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May 3, 2023

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 ICD-10-CM code proposals presented at the March ICD-10 Coordination and Maintenance (C&M) Committee meeting that are being considered for October 1, 2024 implementation.

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.

Anal Fistula

AHIMA supports the proposed expansion of codes for anal and rectal fistulas, with a couple of suggested modifications. The wording of the first Excludes note under category K60, Fissure and fistula of anal and rectal regions, should be revised to state "**abscess or cellulitis of anal and rectal regions (K61.-)**." The current wording is confusing because it suggests that if the patient has a fissure and fistula of the anal and rectal regions with abscess or cellulitis, only a code from category K61, Abscess of anal and rectal regions, should be assigned (and no code from K60 would be assigned). That wording was appropriate when the note was an Excludes1 note. However, since this Excludes1 note is being changed to an Excludes2 note, it appears that the intent is to allow codes from categories K60 and K61 to be assigned together. Other instructional notes included in the code proposal also support allowing codes from both categories to be reported. Therefore, we

recommend that the wording of the Excludes note under category K60 be changed to make the intent clearer.

The proposed “Code first, if applicable” instructional note under proposed new sub-subcategories K60.42, Rectal fistula, complex, and K60.52, Anorectal fistula, complex, should be changed to “Code also, if applicable” notes. A comparable instructional note under proposed new sub-subcategory K60.32, Anal fistula, complex, is a “Code also, if applicable.” The instructional notes under these three sub-subcategories should be consistent, and we believe “Code also, if applicable” is the correct note type.

Coding of Firearm Injuries

We support the proposal to change the default for the external cause code for firearm injuries from “accidental” to “assault.” **This default would need to be changed for ALL types of firearm injuries, not just “unspecified” firearm.**

The presenter provided a persuasive argument for changing the default. The background materials referenced in the proposal as well as a research article titled “[Assessment of the Accuracy of Firearm Injury Intent Coding at 3 US Hospitals](#)” also supported this change. As noted in the code proposal, the majority of nonfatal firearm injuries are assaults, whereas the majority of other types of injuries are accidents. The *ICD-10-CM Official Guidelines for Coding and Reporting* state that “the default code represents that condition that is most commonly associated with the main term or is the unspecified code for the condition.”

While we support changing the default, we do not believe this change alone will resolve the inaccuracies researchers identified in coded data. Education of coding professionals is also needed to ensure that the most appropriate external cause code for the intent, based on the medical record documentation, is assigned. We recommend that different firearm injury scenarios be published in *Coding Clinic for ICD-10-CM/PCS* to provide guidance on the assignment of the appropriate external cause code identifying the intent.

Decreased Blood Glucose Level

AHIMA does **not** support creating new codes for decreased blood glucose levels. The level is not typically documented. Also, there was no indication that medical specialty societies representing physicians who manage diabetes mellitus reviewed or supported this code proposal.

If codes for decreased blood glucose levels are created, we recommend that the code titles and inclusion terms be switched (i.e., “hypoglycemia” should be the term used in the code titles and “decreased blood glucose” should be the inclusion term).

Developmental and Epileptic Encephalopathies and Related Disorders

We support the creation of one new code for developmental and epileptic encephalopathy, but we do **not** support the extensive list of proposed new codes in category Z15, Genetic susceptibility

to disease, for genetic susceptibility to epilepsy and neurodevelopmental disorders. We recommend creating a single Z15 code, as we do not believe the level of detail represented by the proposed Z15 codes is necessary or appropriate.

The “Code also, if applicable” instructional note under proposed new subcategory Z15.1 should be a “Code first, if applicable” note. Per the *ICD-10-CM Official Guidelines for Coding and Reporting*, category Z15 codes cannot be sequenced as the principal or first-listed diagnosis.

Discogenic Low Back Pain

We do **not** support the proposed new codes for discogenic back pain. We believe these codes will cause confusion with existing codes and that “discogenic” or “axial” back pain will often not be documented. For example, the code proposal states that sciatica has come to mean dermatomal or radicular leg pain. Some of the proposed new codes include the phrase “lower extremity pain” in the titles and “leg pain” in inclusion terms. These general terms do not exclude radicular leg pain, but lumbar or lumbosacral disc degeneration with radiculopathy or sciatica is classified to codes in subcategory M51.1, Thoracic, thoracolumbar and lumbosacral intervertebral disc disorders with radiculopathy. Thus, codes in this subcategory could be confused with some of the proposed new codes.

Disruption of Gastrointestinal Tract Anastomosis

We support the proposal to create codes for disruption or dehiscence of gastrointestinal tract anastomosis, repair, or closure, and disruption or dehiscence of closure of internal operation (surgical) wound of abdominal wall muscle or fascia, with one modification to instructional notes. The proposed “Code also, if applicable” notes under the fistula codes should be changed to “Code first, if applicable” notes. This change is necessary to be consistent with a note at the beginning of the “Complications of surgical and medical care, not elsewhere classified” section that states “Use additional code(s) to identify the specified condition resulting from the complication.”

Encounter for Sepsis Aftercare

We support the addition of a code for encounter for sepsis aftercare.

We recommend that an Excludes1 note for “current sepsis” be added under the proposed new code. This note would help to prevent misinterpretation of the instructional note under category Z51 that states “Code also condition requiring care.”

Epileptic Seizures Related to External Causes, Intractable

AHIMA does **not** support the creation of codes for epileptic seizures related to external causes, intractable. Drug-induced epileptic seizures can currently be captured by reporting the existing epileptic seizure codes and the appropriate adverse effect or poisoning code.

The proposed sub-subcategory and code titles are confusing because the only underlying cause described in the proposal is drugs. What other types of external causes are the proposed codes intended to be used for? If the new codes are intended to only describe drug-induced epileptic seizures, then “drug-induced” should be the term used in the code title instead of “external causes.”

Instructional notes are needed under the proposed new codes to identify the drug (i.e., “Code first poisoning due to drug, if applicable” and “Use additional code for adverse effect, if applicable”).

Expansion of Synovitis and Tenosynovitis, unspecified

We support the expansion of code M65.9, Synovitis and tenosynovitis, unspecified, to identify specific anatomic sites.

It was suggested during the C&M meeting that additional codes for “bilateral” be created. We do not support creating “bilateral” codes in every code category that captures laterality. It is reasonable to consider creating a “bilateral” code for conditions that commonly occur bilaterally. But for conditions that typically occur on one side only, the combination of the “left” and “right” codes can be reported for those instances when the condition is bilateral.

Fanconi Anemia

We support the creation of a new code for Fanconi anemia.

It was suggested during the C&M meeting that an Excludes1 note for “Fanconi syndrome” be added under the new code for Fanconi anemia. However, this note could be problematic because there is an Index entry for “Syndrome, Fanconi's (anemia) (congenital pancytopenia).” If the suggested Excludes1 note is added, it might cause confusion with this Index entry. If Fanconi's syndrome is an outdated term for Fanconi anemia, perhaps consideration could be given to deleting this existing Index entry.

Flank Anatomical Specificity

We support the proposed changes to specifically identify the flank, with a couple of suggested modifications.

Proposed new code S30.11, Contusion of abdominal wall and flank, should be deleted because it is duplicative of code S30.10, Contusion of abdominal wall and flank, unspecified.

The phrase “abdominal wall of flank NOS” that appears in inclusion terms under the “unspecified flank” codes in subcategory S31.1, Open wound of abdominal wall without penetration into peritoneal cavity, and S31.6, Open wound of abdominal wall with penetration into peritoneal cavity, is worded incorrectly and should be changed to “abdominal wall, flank NOS.”

Glutamate Receptor, Ionotropic, Gene-Related Neurodevelopmental Disorders

AHIMA does **not** support the creation of extensive codes for glutamate receptor, ionotropic, gene-related neurodevelopmental disorders and genetic susceptibility to these disorders. We do not believe the proposed level of granularity is appropriate for a classification system. Given the anticipated technological advances in genetic testing, it is not feasible to create unique ICD-10-CM codes for each form of a disease related to specific genetic mutations. We recommend that representation of genetic diseases in ICD-10-CM be consistent with ICD-11.

We would support the creation of a single code in category Z15, Genetic susceptibility to disease, for genetic susceptibility to epilepsy and neurodevelopmental disorders, related to glutamate receptor genes. We believe this one code is adequate and no new codes are needed in subcategory F84.8, Other pervasive developmental disorders.

Gulf War Illness

We do **not** support creating a code in category Z77, Contact with and (suspected) exposures hazardous to health, for Gulf War Illness. This category is not the appropriate location for a new code for Gulf War Illness. This category describes exposure only, not an illness or syndrome resulting from this exposure. As stated in the code proposal, Gulf War Illness is an exposure-induced chronic multisystem illness.

We recommend that two new codes be created to separately capture both exposure and the development of symptomatic illness. One code should be created in category Z77 to identify exposure to agents in the Persian Gulf without the development of symptoms. A second ICD-10-CM code should be created to identify the symptomatic syndrome itself. Perhaps the Symptom chapter would be an appropriate location for a new code for Gulf War Illness since this condition includes symptoms from multiple body systems.

The proposed instructional note to “Use additional code to identify associated manifestations” is incorrect. If the patient has developed symptoms or a health condition as a result of an exposure, the reason for the admission/encounter would likely be the management of the symptoms or condition. As noted above, we believe it is inappropriate to classify both the development of a symptomatic illness and hazardous exposures to an exposure code.

Injection Drug Use

We support the creation of a unique code for injection drug use, with a few suggested modifications.

We recommend that the title be modified to clearly exclude self-administration of prescribed, injectable drugs (such as insulin).

The proposed instructional note to “Code also drug type, if known” is not clear. If this note is referring to the substance use, abuse, and dependence codes, we suggest changing the note to a

“Code first” note, as it would seem appropriate to sequence substance use, abuse, or dependence before a Z code for injection drug use. Also, the note would be clearer if stated as, “Code first associated substance use, abuse, or dependence, if known.”

The proposed instructional note stating “code also any other manifestations, if known” is not clear. What is meant by “other manifestations?”

KCNQ2-Related Epilepsy

AHIMA does **not** support the creation of new codes for KCNQ2-related epilepsy. We do not believe this degree of disease specificity related to genetic variants is appropriate for a classification system. Given the anticipated growth in identification of genetic causes of disease, we also do not believe this proposed level of detail in ICD-10-CM is sustainable in the long-term.

We support the creation of a single code in category Z15 for genetic susceptibility to epilepsy and neurodevelopmental disorders, related to ion channel genes.

Lymphoma in Remission

We support the proposed new codes for lymphoma in remission.

We recommend deleting the inclusion terms under proposed new codes C81.1A, C81.2a, C81.3A, C81.4A, C81.7A, C83.0A, C83.1A, C83.3A, C83.5A, C83.7A, C83.8A, C84.4A, C84.6A, C84.9A, C85.9A, C86.51, C86.61, C88.01, C88.21, C88.31, C88.41, and C88.91. These inclusion terms are unnecessary because these types of lymphoma are already identified in inclusion terms at the subcategory level, and “in remission” is included in the code titles.

Monogenic Forms of Obesity

We do **not** support the creation of a new subcategory for obesity due to disruption of MC4R pathway. We recommend creating a single E88 code for obesity due to disruption of MC4R pathway and one code in category Z15 for genetic susceptibility to obesity.

Multiple Sclerosis Phenotypes

We support the proposed expansion of codes for multiple sclerosis.

We do not support the suggestion made during the C&M meeting to expand the code proposal to create codes for acute exacerbation. Currently, ICD-10-CM does not distinguish multiple sclerosis with and without acute exacerbation. We believe adding codes for acute exacerbation is outside the scope of the code proposal presented at the March C&M meeting, and any request for these codes should be brought forward to a future C&M meeting as a new proposal.

Obesity Classes

We do **not** support the creation of new codes to identify obesity classes. The obesity class is not typically documented. Also, there are no proposed instructional notes (under either the existing or proposed new codes) to indicate how the proposed new codes would fit with existing obesity codes. For example, if both morbid obesity and the obesity class are documented, would two codes be assigned or just one?

Before adopting codes identifying the obesity class, we believe additional input regarding how and if the obesity classes are used and documented in practice should be sought from medical specialty societies, including those that treat obesity in the adult population.

If NCHS decides to approve codes for obesity classes, option #1 is preferable to option #2.

Primary Central Nervous System Lymphoma

We support the creation of a code for primary central nervous system lymphoma, but we recommend deleting the Excludes1 note for “primary central nervous system lymphoma, other (C83.89).” According to the topic packet, the majority of cases are diffuse large B-cell lymphoma, and the remaining cell types include lymphoblastic, T-cell, and Burkitt lymphoma. Since other Excludes1 notes direct coding professionals to the appropriate codes for Burkitt, T-cell, and lymphoblastic types of primary central nervous system, an Excludes1 note for “other” primary central nervous system lymphoma is unnecessary.

SCN2A-related Disorders

AHIMA does **not** support the proposal to create new codes for SCN2A-related disorders. As noted above in our comments regarding other code proposals for genetic diseases, we do not believe this degree of genetic disease specificity is appropriate for a classification system, and this proposed level of detail in ICD-10-CM for genetic diseases is not sustainable in the long-term.

We support the creation of a single code in category Z15 for genetic susceptibility to epilepsy and neurodevelopmental disorders, related to ion channel genes.

SLC13A5 Citrate Transporter Disorder

We do **not** support the proposal to create a new code for SLC13A5 Citrate Transporter Disorder. This disorder is very rare, and as stated above, we do not believe this degree of genetic disease specificity is appropriate for a classification system.

We support the creation of a code in category Z15 to capture genetic susceptibility to epilepsy and neurodevelopmental disorders, related to the SLC13A5 gene.

SLC6A1-related Disorders

We do **not** support the creation of a unique code for SLC6A1-related disorders. As stated above, we do not believe this degree of genetic disease specificity is appropriate for a classification system. We recommend that representation of genetic diseases in ICD-10-CM be consistent with ICD-11.

We support the creation of a code in category Z15 to capture genetic susceptibility to this disease.

Social Determinants of Health

We support the creation of new codes for insufficient health insurance coverage and insufficient welfare support.

While we acknowledge the concern raised during the C&M meeting that the term “insufficient” seems vague and ill-defined, insufficient health insurance coverage is a widely used social determinants of health (SDOH) term. Also, the proposed ICD-10-CM codes align with codes in ICD-11.

STXBP1-related Disorders

We do **not** support the creation of a unique code for STXBP1-related disorders, for the reasons noted above regarding genetic diseases.

We support the creation of a code in category Z15 to capture genetic susceptibility to epilepsy and neurodevelopmental disorders, related to synapse-related genes.

Addenda

We support the proposed Tabular and Index Addenda modifications that would become effective October 1, 2024.

We continue to urge NCHS to implement Addenda changes, especially those representing error corrections or other significant changes (such as changing Excludes1 notes to Excludes2 notes), on the earliest possible effective date (i.e., October 1 of the same year for Addenda modifications presented at a March C&M meeting and April 1 of the following year for Addenda modifications presented at a September C&M meeting).

Remaining ICD-10-CM Code Proposals

AHIMA supports the following code proposals as presented at the March C&M meeting, without any modifications:

Carcinoid Heart Syndrome (Disease) (Hedinger syndrome)

Central Centrifugal Cicatricial Alopecia (CCCA)

Cholestatic Pruritis

Eating Disorders

Frontal Fibrosing Alopecia

Kleefstra Syndrome

Post-exertional Malaise/Post-exertional Symptom Exacerbation

Thank you for the opportunity to comment on the proposed ICD-10-CM modifications that would become effective on October 1, 2024. 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,

A handwritten signature in black ink, appearing to read "Lauren Riplinger", is centered on a light gray rectangular background.

Lauren Riplinger, JD
Chief Public Policy and Impact Officer