



November 9, 2009

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) respectfully submits the following comments on the proposed diagnosis code modifications presented at the ICD-9-CM Coordination and Maintenance (C&M) Committee meeting held on September 24-25.

Multiple Gestation Placenta Status

AHIMA supports the proposed codes for multiple gestations. We agree that instructions will be needed to ensure appropriate assignment of these codes, including instructions on how the number of fetuses in a multiple gestation should be classified when one or more of the fetuses has died or there has been a selective reduction. We look forward to participating in the development of the content of these instructions.

Hemolytic Transfusion Reactions (HTR)

We support the proposed new codes for hemolytic transfusion reactions. We also agree with the suggestion that the inclusion term under existing code 999.89, Transfusion reaction NOS, should be moved to proposed new code 999.80, Transfusion reaction, unspecified. Consideration should be given to the appropriate placement of the "use additional code" note under code 999.80, and whether this note belongs under multiple codes if the proposed code expansion for transfusion reactions is approved.

We agree with the suggestion that instructional notes should be added that make it clear that code 780.62, Postprocedural fever, should not be assigned in addition to the codes for hemolytic transfusion reactions.

Transfusion Transmitted Infections

In light of extensive comments at the C&M meeting, AHIMA has serious concerns about the proposed new code for transfusion transmitted infections. This code could result in a great deal of confusion, particularly with regard to sequencing and how long the code can continue to be assigned. As noted at the meeting, sequencing the code for the specific infection after the proposed code for transfusion transmitted infections would go against the coding guidelines for sequencing HIV codes. Also, questions were raised about the appropriate assignment and sequencing of the proposed code when the associated condition develops a long time after the transfusion.

In addition, NCHS commented that since there are medicolegal implications of introducing this code, consideration should be made regarding whether or not to code probable/possible cases. We are very concerned by this statement. The official coding guidelines currently stipulate that, for inpatient admissions, diagnoses documented at the time of discharge as “probable,” or “possible” should be coded as if they were established. The only exceptions are HIV, avian and H1N1 influenza. We would be concerned about setting a precedent by allowing medicolegal implications to be used as a criterion for making exceptions to this guideline, since there are many conditions that may have medicolegal implications.

Rather than creating a unique code for transfusion transmitted infections, we prefer the alternative suggestion of identifying these conditions through the assignment of an infection code in conjunction with an external cause code for blood products.

Febrile Nonhemolytic Transfusion Reaction (FNHTR)

Although we support the proposed new code for febrile nonhemolytic transfusion reaction, our members have told us that febrile transfusion reaction is often not documented as such. It is usually documented as just “transfusion reaction.” This means that many of these cases will be coded as unspecified transfusion reaction instead of being classified to the new code.

We would prefer that the proposed code for febrile nonhemolytic transfusion reaction be located in subcategory 780.6, Fever and other physiologic disturbances of temperature regulation, rather than subcategory 999.8, Other infusion and transfusion reaction.

Post Transfusion Purpura (PTP)

AHIMA supports the creation of a unique code for posttransfusion purpura.

Transfusion Associated Circulatory Overload (TACO)

We support the proposed new code for transfusion associated circulatory overload. Instructions will be needed regarding code sequencing when this code is reported with other associated conditions, such as heart failure. Also, our members have indicated that TACO is often not

specifically documented. Instead, “exacerbation of congestive heart failure associated with transfusion” might be documented. How would this diagnosis be coded (when TACO is not specifically mentioned)?

Transfusion-Associated Hemochromatosis

While we support creation of a new code for transfusion-associated hemochromatosis, the proposed code title “hemochromatosis due to repeated blood cell transfusions” will result in confusion as to when the code should be assigned and what documentation necessary to support code assignment. The proposed code title should be changed to “transfusion associated hemochromatosis.” Physicians are more likely to link the hemochromatosis to the administration of transfusions than to document “repeated” transfusions. The term “repeated” will lead to questions as to how many transfusions should be documented in order to use this code.

We agree with the recommendation to add “iron overload due to chronic transfusions” as an inclusion term under the proposed new code.

Stuttering

AHIMA supports the proposed new code for childhood onset stuttering disorder. We also agree with the suggestion that the title of code 307.0 should be revised to state “adult onset stuttering” rather than “stuttering with onset after puberty.”

A default code will need to be designated in the index for those instances when it is not documented whether it is childhood or adult onset.

The Excludes note for stuttering (fluency disorder) due to late effect of cerebrovascular accident under the proposed new code should also be added under code 307.0.

Stuttering associated with traumatic brain injury or neurological conditions should be classified to code 784.59, Other speech disturbance.

Multiple Sclerosis

While AHIMA opposes the specific code proposal presented at the meeting regarding the expansion of the multiple sclerosis code (on the basis of information from the American Academy of Neurology indicating that the clinical classification of multiple sclerosis is changing), **we do support the recommendation to create unique codes for multiple sclerosis with and without acute exacerbation.**

Neurogenic Claudication

The proposal to create new codes to differentiate spinal stenosis of the lumbar region with and without neurogenic claudication should be referred to the American Academy of Orthopedic Surgeons for review. If they support the proposal, AHIMA would support it as well.

Acquired Absence of Pancreas

We support the proposal to create a unique code for acquired absence of pancreas. However, we do not believe it is necessary to distinguish between partial and total absence of pancreas. We recommend that just one code be created.

Do Not Resuscitate

While we have no objection to creating a unique code for “do not resuscitate status,” we question whether this code will be used consistently. Also, with the growing prevalence of electronic health records, this information will likely be captured electronically, rendering the need for an ICD-9-CM code unnecessary. Capturing this information electronically is a much more accurate, efficient, and cost-effective approach than requiring a coder to manually assign a code.

If the proposed code for “do not resuscitate status” is approved, the official coding guidelines should stipulate the documentation (i.e., physician order) that must be present in the medical record for the current encounter in order to assign the code. Also, a patient’s do not resuscitate status may change during a hospital stay. If the proposed code is approved, guidance will be needed on the use of this code in these instances.

Physical Restraints

Similar to our comments above concerning a proposed code for “do not resuscitate status,” we question whether this code will be used consistently, and we believe this information will most likely be captured in electronic health record systems, negating the possible usefulness of an ICD-9-CM code. Capturing this information electronically is a much more accurate, efficient, and cost-effective approach than requiring a coder to manually assign a code.

We question the value of the addition of physical restraint code, as the current proposed structure does not offer any link to the diagnosis, risk or severity of the patient in relationship to when the restraints were applied. The proposed code does not offer any linkage that would meet the goal of capturing the risk that would result in any meaningful conclusions.

Also, physical restraint status may change during a hospital stay. If the proposed code is approved, guidance will be needed on the use of this code in these instances.

Combat Operational Stress Reaction (COSR)

We support the proposed code for personal history of combat and operational stress reaction.

Regarding the proposed addition of an inclusion term for “combat and operational stress reaction” under category 308, Acute reaction to stress, consideration should be given to whether this inclusion term should state “acute combat and operational stress reaction,” with chronic combat and operational stress reaction classified to code 309.81, Posttraumatic stress disorder. If NCHS agrees, “chronic combat and operational stress reaction” should be added as an inclusion term under code 309.81.

Neurofibromatosis – Schwannomatosis

AHIMA supports the creation of specific codes for Schwannomatosis and other neurofibromatosis.

Mesh Erosion/Mesh Exposure

As also expressed by attendees at the C&M meeting, we are concerned that the terms “mesh erosion” and “mesh exposure” may be used interchangeably. We are also concerned that these terms may not be used consistently across surgical specialties. The proposed new codes are generic and could be used by any specialty, but opinions on the merits of the proposals were not sought from specialty societies other than the American College of Obstetricians and Gynecologists.

Lacking input on the consistent use and interpretation of these terms by non-gynecological specialties, we would not recommend creating a new code at this time. Until such time that the affected medical specialties can agree on a common use and interpretation of these terms, we recommend that mesh erosion and mesh exposure continue to be classified to existing complication codes. We recommend the addition of inclusion terms for mesh exposure and erosion under subcategory 996.7, Other complications of internal (biological) (synthetic) prosthetic device, implant, and graft, and for infection due to mesh under subcategory 996.6, Infection and inflammatory reaction due to internal prosthetic device, implant, and graft. Appropriate index entries should also be added.

Obesity Hypoventilation Syndrome (Pickwickian Syndrome)

AHIMA supports the creation of a unique code for obesity hypoventilation syndrome. Instructional notes should be added to provide sequencing instructions for respiratory and other associated conditions.

Instructions should also be provided as to whether the appropriate obesity code (278.01, Morbid obesity or 278.02, Overweight) should be assigned in conjunction with the code for obesity hypoventilation syndrome, when this information is documented.

Heart Failure Terms Related to Systolic Function

We support the proposed revisions to the heart failure codes with the condition that guidance is provided clarifying that the inclusion terms must be stated by the physician in order to rely on these terms for coding purposes.

