



233 N. Michigan Ave., 21st Fl.
Chicago, IL 60601

phone » (312) 233-1100
fax » (312) 233-1090
web » www.ahima.org

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VIA ELECTRONIC MAIL

Donna Pickett, MPH, RHIA
ICD-10 Coordination and Maintenance Committee
National Center for Health Statistics
3311 Toledo Road
Hyattsville, Maryland 20782

Dear Ms. Pickett:

The American Health Information Management Association (AHIMA) respectfully submits the following comments on the proposed ICD-10-CM code modifications presented at the ICD-10 Coordination and Maintenance (C&M) Committee meeting held on March 5-6.

AHIMA is the national nonprofit association of health information management (HIM) professionals. Serving 52 affiliated component state associations including the District of Columbia and Puerto Rico, AHIMA represents more than 103,000 HIM professionals dedicated to promoting and advocating for best practices and effective standards in health information. AHIMA's credentialed and certified HIM members can be found in more than 40 different employer settings in 120 diverse job functions—consistently ensuring that health information is accurate, timely, complete, and available to patients and providers. AHIMA provides leadership through education and workforce development, as well as thought leadership in continuing HIM research and applied management for health information.

Corneal Dystrophy

AHIMA supports the creation of new codes to capture laterality for corneal dystrophy and corneal transplant complications.

Cough

While we support new codes to distinguish acute, subacute, and chronic cough, we do not believe the duration of the cough should be listed as an inclusion term. Clinical criteria do not belong in ICD-10-CM. Also, these inclusion terms might encourage coding professionals to assume codes may be assigned based on the documented duration of the cough rather than on provider documentation of acute, subacute, or chronic. Additionally, as noted by a physician at the C&M meeting, duration is defined differently in the adult and pediatric populations.

We recommend that the title of proposed new code R05.9 be changed to “Cough, unspecified.” Since duration is not part of the titles of the other new codes for cough, it should not be part of the title of code R05.9.

The inclusion term of “Cough, persistent” under proposed new code R05.3, Chronic cough, might lead to inconsistent data, as some physicians might describe a cough as “persistent” even though it is not clinically defined as a “chronic” cough (e.g., “persistent” cough of five weeks duration).

It is important to note that these new codes for cough would not be reported if the underlying condition is known, per the guideline for signs and symptoms in the ICD-10-CM Official Guidelines for Coding and Reporting.

Dravet Syndrome

We support creation of unique codes for Dravet syndrome.

Drowning/Submersion Occurring in Natural Bodies of Water

AHIMA supports creation of a new subcategory for natural body of water in category Y92, Place of occurrence of the external cause (option 2). Identification of different types of natural bodies of water fits best in the place of occurrence codes, rather than expanding category W69, Accidental drowning and submersion while in natural water.

We recommend that the term “natural” be more clearly-defined in the final set of codes (or a different term used instead). Are man-made bodies of water, such as man-made lakes or ponds, included in these new codes? “Open sea” also needs to be defined. How far out from shore is considered “open sea?” We also recommend adding inclusion terms under the new codes to provide examples of the different types of bodies of water.

Code Y92.878, Other natural body of water as the place of occurrence of the external cause, should be created as well, to capture natural bodies of water not clearly classified to one of the other codes. Examples of other types of bodies of water include strait, channel, sound, gulf, and inlet.

A default code should be designated for “ocean water, NOS” for those instances when the place of occurrence is known to be an ocean, but it is unknown whether the location is open sea, ocean bay, or oceanfront water.

Elevated Liver Enzymes

We support the creation of unique codes for elevation of levels of liver transaminase and lactic acid dehydrogenase.

We recommend the title of proposed new code R74.01 be changed to “Elevation of levels of transaminase” to be consistent with the title of subcategory R74.0.

Esophagitis with Bleeding

We support new codes to identify esophagitis with bleeding, with one modification. Proposed code K20.1, Esophagitis with bleeding, does not appear to be necessary, as it overlaps proposed codes K20.81, Other esophagitis with bleeding, and K20.91, Esophagitis, unspecified with bleeding. **We recommend deleting code K20.1.**

An inclusion term for “Other esophagitis NOS” should be added under proposed new code K20.80, Other esophagitis without bleeding, in order to designate this code as the default when the presence or absence of bleeding is not specified.

