this registration website and will be at the front desk of the Centers for Medicare and Medicaid Services (CMS) and used by the guards to admit visitors to the meeting. Those who attended previous ICD-9-CM Coordination and Maintenance Committee meetings will no longer be automatically added to the visitor list. You must register prior to each meeting you attend.

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

ICD-9-CM Coordination and Maintenance Committee Meeting
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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.

Donna announced that the revised ICD-9-CM Official Guidelines will be posted to the NCHS Classifications website later this month. She also reviewed the requirement for twice yearly new code updates. If any proposals are submitted with a strong and convincing case to be implemented due to new technology then the codes would become affective on April 1, 2005. There were no topics presented today that met that criteria.

The time line for diagnosis changes, included in the proposal packet, was reviewed. Changes to ICD-9-CM resulting from the topics discussed today, if approved, would become effective on October 1, 2005. New proposals must be received at NCHS by January 31, 2005 to be considered for presentation at the April 1, 2005 meeting. Comments for today's meeting topics are due by January 12, 2005 and it was strongly recommended, to ensure timely delivery, that they be submitted via email or express mail.

There is an erratum to the October 1, 2004 addenda which will be posted to the NCHS Classifications web page in the next few weeks.

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

ICD-9-CM Coordination and Maintenance Committee Meeting
ICD-9-CM Volume 1 and 2, Diagnosis Presentations
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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):

Mechanical complication of joint prosthesis
Kevin J. Bozic, M.D., M.B.A., from the University of California at San Francisco, presented an overview of joint replacement therapy and reasons for their failure. Following presentation of the proposed ICD-9-CM tabular changes it was suggested to add a use additional code note to existing code 996.66 (to code the specific joint using V43.6x). Suggestion was made to somehow include complications due to osteolysis since it is the most common cause of aseptic loosening. Question was raised as to whether it is currently allowed to use the V codes with a complication code. These guidelines will be reviewed. One audience member recommended changing the title of proposed new code 996.43 to Failure of prosthetic joint, from fracture, to better differentiate the prosthetic joint breaking from fracture of the bone (as in a peri-prosthetic fracture).

Diabetic retinopathy, diabetic macular edema, and diabetic peripheral neuropathy
Matthew J. Sheetz, M.D., Ph.D., representing Eli Lilly and Company, presented the background information for diabetic retinopathy. Dr. Kelly from CMS raised concern about the potential subjectivity of the terms mild, moderate, and severe, with diabetic retinopathy, and whether visual loss could be used instead. In response, Dr. Sheetz noted that these are specific, and can be identified on slit lamp examination or on a good direct eye examination. It was suggested to create an "unspecified" code; however, Dr. Sheetz stated that in absence of documented specificity, the index should default to the "mild" code. It was suggested that the American Academy of Ophthalmology be consulted prior to any action on these proposed codes. The code first note under code 362.06 was discussed and found to be difficult since it is suggesting sequencing of a secondary diagnosis. In addition, the code range in that note should be 362.01-362.05 rather than 362.01-362.06.

Edward J. Bastyr, III, M.D., representing Eli Lilly and Company, presented the diabetic neuropathy topic. Dr. Laura Powers, representing the American Academy of Neurology (AAN), stated that the Academy is in the process of approving guidelines for the diagnosis of neuropathy and that the definitions included in Dr. Bastyr's presentation do not match the academy's proposed guidelines. She also stated the term "disabling" is very subjective and should not be part of the code title. It was suggested, by several participants, that these code revisions should be held until the AAN finalizes their guidelines. It was further suggested to take into account input from the American Diabetes Association, American Medical Association (AMA) and American Academy of Family Physicians (AAFP) as well as the AAN.

Acute coronary syndrome
Sandra Sieck representing Sieck HealthCare Consulting and Dr. William French presented background information on this topic. There was lengthy discussion regarding whether to change the code titles at this category (410) or, as suggested by several attendees, to include STEMI and NSTEMI as inclusion terms, in the tabular, as well as modify the index. Dr. Kelly from CMS noted

that the criteria given are defined on EKG, and raised the issue of whether other studies might be used for defining MI. It was noted that EKG remains very important in determining treatment. Also, troponins or CK-MB would be used to differentiate cases of NSTEMI from unstable angina. The question was raised as to how STEMI and NSTEMI differ from Q wave and non Q wave MI. It was noted that while these can be similar, with current treatment using revascularization or thrombolytics, it is possible to have a STEMI that results in a non Q wave MI. Also, Q waves appear much later, and it is useful to have the classification use terms for the acute finding of ST elevation, which is present on or close to admission.

