



Summary of September 2012 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 19, 2012 in Baltimore, MD. Donna Pickett, RHIA, from CDC, and Patricia Brooks, RHIA, from CMS, co-chaired the meeting.

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 meeting materials posted on the CMS and NCHS websites. Information from the diagnosis portion of the meeting is posted on the NCHS website and can be accessed at the following link: http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm. Information 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.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials.html>.

No ICD-9-CM code proposals were presented at this meeting. The proposed ICD-10-CM/PCS modifications, if approved by CMS and NCHS, would not go into effect until October 1, 2015, after the code freeze, unless they are specifically requested to be implemented during the code freeze period and CMS and NCHS approve this request, based on the criteria for code set modifications during the code freeze.

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.

Suggestions for diagnosis code proposals for consideration at a future Coordination and Maintenance Committee may be emailed to nchsic9CM@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.

The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled for March 4-5, 2013 and will be held at the CMS building in Baltimore, MD. New code proposals for inclusion on this agenda must be received by **January 4, 2013**.

ICD-10 Implementation Announcements

ICD-10-CM/PCS Implementation Delay

Denise Buening, CMS, announced the implementation of ICD-10-CM/PCS was delayed from October 1, 2013 to October 1, 2014, pursuant to final rule CMS-0040-F issued on August 24. CMS will use the extra year for testing. They will also publish practical ICD-10 transition tools (e.g., checklists, decision trees) that are especially useful for small providers.

Pat Brooks, CMS, explained that, in light of the delay, the partial code set freeze will be implemented as follows:

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011.
- On October 1, 2012 and October 1, 2013 there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.
- On October 1, 2014, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.
- On October 1, 2015, regular updates to ICD-10 will begin.

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2015 once the partial freeze has ended.

CMS National Provider Calls

CMS hosts a variety of National Provider Calls (NPCs) to help the provider community prepare for the US health care industry's change from the ICD-9-CM to ICD-10 medical coding system. All NPCs are free of charge, but registration is required. Presentation materials, written transcripts, and audio recordings from previous ICD-10 NPCs are also available. To obtain registration information for an upcoming ICD-10 NPC or to obtain the presentation materials, written transcripts, and audio recordings from a previous event, please refer to the National Provider Calls and Events web page at <http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html>.

Other ICD-10 Topics

ICD-10 MS-DRG Update

Version 30 (v30) of the ICD-10 MS-DRG Definitions Manual is expected to be available in November 2012, along with a summary of the changes from version 29. The mainframe and PC version of v30 ICD-10 MS-DRG software is expected to be available through the National

Technical Information Service (NTIS) in early 2013. Posted documents and information on ordering v30 software will be posted at <http://www.cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html>.

ICD-10-PCS Addendum Update Plans

CMS has provided examples of the kinds of changes made in ICD-10-PCS each year in a “What’s New” document instead of a detailed addendum. However, CMS is undertaking the development of a more detailed addendum for future updates. Announcements concerning the more detailed addendum will be made at the March 2013 ICD-9-CM C&M Committee meeting.

ICD-10 HAC Translations

The public is encouraged to review CMS’ translations of the hospital acquired conditions (HACs) into ICD-10-CM/PCS codes and to submit comments on these translations. A CMS ICD-10-CM/PCS HAC Translation Feedback Mailbox has been set up for this purpose. This feedback link is titled “CMS HAC Feedback” and is located on the HAC website under the ICD-10-CM/PCS HACs List link on the left side of the page at the following link:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html.

ICD-10 MCE Translations

The Medicare Code Editor (MCE) has been translated to ICD-10 codes and contains the updates to match the ICD-9-CM version 30 that becomes effective October 1, 2012 (FY 2013). Comments on the MCE conversions are encouraged and welcomed and should be sent electronically to Mady Hue at the following e-mail address: Marilu.Hue@cms.hhs.gov. The v30 MCE will become available in November 2012 and will be posted on the CMS ICD-10 MS-DRG Conversion Project web page located at the following link: <http://www.cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html>.

Diagnoses

No ICD-9-CM diagnosis code proposals were presented.

ICD-10-CM Proposals

Cerebrovascular Disease – Bilateral

Some of the codes in the cerebrovascular section indicate laterality, but they do not always provide a “bilateral” option. The American Academy of Neurology proposed new “bilateral” options for cerebral infarction subcategories because cerebral infarctions may occasionally be due to bilateral arterial lesions.

Mononeuropathy – Bilateral

The American Academy of Neurology proposed new “bilateral” codes for upper and lower limb mononeuropathy. Bilateral mononeuropathy is not a true polyneuropathy.

Multifocal Motor Neuropathy

A unique code for multifocal motor neuropathy (MMN) has been proposed by the American Academy of Neurology. This condition is a form of inflammatory neuropathy that most resembles chronic inflammatory demyelinating polyneuropathy (CIDP). Unlike CIDP, MMN is slowly progressive, affects only motor nerves, and there is no paraspinal denervation on electromyogram (EMG).

Aneurysm and Dissection of Precerebral and Vertebral Arteries

The World Health Organization (WHO) added “and dissection” to the title of category I72, Other aneurysm, as well as created codes for aneurysm and dissection of precerebral and vertebral arteries. In ICD-10-CM, dissection of arteries has its own unique codes in subcategory I77.7, Other arterial dissection. Modifications to categories I72 and I77 have been proposed, including new codes for: aneurysm of other precerebral arteries; aneurysm of vertebral artery; dissection of unspecified artery; dissection of vertebral artery; dissection of other precerebral arteries; dissection of artery of upper extremity; and dissection of artery of lower extremity. Excludes2 notes clarifying the appropriate codes for various aneurysms and dissections would also be added.

Congenital Metatarsus Adductus

The American Podiatric Medical Association proposed creating unique codes under Q66.2, Congenital metatarsus (primus) varus, for congenital metatarsus primus varus and congenital metatarsus adductus (with an inclusion term under the latter for congenital metatarsus varus). Metatarsus primus varus and metatarsus varus have unique codes in ICD-9-CM.

Bunions

The American Podiatric Medical Association has recommended that unique codes be created for bunion and bunionette [Tailor’s bunion] (hypertrophy of the lateral condyle of the fifth metatarsal head). A bunion is the hypertrophic medial eminence and the associated soft tissue edema and bursitis on the first metatarsal head. A bunionette [Tailor’s bunion] is hypertrophy of the lateral condyle of the fifth metatarsal head with associated soft tissue edema and lateral bursitis.

Food Protein Induced Enterocolitis Syndrome (FPIES)

New codes have been proposed for food protein-induced enterocolitis syndrome (FPIES), food protein-induced enteropathy, and other allergic and dietetic gastroenteritis and colitis. Associated instructional notes and Excludes notes have also been proposed. FPIES is a gastrointestinal food allergy, which causes symptoms of vomiting usually within 1 to 3 hours after eating the causative food. Diarrhea may also occur, within 5 to 8 hours, and it may be bloody. Vomiting and diarrhea may be so severe as to cause dehydration and even shock. This condition usually occurs in infants, with onset most often before 3 months, but up to 1 year, and usually it resolves by about 3 years of age. It is most often due to milk or soy proteins, but also can be due to rice, or other food proteins. The symptoms of vomiting and diarrhea generally resolve quickly with elimination of the causative food from the diet. In chronic cases, there may be weight loss and failure to thrive. FPIES has also been described in adults, particularly due to shellfish.

Food protein-induced proctocolitis is another distinct gastrointestinal food allergy, which causes blood-streaked stools and usually presents in the first months of life. Other terms for this condition include allergic proctocolitis, food-induced eosinophilic proctocolitis, milk protein-induced proctocolitis, and eosinophilic colitis.

While many allergies are IgE mediated, FPIES and food protein-induced proctocolitis are not IgE mediated and are thought to be cell mediated. Another non-IgE mediated food allergy is food protein-induced enteropathy. It also occurs in young infants, and causes chronic diarrhea, weight loss, and failure to thrive. It is also treated by strict dietary elimination of the allergen and is usually outgrown by age 2 or 3.

Oral allergy syndrome involves symptoms of itching, swelling, or tingling of the lips, mouth, or throat, in response to a food, often to raw fruits or vegetables. This is considered a gastrointestinal allergy, which is IgE mediated, and may also be considered an adverse food reaction.

Age-Related Macular Degeneration

The American Academy of Ophthalmology and the American Society of Retina Specialists have proposed new codes to capture the stages of age-related macular degeneration (AMD) and identify laterality. AMD is a deterioration or breakdown of the eye's macula. The macula is a small area in the retina, the light-sensitive tissue lining the back of the eye. The macula is the part of the retina that is responsible for central vision. There are two types of macular degeneration, dry, non-exudative and wet, exudative. Most people with macular degeneration have the dry form and vision loss is usually gradual. Dry AMD is classified into the following stages from the Age-Related Eye Disease Study (AREDS):

- Early dry AMD (AREDS category 2)
- Intermediate dry AMD (AREDS category 3)
- Advanced dry AMD (part of AREDS category 4)

Wet macular degeneration is any exudative stage of the disease. Dry AMD can evolve to wet AMD. Eyes with active wet choroidal neovascularization are those for whom intravitreal anti-vascular endothelial growth factor injections are administered. Wet AMD is classified into the following stages:

- Active choroidal neovascularization
- Inactive choroidal neovascularization (involved or regressed after treatment)
- Inactive scar

If a patient has bilateral AMD with different stages on each side, two codes would need to be assigned rather than using a bilateral code. A meeting attendee suggested that either a default or additional code is needed for choroidal neovascularization not specified as active or inactive.

Proliferative Diabetic Retinopathy (PDR)

The American Academy of Ophthalmology and the American Society of Retina Specialists have requested new codes to enable better tracking of stages of proliferative diabetic retinopathy and also capture laterality for both the new codes as well as existing diabetic retinopathy codes. Currently, in the diabetes mellitus categories (E08-E11, E13), only one subcategory exists for proliferative diabetic retinopathy. This covers the earliest stages prior to treatment. The earliest stages of proliferative diabetic retinopathy include those with active disease needing therapy (with laser surgery or incisional surgery) and those where the retinopathy has involuted following treatment and likely will not need further laser or surgical intervention. In addition to the stages captured by the existing codes, it is important to be able to capture these stages of proliferative diabetic retinopathy:

- Traction retinal detachment not involving the macula
- Traction retinal detachment involving the macula
- Combined traction retinal detachment and rhegmatogenous retinal detachment
- Stable (previously lasered or operated) proliferative diabetic retinopathy

Stable means the active neovascular process is quieting following laser treatment, vitrectomy surgery, or intravitreal anti-vascular endothelial growth factor therapy.

Meeting attendees suggested creating an unspecified option for instances when the stage is not documented.

Diabetic Macular Edema

The American Academy of Ophthalmology and the American Society of Retina Specialists have requested codes to capture diabetic macular edema that has resolved following treatment. These are still high-risk patients that require follow-up.

Meeting attendees expressed concern that the use of the term “resolved” may be misleading for coding professionals. It was suggested that an alternative term should be considered. It was also suggested that a personal history code might be more appropriate, given the distinctions between active disease and history in the classification.

Retinal Vascular Occlusions

The American Academy of Ophthalmology and the American Society of Retina Specialists are requesting the creation of 7th characters for subcategories H34.81, Central retinal vein occlusion, and H34.83, Tributary (branch) retinal vein occlusion, that would capture the severity of the occlusion (with macular edema, with retinal neovascularization, or stable). Intervention is needed if there is macular edema or neovascularization present. The term “stable” means there is no edema and no reason to treat. The occlusion is still present, but the disease process is not active and intervention is not needed.

A meeting attendee commented that since codes already exist for macular edema and neovascularization, it would seem as though the presence of these conditions with a retinal vascular occlusion could be captured without creating new combination codes in subcategories H34.81 and H34.83.

Primary Open-Angle Glaucoma

The American Academy of Ophthalmology proposed new codes to capture laterality for primary open-angle glaucoma.

Complications of Urinary Devices

The American Urological Association has proposed changes for genitourinary prosthesis, devices, grafts, and implants. The proposed revisions are intended to incorporate appropriate terminology and current urological medical practice.

Revisions and the addition of new codes have been proposed in subcategory T83.0, Mechanical complication of urinary (indwelling) catheter, to capture the correct diagnosis coding of all urinary catheters, not limited to the term “indwelling.”

Revisions and the addition of new codes have been proposed in subcategory T83.1, Mechanical complication of other urinary devices and implants, to account for breakdown, displacement, and

other complications of all existing urinary devices and implants available. It was suggested that Excludes notes and educational materials would be helpful in clarifying the differences between catheters and stents.

New codes have been proposed in subcategory T83.2, Mechanical complication of graft of urinary organ, to identify erosion and exposure of grafts used in the urinary system.

Revisions and additional codes have been proposed in subcategory T83.4, Mechanical complication of devices, prosthetics, implants and grafts of genital tract, to capture the testicular prosthesis implant and to provide clarification regarding the use of these codes. A meeting attendee suggested that codes for breakdown and displacement of other prosthesis of genital tract be added.

Revisions and additional codes have been proposed in subcategories T83.5, Infection and inflammatory reaction due to prosthetic device, implant and graft in urinary system, and T83.6, Infection and inflammatory reaction due to prosthetic device, implant and graft in genital tract, to maintain consistency with the changes being made in other sections and to capture infection and inflammation due to prosthetic device, implant and graft in both the urinary system and genital tract. Additional catheters in addition to stents and other urinary devices are captured in these two sections.

Revisions and additional codes have been proposed in subcategory T83.7, Complications due to implanted mesh and other prosthetic materials. Modifications to ICD-10-CM to capture complications of vaginal mesh were added as part of the FY 2012 update. However, the existing single code only captured the erosion of vaginal mesh or erosion to other surrounding organs or tissues. The codes did not capture the use of urethral mesh which is not placed in the vagina. Also, the use of mesh is not limited to the female population. In order to adequately capture the use of urethral mesh in both men and women, as well as vaginal mesh, this section needs to be more specific and inclusive for both men and women for urethral and vaginal mesh. A meeting attendee suggested consideration be given to adding an Excludes note for mesh used for inguinal hernia repair.

Additional codes have been proposed in subcategory T85.1, Mechanical complication of implanted electronic stimulator of nervous system, to capture information related to the breakdown and displacement of a neurostimulator device of the sacral nerve. Meeting attendees asked how the codes in subcategory T85.1 fit with similar codes in T83.1, Mechanical complication of other urinary devices and implants. It was recommended that all sacral nerve neurostimulator devices be reclassified to subcategory T85.1. Classifying these devices to a nervous system category rather than the urinary system is appropriate because neurostimulators are used for a wide variety of medical conditions.

Revisions have been proposed to subcategory N99.11, Postprocedural urethral stricture, male, in order to capture postprocedural fossa navicularis stricture, male, which would result in re-titling all of the codes in this subcategory and creating a new code for postprocedural urethral stricture, unspecified, male. Meeting attendees questioned the need to re-title all of the codes in this subcategory rather than simply create a new code for postprocedural fossa navicularis stricture in an open slot in this subcategory. The presenter indicated that the code re-titling was being proposed so that the codes are in anatomical order. Meeting attendees felt that listing codes in anatomical order was unnecessary, and that it would be preferable not to disrupt the meaning of existing codes.

Revisions of subcategories R99.52, Complication of other external stoma of urinary tract, and N99.53, Complication of other stoma of urinary tract, have been proposed that would result in

N99.52 codes referring to “incontinent” stomas and N99.53 codes referring to “continent” stomas. It was suggested that either a default code needs to be designated or an unspecified code needs be created for those instances when the stoma is not documented as continent or incontinent. The presenter explained that incontinent stomas are always draining to a bag worn on the outside of the body. The patient has to empty the bag frequently. With a continent stoma, the patient can catheterize it every few hours to empty the urine, which collects inside the body. About 80% of stomas are of the incontinent type.

Chronic Fatigue Syndrome

A proposal to modify the codes for chronic fatigue syndrome was presented at a previous C&M Committee meeting and came back again to the September 2012 meeting. The requester asked that consideration be given to implementing the proposed changes during the code set freeze. Currently, in ICD-10-CM, chronic fatigue syndrome is classified to code R53.82, Chronic fatigue, unspecified. In the international version of ICD-10, chronic fatigue syndrome is classified to code G93.3, Postviral fatigue syndrome. The submitter proposed an expansion of code G93.3, Postviral fatigue syndrome, to create two new codes for postviral fatigue syndrome and chronic fatigue syndrome. An inclusion term for myalgic encephalomyelitis (benign) would be added under the proposed new code for chronic fatigue syndrome. NCHS offered an alternative option that also involved an expansion of code G93.3, but would result in the creation of separate codes for chronic fatigue syndrome and myalgic encephalomyelitis.

The cause or causes of chronic fatigue syndrome remain unknown. While a single cause may yet be identified, another possibility is that chronic fatigue syndrome represents a spectrum of illnesses resulting from multiple possible pathways. Conditions that have been proposed to trigger the development of chronic fatigue syndrome include infections, trauma, immune dysfunction, stress, and exposure to toxins. Research is ongoing. There is no consensus on a single case definition, including whether or not chronic fatigue syndrome and myalgic encephalomyelitis are the same or different conditions.

Microscopic Colitis

Creation of a new subcategory for microscopic colitis has been requested, with new codes for collagenous colitis, lymphocytic colitis, other microscopic colitis, and unspecified microscopic colitis. A meeting attendee questioned whether these terms would commonly be documented in medical records. Another attendee commented that the term “microscopic colitis” appears in pathology reports, and that usually these patients are managed on an outpatient basis.

Indeterminate Colitis

Since WHO added a code for indeterminate colitis in ICD-10, the addition of a new code for this condition is proposed for ICD-10-CM. Indeterminate colitis refers to inflammatory bowel disease with colitis, in which neither Crohn’s disease nor ulcerative colitis can be diagnosed. It comprises about 10% of cases of inflammatory bowel disease. Another clinical term for this condition is colonic inflammatory bowel disease unclassified (IBDU). Approximately half of patients initially diagnosed with indeterminate colitis may subsequently be diagnosed with either Crohn’s disease or ulcerative colitis.

Meeting attendees suggested that the term “indeterminate” could be confused with the term “unspecified” or with inconclusive biopsy results. It was suggested that the code title and associated Index entries should indicate “so stated” to make it clear that “indeterminate colitis” is a

specific diagnostic term. Another recommendation was to add an Excludes1 note for “colitis NOS” under the proposed new code.

Cervical Disc Disorders

Codes for cervical disc disorders in ICD-10-CM were created based on expansion using WHO regions that had been applied for other similar codes, including for the occipito-atlanto-axial region. However, since there are no cervical discs at C1 and C2, it has been suggested that the current code titles for cervical disc disorders involving the occipito-atlanto-axial region are not clinically appropriate. It is proposed to retitle these codes to identify them as cervical disc disorders involving the high cervical region, and to explicitly include C2-C3 and C3-C4 levels. Codes for cervical disc disorders involving the mid-cervical region would have terms added to explicitly include the C4-C5, C5-C6, and C6-C7 disc levels. Codes for cervical disc disorders of the cervicothoracic region would have terms added to explicitly include the C7-T1 level. It is also proposed to create codes for the specific levels of mid-cervical disc disorders, including the C4-C5, C5-C6, and C6-C7 disc levels, as well as a new code for cervical disc disorders of the mid-cervical region that are of unspecified level. A question was raised as to whether codes for “multiple levels” are needed or instructions should be provided indicating that multiple codes should be assigned when multiple levels are involved.

Cervical disc disorders can affect the spinal cord (causing myelopathy), or the nerve roots as they travel through the spinal canal (causing radiculopathy). The seven cervical vertebrae are identified by number, with the highest (C1) being the atlas and C2 being the axis. The axis has the dens process, on which the atlas can turn. Nerve roots come from the spinal cord and exit the spinal canal between each of the cervical vertebrae, with nerve root C1 just above the C1 vertebra, through to C8, which comes out of the spinal canal below the C7 vertebra and above the top thoracic vertebra, T1. There are no cervical discs around C1, so the first intervertebral disc space is between C2 and C3.

Some of the proposed modifications are being considered for implementation during the code set freeze, whereas others are not.

Spinal Cord Disorders Involving the Lumbar and Sacral Regions

Deletion of codes M47.17, Other spondylosis with myelopathy, lumbosacral region, M47.18, Other spondylosis with myelopathy, sacral and sacrococcygeal region, and M51.07, Intervertebral disc disorders with myelopathy, lumbosacral region, has been proposed because these conditions are not clinically possible. Deletion of these codes has been proposed to occur during the code set freeze.

The spinal cord ends in the conus medularis, which most often is located in the upper lumbar region, around L1 to L2. The nerve roots for the lower lumbar and sacral nerves make up the cauda equine and travel through the spinal canal below the conus medularis. Certain disorders involving the lower spine cannot affect the spinal cord, when these occur below where the spinal cord ends, such as spondylosis of the lumbosacral, sacral, and sacrococcygeal regions, or intervertebral disc disorders involving the lumbosacral region.

Adverse Effect of Certain Narcotic Drugs

Deletion of codes T40.1x5, Adverse effect of heroin, and T40.8x5, Adverse effect of lysergide [LSD], has been proposed because these drugs have no accepted medical uses and therefore cannot cause adverse effects. Creation of these codes occurred during broad expansion of the drug categories to create codes for adverse effects, without consideration of whether these codes would

be applicable for clinical practice in the US. Deletion of these codes has been proposed to occur during the code set freeze.

Uterine Scar from Previous Surgery

The American College of Obstetricians and Gynecologists requested new codes that specify the type of incision used on a previous cesarean delivery. Subsequent pregnancy and delivery management may be determined by the previous incision type.

ICD-10-CM Addenda

Proposed ICD-10-CM addenda changes were reviewed. Some of the proposed changes are:

- Addition of inclusion terms for “anal intraepithelial neoplasia III [AIN III]” and “severe dysplasia of anus” under code D01.3, Carcinoma in situ of anus and anal canal;
- Addition of Excludes1 note for “anal intraepithelial neoplasia I and II [AIN I and AIN II] (K62.82)” under code D01.3, Carcinoma in situ of anus and anal canal;
- Addition of Excludes1 note for “prostatic intraepithelial neoplasia II [PIN II] (N43.3)” under code D07.5, Carcinoma in situ of prostate;
- Change of Excludes1 note for “headache syndromes (G44.-)” under category G43, Migraine, to an Excludes2 note;
- Deletion of instructional note under category I23, Certain current complications following ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction (within the 28 period);
- Deletion of Excludes1 note for “acute occlusion of artery of the extremity (I70.2-, I70.3-, I70.4-) under code I70.92, Chronic total occlusion of artery of the extremities;
- Addition of instructional note under code K59.0, Constipation, that directs users to “use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5);”
- Change of instructional note under category S12, Fracture of cervical vertebra and other parts of neck, that states “code first any associated cervical spinal cord injury (S14.0, S14.1-)” to a “code first” note;
- Revision of title of code Z95.0 to state “Presence of electronic cardiac devices,” and addition of inclusion terms for presence of cardiac pacemaker, presence of cardiac resynchronization therapy defibrillator (CRT-D), and presence of cardiac resynchronization therapy (CRT) pacemaker;
- Revision of Index entry for Shin splints (S86.89);
- Addition of Index entry for Diabetes, uncontrolled – code to Diabetes, by type, with hyperglycemia;
- Revision of Index entry for Distress, acute respiratory (adult) (child) (J98.4);
- Revision of Index entries for Distress, respiratory, adult and Distress, respiratory, child (R06.00);
- Revision of Index entries for Insufficiency, pulmonary, following shock and Insufficiency, pulmonary, following trauma (J98.4);
- Revision of Index entries for Thrombosis, thrombotic, heart, not resulting in infarction, and Thrombosis, thrombotic, mural, not resulting in infarction (I51.3).

Audience discussion regarding addenda changes that should be made prior to ICD-10-CM implementation vs. those that should be made post-implementation indicated that some attendees felt that errors in the classification should be corrected prior to implementation.

Procedures

No ICD-9-CM procedure code proposals were presented.

ICD-10-PCS Proposals

Expansion of Thoracic Aorta Body Part Under Heart and Great Vessels System

An expansion of the ICD-10-PCS body part for thoracic aorta under the Heart and Great Vessels System has been proposed to identify both the ascending/aortic arch and descending segments of the thoracic aorta. This proposal would create 122 new codes under the Heart and Great Vessels body system for the following 12 root operations: Bypass, Destruction, Dilation, Excision, Extirpation, Insertion, Release, Repair, Replacement, Reposition, Supplement, and Restriction. Procedures involving the ascending aorta are inherently more complex and carry higher risk than procedures on the descending thoracic aorta. Distinctly identifying procedures performed in the higher risk and more complex anatomy of the ascending aorta and aortic arch will enable more precise outcome measures and treatment analysis.

Temporary Therapeutic Endovascular Occlusion of Vessel

It has been proposed to move qualifier J-Temporary from ICD-10-PCS table 02V to table 04V in order to recognize that the catheter is inserted into the abdominal aorta, not the thoracic aorta. New ICD-9-CM procedure code 39.77, Temporary (partial) therapeutic endovascular occlusion of vessel, was created on October 1, 2012 to classify procedures in which the abdominal aorta is partially occluded via an endovascular balloon catheter. This treatment is for patients with cerebral ischemia. Comparable updates were made to table 02V in ICD-10-PCS such that qualifier J-Temporary was added under the body system 2-Heart and Great Vessels, root operation V–Restriction, and body part value W-Thoracic Aorta. The ICD-10-PCS selection of body part value was based on the description of the procedure in the original proposal, which described the site of the device as the descending aorta, which typically refers to the descending portion of the thoracic aorta. In fact, the catheter is inserted into the abdominal aorta, not the thoracic aorta, with balloons just above and just below the renal arteries. Therefore, the insertion of the qualifier J-Temporary should have been added to the Table 04V so that it can be coded with body system 4-Lower Arteries, root operation V-Restriction and body part 0-Abdominal Aorta.

Since the placement of qualifier J-Temporary in table 02V instead of table 04V was an error, it was suggested during the C&M meeting that consideration be given to making the changes on October 1, 2013, rather than waiting until after the code set freeze. Making the changes during the code set freeze would allow these procedures to be coded correctly at the outset of ICD-10-PCS implementation.