Granulomatous Mastitis

AHIMA supports creation of new codes for granulomatous mastitis.

Since specifying laterality is felt to be important for granulomatous mastitis, consideration should be given to expanding the existing codes in N61, Inflammatory disorders of breast, to capture laterality. This would ensure consistency across the code structure in this category.

Immunodeficiency Status

We believe the proposal for new codes for immunodeficiency still requires significant modifications before being implemented. Therefore, we recommend that this proposal be brought back to a future C&M to ensure all of the remaining issues have been addressed.

Our recommended modifications primarily impact instructional notes. “If known” should be deleted from the “Code first” note under proposed new code D84.81, as the title of this code is “Immunodeficiency due to conditions classified elsewhere.” In order to be classified to this code, it is necessary to know there is an underlying condition. It seems unlikely that one would know the immunodeficiency was caused by an underlying condition, but not know what that condition is.

“Acquired absence of spleen (Z90.81)” and “congenital absence and malformations of spleen (Q89.0)” should be deleted from the “Code first” note under code D84.81, as these codes cannot be sequenced as the principal or first-listed diagnosis.

We recommend changing the Excludes2 note under proposed new code D84.821, Immunodeficiency due to drugs, to a “Use additional code” note that states “Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5.” While immunodeficiency due to immunosuppressant drugs should not be coded as an adverse effect, immunodeficiency caused by a drug aimed at treating the underlying disease should be coded as an adverse effect, as stated in the Third Quarter 2015 issue of *Coding Clinic for ICD-10-CM/PCS*.

The “Code also” note under code D84.821 is incorrect and the intent of this note is unclear. We recommend either deleting this note or changing it to “Use additional code, if applicable, for associated long-term (current) drug therapy (Z79.-).” Neither subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy, nor category Z79, Long-term (current) drug therapy, is a means to “code also drug or medication” causing immunodeficiency. Code Z51.1 may only be used when the reason for admission/encounter is solely for the purpose of administering chemotherapy or immunotherapy for a neoplastic condition, so it should not be reported in conjunction with code D84.821. Category Z79 indicates a patient’s continuous use of a prescribed drug for the long-term treatment of a condition or for prophylactic use and thus might be appropriately reported in conjunction with D84.821. However, as noted above, the correct instructional note referencing codes in Z79 is a “Use additional code” note.

The “Code also” note under code D84.822 should be changed to a “Use additional code” note, as external cause codes can never be sequenced as the principal or first-listed diagnosis code.

Since the title of proposed new code D84.822 is “Immunodeficiency due to external causes,” category Z77, Other contact with and (suspected) exposures hazardous to health, should not be included in the “Code also” note under code D84.822 because it is not an external cause code category.

“Encounter for antineoplastic radiation therapy (Z51.0)” should be deleted from the “Code also external cause” note under proposed new code D84.822, Immunodeficiency due to external causes, as this code is not an external cause code. The appropriate external cause code to add to the “Code also” note is Y84.2, Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure.

Joint-Related Disorders

AHIMA supports the proposed expansion of codes for joint-related disorders, with the exception of proposed sub-subcategory M26.66, Disorder of ligament of temporomandibular joint. It is not clear if or how this condition would be documented in order to appropriately assign codes in this sub-subcategory.

Juvenile Osteochondrosis of Tibia and Fibula

We support the proposed code modifications to better distinguish Blount and Osgood-Schlatter diseases.

“Tibia vara” should be retained as an inclusion term under subcategory M92.5, Juvenile osteochondrosis of tibia and fibula [Blount], rather than adding it as an inclusion term under each individual code within this subcategory.

Neonatal Cerebral Infarction

We support creation of a new subcategory for neonatal cerebral infarction.

The code titles should be modified to more clearly reflect the fact that laterality refers to the side of the brain that is affected.

We also recommend that the Excludes1 note for cerebral infarction (I63.-) be revised to specify that cerebral infarctions outside the neonatal period (rather than any cerebral infarction) are classified to category I63.

Consideration should be given to either creating a unique code for personal history of neonatal cerebral infarction in subcategory Z86.7, Personal history of diseases of the circulatory system, or adding an inclusion term for this condition under code Z86.73, Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits.

Ogilvie Syndrome

AHIMA supports creation of a unique code for Ogilvie syndrome.

