American Health Information Management Association®

233 N. Michigan Ave., 21st Fl., Chicago, IL USA 60601-5809 | www.ahima.org | 312.233.1100

November 10, 2022

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 September ICD-10 Coordination and Maintenance (C&M) Committee meeting and being considered for implementation on October 1, 2023.

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. The AHIMA 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.

Abnormal Rheumatoid Arthritis-related Immunological Findings without Current or Prior Diagnosis of Clinically-Apparent Inflammatory Arthritis

AHIMA supports the proposed new code for abnormal rheumatoid arthritis-related immunological findings, with one recommended change to the code title. We recommend that the phrase "clinically-apparent" be deleted from the code title. This phrase does not add value from a coding standpoint and might cause confusion, as it could be interpreted as requiring explicit documentation of no current or prior diagnosis of "clinically-apparent" inflammatory arthritis. The final code title should state "Abnormal rheumatoid arthritis-related immunological findings without current or prior diagnosis of inflammatory arthritis."

Acinebacter Baumannii Infections

We support the proposed new codes for Acinebacter baumannii infections, resistance to carbapenem, carrier of Acinetobacter baumannii, and carrier of Enterobacterales.

Acute HIV Infection Syndrome and HIV Pre-Exposure Prophylaxis (PrEP)

AHIMA does **NOT** support the proposed new code for acute HIV infection syndrome. **We recommend that the HIV codes in ICD-10-CM be restructured to align with the CDC's HIV stages and terminology,** which would also be more consistent with the structure of HIV codes in ICD-11.

The proposed code for acute HIV infection syndrome would cause a great deal of confusion. Providers typically document acute HIV infection, not acute HIV infection syndrome. Additionally, the CDC classifies HIV in stages, and the first stage is "acute HIV infection" (without the word "syndrome"). If acute HIV infection is documented without the word "syndrome," it is not clear whether proposed new code B23.0 would be assigned or existing code B20. The title of code B20 is "Human immunodeficiency virus [HIV] disease," and there is an inclusion term under this code for "HIV infection, symptomatic." We believe there would be confusion, and potential overlap, between existing code B20 and the proposed new code B23.0.

Although the proposed new code is intended to align with the World Health Organization's ICD-10, which does have a code for "acute HIV infection syndrome," we believe it is more appropriate to align with ICD-11. In ICD-11, HIV is classified by stage and "acute HIV infection syndrome" is no longer a code title. Also, there are a number of significant differences between the HIV codes in ICD-10 and ICD-10-CM, and adopting only the ICD-10 code for "acute HIV infection syndrome" without the context of other ICD-10 HIV codes contributes to the overlap with existing ICD-10-CM codes and potential confusion regarding the use of this code.

Proposed new category B23, Human immunodeficiency virus [HIV] disease resulting in other conditions, is also confusing. What "other conditions" does this category title refer to? According to the C&M topic packet, acute HIV infection syndrome is the initial infection with HIV. In this stage, the HIV infection has not yet "resulted in other conditions." The title of category B23 appears to overlap with code B20, as the development of AIDS-defining illnesses would be considered AIDS, which is classified to code B20.

Regarding the proposed addition of code Z29.81, Encounter for HIV pre-exposure prophylaxis, we recognize the value of tracking this information, but the proper use of this code is not entirely clear. The "Code also" note conflicts with the code title. The note states "Code also contact with and "suspected (exposure) to human immunodeficiency virus [HIV] (Z20.6)," but the code title specifically states "pre-exposure" prophylaxis. Also, is the code intended to be assigned once per prophylaxis regimen, or for each encounter when a prophylactic injection is administered, a prescription for prophylactic medication is renewed, etc.?

Age-Related Osteoporosis with Current Pathological Fracture, Pelvis

We support the proposed new codes for age-related and other osteoporosis with current pathological fracture of pelvis.

Alagille Syndrome

We support creation of a unique code for Alagille syndrome.

Anal Fistula

We support the proposed modifications to differentiate simple, complex, persistent, and recurrent anal and rectal fistulas, with one recommended change. Rather than adding "anal fistula NOS," "rectal fistula NOS,"

and “anorectal fistula NOS” as inclusion terms under codes titled “other” fistula, unique codes should be created for unspecified anal, rectal, and anorectal fistula, as shown below.

