ICD-9-CM Coordination and Maintenance Committee Meeting
Summary of Volumes 1 and 2, Diagnosis Presentations
March 11-12, 2009

The diagnosis portion of the meeting began on March 12, following the completion of the procedure topics on March 11. Donna Pickett, co-chair of the committee, welcomed the members of the audience. Donna informed the audience that March 12, 2009 is World Kidney Day. She reviewed the ICD-9-CM timeline included at the beginning of the topic packet. Written comments for topics presented at this meeting, considered for October 1, 2009 implementation, must be received by the National Center for Health Statistics (NCHS) staff by April 3, 2009. Comments for codes being considered for October 1, 2010 implementation should be received by June 12, 2009. She requested that comments be sent via electronic mail or fax since regular mail is often delayed due to security screening. Contact information for all NCHS staff and the NCHS website are included in the topic packet. Attendees were also reminded that the full topic packet and PowerPoint presentations would be posted on the NCHS website shortly following the meeting. Proposals for the September 2009 meeting should be received by July 17, 2009.

Donna Pickett also announced that continuing education (CE) credits would be available at the close of the meeting for both American Health Information Management Association (AHIMA) credits and for American Academy of Professional Coders (AAPC) credits. 5 CE credits were awarded for Wednesday, March 11, and 4 CE credits were awarded for Thursday, March 12. Ms. Pickett announced that NCHS will no longer provide a hard copy CE certificate at the conclusion of the meetings. Attendees can print a copy of the topic packet table of contents to use as documentation. If further documentation is required, please contact NCHS staff.

Donna Pickett provided an overview on the ICD-10 Final Rule that was published on January 16, 2009. The implementation date for the ICD-10-CM and ICD-10-PCS code sets is October 1, 2013. The rule can be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf. The single date for all users is the date of service for ambulatory & physician reporting or the date of discharge for inpatient settings. ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013, although ICD-9-CM claims for services prior to the implementation date will continue to flow through systems for a period of time. Ms. Pickett noted that the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) have worked collaboratively with the American Hospital Association (AHA), and AHIMA (collectively the Cooperating Parties) on outreach materials. They have conducted four outreach and education conference calls. They plan to have additional calls in the future. To obtain the transcript and slides presented on the calls, please access: http://www.cms.hhs.gov/ICD10/07_Sponsored_Calls.asp#TopOfPage. Educational material and information on future educational outreach calls will be posted at: http://www.cms.hhs.gov/ICD10/05_Educational_Resources.asp#TopOfPage.

The ICD-9-CM Coordination & Maintenance Committee (C&M) will continue to discuss updates to ICD-9-CM, ICD-10-CM, and ICD-10-PCS. These updates will be posted on the relevant CMS and CDC classification web pages. Upon implementation of the ICD-10 code sets the planned new name of the ICD-9-CM Coordination and Maintenance Committee will be the ICD-10 Coordination & Maintenance Committee. Several issues need to be discussed at the September 16-17, 2009 meeting. These issues include a possible freeze on the updating process prior to the implementation of the ICD-10 code sets, and when that freeze should occur. Ms. Pickett concluded her presentation with information on resources available on the CDC and CMS websites. Complete ICD-10-CM and ICD-10-PCS systems are available, including the guidelines, General Equivalence Mappings (GEMs) between ICD-9-CM and ICD-10-CM and ICD-9-CM Volume 3 and ICD-10-PCS (both ways), users guide for the GEMs, abbreviated reimbursement mappings, the development of an ICD-10 version of MS-DRGs, and the ICD-10-CM/ICD-10-PCS Digestive System MS-DRGs.

Comments and discussion on the topics presented were as follows:

Post traumatic seizures

Gregory L. Barkley, MD, from Henry Ford Hospital in Detroit, Michigan, representing the National Association of Epilepsy Centers (NAEC) and the American Academy of Neurology (AAN) presented a clinical overview for this topic. His PowerPoint slides will be available in a separate file on the NCHS classifications website. Dr. Barkley explained that a seizure is a paroxysmal behavioral spell generally caused by an excessive disorderly discharge of cortical nerve cells and epileptic seizures range from clinically undetectable ("electrographic seizures") to convulsions. He also stated that not all seizures are due to epilepsy. The symptoms can vary depending upon the part of the brain involved in the epileptic discharge.

NAEC has requested a new code for post-traumatic seizures that is distinct and excluded from post-traumatic epilepsy. Dr. Barkley also requested a new term, partial status epilepticus, be added at code 345.7, and stated that he would prefer that the title for 345.7 be changed to Partial status epilepticus from Epilepsia partialis continua. Additionally, he discussed the issue of applicable 5th digits for the codes under category 345. That topic was not a part of the topic packet and will be discussed at a future C&M meeting. A member of the audience requested that code 345.7 be excluded from the other epilepsy codes related to status epilepticus (codes 345.2 and 345.3), if other changes are made to code 345.7, to be able to better distinguish the codes. This request will be considered.

While there was general support for the proposal to add a code for post traumatic seizures, there was discussion regarding sequencing of this proposed code and a head injury code, if the patient is still having symptoms of the head injury. It was suggested to use the late effect codes for encounters after the initial head injury. There was also a comment that it is still a problem that physicians do not use terminology consistently regarding convulsions, seizures and seizure disorder, and the code assignment will vary depending on the term used. One person asked how to code post traumatic seizure disorder. Dr. Barkley commented that though he does not personally like the term

seizure disorder, it is synonymous with epilepsy, so the term post-traumatic seizure disorder should be indexed to the epilepsy category.

Cognitive deficits related to Traumatic Brain Injury (TBI) and Neurological Conditions

This proposal is related to the September 25, 2008, proposal in which the Department of Defense (DoD) and the Veteran's Administration (VA) jointly requested changes to the ICD-9-CM classification to better classify traumatic brain injury (TBI) and its associated conditions. From that meeting and comments received, further review was requested for overlap of these conditions with those represented elsewhere in ICD-9-CM. It was also recommended to try placing these codes in Chapter 16, Signs, Symptoms and Ill-Defined Conditions. The original and revised proposals were included for discussion.

Ted Miller, representing several organizations (the American Public Health Association's Injury Control and Emergency Health Services Section, the Children's Safety Network, and the Traumatic Brain Injury Technical Assistance Center) said he likes the exclusions. He suggested that there were issues with including signs and symptoms involving cognition at category 799, with its current title, "Other ill-defined and unknown causes of morbidity and mortality." He suggested renaming category 799 to explicitly add the cognitive symptoms as part of the title.

Escherichia coli - expansion for O157:H7

Dr. Julia Pillsbury, representing the American Academy of Pediatrics, indicated that the Shiga Toxin-producing *E. Coli* infections are usually more life threatening and therefore should be tracked separately. The need to identify the type of infection outbreak in the community is important.

A comment was made that *E. Coli* O157:H7 is a Shiga Toxin-producing *E. Coli* (STEC), and that it could be useful to change the proposed new code to include STEC in the title, and thus include all STEC, not just O157:H7.

It was noted that *E. Coli* O157:H7 is an enterohemorrhagic type, and when it causes enteritis, that it would be coded to category 008. A question was raised about how often it would cause disease other than enteritis. Dr. Barkley, who gave support for this proposal, noted that STEC can cause other infections such as urinary tract infections. Hemolytic uremic syndrome can result from such infections, even without enteritis being present.

One commenter asked what would be coded first, since this infection code (041.4) is usually coded secondarily. There was a comment from Dr. Pillsbury that the Shiga Toxin-producing *E. Coli* condition would be coded first, and the new proposed code would be secondary. The need to identify the type of infection is important.

There was general support for this proposal.

Personal history of corrected congenital malformations

There was general support to expand and add codes to subcategory V13.6 to identify personal history of corrected congenital anomalies, by body system. Dr. Pillsbury commented that the AAP based this request on the need to monitor these patients, and that they may require long term follow-up or therapy. There isn't a good way to indicate the reason for visit if the congenital anomaly has been corrected. A question was raised about the proposed code V13.60, Personal history of (corrected) congenital inborn errors of metabolism and chromosomal anomalies, as to whether these can actually be corrected at this time. Dr. Pillsbury indicated that though some conditions can be corrected by transplant, and new treatments are in development, the chromosomal anomalies really are not able to be corrected now. A comment was made that a number of these conditions may be treated, with partial correction, but with remaining problems that may require follow up and observation, or even continued treatment. She expressed uncertainty about this proposed code, and noted that she would further review this issue with others at AAP.

It was also recommended to retitle existing code V13.61, Hypospadias to include the full code title to be consistent with the proposed new codes. One person commented that the term "corrected" should be reviewed. It does not always mean that the person does not have long term implications. For example the digestive malformations, once corrected, may mean that the person has a long term ostomy that must be monitored and maintained.

There was general support for this proposal to expand and add codes to identify personal history of congenital anomalies by body system.

Acute Idiopathic Pulmonary Hemorrhage in Infants

There was a question about pulmonary hemorrhage of the newborn, and what age it represented, and how to differentiate AIPHI from pulmonary hemorrhage of newborn, which is excluded from the proposed code. It was noted that pulmonary hemorrhage of newborn occurs at 28 days or less, and often is related to prematurity, while the CDC case definition for AIPHI would not include prematurity. There was some discussion regarding the addition of an excludes note at 786.31 for von Willebrand disease.

There was general support for this proposal.

Rheumatic Heart Failure Expansion

One person recommended that this and all of the heart failure proposals be reviewed by clinical organizations such as the American College of Cardiology (ACC), since cardiologists may not use the term "rheumatic" heart failure. Questions raised included how common this disease is and how accurate the current data is since ICD-9-CM defaults to rheumatic for many heart related conditions It was noted during the discussion that while some of the rheumatic heart failure data may be inflated due to ICD assumptions, it is not possible to be certain at this time. It was noted that there have been

articles in Coding Clinic to address this, and another article may be forthcoming. There was a comment that such clarification would be helpful.

Congestive Heart Failure Issues/
Alternative 1 – Congestive Heart Failure Expansion

There was general support for this proposal.

Congestive Heart Failure Issues
Alternative 2 - Systolic Heart Failure, Diastolic Heart Failure, and Combined Heart Failure with Congestive Heart Failure

One person commented that this proposal could be used in conjunction with the proposals in Alternative 1. Another commenter noted that alternatives 1 and 2 need not be considered mutally exclusive. There was discussion of the possibility to merge alternative 1 and 2 and to simplify the codes to add congestion. Another comment was that this looks complex, but that reporting can require so many codes, and thus this combination of codes would save space for reporting.

A question was raised as to why the proposal did not have a code for unspecified systolic heart failure with congestion (that is, without mention of acute or chronic nature), with a similar approach for diastolic and combined heart failure. There was a comment that it would be possible to add this to the proposal, using codes with fifth digit 7, such as 428.27, to be titled Unspecified systolic heart failure with congestion. Nelly Leon-Chisen, representing the American Hospital Association, recommended that proposed code 428.20 be used to show congestion.

Acute Heart Failure Classification and Related Heart Failure Issues

There was a general comment to combine low and high output and use 5th digits. It was suggested to break out proposed code 428.5 and put both low output syndrome and high output failure there to save 428.6 for potential other use. An alternative to that suggestion was to place these both at a new subcategory 428.8 for other heart failure.

Part 1, Low Output Syndrome (with Acute Heart Failure)

There was a question on whether the proposed 428.5, Low output syndrome, could be used alone, and there was agreement that this would be appropriate.

Part 2, High Output Failure

There were no further specific comments on this proposal, beyond those noted above.

Part 3, Acute Right Heart Failure

There was a comment about the combination of both left and right heart failure, and the suggestion to also add a code for that combination.

Part 4, Acute Decompensated Heart Failure

There was a comment that it would be helpful to have it made clear that decompensated is equivalent to acute on chronic, and this would reduce the burden of querying physicians. In addition, one person commenting in support of this proposal suggested indexing the term "compensated" related to heart failure to codes for chronic heart failure.

Heart Failure with Reduced Ejection Fraction, and with Normal Ejection Fraction

There was a suggestion to add "so stated" after the inclusion term Heart failure with reduced ejection fraction being proposed at code 428.2 , Systolic heart failure. Pat Brooks, CMS, objected to the proposal and commented that if clinical criteria were added as an inclusion term, others could ask that clinical criteria be added to other codes as well. Another commenter noted that she sees ejection fraction information documented in the medical record as well as information regarding whether or not diastolic dysfunction exists. Nelly Leon-Chisen, Director of the Central Office on ICD-9-CM of the American Hospital Association (AHA), added that there may be a need to compromise and possibly change the coding guidelines.

Acute Pulmonary Edema with Other Conditions

There was general support for this proposal with commenters indicating it will help clear up capturing pulmonary edema. It was suggested to add a "such as" note and a list of conditions to proposed new code 518.42, Acute pulmonary edema with conditions classified elsewhere. Some specific comments were that acute pulmonary edema is important, and that this would be good for identifying the edema. However, there was also some concern expressed about eliminating a note of long standing (on past inclusion of pulmonary edema due to heart failure at code 428.1, Left heart failure). There was a comment that if edema was worsening due to surgery, but present prior, that it would be important not to exclude the proposed new postoperative pulmonary edema code from other pulmonary edema codes, or vice versa, since these could coexist. A question was raised on the use of the proposed new code for acute pulmonary edema with conditions classified elsewhere, on how this might be applied with conditions where it might be considered intrinsic to the condition, and whether people would be reluctant to code it, for example with inhalation of toxic gas. These issues will be reviewed.

Aortic Ectasia

One person commented that they see this diagnosis frequently in patients who have Marfan syndrome, and it is currently difficult to code it accurately, so the proposed change would make it easier to code. . It was suggested to exclude aneurysm from this new code. It was also suggested to delete the "see also Aneurysm" note from the index, and replace that with a subentry to read "with aneurysm," which would then reference a code. Another person suggested that it would be useful to identify where the ectasia was, such as in the thoracic or abdominal aorta.

Difficult airway
There was general support for this proposal. One specific comment was that it would be useful.

Awaiting Joint Prosthesis
Sue Bowman, representing the AHIMA, indicated that aftercare and explantation status are not the same, and grouping them together in a single code could cause confusion.

Cocaine poisoning
There were no comments on this proposal.

Body Mass Index (BMI)
There were general comments that it may be useful to add an additional code for body mass index of 60 and over for adults. A response was that surgical risk is similar for those over 50. However, one commenter stated that there can be additional uses beyond surgery, where this information could be of value, and that sometimes there is more risk associated with super morbid obesity. It was noted that when the expansion to the obesity codes were made several years ago, there wasn't consensus on the definition for super morbid obesity.

It was also suggested that we could benefit from a split of the proposed code V85.41, with BMI 40.0-49.9, into smaller groupings with BMI of 40-45 and 46-50.

Fecal incontinence
One person asked about the deletion of the excludes note at code 569.49 for incontinence of sphincter ani (787.6) and where this would now be coded. This will be reviewed.

Müllerian anomalies
There was discussion of adding an inclusion term for Müllerian anomalies, NOS. The American College of Obstetricians and Gynecologists (ACOG) will be consulted regarding this question.

There was general support for this proposal

Personal history of vaginal and vulvar dysplasia
There were no comments regarding this proposal.

Addenda Changes to Official ICD-9-CM CD-ROM for October 1, 2009
The audience was reminded that comments for these addenda items should be submitted by April 3, 2009.

Addenda items for consideration for October 1, 2010
There was support for the proposed change to the note at category 438, indicating that this helps clear up that you do not use codes from this category for the initial acute care of the stroke. However, it was suggested to remove the words "and resolve" from the proposed change, since this may conflict with the proposed excludes note that says manifestations should be coded (whether or not they resolve).

There was discussion on the proposed change at subcategory V45.0, Cardiac device in situ. One commenter indicated that there are two issues to consider, some patients have both a pacemaker and a defibrillator. Currently new defibrillators also have pacemaker capabilities. It was suggested to add or change the term to "defibrillator with pacing capability" at the proposed excludes note at V45.01, Cardiac pacemaker, and also to modify the proposed inclusion term to read "with pacing capability" at code V45.02, Automatic implantable cardiac defibrillator. There was discussion on the proposal to exclude the cardiac pacemaker status code from the defibrillator status code, since modern defibrillators include a pacing function. The note will be reviewed with this comment in mind.

There was a comment regarding the changes at main index term Malnutrition, suggesting to reconsider the default for protein malnutrition.