

**ICD-9-CM Coordination and Maintenance Committee Meeting
Summary of Diagnosis Presentations
September 19, 2012**

Donna Pickett, co-chair of the committee, welcomed the members of the audience to the diagnosis portion of the meeting. She introduced two new NCHS staff members, Cheryl Bullock and Shannon McConnell-Lamprey. Ms. Pickett reviewed the timeline included at the beginning of the topic packet informing the attendees of the deadline for written comments on topics presented at this meeting. All diagnosis topics presented during the meeting are being considered for October 1, 2015 implementation, with a few exceptions that are being considered.

Written comments must be received by NCHS staff by November 16, 2012. Ms. Pickett requested that comments be sent via electronic mail to the following email address nchsid9CM@cdc.gov since regular mail is often delayed. Telephone 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 is currently posted on the NCHS website. New proposals for the March 4-5, 2013 meeting must be received by January 4, 2013.

Ms. Pickett also announced the following:

NCHS will no longer provide a hard copy continuing education (CE) certificate for this meeting. Attendees were instructed to contact the respective professional association for further information on CE reporting details. NCHS will continue to report, in this summary, the number of hours for each day of the meeting. The meeting was adjourned at 3:50 pm; attendees may be eligible for 6 CE hours for attending the Wednesday, September 19, 2012 meeting.

Comments and discussion on the topics presented on September 19, 2012 were as follows:

Cerebrovascular disease- bilateral

Some of the codes in the cerebrovascular disease section of ICD-10-CM indicate laterality as unspecified side, right side and left side, while others also include a bilateral option. Because cerebral infarctions may occasionally be due to bilateral arterial lesions, the American Academy of Neurology (AAN) recommends adding codes to indicate bilateral.

Ms. Fisher noted that corrections were needed for the following codes to specify “cerebral” arteries: I63.323, I63.333, I63.513, I63.523 and I63.533.

There were no comments on this proposal.

Mononeuropathy- bilateral

There were no comments on this proposal.

Multifocal Motor Neuropathy

There were no comments on this proposal.

Aneurysm and dissection of precerebral and vertebral arteries

There were no comments on this proposal.

Congenital metatarsus adductus

David Freedman, MD, representing the American Podiatric Medical Association (APMA), provided clinical background on this topic. The APMA has proposed creating unique codes under Q66.2 for congenital metatarsus primus varus and congenital metatarsus adductus. It was noted that primus varus and metatarsus varus each had unique codes in ICD-9-CM (754.52 and 754.53, respectively). This change would restore the anatomical detail that was previously available in ICD-9-CM.

There were no comments on this proposal.

Bunions

David Freedman, MD, representing the American Podiatric Medical Association, provided clinical background on this topic. The APMA has recommended that unique codes be created for bunion and bunionette.

One commenter expressed support for having two separate codes to capture these conditions and notes that clinical documentation is often found in the medical record.

Food Protein Induced Enterocolitis Syndrome (FPIES)

Anna Nowak-Wegrzyn, MD provided clinical overview of this syndrome.

One commenter spoke in support of the change and noted parental frustration in identifying the condition and seeking appropriate treatment. Another commenter suggested adding the FPIES acronym to the index/tabular.

A question was raised whether the non IgE mediated should be added as a non-essential modifier. Dr. Nowak-Wegrzyn responded that there are no other similar conditions qualified with IgE mediated status.

NCHS received a statement from the American Gastroenterological Association in support of this change.

Age-related Macular Degeneration (AMD)

The American Academy of Ophthalmology (AAO) and the American Society of Retina Specialists (ASRS) are requesting tabular modifications to better distinguish the stages of AMD.

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Dr. Trexler Topping, representing AAO and ASRS, was available via telephone to address questions and concerns from the audience regarding stages of the disease, appropriate treatment, clarification of active vs. inactive. He provided additional clinical information differentiating Dry and Wet AMD. Specifically he mentioned that dry AMD can evolve to wet AMD. Also, in response to a question, he stated that at times patients can have AMD bilaterally but with different stages on each side. He agreed that in such cases, two codes would be needed. However, he stated that bilateral disease with the same stage would be expected to be more common, so that more detail as proposed would be useful.

The following questions were raised:

- A question was raised as to how to code this if the documentation only states “choroidal neovascularization”. Should there be a default for this or a separate NOS code?
- Should inclusion terms (dry, wet) be added for each new code under H35.31 and H35.32?
- Related to wet AMD, what if the record just says “with choroidal neovascularization,” not specifying whether active or inactive, then what would be the default code selection? In response, Dr. Topping stated that severe scarring would not be treated, and the default should be active.
- One commenter voiced support for adding the seventh character for the stages of each of the types of AMD, and also (in follow up to Dr. Topping’s statement) recommended adding a note at the seventh character 1 (with active choroidal neovascularization), that it includes “with neovascularization NOS.”

Proliferative Diabetic Retinopathy (PDR)

The American Academy of Ophthalmology (AAO) and the American Society of Retina Specialists (ASRS) are requesting tabular modifications to enable better tracking of proliferative diabetic retinopathy (PDR) and the ability to capture laterality.

Dr. Topping was available via telephone to address questions and clinical concerns.

Ms. Fisher noted that there were typographical errors that would be corrected in the 7th character notes for the following subcategories: E11.33 and E11.34.

One commenter suggested adding an unspecified code since staging documentation may only be prevalent in specialty ophthalmology clinics or eye hospitals, and not in general internist documentation. Dr. Topping responded that an unspecified code for internists to use would be good, as they are not treating this. Another commenter stated that there needs to be a default code for situations where there’s no detailed description of the stage; she also noted rarely seeing documentation that cases were mild. Dr. Topping concurred that a default code may be necessary since documentation in non-ophthalmology settings may focus more on other conditions that they are treating, such as diabetes mellitus.

Diabetic macular edema

The American Academy of Ophthalmology and the American Society of Retina Specialists are requesting codes to capture diabetic macular edema that has resolved following treatment.

Dr. Topping was available via telephone to address questions and clinical concerns.

One commenter asked why do patients still have this, as typically a condition ends when it is resolved. If there was no more treatment, she suggested that a personal history code could be appropriate. Dr. Topping responded that it can reactivate, for example after 3 months.

General consensus from the audience was concern about the use of the term “resolved,” because it may be misleading for coders. It was recommended to change the term “resolved” in E11.3 and other diabetes mellitus categories. Other terms suggested that might mean the same as “resolved” included “in remission” or “quiescent”. NCHS will review these with AAO further.

Retinal vascular occlusions

The American Academy of Ophthalmology and the American Society of Retina Specialists are requesting revisions to the subcategories related to retinal vascular occlusions. It is important to know laterality as there is a 20% incidence of bilaterality.

Dr. Topping was available via telephone to address questions and clinical concerns.

Sue Bowman, AHIMA, noted that one can currently code this condition with multiple codes and asked what is the need for one combination code for this condition? Dr. Topping responded that having one code will have advantages, and make this easier to follow.

Primary open-angle glaucoma

There were no comments on this proposal.

A general statement was raised from the audience on how laterality issues are handled and the need for consistency of how 7th characters are used. One commenter stated there needs to be an across the board principle on including this. NCHS will review this further.

Complications urinary devices

Dr. Jonathan Rubenstein, MD, representing the American Urological Association (AUA) was available via telephone to address questions and clinical concerns.

Mechanical complication of urinary catheter

The AUA proposes revisions and the addition of new codes at T83.0 to capture the correct diagnosis coding of all urinary catheters, not limited to the term “indwelling.”

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Ms. Pickett noted that the inclusion term “Cylinders, pump and reservoir” under T83.098 in the proposal will be removed. Stephanie Stinchcomb from AUA, also indicated that for consistency the inclusion term “Hopkins, ileostomy and urostomy catheters” should be added to T83.018.

Dr. Rubenstein responded to participants’ questions to further describe anatomical placement and usage of the urinary devices included at this subcategory.

Breakdown of other urinary devices

The AUA is requesting revision/addition of codes in the T83.1 section of ICD-10 to account for breakdown, displacement and other complications of all existing urinary devices and implants available.

Ms. Pickett noted that the inclusion term “Nephroureteral and ileal conduit stents” be removed from T83.112.

One commenter expressed support for adding nephroureteral and ileal conduit stents to T83.113 since the use of these are documented quite often.

Dr. Rubenstein provided a clarification about the difference between a catheter (which usually exits the body) and a stent (usually is only inside the body). He also noted that there are exceptions to this general rule.

Another participant suggested adding exclusion notes to clarify when to use codes for catheters vs. stents. There was also a need expressed for educational materials focused on the urinary device types, their placement and usage.

Mechanical complication of graft of urinary organ

There were no comments on this proposal.

Mechanical complication of devices, prosthetics, implants and grafts of genital tract

AUA has requested revisions and the addition of new codes in the T83.4 subcategory to capture the testicular prosthesis implant and to change the order of wording for implanted as well as an inclusion of the parts of the penile prosthesis to include cylinders, pump and reservoir for additional clarification. A suggestion was made to add a code under T83.41 and T83.42 to include breakdown and displacement of other prosthesis of genital tract.

A general comment was made that it is difficult to know what is meant by the term “breakdown”. Is this the same as the valves having mechanical failure from breaking down after a long time? In discussion, it was noted that a mechanical breakdown could include a fractured device, and also a device leaking could be a breakdown.

Infection and Inflammatory reaction due to device, prosthetic, implant and graft in urinary system

The AUA requested revisions and additions of new codes to the categories to maintain consistency and capture the infection and inflammation due to prosthetic device implant and graft in both the urinary system and the genital tract.

Ms. Pickett noted the following corrections:

- Removal of T83.512 Infection and inflammatory reaction due to indwelling ureteral stent
- Removal of T83.519 Infection and inflammatory reaction due to other urinary stents
Nephroureteral and ileal conduit stents
- Add T83.69 Infection and inflammatory reaction due to other prosthetic device, implant and graft in genital tract.

Dr. Rubenstein recommended changing the inclusion note under T83.520 to read “Infection and inflammatory reaction of electrode array or pulse generator or receiver for sacral nerve neurostimulation.”

Complications due to implanted mesh and other prosthetic material to surrounding organ or tissue

The AUA has proposed revision and the addition of new diagnosis codes T83.7 section which is necessary to capture the use of urethral mesh which is not placed in the vagina. This section needs to be more specific and inclusive for both men and women for urethral and vaginal mesh.

One commenter raised the issue of vaginal and other, non-vaginal, and suggested the addition of “other” is needed for consistency within the code description for T83.713.

Stephanie Stinchcomb, representing AUA, noted the title for T83.72 needs to be revised to read “Exposure of implanted mesh and other prosthetic materials” and the title for proposed new code T83.722 should be revised to read “Exposure of implanted vaginal mesh or other prosthetic materials.”

In review of the codes presented, one commenter noted that adding an excludes note for mesh used for inguinal hernia repair should be considered.

Mechanical complication of implanted electronic stimulator of nervous system

The AUA has proposed the creation of additional codes at T85.1, Mechanical complication of implanted electronic stimulator of nervous system, to capture information related to the breakdown and displacement of a neurostimulator device of the sacral nerve.

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There was detailed discussion from the audience regarding T85.1 verses T83.110 in which question was raised as to the best placement of neurostimulator devices, as the devices are being used to treat a wider variety of medical conditions, as it is also approved for fecal incontinence.

There was general consensus from the audience to consider reclassifying of sacral nerve neurostimulation devices to T85, Complications of other internal prosthetic devices, implants grafts, and specifically at T85.1, Mechanical complication of implanted electronic stimulator of nervous system, verses T83, Complications of genitourinary prosthetic devices, implants and grafts. However, there was also the recommendation to put in exclusionary information with such a change. Dr. Laura Powers, representing the American Academy of Neurology, expressed support for coding this to T85.1, for the nervous system.

Postprocedural urethral stricture

The AUA has proposed revisions to N99.1, Postprocedural stricture to be consistent with the organization of the male anatomy. The proposal would result in revising titles of all codes in subcategory N99.11 and propose a new code for unspecified at N99.119.

Sue Bowman, AHIMA, expressed concern with the proposed changes as it would impact data collection. Nelly Leon-Chisen, AHA, also questioned the need to change the code titles vs. adding a new code at the next available opening. Dr. Rubenstein responded that the change was recommended to follow anatomical structure from outside the body (urethra) to inside (bladder).

Stephanie Stinchcomb, representing AUA, expressed that they would like these changes before 2014. Another commenter stated that it is recommended to start dual coding with ICD-9-CM and ICD-10-CM about 9 months ahead of implementation, and suggested that either the changes should be done in 2013, or else should wait until 2015.

Donna Pickett invited further comment on the options that were suggested and discussed.

Complications of stoma of urinary tract

The AUA has proposed revisions to subcategory N99.5, Complications of stoma of urinary tract.

Response from the audience indicated a need for a default or an unspecified code since the terms “continent” and “incontinent” are often not found in the medical documentation.

Dr. Rubenstein provided additional medical information regarding the differences between continent and incontinent stoma. Incontinent stomas are always draining to a bag worn on the outside of the body. The patient has to empty the bag frequently. With a continent stoma, the patient can catheterize it every few hours to empty the urine, which collects inside the body. He also indicated that about 80% of stomas are of the

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incontinent type. One commenter stated that education material is needed for the community.

Chronic fatigue syndrome

Andreas Kogelnik, MD, representing the Coalition 4 ME/CFS, was available via telephone to address questions and clinical concerns.

Lori Chapo-Kroger, representing the Coalition 4 ME/CFS, expressed that many nations, and the World Health Organization, put CFS at G93 in ICD-10, and that this would include everyone but the U.S.

Mary Dimmock, representing the Coalition 4 ME/CFS, questioned why the change must wait until after 2014 when they feel that this is an error in the classification right now (and has been since 2001).

Dr. Kogelnik indicated that the term myalgic encephalomyelitis is used in Europe while the U.S. continues to use the term chronic fatigue syndrome, and that the Coalition 4 ME/CFS considers these two conditions (CFS and ME) to be the same. That is why they want both terms included in the same code.

Nelly Leon-Chisen, AHA, noted support for a need for a code for chronic fatigue syndrome distinct from chronic fatigue, unspecified. She indicated also that with the cause being unknown it is better that the classification not be locked into placing CFS as a viral code. Also, if there is no consensus for ME and CFS being the same then it makes sense to keep them as two separate codes. If research later develops that says they are the same then the data can be aggregated together. However, if the research does not show this, then you don't have them lumped into one code that does not allow you to separate out one from the other.

Sue Bowman, AHIMA, questioned counting all CFS as following a virus infection. She expressed a need for clinical consensus on this condition. Also, she stated that she did not see a rationale for an early change (before 2014).

Microscopic colitis

Nelly Leon-Chisen, AHA, questioned whether coders would see the proposed new terms collagenous colitis and lymphocytic colitis in the medical record documentation. The audience was polled regarding use of the terminology as specified. One commenter noted use of the term "microscopic colitis" in pathology reports, and that usually the patients are seen as outpatients and not admitted to the hospital.

Indeterminate colitis

The World Health Organization has added a code for indeterminate colitis to ICD-10. It is now proposed to add this to ICD-10-CM.

The following questions were raised:

- How does Indeterminate colitis differ from colitis NOS?
- Would the specific term be documented in the medical record?
- Is colitis of undetermined cause the same as Indeterminate colitis?

It was also recommended to add an Excludes1 note at this code for colitis NOS, which is indexed to K52.9.

One commenter said that this could be confusing, because sometimes a biopsy has inconclusive results, and the coder might think that this new code would then apply. One suggestion was to list it in the index as “Indeterminate colitis, so stated.”

Cervical disc disorders

Dr. Berglund noted one correction to code M50.01 to read Cervical disc disorder with myelopathy.

Dr. Laura Powers, AAN, stated that the note at category M50 (Code to the most superior level of disorder) should be considered for revision, as it is only be applicable to a myelopathy and not to a root lesion. Dr. Powers asked the question, “If you have multiple roots do you need a multiple code or do you have an instruction to code multiple codes?” NCHS will review this further.

These changes (in Part 1 of the proposal) are proposed to be effective prior to implementation of ICD-10-CM, and input is sought on this possibility.

Spinal cord disorders involving the lumbar and sacral regions

Dr. Berglund informed the audience it is proposed that codes M47.17, M47.18 and M51.07 be deleted before the implementation of ICD-10-CM.

Sue Bowman, AHIMA, indicated a preference for deleting these codes prior to the implementation of ICD-10-CM since the conditions as described are not clinically possible. However, she also commented that if this was not favored, then since the codes should not be used (because of their clinical irrelevance), it should be OK to wait until after ICD-10-CM implementation before the codes are deleted.

Adverse effect of certain narcotic drugs

There were no comments on this proposal.

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Uterine scar from previous surgery

There was a comment suggesting addition of the term “uterine” before the word “scar” in the code titles at O34.211 and O34.212.

ICD-10-CM Tabular Addenda

Tamar Thompson, representing Salix Pharmaceutical, stated that opioid induced constipation is increasing and it can't be treated with other over-the-counter medications. The commenter also stated that reporting this condition is challenging for coders and billers, so she supported the change to code K59.0, Constipation.

ICD-10-CM Index Addenda

There was a comment that the code assignment for Sesamoiditis should be M25.87-, Other specified joint disorders, ankle and foot (rather than M25.8-).

There was general discussion from the audience regarding what addenda changes would be included prior to implementation of ICD-10-CM vs. post implementation, and what criteria would be used to support these changes. Some indicated that “errors” should be fixed. NCHS welcomes comment on this.