Summary of September 2005 ICD-9-CM Coordination and Maintenance Committee Meeting

The ICD-9-CM Coordination and Maintenance Committee, cosponsored by the National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS), met on September 29-30, 2005 in Baltimore, MD. Donna Pickett, RHIA, from NCHS, and Patricia Brooks, RHIA, from CMS, cochaired the meeting.

Proposed modifications to ICD-9-CM were presented and are summarized below. This summary does not include all of the details of the code proposals or all of the recommendations made at the meeting. For complete details, review the minutes and code proposals posted on the CMS and NCHS websites. Diagnosis code proposals and the minutes from the diagnosis portion of the meeting are posted on the NCHS website and can be accessed at the following link: www.cdc.gov/nchs/about/otheract/icd9/maint/maint.htm. Procedure code proposals and the minutes from the procedure portion of the meeting can be found at the CMS website and can be accessed at the following link: http://www.cms.hhs.gov/paysystems/icd9/.

The deadline for submitting comments is 12/2/05 for the procedure proposals and 12/16/05 for the diagnosis proposals. Comments on procedure code proposals should be submitted to CMS and comments on diagnosis code proposals should be submitted to NCHS (addresses given below).

None of the proposals discussed at the October meeting will go into effect April 1, 2006. Once they are approved by CMS and NCHS, these revisions will go into effect with discharges on or after October 1, 2006.

Suggestions for procedure code proposals to be considered at a future Coordination and Maintenance Committee, as well as comments on procedure proposals presented at the September meeting, may be emailed to Pat Brooks at Patricia.brooks1@cms.hhs.gov or mailed to: Centers for Medicare & Medicaid Services, CMM, HAPG, Division of Acute Care, Mail Stop C4-08-06, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Suggestions for diagnosis code proposals for consideration at a future Coordination and Maintenance Committee, as well as comments on diagnosis proposals presented at the September meeting, may be emailed to Donna Pickett at dfp4@cdc.gov or mailed to: Donna Pickett, National Center for Health Statistics, 3311 Toledo Road, room 2402, Hyattsville, Maryland 20782.
The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled for March 23-24, 2006 and will be held at the CMS building in Baltimore, MD. New proposals for inclusion on this agenda must be received by January 23, 2006.

Diagnoses

Mucositis

Unique codes for mucositis have been requested. Specific ICD-9-CM codes for this condition are needed to enable accurate and consistent statistics on these patients and to be able to measure resource utilization and cost effectiveness of mucositis interventions. Two coding options were presented. The first option would involve creation of new codes for the different anatomic sites of mucositis, distributed throughout ICD-9-CM under the code categories for the relevant sites. The second option would involve creation of a separate for gastrointestinal mucositis, with specific codes for various sites in the gastrointestinal tract. In both options, codes for nasal and vaginal mucositis would be placed in the appropriate site-specific categories.

Mucositis is a frequent complication of anti-cancer treatment that causes redness and/or ulcerative sores in the soft tissues of the mucosal surfaces throughout the body, resulting in severe pain as well as difficulty in or lack of ability to eat, drink, and take oral medications. The rapidly dividing basal cells of the mucosal surfaces throughout the body are especially vulnerable to damage by chemotherapy and radiation therapy. The oral mucosa is the most frequent site of mucositis, but it can also occur along the entire alimentary tract (esophagus, stomach, duodenum, small intestine, colon, and rectum). Treatment of ovarian and nasopharyngeal cancers can also result in vaginal and nasal mucositis, respectively.

Acute and Chronic Gingival Disease

New codes have proposed to distinguish plaque-induced and non-plaque induced gingivitis (for both acute and chronic gingivitis). There are many non-bacterial causes of gingivitis and knowledge of the etiology permits precise therapies to intercept the gingival lesions and prevent their progression. Audience members noted that default codes would need to be identified when the gingivitis is not specified as acute or chronic and the cause is not identified. The presenter recommended that chronic and plaque-induced gingivitis be designated the defaults when the documentation doesn’t provide further specificity.

Acute and Chronic Periodontal Disease

New codes have been proposed to specify localized and generalized periodontal disease. It is important to distinguish between the localized and generalized forms of this condition because different treatment strategies are employed, and these strategies have varied health and economic outcomes.
Although a code for “acute periodontitis” currently exists, the presenter noted that “aggressive” would be a more appropriate term than “acute” and recommended revising the code title (“aggressive periodontitis” is currently an inclusion term under the code for acute periodontitis). He stated that “aggressive” means that it is advancing at a rapid rate. An audience member suggested that perhaps separate codes should be created for “acute” and “aggressive” periodontitis rather than changing an existing code title. It was noted that some clinicians may document “acute periodontitis” and so there needs to be a way to code this diagnosis. Audience members also recommended that a default be designated in case the periodontal disease is not specified as localized or generalized.

**Unsuccessful Endodontic Treatment**

A new subcategory for periradicular pathology associated with previous endodontic treatment has been proposed in category 526, Diseases of the jaws. Within this new subcategory, specific codes have been requested for perforation of root canal space; endodontic overfill; endodontic underfill; and other periradicular pathology associated with previous endodontic treatment.

**Unsatisfactory Restoration of Tooth**

A new subcategory for unsatisfactory restoration of tooth has been proposed in category 525, Other diseases and conditions of the teeth and supporting structures. Within this new subcategory, specific codes have been requested for open restoration margins; unrepairable overhanging dental restorative materials; fractured restorative material without loss of material; fractured restorative material with loss of material; contour of existing restoration biologically incompatible with oral health; allergy to existing restorative material; poor aesthetics of existing restoration; and other unsatisfactory restoration of tooth.

Current dental restorative materials are not permanent and suffer from failure. When damaged surfaces of the teeth are replaced with prosthetic materials, these materials become part of and act like tooth structure. Failure of these materials is then failure or pathology of the dentition. Failed restorations are considered to have a clinically significant loss of function, tissue inflammation, or pulp pathology.

A comment was made that the code for fractured tooth might need to be excluded from the proposed new codes. The presenter noted that when the restorative material fractures, sometimes the tooth fractures as well.

**Severe Sepsis**

At the April 2005 Coordination and Maintenance Committee meeting, an open discussion was held on the coding of severe sepsis. As a result of that discussion, NCHS presented a set of proposed modifications that are designed to facilitate the correct use of the severe sepsis codes so that accurate and complete data can be collected. Some of the proposed
modifications could be implemented independently of the other proposed changes, whereas others are dependent on one another.

The first proposal involves deletion of the instructional note to code first systemic inflammatory response syndrome (SIRS) due to noninfectious process with organ dysfunction that appears under code 785.52, Septic shock. Since it is not possible to develop septic shock in the absence of severe sepsis, an instructional note referencing a code for SIRS due to noninfectious process does not seem to make sense. The parallel instructional note under code 995.94, Systemic inflammatory response syndrome due to noninfectious process with organ dysfunction, that references code 785.52 would also be deleted.

The second proposal involves re-titling the codes in subcategory 995.9, Systemic inflammatory response syndrome (SIRS). For codes 995.91 and 995.92, the code titles and inclusion terms would be switched. The code title for 995.91 would be “sepsis,” with an inclusion term for “systemic inflammatory response syndrome due to infectious process.” Code 995.92 would be re-titled “severe sepsis,” with an inclusion terms for “sepsis with acute organ dysfunction,” “sepsis with multiple organ dysfunction,” and “systemic inflammatory response syndrome due to infectious process with organ dysfunction.” Additionally, the phrase “without organ dysfunction” would be deleted from code 995.93, Systemic inflammatory response syndrome due to noninfectious process without organ dysfunction, and the word “acute” would be added before “organ dysfunction” in the code title for 995.94, Systemic inflammatory response syndrome due to noninfectious process with organ dysfunction. The rationale for this proposal is that the current code titles do not clearly explain the meaning of the codes and their intended use. The codes under subcategory 995.9 were created to allow for the classification of sepsis and severe sepsis and to allow for the identification of whether the SIRS was precipitated by infection or trauma.

In the third proposal, the “code first underlying systemic infection” note under subcategory 995.9, Systemic inflammatory response syndrome (SIRS), would be deleted since it does not properly apply to all codes under the subcategory (an infection is not the underlying cause of SIRS due to a noninfectious process). An instructional note to code first the underlying condition would be added under each of the codes in the subcategory. An instructional note would also be added indicating that when SIRS due to trauma leads to severe sepsis, the trauma code should be sequenced first, but the code for SIRS due to infectious process with organ dysfunction should also be assigned to explain that a systemic infection developed as a result of the trauma. Audience members questioned why this instructional note would be limited to trauma cases rather than applicable to any instance when SIRS due to a noninfectious process leads to severe sepsis.

The fourth proposal involves adding a “use additional code” note for the underlying systemic infection under codes 995.91 and 995.92. This change would mean the sepsis and severe sepsis would be sequenced first, followed by the code for the underlying systemic infection. This would be a reversal of the current sequencing requirement. The sequencing of the codes for SIRS due to noninfectious process would not change (the
trauma or other noninfectious underlying condition would be sequenced before the SIRS code).

The fifth proposal would allow the code describing the acute organ dysfunction to be sequenced first. This change would mean severe sepsis cases might have a wide variety of acute conditions reported as the principal diagnosis, thus complicating the analysis of data on sepsis cases. The decision as to which organ dysfunction should be sequenced first (in the case of multiple organ dysfunction) could be difficult. Unrelated to the sequencing issue, the addition of disseminated intravascular coagulopathy (DIC) to the list of acute organ dysfunctions in the instructional notes under codes 995.92 and 995.94 has also been proposed.

In the sixth proposal, septic shock would be excluded from severe sepsis. If septic shock is present, severe sepsis would be presumed and no additional code for the severe sepsis would be assigned. Septic shock is only present in association with end stage severe sepsis. There were strong objections to this proposal from audience members. Since the code for septic shock is a symptom code, the audience felt that it would not be consistent with coding rules and conventions to report only the symptom code when the underlying condition is known.

Major Osseous Defects

A unique code for major osseous defects has been proposed in category 731, Osteitits deformans and osteopathies associated with other disorders classified elsewhere. This code could be assigned either by itself or in addition to a mechanical complication code. The underlying cause, if known, would be sequenced first.

Osseous defects are the result of extensive bone loss, typically in the area of the hip joint. The most common cause of this bone loss is peri-prosthetic osteolysis from a previous joint replacement, contributing to implant failure and need for revision. Other causes include osteomyelitis, aseptic or osteonecrosis, benign or malignant neoplasms, pathological fractures, severe osteoporosis, or trauma. Osseous defects can also be caused by combinations of these factors. While some bone loss is common and treated incidentally as part of joint replacement, major defects are clinically meaningful since the surrounding bone structure into which the joint implants are placed is not strong enough to mechanically support the implants without prior structural repair. Treatment of major osseous defects of the hip and knee may involve primary or revision hip or knee arthroplasty, often in conjunction with filling the defect with moralized or structural autogenous or allogenic bone graft and providing added mechanical support for the graft itself (using wires, cables, acetabular roof rings, cages, metal wedges, augments, screws, etc.). Combined, these devices provide additional structural support for the hip and knee implants.

