American Health Information Management Association®

July 30, 2007

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) welcomes the opportunity to provide comments on the proposed diagnosis code modifications presented at the March 23rd ICD-9-CM Coordination and Maintenance (C&M) Committee meeting that are slated for October 2008 implementation.

Migraines and Other Headache Syndromes

AHIMA is very concerned about the large number of new codes that are being proposed for various types of headaches. While we acknowledge the value of improving the level of specificity in order to collect better data on headaches, we are concerned that medical record documentation will frequently not support the proposed level of detail, resulting in the less specific codes being used much of the time. A great deal of physician education on documentation of types of headaches would be needed in order to benefit from the more detailed classification of headaches presented in this proposal. Also, ICD-9-CM is a classification system, not a clinical terminology, and we do not feel the proposed level of specificity for headaches is appropriate in ICD-9-CM. However, we do believe that some level of expanded detail for headache codes is warranted. **We recommend that consideration be given to consolidate the extensive list of proposed new codes into a fewer number of codes.**

We also do not believe that a unique code for tension type headache should be created until there is better distinction between this term and existing code 307.81, tension headache. These terms will likely be used interchangeably in medical record documentation, resulting in confusion as to the correct code and inconsistent reporting practices.

1730 M Street, Northwest, Suite 502, Washington, DC 20036
Phone (202) 659-9440 · *fax* (202) 659-9422 · www.ahima.org

The note under proposed code 346.6, Persistent migraine aura with cerebral infarction, which states "use additional code to identify the type of cerebral infarction (codes from 433 and 434 with 5th digit 1)," should be a "code first" note. The cerebral infarction code should be sequenced before the associated migraine code.

If a new category is created for headache syndromes, the title should just state "Headache Syndromes" (rather than "Other Headache Syndromes"), since the proposed new category is the only one for headache syndromes. This modification would be consistent with the proposed Excludes note under code 307.81, Tension headache.

The classification of premenstrual headache needs to be clarified.

Exposure to Toxic Metals and Chemicals

We strongly oppose creating a note instructing the use of an additional code to identify any risk factors for bladder cancer whenever a hematuria code is assigned. Determination of whether or not a patient is at risk for bladder cancer is outside the scope and purpose of the ICD-9-CM classification system. Currently, when supported by appropriate medical record documentation, exposure to hazardous chemicals, family history of malignant neoplasms, history of tobacco use, etc. can be coded without the proposed note instructing coding professionals to do so. Interpretation of the clinical significance of any of these factors is the responsibility of the clinician, not the coding professional. Since the risk factors mentioned in the proposed note are just examples, and don't represent an all-inclusive list, the note could be misinterpreted to imply that it is up to the coding professional to decide if certain information documented in the medical record (such as a chemical exposure or a personal history) represents an increased risk of bladder cancer for that patient and should therefore be coded. As noted above, determining whether a particular situation places the patient at increased risk of a disease is outside the scope of the coding professional's responsibility.

We do support the creation of unique codes for gross and microscopic hematuria, as well as new codes for exposure to arsenic and dyes.

Prophylactic Use of Agents Affecting Estrogen Receptors

We recommend that implementation of the proposed new codes for prophylactic use of agents affecting estrogen receptors be delayed until additional input has been obtained from the American College of Obstetricians and Gynecologists and the physicians on the Editorial Advisory Board of *Coding Clinic for ICD-9-CM*. An outstanding issue is whether the use of agents such as Tamoxifen for patients who have had breast cancer is considered treatment of the cancer or a prophylactic agent to prevent recurrence. In the past, Coding Clinic has characterized Tamoxifen and similar anti-estrogen agents as continued treatment of breast cancer when it is being administered following other breast cancer treatment.

Autoimmune Hepatitis

We support the creation of a unique code for autoimmune hepatitis.

Plateau Iris Syndrome and Pingueculitis

AHIMA supports the creation of unique codes for plateau iris syndrome and pingueculitis. Since plateau iris syndrome is a postoperative condition, we recommend that an inclusion term for "post-iridectomy plateau iris syndrome" be added under the proposed new code and that an Excludes note for plateau iris syndrome be added under category 997 to make it clear that a code from Chapter 17 should not be assigned for plateau iris syndrome.

Personal and Family History of Military Deployment

We recommend that codes for personal and family history of military not be created until they are further refined. While we recognize the benefits of collecting data on personal and family history of military deployment in order to identify health-related issues associated with this deployment, it is clear from the discussion at the C&M meeting that clarification on a number of issues needs to be provided if consistent, meaningful data is to be collected. For example, the scope of the proposed codes should be narrowed. The presenters indicated that the proposed codes are intended to be used only for deployment to armed conflict or war, not all types of deployment, but the descriptions do not make this clear. A definition of "armed conflict" and "war" would be helpful in order to lessen confusion regarding the application of these codes. Also, if the codes are to be used for both civilians and military personnel deployed to armed conflict or war, the word "military" should be removed from the code descriptions. Instructions and time limits for the use of the proposed codes should be provided. For example, an individual may have a personal history of deployment to armed conflict/war, but it has no impact on his current healthcare. And how many generations back is the family history code intended to apply? Immediate family only? Previous generations? Without clarification as to the intended use and scope of these codes, they may be used too broadly and thus yield less meaningful information.

Genital and Other Warts

We support the proposed modifications to subcategory 078.1, Viral warts. We recommend that the title of code 078.19 state "other specified viral warts" instead of "other specified genital warts."

Erythema Multiforme and Other Erythematous Conditions

We support the creation of unique codes for erythema multiforme minor, erythema multiforme major, and Stevens-Johnson syndrome. Clarification needs to be provided as to whether the code for the specific organism should also be assigned when the erythematous condition is caused by infection.

We also support the creation of a new subcategory for exfoliation due to erythematous conditions which identifies the extent of body surface involved. However, we recommend that the description of proposed subcategory 695.5 be revised to state "Exfoliation due to erythematous conditions according to extent of body surface involved" in order to put the condition identified by this subcategory first in the code description. The proposed new subcategory does not identify a default code to be used when the extent of body surface is unspecified. Therefore, we recommend that the description of proposed new code 695.50 be revised to state "Exfoliation due to erythematous condition involving less than 10 percent or unspecified extent of body surface."

We also recommend that staphylococcal scalded skin syndrome be added as an inclusion term under proposed code 695.81, Ritter's disease, and that it also be listed in the Excludes note under subcategory 695.1 and the "code first" note under subcategory 695.5.

Poxviruses

We recommend that a single code be created to identify poxviruses instead of the level of granularity outlined in the proposal. As noted by an attendee at the C&M meeting, many poxviruses are rare in the US. Also, the proposal packet indicated that diagnostics for poxvirus infections are not readily available through commercial vendors, and so clinicians may not be able to make a diagnosis beyond "poxvirus."

Prion Diseases

AHIMA supports the creation of a subcategory for certain prion diseases and the differentiation of variant Creutzfeldt-Jakob disease from other types of Creutzfeldt-Jakob disease.

Carotid Sinus Syndrome

We support the creation of a unique code for carotid sinus syndrome.

Personal History of Fracture

We support the creation of unique codes for personal history of pathologic and traumatic fracture. Guidance on the intended use of these codes, through the official coding guidelines or *Coding Clinic for ICD-9-CM*, in order to ensure the codes are not used when the personal history is not clinically significant. The guidelines will also need to address the difference between a healing fracture and the new personal history codes.

Noncompliance with Renal Dialysis

We support the creation of a code for noncompliance with renal dialysis.

Other Complications of Organ Transplant and Transplant Status

We support the creation of new codes for malignant neoplasm associated with transplanted organ, post-transplant lymphoproliferative disorder, graft-versus-host disease, and transplanted organ removal status. **We recommend that a "code first" note be added under proposed code 199.2, Malignant neoplasm associated with transplanted organ, to indicate that a transplant complication code should be sequenced before this code.** This instructional note would be consistent with the current coding guidelines for transplant complications and the "code first" notes under the other proposed new codes for specific complications of transplanted organs. It would also be consistent with the proposed "use additional code" note under subcategory 996.8, Complications of transplanted organ (this note indicates that code 199.2 should be assigned as an additional code when the transplant complication is a malignancy).

We disagree with the suggestion made during the C&M meeting that a V code should be assigned in conjunction with code 199.2 to identify the transplanted organ. Assigning a V code is unnecessary because the transplanted organ will be identified by the 996.8 code.

We agree with the recommendation made during the C&M meeting that two separate codes should be created for acute and chronic graft-versus-host disease. We believe that the clinical distinctions between the acute and chronic forms warrant the creation of separate codes rather than classifying both to a single code. In order to be consistent with the coding guidelines and instructional notes regarding the sequencing of other transplant complication codes, we agree with the sequencing of graft-versus-host disease as outlined in the proposal packet. The underlying complication code should be sequenced before the proposed code for graft-versus-host disease.

We agree with the suggestion made during the C&M meeting that the inclusion term under proposed code V45.87, Transplanted organ removal status, be modified to include removal due to infection. We also agree with the comment that there needs to be a way to identify the specific organ that has been removed.

Vulvodynia

AHIMA supports the creation of a unique code for vulvodynia.

Fetal Medicine

We have serious concerns regarding the proposal for the classification of conditions affecting a fetus and in utero procedures. We do not believe NCHS should implement any changes in this area until issues surrounding the proposed codes are explored further at another C&M meeting and appropriate revisions to the proposal have been made. We agree with the comment made during the C&M meeting that it would be helpful to include the indexing changes when presenting such a large proposal.

The proposal presented in March is confusing and somewhat problematic. For example, we do not believe a new subcategory for suspected fetal conditions not found should be created in the Obstetrics chapter. Currently, other types of suspected conditions not found are classified to V code categories (V29 and V71). If it is necessary to create a subcategory for suspected fetal conditions not found, it should be created in the V code section in order to be consistent and minimize confusion.

The fact that some of the proposed codes utilize all five digits, and therefore the common fifth-digit subclassification for episode of care won't be used with these codes, is very confusing and causes a disruption of the structure of the codes within the Obstetrics chapter.

We recognize the importance of capturing conditions affecting a fetus and in utero procedures. **However, the complexity of these types of cases and the limitation of the ICD-9-CM structure may mean that the best approach would be to limit the changes in ICD-9-CM to just a few codes and wait for ICD-10-CM to make more substantive changes for this area of medicine.**

Malignant Pleural Effusion

We support the creation of a new code for malignant pleural effusion. We recommend that a note be added under this code indicating that the malignancy should be coded first. This would be consistent with the new code for malignant ascites.

Abnormal Papanicolaou smear of vagina and vaginal HPV
We support the creation of new codes for abnormal vaginal cytologies to mirror those of the cervix.

Secondary Diabetes

AHIMA appreciates the careful consideration that has gone into the development of proposals to capture information on secondary diabetes. **We recommend that two separate categories be created to identify diabetes due to drug or chemical and diabetes due to underlying condition.** Separating these two types of secondary diabetes would alleviate confusion regarding sequencing of the diabetes and the underlying cause.

Input is needed from the endocrinologists regarding whether drug-induced diabetes would always be considered a late effect or whether it could ever be considered a current poisoning or adverse effect.

Guidance will need to be provided as to how secondary diabetes that is not due to either a drug or chemical or an underlying condition should be coded, such as surgically-induced secondary diabetes.

We look forward to seeing the revised proposal at the September C&M meeting.

Addenda Changes

Cirrhosis due to viral hepatitis

We disagree with the proposed Excludes note under code 571.5 and the associated index entry that would result in only viral hepatitis being coded when the patient has cirrhosis due to viral hepatitis. Cirrhosis and viral hepatitis should be coded separately when both are present.

Post-surgical Compartment Syndrome

We recommend that "post-surgical compartment syndrome" be added as an inclusion term under code 998.89, Other specified complications. We agree with the suggestion made during the C&M meeting that a note should be added under code 998.89 indicating that a code from subcategory 729.7, Nontraumatic compartment syndrome, should be assigned as an additional code for post-surgical compartment syndrome.

Diabetes with Hyperglycemia

We disagree with the proposed index change that automatically defaults "diabetes, with hyperglycemia" to diabetes with a fifth digit for uncontrolled. The Editorial Advisory Board of *Coding Clinic for ICD-9-CM* recently discussed this issue and recommended that the physician be queried for clarification as to

whether the diabetes is uncontrolled. The consensus opinion of the Editorial Advisory Board, based on the recommendation of the physician members, was that a diagnostic statement of "hyperglycemia and diabetes" or "hyperglycemia with diabetes" does not necessarily indicate that the diabetes is uncontrolled.

Incidental Surgical Tear

We disagree with the proposed index modification that would make "incidental" a non-essential modifier for Tear, surgical (code 998.2). Past advice in *Coding Clinic for ICD-9-CM* has stated that incidental tears during surgery should not be coded. Assigning code 998.2 for incidental surgical tears would significantly dilute data on an important quality measure such that it would be impossible to distinguish insignificant tears from serious adverse events. Also, incidental surgical tears would not meet the definition of a reportable secondary diagnosis. According to the official coding guidelines, the definition of "other diagnoses" for reporting purposes is an additional condition that affects patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring. An "incidental" surgical tear would meet none of these criteria.

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 2008. 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
Director, Coding Policy and Compliance