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May 4, 2016

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 9-10 and being considered for October 2017 implementation.

### **Abnormal Levels in Urine Collection**

AHIMA supports the proposed code expansion to identify specific types of abnormal findings in urine. As was suggested during the C&M meeting, **the proposed Excludes1 note under subcategory R82.99, Other abnormal findings in urine, should be moved under proposed new code R82.992, Hyperoxaluria.**

### **Abscess of Anal and Rectal Regions**

We support the proposed modifications in category K61, Abscess of anal and rectal regions.

### **Blindness and Low Vision**

This proposal seems overly-complex and confusing, with the potential for miscoding. We also question whether this degree of granularity is necessary, or would typically be documented.

If this proposal is approved, specific index entries would be needed to guide coding professionals to the correct codes. **We also recommend that each proposed new subcategory include an “unspecified” code**, for those instances when blindness or low vision and the affected eye(s) are documented, but not the specific visual impairment category. For example, blindness in the right eye and normal vision in the left eye may be documented, but not the specific category in each eye.

### **Clostridium Difficile**

AHIMA supports the proposed new codes for enterocolitis due to clostridium difficile. We do have concerns regarding the extent to which recurrence will consistently be documented. **We recommend that if there are other terms a clinician might use besides “recurrent,” then**

**these terms be added to the index or as inclusion terms** under the proposed code for “enterocolitis due to clostridium difficile, recurrent.” For example, the presenter for this topic at the September 2015 C&M meeting acknowledged that the term “relapse” is sometimes used to mean recurrence.

### **Dermatomyositis**

We support the proposed modifications in category M33, Dermatopolymyositis. As suggested during the C&M meeting, **the proposed inclusion term for “Dermatomyositis NOS” under subcategory M33.1, Other dermatomyositis, should be moved to proposed code M33.13, Other dermatomyositis without myopathy.**

Also, instructional notes should clarify the use of the proposed new codes for dermatomyositis without myopathy with other dermatomyositis codes. For example, if a patient has dermatomyositis with respiratory involvement and no myopathy, should both codes M33.11 and M33.13 be assigned?

### **Ectopic Pregnancy**

AHIMA supports the creation of new codes to capture laterality for ectopic pregnancy. **We recommend that the inclusion term under proposed code O00.80, Other ectopic pregnancy without intrauterine pregnancy, be changed from “Other ectopic pregnancy NOS” to “Other ectopic pregnancy NEC.”**

### **Encounter for Prophylactic Salpingectomy**

We support the creation of a new code for encounter for prophylactic removal of fallopian tubes. **We recommend putting parentheses around the “s” in “tubes,”** as one fallopian tube may have been removed previously.

### **Exercise Counseling**

We support the establishment of a new code for exercise counseling.

### **Gestational Alloimmune Liver Disease**

AHIMA supports the creation of a unique code for gestational alloimmune liver disease. **Code numbers should be added for the proposed Excludes1 notes** for GALD and neonatal hemochromatosis under code E83.11, Hemochromatosis.

### **Gingival Recession**

We **oppose** the proposal to create several new codes for gingival recession, as it is confusing and there is ambiguity surrounding the practical use of the proposed codes. The codes do not clearly indicate whether only one code should be assigned or multiple codes. The proposal indicated that two diagnostic codes should be submitted for each tooth, one describing if the recession is localized or generalized in the mouth and the second for the degree of severity on each tooth. However, there are no instructional notes under the proposed codes that provide this direction. It is also unclear how, in a practical sense, the proposed codes would be reported per tooth, or how the codes for localized and generalized gingival recession would be used for an individual tooth.

The proposed code structure also does not make it clear that a code for severity should be assigned in conjunction with a code for localized vs. generalized. The use of the “unspecified” code is also unclear. Is this code to be used only when no information is available regarding the gingival recession? What about instances when severity is documented but not localized vs. generalized, or vice versa?

While comparable codes did exist in ICD-9-CM, it is not clear if or how they were being used. There were no instructions in ICD-9-CM indicating that two codes should be reported for each tooth, or that both level of severity and localized vs. generalized should be coded.

### **Hepatic Encephalopathy**

The proposal for an extensive expansion of new codes to capture hepatic encephalopathy seems unduly complicated. Rather than creating numerous combination codes for various types of liver diseases with and without hepatic encephalopathy, **we recommend creating one new code for hepatic encephalopathy which could then be reported as an additional code when appropriate.**

We are also concerned about the proposed inclusion terms regarding West Haven Criteria. What if the provider doesn’t use the West Haven Criteria, or the criteria used are not documented? Would that impact the use of these codes?

If this proposal is approved as presented, a default code for “hepatic encephalopathy NOS” should be designated.

### **In Utero Exposure to Diethylstilbestrol (DES)**

AHIMA supports a unique code for newborn affected by use of Diethylstilbestrol (DES).

### **Lacunar Infarction**

We support creation of a new code for cerebral infarction due to small artery occlusion, with an inclusion term for lacunar infarction. However, if “lacunar” infarction is the more commonly-used term, perhaps it should be the code title.

### **Lump in Breast**

We support the expansion of codes for unspecified lump in breast to include laterality and specific anatomic location. **We recommend an additional code be created for “unspecified lump in breast NOS.”**

### **Multiple Pregnancy – Triplets and Above – Amnion and Chorion Equal to Fetus Number**

AHIMA supports the proposed expansion of category O30, Multiple gestation, to capture triplet, quadruplet, and other multiple gestation pregnancies where each fetus has its own amniotic sac and placenta.

### **Non-Healing and Slow Healing Wounds**

We support the creation of a unique code for non-healing surgical wound. Since the proposal discussed wounds that are slow to heal, **we recommend that “slow healing surgical wound” be added as inclusion term under this new code.**

While we agree there needs to be a way to capture non-healing and slow healing traumatic wounds, we do **not** agree that adding these terms as inclusion terms under code T79.8, Early complications of trauma, is the best approach. By classifying these conditions to a code where a number of different complications of trauma may be classified, it would be impossible to distinguish non-healing and slow healing traumatic wounds from other complications of trauma. We believe it is important to be able to uniquely identify both non-healing surgical and traumatic wounds. Also, it is not clear whether these conditions would always be considered “early” complications of trauma. Therefore, **we recommend that a unique code be created for non-healing traumatic wound**, with an inclusion term of “slow healing traumatic wound.”

Regardless of whether it is decided to classify non-healing traumatic wounds to an existing code or create a unique code, **an Excludes2 note for open fractures needs to be added**, as the open fracture codes have 7<sup>th</sup> characters for “subsequent encounter for delayed healing.” Thus open fractures with delayed healing should be classified to the open fracture codes and not a code in chapter 19. The note should be an Excludes2 note rather than an Excludes1 note because a patient may have other non-healing traumatic wounds that would appropriately be classified to the chapter 19 code.

### **Non-Pressure Chronic Ulcer Severity**

We recommend that an appropriate physician specialty organization be consulted prior to approving this proposal in order to confirm clinical support for distinguishing non-pressure ulcers that do and do not involve necrosis. If clinical support is confirmed, we would support the proposal as well.

Regarding the proposed options, **we prefer option #1**. While there are definite advantages to changes that allow ulcers with and without evidence of necrosis to be classified to the same code and thus avoid the creation of new codes (option #2), we believe it is too late for that approach because “necrosis” is included in the code titles. We do not believe it would be appropriate to classify ulcers not involving necrosis to codes with “necrosis” specified in the code titles, as that would create a conflict between the inclusion terms and the code titles and result in confusing data.

### **Pediatric Cryptorchidism**

AHIMA supports the proposed expansion of codes for undescended testicle and non-palpable testicle, with **the addition of codes to identify laterality** as was suggested during the C&M meeting. **An “unspecified” option should also be added under the two new subcategories for abdominal testis.**

### **Risk Level for Dental Caries**

We support the proposed new codes for risk of dental caries, with **the addition of a code for unspecified risk for dental caries** for those instances when the severity is not documented.

**Type 2 Diabetes Mellitus with Ketoacidosis**

AHIMA supports the creation of codes for type 2 diabetes mellitus with ketoacidosis with and without coma.

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](mailto:sue.bowman@ahima.org).

Sincerely,

A handwritten signature in cursive script that reads "Sue Bowman".

Sue Bowman, MJ, RHIA, CCS, FAHIMA  
Senior Director, Coding Policy and Compliance