Family History of Colon Polyps
Creation of a code for family history of colon polyps has been requested. Though most colon polyps are benign, some types can eventually become cancerous. Individuals who are at higher risk of developing colon polyps include people over age 50, those with a past history of colon polyps, and those who have had a family member diagnosed with colon polyps or with cancer of the large intestine. A family history of colon polyps may prompt screening colonoscopies at earlier ages or with more frequency than average risk individuals. An individual with this family history may also seek medical advice to initiate lifestyle prevention methods.

Takotsubo Syndrome

A code for Takotsubo syndrome, also called “transient left ventricular apical ballooning syndrome, has been proposed in subcategory 429.8, Other ill-defined heart diseases. Effective October 1, 2005, apical ballooning syndrome is indexed to code 429.89, Other ill-defined heart diseases.

Takotsubo syndrome is a reversible left ventricular dysfunction in patients without coronary disease precipitated by emotional or physiological stress. This name refers to the associated left ventricular morphologic features including transient wall-motion abnormalities involving the left ventricular apex and mid-ventricle that accompany this syndrome. Patients commonly present with ST-segment elevation in the precordial leads, chest pain, relatively minor elevation of cardiac enzyme and biomarker levels, and transient apical systolic left ventricular dysfunction. They are usually monitored and treated for left heart failure, dynamic intraventricular obstruction, and arrhythmias. The exact cause of the syndrome is unknown.

The word “tako-tsubo” refers to the round-bottomed, narrow-necked Japanese fishing pot used for trapping octopus. The syndrome was originally recognized and reported in the Japanese population, however, it is now reported more in the white U.S. population and in Europe.

Familial Mediterranean Fever

An expansion of code 277.3, Amyloidosis, has been requested to allow creation of a code for familial Mediterranean fever. Inclusion terms would be added under the new code for benign paroxysmal peritonitis, hereditary amyloid nephropathy, periodic familial polyserositis, and recurrent polyserositis. Familial Mediterranean fever is a rare inherited disorder characterized by regular attacks of inflammation in the lining of the abdominal cavity, chest cavity, skin or joints along with recurrent high fevers. It usually affects people of Mediterranean ancestry, most commonly people of non-Ashkenazi Jewish, Armenian, Arab, and Turkish background. Since there is no diagnostic laboratory test, the diagnosis is usually made based on clinical findings. Treatment using colchicine provides remission or improvement in most patients, though they are subject to further acute attacks.

Central Pain Syndrome, Postoperative Pain
A new subcategory for “pain” has been proposed in the Nervous System chapter. Codes for generalized pain, central pain syndrome, and postoperative pain would be created in this category. Audience members suggested that some of the new codes, such as generalized pain and postoperative pain, might be more appropriately placed in the Symptom chapter. Concerns were also raised as to the proper use of these new codes. For example, should a code for pain of the specific site be reported in addition to the proposed code for postoperative pain? How would terms such as “uncontrolled pain,” “severe pain,” and “chronic pain” be coded? How would overuse of the code for postoperative pain, such as routinely assigning the code for normal pain following surgery, be prevented? Also, the proposal includes a note indicating that localized pain is excluded from the new pain category and should be coded to the site of the pain. Audience members found this note confusing because postoperative pain is often localized in nature.

Less concern was expressed regarding the creation of a code for central pain syndrome. This condition can be caused by damage to the central nervous system. This damage can be traumatic or brain-related (such as stroke, multiple sclerosis, tumors, epilepsy, or Parkinson’s disease). The character and extent of the pain differs widely depending partly on the variety of causes. Patients are treated with pain medications and sometimes antidepressants and anticonvulsants.

Newborn Post Discharge Check

An expansion of code V20.2, Routine infant or child health check, has been requested in order to create a code for a newborn post-discharge follow-up visit. The American Academy of Pediatrics recommends that a follow-up visit take place within 48 hours after discharge when a healthy newborn is discharged from the hospital less than 48 hours following delivery. An audience member suggested that the word “immediate” be included in the code description to clarify the intent of this code and prevent misuse of the code for all newborn visits to the pediatrician’s office.

Attention to Surgical Dressings and Sutures

An expansion of code V58.3, Attention to surgical dressings and sutures, has been requested in order to differentiate between care of surgical and non-surgical dressings. Currently, use of code V58.3 is limited to surgical dressings and sutures. However, the home health industry has a need to identify encounters for change or removal of non-surgical dressings.

Intrauterine Hypoxia and Asphyxia

Revisions to codes in the Perinatal chapter have been proposed to update the classification to appropriately describe hypoxia, hypoxemia, asphyxia, cerebral ischemia, academia, and hypoxic-ischemic encephalopathy. This proposal would impact code descriptions and inclusion terms in categories 768, 775, and 779. Also, distinct codes for
mild and moderate hypoxic-ischemic encephalopathy would be created in category 768. New codes for respiratory arrest of newborn and hypoxemia of newborn unrelated to labor and delivery would be created in subcategory, 770.8. Other respiratory problems after birth. A new code for cardiac arrest of newborn unrelated to birth would be created in subcategory 779.8, Other specified conditions originating in the perinatal period.

