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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 proposed ICD-10-CM code modifications presented at the March ICD-10 Coordination and Maintenance (C&M) Committee meeting.

AHIMA is a global nonprofit association of health information (HI) professionals. AHIMA represents professionals who work with health data for more than one billion patient visits each year. AHIMA's mission of empowering people to impact health drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and providers. Our leaders work at the intersection of healthcare, technology, and business, and are found in data integrity and information privacy job functions worldwide.

Acute and Chronic Metabolic Acidosis

AHIMA supports the creation of new codes for acute and chronic metabolic acidosis.

We recommend that the inclusion term of "respiratory acidosis" under proposed new code E87.29, Other acidosis, be changed to "respiratory acidosis NOS" so it does not overlap with the inclusion terms "acute respiratory acidosis" and "chronic respiratory acidosis" being proposed under codes J96.02, Acute respiratory failure with hypercapnia, and J96.12, Chronic respiratory failure with hypercapnia.

Instructional notes should also be added under code E87.29 indicating that code J96.02 should be assigned for acute respiratory acidosis and code J96.12 should be assigned for chronic respiratory acidosis, in order to prevent code E87.29 from incorrectly being assigned for acute or chronic acidosis.

ANCA Vasculitis

We support creating a new code for antineutrophilic cytoplasmic antibody [ANCA] vasculitis. However, we do not believe category I77, Other disorders of arteries and arterioles, or even chapter 9 (Diseases of the Circulatory System) is the most appropriate location for this code. The three main types of ANCA vasculitis (granulomatosis with polyangiitis, eosinophilic granulomatosis with polyangiitis, and microscopic polyangiitis) are currently classified to codes in category M30,

Polyarteritis nodosa and related conditions, or category M31, Other necrotizing vasculopathies, in chapter 13 (Diseases of the Musculoskeletal System and Connective Tissue). In ICD-11, ANCA vasculitis is classified with systemic autoimmune disorders, which would be consistent with the classification of the three main types of ANCA vasculitis in ICD-10-CM. Therefore, **we recommend that the new code for ANCA vasculitis be created in category M30 or M31 rather than category I77.**

Since the conditions listed in the proposed Excludes2 notes are the three main systemic vasculitides included in ANCA vasculitis, **we recommend changing this to an Excludes1 note**, because it does not seem appropriate to allow codes for these conditions to be assigned in addition to the code ANCA vasculitis code.

Aortic Aneurysm and Dissection

We support the expansion of aortic aneurysm and dissection codes to increase anatomic specificity.

Apnea of Newborn and Related Issues

We support the expansion of codes for apnea and related problems, with a few suggested modifications. Both codes P28.40, Unspecified apnea (of prematurity) of newborn, and P28.44, Apnea of prematurity, describe apnea of prematurity, which will create confusion and inconsistent coding. **Code modifications are needed in order to avoid overlap between these two codes.**

The phrase “ruled out” should be added at the end of the title of proposed new code Z03.83, Encounter for observation for suspected condition related to home physiologic monitoring device.

In addition to creating code Z03.83, we recommend creating a comparable code in category Z05, Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out. Codes in category Z03 may not be used for observation for suspected conditions in newborns, so a code is needed in category Z05 for instances when the observation for suspected condition related to home physiologic monitoring device occurs during the neonatal period.

Atrial Septal and Atrioventricular Septal Defect

While AHIMA supports the expansion of existing codes to identify different types of atrial and atrioventricular septal defects, we are concerned there will be confusion regarding the distinction between proposed codes Q21.10, Atrial septal defect, unspecified, and Q21.11, Atrial septal abnormality, of indeterminate type. **We recommend that NCHS consider omitting code Q21.11 or rewording the code title so it is more clearly distinguishable from code Q21.10.**

Dementia: Stage of Severity, Behavioral and Psychological Symptoms

We generally support the proposed expansion of dementia codes to identify level of severity and types of behavioral and psychological symptoms, with a few suggested modifications. For clarity, we recommend that “severity level” rather than “stage” be used throughout the proposed codes, as the presenter indicated that the distinction in the codes is level of severity, not the disease stage.

“Dementia with anxiety (F02.14, F02.24, F02.34, F02.84)” should be added to the “Use additional code, if applicable” note under categories A81, Atypical virus infections of central

nervous system, G10, Huntington's disease, G20, Parkinson's disease, G30, Alzheimer's disease, and G31, Other degenerative diseases of nervous system, not elsewhere classified.

“Mild cognitive disorder due to known physiological condition (F06.7-) should be added to the “Use additional code, if applicable,” note under category A81, Atypical virus infections of central nervous system, to be consistent with the instructional note changes proposed under categories G10, G20, G30, and G31.

We recommend adding an inclusion term for “multi-infarct dementia” under category F01, Vascular dementia.

Encounter for Pediatric-to-Adult Transition Counseling

We support the creation of a unique code for encounter for pediatric-to-adult transition counseling.

A question addressed in the separate Q&A document posted after the C&M meeting asked if the code title should be “counseling” and suggested that the code might also be applicable to actual treatment. The response was that the code could be applicable for actual treatment. AHIMA does not agree that this code should be assigned for actual treatment and **we do not support changing the code title so that the code is not limited to counseling**. The presenter clearly indicated that the purpose of this type of encounter is counseling. The code proposal states “An encounter for transition counseling can involve counseling related to self-care skill attainment, building health literacy, education about one's own medical summary and emergency care plan, transfer planning, and guided integration into adult care.” If transition counseling is not provided during the encounter and treatment is provided instead, the condition being treated should be coded and the new code for encounter for pediatric-to-adult transition counseling should not be assigned. If both transition counseling and treatment are provided during the same encounter, then it would probably be appropriate to assign codes for both the encounter for transition counseling and the condition being treated. Clarification of proper coding when both transition counseling and treatment are provided during the same encounter should be provided in the *ICD-10-CM Official Guidelines for Coding and Reporting* or *Coding Clinic for ICD-10-CM/PCS*.

Encounter for PPD Test Reading and Medication Review

AHIMA supports the creation of unique codes for encounter for reading of screening test for respiratory tuberculosis and encounter for counseling related to medication management.

“Encounter for PPD test” and “encounter for Mantoux test” should be added as inclusion terms under proposed new code, Z11.11, Encounter for administration of screening test for respiratory tuberculosis. The addition of these inclusion terms would be comparable to the inclusion terms for Mantoux and PPD reading that are being added under code Z11.12, Encounter for reading of screening test for respiratory tuberculosis.

Endometriosis

We support the expansion of codes for endometriosis to specify depth and location, with a few suggested modifications.

It is not clear why an “unspecified” code is being proposed in some subcategories, whereas in other subcategories, the default for unspecified depth is the code for superficial endometriosis. The presenter indicated that defaulting to the codes for superficial endometriosis is not ideal and

would result in misleading data. **We recommend that codes for unspecified depth be created for all endometriosis locations.** For example, codes for “endometriosis of the pelvic sidewall, unspecified,” “endometriosis of the pelvic brim, unspecified,” “endometriosis of the uterosacral ligament(s), unspecified” (with specific codes identifying laterality for each of these locations) should be created in subcategory N80.3, Endometriosis of pelvic peritoneum. For endometriosis of the rectum, sigmoid colon, cecum, appendix, colon, and small, intestine, additional codes should be created for unspecified endometriosis. For endometriosis of the bladder and ureters, unspecified codes should be added. An unspecified code should also be added for endometriosis of diaphragm.

The inclusion term being proposed under codes N80.00, N80.01, and N80.03 is unnecessary and should be deleted because “endometriosis of the cervix” is being added as an inclusion term at the subcategory level (i.e., subcategory N80.0, Endometriosis of uterus).

We recommend expanding proposed codes N80.10, Endometriosis of ovary, unspecified, and N80.20, Endometriosis of fallopian tube, unspecified, to create codes specifying laterality (right, left, bilateral, unspecified), so that laterality can be identified when the depth of the endometriosis is unspecified.

The inclusion term of “Endometriosis of ovary NOS” being proposed under code N80.10, Endometriosis of ovary, unspecified, is unnecessary and should be deleted.

The inclusion term of “Endometriosis of pelvic peritoneum, NOS” being proposed under code N80.30, Endometriosis of pelvic peritoneum, unspecified, is unnecessary and should be deleted.

The title of code N80.311 should be “Endometriosis of the anterior cul-de-sac, **unspecified.**”

The inclusion term of “Endometriosis of the anterior cul-de-sac, NOS” under code N80.311 is unnecessary and should be deleted.

The title of code N80.321 should be “Endometriosis of the posterior cul-de-sac, **unspecified.**”

The inclusion term of “Endometriosis of the posterior cul-de-sac, NOS” under code N80.321 is unnecessary and should be deleted.

Subcategories N80.52, Endometriosis of the sigmoid colon, and N80.55, Endometriosis of the colon, overlap. We recommend deleting subcategory N80.52 and classifying endometriosis of any part of the colon (including the sigmoid colon) to subcategory N80.55, Endometriosis of the colon. Alternatively, subcategory N80.55 could be expanded to create distinct codes for different parts of the colon.

The second inclusion term under code N80.551, Superficial endometriosis of the colon, is unnecessary and should be deleted.

The code number for catamenial pneumothorax in the “Code also, if applicable” note under subcategory N80.B, Endometriosis of cardiothoracic space, should be changed from code J93.83 to code J93.12, as catamenial pneumothorax is classified to code J93.12, Secondary spontaneous pneumothorax. Also, if the proposed new endometriosis codes are approved, the instructional

note under code J93.12 stating “Code first underlying condition, such as catamenial pneumothorax due to endometriosis (N80.8)” will need to be revised to reflect the new codes.

The inclusion term of “Endometriosis of the mediastinal space, NOS” is unnecessary and should be deleted.

Fetal Anomalies

We support the expansion of codes in category O35, Maternal care for known or suspected fetal abnormality and damage, to provide additional specificity regarding fetal abnormalities.

Flank Anatomical Specificity

While we support the creation of new codes to identify the flank anatomical site, we are concerned that the proposed new subcategory for “pain localized to lateral abdomen” may result in confusion and potential overlap with existing codes in subcategories R10.1, Pain localized to upper abdomen, and R10.3, Pain localized to other parts of lower abdomen. **We recommend that Excludes2 notes be added under each of these subcategories for pain localized to lateral abdomen (flank).**

We recommend rewording the title of proposed new subcategory R10.4, Pain localized to lateral abdomen, to state “Pain localized to flank (lateral abdomen),” in order to be consistent with the code titles in this subcategory. It is confusing to use the term “lateral abdomen” in the subcategory title and “flank” in the code titles.

Consideration should be given to whether codes should also be created for flank tenderness, since there are existing codes for abdominal tenderness in subcategory R10.8, Other abdominal pain.

NCHS should review terminology related to “groin,” “flank,” “trunk,” and “abdominal wall” throughout the classification, particularly in the categories addressed in this proposal (L02, S30 and S31), to ensure consistent use of this terminology.

Fournier Disease of Vagina and Vulva

AHIMA supports creation of a unique code for Fournier disease of vagina and vulva.

We recommend deleting the “Code also, if applicable,” note regarding diabetes mellitus, as we believe it will create confusion since Fournier gangrene should not be coded as diabetic gangrene. Specifying that only diabetes mellitus codes ending in “.9” should be coded in conjunction with the new code for Fournier disease is inaccurate because a patient might have diabetic complications that would result in another diabetes code being more appropriate (for example, a patient might have diabetic kidney disease or diabetic retinopathy). Therefore, rather than trying to list all of the diabetic codes that might be appropriate to assign with the new code, we believe it would be simpler to omit the “Code also” note altogether. As with any medical condition, if the patient also has diabetes mellitus, the diabetes should be coded without a specific instructional note directing to do so.

Immunoglobulin A Nephropathy

We support the creation of a unique code for recurrent and persistent immunoglobulin A nephropathy.

Limb Girdle Muscular Dystrophies

We support the addition of codes for limb girdle muscular dystrophy.

Lumbar and Lumbosacral Intervertebral Annulus Fibrosus Defects

We support the creation of a new subcategory for lumbar and lumbosacral annulus fibrosus defects.

We recommend that the word “other” be deleted from the subcategory title, as there are no other codes for lumbar and lumbosacral annulus fibrosus defects.

We also recommend that the terminology in the subcategory and code titles be consistent. The word “disc” is included in the subcategory title but not the code titles. In the body of the code proposal, the defects are described as “annulus fibrosus defects.”

Mild Cognitive Disorder Due to Known Physiological Conditions

AHIMA supports the creation of new codes for mild cognitive disorder due to known physiological condition, with a couple of modifications.

Category S06 appears in mutually exclusive instructional notes—both the “Code first” and Excludes1 notes under proposed new subcategory, F06.7, Mild cognitive disorder due to known physiological condition. **We recommend retaining category S06 in the “Code first” note and deleting it from the Excludes1 note**, since it would be preferable to be able to code both the traumatic brain injury and any associated mild cognitive disorder.

The word “disease” should be added after “Alzheimer’s” in the “Code first” note under proposed new subcategory F06.7.

Poisoning by Methamphetamine

We support the creation of a new subcategory for poisoning by, adverse effect of and underdosing of methamphetamines.

Since poisoning by, adverse effect of and underdosing of methamphetamines are currently classified to codes in subcategory T43.62-, Poisoning by, adverse effect of and underdosing of amphetamines, we recommend that an Excludes2 not be added under this subcategory to refer users to the new codes for methamphetamines.

Post Traumatic Visual Disturbance

We support the creation of a code for post traumatic visual disturbance, but question whether subcategory H53.1, Subjective visual disturbance, is the correct location. The proposal did not indicate that post traumatic visual disturbance is a type of subjective visual disturbance. If it is not a type of subjective visual disturbance, expansion of code H53.8, Other visual disturbances, would be a more appropriate location for the new code.

Primary Blast Injury of Brain

We support the creation of new codes for primary blast injury of brain.

Similar to existing codes for primary blast injury of other anatomic sites, “Blast injury of brain NOS” should be added as an inclusion term under the new subcategory. This would clarify that

the new codes should be assigned even if the blast injury is not specifically documented as “primary.”

We recommend that “blast injury of brain” be added to the Excludes1 note under subcategory S06.0, Concussion, since blast injury of brain is currently indexed to concussion.

Prolonged Grief Disorder

We support the creation of a unique code for prolonged grief disorder.

Although prolonged grief is currently indexed to code F43.29, Adjustment disorder with other symptoms, expanding code F43.8, Other reactions to severe stress, to create a new code for prolonged grief disorder is consistent with the location of this condition in ICD-11.

Recurrent Vulvovaginal Candidiasis

AHIMA supports the creation of codes for acute and chronic candidiasis of vulva and vagina.

Refractory Angina Pectoris

We support the addition of new codes for refractory angina pectoris.

Slipped Upper Femoral Epiphysis, Stable, Unstable

We support the proposed modifications to subcategory M93.0, Slipped upper femoral epiphysis (nontraumatic), to allow a distinction between “stable” and “unstable” and to specify “bilateral” hips.

Short Stature Due to Endocrine Disorder

We support the expansion of code E34.3, Short stature due to endocrine disorder.

The title of proposed code E34.34 is “Other genetic causes of short stature.” “Short, stature” that is not due to an endocrine disorder is indexed to code R62.52, Short stature (child). “Hereditary” is listed as a non-essential modifier for this Index entry. Subcategory E34.3 is limited to short stature due to endocrine disorders, so any non-endocrine genetic causes should not be assigned a code from subcategory E34.3. Therefore, **if there are possible genetic causes of short stature that are not endocrine disorders, the title of code E34.34 should be modified to specify that the genetic causes classified to this code are endocrine in nature.**

Substance Use Unspecified in Remission

We support the creation of codes for substance use, unspecified, in remission.

Existing Index entries should be modified to clarify that categories F10-F19 are for substance use **disorders**, not substance use when there is no related disorder. Currently, the main Index term “Use” directs you to categories that describe substance use “disorders,” but “use” alone does not necessarily indicate the presence of a disorder.

Torsades de Pointes

We support the creation of a unique code for torsades de pointes.

Von Willebrand Disease Types

We support the creation of new codes identifying the type of von Willebrand disease.

Addenda

AHIMA does **not** support changing the Excludes1 note under category J96, Respiratory failure, not elsewhere classified, to an Excludes2 note. Codes in category J96 should not be reported in conjunction with the codes listed in the Excludes1 note, so this note should be retained as an Excludes1 note. Changing the note to an Excludes2 note would lead to incorrect coding practices. Also, there are corresponding Excludes1 notes under many of the codes listed in this Excludes1 note that reference category J96. For example, postprocedural respiratory failure (J95.82-) is listed in the Excludes1 note under category J96, and there is an Excludes1 note for J96 under subcategory J95.82. A code from category J96 should not be assigned if the patient has postprocedural respiratory failure. Thus, changing the Excludes1 note under category J96 would result in conflicting instructional notes across respiratory conditions.

We do **not** support changing the Excludes1 notes under categories R26, Abnormalities of gait and mobility, and R27, Other lack of coordination, to Excludes2 notes. Changing these notes to Excludes2 notes may result in incorrect coding practices. For example, it would not be appropriate to assign code R26.0, Ataxic gait, in conjunction with code R27.0, Ataxia, unspecified.

We recommend revising the proposed wording of the instructional note under code J47.0, Bronchiectasis with acute lower respiratory infection, to state “Code also the infection.” We believe this wording would be less awkward and clearer than “Code also to identify the infection.” We also recommend that NCHS search for any other instances of notes that state “Code also to identify” and change them to “Code also”

We support the remaining proposed Addenda modifications.

Thank you for the opportunity to comment on the proposed new ICD-10-CM codes and other code set modifications. If you have any questions, please feel free to contact Sue Bowman, Senior Director of Coding Policy and Compliance, at (312) 233-1115 or sue.bowman@ahima.org.

Sincerely,



Dr. Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer