Committee Considers ICD-9-CM Changes for 2002

by Sue Prophet, RHIA, CCS

The ICD-9-CM Coordination and Maintenance Committee, cosponsored by the National Center for Health Statistics (NCHS) and the Health Care Financing Administration (HCFA), met on November 17, 2000, in Baltimore, MD. Donna Pickett, RHIA, from NCHS, and Patricia Brooks, RHIA, from HCFA, cochaired the meeting.

Proposed modifications to ICD-9-CM were presented and are summarized below. Unless otherwise indicated, there was general support for the proposed changes. The summary of the Coordination and Maintenance Committee meeting is provided for information purposes only. The comment period for the proposed revisions has expired.

Proposed changes, if approved, would become effective October 1, 2001.

Diagnoses

Minutes from the diagnosis portion of the Coordination and Maintenance Committee meeting, as well as full details of the code proposals, can be found at the NCHS Web site at www.cdc.gov/nchs/icd9.htm.

ICD-10-CM

An update on the status of the development of ICD-10-CM was provided. At the time of the Coordination and Maintenance Committee meeting, final changes were being made to the Tabular section and Index. Testing plans were being developed with the Center for Health Policy Studies, HCFA's Central Data Abstraction Centers, the American Hospital Association, and AHIMA. The final testing plan and possibly some preliminary test results will be presented at the May Coordination and Maintenance Committee meeting.

Acute Coronary Obstruction

Category 411 is titled "Other acute and subacute forms of ischemic heart disease." Therefore, chronic forms of ischemic heart disease should not be assigned a code from category 411. It has been proposed that the code title of code 411.81, Coronary occlusion without myocardial infarction, be changed to include the word "acute" so that there is no confusion regarding whether or not this code should be assigned for cases of chronic ischemic heart disease.

Also, the coding of the terms "occlusion" and "obstruction" in reference to ischemic heart disease is not consistent. Code 411.81 states "occlusion." The term "obstruction" in the Index for ischemic heart disease directs the coder to atherosclerosis. The Excludes note under code 411.81 excludes occlusion due to atherosclerosis, indicating that occlusion and obstruction should be used synonymously. It has been proposed that the term "obstruction" be added both as an inclusion term and part of the Excludes note so that the diagnostic statements of "acute coronary occlusion" and "acute coronary obstruction without myocardial infarction" are assigned the same code.

Dental Caries

At the request of the Association of State and Territorial Dental Directors (ASTDD), the Council of State and Territorial Epidemiologists approved the inclusion of oral health indicators into the National Public Health Surveillance System (NPHSS). The ASTDD is managing the collection of these oral health indicators and had named this NPHSS sub-component the National Oral Health Surveillance System (NOHSS). This system will collect oral health data for national, state, and local purposes.

No existing disease classification system meets the needs of the NOHSS and thus no coding system has been designated for data collection of oral health conditions. The ASTDD has requested an expansion of the ICD-9-CM dental caries codes to

meet the needs of the NOHSS. The proposed codes are needed to help track one of the federal Healthy People objectives, to address the nutritional status of nursing home patients, and to track the use of dental sealants and their availability to children living at or below the poverty level.

According to the proposal, new codes would be created for dental caries limited to enamel, dental caries extending into dentine, dental caries extending into cementum, arrested dental caries, odontoclasia (which would include infantile melanodontia and melanodontoclasia), unspecified acquired absence of teeth, loss of teeth due to accident, and loss of teeth due to local periodontal disease. Multiple dental caries codes may be assigned together.

An audience member suggested revising the proposed code description "loss of teeth due to accident" to state "loss of teeth due to trauma" to encompass traumatic events that may not be accidental. It was also suggested that a code be added for loss of teeth due to dental caries. Audience members raised questions regarding whether multiple codes would be assigned to identify the various ways one patient may have lost several teeth and whether or not the proposed codes for loss of teeth referred to an edentulous patient or one who had lost some but not all teeth (such as ranges of them). The proposal also included new V codes for dental restoration status (including dental crowns status and dental fillings status) and dental sealant status.

Acute Esophagitis

Currently, acute esophagitis is classified to code 530.10, Esophagitis, unspecified. Because it is inappropriate to use an unspecified code for a specified condition, it has been proposed that a new code be created for acute esophagitis.

Constipation

It has been proposed that code 564.0, Constipation, be expanded to create codes for different types of constipation. There are two distinct subtypes: slow transit constipation and outlet dysfunction constipation. Slow transit constipation results from a delay in transit of fecal material throughout the colon secondary to smooth muscle dysfunction. Synonyms include colonic inertia and delayed transit. Laxatives or surgery are used for this type of constipation. Outlet dysfunction constipation results from difficulty evacuating the rectum secondary to failure to relax or paradoxical contraction of the striated pelvic floor muscles during attempts at defecation. Biofeedback to teach relaxation of the pelvic floor muscles is used for this type of constipation. According to the proposal, new codes would also be created for neurogenic and drug-induced constipation. An additional code to identify the responsible drug would be assigned in conjunction with the proposed code for drug-induced constipation. NCHS is considering the addition of a "code first" note under the proposed code for neurogenic constipation to indicate that the underlying cause should be sequenced first.

One audience member suggested creating a new code for dietary constipation, as this condition is seen in many pediatric patients. Members of the audience expressed concern that some of the proposed codes may overlap. It was suggested that codes only be created for the slow transit and outlet dysfunction types of constipation and that neurogenic and drug-induced constipation be classified to the code for other types of constipation.

Urologic Conditions

The American Urological Association has requested new codes for retrograde ejaculation, hematospermia, and dysplasia of prostate. Retrograde ejaculation is a condition in which the nerves that control ejaculation have been damaged, causing the bladder neck to remain open during ejaculation and sperm to be released into the bladder instead of through the urethra. Etiologies for this condition include neurologic or psychogenic conditions, diabetes, trauma, hypertension, ectopic ureterocele, hypertonic external sphincter, medications, and side effects from surgical procedures (e.g., node dissection, transurethral resection of the prostate, bladder neck reconstruction). Retrograde ejaculation is extremely common and can be treated with medication or surgery. When retrograde ejaculation occurs as a postoperative complication, the appropriate 900 code should be sequenced before the proposed new code. It was suggested that a "code first" note be added to instruct coders to first code the underlying cause, such as postoperative complication.

Hematospermia is the presence of blood in the ejaculate. This is a relatively common condition. The exact cause often is not clearly known because semen originates from multiple organs (testicles, epididymis, vas deferens, seminal vesicles, and prostate). Possible etiologies include infection, inflammation, and, less commonly, prostate cancer. Most patients require no

therapy, whereas others may be treated with hormones or antibiotics. Currently, hematospermia is classified to code 608.83, Vascular disorders of male genital organs.

Prostatic intraepithelial neoplasm (PIN) is a frequent pathological finding from prostate needle biopsy. The cells appear dysplastic (abnormal in shape or size). This is not a benign condition, which is a proliferation of normal cells; it is commonly a premalignant condition that must be monitored closely with repeat biopsy. High-grade prostatic intraepithelial neoplasia is the most likely precursor of invasive prostate cancer. Because this condition is not the same as a benign hyperplasia, it would not be appropriate to classify it to the 600 category. There are three levels of PIN, which are classified as PIN I, PIN II, and PIN III. The proposed new code would be used for PIN I and PIN II, and PIN III would be indexed to code 233.4, Carcinoma in situ of prostate. This structure is consistent with the codes for vulvar intraepithelial neoplasia (VIN) and cervical intraepithelial neoplasia (CIN). A member of the audience noted that PIN III needs to be included in the Neoplasm table.

Developmental Hip Dislocation

Hip disorders can occur either congenitally or as children develop. Abnormal angulations and rotations are types of developmental disorders that may lead to hip dislocation. Some of these developmental disorders can improve with modifications in sleeping positions or they may resolve without treatment as development continues. Others may require treatment such as hip pinning. There currently is no code that describes developmental hip dislocation. The only codes that exist are those for congenital hip dysplasia (754.30-754.35) as well as a code for other congenital deformity of the hip joint (755.63). A new code for developmental hip disorder has been proposed. According to the proposal, a new subcategory for developmental dislocation of joint would be created in category 718, Other derangement of joint. Through assignment of the appropriate fifth digit for the specific site, this subcategory would apply to other joints in addition to the hip. An audience member suggested adding an Excludes note under the proposed new subcategory for congenital dislocations. It was suggested that the code for congenital dislocation should be the default code when it is not known if the dislocation is developmental or congenital.

Vascular Complications

Code 997.2, Peripheral vascular complications, is limited to peripheral vessels, so this code can not be assigned for vascular complications of other vessels. Generally, vascular complications of other vessels are classified to the body system in which they belong. A postoperative mesenteric artery embolism is classified to the code for digestive system complications and a postoperative renal artery occlusion is classified to the code for urinary complications. It has been proposed that a new code be created under category 997 for vascular complications of vessels other than peripheral vessels. Additional codes should be assigned for any specific resulting complications. A member of the audience suggested that postoperative mesenteric and renal artery occlusions continue to be classified to the codes for digestive and urinary complications, respectively, because the resulting manifestations relate to these body systems. Another suggestion was to create unique codes for postoperative mesenteric and renal artery occlusions.

Supplementary Classification of Factors Influencing Health Status and Contact with Health Services

Hemophilia A Carrier Status

The American College of Obstetricians and Gynecologists has requested that a new code be established to identify whether a woman is a hemophilia A carrier. Hemophilia is an X-linked genetic condition. The gene is carried by females on one of their X chromosomes and may be passed to their male offspring. Female carriers of hemophilia have one X chromosome with a normal gene and one X chromosome with a defective gene. Thus, there is a 50 percent chance that each of her male children will receive the hemophilia gene and have hemophilia. There is also a 50 percent chance that the hemophilia gene will be passed to her female children. If the female children receive the hemophilia gene, they would also be carriers. Because males have only one X chromosome, any male who inherits the defective X chromosome has hemophilia. Because males receive the X chromosome from their mother and the Y chromosome from their father, males born to a father with hemophilia and a mother who is not a carrier will not have the disease. All daughters born to men with hemophilia will inherit their father's hemophilia gene and thus will be carriers. Some female carriers are asymptomatic and have no health problems or symptoms related to being a carrier. Other female carriers have low factor levels that are associated with bleeding problems such as

excessive menstrual bleeding, bruising, nosebleeds, and bleeding after surgery, dental work, or childbirth. Stress, exercise, medications, and changing hormone levels during menstruation and during and after pregnancy may affect the bleeding patterns of symptomatic carriers.

According to the proposal, two new codes would be established in subcategory V49.8, Other specified conditions influencing health status, for asymptomatic and symptomatic hemophilia A carrier. A member of the audience suggested creating a new category for non-infectious carrier status, because there may be other proposals in the future for new carrier status codes. It was also suggested that a "code also" note be added under the code for symptomatic carrier to indicate that the associated disorder or symptom the individual is experiencing should also be coded.

Clinical Trial Participant

Some payers, including Medicare, will reimburse providers for the cost of routine patient care associated with participation in a clinical trial. There is no ICD-9-CM code to indicate that a patient is a participant in a clinical trial. There is a code, V70.7, for a control in clinical research. Because it is often not known if a patient is a control or participant, it has been proposed that the description of this code be revised to allow its use for both controls and participants in clinical trials. This code would be reported as a secondary code, following the code for the diagnosis being treated.

Reportable/Notifiable Conditions

A number of conditions, such as tuberculosis, gonorrhea, hantavirus pulmonary syndrome, and acute pesticide poisoning, are reportable conditions to state public health authorities due to their serious potential public health impact. Other conditions, such as influenza and bacterial meningitis, are not mandated by state law to be reported, but have significant public health impact and may be voluntarily reported.

Parallel to the required state reporting system, the National Center for Infectious Diseases (one of the Centers for Disease Control and Prevention) maintains the Nationally Notifiable Diseases System that collects data from the states on some of the reportable conditions. For ongoing surveillance and control activities by both the states and the CDC, case definitions have been established for these reportable conditions. These case definitions require the certainty of the condition (i.e., confirmed versus suspected versus probable) to be reported. Currently, no structure exists in ICD-9-CM for identifying the certainty of a diagnosis. Because federal agencies need to migrate to the use of standardized coding for improving efficiency and decreasing administrative burden, it has been proposed that new V codes be created for use in public health reporting. These codes would be used in conjunction with reportable/notifiable conditions and would identify the certainty of a diagnosis. The proposed V codes would be used only by public health practitioners for reporting and monitoring reportable/notifiable conditions, not by hospital or physician office-based coders. These codes would always be secondary codes following the code for the reportable/notifiable condition. According to the proposal, a new V code category would be created for "Notifiable/Reportable Condition Confirmation Status." Within this category, there would be two subcategory codes for confirmed and unconfirmed conditions. Within the subcategory for confirmed conditions, new codes would be created for laboratory-confirmed conditions, clinically-confirmed conditions, and epidemiologically-linked conditions. Within the subcategory for unconfirmed conditions, two new codes would be created for probable and suspected conditions. The ICD-9-CM rule regarding the coding of suspected or probable conditions as if they are confirmed would not be affected by the new V codes.

The audience expressed a great deal of consternation regarding this proposal, due to the potential misuse of these codes by payers and others who might seize these new codes as a way to capture information regarding any "probable" or "suspected" condition, and different users would develop their own definitions and criteria for the use of these codes. It was suggested that perhaps separate public health codes should be created in an Appendix rather than in ICD-9-CM itself. Other suggestions included making the code descriptions more explicit, adding comprehensive explanatory notes regarding the proper use of these codes, or just creating the new codes for the confirmed conditions and not the unconfirmed ones. Many of those in attendance felt that regardless of the specificity of the code descriptions or instructions, the existence of these codes would still lead to varied use and interpretation.

Addenda

Proposed October 2001 addenda changes were reviewed. Proposed revisions include:

- Revision of fifth digit "0" under category 493, Asthma, to include acute exacerbation or unspecified
- Addition of Excludes note under code 575.8, Other specified disorders of gallbladder, for "Hartmann's pouch of intestine (V44.3)"
- Revision of inclusion terms under codes 645.1, Post-term pregnancy, and 645.2, Prolonged pregnancy, to clarify that 40 weeks and 42 weeks mean 40 weeks 0 days and 42 weeks 0 days
- Under code 706.3, Seborrhea, addition of Excludes notes for seborrheic dermatitis (690.10)
- Revision of description of code V72.3 to state "Gynecological examination with or without Pananicolau cervical smear"
- Addition of Index entry for personal history of malignant neoplasm of renal pelvis (V10.59). The American Urological Association recommended that a new code be created for personal history of malignant neoplasm of the renal pelvis rather than creating an Index entry leading to code V10.59
- Addition of Index entry for hyporesponsive episode (780.09)
- Revision of Index entry for high blood sugar to indicate that code 790.2 is the appropriate code assignment
- Addition of Alosetron, Lotronex, Mifepristone, and RU486 to the Table of Drugs and Chemicals

Procedures

Minutes from the procedural portion of the Coordination and Maintenance Committee meeting, as well as full details of the code proposals, can be found on HCFA's Web site at http://www.hcfa.gov/medicare/icd9cm.htm.

ICD-10-PCS

HCFA posted an updated version of ICD-10-PCS on its Web site in November 2000. This updated version contains all of the suggested changes and revisions identified through the extensive testing process. Although there were a number of changes to the Index as well as clarifications to the Tabular section, there were no fundamental changes to the basic structure of the system. Because ICD-10-PCS has been finalized and extensively tested, it is time to evaluate it for implementation. A considerable part of the May Coordination and Maintenance Committee meeting will be devoted to discussing whether the industry should continue using the existing ICD-9-CM procedure codes or whether ICD-10-PCS should be implemented as a new national standard. To facilitate discussion, major organizations, industry groups, manufacturers, publishers, and others will be offered the opportunity to make a brief presentation on whether to move forward to a new procedure coding system or stay with the current system. AHIMA plans to make a presentation at the meeting. Issues such as timing, training requirements, the need for public maintenance committees, and which organizations should participate in maintenance and guideline development need to be addressed. Suggestions on who should lead the educational efforts will be sought.

Transabdominal Cerclage of Cervix

Currently, all types of cervical cerclage are assigned to code 67.5, Repair of internal cervical os. It has been proposed that a unique code be created for transabdominal cerclage of cervix. In this procedure, the cerclage is performed through an abdominal incision, which makes it possible to place the stitch exactly at the level that is needed. This procedure can be carried out when the cervix is very short, effaced, or totally distorted. One audience member expressed concern that medical record documentation might not be clear enough to distinguish the different approaches for performing this procedure, but others felt this would not be a problem.

Transcervical Fetal Oxygen Saturation Monitoring

It has been proposed to create a new code under subcategory 75.3, Other intrauterine operations on fetus and amnion, for transcervical fetal oxygen saturation. Fetal oxygen monitoring technology provides clinicians with a direct measure of fetal oxygen status when an irregular fetal heart rate is present. The transcervical fetal oxygen saturation monitor utilizes a disposable sensor that is inserted through the birth canal once the amniotic membranes have ruptured and the cervix is dilated past 2 centimeters. The sensor rests against the fetal cheek, forehead, or temple and is held in place by uterine forces. As with traditional pulse oximetry, harmless red and infrared light shines into the baby's skin and the reflected light is captured and analyzed. The oxygen saturation is displayed on a monitor screen as a percentage. According to the Food and Drug Administration, this monitor should only be used after maternal membranes have ruptured and on a single fetus in vertex presentation with a gestational age greater than or equal to 36 weeks. It was suggested that the code title "fetal pulse oximetry" might be a more appropriate description, because that is how the procedure is typically documented.

Intracardiac Echocardiography

It has been proposed that a new code be created for intracardiac echocardiography (ICE). Intracardiac echocardiography was developed to assist invasive cardiologists in the catheterization and electrophysiology laboratories or in critical care and intensive care units by providing direct, real-time two-dimensional images and physiologic evaluation from inside the heart. ICE does not provide therapeutic benefits, but is a diagnostic tool used in the performance of another therapeutic procedure.

Through the ICE catheter, a physician is able to visualize therapeutic tools in relation to cardiac anatomy and physiology, optimizing the treatment. An ICE catheter is inserted into the body's venous system using an introducer sheath, through either the femoral vein in the groin or from the internal jugular in the neck. Once the catheter reaches the right atrium or ventricle, the imaging catheter is micro-positioned to see the targets of interest based on the procedure or therapy. Intracardiac ultrasound visualization and assessment of the heart during interventions may include such applications as electrophysiology, such as for ablation therapy for cardiac arrhythmias, interventional cardiology, minimally invasive cardiac surgery, and CCU or ICU monitoring.

According to the code proposal, the new code would be created under subcategory 88.7, Diagnostic ultrasound. Members of the audience suggested that internal echocardiograms be classified differently than external echocardiograms and that internal echocardiograms should be classified to category 37.

Nonoperative Removal of Heart Assist System

A new code for nonoperative removal of heart assist system has been proposed. Nonoperative removal of this device can be done at the patient's bedside, is noninvasive, and requires no anesthesia. According to the code proposal, the new code would be created under subcategory 97.4, Nonoperative removal of therapeutic device from thorax. It was suggested that an Excludes note for this procedure be added under code 37.64, Removal of heart assist system. Until the new code for nonoperative removal of heart assist system becomes effective, code 37.64 should continue to be assigned for this procedure, as directed by the Index.

Lysis of Adhesions

There has been confusion surrounding the definition and coding of lysis of adhesions, particularly digital or mechanical during a non-open procedure. Generally, lysis of adhesions should not be coded unless the adhesions are obstructive to an organ or impair or impede the normal function of an organ. To clarify the proper coding of adhesiolysis, HCFA has proposed additional Index entries indicating that no code should be assigned for lysis of adhesions performed by blunt, digital, manual, or mechanical technique, or that performed without instrumentation. Appropriate Excludes notes for these types of lysis of adhesions would also be added to the Tabular section.

Addenda

Proposed October 2001 addenda changes were reviewed. Proposed revisions include:

- Addition of Excludes notes under codes 01.41, Operations on thalamus, and 01.42, Operations on globus pallidus, for "that by stereotactic radiosurgery (92.30-92.39)"
- Addition of inclusion term for "liver dialysis" under code 50.92, Extracorporeal hepatic assistance
- Addition of Index entry for liver dialysis (50.92)
- Deletion of code 42.23 from Index entry for transesophageal echocardiography (only code 88.72, rather than both codes 88.72 and 42.23, would be assigned for this procedure)

The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled for May 17-18, 2001. New proposals for inclusion on the May agenda must be received by March 17, 2001. Send suggested diagnosis agenda items for the May meeting to: National Center for Health Statistics, ICD-9-CM Coordination and Maintenance Committee, 6525 Belcrest Road, Room 1100, Hyattsville, MD 20782.

Send suggested procedure agenda items for the May meeting to: Health Care Financing Administration, CHPP, PPG, Division of Acute Care, Mail Stop C4-07-07, 7500 Security Boulevard, Baltimore, MD 21244-1850.

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