

Centers for Medicare & Medicaid Services

Moderator: Donna Pickett
September 16, 2010
12:30 p.m. CT

Operator: Good afternoon. My name is Gordon and I'll be your conference operator today. At this time I'd like to welcome everyone to the ICD-9-CM Coordination and Maintenance conference call. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks there will be a question and answer session. If you'd like to ask a question during this time simply press star then the number one on your telephone keypad. If you'd like to withdraw your question press the pound key.

Thank you, Donna Pickett, you may now begin your conference.

Donna Pickett: Thank you, Gordon. Welcome back. I hope everyone had a good lunch and that you did not have two lunches – just checking. We are going to begin again. We are going to continue with the interstitial lung disease proposals. I'll be turning the podium over to Dr. Berglund shortly, but I wanted to thank the ophthalmology group for allowing us to switch these time slots so that the lung disease proposals can be completed in its entirety. So thank you. David?

Dr. David Berglund: All right. I think I'll just stay down here and present from here so I can control this laptop at the same time and display things. We have acute interstitial pneumonia. Now we were just talking again, just to remind everyone, we're talking about the idiopathic interstitial pneumonias, and we're coming back to talk about another one of them. And this one is called acute interstitial pneumonia. And it's a nasty one. It's rapidly progressive, histologically distinct, with what's described as an organizing form of diffuse

alveolar damage, and it looks just like the acute respiratory distress syndrome that is caused by sepsis and shock.

So it is a very destructive type of disease. Now it is commonly fatal rather quickly, often within one to two months of the onset of illness. And this happens to people with an average age of around 50 years, although it can happen over quite a wide age range. And at this point we don't really have any good, proven treatments for it, and again, mortality rate is high, 50 percent or more.

Now the term acute interstitial pneumonia right now is indexed in ICD-9-CM to code 136.3, which is pneumocystosis. The histologic pattern in AIP, the diffuse alveolar damage can occur due to a lot of things. It can occur due to *Pneumocystis carinii* pneumonia or due to cytomegalovirus or due to a number of other things, collagen vascular diseases, drug-induced pneumonitis; and again, it's just like the ARDS in sepsis and shock.

However at this time, as I understand, the term itself, acute interstitial pneumonia is supposed to be reserved for cases of unknown cause, such as idiopathic. And it would then be a specific example of an idiopathic interstitial pneumonia.

So ATS-ATCP requested that we create a specific code for AIP. They did want to have it at 516.3. It's possible that 516.8 might be used for some people and for certain of the known causes those should certainly go to 516.8.

And again, it's got a less favorable prognosis than most of the other idiopathic interstitial pneumonias so it really needs to be distinguished from them. So a specific code is being proposed – 516.33, Acute interstitial pneumonia.

Let me open things up for questions at this time. Anyone here who'd like to come to the microphone to comment? Dr. McCormack, would you like to comment any further?

Dr. McCormack: No.

Dr. David Berglund: Oh OK. So it's – we do have some inclusions or other things called Hamman-Rich. Go ahead.

Dr. McCormack: Right. So it used to be called Hamman-Rich and it was supposed to be a rapidly progressive form of idiopathic pulmonary fibrosis until the path was reviewed retrospectively and proven to be a completely different histopathologic presentation. So this is a diffuse alveolar damage injury instead of a usual interstitial pneumonia lung pathology and it's clearly a distinct disease with a distinct presentation. But somehow you'll have to reconcile the Hamman-Rich that's already in the – in the coding book now, I guess.

Dr. David Berglund: OK. So sorting out how to deal with those differences is one of the things to work on, but yes. OK.

Lisa Taylor: This is Lisa Taylor, I have a clinical question if you could back up.

Dr. David Berglund: Back up – up here?

Lisa Taylor: Yes. So the histologic – histopathology is – you're showing that it is similar to that due to pneumocystis carinii and cytomegalovirus?

Dr. David Berglund: Not necessarily the typical presentation of pneumocystis but pneumocystis can occasionally cause this kind of a pattern, at least.

Lisa Taylor: All right, so that was my question. If a patient has that pattern is the physician going to document AIP and the coder's going to code both, or are we going to have excludes notes saying, "Excluding those with pneumocystis carinii"?

Dr. David Berglund: Well we did propose to have an excludes note for pneumocystis, at least, there, but yes, that ...

Dr. McCormack: So the term acute interstitial pneumonia was indexed under pneumocystis?

Dr. David Berglund: Yes.

Dr. McCormack: But the histopathologies aren't similar, that is ...

Dr. David Berglund: Right, not usually.

Dr. McCormack: Pneumocystis is a pneumonia; it does not present as a diffuse alveolar damage picture histologically. So I think that what defines this is the histopathology and its presentation, and it wouldn't be ordinarily confused very easily by a clinician.

Dr. Dr. David Berglund: Yes. Yes, that does seem to make good sense. I mean I've seen at least some things that seem to say pneumocystis can at least sometimes give us a similar picture but as I understand that's not the usual case, just kind of an occasional thing. OK, other questions or comments on this? And again, we would want to exclude pneumocystis from this. I suppose we could exclude CMV from it too, for that matter, if that's thought to be beneficial.

I don't think there's usually going to be confusion on that because they are fairly distinct most of the time. This would be an idiopathic type of a problem in the relatively unusual time if this did have a similar appearance I think that would be documented, at least – at least I'd hope so.

OK, operator, could you please check the phone lines for us?

Operator: At this time if you have any questions you may press star then the number one on your telephone keypad. Your first question comes from Dr. Jeffrey Linzer. Your line is now open.

Dr. Jeffrey Linzer: I do have a question. Very often the radiologist will read a chest film as an interstitial process and our colleagues in emergency medicine may translate that to an acute interstitial pneumonia as opposed to an acute atypical pneumonia. And I'm afraid a number of physicians will intermix the two. What thoughts does the presenter have on how to help our colleagues not mix that up?

Dr. David Berglund: Sorry, what was the last part, Dr. Linzer?

Dr. Jeffrey Linzer: What can we do to educate either the physicians or what could we do to tweak the terminology so that what is really an acute atypical pneumonia doesn't get translated into an acute interstitial pneumonia?

