Summary of March-April 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 March 31-April 1, 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. Diagnostic 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/paymentsystems/icd9/.

Once they are approved by CMS and NCHS, some changes may go into effect with discharges on or after October 1, 2005, whereas others may not go into effect until October 1, 2006.

Suggestions for diagnosis code proposals for consideration at a future Coordination and Maintenance Committee may be emailed to Donna Pickett at dfp4@cdc.gov or mailed to: National Center for Health Statistics, ICD-9-CM Coordination and Maintenance Committee, 3311 Toledo Road, room 2402, Hyattsville, Maryland 20782.

Suggestions for procedure code proposals to be considered at a future Coordination and Maintenance Committee, may be emailed to Pat Brooks at PBrooks@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.

The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled for September 29-30, 2005 and will be held at the CMS building in Baltimore, MD. New proposals for inclusion on this agenda must be received by July 29, 2005. Anyone wishing to have a new code considered for implementation on April 1, 2006 must make this request at the September meeting and justify the need for expedited implementation to capture new technology.
Diagnoses

Sleep Disorders

In October 2004, new code proposals for insomnia, hypersomnia and sleep apnea were presented at the request of the American Academy of Sleep Medicine. The Academy has requested that additional codes for sleep disorders not included in the October proposal also be considered and that both sets of codes be implemented together in October 2005. The additional requested codes are for circadian rhythm sleep disorders, parasomnias, and sleep-related movement disorders.

Epilepsy

The terminology used to describe different types of epilepsy has changed over the years, and the ICD-9-CM code titles are no longer current. It has been proposed that the code titles for subcategories 345.4 and 345.5 be revised. The new title of subcategory 345.4 would be “ Localization-related (focal)(partial) epilepsy and epileptic syndromes with complex partial seizures,” and the new title of subcategory 345.5 would be “ Localization-related (focal)(partial) epilepsy and epileptic syndromes with simple partial seizures.” Also, it has been proposed that “seizure disorder NOS” and “recurrent seizures NOS” be classified to subcategory 345.9. A single, isolated seizure would continue to be classified to code 780.39. Febrile convulsions that lead to status epilepticus would be classified to subcategory 345.3 instead of code 780.31. A suggestion was made during the meeting to create new codes for febrile seizures that would differentiate between simple and complex.

Cracked Tooth

A new code for cracked tooth caused by normal wear and tear has been requested. Human teeth flex during mastication or during parafunctional habits such as bruxing. In multicurved teeth (molars and premolars), this flexure can force the cusps apart as forces provide a wedging action on the occlusal surfaces. Multicurved teeth may experience incomplete fractures through crack propagation through enamel into dentin without the loss of tooth structure. Dentin, a living material, is innervated directly and indirectly. Teeth become symptomatic as they flex and fluid within the propagating crack moves, causing discomfort to varying degrees. Further crack propagation may lead to devitalizing of the tooth. This condition is occurring with increasing frequency as humans extend their life span and retain their dentition.

Dental Code Modifications

The American Dental Association has requested the addition of inclusion terms under a number of dental codes in order to incorporate current terminology. An alternative to adding inclusion terms would be to just add these terms to the index.
Compartment Syndrome

Compartment syndrome due to trauma is currently indexed to code 958.8, Other early complications of trauma. Nontraumatic compartment syndrome is indexed to code 729.9, Other and unspecified disorders of soft tissue. Site-specific codes for nontraumatic and traumatic compartment syndrome have been proposed. Compartment syndrome involves increased pressure in an enclosed tissue space, leading to decreased blood flow and, potentially, tissue necrosis. It usually occurs within part of an extremity, but it can also occur in the abdomen and other sites. There are multiple compartments in the upper and lower extremity that can be affected by compartment syndrome.

Specific causes of compartment syndrome include burn, frostbite, snakebite, postsurgical edema or bleeding, hemophilia, and anticoagulant therapy. Exertional compartment syndrome is a nontraumatic type that occurs in individuals who exercise a lot (particularly in runners’ legs).

Hematology Issues

New codes have been proposed to uniquely identify essential thrombocythemia, myelodysplastic syndrome, myelofibrosis with myeloid metaplasia, constitutional red blood cell aplasia, and pancytopenia. This proposal involves an expansion of codes 238.7, Neoplasm of uncertain behavior, other lymphatic and hematopoietic tissues, and 284.0, Constitutional aplastic anemia. Although the myeloproliferative disorders and myelodysplastic syndrome are now recognized as hematologic malignancies, for data consistency purposes, they will be maintained with the neoplasms of uncertain behavior in ICD-9-CM.

Essential thrombocythemia is also known as essential thrombocytosis, idiopathic thrombocythemia, and primary thrombocytosis. It involves a markedly elevated platelet count and abnormal platelet aggregation. Additional findings may include hypercellular bone marrow, acrocyanosis, and splenomegaly. Bleeding or abnormal clotting events may occur. Essential thrombocythemia can have certain specific genetic causes, which can be a mutation of the thrombopoietin gene, or a polymorphism in the myeloproliferative leukemia virus oncogene.

Myelodysplastic syndrome refers to a group of acquired bone marrow disorders, which involve dysplastic, hypercellular bone marrow, and peripheral cytopenia. It commonly precedes acute myelogenous leukemia and may be called preleukemia. Myelodysplastic syndrome may be classified (based on examination of peripheral smear and bone marrow) as refractory anemia with or without dysplasia, refractory anemia with ringed sideroblasts with or without dysplasia, and as refractory anemia with excess blasts. Chronic myelomonocytic leukemia has been considered to be related to myelodysplastic syndrome, but it has both myelodysplastic and myeloproliferative characteristics.

Myelofibrosis with myeloid metaplasia may also be called agnogenic myeloid metaplasia, primary myelofibrosis, idiopathic myelofibrosis, or myelosclerosis with myeloid metaplasia. This chronic and progressive disease involves bone marrow being
replaced by fibrous tissue. A progressive anemia results, even though other organs such as the spleen start to make blood. Splenomegaly may also occur.

The aplastic anemias include a diverse group of bone marrow disorders, most of which involve not just anemia, but pancytopenia as well. The hematopoietic marrow cells are generally replaced by fat in aplastic anemia, in comparison to disordered hematopoiesis in myelodysplasias, and fibrosis is myelofibrosis. Pancytopenia is a decrease in all of the cellular elements in the blood, including red cells, white cells, and platelets.

An expansion of code 288.0, Agranulocytosis, has been proposed to create codes for congenital, cyclic, and drug-induced neutropenia. The title of subcategory 288.0 would change to “neutropenia.” Unique codes for unspecified leukocytopenia, lymphocytopenia, other decreased leukocytes, unspecified leukocytosis, lymphocytosis, and other elevated leukocytes have also been requested. These codes would be created in category 288, Diseases of white blood cells.

**Psoas Muscle Abscess**

A new subcategory (567.3) has been proposed for retroperitoneal infections. Codes for psoas muscle abscess and other retroperitoneal abscess would be created in this subcategory. Patients with psoas muscle abscess classically present with fever, flank pain, and limited movement of the hip. In the early twentieth century, it was most commonly due to tuberculosis, as a complication of Pott’s disease (tuberculosis of the spine). However, tuberculosis is a relatively rare cause of psoas muscle abscess in the U.S. today, with the exception of immunocompromised patients. Psoas muscle abscess is now more commonly associated with conditions such as severe kidney infections. A number of organisms can cause psoas muscle abscess.

**Aspiration Syndrome**

At the October 2004 Coordination and Maintenance Committee meeting, code proposals for meconium aspiration and meconium staining were presented. Additional code changes related to neonatal aspiration are now being proposed. The new proposal involves the creation of new codes for aspiration of clear amniotic fluid without respiratory symptoms, aspiration of clear amniotic fluid with respiratory symptoms, aspiration of blood without respiratory symptoms, aspiration of blood with respiratory symptoms, aspiration of postnatal stomach contents without respiratory symptoms, and aspiration of postnatal stomach contents with respiratory symptoms. It was recommended that the changes discussed at the October 2004 meeting and the new proposal be implemented together in October 2005.

**Torsion Dystonia and Athetoid Cerebral Palsy**

New codes to describe athetoid cerebral palsy and acute dystonia due to drugs have been proposed. Code 333.7, Symptomatic torsion dystonia, would be expanded to accommodate the new codes. Athetoid cerebral palsy involves hypotonia, with poor head
control and potential feeding difficulties. Athetoid movements are often noted at about one year of age. Speech is often slurred. Intellect is usually preserved.

A new code for subacute dyskinesia due to drugs in subcategory 333.8, Fragments of torsion dystonia, has also been requested. Additionally, the word "idiopathic" would be replaced with the word "genetic" in the title of code 333.6. The title of subcategory 333.7 would be revised to state, "acquired torsion dystonia."

Myelitis

A number of new codes have been requested for myelitis, encephalitis, and encephalomyelitis:

- Postvaricella myelitis (category 052);
- Herpes zoster myelitis (subcategory 053.1);
- Herpes simplex myelitis (subcategory 054.7);
- Encephalitis and encephalomyelitis in viral diseases classified elsewhere (subcategory 323.0);
- Myelitis in viral diseases classified elsewhere (subcategory 323.0);
- Other encephalitis and encephalomyelitis due to infection classified elsewhere (subcategory 323.4);
- Other myelitis due to infection classified elsewhere (subcategory 323.4);
- Encephalitis and encephalomyelitis following immunization procedures (subcategory 323.5);
- Myelitis following immunization procedures (subcategory 323.5);
- Acute disseminated encephalomyelitis (subcategory 323.6);
- Other postinfectious encephalitis and encephalomyelitis (subcategory 323.6);
- Postinfectious myelitis (subcategory 323.6);
- Toxic encephalitis and encephalomyelitis (subcategory 323.7);
- Toxic myelitis (subcategory 323.7);
- Other causes of encephalitis and encephalomyelitis (subcategory 323.8);
- Other causes of myelitis (subcategory 323.8);
- Acute (transverse) myelitis, not otherwise specified (category 341);
- Acute (transverse) myelitis in conditions classified elsewhere (category 341); and
- Idiopathic transverse myelitis (category 341).

Code titles of several existing codes in the affected categories would be revised to accommodate the modifications.

Myelitis is an inflammation of the spinal cord. It can have a number of possible presentations and possible underlying causes. Transverse myelitis involves a paraparesis or paraplegia, due to the spinal cord dysfunction. Some of the potential causes of myelitis include infectious, post-infectious, post-vaccination, and toxic mechanisms.

A number of other disorders can also cause a secondary demyelinating acute transverse myelitis, including tumor, trauma, herniated intervertebral disc, hemorrhage, dissecting aortic aneurysm, arteritis, and systemic lupus erythematos. Idiopathic transverse myelitis is demyelinating in pathology.
Postnasal Drip

A specific code for postnasal drip has been requested. It would be created through an expansion of code 784.9, Other symptoms involving head and neck.

Postnasal drip is the symptom of fluid or mucous dripping down the back of the throat. There are quite a few possible causes. Sinusitis and allergic rhinitis are among the most common causes. When the underlying cause is known, the code for that condition should be assigned and not the proposed code. The proposed symptom code would be assigned when the cause is not known.