K60.30 Anal fistula, unspecified
K60.40 Rectal fistula, unspecified
K60.50 Anorectal fistula, unspecified

Anuria, Oliguria and Hepatorenal Syndrome Complicating the Puerperium

AHIMA supports the proposed modifications to differentiate hepatorenal syndrome from other postpartum acute kidney failure.

The proposed Excludes1 note under subcategory O90.4, Postpartum acute kidney failure, is confusing because it suggests that all anuria and oliguria are classified to code R34. Puerperal anuria and oliguria are classified to proposed new code O90.49, Other postpartum acute kidney failure. Therefore, **we recommend revising the Excludes1 note to state “non-puerperal anuria and oliguria (R34).”**

Also, the revised Excludes1 note for “anuria and oliguria complicating the puerperium” under code R34 references the entire subcategory O90.4, but puerperal anuria and oliguria would be classified to proposed new code O90.49. **We recommend that the Excludes1 note under code R34 be changed from O90.4- to O90.49.** This change would be consistent with the proposed Index modifications.

Autosomal Dominant Hypocalcemia

We support the creation of new codes for autosomal dominant hypocalcemia and other types of hypoparathyroidism due to impaired parathyroid hormone secretion.

Bronchiolitis Obliterans and Bronchiolitis Obliterans Syndrome

We support the proposed new code for bronchiolitis obliterans and bronchiolitis obliterans syndrome as well as well as a new code for chronic lung allograft dysfunction, with a few additional minor changes. This modified proposal is much clearer than the previously-presented version.

We support a single code for bronchiolitis obliterans and bronchiolitis obliterans syndrome rather than two separate codes because we believe these terms are used interchangeably in provider documentation. It may not always be clear in the medical record documentation whether the patient has bronchiolitis obliterans or bronchiolitis obliterans syndrome, which would result in inconsistent code assignment if separate codes were created. Additional codes describing transplant complications or associated conditions (such as chronic lung allograft dysfunction) will help to provide the full clinical picture.

We recommend that "obliterative bronchiolitis" be added as an inclusion term under proposed new code J44.81, Bronchiolitis obliterans and bronchiolitis obliterans syndrome.

We also recommend that "obliterative bronchiolitis" be changed to "bronchiolitis obliterans" in the proposed "Use additional code" note under code J68.4, Chronic respiratory conditions due to chemicals, gases, fumes and vapors, so that it matches the title of code J44.81.

Additionally, the term “CLAD” should be added as an inclusion term under proposed new category J4A, Chronic Lung Allograft Dysfunction, and also added as an Index term.

We further recommend changing the format of the title of proposed new category J4A to lowercase except for the first word (i.e., “Chronic lung allograft dysfunction” instead of “Chronic Lung Allograft Dysfunction”).

Chronic Migraine with Aura

We support the proposed new codes for chronic migraine with aura.

We recommend that an Excludes1 note for the proposed new subcategory G43.E, Chronic migraine with aura, be added under subcategory G43.1, Migraine with aura.

Coronary Microvascular Dysfunction

AHIMA supports creating new codes for coronary microvascular dysfunction, with a few suggested modifications. We agree that code I21.B is the most appropriate location for a new code for myocardial infarction with coronary microvascular dysfunction, rather than creating the new code in subcategory I21.A, Other type of myocardial infarction. As National Center for Health Statistics staff stated at the C&M meeting, subcategory I21.A is not appropriate because myocardial infarction with coronary microvascular dysfunction is not a “type” of myocardial infarction classified to subcategory I21.A.

We recommend that the phrase "presentation of" be deleted from the titles of proposed new codes I24.81 and I25.85. From a coding standpoint, “presentation of” does not add clarity and could be confusing, since it might be interpreted as indicating that this phrase needs to be documented in order to assign the codes. The code titles should be "Acute coronary microvascular dysfunction" and "Chronic coronary microvascular dysfunction."

A default for instances when coronary microvascular dysfunction is not documented as acute or chronic should be clearly designated by adding an inclusion term under the appropriate code and also adding an Index entry. The presenter indicated that chronic coronary microvascular dysfunction should be the default when acute or chronic is not specified.

Consideration should be given to adding a “Code also, if applicable” instructional note under proposed new code I25.85 to indicate that if the patient also has arteriosclerotic heart disease, the appropriate code from category I25, Chronic ischemic heart disease, should also be assigned.