Dr. David Berglund: OK, well that sounds like a good question; I'll have to defer to Dr. McCormack on that. Any thoughts on what we can ...

Dr. McCormack: Well it's a good point. Acute interstitial pneumonia is more or less a diagnosis that you entertain when those infectious causes and other etiologies have been excluded, and you're really only certain you're dealing with acute interstitial pneumonia when you obtain a lung biopsy and it's shown to be a diffuse alveolar damage pattern, instead of, you know, a pneumonia with organisms demonstrated on Gram stain.

So, you know, I think it's true that a chest x-ray presents a fairly non-specific base of a lot of different interstitial processes, and I think we'll only be using this code when we excluded a lot of the more common and more infectious etiologies that Dr. Linzer mentioned.

Dr. Jeffrey Linzer: Yes, I'm just concerned that there's been so much trampling, if you will, between the terminologies that it could get lost. And would it – do you think it would be helpful if it said, "Acute non-infectious interstitial pneumonia?"

Dr. McCormack: Well in the interstitial lung disease community this is a very standard, well-recognized term. Everybody knows what this means. I acknowledge that in the broader community perhaps it's not that clear, but this is the proper name of this entity. I guess I'd have to defer to the coding elite to tell me whether we need the non-infectious or not. But that – this term as it's shown here, "acute interstitial pneumonia" is familiar to everybody who's familiar with the interstitial lung disease world.

Dr. Jeffrey Linzer: Right. And I certainly appreciate that, but again, like I worry the radiologists will see an interstitial process and the physician will write, "Acute interstitial pneumonia" and you'll end up with this and the patient doesn't actually have that and is going to live more than a couple of months.

Dr. Berglund: There's at least some potential for issues to come with this – from what you're saying, Dr. Linzer, it sounds like the concern would be that at least some other physicians, probably non-pulmonologists would use the same term to mean

something else. And that might get us into trouble if they were given this diagnosis when they should have it.

Dr. Jeffrey Linzer: Exactly.

Dr. David Berglund: And that's ...

Dr. McCormack: Again, I'm out of my element here, but if you were to have in parenthesis Hamman Rich syndrome that further defines it as the interstitial process. It's an old name, which is, you know, in its redefinition means the same thing as acute interstitial pneumonia. So would that clarify things to have acute interstitial pneumonia parenthesis Hamman-Rich syndrome?

Dr. David Berglund: So putting Hamman-Rich as an inclusion here or in parenthesis. Well that's a thought at least, certainly.

Dr. Jeffrey Linzer: David? I'm wondering if you extend your exclusion terms ...

Dr. David Berglund: Add some more exclusion terms just to cover some of these other cases at least a little better, exclude maybe acute atypical pneumonias and things like that?

Dr. Jeffrey Linzer: Correct.

Dr. David Berglund: That might help too; that might cover things.

Lisa Taylor: And the parentheses with the old name in it would be a non-essential modifier that's in parentheses so that would not help the coders.

Dr. David Berglund: It would not help the coder, you're saying? Yes. We could put an inclusion term for Hamman-Rich and that might be a good idea anyway. But yes.

Some other excludes terms I think might be the best option at this point to try to cover some of those other situations a little better – the atypical pneumonias, at least. Nelly?

Nelly Leon- Chisen: Nelly Leon-Chisen. I think this situation that Dr. Linzer is identifying would not be helped by any kind of exclusion note that you could put down in a codebook because if it's a physician documentation, physician diagnosing problem where they may be using the same terminology for a different condition. And so if it's documented as acute interstitial pneumonia no exclude note is going to take the coder out of this new code.

So I think it's more a situation of, you know, perhaps some sort of physician education – and I'm not really sure, you know, where that would be done because you're talking about different specialties. And Dr. Linzer has been talking about for years and – about physician education, and Sue just suggested that Dr. Linzer's going to educate all the physicians.

Dr. Jeffrey Linzer: Had too much coffee too, Sue?

Dr. David Berglund: Yes, well this could be an awkward problem, certainly, if we do have problems with people documenting it exactly this way. If it was a pneumonia with an interstitial process described by the radiologist that might not be – or at least it wouldn't be quite the same thing. But ...

Dr. Jeffrey Linzer: David, I just – I think it's an important aspect that Dr. McCormack's group is trying to capture, and I just think we need to find some way that the waters don't get muddled, so they get the accurate information they're looking for.

Dr. David Berglund: Yes. OK. We'll want to look further at that. Other – any other thoughts on it, Jeff?

Dr. Jeffrey Linzer: No, I would certainly defer to Dr. McCormack for other types of terms that would be helpful so that they can get the best information from this.

Dr. David Berglund: OK. Yes, we certainly don't want to mix it up with other things. At this point I'm not coming up with a lot of other ideas on what direction to go with it but we'll look at it some more and look at all the comments and see what looks like the best approach to take.

OK, let's – are there any other comments? Operator -Gordon, are there any other comments on the phone lines?

Operator: There are no other comments in the queue.

Dr. David Berglund: Thank you so much. OK, that being the case let us now move on to respiratory bronchiolitis-associated interstitial lung disease. This is a clinical manifestation of a type of an interstitial lung disease, respiratory bronchiolitis, which is found in cigarette smokers and causes particular findings, but most of the time is asymptomatic, but occasionally causes the interstitial lung disease, in which case this is what it's called.

And these people usually have a gradual onset of shortness of breath, dyspnea – they have a new, a changed cough. They've usually had very heavy smoking history. Most of the time these are men. They do have particular findings, usually with central lobular emphysema also, that's not really thought to be directly related. Most of the findings are around the lobules of the – or they're more centrally located, that is. There's particular characteristic changes.

Now this disorder has also been somewhat linked to desquamative interstitial pneumonia, which is thought to be a more extensive form of the RBILD, where essentially more of the alveolar spaces are essentially filled with these pigmented macrophages; it's much more diffuse. So when they consider these to be as part of the same spectrum, where depending on how extensive the alveolar macrophages are accumulating you would diagnose one or the other. There are some differences in the clinical presentation findings and prognosis, though, so they're continuing to be described separately.

Now we have had requests from ATS-ATCP for specific codes for this, as well as for the DIP and many other terms here, of course. And it would be useful to have a separate code for this. This, again, this would look basically just like a new code, 516.34, Respiratory bronchiolitis interstitial lung disease. So this would just be one part of this. And we'll cover desquamative interstitial pneumonia shortly, after a couple of other ones.

Any comments on either the clinical aspects of this or on the proposal for a new code here? Dr. McCormack, any thoughts?

Dr. McCormack: There's an important distinction – respiratory bronchiolitis is a different entity than respiratory bronchiolitis interstitial lung disease. Respiratory bronchiolitis is a disorder in smokers, usually in smokers; also people who are exposed to other – or to dusty environments such as coal miners, et cetera, in which you get pigmented macrophages and terminal bronchioles and respiratory bronchioles but no associated interstitial change in the adjacent alveolar septa.

This respiratory bronchiolitis interstitial lung disease represents a more extensive form of that same process, in which the interstitium of the lung becomes involved, and it's at this stage where, you know, the symptoms develop and physiologic abnormalities develop.

DIP, desquamative interstitial pneumonia, is really the extreme end of this spectrum, in which ground glass infiltrates on the CT scan in a much more diffuse process. We do recognize them as distinct entities, DIP we see only quite rarely; respiratory bronchiolitis we see very frequently – respiratory bronchiolitis interstitial lung disease somewhere in between.

Dr. David Berglund: OK. That's helpful. Thank you. A comment?

Lisa Taylor: This is Lisa Taylor. I just – I have a clinical question. So most of these interstitial lung diseases are confirmed with pathological findings? Do physicians use these diagnoses empirically, or do they wait until they get the pathology finding before the diagnosis occurs?

Dr. McCormack: Usually the latter. Usually they use these terms when they're certain, and when a biopsy's been performed, either a transbronchial biopsy through the bronchoscope or a video-assisted thoracoscopic biopsy. So these are usually reserved for when you – when you're certain of the diagnosis based on histopathology. And that goes for acute interstitial pneumonia as well, by the way, the prior topic.

Dr. David Berglund: OK. Yes, the histopathology is an important part of the diagnosis in general on these, yes.

All right, and I will jump to desquamative interstitial pneumonia also, since we just talked about that. And this is on page 18 for those following along. Again, it's a very similar type of disorder; usually it does involve cigarette smokers. As Dr. Dr. McCormack mentioned it can be other causes also. There's characteristic lung function tests, some imaging studies and also the histologic pattern is a very important part of making the diagnosis. And there's particular findings in these cases – the macrophage accumulations within the air spaces are an important part of it. And it's wider – more widely found than the others.

And it is important to be able to distinguish these and to differentiate it from others, including the other things we've mentioned here. We are proposing, at this point, to have a new code for desquamative interstitial pneumonia at 516.37.

Any other comments on desquamative interstitial pneumonia, or on the respiratory bronchiolitis-associated interstitial lung disease? Operator Gordon, could you please check the phone lines and whether we have questions on either of these?

Operator: Certainly. If you have any questions at this time you may press star then the number one on your telephone keypad. At this moment there are no questions in the queue.

Dr. David Berglund: Thank you so much. OK, we're going to skip back to lymphocytic interstitial pneumonia, or lymphoid interstitial pneumonia. This is characterized by infiltration of the pulmonary interstitium with lymphocytes and plasma cells.

There's been some debate on this, whether it was a lymphoproliferative disorder, and that it might progress to lymphoma, but with immunohistochemistry they've been able to basically better differentiate whether things are reactive or neoplastic. So there's very few cases of the LIP that actually go onto malignant transformation or lymphoma; they can much better tell whether that's likely to happen.

This is usually slow onset and people have cough and breathlessness and may find some other constitutional symptoms at the same time. There's a particular number of things that may cause a very similar condition and this may be called the same thing, whether having an underlying cause or not, but there are a number of cases that are idiopathic, with an unknown cause. For the idiopathic interstitial pneumonia if you'd want to just include those that were idiopathic and not all the others.

So this proposal goes on to propose a separate new code, 516.35 for idiopathic lymphoid interstitial pneumonia, including also idiopathic lymphocytic interstitial pneumonitis. And we would exclude lymphoid interstitial pneumonia NOS, or due to a known underlying cause over to the 516.8. And we'd add some notes there at 516.8 to code first the underlying cause is applicable or if known. And we would also use an additional E-code, if applicable, for a drug-induced or a toxic pneumonopathy there because those can also cause this kind of a disorder. But we would exclude the idiopathic lymphoid interstitial pneumonia back to the new code at 516.35.

So any questions or comments on this proposal? Dr. McCormack, would you like to comment on this? Not at this time? We've covered it somewhat? OK. Other comments, and Operator (Gordon) could you let us know if there's any comments on the phone?

Operator: Certainly. If you have any comments you may press star then the number one on your telephone keypad. And there's no further comments in the queue.

Dr. David Berglund: All right, we'll move on to cryptogenic organizing pneumonia, or cryptogenic organizing pneumonitis.

Now this is a particular type of organizing pneumonia with unknown cause, and it has been called other things, such as bronchiolitis obliterans with organizing pneumonia, but now the COP term is preferred. It's generally with a relatively short duration at diagnosis, varying amounts of cough and shortness of breath, particular pattern of lung function tests and findings. And some of these people, at least, do have smoking, but actually in this case non-smokers outnumber smokers.

It's got a particular histological process with this organizing pneumonia involving alveolar ducts and alveoli, sometimes with a bronchiolar polyp also. And most of these people recover on oral corticosteroids but some of them relapse so they recommend prolonged treatment for it.

So again, we've had a proposal to have a specific code for it at 516.3, although it is actually, at this time, indexed to 516.8. But since it's idiopathic it's being proposed to move it and have it at 516.3, since it is an idiopathic interstitial pneumonia to group it with those.

So we have the proposal, it looks like this new code, 516.36, Cryptogenic organizing pneumonia. This would exclude organizing pneumonia NOS, or due to known underlying cause because you can get organizing pneumonias from other causes too, but they should not be called cryptogenic unless you don't know the cause. And reciprocally at 516.8 – we'd exclude this back to the new code.

Questions or comments on this? Dr. McCormack, would you like to comment on this further, or on any of the other?

Dr. McCormack: This is one of the more common of the interstitial lung diseases that we see. It presents as a subacute pneumonia; it's got a very typical pattern of presentation, usually couple of months of symptoms, fevers, weight loss, chills and a pattern on x-ray that looks like pneumonia, but on biopsy there's no evidence of organisms; it doesn't respond to antibiotics, so it's a very distinct clinical entity.

This pathologic entity, this organizing pneumonia, is a component of many different pathologies, including lymphocytic interstitial pneumonia, usual interstitial pneumonia, non-specific interstitial pneumonia – often have elements of organizing pneumonia. So it's a confusing issue for clinicians but this is clearly a distinct clinical entity, cryptogenic organizing pneumonia.

Dr. David Berglund: OK. OK, thank you, Dr. McCormack. Any other comments here?

Operator Gordon, could you please open the phone lines and check whether we have comments there?

Operator: Certainly. At this time if you have any comments you may press star then the number one on your telephone keypad.

Dr. David Berglund: And I think that at this time we've completed going through the interstitial pneumonias and we – now we're going to move to another topic. I'll pass it over to Donna Pickett.

Operator: And there's no questions in the queue.

Dr. David Berglund: Thanks.

Donna Pickett: OK, our next topic for discussion begins on page 32 and it's the glaucoma severity staging. We have a request from the American Academy of Ophthalmology to create new codes that would be important to – would be important to be able to capture the stage of disease when coding for the most commonly encountered types of glaucoma. There is background information in the handout about glaucoma.

And we have in the audience with us today representatives from the American Academy of Ophthalmology, Dr. Michael Repka, who is the Secretary for Federal Affairs for the American Academy of Ophthalmology and a Professor of Ophthalmology and Strabismus at the Wilmer Eye Institute here at Johns Hopkins in Baltimore. And he is joined by Dr. Cynthia Mattox, Health Policy Committee member for the Academy and Chair of the Health Policy Committee for – health policy committee, American Glaucoma Society. Dr. Repka or Dr. Mattox, did you want to talk about any of the clinical issues before I start talking about the coding aspects, or I'll leave it to you.

Dr. Cynthia Mattox: Yes. As far as the clinical aspects ...

Donna Pickett: Dr. Mattox, could you identify yourself for the folks online?

Dr. Cynthia Mattox: Sure. Dr. Cynthia Mattox. As far as the clinical scenarios that we're discussing today, in terms of coding issues are more related to risk stratification and staging of the glaucomas, we're not proposing any new definitions of glaucoma, if that's what you're asking.

Donna Pickett: OK. OK, well I'll go through the coding proposal; if clinical issues do arise, the – you know, you can go to the mike, or for those on the phone let the operator know that you have questions.

OK, so at the 365.01, which is an existing code, the recommendation is to revise the code title and make that open angle with borderline findings low risk, and to delete the inclusion terms at 365.01 but those terms would remain in the alphabetic index; they're just being removed from the tabular list.

At 365.02 we would add a new inclusion term, primary angle closure suspect. A new code would be created at 365.05, open angle with borderline findings – high risk, with an inclusion term for open angle high risk.

And then a new code a 365.06 for primary angle closure without glaucoma damage. At 365.1, at that subcategory we would be adding inclusion notes at all of the individual codes at the .10, the .11, which are referencing the new codes that would be created at the 365.7 expansion.

And again, at the 365.2 codes, again, use additional code notes to assign the glaucoma stage that is going to be referenced as part of the 365.7 expansion. And that use additional code note would also be included at 365.31 and also at 365.52, and at 365.62, 63 and 65.

We would create a new subcategory for glaucoma stage at 365.7. There would be a code first note there to code first the associated type of glaucoma. And then the new codes would be at 365.71, Mild stage glaucoma, at 365.72, Moderate stage glaucoma, .73, Severe stage glaucoma, and .74, Indeterminate stage glaucoma, which would also include glaucoma stage not otherwise specified.

Also as part of the request and working through this, since one of the things that was important was the identification of risk factors, we could not include all of the risk factors in the classification as originally requested, however there was one that clearly was important, and we've added – we're suggesting a new code at the V19.1. We're expanding to create a new subcategory and adding a unique code for family history of glaucoma at V19.11 and then of course the V19.19 for other specified eye disorder.

Also included in your topic package is a number of index modifications related to this proposal. There would be others as well, but we at least wanted to show you some of the changes that would be made as part of this particular proposal.

And there was one other thing that I wanted to point out about the use of the new 365.7x codes and that's that these codes were not being added to each and every code for glaucoma; they were only being added where it is a valid concept to be linked with the underlying condition of glaucoma.

And with that if there are – I'd like to open it up to questions. Are there any questions here in the audience, either of the coding nature or of a clinical nature?

Sue Bowman: Sue Bowman. I just wondered, based on the wording of the use additional code notes, what you would do if the stage is not documented. Would a coder be expected, then, to query the physician, I assume, for the stage? Because it doesn't say, "If known," or anything like that. So ...

Donna Pickett: OK. Dr. Mattox or Dr. Repka?

Dr. Cynthia Mattox: Well hopefully it would be documented. It's been, you know – speaking to the audience, who knows better. But there is the indeterminate stage glaucoma and unspecified in the staging setup, so that could be used, I suppose, in that regard.

Michael Repka: This is Michael Repka, Academy of Ophthalmology. Can we use that as a default, or does it have to be an active insert of the not otherwise specified?

Donna Pickett: Well I'd like to hear from the others. Dr. Mattox and I had had a discussion as to whether or not we needed a unique stand-alone code for unspecified. We didn't present it here; the original discussion was to place it here but if people believe that there needs to be a stand-alone unspecified code that's certainly something we could consider as part of the proposal. And thinking back to some of the earlier discussions in the day about, you know, not having enough

NOS or unspecified codes – Jeanne, can't hear you, and you'll have to go to the mic – after Nelly.

Nelly Leon-Chisen: Oh, OK. Sorry, I'll stand closer to the aisle. Nelly Leon-Chisen I guess as a coder, and I look at other areas where we do have stages, like pressure ulcers and chronic kidney disease. Indeterminate, to me, means something different than unspecified. Unspecified just means it just wasn't documented, you know, and didn't mention it. Indeterminate is almost like, you know, whatever the physician just couldn't help, for whatever reason.

Donna Pickett: OK, so ...

Nelly Leon-Chisen: So I would say – I would say well then maybe have two separate codes because ...

Donna Pickett: OK, one for the indeterminate and one for – as an unspecified? OK.

Jeanne Yoder: Jeanne Yoder, Tri-Care Management Activity, I'm with her.

Donna Pickett: Jeanne I didn't hear that at all, and identify yourself.

Jeanne Yoder: OK. Jeanne Yoder, Tri-Care Management Activity and Nelly has a great idea. The indeterminate is one and then the NOS, you know, either put it at the zero or the nine, where we expect to find those things.

Donna Pickett: OK. Thank you both for those comments. Are there any other comments from the floor? Seeing no one approaching the mike with quick steps, Gordon, could you open the line for questions?

Operator: Certainly. If you have any questions or comments at this time you may press start and then the number one on your telephone keypad. There are no questions or comments at this time.

Donna Pickett: OK, we have a question from the floor.

Ann Fagan: This is Ann Fagan, I'm from CMS. I just have a question about, on page 32, the 365.01 you're adding a language as an inclusion note that duplicates the title, and I don't quite understand that. And likewise at 365.05. So you've got

365.01, open angle with borderline findings, low risk. And then you call it open angle, low risk. So I wonder if that's like important and I'm missing something. I just don't understand it.

And likewise at 365.05, open angle with borderline findings, high risk, which includes open angle, high risk, which is the name of the category.

Donna Pickett: OK. Basically it was to represent the alternative ways that you may see something documented in the record if I'm correct, Dr. Mattox and Dr. Repka. So we just wanted to make sure that whichever way it was noted, both would be represented in the code. But perhaps Dr. Mattox can provide additional information there.

Dr. Cynthia Mattox: I think that second line, where it had open angle, was pre-existing, and the only thing that's actually being added is the low-risk.

Donna Pickett: Is the low-risk?

Dr. Cynthia Mattox: So I don't – I see the duplication; I don't know that it would necessarily be necessary to have it separate.

Donna Pickett: OK. Thank you, Ann. Any other questions? Any thoughts on the proposal? OK, I'm going to be getting a lot of letters from a lot of people this year, aren't I? Everybody's being very silent. OK, any ...

Female: (Inaudible).

Donna Pickett: OK, one more question from the floor.

Tammy Leong-Van Wyk: Tammy Leong-Van Wyk. On the page 33 under 365.7 glaucoma stage code for associated type of glaucoma 365.26 – is that a type? I don't see it in the codes before on the list. Is that a typo?

Donna Pickett: I don't have a code book in front of me. Is that an existing code or do I have a typo?

Tammy Leong-Van Wyk: It is not in the books.

Donna Pickett: It's not? OK then it's probably a typo. Thank you. This proposal was reworked several times, so apologies for little gremlins slipping in there. Dr. Repka?

Dr. Michael Repka: I think that would be 365.20; I think that's what that is, instead of 26.

Donna Pickett: OK, we'll look at the ...

Dr. Michael Repka: OK.

Donna Pickett: Thank you, Dr. Repka. OK, any – Gordon, any final questions from the call-in folks?

Operator: There are no questions in the queue.

Donna Pickett: OK. Well again, thank you, but again, we look forward to receiving your comments. And at this point I'm going to turn the podium back – or the table back over to David for the opioid discussion.

Dr. David Berglund: OK. Those following along in the handout, I am going to skip forward to page 53 here, which is the opioid expansion for ICD-10-CM.

Most of you are probably familiar with opioid drugs that are very strong painkillers and they do have some potential for side effects and other problems. And we did have a proposal by Covidien Pharmaceuticals to differentiate and add basically a large number of codes to be able to differentiate long-acting and short-acting opioids in a basically in a more specific way. And I'm just going to cover this very briefly, in the interest of time.

Essentially at F11 some of the opioid-related disorders in chapter five – it would be proposed to add seventh characters to identify the specific drug that would be involved. These would be zero through nine and then A and B. And they would essentially let us know whether these disorders were related to specific opioid drugs buprenorphine, codeine, fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, oxymorphone, tramadol or other opioids.

Then further at T39 we would add some additional notes here. We would differentiate for acetaminophen and we have a note that would be added that if this was in combination with other narcotics or other drugs that the other code should be done first, at 39.1. So we'd add a new subcategory, new codes at 39. – T39.11 for the poisoning by adverse effect of an underdosing of acetaminophen and .19 for other – for aminophenol derivatives.

We would have, at T39.3 we would add a code first note again for that for NSAIDS, where these were in combination with opioids or other things.

And then at T40 we would have some changes there. T40.0 – well at T40 itself we would have a use additional code note, telling to use the codes there at T39 we just talked about. And at T30 – T40.0 we would add – change the title, so it would be poisoning by adverse effect of an underdosing of opium and other natural origin opium alkaloids. And then we would add some new subcategories and codes. Each of these, at the sixth digit, has the intent – accidental, intentional and others. At T41.01 we would have poisoning by adverse effect of an underdosing of opium. T40.02 we would have short-acting morphine. Again, noting that we had short and long being differentiated now.

At T40.03 we would have poisoning by adverse effect of an underdosing of codeine; .09 would be other natural origin opium alkaloids with an inclusion for thebaine.

T40.1 would be poisoning by adverse effect of an underdosing of heroin and short-acting, semi-synthetic opioid derivatives. So T40.11 would be heroin, T40.12 would be short-acting hydromorphone, .13 would be short-acting oxycodone, .14 short-acting hydrocodone, .15 short-acting oxymorphone, and .19 other short-acting semi-synthetic opioid derivatives.

Now at T40.2 we would have poisoning by adverse effect of an underdosing of long-acting semi-synthetic opioid derivatives and we would exclude the short-acting ones from this. We would have a new subcategory of .21 for long-acting hydromorphone. And again, we've got all of the codes for intent there; I'm not going to read through those, though.

T40.22 would be poisoning by adverse effect of an underdosing of long-acting oxycodone, .23 long-acting morphine, and we would also have inclusions for CR, for contained release morphine, that's similar at some other areas too, I should note.

At T40.24 we would have long-acting buprenorphine, at T40.25 long-acting oxymorphone, T40.29 we would have poisoning by adverse effect of an underdosing of other long-acting semi-synthetic opioid derivatives.

Now we haven't necessarily made as clear where defaults would go; I think we would probably make short-acting the default if we made a default at all, or we might not make a default. We'd be glad to take input on which would be the best approach to take in these cases, if we're proceeding with all this as it is.

Now at T40.3 it's proposed we have poisoning by adverse effect of an underdosing of methadone and other long-acting synthetic opioids, to add to the title there. And we would then have new subcategories at T40.31, poisoning by adverse effect of an underdosing of methadone, .32 long-acting fentanyl, .33 long-acting tramadol, .39 other long-acting synthetic opioids.

Then at T40.4 we would have poisoning by adverse effect of an underdosing of short-acting synthetic opioids, with .41 being short-acting fentanyl, .42 short-acting meperidine, .43 short-acting tramadol and .49 other short-acting synthetic opioids.

Next T40.5 we would have poisoning by adverse effect of an underdosing of cocaine, with T40.51 being powder cocaine and .52 being crack cocaine. And I think – let me take a look at this – and yes, that is the last of all of these. So this is a large number of things. Let's open up for comments. Sue? Sue Bowman?

Sue Bowman: Sue Bowman. Well I have several major concerns. This is an enormous number of codes for one drug category and I'm very concerned about the precedence this would be setting if we did this for every drug category. Also ICD-9 and ICD-10, neither one is intended to be a drug terminology, which is what this structure is sort of almost becoming with this level of detail. And

my other concern is the change in the seventh character structure of how we've been using that seventh character so far to now use it to identify drugs.

Dr. David Berglund: At F11 you'd have concerns about that just to make explicit that concern – that would be at the F11, especially, but there's a great deal of detail in the other area. Yes, Nelly?

Nelly Leon-Chisen: I agree with Sue; this is way too much detail; we could never really have enough room if we wanted to identify every single drug. And the other concern is – and I know you're trying to go for parallelism, but when do you ever get an underdosing of crack cocaine? When is it ever – when is it ever – you know, a prescription where the patient takes less than recommended? I mean – I mean that would be like everybody; if you took nothing, that's underdosing? I mean I think this is major problem.

Dr. David Berglund: Dr. Linzer may just be asking if you had enough of some other substance next time – well. Yes?

Dr. John Cooper: John Cooper, CMS. I have a question about the T40.32, Poisoning by adverse effect of an underdosing of long-acting fentanyl – are they referring to fentanyl patch as being what they mean by long-acting? Because there's really no long-acting fentanyl.

Dr. David Berglund: Let me ...

Dr. John Cooper: So that gets to another point of, you know, defining the short- and long-acting duration.

Dr. David Berglund: Defining short and long-acting is always an issue and we did have potential – there's certainly some potential for issues with that, and in determining – now I'm trying to find the one you were looking at ...

Dr. John Cooper: Page 60.

Dr. David Berglund: Long-acting fentanyl – on page 60. Yes, this is a large enough set of things that it's hard to find the specific one we are looking for. There we go – long-acting fentanyl, T40.32.

Dr. John Cooper: Because essentially the ...

Dr. David Berglund: Fentanyl patch does seem to be here, certainly. So transdermal fentanyl is being proposed here. Now that is a slow release. And one thing about a patch is you can, at least, take it off if you're having trouble, whereas the contained release ones that you take orally you can't really remove those, if need be. So that ...

Dr. John Cooper: What I meant in terms of the distance between it being sustained release versus being considered long-acting.

Dr. David Berglund: Yes. Yes, that's a very good point, certainly. Sustained release and patch or other types of methods of giving something over time do act differently, certainly. This was basically how this was proposed to us; we were just presenting it as proposed. There are potential issues here and we certainly invite these comments. And this may need some further review before determining what should be done here. Thank you for those comments, though. Yes? Gordon could you please check the phone lines for us?

Operator: Certainly. At this time if you have any comments or questions you may press star then the number one on your telephone keypad.

Your first question comes from Dr. Jeffrey Linzer. Your line is now open.

Dr. Jeffrey Linzer: Thank you. Yes, you knew this had to come, didn't you? Yes, I – well let's see, where do we begin – did the FDA specifically ask for this, David?

Dr. David Berglund: Sorry, did we specifically ask for this? We were specifically asked for this via someone else, by Covidien Pharmaceuticals.

Dr. Jeffrey Linzer: But FDA did not request this?

Dr. David Berglund: The FDA did not request this. No, this was a specific request that did come to us, and we're – I will comment – we're – I'm just presenting this essentially as it was put together at that. So we're inviting comments.

Dr. Jeffrey Linzer: Well let me just add a couple more comments. You know, I think it's going to be very difficult for the coders to follow something along this way, unless the

drug table is going to be very specific. I mean for a physician to sit there and go, "Well, it was remifentanyl that they overdosed on, as opposed to alfentanil, and for the coder to figure that out, where that's going to fit in the scheme of things, as much clarity and detail I'd like to see in the code set, I think using the seventh digit in the way that's proposed here is just going to cause a lot of trouble.

And the same issue with the pattern. Between who's going to determine that the medication was under used, you know, that they needed to get a second dose of an analgesic to relieve their pain – is the physician going to document that the medication was underused? And certainly the underdosing of some of these medications that probably shouldn't be dosed at all is a significant issue. So I think this one really needs to go back and be looked at in great detail.

Dr. David Berglund: Yes, certainly underdosing of a painkiller in cases where there are pain, does result in pain, and we do have another pain diagnosis too, but yes, underdosing of – underdosing of heroin and crack cocaine and powder cocaine, those probably are not things we're likely to be thinking of that way, so yes, some of these are things we probably could just remove.

Dr. Jeffrey Linzer: But I think it's the same issue; you have a patient who has a fracture of a long bone, or a patient who's having a vaso-occlusive crisis with sickle cell, and you give them a dose of analgesic and they're still in pain. So you give them an additional dose of analgesic. I don't think anybody is going to document that they underdosed the medication; the patient just needed more medication.

So you're going to have a code in there that not only is not going to be used but is going to be hard to interpret anyhow.

Dr. David Berglund: OK. OK. Well these certainly have raised some great comments, and—

Dr. Jeffrey Linzer: So you should have the – there probably should be a code for underdosing of caffeine.

Dr. David Berglund: Nelly's probably trying to say something too here, but that's OK. She thought better of it.

OK. Thank you, Jeff, for all those excellent comments. Any other comments from the phone lines? Any further on that, Jeff or Gordon – any other comments?

Operator: There are no further questions in the queue. Jeff if you have another comment you may press star one on your telephone keypad.

Dr. David Berglund: All right.

Operator: We – pardon the interruption, we do have a comment from ...

Dr. David Berglund: Oh, we do have a comment?

Operator: Lisa Saake; your line is now open. Lisa Saake your line is now open.

Lisa Saake: This is Lisa – hello? Hello?

Dr. David Berglund: Go ahead.

Lisa Saake: Oh, this is Lisa Saake with Covidien and I worked with Amy at the CDC to develop this proposal. And while the FDA has not requested these categorizations, if you follow the FDA and REMS initiatives there are multiple times, over the past several years, where the issue of the lack of specificity of opioid – the opioid category in ICD-9 has become very problematic in terms of tracking opioid misuse, abuse, or overdose.

So this proposal was an attempt to develop more specificity in death records or ER visit coding around the issue of abuse, misuse, overdose and death because there isn't any good mechanism right now to track the actual cause of overdose that might be found in ER.

In terms of some of the language, you know, obviously we agree that nobody wants to underdose with crack cocaine but in my interfacing with Amy it was thought that we had to work within the existing nomenclature. And so I was a bit limited in suggesting that those types of ICD-10 codes be removed.

So – I mean I just want to emphasize that this request initiated out of trying to track better, in publicly-available databases, the actual molecule that's

involved in the misuse, abuse, overdose, death, diversion and, you know, I hope that, you know, we can work through comments and have this specificity, you know, developed at some point into the future.

Dr. David Berglund: OK. Thank you, Lisa. Certainly this is a very – a very large proposal. There's a lot of things in it and there may be some things we can do that might improve it some. We'll be looking at the comments that we have in determining just how to move forward with it. At this point I think we've covered it in a fair bit of detail here, and I think we will wrap up comments on it. Lisa, thank you for calling in; I'm glad that you had a chance to comment on it also, and to hear the other comments that we got. We'll be looking for comments in writing and determining where to go with this. And at this point, in the interest of time I will wrap up discussion of this and we will turn the podium next over to Donna, I believe, and I believe she will be talking about some urology topics that we had from the American Urological Association. And Donna, you'll need to let me know what page to go to, I think.

Donna Pickett: Sixty-eight, David. The last nine proposals are all from the American Urological Association. And some of them are fairly straightforward, but we do have in the audience – ah, there you are, Dr. Rubenstein. OK. Dr. John Rubenstein, Chesapeake Urology, representing the AUA, and will be available to handle any clinical questions that may arise.

OK. Starting on page 68 the first request is to create expanded codes – and again, this is for ICD-10-CM, not for ICD-9-CM. Currently in ICD-10-CM the only unique code for benign (neoplasm) involving the genitourinary organs is for the spermatic cord at D17.6. AUA is requesting that additional sites within the genitourinary system be added to D17.

So as you can see at D17.7 we're adding a new code, D17.71, D17.72, and of course when we expand we always like to have an “other”, at D17.79. And I will invite questions on this expansion; it's fairly straightforward, but we may have missed something that someone else may be able to identify.

OK, if there are no questions from the floor, Gordon, are there any questions online?

Operator: There's no questions in the queue at this moment, but if you have any questions or comments you may press star then the number one on your telephone keypad.

Donna Pickett: OK, thank you, Gordon. Oh, OK, we have a question from the floor. Cathy?

Kathy Rivera: Is that – it's just – I know ...

Donna Pickett: Oh, sorry, state your name.

Kathy Rivera: Cathy Rivera. It's an NOS question – would be just include those in the 79, other and unspecified?

Donna Pickett: OK, other and unspecified. OK. We seem to be on a roll with NOS' today.

Kathy Rivera: Yes.

Donna Pickett: OK, are there any other questions? OK, we'll move on to page 69, urethral false passage. In ICD-9-CM there is a unique code, urethral false passage, at 599.4. This code was original to the WHO version of ICD-9, and so was also therefore included in ICD-9-CM.

In WHO's ICD-10 there was not a unique code in ICD-10, so there is not a unique code in ICD-10-CM either, and the AUA is actually requesting that a unique code be added to ICD-10-CM as it parallels what is currently in ICD-9 CM. Again, fairly straightforward, but if there are questions from the floor please step to the microphone. And Gordon you can open up the phone lines for questions as well.

Operator: Any questions on the phone you may press star then the number one on your telephone keypad. There are no questions in the queue.

Donna Pickett: OK, then we'll move on to page 70, nodular prostate. Again, you have the background information so I'm not going to read it to you – bless you.

New codes are being requested. N40.2 for nodular prostate, with lower urinary tract symptoms, and N40.3, Nodular prostate without lower urinary tract symptoms. It should be noted that in October 2003 distinctions were

added for this in ICD-9-CM, so basically the request from AUA is to bring that same detail over into ICD-10 CM. Any questions from the floor? I'm getting a thumbs up from Linda Holtzman. OK, thank you, Linda. Any questions on the phone, Gordon?

Operator: There are no questions in the queue.

Donna Pickett: Seeing no one running to the microphone we'll move on to page 71, inflammatory disease of the prostate. In ICD-10-CM, as many of you know, we created a number of combination codes, things that sort of parallel those kinds of questions we would normally receive through coding clinic related to hematuria with various conditions. And so for 10-CM we had created combination codes for acute prostatitis with and without hematuria.

The AUA, however, is requesting that those codes be taken down because they really do not provide any clinical value for work that they do. It should be noted these are being shown as deletions, but again, 10-CM hasn't been implemented yet, so we have an opportunity delete things before the full implementation of 10-CM. Had this proposal come to us after implementation we would have had a real challenge because we don't delete codes. So thank you, AUA, for bringing this now so that we don't have to try to struggle with it later. Are there any questions from the floor on this? Gordon, are there any questions online?

Operator: At this time if you have any questions you may press star then the number one on your telephone keypad. There are no questions in the queue.

Donna Pickett: OK, then we'll move on to page 72, cyst of the prostate. And again, this is another issue where there is a unique code in ICD-9-CM and AUA is requesting that a unique code be added to ICD-10-CM. So the new code would be at N42.83, cyst of the prostate, and of course the companion, .89, other specified disorders of the prostate. Oh, and a deletion of the term at the existing .89, because .89 is not a new code – I'm sorry. But the inclusion term cyst of the prostate would be removed from the .89. Are there any questions from the floor on this? Gordon are there any questions on the call-in line?

Operator: There are no questions in the queue.

Donna Pickett: Thank you. OK, seeing no one going up to the microphone we'll go to page 73. AUA believes that there should be a code in ICD-10-CM to incorporate both the congenital and penile torsion and acquired torsion, penile torsion. This proposal is specific to congenital; there is an existing code in ICD-9-CM for this. So the request is to bring this forward into ICD-10-CM as well. We will have proposals coming to the March meeting for the acquired, but there were some additional issues that we need to kind of hammer out for the acquired, so we have brought forth this one; again, it's an existing code in ICD-9-CM.

Female: (Inaudible).

Donna Pickett: Ah. OK maybe it's – oh, it's another one? OK, sorry – I'm getting all my proposals confused. OK, Stephanie we have to go back to the drawing board and figure out where we are with this. OK. OK, so I stand corrected – we have a new code for the acquired torsion of the penis at N48.82, and a new code at the Q55.63. And we have added the excludes note to make sure that they are excluded from one another and they are excludes one. Are there any questions? Linda?

Linda Holtzman: Yes, just to check the language because on N48.82 it says Acquired torsion of penis acquired, and then the inclusion note says acquired torsion of penis, NOS. I mean it seems like you have too many “acquireds” in there.

Donna Pickett: Ah, thank you.

Linda Holtzman: Also I – I was just wondering what the default would be; in ICD-9 the default is acquired. So I think on the inclusion term, under N48.82 where it currently says, "acquired torsion of penis, NOS," it's not NOS if it's known to be acquired. I think what you really need here is just to take off the word acquired and to say torsion of penis, NOS.

Donna Pickett: OK.

Linda Holtzman: So in other words the default, if a physician doesn't document , which of course they always will, but if per chance that portion of the record is missing and it's not documented whether it's acquired or congenital it will default

Donna Pickett: Default can be here. OK. Thank you, Linda. Any other questions from the audience? OK, Gordon, are there any questions on the phone?

Operator: At this time if you have any questions or comments you may press star and then the number one on your telephone keypad. There are no questions at this time.

Donna Pickett: OK, we're now up to page 74, and we have a proposal to add a code to ICD-10-CM for cyst of the epididymis. That new code would be N50.3. Fairly straightforward. Questions from the floor?

Linda Holtzman: Linda Holtzman. It's actually a clinical question. Just wanted to know how common this is. In ICD-9-CM this goes to just a horrible code, it's other conditions of other male genital organs, which doesn't tell you anything, but if it doesn't happen that often it's probably not that big a deal. So I just wondered if it's very common enough to support its own code.

Dr. Jonathan Rubenstein: Jonathan Rubenstein, Chesapeake Urology. I would say it's a very common thing, and men will often present with unspecified pain; if we find a cyst in the epididymis that could be a source of the pain. It could be a source of a number of genitourinary issues down below. There are some chronic conditions that also sometimes just become acquired in the epididymal area, so it's nice that we have that code to be able to diagnose people with.

Depending on the size of the cyst, it's either going to be ...

Donna Pickett: Dr. – excuse me, Dr. Rubenstein, could you repeat her question?

Dr. Jonathan Rubenstein: Oh, yes, just – the question was just a clinical follow-up – what would be a treatment for somebody with this cyst of the epididymis. In certain severe cases it would be surgery, surgical removal of the cyst in severe cases.

Donna Pickett: Thank you. Are there any other clinical questions? Gordon, are there any questions from folks on the call?

Operator: There are no questions in the queue.

Donna Pickett: OK, moving on to page 75. A unique code was added in ICD-9-CM in 1996 for hidden penis. That code was not carried over into ICD-10-CM so the AUA is actually requesting that that code be created in ICD-10-CM as well, and that new code is Q55.64, Hidden penis. And some of the other synonymous terms are included here at the code. This is the one that I should have been referring to when I said that originally it was going to be acquired and congenital and we pulled the acquired part and we'll bring that to the March meeting; we'll get it right, Stephanie. OK, are there any questions from the floor on this proposal? Gordon are there any questions on the phone?

Operator: If you have any questions you may press star then the number one on your telephone keypad. There are no questions in the queue.

Donna Pickett: Thank you. And moving to page 76, which is the last of the urology proposals, there is a request to create a code for personal history of malignant neoplasm of the ureter. And that new code would be Z85.54. Are there any questions on the need for the code? Any comments from the floor? Gordon, are there any questions on the line?

Operator: There are no questions in the queue.

Donna Pickett: OK. Well I think we can pat ourselves on the back. We knew we had the phone lines until 3:15 and it's, by my watch, almost 10 minutes to 3:00. So I think we have accomplished our goal; we have gotten through everything. It looked a little daunting at the beginning, but I think we've got through it, so pat yourselves on the back. I think you all so much.

But before you leave I do have an announcement. There have been a number of you who have asked about CEU certificates. We had announced this at the last couple of meetings that we would no longer be distributing CEU certificates. I think you would probably need to refer to your specific credentialing organization to figure out how best to submit your

documentation for a meeting that doesn't have prior approval, so I will defer to the different coding organizations. And I'm sure they probably have the information on their website.

That being said, I thank everyone for their attention, their patience, and we hope to see you at the March meeting. Thank you, have a good evening.

Operator: This concludes today's conference call; you may now disconnect.

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