American Health Information Management Association®

April 12, 2006

VIA ELECTRONIC MAIL

Donna Pickett, MPH, RHIA
Medical Classification 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 24th ICD-9-CM Coordination and Maintenance (C&M) Committee meeting.

I will first address those proposals that have been recommended for implementation in October 2006:

Hypoxia of Newborn, Hypoxic Ischemic Encephalopathy, and Related Newborn Issues
It is unclear whether the American Academy of Pediatrics and American College of Obstetricians and Gynecologists have reached agreement on a comprehensive proposal. We believe it is essential for both specialty societies, as well as any other affected specialties, to review and agree upon the entire proposal before the proposed changes are approved and implemented. Significant interpretation and code application problems occur when code revisions are implemented without the input of all affected specialties. This often results in confusion, coding errors, and, ultimately, additional code revisions. These problems could be avoided by ensuring involvement of all of the appropriate specialties in the development of the initial code proposal. We recommend that this code proposal not move forward until all of the affected specialties have reached consensus.

Bandemia
AHIMA supports the creation of a unique code for bandemia. We agree with the recommendation made during the meeting that this code proposal be implemented October 2006 so that it can be implemented in conjunction with the other changes made to category 288.

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Restless Legs Syndrome
We support the creation of a unique code for restless legs syndrome.

2007 Proposals:

Chronic Total Occlusion of Coronary Artery
AHIMA supports option 1, which would create a single code for chronic total occlusion of coronary artery to be assigned in conjunction with the applicable coronary atherosclerosis code. We do not support option 2, which would result in changing the description of subcategory 414.0 and would create several additional codes. We do not believe it is necessary to create unique codes for chronic total occlusion for each type of vessel.

We are concerned about the availability of specific physician documentation regarding chronic total occlusions. Since coding rules preclude the coding of diagnostic test results in the hospital inpatient setting, physicians will need to specifically document a chronic total occlusion in order for it to be coded. Also, clarification will be needed as to how a total occlusion not specified as acute or chronic should be coded.

Non-Hodgkin's Lymphomas
We agree that ICD-9-CM needs to be updated to reflect current medical knowledge concerning the various subtypes of non-Hodgkin's lymphoma. However, we are concerned by the proposal to create new codes for the subtypes in categories 200 and 202 while continuing to classify unspecified non-Hodgkin's lymphoma to code 202.8x, Other lymphomas. We recognize that there is insufficient space to locate the new codes for the subtypes in the same category where non-Hodgkin's lymphoma is currently classified. This is an unfortunate consequence of continued use of an outdated classification system – implementation of ICD-10-CM is certainly the most ideal solution. However, we urge you to seriously consider the ramifications of locating the codes for the subtypes in an entirely different category from unspecified non-Hodgkin's lymphoma. This approach will significantly complicate analysis of non-Hodgkin's lymphoma data. Data analyses on lymphosarcomas and reticulosarcomas would also be complicated because category 200 has been limited to these types of malignant neoplasms and would now expand to include non-Hodgkin's lymphoma subtypes as well.

We also believe it is problematic to create specific codes for subtypes of non-Hodgkin's lymphoma without creating a unique code for unspecified non-Hodgkin's lymphoma.

We recommend that the proposed codes for subtypes of non-Hodgkin's lymphoma be collapsed into fewer codes, a unique code for unspecified non-Hodgkin's lymphoma be created, and that all of the codes for non-Hodgkin's lymphoma be grouped together. We believe category 200 should remain unchanged in order to avoid disruption of analysis and trending of data on lymphosarcomas and reticulosarcomas. Category 209 is currently available and could be used for the new non-Hodgkin's lymphoma codes.

Normal Pressure Hydrocephalus
We agree with the proposal to create a unique code for normal pressure hydrocephalus. However, we recommend expanding code 331.3, Communicating hydrocephalus, to create a code for this condition

rather than creating code 331.5. This would conserve space in category 331 to allow for future expansion if needed.

The code proposal mentioned several manifestations of normal pressure hydrocephalus, including gait impairment, subcortical dementia, and urinary urgency and incontinence. Clarification will need to be provided as to whether these conditions should be coded separately or are considered integral components of the normal pressure hydrocephalus. If they should be coded separately, perhaps a "use additional code" note should be added. If they are considered integral, clarification in *Coding Clinic for ICD-9-CM* would be helpful.

Counseling for Natural Family Planning
We recommend that NCHS work with the American College of Obstetricians and Gynecologists and other affected specialties to ensure consensus on the proposal and the terminology used in the code descriptions.

Endosseous Dental Implant Failure
AHIMA supports this proposal as presented.

Family History of Sudden Cardiac Death
We recommend that the American College of Cardiology, Heart Rhythm Society, and other relevant specialty societies be contacted for input on this proposal. If these organizations confirm that sudden cardiac death is a clinically distinct condition and that it is generally due to electrical causes and not ischemic heart disease, we recommend deletion of the proposed Excludes note. If they also agree that it is possible to survive an episode of sudden cardiac death, consideration should be given to creating a personal history code as well as a family history code.

Human Herpesvirus Infections, including Human Herpesvirus 6 (HHV-6) Encephalitis
We support the creation of new codes for Human Herpesvirus infections. We prefer option 2 , which splits the codes by clinical condition rather than virus type. Using a structure similar to the acute poliomyelitis codes (category 045) might be considered. Category 045 uses a common fifth-digit subclassification to identify the virus type.

Corticoadrenal Insufficiency Including Hypoaldosteronism
AHIMA supports the proposal to distinguish glucocorticoid deficiency from mineralocorticoid deficiency.

Stevens-Johnson Syndrome
We support the proposed new code for Stevens-Johnson syndrome. It would be helpful to add instructional notes to code also any infection (if still present) and to use an E code to identify the drug (if the condition was due to a reaction to a drug). As suggested during the meeting, an inclusion term for erythema multiforme major should be added under this code.

Long-Term Use of Other Drugs
While we support capturing information on the use of antiestrogen agents, we do not believe that this belongs in subcategory V07.3, Other prophylactic chemotherapy, because the use of these agents is not necessarily "prophylactic." *Coding Clinic for ICD-9-CM* has previously instructed that antiestrogen agents administered to a breast cancer patient are considered treatment of the breast cancer. Only if they

are given to a patient who has never had breast cancer (such as someone with a family history) would they be considered prophylactic.

Secondary Diabetes Mellitus
While we support the creation of new codes for secondary diabetes mellitus that parallel category 250, we believe this proposal should be revisited at the September Coordination and Maintenance Committee in order to refine it before finalization. It was noted during the meeting that steroid-induced diabetes mellitus would be included in the proposed new category for secondary diabetes. However, the proposed code descriptions state "diabetes due to underlying condition," with an instructional note advising that the underlying condition should be coded first. Steroid-induced diabetes is not due to an underlying condition, and therefore, attempting to use the proposed new codes for this type of diabetes would be extremely problematic. Currently, steroid-induced diabetes is indexed to code 251.8, Other specified disorders of pancreatic internal secretion. We recommend that consideration be given to the creation of separate code(s) for steroid-induced diabetes mellitus. We believe it would be advantageous to distinguish steroid-induced diabetes from diabetes due to an underlying medical condition. If that is not possible, it will be necessary to structure proposed category 249 to describe secondary diabetes (rather than diabetes due to an underlying condition) and to revise the "code first" note to clarify that the underlying condition should only be coded first when applicable.

Botulism not Associated with Food Poisoning
AHIMA supports the creation of a new code for botulism not associated with food poisoning.

Vulvar Intraepithelial Neoplasia I and II
We support the creation of unique codes for vulvar intraepithelial neoplasia I and II. An additional code is needed for vulvar dysplasia, unspecified.

Multiple Endocrine Neoplasia
We support the proposal to create new codes for multiple endocrine neoplasia (type I, type IIA, type IIB). However, we oppose classifying genetic susceptibility to multiple endocrine neoplasia to a proposed new code for genetic susceptibility to malignant neoplasms of endocrine glands. Since multiple endocrine neoplasia does not represent a malignant neoplasm, it is not appropriate to classify genetic susceptibility to this condition to proposed code V84.05. Genetic susceptibility to multiple endocrine neoplasia is appropriately classified to code V84.8, Genetic susceptibility to other disease.

Anal Sphincter Tear
AHIMA supports the code proposal for anal sphincter tears in gravid and nongravid patients.

Addenda

We agree with proposed changes with a few minor recommendations:

- "Congestion, chest," should be indexed to code 519.9, Unspecified disease of respiratory system, rather than code 460, Acute nasopharyngitis.
- "Congestion, lungs, due to common cold," should be indexed to code 519.9, Unspecified disease of respiratory system, rather than code 460, Acute nasopharyngitits.
- 'Congestion, nose," should be indexed to code 460, Acute nasopharyngitis, rather than code 478.1, Other diseases of nasal cavity and sinuses.

- Index entry for "long-term (current) drug use, selective estrogen receptor modulators (SERM)" directs users to code V07.39, but this code can only be used for prophylactic administration – we recommend inserting the word "prophylactic" into the index entry.

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