Acute pseudo-obstruction of intestine should be deleted as an inclusion term under either code K59.81, Ogilvie syndrome, or code K59.89, Other specified functional intestinal disorders, as it appears under both codes in the proposal.

Osteoporosis-Related Pathological Fractures

We support creation of new codes for age-related and other osteoporosis with current pathological fracture, other site.

Other Type of Uterine Scar

We support creation of a unique code for “maternal care for other type scar from previous cesarean delivery” in order to capture a mid-transverse T incision.

Polyps and Angiodysplasia of Jejunum and Ileum

AHIMA supports the proposed new codes for benign neoplasm, polyp, and angiodysplasia of the jejunum and ileum.

Pressure Ulcer of Mucosal Membrane by Site

We support creation of new codes for ulcers of mucosal membranes.

We agree with the suggestion made during the C&M meeting that clarification from the American Academy of Dermatology should be sought regarding whether or not these types of pressure ulcers are staged and, if so, whether codes specifying the stage are needed.

To ensure accurate and consistent coding, we recommend that Excludes2 notes be created to clearly exclude skin ulcers from the new codes for ulcers of mucosal membranes and to exclude the new codes from the skin ulcer (pressure and non-pressure) codes.

Proposed code J34.019, Other ulceration of nose, does not clearly include or exclude skin ulcers of the nose. Currently, non-pressure ulcers of the skin of sites other than the lower limb are classified to subcategory L98.4, Non-pressure chronic ulcer of skin, not elsewhere classified. The title of code J34.019 should be modified if only ulcerations of the nasal mucosa are intended to be classified to this code. If skin ulcers are also intended to be classified to code J34.019, an inclusion term under this code and an Excludes2 note under subcategory L98.4 (as well as appropriate Index entries) are needed to ensure accurate and consistent coding.

Progressive Fibrotic Interstitial Lung Disease

AHIMA supports the proposal for a unique code for interstitial lung disease with progressive fibrotic phenotype in diseases classified elsewhere, as long as the relevant medical specialty societies support this proposal.

Sickle-Cell Disease

We support creation of new codes to capture sickle-cell disorders with certain types of complications.

We recommend that the “Code also” notes under proposed new codes D57.09, D57.218, D57.418, and D57.818 be changed to “Use additional code” notes. Some of the codes identified in these notes have instructional notes requiring the underlying condition to be coded first.

“Fever presenting with conditions classified elsewhere (R50.81)” can be deleted from the “Code also” note under proposed new codes D57.09, D57.218, D57.418, and D57.818, as there is already an instructional note to “Use additional code for any associated fever (R50.81)” at the category level, which applies to all codes in category D57, Sickle-cell disorders.

If a new code for neonatal cerebral infarction is approved, consideration should be given regarding the appropriateness of including this code in the “Code also” note under proposed new codes D57.03, D57.213, D57.413, and D57.813 (sickle-cell disorders with cerebral vascular involvement).

Siogren’s Syndrome

We support the proposed modifications to subcategory M35.0 to update the terminology for Sjogren syndrome and add codes to capture the involvement of additional body systems.

We recommend that an instructional note be added under this subcategory advising to use an additional code to identify the specific manifestations, if known.

We also recommend that the Excludes1 note under code R68.2, Dry mouth, unspecified, be changed from “dry mouth due to sicca syndrome [Sjogren] (M35.0-)” to “dry mouth due to Sjogren’s syndrome (M35.0-)” to be consistent with the updated terminology for this condition.

Substance Abuse with Withdrawal, Alcohol Use Unspecified with Withdrawal, and Cocaine Use Unspecified with Withdrawal

AHIMA supports the proposed modifications to the substance abuse and use codes to capture withdrawal.

A typo in the titles of proposed new subcategory F13.13 and the codes in this subcategory needs to be corrected. The titles should state “abuse” instead of “dependence.”

In addition to adding or modifying Index entries directly related to the code changes outlined in this proposal, a comprehensive review should be undertaken of all Index entries for substance use/abuse/dependence, as there are inconsistencies that lead to different codes depending on the starting point.

Suspected Foreign Body Ingestion

We support creation of new codes for observation for suspected foreign body ruled out.

We recommend creating an additional code in the proposed new subcategory Z03.82 for “Encounter for observation for other suspected foreign body ruled out.”

Babesiosis

We support the proposed expansion of code B60.0, Babesiosis.

The titles of proposed new codes B60.00, Babesiosis, unspecified, and B60.09, Other babesiosis and piroplasmiasis, should be consistent. Since “piroplasmiasis” is an inclusion term under subcategory B60.0, and the other code titles in this subcategory only reference “babesiosis,” perhaps the title of code B60.09 should be changed to “Other babesiosis.”

C3 Glomerulopathy

AHIMA supports the addition of new codes for C3 glomerulopathy.

Eosinophilic Gastrointestinal Diseases

We support the creation of unique codes for specific types of eosinophilic gastrointestinal diseases.

Should the proposed Excludes2 note under code K52.82, Eosinophilic colitis, be an Excludes1 note? Could a patient have both eosinophilic colitis and one of the conditions listed in the Excludes2 note, or are these conditions mutually exclusive?

Food Insecurity

AHIMA supports distinguishing lack of adequate food and safe drinking water, but we are concerned about creating separate codes for lack of adequate food and food insecurity. The distinction between these circumstances is unclear; these concepts may overlap in medical record documentation, and thus inconsistent application of these codes is likely to occur. We recommend that only two codes be created in subcategory Z79.4, Lack of adequate food and safe drinking water—a code for lack of safe drinking water and a single code that combines the concepts of lack of adequate food and food insecurity.

Consideration should be given as to whether the Excludes1 note under subcategory Z59.4, Lack of adequate food and safe drinking water, should be an Excludes2 note, especially for effects of hunger (T73.0) and malnutrition (E40-E46). Lack of adequate food could potentially lead to starvation or malnutrition, and it would be important to be able to capture these concepts in addition to the lack of adequate food.

We support the addition of new codes for counseling for socioeconomic factors and patient’s noncompliance with dietary regimen due to financial hardship. **We recommend that an additional code be created in sub-subcategory Z91.11 for “other and unspecified” noncompliance with dietary regimen**, for those instances when noncompliance is due to a reason other than financial hardship or the reason for noncompliance is unknown.

Glut1 Deficiency

We support the proposed addition of a unique code for Glut1 deficiency.

We suggest adding “G1D” as an inclusion term under the new code, since this term may be how the condition is documented in medical records.

Hepatic Fibrosis

AHIMA supports the proposed expansion of code K74.0, Hepatic fibrosis.

We recommend that the proposed “Code also” note under code K75.81, Nonalcoholic steatohepatitis (NASH), be changed to a “Use additional code” note, since the corresponding instructional note under subcategory K74.0 is a “Code first” note.

Hypereosinophilic Syndromes

We support the addition of a new subcategory for hypereosinophilic syndromes.

It is not clear why the new subcategory is being created at D72.A when there is plenty of available space in category D72. Why wasn't D72.2 proposed for hypereosinophilic syndromes instead of D72.A?

The proposed new Excludes1 note under code D72.1, Eosinophilia, should include the acronym (i.e., Hypereosinophilic syndromes [HES]).

We recommend that the National Center for Health Statistics (NCHS) consider establishing criteria to provide guidance regarding the circumstances under which new codes should be created for rare conditions, as a number of code proposals involving rare conditions have been presented at recent C&M meetings. Without a set of criteria, it is difficult to apply a consistent approach in assessing code proposals for rare conditions, including an evaluation of the value of unique codes or the extent to which these codes will likely be used.

Intracranial Hypertension

We support creation of new codes for intracranial hypotension, cerebrospinal fluid leak, and headache with orthostatic component.

As suggested by a C&M meeting attendee, we recommend splitting proposed code G96.09, Other cerebrospinal fluid leak, into separate codes for “other cranial cerebrospinal fluid leak” and “other spinal cerebrospinal fluid leak.”

Other Eosinophil Diseases

We support creation of a unique code for drug rash with eosinophilia and systemic symptoms syndrome (DRESS syndrome). However, it is not clear why the new subcategory is being created at D72.B when there is plenty of available space in category D72. Why wasn't D72.3 proposed for DRESS syndrome instead of D72.B?

We **do not support** creation of a new code for eosinophilic granulomatosis with polyangiitis (EGPA). It is inappropriate to create a new code simply because the World Health Organization title of an existing code cannot be changed. We recommend that eosinophilic granulomatosis with polyangiitis [EGPA] be added as an inclusion term under existing code M30.1, Polyarteritis with lung involvement [Churg-Strauss], as EGPA is simply an updated term for this condition.

Pulmonary Eosinophilic Diseases

AHIMA supports creation of a new subcategory for pulmonary eosinophilia. However, it is not clear why the new subcategory is being created at J82.X when there is plenty of space to expand code J82. Why wasn't J82.1 proposed for the new subcategory instead of J82.X?

If the new codes for pulmonary eosinophilic diseases are approved, the code numbers in the proposed new Excludes2 notes under code D72.1, Eosinophilia, should be “J82.-.”

Temperature-Sensitive Acquired Autoimmune Hemolytic Anemias

We support the addition of codes for temperature-sensitive acquired autoimmune hemolytic anemias.

Social Determinants of Health

AHIMA believes it is premature to create new codes for social determinants of health (SDHs) until the terminology has been better standardized and consensus-based definitions have been developed. While we appreciate the importance of collecting standardized data on SDHs, ambiguity of code titles and lack of consensus on SDH terminology or definitions would result in inconsistent use of the proposed codes and non-comparable data. Consensus also needs to be achieved on the SDH information that would be most useful for coded data to capture.

We recommend that approval of new codes for SDHs be delayed until the work of the Gravity Project is completed, as we believe this project will lay the necessary foundation for development of new ICD-10-CM codes for SDHs. The Gravity Project is a national collaborative effort launched by the Social Interventions Research and Evaluation Network (SIREN) to advance interoperable social risk and protective factors documentation. Goals the project aims to accomplish by the end of this year include: development of use cases to support documentation for screening, diagnosis, treatment, and population health management activities within electronic health records (EHRs) and related systems; identification of common data elements and their associated value sets to support the use cases; and development of a consensus-based set of recommendations on how best to capture and group these data elements for interoperable electronic exchange and aggregation.

We are concerned that SDH information is often not documented in patients’ medical records, especially in the outpatient setting. In particular, highest educational level achieved is often not documented. The distinction between “unemployed and seeking work” and “unemployed but not seeking work” is also unlikely to be documented. Even when SDH information is documented, it is often difficult to find, as it may be captured in a variety of different places within the EHR. Also, even when a patient’s SDH data is documented and shared across multiple encounters and healthcare settings, this information will need to be validated at each patient encounter to ensure it is still accurate, as social circumstances can change.

How and when new SDH codes should be reported needs to be addressed. Where and when (which encounter record) will a code be reported to identify the reason why the patient failed to obtain a particular medical service (e.g., failure to have a mammogram performed because of lack of transportation)? Also, the potential for multiple SDH codes to be applicable for a single patient is significant (e.g., the patient may be unable to pay for any of the items described by the proposed new codes in subcategory Z59.6, Low income), resulting in a long list of SDH codes being reported in conjunction with the codes for the patient’s medical condition.

There are several potential issues with the proposed new codes for “unemployed” and “employed” in subcategory Z56.8, Other problems related to employment. For example, since every patient is

either employed or unemployed, is the intent that one of the proposed new codes in subcategory Z56.8 be reported for every patient? How is proposed new code Z56.86, Employed full-time, a “problem” related to employment?

How would this code proposal address collection of coded SDH information in the pediatric population? ICD-10-CM codes apply directly to the patient for whom they are being reported. In the case of a pediatric patient, it is the parent or guardian, not the patient, who is unemployed or unable to pay for certain items or services.

Proposed new codes in subcategory Z60.8, Other problems related to social environment, are particularly ill-defined. What is the definition of a “social interaction?” How are “stressed quite a bit or very much,” “stressed somewhat,” and “can hardly ever count on family and friends in times of trouble” defined? And are these codes intended to be based on the patient’s description of his stress level or the provider’s assessment? What is the time frame for the social issues described by these codes? Stress levels vary day to day. For most patients, being sick or injured and under treatment in a healthcare setting is stressful.

Potential duplication or overlap with existing codes needs to be addressed. For example, these existing codes appear to overlap with some of the proposed new codes:

- Z56.3, Stressful work schedule;
- Z56.6, Other physical and mental strain related to work;
- Z59.7, Insufficient social insurance and welfare support;
- Z60.2, Problems related to living alone;
- Z60.4, Social exclusion and rejection;
- Z53.71, Stress on family due to return of family member from military deployment;
- Z63.79, Other stressful life events affecting family and household;
- Z63.8, Other specified problems related to primary support group;
- Z63.9, Problem related to primary support group, unspecified;
- Z73.0, Burnout;
- Z73.3, Stress, not elsewhere classified;
- Z73.4, Inadequate social skills, not elsewhere classified; and
- Z74.2, Need for assistance at home and no other household member able to render care.