Mild Cognitive Impairment

A new code for mild cognitive impairment has been requested in subcategory 331.8, Other cerebral degeneration. Audience members expressed concerns about the use of such a generic term and the fact that this term could be used to describe cognitive impairment associated with head trauma, dehydration, malnutrition, and strokes. The intent of the proposed code is not to capture these types of cognitive impairment, so there would need to be clear instructions to that effect.

Mild cognitive impairment is a disease entity defined by an impairment in memory (or any other cognitive domain) that is beyond what is normal for age, with relatively intact function in the other cognitive domains. Many patients with this diagnosis go on to eventually develop dementia.

Altered Mental Status

A code for altered mental status has been proposed in subcategory 780.9, Other general symptoms. It was suggested that “change in mental status” be added as an inclusion term. An altered mental status may frequently be described as a symptom of a number of different types of illness. Underlying etiologies include trauma, infection, neoplasm, alcohol, and drugs, as well as endocrine, neurological, psychiatric, and renal disorders. If a specific cause of the altered mental status is documented, the cause should be coded and the proposed symptom code should not be assigned as an additional diagnosis.

Hematology/Aplastic Anemia/Myelofibrosis

A new code for myelophthisis has been proposed in category 284 (the category title would be changed to “Aplastic anemia and other bone marrow failure syndromes”). An instructional note would indicate that the underlying disorder should be sequenced first.

Myelofibrosis involves fibrous tissue replacing normal bone marrow. It usually is accompanied by leukoerythroblastic anemia. It can be a primary hematologic disease or a secondary process. In April 2005, a new code for myelofibrosis with myeloid metaplasia was proposed, with an inclusion term for primary myelofibrosis. The secondary process, known as myelophthisis, may occur in a number of other disorders, including malignancies, infections (particularly fungi and mycoplasma), lipid storage disease (e.g., Gaucher’s disease), sarcoidosis, and osteoporosis.

Complex Febrile Seizure
A unique code for complex febrile seizures has been proposed in subcategory 780.3, Convulsions. It was suggested that status epilepticus should be excluded from the proposed code. For a patient with complex febrile seizures and status epilepticus, code 345.3 should be assigned instead of the proposed new code.

Complex febrile seizures are defined as seizures associated with fever that are focal, prolonged (greater than 15 minutes), or recur within 24 hours in children between 6 months and 5 years of age. They may also be referred to as atypical or complicated febrile seizures. Fever-associated seizures that do not meet these criteria may be called simple febrile seizures. There are significant differences in morbidity between simple and complex febrile seizures. Long-term risk of epilepsy can range from 6-8% in children who have a single feature of a complex seizure to 49% in patients who have all three features. A child with a complex febrile seizure may need neuroimaging and/or long-term anticonvulsant therapy.

**Torsion of Testis**

It has been requested that code 608.2, Torsion of testis, be expanded to create unique codes for torsion of appendix epididymis, extravaginal torsion of spermatic cord, intravaginal torsion of spermatic code, and torsion of appendix testis.

**Lower Urinary Tract Symptoms**

New codes for urinary hesitancy and straining on urination have been proposed in subcategory 788.6, Other abnormalities of urination. The addition of an inclusion term for “enlarged prostate” under code 600, Hyperplasia of prostate, was also proposed, as this term is becoming increasingly common in describing benign prostatic hypertrophy.

**Cervical Stump Prolapse**

A new code for cervical stump prolapse has been requested under subcategory 618.8, Other specified genital prolapse. Currently, prolapse of the cervical stump is indexed under code 618.1, Uterine prolapse without mention of vaginal wall prolapse. However, this is an incorrect classification of this condition because the uterus is no longer present.

**Cytologic Evidence of Malignancy**

A unique code for Papanicolaou smear of cervix with cytologic evidence of malignancy has been requested under subcategory 795.0, Abnormal Papanicolaou smear of cervix and cervical HPV.

**Encounter for Testing of Male Partner of HabitualAborter**

New codes for genetic testing and counseling went into effect October 1, 2005. At the April 2005 Coordination and Maintenance Committee meeting, an expansion of these
new codes was presented in order to distinguish between male and female. At the September meeting, an additional expansion was requested in order to create a unique code for a male encounter for a female partner who is a habitual aborter. The September proposal also included the expansion of code 629.8, Other specified disorders of female genital organs to create a code for habitual aborter without current pregnancy in subcategory.

**Estrogen Receptor Status**

A new V code category has been requested for estrogen receptor status. Within this category, new codes for estrogen receptor positive status and estrogen receptor negative status would be created. The appropriate code for malignant neoplasm of breast would be sequenced first.

About two-thirds of breast cancer patients have an estrogen receptor positive (ER+) tumor. The incidence of ER+ tumors is greater among postmenopausal women than premenopausal women. Patients with estrogen receptors have a somewhat better prognosis and are more likely to benefit from endocrine therapy. Estrogen ablation (by oophorectomy) provides palliation in advanced breast cancer. Tamoxifen is an effective treatment because it can bind to estrogen receptors on breast cancer cells. As an adjuvant therapy in breast cancer treatment, Tamoxifen prolongs the duration of disease-free survival, improves cure rate in receptor positive patients by 20-30%, and reduces the risk of contralateral breast cancer by about 60%.

**Complications and Personal History of In Utero Surgery**

New codes related to in utero surgery have been proposed. With the increased use of in utero surgery to correct fetal anomalies, it is necessary to be able to track the complications associated with this surgery as well as the long-term consequences (for both the mother and baby). A new category for management of pregnancy affected by in utero surgery would be created in the Obstetrics chapter. New codes for maternal complications of in utero surgery, fetal complications of in utero surgery, and maternal in utero surgery status of current pregnancy would be created in this category. New codes have also been proposed in the Perinatal chapter to identify that a newborn has been affected by in utero surgery or by another type of surgical operation performed on the mother. New V codes have also been proposed to identify maternal personal history of in utero surgery and personal history of fetal in utero surgery. A V code for pregnancy with history of in utero surgery during previous pregnancy would also be created in subcategory V23.8, Other high-risk pregnancy.

**Fifth Digit Title Changes for Categories 403 and 404**

With the modifications to category 585, Chronic kidney disease, that became effective on October 1, 2005, corresponding changes were made to the descriptions for the fifth digits for categories 403, Hypertensive kidney disease, and 404, Hypertensive heart and kidney disease. The revised descriptions were based on the structure of the previous
descriptions. After the changes to these fifth digits were finalized, it became evident that they were no longer valid as a result of the changes made to category 585. The revised description for the fifth digit “0” is “without chronic kidney disease.” However, it is not possible to have hypertensive kidney disease or hypertensive heart and kidney disease without having chronic kidney disease.

It has been proposed that the code descriptions for the fifth digits that apply to categories 403 and 404 be revised to distinguish between the mild and severe stages of chronic kidney disease instead of with and without chronic kidney disease. An audience member suggested that the information provided by the fifth digits is no longer necessary and the fifth digits should be eliminated entirely. It was noted that the proposed revisions still don’t provide any additional information because the specific stage of the chronic kidney disease is identified by the 585 code.

It was also proposed that an Excludes note be added under code 585.5, Chronic kidney disease, stage V and an inclusion term be added under code 585.6, End stage renal disease to clarify that code 585.6 should be assigned for chronic kidney disease, stage V on dialysis.

**Inflammation of Post-Procedural Bleb**

A new subcategory for inflammation (infection) of postprocedural bleb has been requested in category 379, Other disorders of eye. Three new codes for different stages of this condition would be created in this subcategory.

Following ophthalmologic procedures that create a filtering bleb (an auxiliary drain on the outside of the eyeball), inflammation (usually infectious), can occur. The bleb is extremely thin-walled and can be easily invaded by bacteria. Filtering blebs are most commonly associated with trabeculectomy for the treatment of glaucoma, but they may also be created with other ophthalmologic procedures.

The post-procedural bleb inflammation has different stages of severity. Stage 1 is characterized by bleb purulence with or without a mild anterior segment inflammation. Stage 2 includes bleb purulence and moderate anterior segment inflammation. Stage 3 includes marked anterior chamber reaction, vitritis, and severe pain. Stage 3 may lead to bleb-related endophthalmitis and acute visual loss. Topical antibiotics may resolve stage 1. Topical drugs and oral antibiotics are needed for stage 2. A subconjunctival antibiotic injection is generally recommended for patients who do not improve within 24 to 48 hours. Repeat injections may be needed for stage 3. After resolution of the infection, surgical revision of the bleb may be needed. Patients with avascular, thin blebs, and recurrent bleb leaks are at risk for repeat infection.

**Optic Nerve Hypoplasia**

A new code for optic nerve hypoplasia was proposed. Although it is a congenital abnormality, the American Academy of Ophthalmology feels the code should be placed
in Chapter 6 (Diseases of the Nervous System and Sense Organs). There was some 
disagreement expressed as to whether this code should be located under disorders for 
optic disc or optic nerve.

Optic nerve hypoplasia is a congenital abnormality of the optic disc which can impair 
vision. It manifests as a small optic nerve that may be accompanied by a peripapillary 
ring (the double ring sign). Optic nerve hypoplasia can be unilateral or bilateral, and 
there may be mild or severe impairment in visual function.

**Diagnosis Addenda**

Proposed diagnosis addenda changes were reviewed. Highlights of the proposed 
revisions include:

- Addition of instructional notes to clarify that stromal tumors are classified to the 
categories for connective tissue tumors;
- Revision of code description for code 255.10 to state “Hyperaldosteronism, 
unspecified” and the addition of an inclusion term for “primary aldosteronism, 
unspecified” (i.e., this revision would result in the code description and inclusion 
term being switched);
- Addition of note under code 288.0, Agranulocytosis, indicating that an additional 
code should be used for any associated fever (780.6);
- Addition of inclusion term for “toxic metabolic encephalopathy” under code 349.82, 
Toxic encephalopathy;
- Addition of Excludes note under code 496, Chronic airway obstruction, unspecified, 
and index entries to indicate that code 491.21, Obstructive chronic bronchitis with 
(acute) exacerbation, should be assigned for decompensated chronic obstructive 
progressive pulmonary disease;
- Addition of Excludes note under code 514, Pulmonary congestion and hypostasis, to 
clarify that hypostatic pneumonia due to or specified as a specific type of pneumonia 
should be coded to the type of pneumonia (480.0–480.9, 481, 482.0–482.49, 483.0– 
483.8, 485, 486, 487.0);
- Addition of inclusion term for “tachygastria” under code 536.3, Gastroparesis;
- Addition of an instructional note and inclusion term to indicate that atony of uterus 
without hemorrhage should be assigned code 669.8x, Other complications of labor 
and delivery, and not 666.1x, Other immediate postpartum hemorrhage;
- Addition of “code first” note under code 780.6, Fever, indicating that the underlying 
condition should be coded first when associated fever is present, such as leukemia, 
neutropenia, and sickle cell disease;
- Revision of title of code 780.95 to state “Excessive crying of child, adolescent, or 
adult;”
- Addition of Excludes note for “aftercare for amputation stump (V54.89)” under 
subcategory V54.1, Aftercare for healing traumatic fracture;
- Addition of Index entry for aneurysm, mycotic, without endocarditis – see aneurysm, 
by site;
- Addition of Index entry for botulism, wound – see wound, open, by site, complicated;
• Revision of Index entries for cachexia, cancerous (799.4 – see also neoplasm, by site, malignant), cachexia due to malnutrition (799.4), and cachexia, malignant (799.4 – see also neoplasm, by site, malignant);
• Addition of Index entry for cholestasis due to total parenteral nutrition (573.8);
• Addition of Index entry for clot, heart, without myocardial infarction (429.89);
• Addition of Index entry for encephalitis, Rasmussen (323.8);
• Addition of Index entry for fibromatosis, congenital generalized (CGF) – 759.89;
• Addition of Index entry for hallux limitus (735.8);
• Addition of Index entry for Hepatitis, viral, type C, in remission (070.54);
• Revision of Index entry for insufficiency, renal (593.9);
• Addition of Index entry for pannus, abdominal (symptomatic) – 278.1;
• Addition of Index entry for pregnancy, complicated (by), appendicitis (648.9);
• Addition of Index entry for PRES (posterior reversible encephalopathy syndrome) – 348.39;
• Addition of Index entry for resistance, thyroid hormone (246.8);
• Addition of Index entry for syndrome, retroviral seroconversion (acute) – V08;
• Addition of Index entry for ulcer, aorta – see aneurysm;
• Addition of Index entry for vasospasm, coronary (413.1);
• Addition of Index entries for VIN (vulvar intraepithelial neoplasia) I and II (624.0).

Procedures

Insertion of Spinal Stabilization Device

A new code for insertion of non-fusion spinal stabilization device has been proposed. Implantation of interspinous process decompression device and spinal fusion procedures would be excluded. CMS recommended that a new code not be created at this time due to limited code availability, the lack of approval by the U.S. Food and Drug Administration (FDA), and the vast array of potential technologies in this area. This procedure should continue to be assigned code 84.59, Insertion of other spinal devices. Several commenters voiced support for continuing to assign 84.49 for this procedure. It was suggested that stringent criteria be established to determine which procedures most need a new code in order to ration the remaining ICD-9-CM procedure codes.

The M-Brace™ Spine Stabilization System is a posterior dynamic flexible stabilization system that is fixed by means of traditional pedicle screws. The device is implanted posteriorly in the lumbar spine to provide dynamic stabilization, without fusion, of the segment being treated for spinal stenosis. The system controls and supports motion in flexion, extension, and lateral bending.

Implantable Hemodynamic Monitor

Two codes have been requested to describe insertion or replacement of implantable sensor for intracardiac hemodynamic monitoring and implantation or replacement of
subcutaneous device for intracardiac hemodynamic monitoring. CMS recommended creation of new codes.

An implantable hemodynamic monitoring system is used in the management of severe heart failure. It has two key components. The first is a lead tipped with a pressure sensor that is placed within the right ventricle at the right ventricular outflow tract. Because the sensor measures cardiac pressures, it is always inserted transvenously into the heart chamber and is never implanted epicardially onto the external surface of the heart. The second component is the monitor device which includes pressure sensing circuitry and memory to process and collect the data obtained by the sensor. This device is implanted in a subcutaneous pocket, usually in the chest. This system provides continuous data and is used to monitor patients under normal living conditions (i.e., while they are at home). Periodically, the data collected by the monitor is downloaded via telemetry for physician analysis and decision-making. The implantable hemodynamic monitoring system allows clinicians to identify early signs of volume overload before they become apparent by physical exam. Clinicians can then immediately adjust treatment to reduce or prevent heart failure deterioration as well as the need for hospital treatment.

**Laparoscopic Hysterectomy**

New codes for laparoscopic total abdominal hysterectomy, laparoscopic radical abdominal hysterectomy, and laparoscopic radical vaginal hysterectomy have been proposed. CMS recommended creation of these new codes.

A total laparoscopic hysterectomy involves excision via laparoscope of the entire uterus with cervix. A total laparoscopic radical hysterectomy involves excision via laparoscope of the uterus, cervix, upper portion of the vagina, lymph nodes, lymph channels, and tissue in the pelvic cavity surrounding the cervix. A laparoscopic modified radical hysterectomy involves excision of the uterus, the medial half of the uterosacral and cardinal ligaments, as well as a portion of the upper vagina. A laparoscopic radical vaginal hysterectomy is a radical hysterectomy whereby laparoscopy is used to perform vaginal removal of the uterus.

**Computerized External Fracture Fixation**

A new code has been requested to describe application of computer-dependent external fixator device. CMS did not make a specific recommendation with regard to this proposal at the meeting. Some attendees felt that a separate code should not be created for the software component of a procedure and device and that only the existing codes for application of external fixation devices should be used. It was noted that a number of procedures employ software technology, but ICD-9-CM does not provide for separate coding of the software component.

The Taylor Spatial Frame (TSF) is a computerized external fixation device that is used to stabilize and reduce fractures and correct post-traumatic or congenital deformities. Indications for this device include open and closed fracture fixation, pseudoarthrosis or
nonunions of long bones, limb lengthening by epiphyseal or metaphyseal distraction, correction of bony or soft tissue deformities, and correction of segmental or nonsegmental bony or soft tissue defects. The Taylor Spatial Frame (TSF) is a type of computerized external fixation device and is for use on all long bones. The TSF consists of pins that are inserted into the bone above and below a fracture, rings or plates that attach to the pins and encircle the limb, and telescoping and pivotal struts that connect the rings or plates together. The TSF is currently the only external fixation system that includes computer software that assists physicians in calculating a prescription for strut adjustment and replacement, allowing gradual correction of fractures and deformities.

**Procedure on Bifurcated Vessels**

A new code describing a procedure performed on a bifurcated vessel was proposed. CMS recommended that a new code not be created, but rather the existing codes should be used to identify the number of vessels treated and number of stents inserted. Audience members expressed confusion as to how to apply the proposed code. The proposed code descriptor does not appear to limit its use to instances when stents are used to treat a lesion at a bifurcation in a vessel, although the presentation at the meeting seemed to indicate that this circumstance was the intended use of the code. Also, it was not clear if the codes for angioplasty, number of vessels treated, and number of vascular stents inserted should also be assigned. If these additional codes should be assigned, it was also not clear how to count the vessels or stents when the proposed code for procedure performed on a bifurcated vessel is used. Are the vessels and stents involved in the procedure on the bifurcated vessel included in the proposed code, or should they be included in the number of vessels and stents specifically identified by the new 00.4x codes?

**Endovascular Mechanical Thrombectomy of Precerebral and Cerebral Vessels**

A new code for endovascular removal of obstruction from head and neck vessel(s) has been proposed. CMS recommended creation of a new code. Endovascular embolectomy, endovascular thrombectomy, mechanical embolectomy or thrombectomy. Any injection or infusion of thrombolytic agent should also be coded. It was also suggested that the number of vessels treated should also be coded (codes 00.40-00.43). A recommendation was also made that CMS consider creating a code for endovascular removal of obstruction from peripheral vessel as well.

Endovascular mechanical thrombectomy is the first surgical treatment available for acute ischemic stroke. Ischemic strokes are much more common than hemorrhagic strokes. They are caused by obstruction and occlusion of the precerebral and cerebral blood vessels by thrombosis, embolism, and stenosis. Until recently, treatment of ischemic strokes has been exclusively medical, involving infusion of anticoagulants and thrombolytic drugs such as tPA. To be effective, intravenous thrombolytic drugs must be administered within 3 hours of the onset of an ischemic stroke. Mechanical thrombectomy physically removes thrombus from the occluded vessel. Unlike tPA, it is not limited to a specific timeframe and can be used to treat patients who are beyond the
3-hour window for tPA. Mechanical thrombectomy is also used for patients who received tPA but it was not effective.

During a mechanical thrombectomy, a balloon catheter is inserted and maneuvered to the carotid artery. A microcatheter and guidewire are then advanced into the appropriate intracranial vessel and placed just beyond the thrombus. A retrieval device, similar in appearance to a corkscrew, is deployed to ensnare the thrombus and withdraw it into the balloon catheter and ultimately out of the body. The balloon catheter is inflated to temporarily arrest blood flow during this maneuver and is then deflated to restore blood flow after the thrombus is extracted. Several passes with the retrieval device may be necessary to ensure the thrombus is completely removed and the vessel lumen has been cleared.

**Cardiac Electrophysiologic Studies**

Creation of a new code for noninvasive programmed electrical stimulation (NIPS) and corresponding revision of code 37.26, Cardiac electrophysiologic stimulation and recording studies, were proposed. CMS supported the proposal. The title of code 37.26 would be revised to state “catheter-based invasive electrophysiologic testing.” Instructional notes would be added to indicate that catheter-based invasive electrophysiologic testing and NIPS should not be coded separately when performed as part of intraoperative testing. Device interrogation only, without arrhythmia induction, is classified to codes 89.45-89.49. When a cardiac resynchronization pacemaker, cardiac resynchronization defibrillator, or automatic cardioverter/defibrillator is implanted or replaced, device testing performed at the same time is inherent in the procedure and should not be coded separately. Several attendees suggested deleting code 37.26 and creating an entirely new code, rather than revising the code descriptor, since the meaning and use of the code would change.

Currently, there is considerable confusion with regard to coding the various types of clinical cardiac electrophysiology studies. There are four basic types of cardiac electrophysiologic studies:

*Electrophysiologic Stimulation and Recording (EPS)*

This is the most invasive type of electrophysiologic (EP) study. Catheters are inserted into the heart through peripheral vessels and the electrical activity of various areas of the heart is recorded. This study involves the induction of life-threatening arrhythmias in order to assess the need for the most appropriate anti-arrhythmic treatment. The procedure must be performed in a cardiac catheterization laboratory or similarly-equipped facility. Code 37.26 is currently assigned for this procedure.

*Noninvasive Programmed Electrical Stimulation (NIPS)*

This type of EP study uses a device that is already implanted, such as an implantable cardiac defibrillator, to induce arrhythmias with the pulse generator via telemetry signals in order to assess the adequacy of the device and program it for optimal functioning or to assess the effectiveness of drug therapy. Although this procedure is considered
noninvasive because no catheters are inserted into the heart, it requires the ability to emergently terminate the life-threatening arrhythmias that are induced, and so it must be performed in a cardiac catheterization laboratory or similarly-equipped facility. Although NIPS is quite different from type described above that uses catheters, it is also classified to code 37.26.

**Intraoperative Testing**

This form of EP testing is done at the time of implantation of a cardiac pacemaker or defibrillator in order to ascertain that it is functioning properly. It is considered an inherent part of the implantation procedure.

**Device Interrogation or Bedside Check**

Device interrogation is simply a download of the information stored in the pulse generator of a cardiac device via telemetry for evaluation of recorded data. It is described by codes 89.45, Artificial pacemaker rate check, 89.46, Artificial pacemaker artifact wave form check, 89.47, Artificial pacemaker electrode impedance check, 89.48, Artificial pacemaker voltage or amperage threshold check, or 89.49, Automatic implantable cardioverter/defibrillator (AICD) check, depending on the type of device being checked.

**Procedure Addenda**

Proposed procedure addenda changes were reviewed. Highlights of the proposed revisions include:

- Addition of terms “BiV” and “biventricular” in Index entries for implantation and replacement of cardiac resynchronization pacemaker and defibrillator;
- Addition of Index entries for insertion of stent(s) in mesenteric and renal vessels (39.90);
- Revision of Index entry for removal of cardioverter/defibrillator pulse generator without replacement (37.79 instead of 37.99);
- Addition of Index entry for repair of rotator cuff by or with graft (83.63);
- Revision of Index entry for repositioning of cardioverter/defibrillator lead(s) (37.75 instead of 37.99);
- Revision of Index entries for repositioning of cardioverter-defibrillator pocket and pulse generator (37.79 instead of 37.99);
- Addition of several inclusion terms under code 37.79, Revision or relocation of cardiac device pocket, to indicate that procedures such as removal of cardiac device/pulse generator without replacement and repositioning of the pulse generator are classified to this code.

**ICD-10-PCS Update**

Staff from 3M provided an update regarding revisions that have been made to ICD-10-PCS and changes that are planned for 2006 and 2007. The system has been updated to
reflect annual ICD-9-CM modifications. Greater specificity has been added for devices and substances. The total number of approaches has been reduced and the descriptions of the devices have been made more precise. The ICD-10-PCS to ICD-9-CM map has been updated and an ICD-9-CM to ICD-10-PCS map has been developed.

In 2006, a prototype of the Medicare DRGs using ICD-10-CM/PCS codes will be completed and a more comprehensive body part value inclusion list will be developed. For 2007, the ancillary sections will be updated. In January 2006, an updated version of ICD-10-PCS will be posted, as well as the ICD-9-CM to ICD-10-PCS map and the updated ICD-10-PCS to ICD-9-CM map. An updated version of the ICD-10-PCS reference manual will also be posted. All of this information can be accessed at this link: http://www.cms.hhs.gov/paymentsystems/icd9/icd10.asp.

Availability of ICD-9-CM

At AHIMA’s request, CMS discussed the issue of the limited number of unassigned ICD-9-CM procedure codes that are available to use for new codes.

CMS outlined a possible hierarchical approach (referred to as a “code creation hierarchy”) for utilizing unassigned ICD-9-CM procedure codes (approaches are listed in order of preference):

1. Assign new codes in the appropriate section of the appropriate body system chapter of ICD-9-CM (preferred approach until available code numbers in appropriate section have been exhausted).
2. If a new code cannot be assigned to the appropriate section of the correct body system chapter, then an attempt will be made to assign the code in the appropriate chapter, but inappropriate section (for example, if there is a need for a spinal procedure code, and there is no space in the spine section of the musculoskeletal chapter, an effort will be made to assign the new code in some other section of the musculoskeletal chapter).
3. If there are no available codes in the appropriate body system chapter, then an attempt will be made to assign a new code in Chapter 00, Procedures and Interventions Not Elsewhere Classified.
4. If there is no space in Chapter 00, new chapter 17 will be created and the new code will be assigned in that chapter.
5. If all of the above options have been exhausted, codes will be randomly assigned to any chapter where there is an unassigned code number. For example, a code for a cardiovascular procedure might be assigned to an available code in the chapter for Operations on the Ear.

No option was presented for handling codes for new procedures once all five of these options have been exhausted.

Several audience members expressed major concerns about the failure of the U.S. to adopt ICD-10-CM/PCS by now, resulting in a serious ICD-9-CM crisis. Several people
noted that all of the options except the first one will negatively impact data analysis, including research, because it will become increasingly difficult to identify related procedures – since they will be scattered all over the classification. A number of concerns about the fifth option were expressed. It was noted that assigning codes to increasingly inappropriate places in the coding system would have a detrimental effect on the quality of our national data. Coding errors will increase, and research using coded data will be flawed due to the inability to find all of the appropriate codes.

Additional suggestions that were raised by audience members for CMS’ consideration included:

- Development of stringent “criteria” for use in determining whether or not a diagnosis or procedure should be granted a new code. This approach would allow CMS to “ration” the dwindling available codes and ensure that they are saved for those diagnoses/procedures for which a code is most needed.
- Consistent with the recommendation for “criteria,” a number of people felt that CMS needed to create new codes more judiciously and attempt to consolidate proposals involving large numbers of new codes into fewer codes whenever possible.
- It was suggested that CMS start re-using codes – such as codes for procedures that are no longer performed or performed infrequently. Several attendees vehemently opposed this suggestion.
- Several people suggested that before CMS completely disrupts ICD-9-CM, and corrupts data to such an extent that ICD-9-CM data are impossible to use, they should simply declare ICD-9-CM volume 3 as “dead” and unable to accommodate any new more new codes.
- It was suggested that new alphanumeric numbers be created in order to make available a new set of unassigned code numbers. CMS stated that this approach would, in effect, create a “new” classification system and be subject to the same HIPAA-mandated regulatory process as ICD-10.