



Summary of March 2008 ICD-9-CM Coordination and Maintenance Committee Meeting

The ICD-9-CM Coordination and Maintenance (C&M) Committee, cosponsored by the National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS), met on March 19-20, 2008 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/classifications_of_diseases_and1.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:

www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.

Once they are approved by CMS and NCHS, some changes may go into effect with discharges on or after October 1, 2008, whereas others may not go into effect until October 1, 2009. Those proposals that are being considered for October 1, 2008 implementation are indicated in the meeting summary below.

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 patricia.brooks2@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 24-25, 2008 and will be held at the CMS building in Baltimore, MD. New proposals for inclusion on this agenda must be received by **July 25, 2008**. Anyone wishing to have a new code considered for implementation on April 1, 2009

must make this request at the September meeting and justify the need for expedited implementation to capture new technology.

Diagnoses

Status of tPA for Stroke (being considered for October 1, 2008 implementation)

The American Academy of Neurology has requested a unique code to indicate that a patient has received tissue plasminogen activator (tPA) for a stroke. TPA has to be started as soon as possible to maximize its benefits and is only approved by the Food and Drug Administration, for treatment of acute stroke patients, within three hours. However, rural or smaller suburban hospitals, or those hospitals which do not have the physician or system support to care and handle potential complications associated with lytic therapy for stroke, will transfer patients directly from the emergency department to a tertiary hospital for critical care after they have initiated tPA. Monitoring how frequently this occurs will be critical in assessing the allocation and organization of resources for acute stroke care within the US healthcare system.

A new code for personal history of receiving tPA for acute ischemic stroke in another hospital's emergency department within the last 24 hours has been proposed in subcategory V87.4, Personal history of drug therapy (this is a new subcategory being implemented on October 1, 2008). It was noted that "last 24 hours" is not adequately descriptive as to the intended timeframe and should be changed to reflect 24 hours prior to admission to this facility. A suggestion was made to consider creating a status code instead of a personal history code. It was also suggested that consideration be given to deleting the reference to the diagnosis in the code title, since that information would be captured through the diagnosis code, and allowing the new code to be used for myocardial infarctions as well as strokes.

Methicillin-Resistant Staphylococcus Aureus (being considered for October 1, 2008 implementation)

Methicillin-resistant *Staphylococcus aureus* (MRSA) is a form of the bacterium *Staphylococcus aureus* that is resistant to treatment with currently available antibiotics in the beta-lactam class, which have traditionally been a treatment of choice for *S. aureus* infections. MRSA accounts for the majority of *S. aureus* infections acquired in healthcare settings. Since the late 1990s, MRSA has caused an increasing proportion of *S. aureus* infections occurring in otherwise healthy people in the general community. Most community-associated MRSA infections are skin and soft tissue infections that are not life-threatening. However, severe and invasive infections also occur.

While data indicate that MRSA is becoming more prevalent, it is preventable. Infection control guidelines produced by the Centers for Disease Control and Prevention and the Healthcare Infection Control and Prevention Advisory Committee outline strategies to prevent transmission of multidrug-resistant organisms, including MRSA, in healthcare settings. In the community, strategies focusing on increased recognition and appropriate

management of new infections, meticulous wound care, and enhanced hygiene have been effective in limiting transmission of MRSA.

The Department of Health and Human Services has requested that ICD-9-CM codes be modified in order to better identify and track MRSA infection and colonization. According to the proposal, new codes for Methicillin-susceptible *Staphylococcus aureus* (MSSA) and Methicillin-resistant *Staphylococcus aureus* would be created in subcategories 038.1, Staphylococcal septicemia, 041.1, Bacterial infection in conditions classified elsewhere and of unspecified site, Staphylococcus, and 482.4, Pneumonia due to Staphylococcus. New codes for Methicillin-susceptible *Staphylococcus aureus* and Methicillin-resistant *Staphylococcus aureus* would also be created in subcategories V02.5, Carrier or suspected carrier of infectious diseases, Other specified bacterial diseases and V09.0, Infection with microorganisms resistant to penicillins. A new code for personal history of Methicillin-resistant *Staphylococcus aureus* would be added under subcategory V12.0, Personal history of infectious and parasitic diseases. MSSA and MRSA colonization would be classified to the new codes for carrier status.

Commenters noted that creating a code for MRSA in category V09, Infection with drug-resistant microorganisms, would be redundant with other codes in this proposal. It was suggested that code V09.0, Infection with microorganisms resistant to penicillins, not be expanded, but be retained with its current code title to describe penicillin-resistant infections other than MRSA. An instructional note should be added under code 795.3, Nonspecific positive culture findings, to direct users to the new codes in subcategory V02.5 for MSSA and MRSA colonization.

Fever and Other Physiologic Disturbances of Temperature Regulation (being considered for October 1, 2008 implementation)

A proposal to expand code 780.6, Fever, was presented at the September 2007 C&M Committee meeting. That proposal included new codes for postprocedural fever and fever presenting with conditions classified elsewhere. A representative of the American Academy of Pediatrics requested a further expansion of this code. The complete proposal presented at the March C&M Committee meeting involves an expansion of code 780.6 to create codes for fever presenting with conditions classified elsewhere, postprocedural fever, postvaccination fever, chills (without fever), and hypothermia. An instructional note under the proposed new code for fever presenting with conditions classified elsewhere would indicate that the underlying condition associated with the fever, such as leukemia, neutropenia, or sickle-cell disease, should be coded first. The title of subcategory 780.6 would be changed to “fever and other physiologic disturbances of temperature regulation.”

It was suggested that the Excludes note under the proposed new code for postprocedural fever which states “fever associated with confirmed infection – code to infection” should be located under subcategory 780.6, since it applies to all the codes within this new subcategory. It was also suggested that the proposed code for “fever, unspecified” have

an Excludes note for neonatal fever (referring users to code 778.4, Other disturbances of temperature regulation of newborn).

Disruption of Operation Wound (being considered for October 1, 2008 implementation)

Changes to subcategory 998.3, Disruption of operation wound, have been proposed that would create new codes for unspecified disruption of wound and disruption of traumatic injury wound repair. Inclusion terms would be added under existing codes 998.31, Disruption of internal operation wound, and 998.32, Disruption of external operation wound, to clarify “internal” vs. “external.” The title of subcategory 998.3 would be revised to state “Disruption of wound.”

It was suggested that the proposed inclusion term for “disruption of any suture materials or method” under subcategory 998.3 be modified to clarify the intent.

Activity Codes (being considered for October 1, 2008 implementation)

Currently, there is no way to code the activity in which a person is engaged that results in a health condition or injury. Activity codes are included in ICD-10-CM. The US Department of Defense has proposed a new section for activity codes in the External Cause chapter of ICD-9-CM. This proposal involves an extensive list of new External Cause codes describing the activity the individual was engaged in that led to the injury or health condition for which he is seeking healthcare. The proposed new codes parallel the activity codes that are in ICD-10-CM. Extensive guidelines would need to be developed regarding the use of activity codes.

Commenters raised a number of strong objections to implementing this proposal in October, due to the extensiveness of the proposal and the limited amount of time to provide input on this proposal. Also, a significant amount of education would need to be provided prior to implementation, and encoding products and data reporting systems would need to be updated, so more advance notice of a change of this magnitude is needed. It was recommended that this proposal be considered for implementation in October 2009 instead of October 2008.

Injuries and External Cause Codes for Military Operations (being considered for October 1, 2008 implementation)

To improve the ability of the Department of Defense to identify the cause of injuries among the military population and assist with prevention of these injuries, a number of expansions to the External Cause codes have been proposed. A new fourth-digit subdivision is being proposed for water transport accidents, categories E830-E838, to identify military watercraft. New external cause codes have been proposed to identify injuries due to war operations by fires and conflagrations; bullets and fragments, explosion of marine weapons; other explosion; destruction of aircraft; other forms of conventional warfare; nuclear weapons; and other forms of unconventional warfare. New external cause codes have also been proposed for injuries due to war operations but

occurring after cessation of hostilities. This proposal also includes new external cause codes for overexertion and strenuous and repetitive movements or loads.

New codes for stress fracture of femoral neck, shaft of femur, and pelvis have also been proposed. New V codes have been proposed for family disruption due to family member on military deployment, family disruption due to return of family member from military deployment, personal current military deployment status, and personal history of return from military deployment.

In an effort to improve collection of external cause data for health conditions other than injuries, it has been proposed that “use additional code” notes be added at the beginning of certain chapters and at certain codes to instruct coders that external cause codes should be used with diagnoses that result from an external cause.

As with the activity code proposal, a number of commenters recommended that this proposal not be implemented this October in order to give the injury community and other stakeholders more time to review the details of the proposal, provide education, and incorporate the extensive changes into software and other products.

Exposure to Harmful Chemicals and Other Harmful Substances (being considered for October 1, 2008 implementation)

New subcategories in category V87 have been proposed for contact and (suspected) exposure to hazardous metals, hazardous aromatic compounds, and other potentially hazardous substances. Specific codes for arsenic, other hazardous metals, aromatic amines, benzene, other hazardous aromatic compounds, and mold would be created.

Incidental Dural Tear (being considered for October 1, 2008 implementation)

An incidental dural tear, or incidental durotomy, is an unintended tear of the dura mater during spine surgery or other invasive extradural procedures such as epidural injections, resulting in some cerebrospinal fluid leakage. The dural laceration and resulting leakage of spinal fluid have associated risks, with the potential for persistent cerebrospinal fluid leak, headache, urine retention, meningitis, infection, neural compression, and the late development of a pseudomeningocele.

Dural tears are undesirable but relatively commonplace in spine surgery, particularly revision spine surgery due to a greater risk of adhesions to the dura itself and greater deformity requiring repair. Other surgical factors increasing the risk of incidental dural tear include location of the surgery (thoracic or lumbar vs. cervical, procedure inside the spinal column or not), type of surgery (fusion vs. simple disk removal or decompression), and number of spine levels involved (multiple levels vs. single level). Patient factors that increase risk include diagnosis (curvature of the spine, spondylolisthesis, spinal stenosis, and disk herniation), and comorbid conditions associated with a thinning dura (smoking, diabetes, epidural steroid injections, and cancer treatment).