Nonasthmatic Bronchospasm

A new code has been requested for nonasthmatic bronchospasm. A child may present with bronchospasm, but he has not been diagnosed with asthma. Currently, bronchospasm is indexed to code 519.1, Other diseases of trachea and bronchus, not elsewhere classified.

Body Mass Index (BMI), Pediatric

On October 1, 2005, new ICD-9-CM diagnosis codes will become effective for body mass index (BMI) in adults. The American Academy of Pediatrics has requested that new codes also be established for pediatric BMI that use the value ranges for children as currently represented in the Centers for Disease Control and Prevention (CDC) growth charts. BMI has been a common approach to determine if adults are overweight or obese, and recently, there has been increased attention on using it for pediatric patients as well. BMI is calculated from weight and height measurements and then used to compare a child’s weight relative to stature with other children of the same age and gender. The percentile lines on the growth chart indicate the rank of the child’s measurement. For example, when the child’s BMI-for-age is plotted on the 95th percentile line, it means that 5 of 100 children (5%) of the same age and gender in the reference population have a higher BMI-for-age than that child. A table showing the percentile cut-off values is used to help determine children at risk for being overweight, indicating a nutrition-related health concern. BMI can be used to characterize underweight as well as overweight status.

Transfusion Related Acute Lung Injury (TRALI)

A new code for transfusion related acute lung injury (TRALI) has been proposed in category 518, Other diseases of lung. Transfusion related acute lung injury is a serious pulmonary syndrome seen in a small percentage of patients who have received blood products. The diagnostic features can include acute respiratory distress, acute bilateral pulmonary edema (noncardiogenic), severe hypoxemia, hypotension (rarely hypertension), and fever. The onset of TRALI is usually within 1-6 hours following a transfusion. The mortality rate is between six and ten percent. Treatment requires interruption of the transfusion and, in some cases, ventilation with hemodynamic support.
The vast majority of cases resolve within ninety-six hours with ventilatory support. Resolution is generally complete and few, if any, residual damages occur. According to the Center for Biologics Evaluation and Research, TRALI is the third leading cause of transfusion related death. The majority of deaths were associated with fresh frozen plasma transfusions, with fewer being caused by packed red blood cell transfusions and platelet transfusions. In most cases, follow-up donor antibody screens showed donors who were positive for anti-HLA or anti-granulocyte antibodies.

Genetic Testing

On October 1, 2005, new ICD-9-CM diagnosis codes will be implemented for genetic testing associated with procreative management. It has been recommended that parallel codes be created for genetic screening not associated with procreative management and that both sets of codes be implemented in October 2005.

Inconclusive Imaging Tests due to Excess Body Fat

A new code has been proposed for “image test inconclusive due to excess body fat.” Code V72.5, Radiological examination, not elsewhere classified, would be expanded to accommodate the new code. According to radiologists, the prevalence of obesity has led to an increase in occurrence of inconclusive imaging test results due to excess body fat. Excess body fat reduces the ability to diagnose and treat patients using imaging technologies that have become the cornerstone of modern medicine (x-rays, CT scans, ultrasound, magnetic resonance imaging). It can be difficult or impossible to tell whether a patient has a kidney obstruction, to distinguish a benign fibroid tumor from ovarian cancer, or to see whether a fetal heart is developing properly.

It was suggested that the new code be placed in category 793, Nonspecific abnormal findings on radiological and other examination of body structure, rather than creating a V code. Others felt that an inconclusive test due to excess body fat was not the same thing as an abnormal radiological finding.

Encounter for Hearing Examination Following Failed Hearing Screening

An expansion of code V72.1, Examination of ears and hearing, has been proposed to create a code for “encounter for hearing examination following failed screening.” Children are routinely screened for proper hearing function, and those who fail the initial screening may have additional audiology testing performed before a diagnosis of a hearing problem is made. The proposed code would describe the reason for the visit for the additional testing.

Central Pain Syndrome, Postoperative Pain

New codes for generalized pain, central pain syndrome, and postoperative pain have been proposed. Currently, there are codes for pain found in both the body system chapters and the symptom chapter. Therefore, several options were presented for consideration. One option would be to create a new category in the nervous system chapter. Another option
would be create codes for generalized pain and central pain syndrome in subcategory 780.9, Other general symptoms and to create a code for postoperative pain in category 997, Complications affecting specified body systems, not elsewhere classified. A third option would be to create a code for central pain syndrome in subcategory 349.8, Other and unspecified disorders of nervous system and create a code for postoperative pain in subcategory 998.8, Other specified complications of procedures, not elsewhere classified. Many meeting attendees seemed to prefer the first option. Concern was expressed as to when and for how long the proposed postoperative pain should be assigned, especially in non-acute care settings such as home health. It was suggested that central pain syndrome be classified to a code in the nervous system chapter and include thalamic pain syndrome (currently indexed to code 348.8, Other conditions of brain) and myelopathic pain.

Central pain syndrome can be caused by damage to the central nervous system. This 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. These patients are treated with pain medications and sometimes antidepressants or anticonvulsants.

Postoperative pain is currently indexed to “see Pain, by site.” However, coding only the site of the pain does not indicate that it is postoperative in nature. In the past, published coding advice has instructed coders to code the underlying cause of the pain (such as diabetic neuropathy), or the site of the pain, and to not use a postoperative complication code.

**Sensorineural Hearing Loss**

New codes for unilateral and asymmetrical sensorineural hearing loss have been requested in subcategory 389.1, Sensorineural hearing loss. It has also been proposed that the word “bilateral” be added to the titles of existing codes 389.11, 389.12, 389.14, and 389.18.