Chronic kidney disease

Leslie Stevens, M.D., representing the National Kidney Foundation and Richard Hamburger, M.D. representing the Renal Physicians Association presented background information on this topic. There was some discussion as to how to distinguish and where to place the different stages of renal disease. It was further suggested that two proposals be presented at the April 1, 2005 ICD-9-CM C&M meeting. There were many comments regarding the titles for proposed codes 585.5 and 585.6 with the only difference being the use of dialysis and that diagnoses should not be linked to procedures. There was additional concern that the timeframes (in the proposed note) would not be easily identifiable by the coders. This may be something the physician knows but it may not always be documented. Dr. Hamburger commented that the anemia code which refers to end stage renal disease (ESRD) could have instead used the term chronic kidney disease (CKD).

History of fall

Laurie Feinberg, M.D., from the Centers for Medicare and Medicaid Services (CMS) presented this topic for discussion. Dr. Laura Powers, representing the American Academy of Neurologists voiced support for this code since it would also be used by physical therapists to help identify those patients who may be at risk for future falls.

Bed confinement status

Nellie Leon-Chisen of the American Hospital Association presented this topic for discussion. There were no comments regarding this proposal.

Insomnia, hypersomnia and sleep apnea

Bart Sangal, M.D., representing the American Academy of Sleep Medicine presented background information. One comment was that idiopathic insomnia and primary insomnia (both proposed to be included in new code 307.42) are not synonymous. The American Academy of Neurology (AAN) recommended placing primary insomnia at category 349, Other and unspecified disorders of the nervous system. The same comment was made about the placement of both idiopathic hypersomnia and primary hypersomnia at proposed new code 307.44. Again, the primary should be placed at category 349. The AAN also raised the issue of the placement of the proposed new code 349.32, Insomnia due to mental health condition; Dr. Powers noted that this could have been proposed to chapter 5 (Mental disorders), but the placement at category 349 was fine from the AAN standpoint. It was also suggested to remove the word "organic" from the titles at proposed new subcategory 349.5, Organic sleep apnea since sleep apnea is always organic.

Androgen insensitivity syndrome

One comment was made as to whether the items currently listed under existing code 257.8, should be added as inclusion terms to proposed new code 259.5 or just index them to this new code. Since the terms currently listed under existing code 257.8 are considered obsolete it was suggested that they be indexed to the new code, however, not to list them at the code.

Volume depletion, dehydration, hypovolemia

There were no comments regarding this proposal.

Asphyxia and hypoxemia

There were a few comments regarding how to index different causes of asphyxia such as suffocation. NCHS will check into this further.

Teratogens

It was suggested, by the AAN, to list those drugs that are the "biggest offenders" as inclusion terms. For convulsants these drugs would include Depakote and Dilantin. However, it was also suggested that only generic drug names should be listed and not trade names.

Long Q-T syndrome

One commenter stated that their physicians frequently record "prolonged QT" and wanted to know whether this would be indexed to this new code or to the EKG finding code. NCHS will check into the proper placement of this.

Secondary diabetes mellitus

It was suggested to also create a new code for diabetes due to a drug (such as steroids) as this currently is indexed to code 251.8, Other specified disorders of pancreatic internal secretion. Another comment suggested adding a code also note for V58.67, Long-term (current) use of insulin. Since these patients can also develop manifestations similar to those of primary diabetes mellitus patients, comments were invited as to whether or not those manifestation codes should be used with this new proposed code. The general opinion was that they should be able to be used with this new code.

Mechanical complication of ventilator

A question was raised as to why this code was proposed as a complication and not just as another V46.1x code. A suggestion was made to change the title of code V46.12, Encounter for respirator dependence during power failure, to reflect all mechanical failures of respirators, rather than create a new code at 997.3. Another commenter stated that the classification should not include nonimplanted devices in the complications categories.

Suicidal ideation

There was general agreement on the creation of this code. It was further suggested that a specific code should also be created for suicidal tendencies since right now it is indexed to a nonspecific code (300.9, unspecified nonpsychotic mental disorder).

Excessive crying in child, adolescent, or adult

There were no comments regarding this proposal.

ICD-9-CM Coordination and Maintenance Committee Meeting
ICD-9-CM Volume 1 and 2, Diagnosis Presentations
October 8, 2004

Urinary obstruction
There were no comments regarding this proposal.

Fat necrosis of peritoneum
There were no comments regarding this proposal.

Refractory anemia/Myelodysplastic syndrome
One commenter raised the question as to why a new code was not being proposed. At this time NCHS is not considering adding new codes to this chapter. It was suggested to add excludes notes at previously existing codes since this proposes to redirect coders to existing codes.

Meconium passage
There were no comments regarding this proposal.

Addenda
There was some discussion regarding the proposal to change the range of codes listed, for heart failure, at categories 402, Hypertensive heart disease, and 404, Hypertensive heart and renal disease. Related to the changes to 487, Influenza, some comments were made regarding the intent of excluding hemophilus influenzae from this category, that it was not intended to cover a potential overlap of hemophilus influenzae pneumonia with viral influenza. Concern was raised about using the 487.0 code first, if a bacterial pneumonia was present.