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American Health Information Management Association®

April 1, 2011

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 March 9-10.

ICD-9-CM Topics

Seclusion Status

While AHIMA supports the creation of a code to identify seclusion status, the title does not reflect the intent of the use of this code as described in the background material provided in the topic packet. There could be confusion as to the difference between seclusion and isolation, as well as confusion as to whether this code should be used for types of seclusion that may be unrelated to behavioral health issues.

We recommend that the code title be expanded, and appropriate inclusion terms added, to more clearly reflect the intended use of this code. We also recommend that clarification be provided on the documentation necessary to support a code assignment for seclusion status, through the *ICD-9-CM Official Guidelines for Coding and Reporting* or *Coding Clinic for ICD-9-CM*,.

Vitreomacular Adhesion

We support the proposed new code for vitreomacular adhesion.

Partial Tear of Rotator Cuff

We support the creation of a unique code for partial tear of the rotator cuff, but agree with the comment made by a C&M meeting attendee that clarification as to the difference between a partial and complete tear of the rotator cuff should be sought from the American Academy of Orthopedic

Surgeons. Based on the discussion at the meeting, there are apparently differences of opinion as to whether the difference between partial and complete is determined by number of muscles involved or thickness of the tear, which could result in discrepancies between the reported diagnosis code and associated procedure code.

We also recommend that a default be indicated in the index for those situations when there is no information as to whether the tear is partial or complete.

Malnutrition

Due to the limited lifespan of ICD-9-CM and the fast-approaching implementation of ICD-10-CM, we question whether it is worthwhile to make the proposed modifications to update the classification of malnutrition in ICD-9-CM and to potentially change trend data at this time. It may be preferable to focus on updating the classification of malnutrition in ICD-10-CM rather than in ICD-9-CM.

Regardless of whether these modifications are made in ICD-9-CM as well as ICD-10-CM, we agree with the commenters at the C&M Committee meeting who indicated concern regarding the use of the word "in." As the codes are structured in the proposal, it is not clear whether the codes in the proposed subcategory for severe malnutrition in injury, illness or other disorders are intended to only be used when there is a documented relationship between the severe malnutrition and another condition, or they are to be used whenever severe malnutrition and another condition both happen to present. If the latter interpretation is correct, codes in the new subcategory would likely be used for almost all cases of severe malnutrition, since there is a proposed code for "severe malnutrition in other disorders." If there does not need to be a documented relationship between the severe malnutrition and another condition, the only time these codes wouldn't be used for severe malnutrition is when the patient has no other clinical condition.

To add to the confusion concerning the meaning of the word "in," proposed instructional notes included in the proposal refer to "severe malnutrition **related to** acute injury, illness and other disorders," and the proposed index entries use the terminology "related to (due to)." However, the titles of the proposed codes for severe malnutrition don't specify "related to." So, there is a discrepancy between the terminology used in the proposed instructional notes/index entries and the proposed code titles.

The proposed code for severe malnutrition, unspecified (code 262.10), is located in a subcategory for severe malnutrition in injury, illness, or other disorders. This location does not seem accurate because unspecified severe malnutrition may or may not be related to (or present with, depending on the meaning of "in") another clinical condition. Also, the proposed revision of the title of category 262 states "Other specified severe protein-calorie malnutrition," which would not include **unspecified** severe protein-calorie malnutrition. **We recommend that either code 263.9, unspecified protein-calorie malnutrition, be assigned for unspecified severe malnutrition or code 262.0 (rather than code 262.10) be created for unspecified severe malnutrition.** If code 262.0 is created for unspecified severe malnutrition, the title of category 262 would need to be revised to state "Other and unspecified severe protein-calorie malnutrition."

Our members have indicated that the diagnosis of malnutrition is not typically documented with one specific cause of malnutrition. What code would be assigned if the physician determines that it is the result of a variety of acute and chronic illnesses, environmental and social circumstances? Should all of the applicable codes be assigned?

The distinction between severe protein-calorie malnutrition and severe malnutrition NOS needs to be clearer.

We are concerned about the revisions to the index entries for first, second, and third degree malnutrition. These changes in the classification of malnutrition will seriously disrupt data trends.

Also, two proposed index entries appear to conflict with one another. The index entry for Malnutrition, degree, severe indicates code 262.10, whereas the index entry for Malnutrition, severe, indicates code 263.9.

The proposed index entry revisions indicate that malnutrition related to acute illness or injury, chronic illness, and environmental or social circumstances would be classified to codes in the proposed new subcategory for severe malnutrition in injury, illness or other disorders. However, this subcategory specifies "severe" malnutrition, whereas the index entries do not. Is the intent that all malnutrition due to an underlying illness or injury, or environmental or social circumstances, would be classified to the new codes regardless of whether the malnutrition is severe or not?

Solitary Pulmonary Nodules

We support creation of a unique code in category 793, Nonspecific abnormal findings on radiological and other examination of body structure, for solitary pulmonary nodule. However, rather than the two codes proposed at the C&M Committee meeting, **we recommend that just one code be created that could be assigned no matter how many solitary pulmonary nodules are identified.** We agree with the comments made at the meeting that the phrase "more than one finding" is confusing, but we think a single code for solitary pulmonary module(s) would be the preferable approach. Our members have indicated that the specific information needed to assign one of the proposed new codes will likely only be documented for the initial encounter, resulting in other codes being used (rather than the proposed new codes) for subsequent encounters. This issue further supports our recommendation that one code, rather than two codes, should be created.

The written material for this proposal indicated that the term "single pulmonary nodule" is not indexed. However, there is an index entry for "Nodule, lung, solitary (518.89)." If the code proposal is approved, this index entry will need to be revised.

Wandering

AHIMA supports creation of a code for wandering. Our preference is option 1, which would involve creation of code 799.83, Wandering in diseases classified elsewhere. While we recognize that in some

ways this proposal might fit better as a V code (option 2), since wandering describes an "at risk" behavior rather than a true symptom or condition, proposed code 799.83 makes it clear that the intent of the code is only to capture wandering associated with a medical condition. This might help to prevent some of the potential misuses of a code for wandering that were suggested at the C&M Committee meeting, such as a young child who wanders away from home.

We agree with the suggestions made at the meeting to add Alzheimer's disease, dementia, and developmental delay to the "code first" note under the new code. We also agree with the recommendation to add a "use additional code" note under code 294.11, Dementia in conditions classified elsewhere with behavioral disturbance, as well as under the other coders for common underlying disorders.

To clarify the intent of the new code, we recommend adding notes to indicate that this code should not be used for escapes from a lock down unit or absconding from a healthcare facility. The issue of whether the proposed code for wandering could be used when an individual wanders off due to disorientation as a result of substance abuse. Although not originally considered part of the original intent of this code proposal, there is nothing in the code proposal that would prohibit the use of the code in this circumstance. Wandering is also associated with certain sleep disorders (such as sleepwalking), with the same safety risks as those associated with the types of wandering originally envisioned by the code requester, so consideration also needs to be given as to whether this code may be used for sleep-related wandering as well.

Acute Kidney Diseases and Related Disorders

We recommend that the proposed modifications for acute kidney diseases and related disorders not be implemented in ICD-9-CM. The proposed changes are major and would significantly impact longstanding trend data. In addition to completely reclassifying acute renal insufficiency, this proposal involves changing the title of category 584 and code 584.9. Acute renal insufficiency and acute renal failure are commonly-documented conditions. Given the short lifespan ICD-9-CM has left, we do not believe it is appropriate to seriously disrupt acute kidney disease data at this time. **We recommend that modifications to reflect current understanding of acute kidney disease be made in ICD-10-CM instead of ICD-9-CM.**

However, if NCHS decides to move forward with the proposed modifications, we offer the following comments:

The term "nontraumatic" should be added to the title of proposed new subcategory 584.1, Acute kidney injury, to clearly differentiate these codes from traumatic injuries to the kidney.

Consideration needs to be given to the appropriate classification of acute renal insufficiency. Based on the discussion at the C&M Committee meeting, there does not appear to be clear clinical agreement that acute renal insufficiency should be classified to the proposed code for acute kidney injury.

Proposed code 584.2, Acute kidney disease without AKI, should more be more clearly distinguished from the proposed revision of code 584.9, Acute kidney injury or disease, unspecified. If a patient has acute kidney disease with no mention of acute kidney injury, would the appropriate code assignment be 584.2 or 584.9? What diseases would be indexed to code 584.2? Is it necessary to have this separate code or would it be sufficient to index acute kidney disease without AKI to code 584.9?

Since the Renal Physicians Association opposes the proposed codes for stages of acute kidney injury because these terms are not yet in use, these codes should not be implemented at this time even if other parts of the proposed modifications are implemented. Also, the proposed codes for stages do not address how a diagnosis of acute kidney injury, stage 1-2 or stage 2-3, or stage unable to be determined, would be coded.

The proposed new code 584.10, Acute kidney injury, unspecified stage, is very similar to the proposed revision of code 584.9, Acute kidney injury or disease, unspecified. Which conditions will be classified to code 584.10 vs. 584.9? Since physicians often use the terms acute renal insufficiency, acute renal failure, and acute kidney injury interchangeably It may be more appropriate to index acute renal insufficiency, acute renal failure, and acute kidney injury NOS to 584.9 rather than 584.10 since physicians often use these terms interchangeably.

Smoke Inhalation

We support the creation of a new code in category 508, Respiratory conditions due to other and unspecified external agents, for respiratory conditions due to smoke inhalation.

We also support the additional associated modifications to instructional notes and index entries, with a couple of recommended additions to the proposed additional Excludes note under the section heading for "Toxic Effects of Substances Chiefly Nonmedicinal as to Source (980-989)." In addition to adding an Excludes note for respiratory conditions due to smoke inhalation NOS (508.2), we also recommend adding Excludes notes for Smoke inhalation NOS (508.2) and smoke inhalation due to chemical fumes and vapors (506.9). The addition of these Excludes notes would provide further clarification as to the conditions that are classified to the Respiratory System chapter rather than the Injury and Poisoning chapter.

Positive Finding for Interferon Gamma Release Assays (IGRA)

AHIMA supports the creation of a code for nonspecific reaction to cell mediated immunity measurement of gamma interferon antigen response without active tuberculosis. We agree with the proposal to create this code in subcategory 795.7, Other nonspecific immunological findings, rather than expand code 795.5. Expanding code 795.5 would result in redefinition of a longstanding code.

We agree with recommendations made during the C&M Committee meeting to add an inclusion term for the actual name of the test and to specify, either in the code title or an inclusion term, that this represents a blood test.

Atypical Femoral Fracture

We **oppose** creating a new code for atypical fracture of the subtrochanteric region and femoral shaft. Based on input provided by the American Academy of Orthopedic Surgeons, as well as comments made during the C&M Committee meeting, the use of the term "atypical" is not limited to the type of fracture described in the code proposal, but may also be used to describe many other, non-simple fracture patterns.

We support creation of a V code for long-term (current) use of bisphosphonates.

Severely Calcified Coronary Lesions

While we support the creation of a unique code for coronary atherosclerosis due to calcified coronary lesion, we recommend that "severely" be taken out of the proposed code title, as this term will often not be documented. We also recommend that the term "plaque" be added either as an inclusion term or replace the word "lesion" in the code title, as plaque is often the term found in medical record documentation.

Hepatopulmonary Syndrome

AHIMA supports the establishment of a new code for hepatopulmonary syndrome.

Infection Following Transfusion

We support the creation of a code for infection related to transfusion, infusion, or injection of blood and blood products. We recommend that the title of the proposed code specifically state "acute," since the code proposal indicated that the intent is to capture acute, not chronic, infections. The inclusion of the word "acute" in the code title would make this intent clearer than a guideline or instructional note.

While we recognize that the title of existing code 999.39 includes the word "following," we agree with the commenter at the C&M Committee meeting who was concerned that "following" is a rather nebulous term denoting only the timing of events and does not indicate a cause and effect relationship between the transfusion and the infection. We would prefer the use of a term that more clearly establishes a cause and effect relationship between the transfusion and the infection.

We agree with the addition of a "code first" note to clarify that HIV disease should be sequenced before the proposed new code. We also agree with the commenter at the meeting that consideration should be given as to whether V08, Asymptomatic human immunodeficiency virus [HIV] infection status, should be included in this note.

Instructional notes should also be added to address the sequencing of transfusion-related infections other than HIV (such as hepatitis).

Postoperative Respiratory Failure

AHIMA supports the code proposal to create unique codes for acute respiratory failure following trauma and surgery, other pulmonary insufficiency, not elsewhere classified, following trauma and surgery, and acute and chronic respiratory failure following trauma and surgery.

However, similar to our comments above concerning infection following transfusion, **we recommend that the proposed code titles state a more explicit cause and effect relationship between the respiratory condition and the trauma or surgery** than the word "following." "Following" denotes only a sequence of events, not a relationship. Index entries use the phrase "due to" (e.g., index entry for respiratory failure due to trauma, surgery or shock), but the code titles do not explicitly describe a cause and effect relationship. Some of the existing and proposed Excludes notes use the phrase "associated with" when referring to the codes for respiratory conditions following trauma and surgery, which also has a more explicit cause and effect meaning than the actual code titles.

Postoperative Shock

We support the creation of a new category for postoperative shock, with specific codes for cardiogenic postoperative shock and septic postoperative shock.

We recommend changing the proposed "code first" note under the new code for septic postoperative shock to indicate the underlying infection, rather than systemic inflammatory response syndrome (SIRS), should be coded first. The proposed "code first" note for SIRS is incorrect because the SIRS codes cannot be sequenced first (the underlying infection must always be sequenced first). For the same reason, the existing note under code 785.52, Septic shock, indicating that the SIRS code should be coded first is also incorrect.

We agree with the comment made during the C&M Committee meeting that the Excludes note for postoperative shock under code 785.59, Other shock without mention of trauma, should be moved to subcategory 785.5, Shock without mention of trauma.

Drug-Induced Pancytopenia

While we support the code proposal to create a specific code for drug induced pancytopenia, we agree with the recommendation made at the C&M Committee meeting to create a unique code for chemotherapy- induced pancytopenia.

Hypertrophic Cardiomyopathy

AHIMA supports the proposed restructuring of code 425.1, Hypertrophic obstructive cardiomyopathy, as a subcategory for hypertrophic cardiomyopathy, with unique codes to differentiate hypertrophic obstructive cardiomyopathy and other hypertrophic cardiomyopathy.

Acute Interstitial Pneumonitis

We are concerned that the proposal for a new code for acute interstitial pneumonitis and the associated proposed index modifications will lead to confusion and inconsistent data. Physicians often use the terms "pneumonia" and "pneumonitis" interchangeably, so the proposed index entry for "pneumonia, interstitial, acute, meaning acute interstitial pneumonitis (516.33)" is confusing and will result in excessive querying of physicians. The proposed revision of the title of subcategory 516.3 to state "idiopathic interstitial pneumonia," whereas the title of proposed code 516.33 indicates "pneumonitis" further adds to the confusion as to the intended distinction between interstitial pneumonia and interstitial pneumonitis.

Pneumothorax and Air Leak

We support the proposed new codes for postoperative air leak, primary spontaneous pneumothorax, secondary spontaneous pneumothorax, other air leak, and other pneumothorax.

Thalassemia

We support the proposal to expand the ICD-9-CM codes for thalassemias.

Infection Due to Central Venous Catheter

We support the creation of new codes to distinguish bloodstream infections and local infections due to central venous catheter. However, we agree with the recommendation made at the C&M Committee meeting to create two new codes for bloodstream infection due to central venous catheter and local infection due to central venous catheter and modify existing code 999.31 to be used for unspecified infections due to central venous catheter. This approach would avoid significantly changing the meaning of an existing code.

We do have some concerns as to whether the category of infection (local vs. bloodstream) will always be documented. The index should indicate a default when the information as to whether the infection is local vs. bloodstream is not available.

We recommend adding cellulitis as one of the examples in the note under subcategory 999.3, Other infection, complications of medical care NEC, indicating that an additional code should be used to identify the specified infection.

Atrial Fibrillation and Flutter

While we support an expansion of the atrial fibrillation and flutter codes to capture greater specificity, we are concerned that some of the clinical distinctions in the proposed codes may not always be documented, particularly the distinction between persistent atrial fibrillation and long standing persistent atrial fibrillation.

Consideration should be given to expanding specificity further by creating unique codes for some of the inclusion terms listed under proposed code 427.39, Other atrial fibrillation, since these seem to represent disparate types of atrial fibrillation. Also, clarification is needed regarding "first episode atrial fibrillation." What is the definition of "first episode?" Does this specific terminology need to be documented, or is documentation indicating that the patient has never experienced atrial fibrillation previously sufficient?

In the ICD-10-CM part of this proposal, we are also concerned about whether the clinical distinctions of chronic vs. permanent vs. long standing persistent atrial fibrillation will typically be documented or have a consistent meaning when they are documented.

Novel Influenza

AHIMA is concerned that the level of specificity contained in the code proposals for modification to the influenza codes is beyond the level of detail that would typically be documented. Data inconsistency will likely result due to disparities between the code descriptions and the documentation of the type of influenza in patients' medical records.

As a commenter noted at the C&M Committee meeting, if influenza documented only as "H1N1 flu" is intended to be classified to the seasonal influenza codes rather than modified subcategory 488.1, Influenza due to identified 2009 H1N1 influenza virus, this would need to be clarified through the addition of index entries and instructional notes.

Also, the word "origin" in some of the proposed Excludes notes and inclusion terms is confusing, since the origin of a particular influenza virus will not typically be documented in the medical record. Therefore, it would be difficult for coders to apply these instructional notes without querying the physician.

ICD-9-CM Diagnosis Addenda

We disagree with changing the index entries for impaction of bowel and intestine by calculus or other specified type NEC to indicate code 560.32, Fecal impaction. Since this code specifically references "fecal" impaction, it is not appropriate for non-fecal types of impaction. We recommend that the index entries for bowel or intestinal impaction by calculus or specified type NEC continue to indicate code 560.39, Other impaction of intestine.

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

- Add an Excludes note for "developmental delay" under revised categories 317, Mild intellectual disabilities, and 318, Other specified intellectual disabilities;
- Delete code 485 from the Excludes note under code 514, Pulmonary congestion and hypostasis, in addition to the proposed deletion of code 486.

ICD-10-CM Topics

Place of Occurrence

We support the proposed expansion of code Y92.00, Unspecified non-institutional (private) residence as the place of occurrence of the external cause, to identify specific rooms.

Other Chronic Pain

We support the creation of a unique code for other chronic pain.

Migraines

We support the proposed modifications to the migraine codes.

Landau-Kleffner Syndrome

We support the reclassification of Landau-Kleffner syndrome.

Epilepsy and Recurrent Seizures

We support the proposed modifications to the codes for epilepsy and recurrent seizures.

Epileptic Seizures Related to External Causes

AHIMA supports the proposed code modifications for epileptic seizures related to external causes.

In the written material for this proposal, it mentions that an Excludes2 note is being proposed so that the appropriate epilepsy syndrome would be coded first, when applicable. However, an Excludes2 note is not a sequencing instruction. If the intent is that the appropriate epilepsy syndrome should be sequenced first, it should be a "code first" note, not an Excludes2 note.

Vascular Headaches

We support the proposed code modifications for vascular headaches.

In the written material for the proposal, it states that the proposed Excludes2 note is intended to ensure that a more specific migraine or headache code is used when that information is available. This statement implies that the migraine and headache codes listed in the proposed Excludes2 note should not be assigned in conjunction with the vascular headache code. However, an Excludes2 note means that both conditions may be coded together. An Excludes1 note would indicate these conditions could not be coded in conjunction with the vascular headache code. Was the intent that the note be an Excludes1 note rather than Excludes2?

Post-traumatic Headache

We support the proposed modifications to the instructional notes for post-traumatic headache and postconcussional syndrome.

Ventral Hernia

We support the proposed modifications to category K43, Ventral Hernia, to be consistent with the World Health Organization's changes in ICD-10. We also agree with the suggestion made at the C&M Committee meeting to add "epigastric hernia without obstruction or gangrene" as an inclusion term under code K43.9, Other and unspecified hernia without obstruction or gangrene.

Methicillin Resistant Staphylococcus Aureus (MRSA) and Drug Resistance

AHIMA supports the creation of specific codes to capture Methicillin resistant and Methicillin susceptible Staphyloccus aureus infections (MRSA and MSSA, respectively), in Chapter 1, Certain infectious and parasitic diseases, and Chapter 21, Factors influencing health status and contact with health services. We also support the expansion of code Z16, Infection with drug resistant microorganisms, to capture a variety of drug resistances, as well as new codes for carrier of MRSA and MSSA and personal history of MRSA or MSSA infection.

We prefer to have specific codes created in Chapter 1, rather than the suggestion that was made at the C&M Committee meeting to just create Z16 codes and require the use of one of these codes with the infection code to capture the drug resistance component. By creating infection codes that include common types of drug resistance, the linkage between drug resistance and a particular infectious disease can more easily be made. If the infectious disease code fully captures the drug resistance, we do not believe it is necessary to also assign a code from category Z16, Resistance to antimicrobial and antineoplastic drugs, and the instructional notes should reflect this.

Underdosing

AHIMA supports the proposed modification of the notes at the beginning of the section "Poisonings by, adverse effects of and underdosing of drugs, medicaments and biological substances (T36-T50)," as well as the proposed deletion of underdosing codes that are not clinically appropriate. However, as noted at the C&M Committee meeting, a couple of the codes proposed for deletion, T40.2x6, Underdosing of other opioids, and T40.3x6, Underdosing of methadone, should be retained because they include drugs for which the concept of underdosing is clinically appropriate.

We support the proposed modifications of subcategory of subcategory Y63.6, Underdosing and nonadministration of necessary drug, medicament or biological substance.

We **oppose** the proposed deletion of codes in subcategory Z91.1, Patient's noncompliance with medical treatment and regimen. These codes should be retained, as they provide valuable information

as to the reasons underdosing occurs. Consideration should be given to expanding these codes to capture caregiver intentional and unintentional underdosing.

Orthopedic Deformities

We support the creation of new codes for various types of orthopedic deformities.

Hidden or Buried Penis

We support the creation of a unique code for buried penis, acquired. An inclusion term of "hidden penis, acquired" should be added under the new code, since physicians may document this term instead of "hidden penis." As noted at the C&M Committee meeting, a default needs to be indicated in the index for those situations when it is not known whether this condition is congenital or acquired.

Glasgow Coma Scale

We support the proposal to create new codes to capture the total score for the Glasgow coma scale. However, we recommend that proposed code R40.245, Other coma, without documented Glasgow coma scale score, or with partial scale reported, as this code appears to overlap the use of existing code R40.20, Unspecified coma. If the Glasgow coma scale score isn't documented, code R40.20 should be assigned rather than creating code R40.245.

Instructional notes should be added to indicate whether or not the proposed new codes are intended to be assigned in addition to existing codes in subcategories R40.21 – R40.23 (when the documentation is present to support a code from both subcategories).

Also, since the title of the proposed new subcategory specifically identifies the Glasgow coma scale, should the titles of subcategories R40.21 – R40.23 be revised to specify "Glasgow" as well, or are the codes in these subcategories intended to be used for other types of coma scales in addition to the Glasgow coma scale?

Femoroacetabular Impingement

We support the creation of new codes to identify femoroacetabular impingement. An instructional note should be added to clarify that if more than one type of impingement is present, multiple codes should be assigned.

Dehiscence of Amputation Stump

We support the proposal to create a specific code for dehiscence of amputation stump. As noted during the C&M Committee meeting, the proposed Excludes note under existing code T81.31, Disruption of external operation (surgical) wound, not elsewhere classified, should be an Excludes1 note.

Benign Shuddering Attacks

AHIMA supports the addition of a unique code for benign shuddering attacks.

Pulmonary Conditions

We support the expansion of code J84.0, Alveolar and parieto-alveolar conditions, as well as the creation of a new code for unspecified pulmonary fibrosis and a new subcategory for other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere.

The Excludes note under proposed new code J84.171, Idiopathic pulmonary hemosiderosis, needs to be specified as an Excludes1 or Excludes2 note.

Complications of Genitourinary Devices, Implants and Grafts

While we recognize the American Urological Association's desire to revise category T83, Complications of genitourinary prosthetic devices, implants and grafts, to incorporate modern terminology and current urological practice, we have concerns about whether the proposed code modifications may overlap with other codes or fail to clarify the types of devices that would appropriately be classified to each code. For example, how do proposed new codes T83.012, T83.022, and T83.092, which deal with mechanical complications of indwelling ureteral stents, impact existing codes T83.112, T83.122, and T83.192, which deal with urinary stents? It would seem as though these existing coding would need to be modified as part of this code proposal in order to avoid overlap among codes.

Proposed new codes T83.411 T83.412, and the proposed revision to code T83.418 overlap with codes T83.110, T83.111, and T83.118.

Proposed new code T83.421 and the proposed revision of code T83.428 overlap with codes T83.121 and T83.128.

Proposed new codes T83.491 and T83.492 and the proposed revision to code T83.498 overlap with codes T83.191, T83.190, and T83.198.

The revised modification of code T83.038, Leakage of other urinary catheter, and the proposed new code T83.422, Displacement of urinary device (implanted), are quite vague, so index entries and inclusion terms would be helpful to clarify the types of devices that are intended to be classified to these codes.

The titles of proposed new code T83.52, Infection and inflammatory reaction due to other urinary devices and implants, and the proposed revision to code T83.59, Infection and inflammatory reaction due to other prosthetic device, implant and graft in urinary system, seem very similar. Index entries and inclusion terms would be helpful in clarifying the types of devices that are intended to be classified to each of these codes.

For those codes that distinguish between an indwelling urethral catheter and other urinary catheter, a default will need to be identified for use when the medical record documentation does not reflect the type of urinary catheter involved.

Since the American Urological Association indicated during the C&M Committee meeting that nephrostomy and urostomy tubes would fall under the category of "other" urinary catheter, these terms should be added as inclusion terms under the codes for "other urinary catheter" in order to clarify the appropriate classification of these devices.

We support the proposed modifications to subcategory T85.1, Mechanical complication of implanted electronic stimulator of nervous system.

Posterior Reversible Encephalopathy Syndrome (PRES) and Cerebral Vasoconstriction

AHIMA supports the creation of a new subcategory for cerebral vasospasm and vasoconstriction and new codes for acute cerebrovascular insufficiency, cerebral ischemia (chronic), and posterior reversible encephalopathy syndrome (PRES).

It is not clear why a new code for unspecified cerebrovascular disease is being proposed in subcategory I67.8, Other specified cerebrovascular diseases, since there is an existing code for unspecified cerebrovascular disease (code I67.9) and subcategory I67.8 is for "other specified" cerebrovascular diseases. Therefore, **we recommend that code I67.80 not be implemented as part of this proposal**.

Acute Necrotizing Hemorrhagic Encephalopathy

We support the proposed modifications of subcategory G04.3, Acute necrotizing hemorrhagic encephalopathy.

Acute Disseminated Encephalitis and Encephalomyelitis (ADEM)

We support the proposed modifications of subcategory G04.0, Acute disseminated encephalitis and encephalomyelitis (ADEM).

Cerebellar Ataxia in Diseases Classified Elsewhere

We support the creation of unique codes for systemic atrophy primarily affecting central nervous system in myxedema and cerebellar ataxia in diseases classified elsewhere.

Reclassification of Hemorrhoids in ICD-10

While we support the proposed modifications to the hemorrhoid codes necessitated by changes in the World Health Organization's ICD-10, we recommend that the terms proposed for deletion be appropriately indexed to the new codes (and possibly retained as inclusion terms as well), since these terms are still commonly used in medical record documentation.

Concussion Codes

We support the proposed modifications to subcategory S06.0x, Concussion. Per the discussion at the C&M Committee meeting, an instructional note should be added indicating that the traumatic brain injury codes should be used for concussion with loss of consciousness greater than 24 hours.

ICD-10-CM Addenda

Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery (P00-P04)

After further review of the note proposed for deletion that currently appears at the beginning of the section "Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery (P00-P04)," AHIMA recommends retaining the first sentence of the note, modifying the second sentence, and deleting the third sentence. The suggested modification to the note would read as follows (revised wording is shown in bold):

Note: These codes are for use when the listed maternal conditions are specified as the cause of confirmed morbidity or potential morbidity which have their origin in the perinatal period (before birth through the first 28 days after birth). Codes from these categories are also for use for ***observation of*** *newborns who are suspected of having an abnormal condition resulting from exposure from the mother or the birth process, but without signs or symptoms, and, which after examination and observation, is found not to exist.*

However, we also believe that the codes themselves need to be modified. The current structure of categories P00-P04 is very problematic because they capture the concepts of a confirmed condition, a suspected condition, and a condition that has been definitively ruled out in a single code. In ICD-9-CM, category V29 captures the concept of observation of a newborn who is suspected of having an abnormal condition resulting from exposure from the mother or the birth process, but without signs or symptoms, and, which after examination and observation, is found not to exist, whereas in ICD-10-CM, this concept is included in codes that also capture confirmed instances of the newborn being affected by maternal factors or complications of pregnancy, labor, and delivery. The very different concepts of "confirmed" and "ruled out" should not be captured in the same code.

Since we realize that issues with the structure of categories P00-P04 may not be able to be addressed before the code set freeze, the suggested modification of the note indicated above is intended to be a temporary, partial solution until the larger problem can be addressed.

Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances (T36-T50)

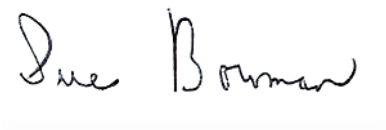
Regarding the proposed Excludes note for adverse effects at the beginning of the section "Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances (T36-T50)," we recommend that this note be changed to a "code first" note. NCHS indicated that this note is the

same as the note in the section "Poisonings by Drugs, Medicinal and Biological Substances (960-979)" in ICD-9-CM. However, in ICD-9-CM, this section does not include codes for adverse effects (the drug causing the adverse effect is identified with an E code), so the note is appropriate as an Excludes note. The corresponding section in ICD-10-CM includes both poisonings and adverse effects, so the notes should clearly reflect the proper sequencing of the poisoning and adverse effect codes and the manifestation or nature of the adverse effect. We recommend that the sequencing of adverse effect codes be the same in ICD-10-CM as they are in ICD-9-CM – with the nature of the adverse effect sequenced first, followed by a code to identify the drug.

We support the remainder of the proposed ICD-10-CM addenda modifications.

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,



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