Otolaryngologists perform audiometric studies to evaluate hearing loss. When an asymmetric hearing loss (a bilateral hearing loss whereby the hearing loss is worse in one ear) or unilateral sensorineural hearing loss is noted, the patient is referred for further testing. Findings of asymmetric or unilateral sensorineural hearing loss may indicate a retrocochlear lesion, such as an acoustic neuroma or meningioma.

**Encounter for Pregnancy Test, Pregnancy Confirmed**

The American College of Obstetrics and Gynecology has requested a new code in subcategory V72.4, Pregnancy examination or test, for “encounter for pregnancy test, positive result.” The Excludes note under subcategory V72.4 indicates that a code from subcategory V22, Normal pregnancy, should be assigned for a positive test result. However, instant results can now be provided, and the test is usually administered by a nurse or other non-physician provider. Since there is no actual supervision of the pregnancy during the encounter for the testing, the use of a V22 code is incorrect.
It has been recommended that the proposed new code be implemented October 1, 2005 to allow for the use of the code as quickly as possible.

**Other Conditions or Status of Mother Complicating Pregnancy**

The American College of Obstetrics and Gynecology has requested that a new category be created in chapter 11 (Complications of Pregnancy, Childbirth, and the Puerperium) to allow for the classification of numerous conditions that affect pregnancy but cannot currently be coded specifically. This new category would include codes for smoking, obesity, bariatric surgery status, coagulation defects, epilepsy, spotting, and uterine size and date discrepancy.

**Bariatric Surgery Status**

A code for bariatric surgery status has been proposed in subcategory V45.8, Other postprocedural status. It is important to be able to identify patients who have undergone this type of surgery because of the potential impact this might have on future healthcare.

**Elevated Tumor Associated Antigens [TAA]**

The creation of a new subcategory in category 795, Other and unspecified abnormal cytological, histological, immunological, and DNA test findings, to capture elevated tumor associated antigens [TAA] has been proposed. Within this new subcategory, there would be codes for elevated carcinoembryonic antigen [CEA], Elevated CA 125, and other elevated tumor associated antigens.

Understanding of the mechanism involved in the induction of immunity and the recognition of antigens by effector cells has improved dramatically over the past decade. Testing for elevations in tumor associated antigens [TAA] (antigens that are relatively restricted to tumor cells) and tumor specific antigens [TSA] (antigens unique to tumor cells) in the diagnosis of and follow-up care for many cancers has become common practice. A unique code for elevated prostate specific antigen [PSA] was created when this test became routine in the diagnosis of prostate cancer. Many additional TAA and TSA tests have now become routine.

**Antepartum Testing on Father**

New codes for “testing for genetic disease carrier status of male” and “other genetic testing of male” have been proposed in subcategory V26.3, Genetic counseling and testing. New codes for genetic disease carrier status and other genetic testing that were previously proposed and are slated for implementation on October 1, 2005 would be revised to limit their use to female patients. It has also been proposed that the title of category V28 be revised to state, “encounter for antenatal screening of mother.”

Often the male partner of a woman who is planning to conceive or is already pregnant will be evaluated for possible conditions that may affect a fetus. The proposed codes
would only be for use on the record of the patient (the male being tested), not on the
to female’s record.

*Macrophage Activation Syndrome*

A new code for hemophagocytic syndromes has been proposed in category 288, Diseases of white blood cells. There are several disorders that have in common excessive and abnormal activation of macrophages, which are mature forms of the monocytes of the blood and bone marrow. These overzealous macrophages destroy blood cells (eat up or phagocytize red cells, other white cells and platelets) and cause liver damage and bleeding problems and have a high mortality rate. The most common of these conditions are macrophage activation syndrome, hemophagocytic syndrome, and familial hemophagocytic lymphohistiocytosis. Macrophage activation syndrome occurs mostly in patients with rheumatoid arthritis who are on immunosuppressive therapy. Hemophagocytic syndrome, also called infection- or viral-associated hemophagocytic syndrome, is triggered by an infection. The virus that causes infectious mononucleosis is the best known of the infections that can cause this disorder. Familial hemophagocytic lymphohistiocytosis is an inherited type. Due to the rare nature of these disorders, only one code encompassing all types is being proposed.

*Unspecified Adverse Effect of Drug, Medicinal and Biological Substance*

In an effort to improve the coding of adverse effects of drugs and drug allergies, and to reduce the use of code 995.2, Unspecified adverse effect of drug, medicinal and biological substance, it is being proposed that code 995.2 be modified. The use of code 995.2 should be used in very rare circumstances, when no information is provided regarding the adverse effect. It should never be used in the inpatient setting. However, there are a number of terms representing specific adverse effects that are indexed to code 995.2. All nonspecific terms for allergies to drugs are also indexed to code 995.2.

Two options were presented for consideration. The first option would expand code 995.2 to include specific codes for unspecified adverse effects of anesthesia and insulin and remove all drug allergies from code 995.2. The title of code 995.3, Allergy, unspecified, would be changed to “allergic reaction, not elsewhere classified,” and this code would be expanded to include specific codes for allergy, unspecified, Arthus’ phenomenon, other drug allergy, and other allergic reaction, not elsewhere classified. All drug allergies would be moved from code 995.2 to subcategory 995.3. In the second option, code 995.2 would be expanded to include codes for Arthus’ phenomenon, other drug allergy, and unspecified adverse effects of anesthesia and insulin. Thus, drug allergies would not be re-classified to code 995.3 and no changes would be made to code 995.3.

