



November 13, 2015

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-10 Coordination and Maintenance (C&M) Committee meeting held on September 22-23.

Release of 2017 Addenda

AHIMA urges the CDC to release the 2017 Addenda early in 2016, preferably in January, since this Addenda is anticipated to be more extensive than usual as a result of the partial code freeze that has been in effect for the last few years. Adequate time will be needed for software vendors, payers and providers to incorporate the changes, test the changes and educate providers and coding professionals for implementation October 1, 2016.

Implementation of March 2016 C&M topics

Given the large size of the 2017 Addenda, no diagnosis topics presented at the March 2016 C&M Committee meeting should be implemented on October 1, 2016. Any code proposals presented at the March meeting that are approved should be scheduled for implementation on October 1, 2017.

Abscess of Anal and Rectal Regions

AHIMA supports the expansion of codes for anal and rectal abscesses.

Is it possible to have both an anal abscess and an intrasphincteric or intersphincteric abscess? If so, the Excludes1 notes under K61.0, Anal abscess, would need to be changed to Excludes2 notes.

Acquired Hydrocephalus

We support the creation of a new code for acquired hydrocephalus of newborn, but agree with the comment made during the C&M meeting that **a default needs to be designated** for use when it is not known whether the hydrocephalus is congenital or acquired.

Amblyopia Suspect

AHIMA supports the proposed codes for amblyopia suspect. We are concerned about creating codes for “suspected” conditions, but realize a precedent has already been set with the codes for “glaucoma suspect.”

Amyotrophic Lateral Sclerosis (ALS)

We support the proposed modifications to subcategory G12.2, Motor neuron disease, including the additional modifications the American Academy of Neurology proposed during the C&M Committee meeting.

Asthma Control Status: Controlled and Uncontrolled

While we support the proposed modifications to the asthma codes, a default should be identified in each subcategory for situations when it is not known whether the asthma is controlled or uncontrolled.

We also recommend that **a new code be created in each subcategory for “controlled”** rather than modifying the existing codes for “uncomplicated” asthma. Modification of existing codes results in changing the meaning of the code, which is problematic for data trending and analysis purposes.

Clarification needs to be provided, either through instructional notes or advice in *Coding Clinic for ICD-10-CM/PCS*, as to whether it may be appropriate for multiple codes from a subcategory to be assigned for the same encounter – in order to capture both the severity (controlled or uncontrolled) and the presence of acute exacerbation or status asthmaticus.

Atrial Fibrillation

AHIMA does not support the creation of a unique code for “first detected atrial fibrillation.”

Regarding the other proposed modifications, we are concerned as to whether this level of detail will typically be documented. We also do not believe these modifications should be approved without the support of the American Heart Association and American College of Cardiology.

Additionally, the need for the proposed “code also” notes under several I48 subcategories is unclear. It would be appropriate to assign separate codes for the listed conditions even without a “code also” note.

Chronic Hepatitis vs. Hepatitis Carrier

We support the proposed change in classification of viral hepatitis carrier in order to be consistent with ICD-10.

Clostridium Difficile

The proposed modifications to code A04.7, Enterocolitis due to Clostridium difficile, should not be approved without the support of the relevant medical specialty societies.

If the physician organizations support the importance of distinguishing recurrence, then we recommend that only two codes be created – for “recurrent” and “not specified as recurrent.” We do not believe a third code for “initial” should be created. “Initial” is not clearly distinct from “not specified as recurrent.” Also, the word “initial” has already created confusion in the use of the classification due to multiple definitions, and so adding the word “initial” in these codes would just add to the confusion.

If a specific code for “recurrent” enterocolitis due to clostridium difficile is created, we recommend that advice be published in *Coding Clinic for ICD-10-CM/PCS* as to the appropriate documentation needed to assign the “recurrent” code. Does the provider need to specifically document “recurrent?” What about the use of the term “relapse” (which the presenter acknowledged is often how recurrence is documented) or other similar terms?

Congenital Heart Disease and Heart Failure

AHIMA supports option 1, as it would provide the desired information concerning pediatric heart failure due to congenital heart defects without the disruption of the code structure proposed in option 2.

Contact with Knife, Sword or Dagger

We support the proposed modifications to categories W25, Contact with sharp glass, W26, Contact with knife, sword, or dagger, and W45 Foreign body or object entering through skin.

Encounter and Surveillance Codes for Implantable Subdermal Contraceptives

We support the proposed modifications to codes for encounters pertaining to the use of contraceptives, assuming the American Congress of Obstetricians and Gynecologists supports the changes to their original proposal.

Encounter for Examination of Eyes and Vision with Abnormal Findings

While we support the proposed modifications for encounters for examination of eyes and vision with abnormal findings, we recommend that the wording of these codes be reviewed along with the corresponding hearing examination codes, Z01.110 and Z01.118. Both proposed code Z01.010 and existing code Z01.110 fall in a subcategory for “with abnormal findings,” but there may not be any abnormal findings during the current encounter. It seems incorrect to assign a code in a category for “with abnormal findings” if the patient is seen for a vision or hearing examination following a failed screening and no abnormal findings are identified during the current examination. Also, if the patient is seen for a vision or hearing examination following a failed screening and abnormal findings are identified during the current encounter, should two codes be assigned (Z01.010 + Z01.018 or Z01.110 + Z01.118)?

End Stage Heart Failure, Right Heart Failure and Biventricular Heart Failure

While AHIMA supports the proposed expansion of category I50, Heart failure, to capture end stage, right ventricular, and biventricular failure, **we do not agree with the proposal to create codes for “undetermined classification.”** This terminology is confusing, lacks a clear definition, and potentially overlaps with codes describing heart failure “without mention of end stage.” We feel that creation of codes for end stage heart failure and without mention of end stage is sufficient.

We agree with the suggestion made during the C&M Committee meeting that **the note at the proposed new codes I50.52 and I50.53 be revised to state “Code also the type of left ventricular failure (I50.2-I50.43), if known.”** Code I50.1, Left ventricular failure, unspecified, should not be included in this note, as it does not add any information. The addition of the phrase “if known” is needed so that the additional code can be omitted if the type of left heart failure is unknown.

External Cause Codes for Work-Related Musculoskeletal Disorders Caused by Ergonomic Hazards

We support the creation of new category X50, Overexertion and strenuous or repetitive movements.

We recommend that a more common example be used as an inclusion term under code X50.3, Overuse from repetitive movements, than “kicking a carpet stretcher with knee.”

“Prolonged computer use” should be added as an index entry or an inclusion term under the appropriate X50 code.

Gingival Recession

AHIMA does not support the proposed new codes for gingival recession. The value of the proposed codes is not clear without identification of the location. For example, a patient could have minimal recession in one area and moderate recession in another area. Assigning codes

for both minimal and moderate gingival recession would be confusing and of limited value without information regarding the location of the different levels of severity.

Also, the proposed instructional note states that one code from K06.00-K06.03 and one code from K06.04-K06.05 is required for complete representation of gingival recession. However, if the patient has different levels of severity in different locations, should multiple codes from K06.00-K06.03 be assigned? Or should just one code for the highest severity level be assigned? And does code K06.00 refer to the recession being unspecified as minimal, moderate, and severe only, or does it also refer to the recession being unspecified as severe, localized, or generalized? If it is known that the recession is moderate but not whether it is severe, localized, or generalized, what code(s) should be assigned, since the instructional note states that two codes, one from K06.00-K06.03 and one from K06.04-K06.05, must be assigned?

Heart Failure with Reduced Ejection Fraction and with Normal Ejection Fraction

We support the addition of inclusion terms under subcategories I50.2, I50.3 and I50.4 to align with terminology from the American College of Cardiology Foundation/American Heart Association Guidelines pertaining to definitions of heart failure.

Hepatic Encephalopathy

We do not believe the proposal regarding hepatic encephalopathy is ready for implementation. We urge the CDC to consult with the appropriate medical specialty societies regarding the best approach for improving the classification of hepatic encephalopathy.

High Output Heart Failure

AHIMA supports the proposed creation of a new code for high output heart failure. We recommend that an additional code be created for “other heart failure.”

We do not believe an Excludes note for “septic shock” is needed under the proposed code for high output heart failure.

Hypertension in Pregnancy Code Section Updates

We support the proposed revision of codes for hypertension in pregnancy. We also request that the American Congress of Obstetricians and Gynecologists be consulted regarding the coding of secondary pulmonary hypertension in pregnancy and whether any additional code modifications should be made.

Hypophosphatasia

Although we don’t object to creating a unique code for hypophosphatasia, **we recommend that the CDC consult with the relevant medical specialty societies** regarding the need for a specific code prior to approval of this code proposal.

We do not believe the proposed “code also” note is necessary, since the listed conditions are not part of hypophosphatasia and would be coded separately without a “code also” note.

Infection Following a Procedure

AHIMA supports the proposed expansion of code T81.4, Infection following a procedure, to capture specific types of surgical site infections. **We also recommend a similar expansion of code O86.0, Infection of obstetric surgical wound.**

The Excludes1 note under T81.4 for “postprocedural retroperitoneal abscess (K68.11)” should be changed to an Excludes2 note, since this condition could be present along with a condition described by a T81.4 code.

Inflammatory Disorders of Breast

We support the expansion of code N61, Inflammatory disorders of breast, to better distinguish mastitis from breast abscesses.

Intestinal Obstruction

We believe the proposal for new codes to better distinguish the severity of intestinal obstruction **is incomplete and requires further refinement before being approved for implementation.** The proposed modifications of K56, Paralytic ileus and intestinal obstruction without hernia and K91, Intraoperative and postprocedural complications and disorders of digestive system, not elsewhere classified, overlap with each other, so further changes are needed to more clearly differentiate these codes.

This proposal also does not address the codes for hernia with obstruction or how those codes would be used in conjunction with the proposed new codes.

Lysosomal Acid Lipase (LAL) Deficiency

AHIMA supports the proposed creation of a unique code for lysosomal acid lipase deficiency.

Mediastinitis

AHIMA supports the proposal to create a new code for mediastinitis.

Megacolon

We support the creation of a unique code for toxic megacolon.

Non-Exudative AMD

While we support the proposed modifications of code H35.31, Nonexudative age-related macular degeneration to better distinguish the stages of this condition, **we request that the older term “advanced dry stage” remain as an index entry** to guide coders to the appropriate code when providers still document that terminology.

We also recommend that **a default be designated when “advanced atrophic” is documented, but subfoveal involvement is not documented.**

Observation and Evaluation of Newborns for Suspected Conditions Ruled Out

AHIMA commends the CDC and the American Academy of Pediatrics for their efforts to improve the P00-04 block of codes and establish a new category for “encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out.”

We recommend an additional change to the introductory note for the P00-P04 code block. The entire second sentence in the introductory note should be deleted. This sentence states “Codes from these categories are also used for use for newborns who are suspected of having an abnormal condition resulting from exposure from the mother or the birth process”

Proposal to Change Excludes Designations for Epilepsy

We support the proposed changes to Excludes designations under category G40, Epilepsy and recurrent seizures.

Pulmonary Hypertension

We urge the CDC to **seek input from the appropriate medical specialty societies** prior to moving forward with the proposed modifications of pulmonary hypertension codes. The changes are quite extensive and warrant confirmation of medical specialty support.

We recommend that consideration be given to **combining proposed code I27.24 with proposed code I27.29**. It is not clear what is meant by “other unclear multifactorial mechanisms” or how this would be documented, and there seems to be overlap between I27.24 and I27.29.

Consideration should also be given to whether the “code also” note under code I27.29 should say “code also, **if known**, associated underlying condition,” as there may be occasions when the underlying condition is not known.

The Excludes1 note for secondary pulmonary hypertension under existing code I27.0 should be changed so that the code number includes a dash (I27.2-), since I27.2 would be expanded under this proposal and there would be multiple choices of secondary pulmonary hypertension codes.

Consideration should be given to changing the proposed inclusion term for “Pulmonary arterial hypertension, associated with other conditions” under code I27.0. This inclusion term could potentially be confused with secondary pulmonary hypertension.

Risk Level for Dental Caries

We oppose the proposed expansion of subcategory Z87.1, Personal history of diseases of the digestive system, to capture personal history of risk for dental caries. According to the proposal, the intent is to capture low, moderate, and high risk of dental caries. However, “personal history” codes will not accomplish this objective, as these codes would indicate that the patient has a personal history of a risk that is no longer present.

Subarachnoid Hemorrhage

AHIMA supports the proposed deletion of codes in subcategory I60.2, Nontraumatic subarachnoid hemorrhage from anterior communicating artery.

Vascular Disorders of Intestine

We support the proposed expansion of code K55.0, Acute vascular disorders of intestine, to better distinguish the severity of intestinal ischemia.

We recommend that the inclusion terms “necrosis of intestine” and “gangrene of intestine” should be added under proposed subcategories K55.02, Acute infarction of small intestine, and K55.04, Acute infarction of large intestine.

ICD-10-CM Addenda

AHIMA supports the proposed ICD-10-CM Addenda modifications.

One of the Addenda changes is correction of a code number in an Excludes1 note under code Z79.89, Other long-term (current) drug therapy. This note actually appears under code Z79.891, Long-term (current) use of opiate analgesic.

Thank you for the opportunity to comment on the proposed ICD-10-CM 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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