High Cardiac Output Heart Failure

We support the proposed new code for high cardiac output heart failure.

Encounters for Insertion, Checking, or Removal of Intrauterine Contraceptive Device

We support the proposed modifications to better classify encounters for intrauterine contraceptive device insertion and removal as well as the additional modifications suggested at the meeting (removal of “incidental finding” from the proposed excludes note under code V25.42 and the addition of a code for “removal with immediate reinsertion of intrauterine contraceptive device”).

External Cause Status

We **oppose** the proposed addition of the word “legal” in the inclusion term under code E000.0, Civilian activity done for financial or other compensation. The addition of this word could potentially cause greater confusion rather than provide clarification. To address issues such as whether this code applies to activities such as bank robberies, perhaps question(s) could be published in *Coding Clinic for ICD-9-CM*.

Regarding the proposed inclusion term under code E000.8, Other external cause status, we recommend that examples be provided (in a “such as” format) to provide clarification, since the inclusion term by itself is not entirely clear as to the types of situations it is intended to refer to. In fact, we recommend that common examples be provided under all of the codes in category E000. The examples discussed at the C&M meeting were helpful in providing clarification as to the appropriate use of each of the codes in this category. It would be preferable to list these examples as part of the inclusion terms under the codes rather than just publishing them in *Coding Clinic for ICD-9-CM*. Additional clarification regarding the application of these codes should be provided through Q&As in *Coding Clinic*.

Heat Illness (Heat Exhaustion, Heat Injury, and Heat Stroke)

The proposed new code for heat injury should not be implemented at this time. As suggested at the meeting, input is needed from a number of specialty societies. Concerns were expressed that this term is not commonly used in the civilian environment. And the US Army definition of this term should not be added to the classification since it is not a universally accepted definition.

Retained Foreign Bodies

We agree with the suggestion made during the meeting that the proposed code for “personal history of retained foreign body fully removed” fits better in subcategory V15.5, Personal history of injury, than in subcategory V87.3, Contact with and (suspected) exposure to other potentially hazardous substances.

We support the creation of a new category for retained foreign body status, but question whether the level of specificity in identifying the type of embedded material outlined in the proposal is necessary. Perhaps some of the proposed codes could be collapsed into somewhat broader codes that would still capture sufficient specificity.

We agree with the suggestion that the word “nontherapeutic” should be added to the title of proposed subcategory V90.0, Retained radioactive and depleted isotope fragment status.

We also agree with the comments indicating that guidance is needed on the definition of the term “retained” in ICD-9-CM.

Homicidal Ideations

AHIMA supports the proposed new code for homicidal ideations.

Should the word “ideations” be singular or plural? It is singular in existing code V62.84, Suicidal ideation, and plural in the proposed code V62.85, Homicidal ideations. We recommend that the code titles should be consistent. If “ideations” is more accurate, the title of code V62.84 should be revised for consistency.

Long-Term Use Versus Prophylactic Use of Medications

We support the proposed modifications to category V07, Need for isolation and other prophylactic measures, to make it clear that certain codes in this category may be used for any long-term use of certain agents, whether they are being use prophylactically or as part of an active treatment plan.

For clarity, the title of subcategory V07.5 should be revised to specify that these codes are for long-term use of agents affecting estrogen receptors and estrogen levels for prophylaxis or treatment.

We agree with the comment that “long-term” should not be a non-essential modifier in index entries for codes in subcategory V58.6, Long-term (current) drug use. The use of the drug must be long-term in order to appropriately assign a code from subcategory V58.6.

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Jaw Pain

We support creation of a unique code for jaw pain. However, we disagree with the suggestion made during the meeting that the new code should be located in category 526, Diseases of the jaws. We prefer the original proposal, which would locate the new code in subcategory 784.9, Other symptoms involving head and neck. Although jaw pain is currently indexed to code 526.9, Unspecified disease of the jaw, it does not belong in this category because this symptom does not necessarily represent a disease of the jaws. As noted at the C&M meeting, it may be a symptom of a myocardial infarction.

Temporomandibular joint pain should be clearly excluded from the new code.

Addenda

Regarding the proposed revisions to the notes under code 799.82, Apparent life threatening event in infant, the note stating "Use additional code(s) for associated signs and symptoms" should include the phrase "if confirmed diagnosis is not known" in order to clarify that the signs and symptoms shouldn't be coded if the underlying diagnosis is known.

We support the remainder of the proposed addenda changes, including the suggested changes made during the C&M Committee meeting.

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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