In determining which option to select, a decision will need to be made as to whether unspecified reactions to injections should remain in category 999, Complications of medical care, not elsewhere classified, or be moved to subcategory 995.2.
Immunotherapy

It has been proposed that code V58.1, Chemotherapy, be expanded to allow the creation of a new code for encounter for immunotherapy for neoplastic condition. The title of the code for encounter for chemotherapy would be revised to state, “encounter for antineoplastic chemotherapy.” The title of subcategory V58.1 would be “encounter for chemotherapy and immunotherapy for neoplastic conditions.”

Immunotherapy, also called immune therapy and biologic therapy, is treatment that stimulates the body’s immune defense system to fight infection and disease. It is not classified as chemotherapy. Unlike traditional cytotoxic chemotherapies that attack cancer cells themselves, immunotherapy is designed to enhance the body’s defenses by mimicking the way natural substances activate the immune system. This can stimulate the growth and activity of cancer-killing cells. An example of immunotherapy is high-dose interleukin-2, which is used in the treatment of malignant melanoma and renal cell carcinoma.

It was suggested that code V07.3, Other prophylactic chemotherapy, be excluded from the V58.1 codes. A recommendation was made that the modifications to code V58.1 be implemented on October 1, 2005.

Proposed Addenda

Proposed diagnosis addenda changes were reviewed. The proposed revisions include:

- Addition of inclusion term for “pneumonia due to Pneumocystis jiroveci” under code 136.3, Pneumocystosis;
- Addition of inclusion term for “Post-Traumatic Stress Disorder (PTSD)” under code 309.81, Other specified adjustment reactions;
- Addition of note under code 440.24, Atherosclerosis of the extremities with gangrene, indicating that an additional code should be used to identify any associated ulceration (707.10-707.9);
- Addition of inclusion term for “female genital mutilation status, type 4” under code 629.20, Female genital mutilation status, unspecified;
- Addition of Excludes note for aphasia due to late effects of cerebrovascular disease (438.11) under code 784.3, Aphasia;
- Addition of inclusion term for “hyperglycemia NOS” under code 790.29, Other abnormal glucose;
- Addition of inclusion term for “abnormal blood level of lead” under code 790.6, Other abnormal blood chemistry;
- Addition of Excludes note for “lead poisoning (984.0-984.9)” under code 790.6, Other abnormal blood chemistry;
- Addition of Index entry for Dieulafoy lesion of esophagus (530.82);
- Revision of Index entry for microvascular disease (code to condition);
- Revision of Index entry for feeding problem in infancy or early childhood (783.3);
- Revision of Index entry for flexion, deformity (736.9);
- Addition of Index entry for tracheostomy granuloma (519.09);
• Addition of Index entry for autoimmune hepatitis (571.49);
• Addition of Index entry for post-cardiac surgery (syndrome) injury (429.4);
• Addition of Index entry for Talon noir (default code of 924.20, with site-specific Index entries).

“Possible/Probable” Guideline

Donna Pickett presented results of an informal survey conducted by the American Health Information Management Association (AHIMA) and American Hospital Association (AHA) on whether the inpatient coding guideline for coding “suspected,” “possible,” “probable” diagnoses should be changed to match the outpatient coding guideline. In the draft ICD-10-CM coding guidelines, the inpatient and outpatient guidelines for “suspected”, “possible,” and “probable” diagnoses are the same (i.e., code to the highest degree of certainty). In the AHA survey (31 respondents), 71% did not support changing the inpatient guideline; 10% did support making the change; and 19% were uncertain. In the AHIMA survey (49 respondents), 51% did not support a change to the inpatient guideline; 32% supported a change; and 16% were uncertain. When the results of the two surveys are combined, 58% did no support changing the guideline and 24% did support the change.

Respondents who support changing the inpatient guideline offered the following reasons: the current guideline results in patients being inappropriately “labeled” with a diagnosis which can adversely affect the patient’s ability to obtain insurance; need for uniformity and consistency between the inpatient and outpatient guidelines; coding is easier to teach if there is one set of guidelines for both the inpatient and outpatient settings; and changing the inpatient guideline would improve data accuracy.

Respondents who do not support changing the inpatient guideline for coding “suspected,” “possible,” and “probable” diagnoses offered the following reasons: the basis for the guideline still exists (it explains medical necessity, resource use, etc.); use of the terms “suspected,” “possible,” and “probable” by physicians means it is his/her best clinical judgment that the patient has the condition and is being treated for it; and certain conditions cannot be confirmed without an autopsy (e.g., Alzheimer’s).

Attendees at the Coordination and Maintenance Committee meeting stated the following:
  ▪ Conditions documented as “suspected” or “possible” during the hospitalization, but not documented at discharge, are sometimes being picked up and coded;
  ▪ There will be a huge change in trend data if the guideline is changed;
  ▪ The quality of the data is already poor because some hospitals are not following the inpatient guideline;
  ▪ Data is needed on what percentage of discharges would be affected by a guideline change;
  ▪ Patients have reported difficulty in getting “possible” diagnoses that have later been “ruled out” expunged from databases - these diagnoses continue to follow the patients when they apply for insurance, even though it was ultimately determined that the patient does not have that diagnosis;
  ▪ Additional (more formal) research should be conducted.
Suggested alternatives to handle “possible” and “probable” diagnoses included:
  - Create a modifier to identify that workup is ongoing or the level of certainty of the diagnosis;
  - Add a sixth digit to the diagnosis code to identify that it is a provisional diagnosis;
  - Exclude certain diagnoses from the current guideline (such as cancer, epilepsy, multiple sclerosis);
  - Apply the inpatient guideline only to the principal diagnosis and not to secondary diagnoses;
  - Add a field on the UB-04 to identify whether the diagnosis is “suspected” or not (similar to the “present on admission” indicator that is part of the draft UB-04).

Suggested next steps included continuing to work with the healthcare industry to evaluate possible solutions and to solicit additional input from users of clinical data (such as researchers).

**Sepsis Coding**

An open discussion was held to obtain feedback on the use of the codes for systemic inflammatory response syndrome (SIRS), sepsis, and septic shock. SIRS has many causes - if it is caused by an infection, then the patient has sepsis. Organ failure associated with or due to an inflammatory response that was caused by an infection is severe sepsis. However, it is sometimes difficult to determine what the cause was, both for the physician and coder.

Commenters pointed out that following:
  - It is important to find out whether the organ dysfunction is due to the SIRS – sometimes a patient may have another underlying cause of the organ dysfunction (such as chronic obstructive pulmonary disease causing respiratory failure);
  - There are many problems with how the terms sepsis, septicemia, severe sepsis, and septic shock are used;
  - Coders need clear guidelines on sequencing, especially concerning when to apply the chapter-specific guidelines vs. overarching guidelines for selection of principal diagnosis (the revised guidelines that became effective April 1, 2005 did not address this);
  - A clinician noted that pneumonia with subsequent respiratory failure equates to severe sepsis, but it would not be appropriate for a coder to assign the code for severe sepsis without this condition clearly being documented in the medical record;
  - When multiple disorders are present, such as chronic obstructive pulmonary disease, congestive heart failure, and pneumonia, along with sepsis and respiratory failure, it may not be very clear as to which condition caused the respiratory failure (it would be appropriate to query the physician in such cases).

The feedback received at the meeting will be discussed by the Cooperating Parties as part of their efforts to clarify the proper coding of sepsis and SIRS through code modifications and/or improved coding guidelines.
Procedures

Subtalar Joint Arthroereisis

Creation of a unique code for subtalar joint arthroereisis has been proposed in subcategory 81.1, Arthrodesis of foot and ankle. The title of this subcategory would be revised to state, “arthrodesis of foot and ankle and arthroereisis.” Currently, code 81.99, Other operations on joint structure, is assigned for subtalar joint arthroereisis.

Subtalar joint arthroereisis is performed to treat collapsing pes valgo planus, or flexible flatfoot. Arthroereisis is the limitation of exogenous joint motion without complete arthrodesis. It limits excessive motion at the involved joint axis. It limits excessive valgus motion at the subtalar joint and retains the varus range of motion. Arthrodesis, by contrast, prevents all motion across the joint axis by creating a surgical fusion of the joint. There are various surgical techniques for performing a subtalar joint arthroereisis. The subtalar Maxwell-Brancheau arthroereisis implant is an internal orthotic that aims to restore the arch by blocking the anterior and inferior displacement of the talus and by preventing the foot from pronating. By doing so, it allows normal subtalar joint motion. Tissue grows normally around the implant and aids in holding it in place.

A modified subtalar arthroereisis is obtained by implanting an endoprosthesis manufactured from ultrahigh molecular weight polyethylene. The implant is shaped into a peg that is implanted into the dorsal surface of the calcaneus just anterior to the posterior facet of the subtalar joint and fixed with polymethylmethacrylate. The implant’s purpose is to eliminate abnormal pronation, correct heel valgus, and produce an increase of the medial longitudinal arch in growing children.

Subtalar stabilization of the planovalgus foot can also be achieved with staple arthroereisis. This procedure attempts to correct alignment, restore balance, and allow continued function.

Calcaneo-stop with retrograde endorthesis implantation is another type of surgery performed to correct calcaneal valgus or flat foot, in children between the ages of 9 and 13. A retrograde endorthesis screw is placed at the level of the external opening of the tarsal sinus, a space between the talus and the exterior calcar, until it abuts at the correct length on the lateral process of the talus. The screw contains proprioceptive receptors, neuroreceptors that integrate at the medullary and spinal level a contracting reflex of the spinators, that transmit the impulses required for active correction of the flat foot precisely at the phase it is needed. The retrograde endorthesis does not need to be removed, since it is designed so that it is incorporated into the bone structure of the calcar during growth at the end of its function.

360 Degree Spinal Fusion

It has been recommended that code 81.61, 360 degree spinal fusion, single incision approach, be deleted. An inclusion term for ALIF (anterior lumbar interbody fusion)
would be added under code 81.06, Lumbar and lumbosacral fusion, anterior technique, and inclusion terms for inter-transverse process technique, PLIF (posterior lumbar interbody fusion), and TLIF (transforaminal lumbar interbody fusion) would be added under code 81.08, Lumbar and lumbosacral fusion, posterior technique.

The creation of code 81.61 has generated considerable confusion as to when it should be used. The ICD-9-CM terminology is not consistent with physician documentation of spinal fusions. Therefore, code 81.61 is being used inconsistently.

**Hip Replacement Bearing Surfaces**

Creation of three new codes to identify the type of bearing surface used in hip replacements has been proposed. These codes would be placed in subcategory 00.7, Other hip procedures, and would specify whether the bearing surface was metal on polyethylene, metal-on-metal, or ceramic-on-ceramic. Notes would be added under the codes for hip replacements and revisions instructing coders to “code also type of bearing surface, if known.” If the necessary information is not in the medical record, the code for the bearing surface would not be assigned.

Hip prostheses currently last approximately 10-15 years before they need to be replaced. There have been ongoing efforts to find bearing materials that will prolong the life of these devices and that will allow a high level of functioning. Currently, most of these devices use either a metal-on-metal or metal on polyethylene bearing surface. A new bearing surface, ceramic-on-ceramic, offers the possibility of extending the life of hip prostheses by reducing the amount of friction and providing a less biologically reactive material than is provided by polyethylene or metal surfaces. Distinct codes to describe the type of bearing surface would provide better data on patient outcomes.

A question was raised as to whether the proposed codes should be broadened to allow their use for bearing surfaces of other types of joint replacements, such as knees. The presenter indicated that there would not be value in making the codes more generic because metal-on-metal and ceramic-on-ceramic would not be used for knee replacements. One commenter suggested that it would be helpful if manufacturers would start to provide documentation of the bearing surface through labels that could be affixed in the medical record. A representative of a manufacturer agreed to explore this option.

**Implantation of Interspinous Process Decompression Device**

New codes for implantation of interspinous process decompression device and removal of spinal device have been proposed in subcategory 84.5, Implantation of other musculoskeletal devices and substances. Currently, code 84.59, Insertion of other spinal devices, is assigned for implantation of interspinous process decompression device.

The X STOP interspinous process decompressive (IPD) implantable device is currently being implanted under clinical trials, and approval by the U.S. Food and Drug Administration (FDA) is anticipated in the second quarter of 2005. This device was designed to treat patients with lumbar spinal stenosis who normally experience pain and
tingling in their legs while standing or extending, and experience pain relief while sitting or flexing their lumbar spine. The X STOP is placed between the lumbar spinous processes of the stenotic level(s) in order to limit extension of these level(s). Initially, the procedure is performed predominantly in the inpatient setting, but clinical trials indicate that eventually it will be primarily performed as an outpatient procedure.

**External Fracture Fixation Devices**

A proposal was submitted for a series of new codes to differentiate between the various types of fracture fixation devices. Two new subcategories would be created for “application of external fixation device, ring system” and “application of external fixation device, other multiplanar system,” with fourth digits to indicate the anatomical site. Suggestions for placement of the new codes ranged from a new chapter (17) to expansion of existing subcategory 84.9. Other operations on musculoskeletal system. Commenters expressed concern about the number of codes being proposed, particularly given the fact that ICD-9-CM is running out of space and an implementation date for ICD-10-PCS is still unknown. It was suggested that just two codes be created, for the ring system and other multiplanar system, rather than creating a series of site-specific codes. The diagnosis codes and other procedure codes would identify the affected anatomical site.

External fixation is an external scaffold designed to secure bone fragments with temporary percutaneous implants. The purpose is to provide a stable healing environment for the restoration and healing of bone and soft tissue. External fixators may be applied to function in one of three ways:

1. **Neutralization** – Holding the limb out to length; protecting the fracture site from loading (neutralizing the load);
2. **Compression** – Compressing the fracture fragments together in an effort to increase stability and facilitate the healing of fresh fractures and non-unions;
3. **Distraction** – Pulling the fracture or osteotomy apart so that bone will regenerate and thus lengthen the limb.

**Infusion of Liquid Radioisotope**

New codes to capture the three component parts of infusion of liquid radioisotope into the brain have been proposed. These codes would be created in subcategory 01.2, Craniotomy and craniectomy, and would describe: insertion of catheter into cranial cavity; removal of catheter from cranial cavity; and infusion of liquid brachytherapy radioisotope. Three codes are necessary because these procedural steps are not performed during the same operative encounter.

Iotrex™ is an organically bound liquid form of Iodine-125 used in intracavitary brachytherapy with the GliaSite® Radiation Therapy System. After a malignant tumor has been resected from the brain, a balloon catheter is implanted temporarily inside the cavity. The patient is released from the hospital. After a period of three days to three weeks, the patient is readmitted. At this time, the liquid I-125 (Iotrex™) is infused into the catheter, and intracavitary radiation is delivered to the target area. The emitted gamma radiation from Iotrex™ is delivered directly to the margins of the tumor bed.
Because the radiation dose rapidly decreases beyond the tumor site, there is minimal damage to surrounding healthy tissue. This approach allows the physician to maximize total radiation to the target area. After three to seven days, the Iotrex™ is removed.

**Radiofrequency Ablation of (Chronic) Total Artery Occlusion**

The creation of a distinct code in subcategory 00.6, Procedures on blood vessels, for radiofrequency crossing of total vessel occlusion(s) has been proposed. Currently, there is no way to code this procedure. Only the angioplasty (and stent insertion if performed) would be coded. It would be incorrect to assign code 36.09, Other removal of coronary artery obstruction, 39.59, Other repair of vessel, or 39.99, Other operations on vessels, to identify the radiofrequency crossing of a total vessel occlusion.

Commenters recommended that “radiofrequency” be deleted from the proposed code title in order to use this code for other devices that may use ultrasound, microwave, or laser to accomplish the same result.

Chronic total occlusion (CTO) is defined as coronary or peripheral artery occlusion of more than one-month duration. Between ten and twenty percent of patients currently undergoing percutaneous interventions in major catheterization laboratories have this condition. Successful opening of CTOS improves anginal status, increases exercise capacity, and reduces the need for bypass surgery. Opening a CTO is a major challenge because the plaque tends to be very hard, fibrotic, and calcified, blocking the flow of imaging contrast used to visualize the path of the artery. Threading a guidewire through a CTO creates risk of vessel perforation, if the guidewire can even penetrate the blockage, since the path of the artery cannot be seen. Historically, patients with CTO have not been treated by angioplasty because this type of blockage complicates the procedure. Bypass surgery is generally performed instead.

The Safe-Cross® System is designed to open a CTO. With an optical fiber embedded into the guidewire, the system is able to provide guidance feedback to the operator through optical coherence reflectometry. It recognizes the vessel wall and alerts the operator to steer the wire away to prevent subintimal passage or perforation. Also, the device is able to deliver radiofrequency energy (vaporization) to micro-ablet a small hole into a CTO of an artery to facilitate passage of the guidewire. Only after a guidewire is across the occlusion can angioplasty and stent insertion take place.

**Endovascular Implant in Thoracic Aorta**

A new code has been requested to identify endovascular implantation of graft in thoracic aorta. This code would be created in subcategory 39.7, Endovascular repair of vessel. Code 39.79, Other endovascular repair (of aneurysm) of other vessels, is currently being assigned for this procedure.

A defect of the thoracic aorta, whether caused by structural weakness of the aortic wall (aneurysm, dissection), trauma, or a complication of previous surgery, is a potentially life-threatening condition. Traditional treatment requires open surgical repair of the
damaged portion of the thoracic aorta. Surgery and recovery are challenging for these patients due to the thoracotomy required to access the thoracic aorta behind the heart and lungs and the comorbidities that these patients often have. Endovascular stent-grafting of the thoracic aorta provides a minimally invasive alternative. The endoprosthesis is a conduit constructed of ultra-thin graft material with an integrated, self-expanding metallic stent-graft. The function of the endoprosthesis is to internally reline the damaged portion of the thoracic aorta, excluding it from the blood circulation.

Endovascular grafting is accomplished through a small incision, normally in the patient’s leg or groin, providing access to the femoral or iliac artery. Using image-guided, catheter-based techniques, the endoprosthesis is maneuvered through the peripheral vasculature and abdominal aorta and is positioned in the damaged section of the thoracic aorta. Following deployment, imaging is used to confirm proper position in the aorta. Balloon touch-up is then utilized to ensure proper fit of the device to the aortic wall. In some cases, an additional device may be deployed to ensure coverage of the entire segment to be treated or to better accommodate irregular anatomy.

Infusion of Immunosuppressive Antibody Therapy at the Time of Transplantation

A new code has been proposed in subcategory 00.1, Pharmaceuticals, for the intravenous infusion of immunosuppressive antibody therapy during the induction phase of solid organ transplantation. Currently, code 99.29, Injection or infusion of other therapeutic or prophylactic substance, would be assigned for this procedure.

Immunosuppressive antibody therapies immunomodulate and prevent the immunologic activity against foreign antigens present in a transplanted organ. Immunosuppression is used in solid organ transplantation to prevent rejection in the induction phase as well as the maintenance phase and can be used to reverse an ongoing rejection episode. The induction phase occurs prior to, during, or immediately after surgical transplantation. Immunosuppressive antibody therapies contain antibodies that preferentially bind to antigens expressed on lymphocytes, specifically T-cells that are responsible for allograft rejection. As a result, T-cells may be depleted, proliferation is inhibited, and cell surface antigens are immunomodulated, leading to T-cell clearance from the blood and peripheral lymphoid tissues.

For renal transplant patients, immunosuppressive antibody therapies used during the induction phase of transplantation are typically administered via the peripheral or central vein. In contrast to maintenance therapy, which requires stable doses over a long period of time, induction therapy is administered in short courses during the initial hospital stay. Multiple infusions might be given during a single hospital admission.

Failure of ICD-9-CM to Meet Future Coding Demands

Several commenters (including AHIMA) expressed concerns that the limitations of ICD-9-CM are reaching crisis proportions, particularly in light of the failure of the Department of Health and Human Services to initiate the regulatory process for adoption of ICD-10-CM and ICD-10-PCS. It is possible that ICD-9-CM could run out of space for new codes
before ICD-10-CM and ICD-10-PCS are implemented. Commenters suggested that the Coordination and Maintenance Committee may need to start restricting the creation of new codes (perhaps by prioritizing code proposals and only implementing those identified as being the highest priority) in an effort to make ICD-9-CM last as long as possible.

Procedure Addenda

Proposed procedure addenda changes were reviewed. The proposed revisions include:

- Addition of Index entry for STARR (stapled transanal rectal resection) – 70.52;
- Revision of Index entry for “Test, fetus, nonstress” (75.34 instead of 75.35);
- Addition of note under subcategory 00.2, Intravascular imaging of blood vessels indicating that this subcategory includes real-time imaging of lumen of blood vessel(s) using sound waves;
- Addition of Excludes note for “magnetic resonance imaging (MRI) (88.91-88.97) under subcategory 00.2, Intravascular imaging of blood vessels;
- Revision of Excludes notes for “kyphoplasty” and “vertebroplasty” under code 03.53, Repair of vertebral fracture, to indicate that code 81.66 is the correct code for kyphoplasty and code 81.65 is the correct code for vertebroplasty.

ICD-10-PCS Update

An update on ICD-10-PCS was provided by staff from 3M Health Information Systems. In 2004, a set of coding guidelines was developed for ICD-10-PCS with input from AHIMA, the American Hospital Association, CMS, and NCHS. The definition and application of the root operations “revision” and “repair” were changed in the Medical/Surgical section. The Laboratory section was deleted. The code description file was converted to a text format.

In 2006, ICD-10-PCS will be updated to reflect ICD-9-CM changes. Specificity for coding medical devices and administered substances will be increased to be consistent with demands for greater detail to support requirements for identifying new medical technology. 3M will solicit outside assistance to update the Radiology section. The ICD-9-CM to ICD-10-PCS crosswalk will be completed. The DRGs will be converted to the ICD-10-CM and ICD-10-PCS coding systems, with the goal being to produce a prototype of the DRGs in the new code sets by the end of 2005.

The most recent version of ICD-10-PCS is available on the CMS website at the following link: http://cms.hhs.gov/paymentsystems/icd9/icd10.asp.