The addition of an Excludes1 note under proposed new code I24.81, Acute coronary microvascular dysfunction, directing coding professionals to code I21.B for myocardial infarction with coronary microvascular dysfunction would also be helpful.

Dense Breast(s) on Mammography

We support the creation of new codes for dense breast(s).

Since some radiology systems classify breast density by numbers instead of letters, we recommend that numbers be added as inclusion terms or as Index entries, to clarify that density described as “1” corresponds to “A,” “2” corresponds to “B,” etc.

Eating Disorders

We support the proposed modifications for eating disorders.

We recommend adding an instructional note under category F50, Eating disorders, to direct coding professionals to "Use additional code to identify body mass index (BMI), if known (Z68.-)."

Extraocular Muscle Entrapment

We support the proposed new codes for extraocular muscle entrapment.

Familial Adenomatous Polyposis

AHIMA supports Option #2, creation of a new code for familial adenomatous polyposis, in category D13, but we also recommend that a code for "genetic susceptibility to familial adenomatous polyposis" additionally be created in subcategory Z15.8, Genetic susceptibility.

We disagree with Option #1, which would create a code for "familial adenomatous polyposis" in subcategory Z15.8. Codes in category Z15 describe genetic susceptibility to diseases rather than the presence of a disease. However, we believe it would be appropriate to create a code in category Z15 for genetic susceptibility to familial adenomatous polyposis to use when an individual has been identified as having the genetic mutation but has not yet developed polyps.

We recommend that the phrase "clinical findings" in the proposed "Code also" note under code D13.91 be changed to "conditions," since benign and malignant neoplasm of colon represent definitive diagnoses rather than clinical findings.

Family History of Adenomatous Polyps

We support the expansion of code Z83.71, Family history of colonic polyps, with a few additional modifications.

The inclusion term for "Conditions classifiable to K00-K93, or unspecified," under sub-subcategory Z83.71, Family history of colonic polyps, is incorrect and should be deleted. This note does not belong under sub-subcategory Z83.71 because colon polyps are not classified to the entire K00-K93 code range. An inclusion term for "Conditions classifiable to K00-K93" already exists under subcategory Z83.7, Family history of diseases of the digestive system, which is the appropriate placement for this note.

We also recommend that "D12" be added to the inclusion term under subcategory Z83.7 so that it states "Conditions classifiable to **D12**, K00-K93." This modification is necessary because adenomatous colon polyps are classified to category D12 rather than a "K" code.

The proposed Excludes2 note for "family history of adenomatous polyps (Z83.71-)" under sub-subcategory Z83.71 is incorrect and should be deleted because this note appears under the same sub-subcategory that the note references.

The phrase "history of" should be added after the word "family" in the title of proposed new code Z83.718.

We also recommend that code Z86.010, Personal history of colonic polyps, be similarly expanded to identify a personal history of different types of colonic polyps.

Flank Anatomical Specificity

We support the proposed code expansion to more specifically capture the flank anatomic region, with a few suggested modifications.

The code number in the Excludes2 note for “pain localized to lateral abdomen” under code R10.3, Pain localized to other parts of lower abdomen, is incorrect. The correct code number is R10.A-, not R10.4-.

The phrase “lateral flank abdomen” in the title of proposed new subcategory R10.A is not clear. We recommend changing it to "flank (lateral abdomen)." The revised subcategory title should state “Pain localized to flank (lateral abdomen).”

We recommend that the proposed addition of "and latus region" in subcategory S30.1 be changed to "and flank" to be consistent with terminology used throughout the rest of the proposed modifications.

Proposed new code S30.11 should be deleted or the title revised because it overlaps with the other codes in this subcategory. All of the codes in subcategory S30.1 describe contusion of abdominal wall and latus region.

Foreign Body Entering Into or Through a Natural Orifice

We support the creation of a new category for foreign body entering into or through a natural orifice.

The proposed "Code also, if known" note at the beginning of the T15-T19 section should be changed to a "Use additional code" note, as the note directs users to external cause codes, and external cause codes cannot be sequenced as the principal diagnosis.

The proposed inclusion term under code W44.8 for "foreign body NOS entering into or through a natural orifice" should be moved to code W44.9, Unspecified foreign body entering into or through a natural orifice.

Frailty Risk Analysis Index

AHIMA does **NOT** support the proposed new codes for other age-related physical debility and frailty risk.

Proposed new code R54.8, Other age-related physical debility, is very confusing. Since there are no other R54 codes describing age-related physical debility, what does the term “other” in the proposed new code refer to? The intent of this code is not clear because the title of the code is the same as existing code R54 except for the addition of the word “other,” and it has the same inclusion terms.

The new subcategory for frailty risk does not identify the risk scoring system underlying the proposed codes. The presenter at the C&M meeting indicated that the source of this risk scoring system is Epic, an electronic health record (EHR) system vendor. Not all healthcare providers use an Epic EHR system. Additionally, a risk scoring system incorporated in ICD-10-CM should be a nationally accepted standard.

Immunoglobulin A Nephropathy (IgAN)

We support the proposed new codes for immunoglobulin A nephropathy (IgAN), with one suggested modification.

The titles of proposed new codes N02.B1 and N02.B2 overlap, as code N02.B1 describes IgAN with "glomerular lesion" and code N02.B2 describes IgAN with "focal and segmental glomerular lesion." One of the code titles should be revised so that these codes are clearly distinct.

Inappropriate Sinus Tachycardia (IST)

We support the creation of a new code for inappropriate sinus tachycardia, but recommend that the phrase "so stated" be used in the code title rather than "as stated." The phrase "so stated" would be clearer and would also be more consistent with other codes in the ICD-10-CM classification.

We recommend adding the acronym "IST" either in brackets in the code title or as an inclusion term.

An Excludes1 note for inappropriate sinus tachycardia should be added under code R00.0, Tachycardia, unspecified. A corresponding Excludes1 note for unspecified tachycardia should also be added under the proposed new code.

Insulin Resistance Syndrome

We support the expansion of code E88.81 to identify types A and B insulin resistance syndrome.

The word "resistance" should be added at the end of the title of subcategory E88.81, so the title states "Metabolic syndrome and other insulin **resistance**."

Intestinal Microbial Overgrowth

AHIMA supports the proposal for a new sub-subcategory for intestinal microbial overgrowth.

We recommend that an additional code be created in new sub-subcategory K63.82 for "intestinal microbial overgrowth, unspecified."

Intrahepatic Cholestasis in Pregnancy

We support the addition of new codes for intrahepatic cholestasis in pregnancy.

Leukodystrophies

We support the proposal to create new codes for leukodystrophies.

Lymphoma in Remission

We support the creation of new codes for different types of lymphoma in remission.

Lysosome-Associated Membrane Protein 2 (LAMP2) Deficiency (Danon Disease)

We support the proposed addition of a new code for lysosome-associated membrane protein 2 [LAMP2] deficiency.

We recommend adding a “Code also” instructional note indicating that any associated manifestations should also be coded. If a separate code should be assigned for cardiomyopathy, this condition should be specifically mentioned in the ”Code also” note. Since the information in the C&M topic packet stated that Danon disease represents one of the most aggressive cardiomyopathies ever characterized, it is not clear if cardiomyopathy would be considered inherent or should be separately coded.

MED13L Syndrome

We support creating a unique code for MED13L syndrome.

We recommend not capitalizing the word “Syndrome” in the code title or inclusion term in order to be consistent with other ICD-10-CM codes.

Membranous Nephropathy

AHIMA supports the proposed new codes for membranous nephropathy, with one suggested change. We recommend that "NOS" be added after "membranous nephropathy" in the Excludes1 note under code N06.20, as there are other proposed new codes in N04.2- that describe specific types of membranous nephropathy with nephrotic syndrome. This change would be consistent with the inclusion term under code N04.20.

Myelin Oligodendrocyte Glycoprotein Antibody Disease

We support creating a unique code for myelin oligodendrocyte antibody disease, with a few suggested modifications.

Should the disease name be capitalized in the code title, as shown in the proposal in the topic packet, or should only the first word be capitalized? The disease name is not capitalized in the background material in the topic packet.

An additional new code, G37.89, for “other specified demyelinating diseases of central nervous system” should be created.

We recommend adding “if known” to the “Code also” note under the proposed new code.

Nontraumatic Coma Due to Underlying Condition

We support the proposed addition of a new code for nontraumatic coma due to underlying condition, with a few suggested revisions.

The word “known” should be added to the title of the new code, so that it states “Nontraumatic coma due to **known** underlying condition.” Coma is always due to an underlying cause, so this revision will clarify that if the underlying condition is not known, the appropriate code is R40.20, Unspecified coma.

We recommend that an Excludes1 note for "Nontraumatic coma due to known underlying condition (R40.2A)" be added under code R40.20.

An Excludes1 note should also be added under code R40.2A to indicate that when there are combination codes that include coma (such as code E10.11, Type 1 diabetes mellitus with ketoacidosis with coma), only the combination code should be assigned and code R40.2A should not be assigned.

Obesity in Children, Adolescents, and Adults

AHIMA does **NOT** support the proposed changes to the ICD-10-CM obesity codes.

We disagree with the proposed change in the title of codes E66.01 and E66.2 from "morbid (severe)" to "extreme" obesity. The term “extreme obesity” is not typically documented by providers, and the definition is not clear. This term is not mentioned in the background material for this proposal, including in the descriptions of the obesity classes. We are also concerned about significantly changing the titles of existing codes. Also, while the proposed Index changes indicate extreme obesity would be classified to the new codes for class 3 obesity, the term "extreme obesity" does not appear as an inclusion term under these codes.

It is confusing that the proposal classifies "extreme" obesity to both the new codes E66.813 and E66.823 and existing code E66.01. While we recognize that code E66.01 is intended to be assigned when extreme obesity is documented as being due to excess calories, we believe “due to excess calories” would not typically be documented, resulting in confusion as to the appropriate code to assign for extreme obesity. There are also no proposed instructional notes under either code E66.01 or proposed new E66.8- codes to clarify the distinction between these codes, which would lead to potential overlap between the codes.

How would severe obesity due to excess calories be coded? There is no proposed inclusion term under code E66.01 for severe obesity, the title of this code is proposed to be changed to “extreme obesity due to excess calories,” and the proposed Index modifications for severe obesity direct coding professionals only to the proposed new codes for obesity in children, adolescents, and adults. It is not clear whether severe obesity due to excess calories would be classified to code E66.01, Extreme obesity due to excess calories or code E66.09, Other obesity due to excess calories.

Rather than revising the title of code E66.01 and creating confusion and overlap between this code and the proposed new codes, we recommend that consideration be given to deactivating subcategory E66.0, Obesity due to excess calories. The background material in the topic packet states that identifying excess calories as the cause of obesity does not reflect current medical understanding. If that is the case, then the use of E66.0- codes seems inappropriate. It would be more in line with current medical understanding of obesity to use the proposed new E66.81- and E66.82- codes to classify all obesity except for drug-induced obesity (code E66.1) and morbid obesity with alveolar hypoventilation (code E66.2). This would be consistent with ICD-11, which does not include codes for obesity due to excess calories. If there is concern about aligning with ICD-10, ICD-10-CM already differs significantly from ICD-10 in the coding of morbid obesity. In the World Health Organization’s ICD-10, morbid obesity is classified to code E66.8, Other obesity.

Phelan-McDermid Syndrome

We support creating a unique code for Phelan-McDermid syndrome.

Short Bowel Syndrome and Intestinal Failure

We support the proposal for a new subcategory for short bowel syndrome, with a couple of additional suggested modifications.

Inclusion terms are needed under proposed new codes K90.821 and K90.822 to clarify the meaning of the phrases "colon in continuity" and "without colon in continuity."

An Excludes1 note should be added to indicate that code K91.2, Postsurgical malabsorption, not elsewhere classified, should not be assigned with the new codes for short bowel syndrome, since postsurgical malabsorption is inherent in short bowel syndrome.

Sickle-Cell Retinopathy

We support the creation of new codes for sickle-cell retinopathy.

Wasting Disease (Syndrome) Due to Underlying Condition

We support the proposed new code for wasting disease (syndrome) due to underlying condition. The modifications that were made to the proposal in response to concerns raised at previous C&M meetings are much appreciated.

Under existing code R64, Cachexia, there is an Excludes1 note for nutritional marasmus (E41). Consideration should be given as to whether this Excludes1 note should also be added under the new code, or if nutritional marasmus can be coded in addition to the proposed new code for wasting disease (syndrome) due to underlying condition.

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

Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer