



November 18, 2010

VIA ELECTRONIC MAIL

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

Dear Ms. Pickett:

The American Health Information Management Association (AHIMA) respectfully submits the following comments on the proposed diagnosis code modifications presented at the ICD-9-CM Coordination and Maintenance (C&M) Committee meeting held on September 15-16.

ICD-9-CM Proposed Modifications

Infection Following Transfusion

While AHIMA recognizes the value of a unique code for infection following transfusion, infusion, or injection of blood and blood products, we are concerned about potential confusion regarding the use of this proposed code. For example, some time may elapse before a transfusion-associated infection develops. Also, the infection may be present for many years, or for the rest of the patient's life (as in the case of HIV infection), leading to questions regarding the use of the proposed code for all subsequent healthcare encounters related to an infection resulting from a transfusion. It was suggested that perhaps separate codes for infections following transfusion that are acute vs. chronic or a late effect should be created. AHIMA believes that this approach would create more confusion, not less, as to the appropriate use of these codes. **We believe it would be preferable to create a single code, as originally proposed, and provide detailed guidance on when and how this code should be used.**

Anaphylactic Reaction and Other Serum Reaction

We support the proposed modifications and new codes for anaphylactic and serum reactions. We suggest that Excludes notes for the ABO incompatibility reactions classified to subcategory 999.6 be added under the proposed new codes for anaphylactic reaction and serum reaction due to administration of blood and blood products.

Mesh Erosion/Mesh Exposure

AHIMA supports a modification of option 2 for creation of new codes for mesh erosion/mesh exposure. While we prefer the creation of new codes for these complications in the Genitourinary System chapter, we recommend that only a single code be created to capture both mesh erosion and exposure rather than creating two separate codes. We are concerned that documentation may not adequately distinguish between these conditions. **We believe it is preferable to create a unique code in a female genitourinary category to limit the use of the code to female genitourinary procedures**, since the terms “mesh erosion” and “mesh exposure” may have different meanings when used by other surgical specialties.

We disagree with the proposed addition of a “use additional code” under subcategory 996.7, Other complications of internal (biological) (synthetic) prosthetic device, implant, and graft (as described in option 2 of the proposal). Since a new code in category 629, Other disorders of female genital organs, would specifically describe the complication of mesh erosion and exposure, it would not be necessary to assign a code from subcategory 996.7. An Excludes note for “other specified complications classified elsewhere” already exists under category 996.

Malnutrition

We generally support the proposed modifications and new codes for malnutrition, with a few additional suggestions. “Frailty” should be deleted from the proposed “code first” note under proposed new codes 262.13, Severe malnutrition in chronic illness and 262.19, Severe malnutrition related to other disorders. The title of proposed code 262.19 should be revised to state “Severe malnutrition in other disorders.”

Malnutrition NOS and severe malnutrition shouldn’t both default to code 263.9, Unspecified protein-calorie malnutrition. Consideration should be given to creating a unique code for severe malnutrition NOS.

For severe malnutrition in chronic illness, we recommend that malnutrition be allowed to be appropriately sequenced first when it meets the definition of principal diagnosis (rather than creating “code first” notes that require the related chronic illness to be sequenced first).

We appreciate the proposal to re-index protein malnutrition and severe malnutrition, since these terms are currently indexed to codes that are not typically the intent when these terms are documented.

Lymphangioliomyomatosis

We support the creation of a unique code for lymphangioliomyomatosis.

Dementia Unspecified With and Without Behavioral Disturbance

AHIMA supports the creation of unique codes for unspecified dementia with and without behavioral disturbance. Proposed code 294.20, Dementia unspecified without behavioral disturbance, should be identified as the default (when it is not known whether there is a behavioral disturbance) by adding an inclusion term under this code.

Elective C-Sections Prior to 39 Weeks

We do not support the proposed new code for late preterm onset of labor, with delivery. The use of both the terms “late” and “preterm” in the proposed code title is confusing, as it is difficult to comprehend how the onset of labor can be both late and preterm at the same time. Also, the proposed code would not be limited to patients undergoing elective c-sections prior to 39 weeks, even though that is the group of patients this code is intended to capture. This code would be assigned for every patient arriving at the patient in labor in the 37th or 38th week of gestation who delivers. **We recommend that a code specific to the situation needing to be identified be created (i.e., a code for elective c-section presenting in labor prior to 39 weeks).**

Personal History of Gestational Diabetes

We support the creation of a unique code for personal history of gestational diabetes. However, this code might more appropriately be located in subcategory V13.2, Personal history of other genital system and obstetric disorders, rather than proposed subcategory V12.2, Personal history of endocrine, metabolic, and immunity disorders, since gestational diabetes is classified to chapter 11 (not chapter 3) and is specifically a pregnancy-related condition.

Encounter for Fetal Viability Ultrasound/Personal History of Ectopic Pregnancy

While AHIMA supports the creation of new codes for pregnancy with history of ectopic pregnancy and pregnancy with inconclusive fetal viability, we disagree with the proposed placement of the code for pregnancy with inconclusive fetal viability in subcategory V23.4, Pregnancy with other poor obstetric history. Since the inconclusive fetal viability refers to the current pregnancy and not a previous pregnancy, this code does not belong in a subcategory for pregnancy with poor obstetric history. A more appropriate code assignment would be V23.6 or V23.87.

Adult Pulmonary Langerhans Cell Histiocytosis (PLCH)

We support the proposed code for Adult Pulmonary Langerhans Cell Histiocytosis.

Acquired Absence of Joint

We support the proposal for new codes for acquired absence of joint and aftercare following explantation of joint prosthesis. The proposal presented at the September C&M meeting represents a significant improvement over previous versions of this proposal.

Glaucoma Severity Staging

While we recognize the value of capturing the glaucoma stage, we are concerned that this information frequently won't be documented. If the proposal for creation of codes for glaucoma stages is implemented, the proposed "use additional code" notes under the glaucoma codes indicating that an additional code should be assigned for the stage should be revised to state "use additional code, if known."

Also, a unique code for "glaucoma stage NOS" should be created rather than classifying it to the code for indeterminate stage glaucoma. There is a significant difference between being clinically unable to determine the glaucoma stage and the stage not being documented.

We support the proposed new code for family history of glaucoma.

Corticobasal Degeneration

AHIMA supports creation of a unique code for corticobasal degeneration.

Pulmonary Arteriovenous Malformation and Pulmonary Atresia

We support the proposal for new codes describing pulmonary artery coarctation and atresia, pulmonary arteriovenous malformation, and other anomalies of pulmonary artery and pulmonary circulation.

Complications of Stem Cell Transplant

We support the creation of a unique code for complications of stem cell transplant rather than classifying these complications to the existing code for complications of bone marrow transplant. As noted in the documentation for this C&M topic, many stem cell transplantation procedures are performed using stem cells collected from the peripheral blood rather than from the bone marrow. Stem cells can also be collected from umbilical cord blood.

Pseudobulbar Affect

We support the creation of a new code for pseudobulbar affect. The proposed "code first" note under the new code should be revised to state "code first underlying cause, if known," since there may be occasions when the underlying cause is not known.

Reportable Malignant Skin Cancers

We support the proposal to expand codes under category 173, Other malignant neoplasm of skin, to distinguish basal and squamous cell skin cancers from other types of skin cancers.

Disorders Due to Intrinsic Circulating Anticoagulants, Antibodies, or Inhibitors

It is not entirely clear from the proposal to expand code 286.5, Hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors, what the prevalence of these conditions is or if the applicable medical specialty societies support the proposal. **We recommend confirming support from the physician community before implementation of this proposal.**

Interstitial Lung Diseases of Childhood

We prefer option 1 for this proposal, as we don't believe the level of specificity in option 2 would typically be supported by medical record documentation. Excludes notes for interstitial lung diseases not of childhood should be added under the proposed new codes.

Idiopathic Pulmonary Fibrosis

We support creation of a unique code for idiopathic pulmonary fibrosis.

Nonspecific Interstitial Pneumonitis

While we support a new code for idiopathic non-specific interstitial pneumonitis, the proposed Excludes note under this new code is confusing. According to this Excludes note, non-specific interstitial pneumonia NOS is classified to code 516.8, Other specified alveolar and parietoalveolar pneumonopathies, instead of the proposed new code for idiopathic lymphoid interstitial pneumonia. However, since "idiopathic" means "of unknown cause," the distinction between idiopathic non-specific interstitial pneumonitis and non-specific interstitial pneumonia NOS is not clear. It would seem as though both of these terms should be classified to the same code.

Also, instructional notes and index entries will need to provide clear direction regarding the appropriate classification for related or similar terms. For example, this proposal indicates (by an Excludes note) that non-specific interstitial pneumonia NOS would be classified to code 516.8, and a separate C&M proposal for a new code for idiopathic pulmonary fibrosis indicates that proposed code 516.30 would be assigned for idiopathic interstitial pneumonia, not otherwise specified. These terms (non-specific interstitial pneumonia NOS, idiopathic interstitial pneumonia, not otherwise specified, and idiopathic non-specific interstitial pneumonitis) are similar and could be confusing to coding professionals, particularly since the medical record documentation may not clearly distinguish among these conditions. Currently, "interstitial pneumonia" (not specified as acute or chronic) is indexed to code 516.8, without a distinction of "non-specific" or "idiopathic." Unless the terms used in the proposed codes are clearly documented in the medical record, the proposed codes for interstitial pneumonia may be used inconsistently.

Acute Interstitial Pneumonia

We support a unique code for acute interstitial pneumonia. As commenters noted during the C&M meeting, if this term is documented by the physician in the medical record to describe the patient's

condition, the proposed new code will be assigned, even if the physician really means an acute atypical pneumonia rather than a true acute interstitial pneumonia.

Respiratory Bronchiolitis-associated Interstitial Lung Disease

AHIMA supports the creation of a specific code for respiratory bronchiolitis interstitial lung disease. An Excludes note for this new code should be added under subcategory 466.1, Acute bronchiolitis.

Lymphocytic Interstitial Pneumonia

While we support the creation of a unique code for idiopathic lymphoid interstitial pneumonia, the proposed Excludes note under this new code is confusing. According to this Excludes note, lymphoid interstitial pneumonia NOS is classified to code 516.8 instead of the proposed new code for idiopathic lymphoid interstitial pneumonia. However, since “idiopathic” means “of unknown cause,” the distinction between lymphoid interstitial pneumonia NOS and idiopathic lymphoid interstitial pneumonia is not clear. It would seem as though both of these terms should be classified to the same code.

Cryptogenic Organizing Pneumonia

We support the creation of a new code for cryptogenic organizing pneumonia. According to an Excludes note in the proposal, organizing pneumonia NOS would be classified to code 516.8 rather than the new code. However, since the proposal indicates that cryptogenic organizing pneumonia is a “clinicopathologic entity involving a histopathologic organizing pneumonia of unknown cause,” it is not clear why organizing pneumonia NOS wouldn’t be classified to the new code.

Desquamative Interstitial Pneumonia

AHIMA supports the creation of a code for desquamative interstitial pneumonia.

ICD-9-CM Proposed Addenda

We support the proposed ICD-9-CM addenda modifications, with the addition of the following changes that were suggested by C&M attendees:

- Change the “code first” note under code 536.3, Gastroparesis, to “code first, if known” instead of “code first, if applicable;”
- Spell out the abbreviation “CNS” in the proposed index entry for Siderosis, CNS;”
- Add index entries for additional vertebral levels for “Tear, annular thrombosis,” since the proposed index entry is specifically for the thoracic level.

ICD-10-CM Proposed Modifications

Opioids Expansion

AHIMA **opposes** the proposal for an extensive expansion of the poisoning, adverse effect, and underdosing codes to allow specific identification of the opioid molecules, and the expansion of F11, Opioid related disorders to identify the type of opioid. The proposed level of detail is inconsistent with the structure and scope of a classification system and would be more appropriate for a drug terminology. ICD-10-CM is not, and is not intended to be, a comprehensive drug terminology. Also, we are concerned about the precedent that incorporation of this level of detail for a single drug category would set for other drug-related code categories. Additionally, the proposed 7th characters for F11 are an inappropriate use of the ICD-10-CM 7th character structure. And, as noted during the C&M meeting, some of the proposed codes may not be clinically appropriate (such as an underdosing code for crack cocaine). Also, it is extremely unlikely that the detail necessary to assign many of the proposed codes would be available in medical record documentation. **However, our primary concern with this proposal is that this level of specificity about the drug type, including identification of drug molecules, is not appropriate in a classification system.**

Weeks of Gestation of Pregnancy

While we support the creation of a new category to identify weeks of gestation, guidance will need to be provided on the use of these codes. For example, is the number of weeks at admission or discharge coded? Whose documentation can be used for coding the number of weeks?

Also, the proposed new codes should be consistent with the definitions of trimester at the beginning of chapter 15. For example, the proposed code for week 28 indicates second trimester, whereas the definitions of trimester indicate that week 28 is in the third trimester.

We agree with the suggestion made during the C&M meeting that the concept of weeks of gestation should be placed in a single subcategory to conserve space. While it was noted that the proposed approach involving multiple new subcategories was intended to leave space for future expansion to identify the days within the weeks of gestation, AHIMA would be opposed to this level of detail in ICD-10-CM. While identifying the week of gestation seems appropriate, identifying the specific days within the week of gestation is a level of granularity that does not belong in a classification. Therefore, **we recommend that the proposed codes for weeks of gestation be located in a single subcategory to allow other subcategories to be used for other clinical concepts.**

Weeks of Gestation for Newborn

We support the proposed expansion of subcategories P07.2, Extreme immaturity of newborn, and P07.3, Other preterm newborn, to identify the specific week of gestational age. We concur with the American Hospital Association that beginning and ending limits should be added to each code, so that the gestational ages included in each code are abundantly clear.

The term “NOS” should be added to the proposed inclusion term under code P07.20 to clarify the use of this code.

Benign Neoplasm of Genitourinary Organs

AHIMA supports the creation of unique codes for benign lipomatous neoplasm of kidney and other genitourinary organ. A commenter suggested either including unspecified benign lipomatous neoplasm in the proposed code for benign lipomatous neoplasm of other sites or creating a unique code. However, this suggestion is unnecessary, as code D17.9, Benign lipomatous neoplasm, unspecified, already exists.

Urethral False Passage

We support the proposed code for urethral false passage.

Nodular Prostate

We support the creation of new codes for nodular prostate with and without lower urinary tract symptoms.

To be consistent with the structure of other codes in category N40, we recommend reversing the order of the two proposed codes for nodular prostate – the code for nodular prostate without lower urinary tract symptoms should be the first code (N40.2) and that with lower urinary tract symptoms should be the second code (N40.3).

“Nodular prostate NOS” should be added as an inclusion term under the code for nodular prostate without lower urinary tract symptoms.

Inflammatory Disease of the Prostate

We have no objection to the deletion of the codes distinguishing acute and chronic prostatitis with and without hematuria, since this deletion is occurring prior to ICD-10-CM implementation.

Cyst of Prostate

We support the creation of a unique code for cyst of prostate.

Acquired and Congenital Torsion of Penis

We support the proposed codes for acquired and congenital torsion of penis. We concur with the suggestion that the second instance of the word “acquired” should be deleted from the title of proposed code N48.82. We also agree that the word “acquired” should be deleted from the inclusion term under proposed code N48.82 to clarify that torsion of penis NOS is classified to this

code. However, it is not clear from the proposal whether the default for torsion of penis NOS should be the acquired or congenital form. The proposal notes that congenital torsion of the penis is a common occurrence in pediatric patients. Should the default be different based on the age of the patient? Clarification should be obtained from the American Urological Association in order to ensure the most appropriate default for unspecified torsion of penis is selected.

Cyst of Epididymis

We support the proposed code for cyst of epididymis.

Hidden Penis

We support the proposed code for hidden penis.

Personal History of Malignant Neoplasm of Ureter

We support the creation of a code for personal history of malignant neoplasm of ureter.

Visual Agnosia and Related Conditions

We support the proposal to create a new code for visual agnosia, with inclusion terms under this code for prosopagnosia and simultanagnosia. If these conditions are commonly due to an underlying condition, we recommend adding an instructional note indicating that the underlying condition should be coded first, if known (or if applicable).

Displacement/Dislocation of Internal Hip Prosthesis

While we understand the clinical rationale for the proposed revision of the titles of codes T84.022 and T84.023 to indicate “instability” instead of “dislocation,” it might be confusing to change the titles of just these two codes when the titles of subcategory T84.02 and the other individual codes in this subcategory say “dislocation.” Since “instability of internal joint prosthesis” is an inclusion term under subcategory T84.02, and none of the codes in this subcategory distinguish between instability and dislocation, it would seem as though the codes in subcategory T84.02 are intended to be used for either dislocation or stability. So it seems unnecessary to change any of the code titles to state “instability” instead of “dislocation.” If only the title of the codes for knee prosthesis is changed, it might create confusion as to how instability of other joint prostheses should be coded – and why the other codes weren’t revised to reflect “instability” as well.

If the inclusion term under subcategory T84.02 does not sufficiently clarify that the codes in subcategory T84.02 should be used for either instability or dislocation, **we recommend that the titles of subcategory T84.02 and all of the codes in this subcategory be revised to state “Dislocation or instability.”**

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Gastroparesis

AHIMA supports the proposal to create a specific code for gastroparesis, with the following modifications to the proposal:

The proposed Excludes2 note under this new code should be deleted, as it is unnecessary and will create confusion, particularly when considered in conjunction with the proposed “code first” note.

In the instructional note to code first underlying disease, if known, codes E10.43, E11.43, and E13.43 should be added to the parenthetical for diabetes mellitus.

Also, under codes E08.43, E09.43, E10.43, E11.43, and E13.43, the inclusion term for diabetes with diabetic gastroparesis should be deleted and a “use additional code” note for the new gastroparesis code should be added.

ICD-10-CM Proposed Addenda

AHIMA supports the proposed ICD-10-CM addenda modifications, with the modification that instead of deleting the inclusion term for “circumscribed brain atrophy” under code G31.01, Pick’s disease, this inclusion term should be revised to state “frontotemporal circumscribed brain atrophy.”

Thank you for the opportunity to comment on the proposed diagnosis code revisions. 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