



November 15, 2012

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 September 19.

ICD-10-CM Topics

Unless AHIMA's comments below explicitly state support for implementation during the code set freeze, we believe the code proposals should not go into effect until October 1, 2015, after the end of the code freeze, as they do not meet the criteria for implementation during the code freeze.

Cerebrovascular Disease - Bilateral

While AHIMA supports the creation of new codes for bilateral cerebral infarctions, we recommend that NCHS comprehensively review all of the code categories for which the concept of laterality applies and adopt a standardized approach for handling laterality. For example, as indicated by this proposal as well as other proposals that have been presented at a C&M meeting, some conditions do not have codes specifying laterality, and not all code categories identifying laterality include a "bilateral" option. The rationale for these differences is not clear, and is apparently not clear to some of the specialty societies either, since they are starting to come forward with proposals to expand laterality options. Rather than dealing with the addition or expansion of laterality options one code at a time as the respective specialty society brings forth a proposal, we recommend that NCHS identify all of the codes to which the concept of laterality applies, compare the laterality options, and work with the specialty societies to determine if new codes for laterality should be created. If codes identifying laterality do not include a "bilateral" option, there should be a clinical rationale (i.e., the condition almost never occurs bilaterally), in order to ensure consistency in the application of the laterality concept across the classification.

Mononeuropathy – bilateral

AHIMA supports adding codes for bilateral mononeuropathy.

Multifocal Motor Neuropathy

We agree with the proposal to create a unique code for multifocal motor neuropathy.

Aneurysm and Dissection of Precerebral and Vertebral Arteries

We agree with the proposal for new aneurysm and arterial dissection codes.

The proposed new codes in subcategory, I77.7, Other arterial dissection, should be added to the Excludes2 note under category I72, Other aneurysm.

Congenital Metatarsus Adductus

AHIMA supports the proposed addition of new codes for congenital metatarsus primus varus and congenital metatarsus varus, as this would restore the level of anatomical detail that was available in ICD-9-CM.

Bunions

We agree with the proposed addition of unique codes for bunion and bunionette. However, we recommend considering whether codes should be created for bilateral bunions and bunionettes. As noted earlier in our comments, we believe the availability of bilateral options should be standardized across the classification, barring any clinical reason why a bilateral option wouldn't make sense. And considering bilateral options at the time codes for bunion and bunionette are being created would avoid the need to potentially address expansion of laterality options as a separate issue down the road.

Food Protein Induced Enterocolitis Syndrome (FPIES)

AHIMA supports the creation of new codes for food protein-induced enterocolitis syndrome, food protein-induced enteropathy, and other allergic and dietetic gastroenteritis and colitis, as well as the other related modifications.

The acronym "FPIES" should be added to the Index and as an inclusion term under the new code for food protein-induced enterocolitis syndrome, since the acronym may be the diagnostic term found in the medical record documentation.

Age-Related Macular Degeneration (AMD)

We agree with the proposed expansion of the codes for age-related macular degeneration to distinguish between dry (non-exudative) and wet (exudative) age-related macular degeneration and to identify the stages.

For the proposed 7th characters for the stages under subcategory H35.32, Exudative age-related macular degeneration, a default should be designated when active vs. inactive choroidal neovascularization is not documented. According to the presenter at the C&M meeting, the default should be active choroidal neovascularization, so “with choroidal neovascularization NOS” should be added under the 7th character for “with active choroidal neovascularization.”

Proliferative Diabetic Retinopathy (PDR)

AHIMA supports the proposed Tabular modifications to enable better tracking of proliferative diabetic retinopathy and capture laterality. An unspecified option is needed for those instances when the stage is not documented.

Diabetic Macular Edema

AHIMA **disagrees** with the proposed creation of a code for “type 2 diabetes mellitus with diabetic macular edema, resolved following treatment.” Conditions that have resolved should be classified to a personal history code, not a code in a category representing active disease.

Retinal Vascular Occlusions

We **do not support** the creation of 7th characters in subcategories H34.81, Central retinal vein occlusion, and H34.83, Tributary (branch) retinal vein occlusion, to identify when these conditions occur with macular edema or retinal neovascularization. Codes already exist for macular edema and retinal neovascularization, so these codes can be assigned in conjunction with the code for retinal vein occlusion to identify the presence of both conditions. A 7th character for “stable” is also not needed, as the proposal indicated that “stable” means there is no macular edema or neovascularization, so the absence of a code for macular edema or retinal neovascularization would indicate the occlusion is stable.

If NCHS decides to go ahead and create the proposed 7th characters, then Excludes1 notes should be added under the existing codes for macular edema and retinal neovascularization to indicate they should not be assigned with a code for retinal vascular occlusion.

Primary Open-Angle Glaucoma

We have no objection to expanding the subcategory for primary open-angle glaucoma to capture laterality.

As noted earlier in our comments, NCHS should review all code categories across the classification to which the concept of laterality applies and strive for a consistent approach in capturing laterality.

Complications of Urinary Devices

We support the proposed modifications for complications of urinary devices. The proposed inclusion term for “Hopkins, ileostomy and urostomy catheters” under code T83.028 should also be added under code T83.018.

We agree with the audience consensus to reclassify sacral nerve neurostimulation devices to T85, Complications of other internal prosthetic devices, implants, and grafts, versus T83, Complications of genitourinary prosthetic devices, implants and grafts. Subcategory T85.1, Mechanical complication of implanted electronic stimulator of nervous system, is a better location for mechanical complications of neurostimulators than subcategory T83.1, Mechanical complication of other urinary devices and implants. Neurostimulator codes should be classified to the nervous system, not the urinary system, because they may be used for non-urinary purposes.

We agree with the suggestion made during the C&M meeting that educational resources should be developed that explain the various urinary device types (e.g., the distinction between stents and catheters) and their placement and usage.

We also support the proposed modifications to subcategory T83.7, Complications due to implanted mesh and other prosthetic material to surrounding organ or tissue, including additional suggested modifications made during the C&M meeting (e.g., adding “other” to the title of proposed new code T83.713, deletion of phrase “into surrounding organ or tissue” from title of subcategory T83.72, and revision of title of proposed new code T83.723 to reflect that this code is exposure of implanted mesh other than vaginal, addition of Excludes2 note for mesh used for inguinal hernia repair).

Postprocedural Urethral Stricture

While we support the addition of a unique code for postprocedural fossa navicularis stricture, male, we oppose the proposed revision of all of the codes in subcategory N99.11, Postprocedural urethral stricture, male. It would be very disruptive to change the meaning of all of the codes in this subsection in order to add one code. Not only has the healthcare industry already done a great deal of work to revise policies and programming logic in preparation for the ICD-10-CM transition, and so any changes to codes would require significant re-work, but this code proposal would not go into effect until at least one year after ICD-10-CM implementation (because of the code freeze). Thus, data trends would be significantly impacted by this modification because the meaning of codes in subcategory N99.11 would change a year after implementation. An important classification maintenance principle is that the meaning of codes should not be altered.

According to the presenter, the only rationale for re-numbering all of the types of postprocedural urethral stricture classified to subcategory N99.11 is to sequence them in order by anatomical site. Codes throughout the classification are not necessarily sequenced in anatomic order, nor is it necessary

to do so. Therefore, **AHIMA recommends that the existing codes in subcategory N99.11 remain unchanged and a new code for postprocedural fossa navicularis stricture be assigned to the first open slot in this subcategory.**

Complications of Stoma of Urinary Tract

AHIMA supports the proposed modifications to subcategory N99.5, Complications of stoma of urinary tract. Since the medical record documentation may not always indicate whether the stoma is continent or incontinent, either a default code needs to be designated or unspecified code options should be created.

Chronic Fatigue Syndrome

AHIMA recommends that chronic fatigue syndrome be given a unique code and not be classified to code R53.82, Chronic fatigue, unspecified. However, we do not believe this condition belongs in subcategory G93.3, Postviral fatigue syndrome, although we recognize this is where the international version of ICD-10 has classified chronic fatigue syndrome. As stated in the background material provided with the code proposal, the cause or causes of chronic fatigue syndrome remain unknown. Therefore, it would not be appropriate to classify this condition as postviral.

Given the lack of clinical consensus on whether chronic fatigue syndrome and myalgic encephalomyelitis are the same or different conditions, and the fact that these terms are sometimes used interchangeably in medical record documentation, we **do not believe** it is appropriate to create a unique code for myalgic encephalomyelitis. Until such time as there is consensus on a case definition that classifies chronic fatigue syndrome and myalgic encephalomyelitis as separate and distinct conditions, myalgic encephalomyelitis should be indexed to (and listed as an inclusion term under) the code for chronic fatigue syndrome. At this time, separate codes would not produce good data on which to base research on these conditions, as overlaps between the conditions and interchangeable use of terms would result in a mix of both conditions being assigned to both codes.

Although chronic fatigue syndrome does not represent a new disease, **AHIMA recommends that consideration be given to creating a new code for this condition during the code freeze.** We believe that since chronic fatigue syndrome has had a unique code in ICD-9-CM for some time, the lack of a unique code in ICD-10-CM should be considered an error or oversight.

Microscopic Colitis

Although AHIMA has no objection to the proposed expansion of microscopic colitis codes, we are concerned that this level of specificity will frequently not be documented.

Indeterminate Colitis

While we support adding a code for indeterminate colitis in order to be consistent with modifications made to the international version of ICD-10, we recommend that “so stated” be added to the code title

and that an Excludes1 note for “colitis NOS” be added under this code. These additional modifications are necessary in order to clarify that the term “indeterminate” needs to be explicitly documented and does not have the same meaning as “unspecified.”

Cervical Disc Disorders

AHIMA supports the modifications in Part 1 of the code proposal for cervical disc disorders and agrees that they warrant implementation during the code freeze. They constitute corrections of errors, since the current titles of codes M50.01, Cervical disc disorders with myelopathy, occipito-atlanto-axial region, and M50.11, Cervical disorder with radiculopathy, occipito-atlanto-axial region, are clinically inappropriate. Also, these modifications do not involve the creation or deletion of codes, but rather, revision of code titles to accurately reflect the clinical intent of the use of these codes and the addition of inclusion terms to clarify the use of the cervical disc disorder codes.

We **do not support** the modifications in Part 2 of the code proposal, as it is not clear why this level of detail is necessary. ICD-10-CM is a classification, not a terminology.

Spinal Cord Disorders Involving the Lumbar and Sacral Regions

We support the proposed deletion of codes M47.17, M47.18, and M51.07 and agree that they warrant deletion during the code freeze. Since the conditions described by these codes are clinically impossible, these proposed changes constitute correction of an error. To avoid confusion as to when and how these codes are supposed to be used and possible misuse of these codes after ICD-10-CM implementation, it makes sense to delete the codes before ICD-10-CM is in use.

Adverse Effect of Certain Narcotic Drugs

AHIMA supports the proposed deletion of codes for adverse effect of heroin and adverse effect of lysergide [LSD], since these drugs have no accepted medical uses, and we agree that they should be deleted during the code freeze. The proposed code deletions represent error correction since these codes are clinically inappropriate.

Uterine Scar from Previous Surgery

We support the proposed new codes to specify the type of incision used on a previous cesarean delivery. The word “uterine” should be inserted before the word “scar” in the titles of proposed new codes O34.211, O34.212, and O34.219, as well as in the title of subcategory O34.21. Additionally, we recommend that the title of proposed new code O34.219 be revised to state “Maternal care for other and unspecified type uterine scar from previous cesarean delivery.”

ICD-10-CM Addenda

AHIMA supports the proposed Addenda modifications. However, we recommend that additional Index entry modifications and new instructional notes are needed in conjunction with the proposed revision to the Index entries for “Thrombosis, heart” and “Thrombosis, mural” in order to avoid confusion and potentially contradictory instructions and Index entries. There are several related Index entries that are not included in the proposed revisions. For example, “Thrombosis, cardiac, not resulting in infarction” currently directs users to code I24.0, Acute coronary thrombosis not resulting in myocardial infarction, and this entry is not part of the proposed revision. There are also Index entries for Embolism and Occlusion that point to I24.0, and they are not being revised, either. So, all of the related Index entries need to be evaluated for possible revision as well. Also, the proposed revisions imply that all thromboses of the heart not resulting in infarction are classified to code I51.3, Intracardiac thrombosis, not elsewhere classified. However, acute coronary thrombosis not resulting in myocardial infarction is classified to code I24.0. Sub-entries should be added under all of the Index entries for thrombosis, cardiac, heart, and mural to clarify that an acute coronary thrombosis not resulting in infarction is classified to code I24.0. Additionally, consideration should be given to adding an Excludes1 note under code I24.0 indicating that an old or unspecified cardiac thrombosis is classified to code I51.3.

We strongly recommend that changes constituting error correction, rather than enhancements or refinements, should be corrected for the October 2013 version of the classification, during the code set freeze, rather than waiting until after ICD-10-CM implementation. Examples of such errors include incorrect Index entries, conflicting instructional notes, instructional notes or Index entries sending users to non-existent codes, or clinical impossibilities. Correcting errors in the classification prior to ICD-10-CM implementation will reduce post-implementation confusion, misinterpretation of codes, instructional notes, or Index entries, and inaccurate coding.

Thank you for the opportunity to comment on the proposed diagnosis code modifications. 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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