The majority of dural tears are observed and repaired intraoperatively, with suturing, fat grafts and/or fibrin glue. Follow-up care in the hospital typically includes 24 hours of bed rest, close monitoring, and use of steroids or drugs.

A new code for accidental puncture or laceration of dura during a procedure has been proposed. Commenters expressed a preference for locating the new code in the nervous system chapter instead of the complication chapter. The proposal included a note under the new code instructing the use of an additional code for associated conditions, with examples of these conditions listed. Some commenters felt that since the classification typically doesn't generally list possible risk factors for a condition under the code for that condition, it would be best to omit the proposed "use additional code" note.

Other Venous Embolism and Thrombosis

The Agency for Healthcare Research and Quality has requested changes to the codes for venous thrombosis and embolism. In 1993, codes were implemented to describe phlebitis and thrombophlebitis of veins of the upper extremities. However, no corresponding codes were created to distinguish venous embolism and thrombosis affecting the upper extremities. Additionally, the term "thrombophlebitis" is outdated terminology. The presence of phlebitis (inflammation of the vein) in association with thrombosis has no clinical or prognostic significance. Patients with venous thrombosis are now categorized as having superficial or deep venous thrombosis affecting a specified vein defined by name or location. With the increasing use of PICC lines, central catheters, tunnel dialysis catheters and wired cardiac devices, deep vein thrombosis of the major veins in the thorax and upper extremities has become very common. There is a need to create codes to define venous thrombosis affecting the vessels in the thorax, neck, and upper extremities.

In 2004, codes for venous embolism and thrombosis of deep vessels of lower extremity, were implemented. These changes did not address the problem of superficial thromboses of lower extremities, and there is a need to define thromboses affecting those sites. Currently, many of these sites are indexed to one code, 453.8, Other venous embolism and thrombosis of other specified veins.

It would also be beneficial to be able to identify patients with sub-acute or chronic deep vein thrombosis or chronic pulmonary embolism who are receiving anticoagulation treatment but are no longer in the initial episode of care. Patients with venous thromboembolic disease often require a subsequent hospital admission for treatment of a complication, such as extension of the initial thrombosis or anticoagulant-related bleeding.

It has been proposed that the titles of existing codes for pulmonary embolism and venous embolism and thrombosis be modified to state "acute," with a parenthetical indicating initial episode of care. New codes have been proposed for subacute or chronic embolism and thrombosis of the deep vessels of the lower extremity, with a parenthetical indicating subsequent episode of care. An instructional note under the new codes for subacute or chronic venous embolism or thrombosis would indicate that an additional code should be assigned for associated longer-term (current) use of anticoagulants (V58.61), if

applicable. Additionally, new codes for venous embolism and thrombosis of superficial vessels of lower extremities, superficial and deep veins of upper extremities, axillary veins, subclavian veins, internal jugular veins, and other thoracic veins.

Commenters noted that the terms subacute and chronic are not used to describe embolism and thrombosis. There is potential overlap between the proposed new codes and the code for personal history of venous thrombosis and embolism. It was noted that currently, codes V58.61, Long-term (current) use of anticoagulants, and V12.51, Personal history of venous thrombosis and embolism, are assigned for patients who have previously been treated for a deep vein thrombosis and are receiving anticoagulation therapy. Concerns were also expressed about “initial episode of care” and “subsequent episode of care,” since these terms are not well-understand and lack a standard definition.

Venous Complications in Pregnancy and the Puerperium

The Agency for Healthcare Research and Quality has proposed code changes for venous complications in pregnancy and the puerperium. There is a need to improve the specificity of ICD-9-CM codes used to define deep vein thrombosis and pulmonary embolism in pregnant and postpartum women. The proposal involves changing the description of codes 671.3x and 671.4x to remove pelvic thrombophlebitis from the code title and to limit these codes to the acute (initial or unspecified) episode of care, adding new codes for subacute or chronic plebothrombosis (subsequent episode of care), and adding new codes under category 670, Major puerperal infection, to identify postpartum endometritis, postpartum sepsis, and postpartum septic pelvic thrombophlebitis (the three most serious manifestations of major puerperal infection). An instructional note under the new codes for subacute or chronic plebothrombosis would indicate that an additional code should be assigned for associated longer-term (current) use of anticoagulants (V58.61), if applicable.

Hepatic Coma and Hepatic Encephalopathy

In order to differentiate less severe hepatic encephalopathy from cases with hepatic coma, new codes have been proposed for hepatic encephalopathy and hepatic coma. In the past, these conditions were both classified to code 572.2, Hepatic coma. Hepatic encephalopathy involves altered consciousness and behavior related to insufficient liver function. It has a range of severity, from altered consciousness, sleep disruptions, and forgetfulness in stage 1; confusion, bizarre behaviors, and disorientation in stage 2; lethargy and profound disorientation in stage 3; to coma in stage 4.

