



June 13, 2008

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) welcomes the opportunity to provide comments on the proposed diagnosis code modifications presented at the March 19th and 20th ICD-9-CM Coordination and Maintenance (C&M) Committee meeting that are slated for October 2009 implementation.

Other Venous Embolism and Thrombosis

AHIMA does not support creating new codes that distinguish acute venous embolism and thrombosis from the subacute and chronic forms of these conditions. The background material included in the C&M agenda packet indicated that an active thrombosis often continues to be coded simply because the patient is receiving anticoagulant treatment. However, *Coding Clinic for ICD-9-CM* has provided advice in the past that codes V58.61, Long-term (current) use of anticoagulants, and V12.51, Personal history of venous thrombosis and embolism, should be assigned when a patient with a history of venous thrombosis, but who does not currently have an active thrombosis, is receiving anticoagulation therapy. Assignment of the current thrombosis code would not be considered proper coding for this situation. Therefore, compliance with current coding advice will distinguish patients on anticoagulant therapy to prevent recurrence of a venous thrombosis from patients who currently have an active thrombosis.

We oppose distinguishing venous emboli and thromboses by initial and subsequent episode of care. Although these terms are used in the acute myocardial infarction codes, "episode of care" is not clearly defined and has created confusion. For example, if the patient is seen first in a physician's office and is subsequently hospitalized, is the hospitalization considered a subsequent episode of care or still part of the initial episode? If the patient is transferred from one hospital to another, should the receiving hospital

report subsequent episode of care or would the care received at the second hospital still be considered part of the initial episode?

During the C&M meeting, it was suggested that “encounter” be used instead of “episode.” While “encounter” is somewhat better understood than “episode,” it would still be problematic because notation of a previous encounter is not always documented in the medical record. Also, for those instances when a patient might first be seen in a physician’s office or clinic and then immediately admitted to the hospital, it is not clear how useful it would be to distinguish these encounters.

Venous embolism and thrombosis are not typically documented as subacute or chronic, which would mean that “unspecified” would be used the majority of the time. And as a commenter noted during the C&M meeting, the proposed new codes for chronic venous embolism and thrombosis might overlap with the use of the existing personal history code.

AHIMA supports the proposed creation of a new code for venous embolism and thrombosis of superficial vessels of lower extremities. We also support the proposed new codes for venous embolism and thrombosis of superficial and deep veins of upper extremities, axillary veins, subclavian veins, internal jugular veins, and other thoracic veins.

Venous Complications in Pregnancy and the Puerperium

For the same reasons noted above, we oppose creating new codes to distinguish acute, subacute, and chronic deep phlebothrombosis complicating pregnancy and the puerperium, or distinguishing this condition by episode of care.

We support the proposed new codes for puerperal endometritis, puerperal sepsis, puerperal septic thrombophlebitis, unspecified major puerperal infection, and other major puerperal infection. Instructional notes should be provided as to how the proposed code for puerperal sepsis fits with the existing sepsis codes. For example, if the intent is that the existing sepsis codes should not be used with the proposed code for puerperal sepsis, an Excludes note should be added under codes 995.91, Sepsis, and 995.92, Severe sepsis, to refer people to the new code.

Hepatic Coma and Hepatic Encephalopathy

We recommend that the title of code 572.2 be revised to state “Hepatic encephalopathy,” with “hepatic coma” added as an inclusion term, instead of creating new codes for hepatic encephalopathy and hepatic coma. As noted during the C&M meeting, the term “hepatic coma” is generally not used. Also, since hepatic coma is a type of hepatic encephalopathy, the proposal to create separate codes would cause confusion.

Premature Birth Status

AHIMA supports the creation of new codes to identify premature birth status. We agree with the suggestion made during the C&M meeting that the word “completed” be added to the code titles to clarify the number of weeks of gestation.

Instructional notes should be added to the classification to clarify the use of the proposed new codes versus subcategory 765.2, Weeks of gestation. Consideration should also be given to locating the proposed new codes in a “personal history” section, since “personal history of premature birth” seems more applicable than “premature birth status.” Potential alternative locations to consider would be subcategory V15.8, Other specified personal history presenting hazards to health, or newly-created category V87, Other specified personal exposures and history presenting hazards to health.

Acute Chemical Conjunctivitis

We support the creation of a new code for acute chemical conjunctivitis.

Acute Heart Failure

We oppose the proposal for new codes to describe heart failure with and without pulmonary edema. We are concerned by the extensive number of new codes being proposed, which makes the coding of heart failure unnecessarily complex and confusing. We are also concerned that the proposed changes would significantly change the coding of heart failure with pulmonary edema and impact trend data. The background material included in the agenda packet indicated that heart failure with pulmonary edema has always been coded to 428.1, Left heart failure. **This statement is not entirely correct.** Heart failure with **acute** pulmonary edema is indexed to code 428.1. However, congestive heart failure with acute pulmonary edema is indexed to code 428.0, Congestive heart failure, unspecified. Therefore, the classification of congestive heart failure with pulmonary edema to a new code in subcategory 428.1, Left heart failure, would be a significant change. Also, it is not clear from the proposal if the intent of the proposed codes is to capture acute pulmonary edema with heart failure, or any type of pulmonary edema with heart failure. Some of the inclusion terms under the proposed codes state “acute pulmonary edema” or “acute edema of lung,” whereas the code titles only state “pulmonary edema” (without qualifying it as “acute”).

If the intent of the proposal is to separately identify the presence of pulmonary edema with heart failure, **we recommend that the index entries and instructional notes be modified to allow separate reporting of the pulmonary edema code with the heart failure code instead of creating new codes.**

We recommend that the word “unspecified” be deleted from the title of code 428.0, as it is confusing because there are no codes for “specified” forms of congestive heart failure.

We support the proposed new codes for acute and chronic rheumatic heart failure and acute and chronic heart failure. We also agree with the comment made during the C&M meeting that, if new rheumatic heart failure codes are created, the word “unspecified” should be added to the title of existing code 398.91, Rheumatic heart failure (congestive).

Family Circumstances

AHIMA supports the proposed new codes for family disruption, parent-child problems, and substance abuse in family. Codes should also be created for problem between biological parent and child and parent-child problem due to death of a parent. The title of proposed code V61.09 should be changed to state “Family disruption, other and unspecified.”

Regarding the two proposed options for a new code for foster care (status), we would prefer locating this code in subcategory V60.8, Other specified housing or economic circumstances. It seems to fit better with the other situations classified to category V60 than with the inclusion terms under code V62.5, Legal circumstances.

Autoimmune Lymphoproliferative Syndrome

We support creation of a new code for autoimmune lymphoproliferative syndrome.

Nursemaid’s Elbow

We support the proposal to create a new code for nursemaid’s elbow. However, we recommend that the proposed code title and inclusion term be switched so that “nursemaid’s elbow” is the code title, since that is how the condition is typically documented. We also recommend that the 5th digits for the other codes in category 832, Dislocation of elbow, not be required for the new code because they are not applicable to nursemaid’s elbow. There is precedent in ICD-9-CM for only requiring 5th digits for some of the codes in a category (for example, in category 719, Other and unspecified disorders of joint, the 5th digits applicable to the other codes in this category do not apply to code 719.7, Difficulty in walking).

Awaiting Joint Prosthesis

We support creation of a code to identify patients that have had a joint prosthesis removed and are awaiting joint prosthesis replacement. However, we recommend that two codes be created – for “joint prosthesis explantation status” and for “encounter for joint prosthesis replacement.” This approach will provide the ability to distinguish patients who have had a joint prosthesis removed and may or may not have a joint prosthesis inserted at a later date from patients who are being admitted for the insertion of a new prosthetic joint after a joint prosthesis has previously been removed.

Gastroschisis

We support the creation of new codes for omphalocele and gastroschisis.

Underimmunized or Lapsed Immunization Status

We support creation of a new code for underimmunized status. However, instructional notes and the official coding guidelines will need to clearly explain how this code should be used and how it differs from the codes in subcategory V64.0, Vaccination not carried out. Circumstances when the new code might be reported in conjunction with a code from subcategory V64.0 will also need to be explained.

Encounter for Serologic Antibody Testing

While we support creation of a unique code for pre- and post-vaccination serologic testing, we recommend that the proposed code title and inclusion term be revised to be more descriptive of the service intended to be identified, so that the code could not be inappropriately used for allergy testing or HIV antibody testing.

Pre-procedural Evaluations

We oppose the creation of a new code for laboratory examination as part of a general medical examination. We are concerned that this code will just cause confusion. The laboratory performing the laboratory test(s) is not performing a general medical examination, so the code description does not seem applicable. Also, the laboratory will not necessarily know that the tests are part of a general medical examination performed by the physician.

We also oppose the addition of an instructional note under code V70.0, Routine general medical examination at a health care facility that would indicate an additional code should be assigned for blood testing associated with a routine general medical examination. If a physician's office draws blood for testing as part of a routine general medical examination, we recommend that they only assign code V70.0. For a laboratory facility separate from the physician's office that draws blood for testing and/or performs the laboratory tests, existing code V72.6, Laboratory examination, should be assigned. The official coding guidelines currently state that codes V72.5, Radiological examination NEC, and V72.6 should be used if the reason for the patient encounter is for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis.

We support the creation of a unique code for pre-procedural laboratory examination. The expansion of code V72.6 to create a new code for pre-procedural laboratory examination would result in the creation of a new code for "other laboratory examination" which should be used for the routine laboratory testing currently assigned to code V72.6.

We also support the proposed new Excludes note under code V72.5 and the proposed inclusion terms under codes V72.6 and V72.83.

Poisoning by Antidepressants and Psychostimulants

AHIMA supports the proposed expansion of code 969.0, Poisoning by antidepressants, to uniquely identify different classes of antidepressants.

We also support the proposed expansion of code 969.7, Poisoning by psychostimulants, to split out caffeine from other types of psychostimulants. As a commenter noted during the C&M meeting, an additional code is needed for poisoning by amphetamines or methamphetamines, not otherwise specified, for those instances when it has not been determined which it is.

Retinal and Choroidal Neoplasms of Uncertain Behavior

We support the creation of a unique code for neoplasm of unspecified nature, retina and choroid. Comprehensive index entries for the various terms describing this condition will be needed to ensure that coding professionals arrive at the correct code, since “neoplasm” may not be mentioned in the documentation. It was noted during the C&M meeting that this condition is sometimes referred to as “suspected melanoma.” In the outpatient setting, diagnoses documented as “suspected” are not coded as if they are confirmed, so the proposed new code would be assigned for a diagnosis of suspected melanoma of the retina in the outpatient setting. However, for facility reporting in the hospital inpatient setting, a final diagnosis documented as “suspected” is coded as though the condition exists or has been established, so a final diagnosis of “suspected melanoma of the retina” would be assigned the melanoma code rather than the proposed new code. Therefore, it would be confusing to add an Excludes note for “suspected melanoma” under code 190.5, Malignant neoplasm of retina.

Inclusion Body Myositis

We support the proposed new code for inclusion body myositis.

Mesial Temporal Sclerosis

We support the creation of a unique code for temporal sclerosis, with inclusion terms for hippocampal sclerosis and mesial temporal sclerosis.

Since temporal sclerosis and epilepsy are generally present together, we recommend that the proposed Excludes notes under category 345, Epilepsy and recurrent seizures, not be added in order to avoid confusion as to whether both conditions should be coded. Instead, an instructional note should be added under the proposed code for temporal sclerosis indicating that epilepsy should be coded first, if applicable.

Exposure to Algae

AHIMA supports the creation of a new code for contact with and (suspected) exposure to algae bloom.

Addenda Changes (for October 1, 2009 consideration)

Instructional Notes in the Open Wound Section

We do not agree with the proposed changes to the instructional notes at the beginning of the Open Wound section. We recognize that a modification to the instructional notes in the classification is necessary because there is currently a conflict between the “use additional code” notes in the Open Wound section and under code 040.42, Wound botulism. However, the proposed notes in the Open Wound section are confusing because wound botulism is not a systemic infection. There is also potential conflict between the proposed instructional notes and the coding guidelines for SIRS.

We recommend that the existing “use additional code” notes under code 040.42 and in the Open Wound section be deleted. Either the infection or the open wound should be allowed to be sequenced first, depending on which one meets the definition of principal/first-listed diagnosis. Also, the elimination of the notes regarding sequencing of infections and open wounds would ensure that the SIRS coding guidelines could be appropriately followed, without any conflicts with notes in the classification.

Seizures

We recommend that the various index entries for seizures be reviewed for consistency and additional index entries be considered when they would provide clarification for the proper coding of epilepsy and other types of seizures. We agree with the commenter who suggested at the C&M meeting that an index entry be added for non-epileptic seizure.

AHIMA supports the other proposed Addenda changes.

Thank you for the opportunity to comment on the proposed diagnosis code revisions slated for implementation in October 2009. 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
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