



June 10, 2009

VIA ELECTRONIC MAIL

Donna Pickett, MPH, RHIA
Medical Systems Administrator
National Center for Health Statistics
3311 Toledo Road
Room 2402
Hyattsville, Maryland 20782

Dear Donna:

The American Health Information Management Association (AHIMA) welcomes the opportunity to provide comments on the proposed diagnosis code modifications presented at the March 12th ICD-9-CM Coordination and Maintenance (C&M) Committee meeting that are slated for October 2010 implementation. Our comments pertaining to code proposals slated for October 2009 implementation were sent previously.

Post Traumatic Seizures

AHIMA supports the proposed code for post traumatic seizures. However, we agree with commenters at the C&M meeting that physicians do not use terminology pertaining to seizures consistently, so these codes will also not be used consistently and code assignment will depend on the term the physician uses

Since post traumatic seizure disorder should be classified to the epilepsy codes rather than the proposed code, this term should be indexed and should also be added under the proposed Excludes note for the new code for post traumatic seizures.

Sequencing instructions should be provided for those instances when post traumatic seizures occur as part of an acute head injury.

Cognitive Deficits Related to Traumatic Brain Injury (TBI) and Neurological Conditions

We support the proposal, as revised for the March 2009 C&M meeting, to create a new subcategory for signs and symptoms involving cognition. We agree with the conditions that would be excluded from the new subcategory. We also agree with the recommendation made during the C&M meeting that the title of category 799 be expanded to explicitly include the new subcategory for signs and symptoms involving cognition.

Escherichia coli – Expansion for O157:H7

While AHIMA supports the creation of a unique code for Escherichia coli [E. coli] O157:H7, we recommend that the title of proposed new code 041.49 be changed to “Other and unspecified Escherichia coli [E. coli],” since there may be instances when the type of E. coli is not specified.

Personal History of Corrected Congenital Malformations

While we support the creation of unique codes for personal history of various types of congenital malformations, we are concerned that the word “corrected” in the proposed code titles could be misconstrued to mean there is no residual condition or long-term consequences. As was noted during the C&M meeting, there may still be long-term implications for some of these conditions. Consideration needs to be given as to the appropriate use of these codes. If the condition has been treated, or partially corrected, but it has not been fully corrected and the patient requires long-term follow-up or even continued treatment, would these codes still be appropriate? Or are these codes limited to situations when the congenital anomaly has been fully corrected, with no long-term consequences or need for ongoing follow-up or monitoring? And if the anomaly must be fully corrected to use these codes, how clear will the medical record documentation be as to whether the condition has been partially vs. fully corrected?

Also, **we recommend that the proposed code for personal history of (corrected) congenital inborn errors of metabolism and chromosomal anomalies not be established** at this time, as it was made clear during the meeting that these conditions are not currently able to be corrected.

Acute Idiopathic Pulmonary Hemorrhage in Infants

AHIMA supports the creation of a unique code for acute idiopathic pulmonary hemorrhage in infants.

Heart Failure Proposals

Since there are a number of proposed changes to the heart failure codes, AHIMA recommends that all of the heart failure proposals be reviewed by the appropriate medical specialty societies, such as the American College of Cardiology, prior to finalization of these modifications.

Rheumatic Heart Failure

We support the proposal to add “use additional code” notes under category 391, Rheumatic fever with heart involvement, and code 398.91, Rheumatic heart failure (congestive), to identify the type of heart failure. This should not change longstanding *Coding Clinic* advice that assumptions should not be made that the congestive heart failure is rheumatic in nature. As stated repeatedly in *Coding Clinic*, unless ICD-9-CM directs the coder to assign the code for rheumatic

congestive heart failure or the physician states the condition is "rheumatic," it is inappropriate to assign a code for rheumatic congestive heart failure. Physicians on the *Coding Clinic* Editorial Advisory Board have consistently stated that coders should not assume that the congestive heart failure is rheumatic in nature even though a patient may have a disorder involving both the mitral and aortic valves (which the ICD-9-CM presumes to be rheumatic in origin).

Alternative 1 – Congestive Heart Failure Expansion

We support the proposed expansion of code 428.0, Congestive heart failure, unspecified, to identify whether the congestive heart failure is acute, chronic, or acute on chronic.

If Alternative 2 is **not** adopted, we recommend that the word "unspecified" be deleted from subcategory 428.0, Congestive heart failure, unspecified. If there are no codes for "specified" types of congestive heart failure, the word "unspecified" is inappropriate. However, if Alternative 2 is adopted, which would incorporate the concept of "congestion" into the codes for systolic and diastolic heart failure, then "unspecified" in subcategory 428.0 would be appropriate.

Alternative 2 – Systolic Heart Failure, Diastolic Heart Failure, and Combined Heart Failure with Congestive Heart Failure

Alternative 2 is not mutually exclusive from Alternative 1, so both proposals could be implemented. The expanded codes for acute, chronic, and acute on chronic congestive heart failure presented in Alternative 1 would provide more detailed information about the congestive heart failure when the heart failure is not documented as systolic, diastolic, or combined.

AHIMA supports Alternative 2, with an additional suggested modification. Alternative 2 does not have the ability to uniquely identify systolic/diastolic/combined heart failure with congestion, but not specified as acute/chronic/acute on chronic. **The codes for unspecified systolic heart failure, unspecified diastolic heart failure, and unspecified combined systolic and diastolic heart failure should also be split out to identify whether or not congestion is present.** We believe that physicians are more likely to document the congestive nature of the heart failure than the acuity of the heart failure. Therefore, we believe distinct codes to capture the congestive nature of systolic/diastolic/combined heart failure when the acuity of the heart failure is unspecified are necessary.

We recommend that the proposed modifications described in both Alternatives 1 and 2 be adopted (with the additional creation of codes for systolic/diastolic/combined heart failure that specify the presence or absence of congestion when the acuity of the heart failure is unspecified).

Acute Heart Failure Classification and Related Heart Failure Issues

While we support the creation of unique codes for low output syndrome and high output heart failure, we agree with the suggestion made during the C&M meeting that both codes should be created in a single subcategory to preserve unused code numbers for future use.

Acute Right Heart Failure

While AHIMA supports the creation of unique codes for acute, chronic, and acute on chronic right heart failure, this proposal needs to be coordinated with Alternative 1 of the congestive heart failure expansion to ensure there are no conflicts. In Alternative 1 of the congestive heart failure proposals, right heart failure (secondary to left heart failure) is an inclusion term under the proposed new codes for congestive heart failure. In the acute right heart failure proposal, right heart failure secondary to left heart failure is an inclusion term under the proposed new codes for right heart failure. A decision needs to be made as to the appropriate code assignment for right heart failure secondary to left heart failure. Consideration should be given to historical trend data and the impact of changing the code category where right heart failure secondary to left heart failure has historically been assigned. It is currently classified to code 428.0, Congestive heart failure, unspecified.

Instructional notes and index entries should also be created to provide direction as to how these codes should be used (or not used) in conjunction with the codes for congestive heart failure and systolic/diastolic/combined heart failure.

Acute Decompensated Heart Failure

We support the proposal to index decompensated heart failure to the “acute on chronic” heart failure codes. It would also be helpful to add an inclusion term for decompensated heart failure under each of the “acute on chronic” heart failure (for example, the inclusion term under code 428.23 would state “decompensated systolic heart failure”).

We recommend that compensated heart failure be indexed to the chronic heart failure codes.

Heart Failure with Reduced Ejection Fraction and with Normal Ejection Fraction

AHIMA **opposes** the proposed addition of inclusion terms for reduced and normal ejection fraction under the heart failure codes. We agree with the comment made during the C&M meeting that it is inappropriate to include clinical criteria in ICD-9-CM. It is the provider’s responsibility to document the type of heart failure, based on his review of test results and clinical findings and his clinical judgment.

Acute Pulmonary Edema with Other Conditions

We support the proposal for modifications that would enable separate reporting for acute pulmonary edema. We agree with the suggestion made during the C&M meeting that a list of examples of associated conditions should be added under proposed new code 518.42, Acute pulmonary edema with conditions classified elsewhere. Also, if this code should not be reported with certain conditions because acute pulmonary edema is considered inherent to the condition, instructional notes providing this direction should be added.

A potential area of confusion is the use of proposed new code 518.40, Acute pulmonary edema, unspecified, versus proposed new code 518.42, since it may not always be clear whether another co-existing condition is associated with the acute pulmonary edema or unrelated to it. The appropriate use of these codes may need to be further clarified through *Coding Clinic for ICD-9-CM*.

Aortic Ectasia

AHIMA supports the creation of a unique code for aortic ectasia. An Excludes note for aneurysm should be added under this code. We agree with the suggestion made during the C&M meeting that the proposed index entries for aortectasia “with aneurysm” should be changed to “see aneurysm” references instead, since there are multiple aneurysm codes (so it wouldn’t be appropriate to reference a single aneurysm code).

Difficult Airway

We support the creation of a unique code for difficult airway.

Awaiting Joint Prosthesis

AHIMA recommends that separate codes be created for aftercare following joint prosthesis explantation and explantation status. In the *ICD-9-CM Official Guidelines for Coding and Reporting*, “aftercare” and “status” have different meanings, so they should not be classified to the same code. A code for aftercare following joint prosthesis explantation could be used to explain the reason for the admission/encounter for implantation of a new prosthesis, whereas a code for explantation status could be used for admissions/encounters unrelated to implantation of a new prosthesis (to show that an individual has had a joint prosthesis removed and a new prosthesis has not yet been implanted).

Cocaine Poisoning

We support the creation of a unique code for cocaine poisoning.

Body Mass Index (BMI)

We support the proposed expansion of the BMI codes.

Fecal Incontinence

AHIMA supports the expansion of the fecal incontinence code and the creation of a unique code for fecal impaction.

Müllerian Anomalies

We support the creation of new codes for various types of Müllerian anomalies. As noted by an attendee at the C&M meeting, a determination needs to be made as to the proper code assignment for Müllerian anomalies, not otherwise specified.

Personal History of Vaginal and Vulvar Dysplasia

We support the creation of unique codes for personal history of vaginal and vulvar dysplasia.

Addenda Items for Consideration for October 1, 2010

AHIMA supports the proposed Addenda items being considered for October 1, 2010 with the following exceptions:

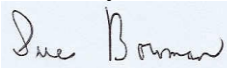
- We recommend that the wording of the proposed revision to the note under category 438, Late effects of cerebrovascular disease, match the corresponding Excludes note. The Excludes note indicates that any manifestations occurring during the initial episode of care should not be assigned a code from category 438, whereas the explanatory note under category 438 indicates that the codes in this category should not be used for manifestations that are treated and resolve during the initial episode of care. We believe the Excludes note accurately reflects the intent, which is that codes in category 438 should not be used for any manifestations occurring during the initial episode of care, regardless of whether they are treated or resolve during that episode of care.
- We agree with the proposed addition of an Excludes note under code V45.01, Cardiac pacemaker, and an inclusion term under code V45.02, Automatic implantable cardiac defibrillator. Per the suggestion at the C&M meeting, the proposed Excludes note and inclusion term should be modified to include “with pacing capabilities.”

Donna Pickett
June 10, 2009
Page 7

- While we support the addition of index entries for “Ischemia, demand,” and “Ischemia, supply,” **we recommend that the classification of these conditions to code 414.9, Chronic ischemic heart disease, unspecified, and the proposed “see also” note be reconsidered.** The *Coding Clinic* Editorial Advisory Board recommended the assignment of code 411.89, Other acute and subacute forms of ischemic heart disease, other. Also, the cross-reference to “see also Angina” does not seem consistent with the proposed assignment of code 414.9. **We recommend that input be obtained from the appropriate medical specialty societies to determine whether demand ischemia and supply ischemia should be considered “chronic” or “acute and subacute.”**
- In conjunction with the other proposed revisions to index entries under Malnutrition, the default index entry for Malnutrition, protein, should be changed to code 263.9, Unspecified protein-calorie malnutrition, since this is the more common type of protein malnutrition.

Thank you for the opportunity to comment on the proposed diagnosis code revisions slated for October 2010 implementation. If you have any questions, please feel free to contact me at (312) 233-1115 or sue.bowman@ahima.org.

Sincerely,



Sue Bowman, RHIA, CCS
Director, Coding Policy and Compliance