Since hepatic coma is a type of hepatic encephalopathy, commenters felt that it would be confusing to have separate codes. Also, since the term “hepatic coma” is generally not used today, it was suggested that the existing code be re-titled to state “hepatic encephalopathy,” and “hepatic coma” be added as an inclusion term, rather than creating new codes.

Prematurity Birth Status

A new V code subcategory for prematurity status has been proposed. Since premature birth can lead to a number of problems later in life, it would be of value to be able to track the status of those born prematurely. The proposed new codes would identify the number of weeks of gestation.

It was suggested that the code titles should state “completed” weeks of gestation. In response to a comment suggesting that the proposed codes might overlap with existing codes in the perinatal chapter, since perinatal codes can be used throughout the patient’s life, it was noted that the proposed codes would be used when there is no current health problem specifically associated with the prematurity, but the status is an important consideration to document. Even in the absence of a specific health problem, there are risks associated with prematurity, and it may impact future care. There may also be preventive treatments needed, or psychosocial issues, without a current physical diagnosis related to the prematurity. It was suggested that instructional notes would be helpful to clarify how the proposed codes should be used, as opposed to other existing codes. It was also suggested that it might be preferable to locate the new codes in a personal history category, instead of category V21, Constitutional states in development.

Acute Chemical Conjunctivitis

A new code for acute chemical conjunctivitis has been proposed. Chemical conjunctivitis may place a patient’s vision at significant risk, but not be as serious as an alkaline (code 940.2) or acid (code 940.3) burn of the eye. It can result when any irritating substance enters the eye. Common irritants include household cleaners, sprays, smoke, smog, industrial pollutants, and chlorine in swimming pools.

Acute Heart Failure

New codes have been proposed that would differentiate congestive heart failure, left heart failure, rheumatic heart failure, and unspecified heart failure by acute, chronic, and acute on chronic. Congestive heart failure and left heart failure would also be differentiated by the presence or absence of pulmonary edema. Congestive heart failure with pulmonary edema would be classified to a new code in subcategory 428.1, Left heart failure.

Commenters expressed concern that this proposal would significantly alter trend data, since congestive heart failure with acute pulmonary edema is currently classified to the congestive heart failure code, not the left heart failure code. It was also suggested that it would be simpler to assign a separate code for pulmonary edema, if the intent is to be able to capture heart failure with and without pulmonary edema, instead of creating an extensive number of new combination codes. Commenters also pointed out that the word “unspecified” should be deleted from the title of code 428.0, Congestive heart failure, unspecified.

Family Circumstances

New V codes have been proposed for family disruption due to: divorce or legal separation; parent-child estrangement; child in welfare custody, and child in foster care or

in care of non-parental family member. New codes have also been proposed for adopted child-parent problem, foster child-parent problem, substance in abuse in family, and foster care status.

It was suggested that an additional code be created for problems between parent and biological child. Problems due to the death of a parent may also warrant a unique code.

Autoimmune Lymphoproliferative Syndrome

A new code has been proposed for autoimmune lymphoproliferative syndrome (ALPS). ALPS is a rare disease caused by a genetic defect resulting in lymphocytes not dying off as they should, resulting in an overabundance of lymphocytes in many tissues. Clinical features present early in childhood or even at birth and include chronic multifocal lymphadenopathy, splenomegaly, autoimmune hemolytic anemia, and often other immune cytopenias. Though the majority of patients improve with steroid therapy, and generally, autoimmune complications lessen in severity as a patient gets older, they have a greater risk of developing lymphoma.

Nursemaid's Elbow

A new code has been proposed for nursemaid's elbow in category 832, Dislocation of elbow. This condition is a subluxation of the radial head commonly seen in children under the age of five.

A commenter noted that the fifth digits identifying the anatomic site of the dislocation that apply to all of the other codes in category 832 don't apply to the proposed new code.

Awaiting Joint Prosthesis

A new code for "awaiting joint prosthesis replacement" has been proposed in subcategory V54.8, Other orthopedic aftercare. Sometimes it is necessary to remove a joint prosthesis (such as for infection of that site) and have the patient readmitted at a later time, after the infection heals, before completing the joint replacement procedure. Currently, there is not a good way to capture this situation in the classification.

Commenters felt that the code title is confusing. It was suggested that two codes be created, one for joint prosthesis explantation status and an "encounter for" code to capture the reason for encounter for patients with an explanted joint who is being admitted for the placement of a new prosthetic joint.

Gastroschisis

Two new codes for gastroschisis and omphalocele have been proposed. Gastroschisis is a congenital ventral body wall defect, adjacent and usually to the right of the umbilical cord insertion that results from the failure of the developing abdominal wall to completely close. This allows the extrusion of the fetal intestines from the defect. The exposed intestines are not covered by a membranous sac which results in a prolonged

exposure to amniotic fluid. This results in a thick, swollen, and inflamed intestine, increasing the risk of heat and fluid loss and infection after birth.

Omphalocele is a separately distinct ventral wall defect. In this case, the intestines are usually covered by a membranous sac, with the intestine only being exposed if the sac ruptures. More than half of the patients with this condition will have abnormalities of other organs or body parts.

Underimmunized or Lapsed Immunization Status

A new code for underimmunization status has been proposed in subcategory V15.8, Other specified personal history presenting hazards to health. A significant number of children are under immunized. They may have received none or only some of the immunizations according to the recommended immunization schedule. Some common reasons for this situation include immigration to the US, foreign adoptees who may not have been fully immunized according to the US scheduled recommendations, families moving without re-establishing with a new provider to continue the recommended vaccination schedule, and lack of health insurance coverage for immunizations. Studies show that there is a poor “catch-up” rate for delinquent immunizations in older children.

While there are ICD-9-CM codes in subcategory V64.0 to indicate why an immunization was not carried out when offered, there is no current code to indicate the status of the person who is at risk due to being behind schedule for the recommended immunization schedule. These individuals place themselves and others at risk of contracting and spreading a given disease for which they are not immunized.

The V64.0 codes should be used only when a vaccination is refused at the time of an office visit. The new proposed code would be used when a child is being seen at the physician’s office, and it needs to be documented that the child has not previously received vaccinations that would be expected for age. If a vaccination is refused during an office visit and the child is also behind schedule on his or her immunizations, it would be appropriate to report both codes.

Encounter for Serologic Antibody Testing

An expansion of code V72.6, Laboratory examination, has been proposed to create a unique code for antibody response examination. Vaccination providers frequently encounter individuals who do not have adequate documentation of their vaccination status (for example, foreign adoptees). Pre-vaccination serologic testing may be indicated to determine immunity as an alternative to unnecessary vaccinations for certain antigens. Also, pre-vaccination serologic testing for susceptibility may be considered to reduce the cost of vaccinating adult populations that may have an expected high prevalence of a given disease (such as hepatitis B infection). Post-vaccination testing for antibody response may be needed to help determine appropriate post exposure prophylaxis. For example, post-vaccination testing may be indicated for healthcare workers who have received the hepatitis B vaccine but have blood or patient contact and are at ongoing risk for injuries with sharp instruments or needle sticks.

Commenters expressed concern that the proposed code title and inclusion term (“immunity status testing”) may be confused with other types of laboratory testing that are not intended to be classified to the proposed code (such as allergy testing or HIV antibody testing). Consideration should be given to re-wording the title and inclusion term, and/or adding instructional notes, to clarify the intent of the proposed code.

Pre-Procedural Evaluations

An expansion of code V72.6, Laboratory examination, has been proposed to create new codes for laboratory examination as part of a general medical examination and pre-procedural laboratory examination. An inclusion term for “encounters for blood and urine testing” would be added under subcategory V72.6. It has also been proposed that “examination prior to chemotherapy” be added as an inclusion term under code V72.83, Other specified preoperative examination.

Commenters felt that the title of the proposed code for laboratory examination as part of a general medical examination was confusing and should be re-worded. One suggestion was to change the title to “Laboratory examination ordered as part of a general medical examination.” There was also some discussion as to whether both code V70.0, Routine general medical examination at a health care facility, and the proposed laboratory examination code could be used together.

Poisoning by Antidepressants and Psychostimulants

An expansion of code 969.0, Poisoning by antidepressants, has been proposed to create unique codes for each of the seven current classes of antidepressants. An expansion of code 969.7, Poisoning by psychostimulants, has also been proposed in order to create distinct codes for caffeine, amphetamines, and methamphetamines.

Commenters noted that a default needs to be identified for situations when it is unknown whether an amphetamine or methamphetamine is involved in the poisoning. It was suggested that consideration be given to specific drugs, including aminophylline and theophylline, as well as caffeine, which may be given to neonates to stimulate breathing based on a psychostimulant effect. Aminophylline is indexed to code 975.7, Poisoning by antiasthmatics, but can act as a psychostimulant.

Retinal and Choroidal Neoplasms of Uncertain Behavior

A new code has been proposed for neoplasm of unspecified nature of the retina and choroid. An eye examination may reveal a black or dark area or spot within the retina. Ophthalmologists must continue to evaluate these areas as they are suspicious of a retinal melanoma. Although these dark areas are correctly referred to as neoplasm or suspected melanomas, a biopsy of the retina is difficult and poses a risk to the eye and is performed only after such an area or spot grows, so there is generally no tissue sample to confirm the diagnosis.

A commenter noted that a diagnosis of “suspected melanoma of the retina” in the hospital inpatient setting would lead to the assignment of the code for malignant neoplasm being assigned instead of the new code. Consideration should be given to providing instructions as to how a diagnosis of “suspected melanoma of the retina” should be coded. It was also suggested that an Excludes note for the proposed new code be added under code 190.5, Malignant neoplasm of retina.

Inclusion Body Myositis

Creation of a new subcategory for “inflammatory and immune myopathies NEC” has been proposed in category 359. Muscular dystrophies and other myopathies. A new code for inclusion body myositis (IBM) would be created in this new subcategory. IBM is an inflammatory myopathy that is not due to some other identifiable disease.

Mesial Temporal Sclerosis

A new code has been proposed for temporal sclerosis. Hippocampal sclerosis and mesial temporal sclerosis would be listed as inclusion terms. Localization related epilepsy can be an acquired condition, and the largest numbers of focal seizures arise from the temporal lobes. These are often due to structural changes in the brain, including tumors, vascular malformations, developmental cortical malformations, and scarring. There are structures in this region which are particularly prone to both traumatic injury and hypoxic injury, resulting in sclerosis. The most common of these is mesial temporal sclerosis (or hippocampal sclerosis). This is a frequent discharge diagnosis from epilepsy units, particularly because it is potentially amenable to surgical removal to reduce the frequency of, or eliminate, seizures.

It was noted that it is appropriate to assign the epilepsy code and the proposed new code for the same encounter, when both conditions are present. A commenter pointed out that it would generally be appropriate to sequence the epilepsy code first.

Exposure to Algae

A new V code has been proposed for contact with and (suspected) exposure to algae bloom. Last year, a code was created to identify the external cause of the symptoms and conditions associated with algae blooms. The proposed V code would identify the possible contact and exposure to an algae bloom for an individual who have been in the vicinity of the bloom but has not yet developed symptoms, or for someone who may have symptoms suspicious of being in the vicinity of an algae bloom, but a definitive cause has not been confirmed.

Diagnosis Addenda

Proposed diagnosis addenda changes were reviewed. Some of the proposed addenda changes are being considered for implementation on October 1, 2008. See the ICD-9-CM Coordination & Maintenance Committee meeting proposals posted on the NCHS web site for a complete list of the proposed diagnosis addenda changes addressed at the March

meeting and identification of those proposed addenda changes being considered for October 1, 2008 implementation. Highlights of the proposed revisions include:

- Addition of inclusion term for acute kidney injury (nontraumatic) under code 584.9, Acute renal failure, unspecified;
- Addition of Excludes note for traumatic kidney injury (866.00) under code 584.9, Acute renal failure, unspecified;

NOTE: A commenter suggested that the entire range of codes in category 866 should be included in the Excludes note.

- Addition of Excludes note for infection due to portacath (999.31) under code 996.62, Infection and inflammatory reaction due to internal prosthetic device, implant, and graft;
- Revision of title of code 041.3 to state “Klebsiella pneumoniae;”
- Addition of Excludes note for hemorrhage due to long-term use of anticoagulant (code to condition) under category 286, Coagulation defects;
- Addition of Excludes note for hemorrhagic disorder to extrinsic anticoagulants (see Table of Drugs and Chemicals) under code 286.5, Hemorrhagic disorder due to intrinsic circulating anticoagulants;
- Deletion of the instructional note indicating that an additional E code should be assigned to identify the cause, if drug induced, that appears under code 286.7, Acquired coagulation factor deficiency;
- Addition of an instructional note at the beginning of the Open Wound section indicating that any associated systemic infection, such as wound botulism, should be coded first;
- Revision of the “use additional code” note at the beginning of the Open Wound section to state “use additional code to identify localized or superficial infection;”

NOTE: Commenters expressed concerns about the above two proposed addenda changes because there appears to be a possible sequencing conflict between open wounds and infections such as wound botulism.

- Revision of the title of code 996.43 to state “Breakage (fracture) of prosthetic joint;”
- Addition of Index entries indicating that diabetes with hyperglycemia, inadequately controlled diabetes, and poorly controlled diabetes, should be coded to diabetes, by type, with 5th digit for not stated as uncontrolled;
- Addition of Index entry indicating that diabetes, out of control, should be coded to diabetes, by type, with 5th digit for uncontrolled;
- Addition of Index entries for end of life and worn out joint prosthesis (see also Complications, mechanical, devices NEC, prosthetic NEC, joint) (996.47);

NOTE: Commenters objected to these proposed index entries due to concerns about classifying a joint prosthesis that has reached the natural end of its life as a complication.

- Addition of Index entry for melanoma in situ (see Melanoma, by site);
- Addition of Index entry for Methadone use (304.00);
- Addition of nonessential modifiers for “oral” and “intravenous” to the Index entries for admission for chemotherapy;
- Addition of Index entry for bradykinesia (781.0);
- Addition of Index entry for elevated glomerular filtration rate (see Findings, abnormal, without diagnosis);

- Addition of Index entries for injury, deep tissue (see Contusion) and injury, deep tissue, meaning pressure ulcer (707.25);
- Addition of Index entry for leukoaraiosis (437.1);
- Addition of Index entries for neuropathy, progressive, hypertrophic interstitial (356.9) and neuropathy, progressive, inflammatory (357.89);
- Addition of Index entry for seizure disorder (see also Epilepsy) (345.9).
NOTE: Objections to the indexing of Seizure(s) disorder to epilepsy were raised, and NCHS responded that this is a follow up to previous changes that have already been made. It was also suggested that the term “non-epileptic seizure” be added to the Index.

Procedures

If approved, the procedure code proposals would be implemented October 1, 2008.

Robotic Assisted Surgery

Currently, the ICD-9-CM procedure classification does not recognize the use of robotics in surgical procedures. Instructions in the Index indicate that only the actual procedure performed should be coded. However, the addition of robotic assistance to laparoscopic surgery has become a standard surgical approach for a number of procedures. It provides the surgeon with increased range of motion, dexterity, precision and reproducibility that are not available with open and/or conventional laparoscopic surgeries. Robotic assistance is also used in spinal fusion procedures. It allows the surgeon to more accurately place pedicle and facet screws in either open or percutaneous procedures.

A new subcategory and six new codes have been proposed to capture the use of robotic assistance during a procedure. These codes would be reported in addition to the primary procedure. Computer assisted surgery is not the same as robotic assistance, so the computer assisted surgery codes would be excluded from the new codes.

Commenters expressed a preference for creating one new code for robotic assistance, rather than the several proposed codes that describe the various approaches. It was noted that the approach would be captured with the primary procedure code. For procedures that do not distinguish the approach in ICD-9-CM, consideration should be given to creating new codes for these procedures rather than including the approach in the robotic assistance codes.

Total Reconstruction of the Breast

Reconstruction of the breast after mastectomy is an evolving field. With the development of increasingly complex procedures, the current ICD-9-CM procedure code 85.7, Total reconstruction of breast, no longer sufficiently distinguishes among the different types of breast reconstruction.

Implant reconstruction is the easiest to perform, with shorter operative times and postoperative recovery than other methods. However, there are a number of implant-related complications and their frequency increases over time. The most common complications include asymmetry, malposition, implant rupture, deflation, and capsular contracture in which the scar tissue around the implant contracts. Up to fifty-seven percent (57%) of women who have undergone implant reconstruction will return for reoperation to correct these complications. Latissimus flap reconstruction is an example of a pedicled flap in which the flap remains attached to its original blood supply while being rotated to a new location. The back's latissimus dorsi muscle and its overlying skin and fat are raised and transferred to the anterior chest wall. Due to the size limitation, this technique is most commonly used in combination with an implant.

The transverse rectus abdominus myocutaneous (TRAM) flap, which uses the rectus abdominus muscle in the abdomen, has become the most popular choice for autologous breast reconstruction. In the pedicled TRAM technique, the flap has its blood supply based on the superior epigastric artery and veins. The flap of muscle, fat and skin is dissected free and rotated through a subcutaneous tunnel into the mastectomy defect. The flap is then shaped into the form of a breast and sutured to its proper location. The free TRAM flap is based on the inferior blood supply, the deep inferior epigastric artery and veins. The flap, along with the inferior vascular pedicle, is dissected free and detached from the patient's body. Then the flap is brought to the mastectomy site where the deep inferior epigastric vessels are reconnected to vessels in the chest.

The deep inferior epigastric perforator (DIEP) flap is composed of abdominal skin and fat and is based on the deep inferior epigastric vessels. The important difference between the DIEP flap and the free TRAM flap is that the DIEP flap does not depend on harvest of the rectus muscle as a vascular carrier. The rectus muscle remains intact as the perforating blood vessels are dissected free, hence the term "perforator flap." The superficial inferior epigastric artery (SIEA) flap is very similar to the DIEP flap in that it uses the same abdominal tissue for breast reconstruction, but the flap is supplied by the superficial inferior epigastric artery and veins. The gluteal artery perforator (GAP) flap uses skin and fat from the lower buttock region to reconstruct a breast. Depending on the vasculature of the flap, the variations may be known as the superior gluteal artery perforator (SGAP) flap or the inferior gluteal artery perforator (IGAP) flap.

A new subcategory and several new codes have been proposed in order to differentiate various autologous reconstructive procedures of the breast. Specifically, new codes would be created for the latissimus dorsi myocutaneous flap, unspecified TRAM flap, pedicled TRAM flap, free TRAM flap, free DIEP flap, free SIEA flap, free GAP flap, and other total reconstruction of breast.

Episiotomy and Repair of Spontaneous Lacerations

Current coding guidance states that an episiotomy that extends spontaneously is considered to be a laceration. Repair of the extension and laceration is assigned to the appropriate code under subcategory 75.6, Repair of other current obstetric laceration. Code 73.6, Episiotomy, would not be assigned. This coding practice results in inaccurate

reporting of the episiotomy rate and does not allow proper tracking of episiotomies that extend spontaneously. Patients are increasingly interested in the episiotomy rates of providers, and provider rates are often gathered through the use of ICD-9-CM procedure coded data.

It has been proposed that an instructional note be added under category 75.6 indicating that if an episiotomy is also performed, it should be coded as well. This would allow the reporting of both the episiotomy and obstetric laceration repair codes when an episiotomy extends spontaneously.

Endoscopic Pulmonary Airway Flow Measurement

A new type of assessment of intrapulmonary air flow is under development. This method measures intrapulmonary airflow using intrapulmonary balloon catheters inserted into diseased portions of the lung during bronchoscopy. This information may help in clinical scenarios such as selecting appropriate patients for endobronchial valve therapy or lung volume reduction surgery. It is also theorized that this new process may be used to measure the effectiveness of current treatments and the disease progression of chronic obstructive pulmonary disease.

A new code for endoscopic pulmonary airway flow measurement has been proposed. Commenters expressed concern with locating the new code in subcategory 33.7, Endoscopic insertion, replacement and removal of therapeutic device or substances in bronchus or lung, since this subcategory title is not broad enough to encompass the new procedure and all of the codes in this subcategory represent therapeutic procedures. It was suggested that either the new code for endoscopic pulmonary airway flow measurement should be moved to a different location or the title of subcategory 33.7 should be revised to cover diagnostic as well as therapeutic procedures.

Implantation of Bilateral Ventricular Assist Devices

Heart assist devices provide temporary support for one or both sides of the native heart in circumstances where the heart has failed, potentially giving the patient's heart the opportunity to rest and possibly recover. Possible causes for the heart failure include acute cardiomyopathy, acute myocardial infarction, failed transplant, myocarditis, and post-cardiotomy shock.

Approximately fifty percent (50%) of the patients supported on external ventricular assist devices require simultaneous support of both the right and left ventricles of the heart. Biventricular support is the preferred approach for patients who are likely to develop biventricular failure. Patients in need of biventricular support have higher survival rates if support is initiated for both ventricles at the same time, rather than sequentially. Although it is preferable to initiate biventricular support concurrently, transient right-sided heart failure can occur following implantation of destination ventricular assist devices, and full but temporary support of the right ventricle may be needed. Often a temporary moderate-term device is used in combination with the implanted left-sided system to deliver support in these situations.

Modifications to subcategory 37.6, Implantation of heart and circulatory assist system, have been proposed in order to improve specificity and add clarity regarding the reporting of bilateral external heart assist devices. A new code would be created for implantation or insertion of biventricular external heart assist system. The title of code 37.65 would be modified to state “Implant of single ventricular (extracorporeal) external heart assist system.” The title of code 37.64 would be modified to state “Removal of external heart assist system(s) or device(s).” The addition of inclusion terms and Excludes notes would provide additional clarity regarding the proper coding of heart assist devices. In the proposed Addenda changes, revision of the title and instructional notes for code 37.62, Insertion of non-implantable heart assist system, would also help to provide additional guidance. Commenters suggested that brand names for these devices be added to the Index to help provide further direction as to the correct code assignment.

Procedure Addenda

Proposed procedure addenda changes were reviewed. See the ICD-9-CM Coordination & Maintenance Committee meeting proposals posted on the CMS web site for a complete list of the proposed procedure addenda changes addressed at the March meeting.

Highlights of the proposed revisions include:

- Addition of Excludes note for percutaneous (endoscopic) feeding jejunostomy (46.32) under code 44.32, Percutaneous [endoscopic] gastrojejunostomy;
- Revision of inclusion term under code 44.32 to state “PEGJJ” instead of “PEG;”
- Revision of title of code 84.56 to state “Insertion or replacement of (cement) spacer;”
- Addition of inclusion term for C.A.T. scan of heart under code 87.41, Computerized axial tomography of thorax;
- Addition of inclusion terms for splinting and strapping under code 97.14, Replacement of other device for musculoskeletal immobilization;
- Addition of Index entry for Zenith® Renu™ AAA graft (39.71);
- Addition of Index entry for CentriMag® acute circulatory support device (37.62);
- Addition of Index entries for conversion, gastrostomy to jejunostomy (endoscopic), for bypass (44.32) and for feeding tube placement (46.32);
- Addition of Index entry for HeartMate® implantable heart assist system (37.66);
- Revision of Index entry for implant, heart assist system, pVAD (percutaneous VAD) (see Insertion, circulatory support device);
- Addition of Index entry for implant, heart assist system, TandemHeart® (see Insertion, circulatory support device);
- Addition of Index entry for implant, heart assist system, that for destination therapy (DT) (37.66);
- Addition of a number of site-specific Index entries under incision (and drainage), abscess;
- Addition of Index entry for Thoratec® implantable ventricular assist device (IVAD™) (37.66);
- Addition of Index entry for Vectra® vascular access graft (86.07).

ICD-10-PCS Update

CMS announced that a new ICD-10 webpage has been created for ICD-10. The ICD-10 webpage includes both ICD-10-PCS and ICD-10-CM information for downloading. The webpage can be located at the following link: <http://www.cms.hhs.gov/ICD10/>.

CMS has asked 3M to update the ICD-10 to ICD-9-CM General Equivalence Mapping (GEM) files (also referred to as crosswalks) next year by adding a new field for payment mapping. The new payment mapping field would indicate the best ICD-9-CM code for any ICD-10-CM or PCS code for payment purposes. This will facilitate the work of the various policy groups within CMS as well as outside insurers in their work to update current payment systems with ICD-10 codes. While it will not always be possible to pick a single ICD-9-CM code to represent an ICD-10 code, this will be our goal. There will be incidences where multiple ICD-9-CM codes will be required in the new payment mapping field.

CMS pointed out that the use of this one new payment mapping field would not provide the user with the ability of taking advantage of the significant increase in detail within ICD-10. Those who perform additional analysis to implement more appropriate use of the new ICD-10 codes should use the complete GEM mappings already posted on the CMS website at: <http://www.cms.hhs.gov/ICD10>. However, the new payment mapping field will give numerous users a head start in analyzing the conversion of payment, quality, and reporting systems. This field will serve as an excellent starting point for converting payment and coverage systems.