



Summary of September 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 September 24-25, 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. Diagnosis code proposals and the minutes from the diagnosis portion of the meeting are posted on the NCHS website and can be accessed at the following link:

www.cdc.gov/nchs/about/otheract/icd9/maint/maint.htm. Procedure code proposals and the minutes from the procedure portion of the meeting can be found at the CMS website and can be accessed at the following link:

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

An April 1, 2009 implementation date was proposed for one of the procedure code proposals. If this proposal is approved, CMS will make a decision as to the implementation date based on the comments received. The rest of the proposed code modifications, if approved by CMS and NCHS, would go into effect with discharges on or after October 1, 2009.

Suggestions for procedure code proposals to be considered at a future Coordination and Maintenance Committee, as well as comments on procedure proposals presented at the September meeting, may be emailed to Pat Brooks at Patricia.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.

Suggestions for diagnosis code proposals for consideration at a future Coordination and Maintenance Committee, as well as comments on diagnosis proposals presented at the September meeting, may be emailed to Donna Pickett at dfp4@cdc.gov or mailed to: Donna Pickett, National Center for Health Statistics, 3311 Toledo Road, room 2402, Hyattsville, Maryland 20782.

The deadline for receipt of public comments on the code proposals slated for implementation on October 1, 2009 is December 5, 2008.

The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled for March 11-12, 2009 and will be held at the CMS building in Baltimore, MD. New proposals for inclusion on this agenda must be received by **January 9, 2009**.

Diagnoses

Traumatic Brain Injury (TBI) and Related Topics

The Department of Defense and the Veteran's Administration have jointly requested changes to the ICD-9-CM classification to better represent traumatic brain injury (TBI) and associated short-term and long-term manifestations.

It has been proposed to revise the section headings for fracture of skull and intracranial injury excluding those with skull fracture to state "intracranial injury (traumatic brain injury) due to fracture of skull" and "intracranial injury (traumatic brain injury), excluding those with skull fracture," respectively. The title of category 850 would be changed to "Intracranial injury (traumatic brain injury) not associated with specific brain injury" and inclusion terms for traumatic brain injury would be added under the codes in this category. The titles of categories 851, 852, and 853 would also be revised to indicate traumatic brain injury. The terms mild, moderate, and severe traumatic brain injury would be introduced as inclusion terms. Corresponding changes to the index would also be made. A new code for acute manifestations of traumatic brain injury would be created in category 349, Other and unspecified disorders of the nervous system (the code for the associated injury would be sequenced first). A new subcategory for cognitive symptoms due to conditions classified elsewhere would also be created in this category. New codes in this subcategory would identify specific cognitive deficits, including deficits pertaining to attention or concentration, memory, language or speech, visiospatial, psychomotor deficit, and frontal lobe and executive function. Another new subcategory would be created in category 349 for other symptoms of nervous system due to conditions classified elsewhere. This subcategory would include codes for irritability, impulsivity or disinhibition, emotional lability, anxiety or depressive symptoms, apathy or lack of spontaneity, and sensitivity to light or noise. The underlying condition would be coded first and an additional code would be assigned for late effect of injury.

New codes have been proposed for history of combat or operational stress reaction, history of traumatic brain injury, encounter for blind or low-vision rehabilitation, screening for traumatic brain injury, and screening for swallowing and feeding. The addition of inclusion terms and Excludes notes under various codes has also been proposed.

An alternative approach to the proposed changes was presented. This approach was based on concerns that re-titling section headings would inappropriately alter the meaning and would not accurately describe all of the codes included in those sections. Therefore, the

alternative option would involve more minor changes and the inclusion of “traumatic brain injury” only in those code titles where it is appropriate. Also, instead of creating a new code for acute manifestation of traumatic brain injury, the existing coding guideline that allows the reporting of a symptom or condition code in conjunction with a late effect code would be applied. Instead of creating new codes in category 349 for other symptoms of nervous system due to conditions classified elsewhere, code 799.2, Nervousness and restlessness, could be expanded to include these symptoms. Noise and light sensitivity could be classified to existing codes rather than creating a new code.

External Cause Status

A proposal for a new category for external cause status that would indicate the status of the person at the time the event occurred was presented. This proposal represented a revised version of the proposal presented at the March 2008 Coordination and Maintenance Committee meeting. New codes in this category would include civilian activity done for income or pay, student activity, military activity, and non-paid, non-student activity. Corresponding guidelines would be developed that would allow a code from the new category could be used with any external cause code.

Activity Codes

A modified version of the proposal for new external cause codes for activity from the March 2008 Coordination and Maintenance Committee was presented. The activity codes are mutually exclusive from all other external cause codes. This proposal involves an extensive set of new categories to identify the activity of the person seeking healthcare for an injury or health condition. These new codes could be used with external cause codes for cause and intent if identifying the activity would provide additional information on the event.

External Cause Codes for Military Operations

The Department of Defense has requested new external cause codes to allow for the identification of the causes of injuries among the military population to assist with prevention of these injuries.

A new fourth-digit subdivision is being proposed for water transport accidents, categories E830-E838, to identify an occupant of military watercraft. This is in keeping with the structure of the categories for air and space transport accidents which have a fourth-digit subdivision for military aircraft.

Codes under category E922, Accident caused by firearm and air gun missile, identify the types of firearms that cause an injury. There is currently now way to identify injuries caused by mechanical malfunctions of these firearms. A new code is being proposed for this concept.

A full expansion of codes under categories E990-E999, Injuries resulting from operations of war, is being proposed to allow for more specific identification of these causes.

Embedded Fragments Status

The Department of Defense has requested new V codes for embedded fragment status to identify the type of embedded material. Injuries from explosions often include fragments or splinters from the explosive device embedding in the injured individual. In some cases, the fragments can be removed. In other cases, they are too difficult to remove because of their number or anatomical location. Any embedded object has the potential to cause infection due to the object itself or any organism present on it when it entered the body. An embedded magnetic object is a contraindication to a magnetic resonance imaging test. Some typed of embedded fragments, such as those composed of lead, pose long-term health risks. Certain metal alloys may also be long-term toxicological hazards.

The proposed new V code category would be used as secondary status codes for cases such as injury codes that include the presence of a foreign body, or with toxic effect codes. The new category has several new codes to identify the type of embedded material. Although this category would be useful primarily for the military, the codes would also be applicable to any injury resulting in embedded fragments. The new codes would not be applicable to or overlap with internal medical devices. Meeting participants noted that the proposed codes might potentially overlap with existing codes for retention of foreign body, so this would need to be taken into consideration if the proposal is approved.

A new code has also been proposed for personal history of embedded fragment removal. It would be a status code that would be used to identify potential health hazards associated with having had embedded fragments.

Venous Thrombosis and Embolism

The Agency for Healthcare Research and Quality (AHRQ) has requested new codes and modification of existing codes for venous thrombosis and embolism. AHRQ's proposal was originally presented at the March 2008 C&M Committee meeting. The September proposal reflects comments received after the March meeting.

AHRQ's proposal is intended to distinguish a new thrombus, requiring initiation of or intensified anticoagulation therapy, from an old or chronic thrombus, which requires continuation of established therapy. The goals of this proposal are:

- Creation of codes to define venous thrombosis affecting the vessels in the thorax, neck, and upper extremities;
- Creation of codes for superficial thromboses of lower extremities similar to codes created in 2004 for venous embolism and thrombosis of deep vessels of lower extremity (codes 453.40-453.42);
- Identification of patients with 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; and

- Better tracking of these patients because they are at high risk for recurrence of thrombosis or embolism, particularly in the first 1-3 months after the initial diagnosis.

Two options were presented. The first option proposes codes for acute and chronic venous thrombosis and embolism with a default to the acute code when acuity is not specified. This would allow the ability to select “chronic” when a thrombosis is clearly documented as such. New codes would be created for chronic pulmonary embolism and infarction, chronic venous embolism and thrombosis of deep vessels of lower extremity, venous embolism and thrombosis of superficial vessels of lower extremity, chronic venous embolism and thrombosis of other specified vessels, and acute venous embolism and thrombosis of other specified veins. Existing codes in subcategory 453.4, Venous embolism of deep vessels of lower extremity, would be revised to specify “acute.” Modifications to category 671, Venous complications in pregnancy and the puerperium, have also been proposed which would add inclusion terms and instructional notes to a use an additional code for deep vein thrombosis and long-term (current) use of anticoagulants, if applicable.

In the second option, index entries would be added to clarify the use of codes V12.51, Personal history of venous thrombosis and embolism, or V12.52, Personal history of thrombophlebitis, rather than creating new codes for chronic venous thrombosis and embolism. These additional index entries would serve as a reminder to clearly establish whether the thrombosis or embolism is a new (acute) or an old diagnosis. An Excludes note would be added under code 415.1, Pulmonary embolism and infarction, and under codes in category 453, Other venous embolism and thrombosis, to serve as a reminder that history of or a resolved thrombosis should be coded to the subcategory V12.5, Personal history of circulatory system diseases. New codes would be created for venous embolism and thrombosis of specific veins. The proposed changes to category 671 described under the first option are also part of the second option.

Epilepsy Versus Seizure

A representative of the National Association of Epilepsy Centers discussed non-epileptic seizures, the difference between repetitive and recurrent seizures, and intractability. It was proposed that inclusion terms for “pharmacoresistant,” “treatment resistant,” “refractory (medically),” and “poorly controlled” be added under the fifth digit for “with intractable epilepsy” for category 345, Epilepsy and recurrent seizures.

The presenter indicated that epilepsy is a syndrome of two or more unprovoked or recurrent seizures on more than one occasion. Seizures immediately following injuries, including those occurring with a two week time frame, would be considered non-epileptic, but seizures that occur later than two weeks after the head injury would be considered epileptic.

The presenter noted that repetitive seizures are not the same as recurrent seizures. The term “recurrent seizures” is used to indicate a patient with epilepsy who had previously controlled seizures who has had a return of seizures or that the rate of seizures has

increased in that patient. Repetitive seizures are several seizures in a short period of time. The term “breakthrough seizure” is used for patients with epilepsy who have not had a seizure for a long interval and then had another seizure

Insomnia, Initiating Versus Maintaining Sleep

The National Sleep Foundation has requested modifications to subcategory 327.0, Organic disorders of initiating and maintaining sleep, to better reflect the evolving understanding of sleep medicine. Currently, this subcategory includes both disorders of initiating and maintaining sleep, so it is not possible to distinguish these two forms of insomnia. Additional specificity will allow providers to design a better course of treatment. It will also permit researchers to make inferences about sleep maintenance versus sleep initiation and add greater depth to the analyses of these conditions. Existing codes 327.01 and 327.02 would be revised to state “disorder of initiating sleep” instead of “insomnia,” and new codes would be created for unspecified disorder of maintaining sleep, disorder of maintaining sleep due to medical condition classified elsewhere, and disorder of maintaining sleep due to mental disorder.

Endometrial Intraepithelial Neoplasia [EIN]

It has been proposed that two new codes be added under subcategory 621.3, Endometrial hyperplasia, for benign endometrial hyperplasia and endometrial intraepithelial neoplasia [EIN]. It was acknowledged that there is some overlap between the existing and proposed codes, but it is hoped that medical record documentation will migrate to the use of the new EIN terminology.

Dysphonia

The American Speech-Language-Hearing Association has recommended modifications to subcategory 784.4, Voice disturbance, in order to clarify and delineate the disorders of phonation and resonance. The title of this subcategory would be changed to “Voice and resonance disorders,” and new codes would be created for dysphonia, hypernasality, and hyponasality.

Currently, dysphonia, hoarseness, hypernasality, hyponasality, and change in voice are all classified to code 784.49, Other voice disturbance. Voice disturbance is a disorder of phonation, whereas hypernasality and hyponasality are disorders of resonance.

Dysphonia is a disorder of phonation (voice production). Like aphonia, which is a complete loss of voice, dysphonia is a symptom of a laryngeal disorder affecting the structure and/or function of the larynx. Dysphonia is distinct from impairments of resonance and nasal air flow. Disorders of resonance and nasal air flow may be due to impairment(s) affecting the structure and/or function of the oral cavity, nasal airway, and/or the velopharyngeal port. Hypernasality is excessive nasality and hyponasality is diminished nasality.

Fluency Problems

The American Speech-Language-Hearing Association has proposed new codes for dysarthria and fluency disorder under subcategory 438.1, Late effects of cerebrovascular disease, Speech and language deficits, and for dysarthria and stuttering with onset in childhood under subcategory 784.5, Other speech disturbance. They have also recommended revising the title of code 307.0 to state “psychogenic stuttering.” Some meeting participants expressed concern about moving codes for stuttering out of the Mental Disorders chapter.

Stuttering is defined as a disruption in speech production characterized by primary behavioral symptoms that include sound and syllable repetitions, blocks (articulatory fixations that prevent the speaker from moving forward in his or her speech), and inappropriate prolongations of speech sounds. There are three major recognized forms of stuttering: stuttering with onset in early childhood, psychogenic stuttering, and fluency disorder subsequent to brain lesion or disease, most typically as a result of cerebral vascular events (sometimes called neurogenic stuttering).

Wrong Site, Wrong Surgery, Wrong Patient

The Centers for Medicare and Medicaid Services has requested the creation of new external cause codes to better identify and track wrong site, wrong surgery and wrong patient. This proposed ICD-9-CM modification should also complement and enhance prevention and surveillance activities currently being undertaken by a number of public and private sector healthcare organizations. Wrong site, wrong surgery, and wrong patient are on the list of the National Quality Forum’s “never events.” Some meeting participants expressed concern about limitations in the number of ICD-9-CM diagnosis codes CMS is able to process, making it difficult to include external cause codes within the first nine diagnosis code fields that would be processed.

Tumor Lysis Syndrome

A new code for tumor lysis syndrome has been proposed in subcategory 277.8, Other specified disorders of metabolism. An additional code would be assigned for associated conditions. If drug-induced, an E code would also be assigned to identify the cause.

Tumor lysis syndrome is a group of metabolic complications that can occur after treatment of cancer, usually lymphomas and leukemias, and sometimes even without treatment. These complications are caused by the breakdown products of dying cancer cells and include hyperkalemia, hyperphosphatemia, hyperuricemia, hypocalcemia, and acute renal failure.

Meeting participants suggested adding a note under code 584.8, Acute renal failure, with other specified pathological lesion in kidney, indicating that the tumor lysis syndrome should be coded first, if present.

Fertility Preservation Prior to Antineoplastic Therapy

Creation of a new code for encounter for fertility preservation counseling in subcategory V26.4, Procreative management, general counseling and advice, has been proposed. Certain treatments, such as cancer treatment, can cause fertility. The new code would be used when an individual seeks advice regarding fertility preservation prior to undergoing a treatment that may affect fertility.

Fitting/Adjustment of Gastric Lap Band

Expansion of code V53.5, Fitting and adjustment of other intestinal appliance or device, has been proposed in order to create a code for fitting and adjustment of gastric lap band. The title of subcategory V53.5 would need to be revised to include gastric devices.

In gastric banding, an inflatable silicone prosthesis is placed around the top portion of the stomach to reduce the size of the stomach, thus restricting food intake and causing weight loss. The band may be periodically adjusted to achieve the optimal restriction of food intake necessary for weight loss while still allowing adequate nutrition. During pregnancy, the band may need to be adjusted to allow additional intake to assure optimal nutrition for mother and baby. Although a port is inserted to allow patients to self-adjust the band, often a physician office visit is required to achieve optimal adjustments.

Failed Sedation

The American Society of Anesthesiologists has requested an expansion of code 995.4, Shock due to anesthesia, to create new codes for shock due to anesthesia and failed moderate sedation during procedure. The title of subcategory 995.4 would be changed to state "Shock and other adverse effects due to anesthesia." A new code for history of failed moderate sedation has also been proposed.

Under some circumstances, moderate (conscious) sedation by non-anesthesia providers can be sufficient to provide safe and satisfactory pain relief and/or amnesia to patients undergoing noxious procedures that do not ordinarily require a full anesthetic. In some situations, however, this may produce inadequate sedation, making the procedure more difficult to perform and less satisfactory to the patient. This may also produce unsafe conditions for the patient. Reasons for failed moderate sedation include situations when maximum prudent and safe medication doses are administered, but the patient remains inadequately sedated for the procedure; patient exhibits idiosyncratic responses to the medication administered; patient becomes more deeply sedated than intended; respirations are depressed such that adequate air exchange is compromised; and hemodynamic changes occur, posing potential risks to the patient. One of these situations may have arisen during a previous procedure performed under moderate sedation, necessitating planned intervention during subsequent procedures.

Transfusion Reaction

Currently, ICD-9-CM indexing combines ABO incompatibility reactions with minor blood group antigen reactions. Given the increasing focus on ABO and Rh transfusion reactions as potentially preventable complications of transfusion therapy, there is a need to distinguish these transfusion reactions from reactions to minor blood antigens. Changes have been proposed that would limit the use of code 999.6 to ABO-related transfusion reactions and to create a new code for other specified transfusion reactions.

Immunologic transfusion reactions result from the interaction(s) of inherited or acquired antibodies with foreign antigens associated with cellular or humoral components of transfused blood products. When administering blood, hospitals routinely type and crossmatch blood for ABO and Rh antigens, unless emergent needs do not allow for it. However, other minor antigens (e.g., Kell, Duffy, Kidd, Lewis, E, M, N, P, S) may also cause acute or delayed hemolytic transfusion reactions. These reactions can result in similar clinical findings as ABO or Rh transfusion reactions. Most patients do not develop antibodies to these minor antigens and therefore are not susceptible to these reactions. Patients who receive frequent blood transfusions may develop antibodies to these minor antigens and subsequent reactions. Hospitals may choose to screen blood for these minor antigens and process the blood appropriately before administering the transfusion, but this is generally limited to patients who have already experienced a transfusion reaction to a minor antigen. Therefore, the reactions to minor antigens are generally not considered preventable.

Hypoxic-Ischemic Encephalopathy (HIE)

An expansion of code 768.7, Hypoxic-ischemic encephalopathy (HIE), has been proposed to create new codes that distinguish mild, moderate, and severe hypoxic-ischemic encephalopathy. It was noted that there are well-defined clinical definitions for these variations of HIE.

Antineoplastic Chemotherapy Induced Anemia

A new code for antineoplastic chemotherapy induced anemia has been proposed. This is a type of anemia acquired secondary to the administration of antineoplastic chemotherapy. Cancer and its treatment can interfere with the supply of red blood cells by inhibiting the production of bone marrow. This type of anemia is only rarely a hemolytic process and is not truly an aplastic process. Antineoplastic chemotherapy induced changes are usually short-term and they do not commonly reduce the marrow cellularity to a point of aplasia.

Family Circumstances

New codes in subcategory V61.0, Family disruption, have been proposed for family disruption due to death of family member and family disruption due to extended absence of family member. A revised version of a March 2008 C&M proposal for expansion of subcategory V61.2, Parent-child problems was also presented. This proposal would involve creation of new codes for counseling for parent-biological child problem,

counseling for parent-adopted child problem, and counseling for parent (guardian)-foster child problem.

Personal History of Immunosuppression, Estrogen, and Steroid Therapy

New codes for personal history of immunosuppression therapy, estrogen therapy, and steroid therapy have been proposed in subcategory V87.4, Personal history of drug therapy. A meeting participant suggested that consideration be given to distinguishing personal history of systemic steroid use vs. inhaled steroid use, since the risk is very different.

Apparent Life Threatening Event (ALTE) in an Infant

A new code for apparent life threatening event in an infant has been proposed in category 799, Other ill-defined and unknown causes of morbidity and mortality. It was suggested that additional codes be assigned for the individual symptoms.

An Apparent Life Threatening Event (ALTE) in an infant has been defined by a National Institutes of Health (NIH) Consensus Development Conference as “an episode that is frightening to the observer and that is characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid, but occasionally erythematous or plethoric), marked change in muscle tone (usually marked limpness), choking or gagging.” Some previously used terms include aborted crib death and near-miss sudden infant death syndrome (SIDS), but according to the NIH Consensus Development Conference, these terms should be abandoned because they imply a possibly misleadingly close association between this type of spell and SIDS.

The term “ALTE” describes a clinical syndrome. A variety of identifiable diseases or conditions can cause such episodes (e.g., gastroesophageal reflux, respiratory disease, or seizures), but in approximately half of the cases, no cause is identified. These episodes can occur during sleep, wakefulness, or feeding and occur in infants who were generally born at greater than 37 weeks gestational age.

Newborn Post-Discharge Health Check

New codes for newborn health supervision under 8 days old and 8 to 28 days old have been proposed in category V20, Health supervision of infant or child. The American Academy of Pediatrics recommends that all otherwise healthy newborns who are discharged from the hospital less than 48 after delivery should be examined by their primary care provider within 2 days after discharge.

Torus Fracture

New codes for torus fracture of ulna alone and of both radius and ulna have been proposed.

Pouchitis

Creation of a new subcategory (569.7) for complications of intestinal pouch has been proposed. This subcategory would contain a new code for pouchitis. Pouchitis is a nonspecific inflammation of an internal ileoanal pouch. Presenting symptoms of pouchitis include diarrhea, which may be bloody, along with urgency and incontinence. This may be accompanied by abdominal pain, fever, loss of appetite, and general malaise. Pouchitis is usually treated successfully with antibiotics. However, relapse is common.

Gout

New codes to differentiate the stages of gouty arthropathy have been requested. These codes would differentiate acute gouty arthropathy and chronic gouty arthropathy with and without tophi. It was suggested that consideration be given to creating a unique code for hyperuricemia.

Gout is a disorder in which urate (uric acid) crystals are deposited in joints and soft tissues with accompanying inflammation and degenerative changes. This is generally associated with hyperuricemia (excessive uric acid in the blood), although hyperuricemia does not always progress to gout. There are four progressive stages of gout:

- Asymptomatic urate deposition or accumulation: There is documented evidence of uric acid accumulation in the tissues of a patient with concomitant hyperuricemia, but without an established diagnosis of gout yet.
- Acute gout (also known as gout attacks or gout flares): Acute gout is an acute symptomatic inflammation caused by urate crystals in one or more joints.
- Intercritical gout: This includes the interval between gout flares, during which time joints symptomatically return to normal, often in the face of persistent hyperuricemia.
- Chronic tophaceous gout: This stage of chronic arthritis is associated with tophi, concentrated urate crystal deposits in and around joints and in subcutaneous tissue. The arthritis is characterized by tender and swollen joints. Tophi usually appear only after a patient has had gout for several years.

Colic

Colic generally affects newborns and infants between 3 and 12 weeks of age. The etiology is unclear. Currently, infantile colic is classified to the codes for abdominal pain, which does not seem appropriate, since the underlying cause may not be related to abdominal pain. A unique code for infantile colic has been proposed in category 789, Other symptoms involving abdomen and pelvis. It was suggested that adult colic either continue to be indexed to the codes for abdominal pain or else create a unique code for it as well. It was also suggested that a note be added under the proposed new code to exclude renal colic.

Vomiting

New codes for bilious emesis and vomiting of fecal matter have been proposed in subcategory 787.0, Nausea and vomiting. An expansion of code 779.3, Feeding problems in newborn, has also been proposed in order to create unique codes for feeding problems in newborn, bilious vomiting in newborn, and failure to thrive in newborn. The intent of the proposed codes in category 779 is that they would be limited in infants under 28 days of age. The title of subcategory 779.3 would be revised to state “Disorder of stomach function and feeding problems in newborn.”

Merkel Cell Carcinoma

New site-specific codes for Merkel cell carcinoma have been proposed in subcategory 209.3, Malignant poorly differentiated neuroendocrine tumors. Merkel cell carcinoma is an aggressive neuroendocrine skin cancer.

Secondary Neuroendocrine Tumors and Personal History of Neuroendocrine Tumors

New site-specific codes for secondary neuroendocrine tumors have been proposed in category 209, Neuroendocrine tumors. Creation of a new code for personal history of malignant neuroendocrine tumor has been proposed in category V10, Personal history of malignant neoplasm. An additional code would be assigned for any continuing functional activity. It was suggested that it might be useful to create “personal history” codes that distinguish history of benign and malignant neuroendocrine tumors.

Inconclusive Mammogram

A new code for inconclusive mammogram has been proposed in category 793, Nonspecific abnormal findings on radiological and other examination of body structure. This code would include dense breasts. This is not considered an abnormal condition, but it may result in inconclusive mammogram results and thus require further testing to confirm that no malignant condition exists. Since dense breasts are not considered abnormal, the title of category 793 would be modified so that the word “abnormal” is nonessential.

Diagnosis Addenda

Proposed diagnosis addenda changes were reviewed. Highlights of the proposed revisions include (note that these are only proposed at this point – they have not been finalized):

- Addition of inclusion term for “hypothyroidism following therapy, such as irradiation” under code 244.1, Other postablative hypothyroidism;
- Addition of inclusion term for “hypothyroidism resulting from administration or ingestion of radioactive iodide” under code 244.2, Iodine hypothyroidism;

- Addition of note under code 251.3, Postsurgical hypoinsulinemia, indicating that additional codes should be used to identify any associated acquired absence of pancreas, secondary diabetes mellitus, and insulin use;
- Revision of code titles in category 584 to state “acute kidney failure;”
- Addition of inclusion term for “coccyx” under code 707.03, Pressure ulcer, lower back;
- Addition of inclusion term for “chronic fracture” under subcategory 733.1, Pathological fracture;
- Addition of note under Open Wounds section indicating that any associated systemic infection with systemic effects, such as wound botulism, should be coded first, and revision of the “use additional code” note in this section to indicate that an additional code should be used to identify a localized or superficial infection;
- Addition of Excludes note under subcategory V54.0, Aftercare involving internal fixation device, for aftercare involving internal fixation devices used for fracture treatment;
- Addition of Excludes note under subcategory V54.1, Aftercare for healing traumatic fracture, for aftercare following joint replacement;
- Addition of Excludes note under subcategory V54.2, Aftercare for healing pathologic fracture, for aftercare following joint replacement;
- Revision of Index entry for prophylactic administration of antibiotics (V58.62);
- Addition of Index entry for school examination following surgery (V67.0);
- Addition of Index entries for worn out artificial heart failure (996.02), pacemaker lead or battery (V53.31), and joint prosthesis (996.46).

Procedures

Cardiac Contractility Modulation

Two new codes in chapter 17, Other miscellaneous procedures, have been proposed for implantation of rechargeable cardiac contractility modulation, total system (CCM) and implantation or replacement of cardiac contractility modulation (CCM) rechargeable pulse generator only. Implantation of the CCM system includes formation of pocket, transvenous leads, including placement of leads, placement of catheter into left ventricle, intraoperative procedures for evaluation of lead signals, obtaining sensing threshold measurements, and obtaining defibrillator threshold measurements.

The CCM device is designed for the treatment of patients with moderate to severe heart failure. It generates CCM signals, which are non-excitatory impulses delivered to the heart during a period of time called the absolute refractory period. Unlike a pacemaker, the CCM signals do not initiate a new heartbeat. Rather, these signals are intended to enhance the strength of the heart and overall cardiac performance. The implantation of the device may occur alone, in the presence of a pre-existing automatic implantable cardioverter/defibrillator (AICD), or in a combined implantation with an AICD. Implantation of a CCM system is more complex and requires more operating room time

than insertion of either pacemakers or defibrillators because of the additional testing required to ensure appropriate function.

Endovascular Bioactive Coil

A new code for endovascular treatment of vessel(s) of head or neck using bioactive coils has been proposed in subcategory 39.7, Endovascular repair of vessel. This proposal also involves revising the title of subcategory 39.7 as well as the titles of some of the codes in this subcategory. Subcategory 39.7 would be re-titled to state “Endovascular treatment of vessel(s).” The title of code 39.72 would be revised to state “Endovascular treatment of head and neck vessels NEC” and the title of code 39.79 would be revised to state “Other endovascular treatment of other vessels.”

Existing code 39.72, Endovascular repair or occlusion of head and neck vessels, does not differentiate between the use of bare platinum coils and more advanced coils that include biodegradable polymers. Bioactive coils include a biologically active agent that is designed to enhance occlusion rates and thrombus formation. These bioactive coils have been shown to improve clinical outcomes (aneurysm occlusion durability).

Endoscopic Bronchial Valve Insertion in Single and Multiple Lobes

A new code for endoscopic insertion or replacement of bronchial valve(s), multiple lobes, is being proposed in subcategory 33.7, Other endoscopic procedures in bronchus or lung. The title of existing code 33.71 would be revised to specify single lobe.

Existing code 33.71, Endoscopic insertion or replacement of bronchial valve(s), does not differentiate between single vs. multiple lobes of the lung. Patients requiring treatment across multiple lobes compared to a single lobe often have different indications. Endobronchial valve insertion is currently being investigated for two indications: the treatment of severe emphysema and the control of prolonged air leaks. For severe emphysema, multiple lobes are typically treated during an individual procedural episode. For air leaks, it is most common for only one lobe to be treated, often resulting in fewer valve placements. The clinical resources and the time required to perform the procedure on patients who require valve insertion in multiple lobes are greater than those needed for patients requiring single lobe treatment.

Vascular Imaging

A new code was proposed to identify the VeinViewer® technology for vascular imaging. CMS recommended that code 88.90, Diagnostic imaging, not elsewhere classified, be assigned for this technology instead of creating a new code.

The VeinViewer® is a vascular imaging system that illuminates subcutaneous vasculature by imaging the vein’s location on the surface of the skin. This technology is particularly useful for patients who have difficult venous access. Meeting participants were generally not supportive of creating a unique code for this technology.

Laser Interstitial Thermal Therapy (LITT) for Brain Tumors

A new subcategory with several site-specific codes for laser interstitial thermal therapy (LITT) has been proposed in category 17, Other miscellaneous procedures. This procedure involves the use of a laser probe to ablate tumors. The LITT technology enables the surgeon to focus the laser energy on the targeted tumor tissue, while largely avoiding damage to surrounding healthy tissue.

Intraoperative Anesthetic Effect Monitoring and Titration (IAEMT)

A new code for intraoperative anesthetic effect monitoring and titration (IAEMT) has been proposed in subcategory 00.9, Other procedures and interventions. IAEMT uses brain monitoring technology to guide anesthesia care. It is performed by anesthesia professionals to assess the hypnotic component of anesthetic effect and to adjust the level of anesthetic medications to achieve an optimal or desired level of anesthetic effect.

Endoscopic Insertion of Colonic Stent

New codes for endoscopic insertion of colonic stent(s) and other insertion of colonic stent(s) have been proposed in subcategory 46.8, Dilation and manipulation of intestine. As an alternative to emergency large bowel surgery, patients with acute malignant colonic obstruction can be effectively treated with a colonic stent insertion or other non-endoscopic means, followed by subsequent elective surgical resection and anastomosis. Recently, the use of self-expandable metal stents for the relief of malignant or benign colonic obstruction as an alternative or bridge-to-surgery has become more acceptable.

Procedure Addenda

Proposed procedure addenda changes were reviewed. Highlights of the proposed revisions include (note that these are only proposed at this point – they have not been finalized):

- Revision of title of subcategory 80.0 to state “arthrotomy for removal of prosthesis without replacement;”
- Addition of inclusion term for “removal of prior prosthesis – do not code separately” under subcategory 81.5, Joint replacement of lower extremity;
- Addition of inclusion term for “partial knee replacement” under code 81.54, Total knee replacement;
- Addition of inclusion term for “partial elbow replacement” under code 81.84, Total elbow replacement;
- Addition of Index entries for:
 - Graft, skin, free, breast, deep inferior epigastric artery perforator (DIEP) flap, free (85.74);
 - Graft, skin, free, breast, gluteal artery perforator (GAP) flap, free (85.76);
 - Graft, skin, free, breast, superficial inferior epigastric artery (SIEA) flap, free (85.75);

- Shunt, ventricular to peritoneal (02.34);
- Suture, obstetric laceration NEC, periurethral (75.69);
- Wang needle aspiration biopsy, bronchus (33.24).

ICD-10 Update and Effect on MS-DRGs

Rhonda Butler from 3M provided an ICD-10 update. She noted that although ICD-10-CM and ICD-10-PCS contain more codes than ICD-9-CM, a larger number of codes doesn't mean greater system complexity. Complexity comes from inconsistency, incompleteness, ambiguity, and lack of capacity, which are all attributes of ICD-9-CM.

The process of converting MS-DRGs to ICD-10-CM/PCS using the General Equivalence Mappings was discussed. 3M started with the digestive system section of MS-DRGs, and the conversion of this section will be posted on the CMS web site by the end of 2008. They found the conversion process to be pretty straightforward and not nearly as difficult as originally anticipated.

MS. Butler also described the development of a reimbursement map. CMS asked 3M to develop a reimbursement map as a result of requests from other payers for assistance in determining how to convert payment systems to ICD-10-CM/PCS. The reimbursement mappings are designed to be interposed between data submitted using ICD-10-CM/PCS codes and legacy systems using ICD-9-CM codes so data can continue to be processed without converting the legacy system to ICD-10-CM/PCS. The reimbursement mappings will indicate which alternative ICD-9-CM code is the most appropriate choice for reimbursement. Although the vast majority of ICD-10-CM/PCS codes are translated to a single ICD-9-CM code, there are instances when an ICD-10-CM/PCS code is translated to more than one ICD-9-CM code. In these cases, historical ICD-9-CM code frequency data are used to determine the most commonly used ICD-9-CM code among the ICD-9-CM code alternatives.

3M continues to develop the annual updates to ICD-10-PCS to include new codes which have been incorporated into ICD-9-CM. They also continue to refine ICD-10-PCS based on additional analyses and public recommendations. A new root operation, "supplement," has been added. The definition is "putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part" (e.g., herniorrhaphy using mesh). An ICD-10-PCS body part key has been developed which helps users choose the correct ICD-10-PCS body part for a given anatomical term or procedure site. It will be included in the 2009 version of ICD-10-PCS. An updated 2009 version of ICD-10-PCS will be posted on CMS' ICD-10 web site by the end of 2008.

Cooperating Parties and Physicians Update on ICD-10

The Cooperating Parties (AHIMA, AHA, CMS, and NCHS) provided an overview of ICD-10-CM/PCS, including: current problems with ICD-9-CM; structure of ICD-10-CM and ICD-10-PCS and how they differ from ICD-9-CM; and AHIMA's and AHA's plans for education and resources and recommendations for implementation strategies. The

slide presentation is available on the CMS web site. Two physicians also provided comments on the need for better data than is currently available using ICD-9-CM and described how improved data using ICD-10-CM/PCS would benefit physicians.