American Health Information Management Association®

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VIA ELECTRONIC MAIL

Donna Pickett, MPH, RHIA
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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 ICD-9-CM Coordination and Maintenance (C&M) Committee meeting held on September 27-28.

**Retrolental Fibroplasia (Retinopathy of Prematurity)**

Although AHIMA supports the creation of new codes for retinopathy of prematurity, we question whether each stage requires its own unique code. Consideration should be given to grouping some of the stages together and creating fewer codes. This would allow conservation of space in subcategory 362.2, Other proliferative retinopathy, in case there is a need to create additional codes in this subcategory in the future.

We support the suggestion that the title of code 362.21 should be changed to "cicatricial retinopathy of prematurity," since "retrolental fibroplasia" is an outdated term. "Retrolental fibroplasia" should be retained as index and inclusion terms.

If there are additional terms that equate to the stages of retinopathy of prematurity, they should be added as index and inclusion terms, in case the physician uses different terminology than the stage number.

**Necrotizing Enterocolitis**

We support the proposal to create new codes for necrotizing enterocolitis that are differentiated by the presence of pneumatosis and perforation. The title of proposed new code 777.50 should state "Necrotizing enterocolitis in fetus or newborn without pneumatosis or perforation."

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We do not agree with the suggestion to create codes that distinguish necrotizing enterocolitis by stage, due to concerns that the documentation may not identify the stage.

**Disruption of Operation Wound**

AHIMA supports the proposed changes to subcategory 998.3, Disruption of operation wound, to clarify internal and external operation wounds. The word "unspecified" should be added to the code title of proposed new code 998.30, Disruption of operation wound. An Excludes note for anastomotic leak should be added under code 998.31, Disruption of internal operation wound. The inclusion term of "full-thickness or deep disruption or dehiscence" under code 998.31 needs to be clarified, as it is not clear what this is referring to.

**Neuroendocrine Tumors**

Due to the number of questions and issues that arose during the C&M meeting, AHIMA recommends that a revised proposal be brought back to the next C&M meeting. As part of this revised proposal, the distinctions of foregut, midgut, and hindgut should not be used, as these terms are not typically found in medical record documentation.

**Eosinophilic Gastrointestinal Disorders**

We support the revised version of the proposal for new codes for eosinophilic gastrointestinal disorders that was posted following the September C&M meeting.

**Heparin-Induced Thrombocytopenia**

We support the proposal to add a new code for heparin-induced thrombocytopenia, and we agree with the suggestion that a note should be added under this new code to indicate that an External Cause code should also be assigned for the drug. An article about this condition should be published in *Coding Clinic for ICD-9-CM* to explain why it belongs in category 289 rather than 287 (since the code for secondary thrombocytopenia is in category 287).

**Extravasation of Vesicant Chemotherapy**

AHIMA supports the creation of a new code for extravasation of vesicant drugs, but we agree with the suggestion that the code should be broad enough to encompass all drugs that cause injury with extravasation, rather than being limited to chemotherapy drugs. We also recommend that the new code be created under 999.9 instead of 999.2, since this is not a vascular complication. We believe extravasation of vesicant drugs fits better under code 999.9 than 999.8.

**Pressure [Decubitus] Ulcer Staging**

AHIMA supports the creation of unique codes to capture the stage of a decubitus ulcer. We recognize that because of the limitations of ICD-9-CM, the best option is to create a separate subcategory for the stage.

Due to space constraints, it is not possible to mirror ICD-10-CM and capture the site and stage in a single code.

It was suggested during the meeting that the title of the new subcategory should be changed to "Pressure [decubitus] ulcer stages." However, the title should not be changed unless the title of subcategory 707.0 is also changed. The titles of these two subcategories should match.

Coding guidelines will need to address how to handle ulcers that progress from one stage to another during a hospitalization. Official guidance will also need to be given as to whether non-physician documentation can be used to identify the stage for coding purposes, since this information is typically found in the nursing, and not the physician, documentation. Additionally, guidance will need to be provided on how a "healed" decubitus ulcer should be coded, as well as the coding of ulcers involving deep tissue injury.

**Ventilator-Associated Pneumonia**

AHIMA supports the creation of a unique code for ventilator-associated pneumonia. An Excludes note should be added under code 999.9 to refer people to the new code.

**Acanthamoeba Keratitis/Fusarium Keratitis**

We support the proposed new code and other tabular changes in order to properly code acanthamoeba keratitis and fusarium keratitis.

**Lipid Rich Plaque**

Although AHIMA has no objections to creating a code for coronary atherosclerosis due to lipid rich plaque, we question whether this information will be frequently documented.

**Long-Term Current Use of Methadone**

Since subcategory V58.6 is almost full, we prefer option 2, which would involve adding "long term current use of methadone" as an inclusion term under code V58.69 instead of creating a unique code. Guidance would need to be provided (preferably in the form of an instructional note) as to whether a code from category 304, Drug dependence, should also be assigned.

**Wheelchair Dependence**

We are concerned that the proposed code for wheelchair dependence would not adequately provide the information being sought. As noted by commenters at the meeting, wheelchair dependent individuals have varying degrees of mobility. Before implementing this code, further consideration should be given as to whether this code will meet desired data needs and whether there is another way to better capture the risks associated with immobility.

**Nontraumatic Hematoma/Post-traumatic Seroma**

While we support the proposal to create new codes for nontraumatic hematoma of muscle and post-traumatic seroma, consideration should be given as to whether post-traumatic seroma should be coded as a late effect.

**Acquired Absence of Cervix and Uterus**

AHIMA supports the proposed new codes for acquired absence of cervix and uterus, including the placement of these codes in the V code section rather than the genitourinary disorder section. **However, we recommend that the title of proposed new category V88 be changed to "Acquired absence of other organ."** This would allow future expansion in this category for new codes for acquired absence of additional organs.

**Prophylactic Use of Agents Affecting Estrogen Receptors and Estrogen Levels**

AHIMA supports the proposed new codes for prophylactic use of agents affecting estrogen receptors and estrogen levels. The coding guidelines should make it clear that there are circumstances when a current cancer code would be reported with one of these new codes, as is described in the code proposal summary. **It would also be helpful to add "current breast cancer" to the "use additional code" note under proposed new subcategory V07.5.** This would provide further clarification regarding the use of the current cancer codes with the new codes.

**Staged Breast Reconstruction**

We prefer option 2 for the staged breast reconstruction proposal (this option involved the creation of a unique code in category V51, Aftercare involving the use of plastic surgery, for encounter for breast reconstruction following mastectomy). This option is better than option 1 because it provides more specific information as to the reason for the encounter. An encounter for breast reconstruction fits well in the category of aftercare, whereas code V45.71 is a status code and doesn't describe the reason for the encounter. Option 3 is unnecessarily complex. Also, the level of detail in option 3 regarding the specific procedure performed is unnecessary because this information will be captured by the procedure codes.

Another option to consider would be to create a code for encounter for breast reconstruction following mastectomy in subcategory V58.4, Other aftercare following surgery, instead of in category V51. A code for aftercare following surgery for neoplasm already exists in subcategory V58.4. Consideration should be given as to how this code should be used with the proposed new code (regardless of which category the new code is created in). Should code V58.42 be used with the proposed new code, or should it exclude the new code?

We support the creation of new codes for deformity and disproportion of reconstructed breast.

Prior to finalization of the changes outlined in the proposal, feedback should be obtained from the appropriate medical specialty societies to ensure they are in agreement.

**Leukemia in Relapse**

AHIMA has no objection to the proposed changes to the fifth digits for the leukemia codes in order to capture leukemia that has relapsed. However, the fact that the leukemia has relapsed may not be consistently documented. **To clarify that the fifth digit of "0" is the default when there is no mention of remission or relapse, the description of this fifth digit should be revised to read "without mention of being in relapse or having achieved remission."**

**Fever Presenting with Conditions Classified Elsewhere**

We support the creation of new codes for fever presenting with conditions classified elsewhere and postprocedural fever. The Excludes note for fever associated with confirmed infection should appear under subcategory 780.6 rather than under proposed new code 780.62.

**Abnormal Anal Cytologies and Anal Intraepithelial Neoplasia (AIN)**

We support the proposed new codes for abnormal anal cytologies and intraepithelial neoplasia.

**Functional Urinary Incontinence and Functional Quadriplegia**

AHIMA supports the proposed new codes for functional urinary incontinence and functional quadriplegia, but we recommend that Excludes notes be added under the new codes to clarify the conditions for which these codes should not be used. "Code first" notes are also needed under the proposed codes to indicate that the underlying condition should be sequenced first.

**Vulvar Vestibulitis and Other Vulvodynia**

We support the proposed new codes for vulvar vestibulitis and other vulvodynia. **We recommend that the description of proposed code 625.79 be changed to read "Other and unspecified vulvodynia" to clarify the intent and use of this code.**

**External Cause for Overexertion, Strenuous and Repetitive Movements**

While we support the proposal to expand category E927 to capture specific types of overexertion and repetitive movements that can result in injury, the descriptions of the proposed new codes are rather ambiguous, subjective, and potentially overlapping. Clearer descriptions and additional inclusion terms would be helpful to ensure proper and consistent use of the codes. Also, default codes for overexertion and repetitive movements that are not further specified are needed.

**Personal History of Antineoplastic Chemotherapy and Monoclonal Drug Therapy**

We support the proposal regarding new codes for personal history of antineoplastic chemotherapy and monoclonal drug therapy, but agree with the comments made during the meeting that the proposed new subcategory should be expanded to include other types of drugs, so that it is not limited to antineoplastic drugs.

**Contact with and Exposure to Mold**

AHIMA supports the proposed new code for contact with and exposure to mold.

**Suspected Fetal Conditions Not Found and Antenatal Screening**

While we support the intent of the proposal for suspected fetal conditions not found, we believe that the proposed new category could be confusing and that extensive guidance and instructional notes regarding the proper use of this category would need to be provided. Issues that need to be addressed include:

- Is proposed category V89 intended to be used when the patient has signs or symptoms, or is it intended to be comparable to category V71? If is it intended to be comparable to category V71, an Excludes note should be added under category V71 and an instructional note similar to the one under this category should be added under category V89 (to explain when codes in this category should be used).
- If codes from category V89 can be used when the patient has signs or symptoms, should the signs and symptoms also be coded?
- What is the difference between category V89 and screening codes? Can V89 codes be used in conjunction with screening codes?
- Should codes from V89 only be used when the reason for the encounter is to test for the suspected condition? Or can they be used as secondary codes for encounters for other reasons to indicate that at some point in the pregnancy, a condition was suspected, but found not to exist? If V89 codes can only be used when the reason for the encounter is for testing for the suspected condition, should the category title be changed to state "Encounter for evaluation of suspected fetal conditions not found?"
- It is not clear how category 656 fits with category V89, particularly with the proposed modification to add "known or suspected" to the code title. The proposal indicates that known or suspected fetal anomalies affecting management of mother, not ruled out (category 655) are excluded from proposed new category V89, but does not mention the conditions classifiable to category 656.
- Code V28.3 needs to be excluded from categories 655, 656, and V89.
- Modifications to categories 655 and 656 need to be made to clarify that these categories are for known or suspected fetal anomalies and fetal and placental problems that have not been ruled out, whereas category V89 is for suspected fetal conditions that have been ruled out.
- There is still potential overlap and confusion between categories 655/656 and V89. The proposed Excludes note under category V89 appears to make a distinction between suspected conditions that have been ruled out (category V89) and those that have not been ruled out (category 655). However, this distinction is not made in the code descriptions. The title of category V89 states "not found," but this terminology is not the same as "ruled out." "Not found" can mean that the test(s) performed during this encounter did not establish the condition. But what if the physician is still not sure that the condition can be ruled out and orders additional tests for a future encounter?

Given the number of unanswered questions and lack of clarity with regard to the proper use of category V89 and its relationship with other ICD-9-CM codes, **we recommend that a revised proposal**

**(containing appropriate instructional and Excludes notes) be brought back to the March C&M Committee prior to implementing these new codes.**

**Cervical Shortening**

AHIMA supports the proposed new code for cervical shortening.

**Secondary Diabetes Mellitus**

We support the proposal to create a new category for secondary diabetes mellitus. This proposal is a much-improved version over previous proposals. We also support the Endocrine Society's recommendation to include fifth digits for "controlled" and "uncontrolled." This distinction between "controlled" and "uncontrolled" diabetes is commonly documented by physicians and is used to justify the need for a hospital admission. As with category 250, determination of the appropriate fifth digit to assign should continue to be based on physician documentation.

**Newborn Post-Discharge Health Check**

AHIMA supports the proposed new codes for routine newborn health checks. Based on comments made by the American Academy of Pediatrics during the meeting, it is our understanding that the proposed codes will be revised to state "96 hours" instead of "72 hours."

**Androgen Insensitivity Syndromes**

We support the proposal to create new codes for androgen insensitivity syndrome. **We recommend that the word "complete" be added to the title of proposed code 259.51 to clearly differentiate it from code 259.52.** This would also make the wording of the two code descriptions more consistent.

**Hungry Bone Syndrome**

We support the proposed new code for hungry bone syndrome.

**Isolated Systolic and Diastolic Hypertension**

**AHIMA opposes the proposal to create new codes for isolated systolic and diastolic hypertension (we do not support either option that was presented).** As was noted by commenters during the meeting, the terms used in the proposed codes are not typically documented by physicians. The use of the term "isolated" could be confused with an isolated elevated blood pressure reading. Also, since this proposal came from a chapter of a hypertension organization, it would be important to obtain input from other medical specialty societies involved in the treatment of hypertension before finalizing any new codes for hypertension.

## Addenda

We support the proposed addenda revisions, including the following recommendations made during the meeting:

- Delay creation of an index entry for "cognitive deficit" until the Academy of Neurology's forthcoming related code proposal is considered;
- Consider making a distinction between "premature" and "routine" end of life of devices;
- Consider adding index entries for end of life or worn out defibrillators and neurostimulators;
- The proposed index entry for "Twiddler's" should read "Twiddler's syndrome;"
- The proposed index entries for "Vaccination, delayed" and "Delay, vaccination" should default to the unspecified code (V64.00), and additional subentries should be created for codes V64.00-V64.07 and V64.09.

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