ICD-9-CM Committee Proposes New Codes, Changes

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This is part one in a two-part summary of proposals from the November ICD-9-CM Coordination and Maintenance Committee meeting. Part 2 will be published in the April 2002 *Journal of AHIMA*.

The ICD-9-CM Coordination and Maintenance Committee, cosponsored by the National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS), met in November 2001, in Baltimore, MD. Donna Pickett, RHIA, from NCHS, and Patricia Brooks, RHIA, from CMS, co-chaired 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. This summary is provided for information purposes only. The comment period for the proposed revisions has expired.

Proposed changes, if approved, would become effective October 1, 2002.

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, www.cdc.gov/nchc/icd9.htm.

Use of V Codes for Procedures

A discussion was held on the potential use of V codes for procedures representing new technology in order to meet the requirements specified in the Benefits Improvement and Protection Act of 2000 (BIPA) to incorporate new technologies into ICD-9-CM more quickly. Due to serious space constraints in the ICD-9-CM procedure codes, it had been suggested that V codes be considered as an alternative way to track new technology procedures.

A proposal was presented to create "flag" codes in the V code section. This would significantly reduce the number of new procedure codes needed to describe new technology. An ICD-9-CM procedure code would be used to identify the basic procedure performed and a flag code would indicate that this procedure utilized new technology. Participants expressed a number of concerns regarding this concept. One concern was that it would be confusing to mix procedural information in the diagnosis classification system. Another concern was that it would be difficult to identify which procedure code the flag code applied to if multiple procedures were performed.

It was suggested that use of V codes in this manner might violate HIPAA because the diagnosis classification system was only designated as the standard code set for diagnoses, not procedural information. Also, there is an ever-increasing need to expand V codes in order to capture data about healthcare provided in non-acute care settings. Use of available V codes to describe procedural information would reduce the number of available V codes.

Toxic Shock Syndrome

Toxic shock syndrome is a severe illness caused by a bacterial infection, characterized by high fever of sudden onset, vomiting, diarrhea, and myalgia, followed by hypotension and, in severe cases, shock. A sunburn-like rash with peeling of the skin, especially on the palms and soles, occurs during the acute phase. It was originally observed almost exclusively in menstruating women using high-absorbency tampons, with the infective agent being *Staphylococcus aureus*. However, a nearly identical syndrome has subsequently been seen in males and females of different ages infected with Group A Streptococcus. The mortality rate for this disease is 85 percent.

A unique code in subcategory 040.8, Other specified bacterial diseases, has been proposed to describe toxic shock syndrome. An additional code should be assigned to identify the causal organism, if known.

West Nile Virus

In recent years, cases of human West Nile virus have increased. In otherwise healthy patients, West Nile virus may be mistaken for the flu, and no medical care may be sought. In the elderly or those with weakened immune systems, the infection is often severe and potentially life threatening. Encephalitis is a common complication.

Currently, West Nile virus is included in a code with a variety of other mosquito-borne fevers. Creation of a unique code in category 066, Other arthropod-borne viral diseases, has been proposed.

Symptomatic Menopause

Currently, there is overlap between codes 256.2, Postablative ovarian failure, and 627.4, States associated with artificial menopause. The note under code 627.4 indicates that it is to be used for menopausal symptoms due to artificial menopause, but there is no instruction indicating whether a code from category 256 should be assigned with 627.4 or not. It has been proposed that an instructional note be added, indicating that code 256.2 should be used in conjunction with code 627.4 for artificially induced menopause.

It was also proposed that the code titles for codes 627.2, 627.4, and V49.81 be revised to clarify that the codes in category 627 are for symptomatic menopause and code V49.81 is for asymptomatic menopause. Also, the "use additional code" note under subcategory 256.3 needs to be corrected because the codes in this subcategory are for naturally occurring ovarian failure and therefore correspond with code 627.2, Menopausal or female climacteric states, not 627.4, States associated with artificial menopause.

A question arose as to the proper code assignments for a patient who has had her ovaries removed and presents for bone density testing. NCHS responded that codes 256.2, Postablative ovarian failure, and V45.77, Acquired absence of genital organs, should be assigned for this scenario.

Pulmonary Manifestations of Cystic Fibrosis

The current codes for cystic fibrosis only include that with and without meconium ileus. Because pulmonary manifestations may or may not be present and it is the pulmonary manifestations that are the determinant of the course of the disease, it has been requested that an additional code be created for cystic fibrosis with pulmonary manifestations. Additional codes for cystic fibrosis with complications of pancreatic enzyme replacement therapy and for that with other complications were also requested.
It was suggested that a code be created for cystic fibrosis with multiple manifestations. However, it was felt that better data would result if multiple codes were reported to individually identify the manifestations.

The audience noted that there is confusion regarding a "complication" versus "manifestation" of cystic fibrosis. In fact, both the code proposal and advice regarding cystic fibrosis code assignments published in *Coding Clinic for ICD-9-CM* have used these terms interchangeably. Therefore, it is unclear whether pulmonary conditions that cystic fibrosis patients often develop (such as pneumonia or bronchitis) are included in the proposed new codes or not. It was recommended that further clarification of the intent of the proposed new codes be obtained before adoption of the proposal.

Heart Failure

A revision of the heart failure codes was originally presented at the May Coordination and Maintenance Committee meeting. At that meeting, representatives from Kaiser Permanente explained that the current ICD-9-CM codes do not adequately describe the various types of heart failure recognized today. They noted that it is important to be able to identify and differentiate between systolic and diastolic heart failure. The proposal for a code expansion presented at the May meeting was not well received by either the audience members or Kaiser Permanente representatives. The audience members expressed concerns about the number of new codes being proposed and the probable lack of information in the medical record to allow

selection of the correct code. The Kaiser Permanente representatives felt that the proposal was too complicated. A revised version of the proposal was presented at the November meeting.

The revised proposal would delete the word "congestive" from the codes in categories 402 and 404 (the code descriptions would read "with heart failure" or "without heart failure"). Category 428 would be expanded to include specific codes for acute and chronic systolic and diastolic heart failure. While some concern was expressed again that physicians do not necessarily document whether the heart failure is systolic or diastolic, the presenters noted that this information effects the treatment plan and new physicians are being educated to document heart failure in this manner. An audience member suggested that new codes for "acute-on-chronic" systolic and diastolic heart failure might also be needed.

Vascular Disease

New codes describing atheroembolism, varicose veins, postphlebitic syndrome, chronic venous hypertension, and non-aortic arterial dissection were proposed. Atheroembolism is also known as "cholesterol embolism" and due to its manifestations, it has also been called "blue toe syndrome." Atheroembolism occurs when plaque in the aorta disrupts, showering debris into circulation, where it lodges in small terminal arterial branches. The primary manifestations are splotchy purplish areas of discoloration of skin in the extremities, often the toes and along the outer aspect of the feet. These may be terribly painful and may lead to patchy gangrene.

Though most common in the vessels of the extremities, atheroemboli have been found in virtually all tissue, and can lead to renal failure. When it is disseminated, this condition has a very high associated mortality, predominantly from renal failure, but also from progressive failure to thrive. Surgical treatments consist of surgical bypass or endarterectomy. Medical treatment requires the use of antiplatelet agents. Antithrombolytic agents are not advised due to concern that they may further disrupt plaque. Because thrombosis and embolism involve true clots and atheroemboli are degenerative material from plaque, it was recommended that new codes be created for atheroembolism. The proposal included creation of a new category for atheroembolism, with unique codes for atheroembolism of the upper and lower extremities and the kidney.

Currently, ICD-9-CM codes for venous disease allow only for the coding of varicose veins and postphlebitic syndrome. There are no specific codes for venous disease due to chronic venous hypertension not associated with deep vein thrombosis. For varicose veins, codes exist only for ulceration and inflammation, not for the other symptoms associated with this condition. Also, there are no unique codes for the symptoms associated with postphlebitic syndrome. It has been proposed that a new varicose vein code be created for varicose veins with other complications (e.g., edema, pain, swelling) and the postphlebitic syndrome code be expanded to allow for the coding of the symptoms of this condition (ulcer, inflammation). The codes for postphlebitic syndrome would include chronic venous hypertension with deep vein thrombosis but not that without deep vein thrombosis. Audience members expressed concern that physicians may not document a diagnosis of "postphlebitic syndrome," but instead just indicate that the patient has a lower leg ulcer and a history of phlebitis. The physician presenter indicated that the physician documentation should specifically link the postphlebitic syndrome to the ulcer in order to use these codes.

It has also been proposed that a new subcategory be created for chronic venous hypertension, with unique codes for the associated complications (ulcer, inflammation). Chronic venous hypertension due to deep vein thrombosis would be classified to the postphlebitic syndrome codes.

An instructional note would be added under subcategory 707.1, Ulcer of lower limbs, except decubitus, indicating that an associated underlying condition of chronic venous hypertension with ulceration or postphlebitic syndrome with ulceration should be coded first.

It has also been proposed that unique codes for dissection of the carotid, iliac, and renal arteries be created. ICD-9-CM provides a code for arterial dissection of the aorta, but not other sites. Although the aorta is the most common site for dissections, they may occur in other arteries. An arterial dissection is defined by blood coursing within the layers of the arterial wall. A dissection is an aneurysm. True aneurysms involve dilatation of all three arterial wall layers. The term "dissecting aneurysm" is a misnomer. Arterial dissections are common complications of interventional procedures. An audience member asked if a new code is also needed for dissection of the pulmonary artery. The clinical presenter indicated that the pulmonary artery does not generally dissect.

Residuals Following Cerebrovascular Accident

Facial droop is a common residual of a cerebrovascular accident. Currently, there is no specific late effect code for this residual in category 438, Late effects of cerebrovascular disease. In addition to a new late effect code for facial droop, new codes for other late effects of cerebrovascular disease were proposed. They include ataxia, vertigo, alteration of sensation, alteration of visual field, abnormal extraocular movements, and other visual disturbances. It was suggested that code title for the proposed new code for facial droop should state "facial weakness." A question was raised as to how these residuals would be coded if the cerebrovascular accident was current, as opposed to a late effect.

Abnormal Findings on Cervical Pap Smear

It has been proposed that the following inclusion terms be added under code 622.1, Dysplasia of cervix (uteri): cervical intraepithelial neoplasia I (CIN I), cervical intraepithelial II (CIN II), high-grade squamous intraepithelial dysplasia (HGSIL), and low-grade squamous intraepithelial dysplasia (LGSIL).

HGSIL and LGSIL are terms used in the Bethesda system of the National Cancer Institute. This system differs slightly from the CIN system. Under the Bethesda system, both CIN II and high-grade squamous intraepithelial dysplasia equate to *in situ* cancer of the cervix. As carcinoma *in situ* can only be confirmed by biopsy, not by cytology, and the Bethesda system classifies cytology findings, both CIN II and GSIL will be classified to code 622.1.

It was also proposed that several new codes be created to identify the different types of abnormal findings based on the Bethesda system. Code 795.0, Nonspecific abnormal Papanicolaou smear of cervix, would be expanded to accommodate new codes describing atypical squamous cell changes of undetermined significance favor benign, atypical squamous cell changes of undetermined significance favor dysplasia, and other nonspecific abnormal Papanicolaou smear of cervix.

Ectopic Pregnancy with Uterine Pregnancy

The increased use of assisted reproductive technologies has lead to an increase in multiple gestation pregnancies with ectopic pregnancies co-existing with intrauterine pregnancies. Therefore, it has been proposed that combination codes be created for an ectopic and intrauterine pregnancy. Alternative options included adding codes in subcategory 633.8, Other ectopic pregnancy, or expanding the current ectopic pregnancy codes in category 633. The audience generally preferred expanding the codes in category 633, because this would allow the various types of ectopic pregnancies, with and without a co-existing intrauterine pregnancy, to be grouped together. For example, code 633.1, Tubal pregnancy, would be expanded to allow unique codes for tubal pregnancy with intrauterine pregnancy and without intrauterine pregnancy.

Exposure to Anthrax

Due to the recent deaths and illness caused by anthrax exposure in the mail, it has been proposed that specific codes for exposure to anthrax and observation for suspected contact with anthrax be created. For patients who have actually been exposed to anthrax or who have come in contact with anthrax spores, proposed new code V01.81, Contact with or exposure to anthrax, would be assigned. For individuals who have concern that they may have been exposed, seek evaluation, but are found not to have been exposed, new code V71.82, Observation and evaluation for suspected exposure to anthrax, was proposed. The condition must have been ruled out in order for V71.82 to be assigned. For asymptomatic patients who test positive by nasal swab, proposed new code 795.31, Nonspecific positive findings for anthrax, would be assigned.

Participants asked how a population being screened for anthrax should be coded. NCHS recommended assigning proposed code V01.81 because the screening would probably be performed due to a suspected exposure to anthrax. A question was also raised during the meeting as to the appropriate E code for anthrax. Currently, the correct code is E968.8, Assault by other specified means.

Severe Sepsis

A proposal was submitted for creation of a new subcategory for Systemic Inflammatory Response Syndrome (SIRS), with specific codes for SIRS with and without organ failure. SIRS is a major complication of infection and trauma. Currently, septicemia, sepsis, and SIRS are all classified to category 038. SIRS is a clinical response to an insult that includes systemic

inflammation, elevated or reduced temperature, rapid heart rate and respiration, and elevated white blood cell count. There is a continuum of illness, from initial insult, either infection or trauma, to SIRS.

The American College of Chest Physicians and the Society of Critical Care Medicine have defined SIRS accompanied by organ failure as severe sepsis. Although the term "sepsis" generally denotes an infectious process, infection does not always accompany SIRS or severe sepsis. Nor is the term "septicemia," defined as the presence of pathogenic microorganisms or their toxins in the blood, synonymous with severe sepsis.

The advances in critical care medicine, the increased use of more potent and broader spectrum antibiotics, immunosuppressive agents, and new technologies will have a direct impact on the incidence of severe sepsis. It is anticipated that a significant increase in cases of severe sepsis will occur over the next decade, necessitating the ability to specifically track this condition.

The new codes have been proposed in category 900 to differentiate them from the septicemia codes. Inclusion of a code for severe sepsis in the Infectious Disease chapter would lead to confusion and would preclude the use of the code in cases where no infection is present. According to the proposal, severe sepsis would be considered synonymous with SIRS with organ failure. An additional code would be assigned for the specific type of organ failure.

Audience members expressed concern that physicians may not use the term "severe sepsis" to exclusively mean SIRS with organ failure. Issues of proper sequencing were also raised. Should the underlying condition, either infection or trauma, always be sequenced as the principal diagnosis, even when the patient presents with SIRS? What if the patient is admitted because of organ failure? Should the organ failure, underlying cause, or SIRS be sequenced as the principal diagnosis?

It was noted that severe sepsis and SIRS would usually not be the principal diagnosis since the patient typically is admitted for the underlying infection or trauma and develops SIRS while in the intensive care unit. Severe sepsis is the body's response to the severe insult or infection. A suggestion was raised during the meeting that perhaps severe sepsis should have a separate code from SIRS and that there should be separate codes for that with an infection versus that due to some other underlying cause.

Aftercare Codes

At the May 2001 Coordination and Maintenance Committee meeting, AHIMA's Long Term Care Section presented a proposal to significantly expand the aftercare codes so that there would be unique codes for aftercare following treatment of traumatic and pathological fractures and joint replacements, and following surgery on specified body systems. Based on discussion at that meeting, a revised proposal was developed and presented at the November meeting.

Due to the interest in using V codes in the home health prospective payment system (PPS), CMS home health PPS representatives also provided input to the proposal. CMS noted that the proposed V codes could be cross-walked such that they could work with the home health PPS grouper. Rehabilitation and other long-term care settings would also benefit from this V code expansion. The audience was most supportive of the revised version. It was decided that NCHS would work with AHIMA and CMS to refine the proposal, with the goal still to implement new aftercare codes in October 2002.

Paintball Gun Injury

New external cause codes have been proposed for paintball guns. Serious injuries have resulted when a paintball has hit someone at close range. New codes would appear in categories E922, Accident caused by firearm and air gun missile, E955, Suicide and self-inflicted injury by firearms, air guns, and explosives, and E985, Injury by firearms, air guns, and explosives, undetermined whether accidentally or purposely inflicted. As there is no room in the assault codes, paintball gun injuries due to assault will need to be indexed to code E968.8, Assault by other specified means.

Addenda

Proposed October 2002 addenda changes were reviewed. The proposed revisions include:

- addition of Excludes note under code 436, Acute, but ill-defined, cerebrovascular accident, for "postoperative cerebrovascular accident (997.02)"

- revision of instruction note under subcategory 707.1, Ulcer of lower limbs, except decubitus, to state "code first any associated underlying condition, if applicable" (this change is intended to clarify that there is not always an associated underlying condition, and, if this is the case, it is appropriate to sequence the 707 code first)
- addition of Index entries for spinal headache complicating labor and delivery and postpartum spinal headache (668.8)
- deletion of the "see also Disease, renal" instruction under the Index entries for kidney and renal insufficiency

The comment period for the proposed revisions has expired. If approved, the changes would become effective on **October 1, 2002**. The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled for April 18–19, 2002. New proposals for inclusion on the May agenda must be received by February 18, 2002.[1, 2]

Notes

1. 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.

2. Send suggested procedure agenda items for the May meeting to Centers for Medicare & Medicaid Services, CMM, PPG, Division of Acute Care, Mail Stop C4-08-06, 7500 Security Boulevard, Baltimore, MD 21244-1850.

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Article citation:
Prophet, Sue. "ICD-9-CM Committee Proposes New Codes, Changes." *Journal of AHIMA* 73, no.3 (2002): 62-67.