If the proposal for expansion of code Z59.6, Low income, is approved, an additional code for “Low income, unspecified” should be created, for those instances when the items or services the patient is unable to pay for are unknown or not documented.

AHIMA believes the collection of ICD-10-CM-coded SDH data can play an important role in improving population health management, developing community services, identifying regional variations, and refining care delivery and payment models. We look forward to working with NCHS and other stakeholders on addressing the issues noted above so that coded SDH data is accurate and consistent.

ICD-10-CM Addenda

AHIMA offers the following recommendations regarding the proposed Addenda modifications:

Tabular Addenda

We recommend that the proposed revision of the title of code Q51.28 be changed to “Other and unspecified doubling of uterus.”

Index Addenda**Abscess, presacral K65.1**

The correct code for a presacral abscess is K68.19, per the First Quarter 2019 issue of *Coding Clinic for ICD-10-CM/PCS*.

Arthritis, cervical M47.812

Existing Index entries under “Arthritis, spine” and “Arthritis, vertebral” direct users to “see Spondylopathy, inflammatory.” The Index entry for “spondylopathy, inflammatory, cervical region” directs users to code M46.92, which is different than the proposed new Index entry for “Arthritis, cervical.” Index entries for “Arthritis, cervical,” “Arthritis, spine,” and “Arthritis, vertebral” should be consistent. If a diagnosis of “arthritis” of the spine should be classified to category M47 instead of M46, the existing Index entries should be modified.

Additionally, there are no existing Index entries for “Arthritis, thoracic” or “Arthritis, lumbar.” We recommend that Index entries be added for these sites as well as for the cervical region.

Elevated, elevation, troponin R77.8

The correct code for elevated troponin is R79.89. Per the discussion at the February 2019 meeting of the *Coding Clinic for ICD-10-CM/PCS* Editorial Advisory Board, troponin is a structural muscle protein, not a plasma protein.

Emaciation (due to malnutrition) ~~E41~~ E43

The Third Quarter 2017 issue of *Coding Clinic for ICD-10-CM/PCS* stated that code R64, Cachexia, should be assigned for emaciation that is not documented as due to malnutrition. Retaining the nonessential modifier “due to malnutrition” in the Index entry will continue to result in incorrect coding, since it suggests that any diagnosis of emaciation, regardless of whether or not it is due to malnutrition, is classified to E43. We recommend that the following modifications be made to this Index entry in order to clarify that code R64 should be assigned for emaciation that is not due to malnutrition:

Emaciation (~~due to malnutrition~~) ~~E41~~ E43 R64
- due to malnutrition E43

Fistula, bile duct, with calculus, stones, with cholecystitis, with obstruction K80.41

We **do not support** adding this Index entry. It would increase confusion regarding the appropriateness of assigning separate codes for both the fistula and obstruction. Per the First Quarter 2019 issue of *Coding Clinic for ICD-10-CM/PCS*, both codes K80.41, Calculus of bile

duct with cholecystitis, unspecified, with obstruction, and K83.3, Fistula of bile duct, may be assigned when these conditions are present. The proposed Index entry suggests that no separate code to capture the fistula should be assigned.

Infection, intrauterine inflammation O41.12

We recommend that this Index entry either be modified to specify chorioamnionitis or an additional Index entry be added for non-obstetric infection and inflammation of the uterus. The Index entries for “Infection, uterus” and “Inflammation, uterus,” direct users to “see Endometritis.”

Spondyloarthritis, axial, non-radiographic

Rather than creating new Index entries for each spinal region, we recommend creating a single Index entry that states “Spondyloarthritis, axial, non-radiographic—see Spondylopathy, inflammatory, specified type NEC.” Index entries for each spinal region already exist under this Spondylopathy subterm.

The code numbers for the proposed Index entries should not be listed in parentheses.

Thank you for the opportunity to comment on the proposed ICD-10-CM code modifications. If you have any questions, please feel free to contact Sue Bowman, senior director of coding policy and compliance, at (312) 233-1115 or sue.bowman@ahima.org.

Sincerely,



Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer