Dear Ms. Pickett and Dr. Berglund,

The Association of Clinical Documentation Improvement Specialists (ACDIS) is pleased to comment on the Centers for Disease Control and Prevention (CDC) proposed changes to the fiscal year 2012 ICD-9-CM codes, as detailed in the March 9-10, 2011 Diagnosis Agenda of the ICD-9-CM Coordination and Maintenance Committee Meeting.

ACDIS is a professional association representing more than 2,300 clinical documentation improvement (CDI) professionals nationwide. Their backgrounds include Registered Nurses (RNs), Health Information Management (HIM) professionals, case managers, quality improvement personnel, and physicians.

CDI professionals work to ensure complete and accurate documentation in the medical record, which is integral to accurate assignment of ICD-9-CM diagnosis and procedure codes discussed in the March 9-10 ICD-9-CM Coordination and Maintenance Committee Meeting. Their work also helps to ensure the accurate reporting of quality measures, medical necessity of inpatient admissions and procedures, hospital and physician profiles, and other publicly available data.

The first page of the ICD-9-CM Official Guidelines for Coding and Reporting discusses the importance of the relationship between the provider and the coder; without that relationship accurate coding is impossible. The guidelines state: “A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.” This is ACDIS’ mission and reason for existence: facilitating the relationship between the physician and the HIM/coding professional.

Our detailed comments and rationale on the proposed changes are below.

**Malnutrition (p.10)**

We support the current proposal to change the Table of Diseases but ask that the Index to Diseases be amended as follows:

- **Degrees of malnutrition**
  
  We ask that first degree, second degree, and third degree malnutrition do not link to malnutrition, unspecified. It is ACDIS’s understanding that first degree malnutrition is mild malnutrition, second degree malnutrition is moderate malnutrition, and third degree malnutrition is severe malnutrition. We trust that you are in contact with the American Dieticians Association and ASPEN as to how these should be defined and classified; we will support whatever they recommend.

- **Underlying causes of mild and moderate malnutrition**
  
  ACDIS does not understand why the underlying causes of malnutrition (e.g., the fifth digits for 262) are ascribed only to severe malnutrition when these circumstances also occur in categories 260, 261, and mild to moderate malnutrition. ACDIS believes that the fifth digits of the
underlying cause of malnutrition used in category 262 should also be applied to Category 260, 261, and 263 so that the data set differentiates the underlying causes of all variations of mild, moderate, and severe malnutrition. This is very important, given that the ADA and ASPEN will soon release their definitions of mild, moderate, and severe malnutrition syndromes and that those of us involved with clinical documentation and coding integrity wish to apply these definitions and their underlying causes uniformly.

**Acute Kidney Diseases and Related Disorders (p. 19)**

We oppose the National Kidney Foundation’s proposed revision of ICD-9-CM code 584 (Acute kidney failure) to “Acute kidney disease and disorders and acute tubular-interstitial diseases.”

Instead, we recommend that 584 be titled as follows:

- 584: Acute kidney injury
  - Includes: acute renal failure and acute kidney failure

We also oppose the creation of proposed new codes 584.1 and 584.2. The term acute kidney disease without acute kidney injury should not be introduced into this category because all the conditions described by the 584 code series represent acute kidney injury.

Instead, we propose that category 584 (584.5 though 584.9) remain the same, with the proposed title change above, but that the series expand to include a fifth digit, as follows:

- 584.x0, acute kidney injury (AKI) unspecified stage
- 584.x1, AKI stage 1
- 584.x2, AKI stage 2
- 584.x3, AKI stage 3

If the ICD-9-CM Coordination and Maintenance Committee does not opt to eliminate the designation of “acute kidney disease without acute kidney injury”, we ask that this be added as a fifth digit of “.x4” rather than creating a new code, such as the following:

- 584.x4, acute kidney disease without acute kidney injury.

We also propose that the modifying term “acute” be placed before all lesions in the 584 series, to avoid confusion with chronic lesions. So 584.5 would read, “Acute kidney injury with acute lesion of tubular necrosis, stage 3,” for example.

Without the benefit of access to the KDIGO practice guideline on acute kidney injury that will be released this summer, ACDIS believes that most physicians equate acute renal failure, acute kidney failure, and acute kidney injury as the same disease, albeit with differing stages or levels of severity. Examples of this include:
• In a Contempo article published in the Journal of the American Medical Association on February 12, 2003, Naveen Singri, MD and colleagues defined acute renal failure as “an abrupt decline in renal function” manifested as “an increase in the serum creatinine for 2 weeks or less of 0.5 mg/dl if the baseline is less than 2.5 mg/dl or an increase in serum creatinine by more than 20% if the baseline is more than 2.5 mg/dl.” While ACDIS does not have access to this reference, it believes that this definition was in vogue prior to 2004-2005 and disseminated as Nephrology Self-Assessment Program (NephSAP), thus many physicians still define acute renal failure in this light.

• In 2004, the the Acute Dialysis Quality Initiative (ADQI) group developed the RIFLE system through a broad consensus of experts. Note that its designations of acute kidney (renal) risk, injury, and failure are not part of the CDC’s proposal. This will be confusing to most practitioners, given that Paula Drennan equated acute renal failure and acute kidney injury to be the same disease and cited both the RIFLE and AKIN criteria in her review for critical care physicians as published in Critical Care Medicine, Volume 38 (1), 2010.

• Dorland’s Medical Dictionary states that the adjective “renal” means “pertaining to the kidney”. ACDIS believes that most physicians will not be able to differentiate “acute renal failure” and “acute kidney failure” as different diseases. Should the ICD-9-CM Coordination and Maintenance Committee not equate these as the same disease, and thus assign different codes for these terms without a clear supporting reference in the literature as to how they are different, those of us involved in advocating clinical documentation and coding integrity will have to expend tremendous resources negotiating these terms with confused and wary providers.

ACDIS strongly opposes the requirement of a pathology specimen for the use of the 584 codes, i.e., a biopsy to prove “pathological lesions of the kidney”. It would be extremely detrimental to have this requirement in order to report 584.8. Note that this was not included in the agenda, but it was discussed during the live March 9-10 meeting and included in slides presented during the discussion.

The consequences of this requirement, should it be made final, include the following:

• There is no precedent anywhere in ICD-9-CM Volume 1 or 2 that a pathology report is essential in assigning a pathological disease. In fact, Coding Clinic prohibits the coding of diagnoses on pathology reports for inpatients unless corroborated by the attending physician.
• Renal biopsies are not often performed in establishing renal diseases, especially when the patient’s kidneys are acutely compromised. A renal biopsy is usually not necessary to diagnose acute tubular necrosis or acute cortical necrosis, given that these can be presumed by the clinical circumstances or through noninvasive testing. Will these diagnoses require pathological proof in order to be coded?
• This may lead to renal biopsies that are not in the patient’s best interest, given that physicians may wish for their patients’ conditions to be accurately reported in ICD-9-CM administrative databases.
• This disenfranchises the coding of “uncertain diagnoses” documented at the time of discharge, especially in facilities where patient’s present with acute renal failure and are transferred for further evaluation.
• This will require that the codes in 580-583 be re-labeled....note how the codes with the 4th digit of 8 are labeled “other specified pathological lesion of the kidney”. Will these diagnoses also require pathology reports to be reported?

Finally, given that ACDIS does not have the ICD-9-CM Coordination and Maintenance Committee’s proposal for how the Index to Diseases will be amended to reflect the changes in the table, we caution the CDC to be very careful how this is constructed, given that coders are required to reference the Index to Diseases first before referring to the Table of Diseases. Currently, while the Index to diseases allows acute renal failure to be coded according to its associated renal pathologies, the Index does not allow the same luxury for acute kidney injury. To replicate this mistake in 2012 would be extremely difficult for coders in their efficient assignment of clinically congruent codes, much like the difficulty coders had when stroke and cerebrovascular accident were not deemed the same disease by ICD-9-CM prior to 2004.

ACDIS strongly urges that the Index to Diseases equate acute kidney injury, acute renal failure, and acute kidney failure as the same illness and direct the coder to assign a code from the 584 category. In so doing, ACDIS recommends that the primary entry for category 584 be acute (nontraumatic) kidney injury and that acute renal failure and acute kidney failure reference acute kidney injury, much like today when one references kidney failure in the Index to Diseases, one is referred to renal failure. Likewise, under the heading of acute kidney injury, there must be a clear description of how to use the recommended 5th digit as we have suggested above. The listing for acute kidney disease must be listed to “See acute kidney injury” and “acute renal insufficiency” must be listed to “see acute kidney disease” so that coders have clear direction in assigning these codes. Our guess is that most acute kidney (renal) disease and acute kidney (renal) insufficiency will code to 584.94 if our methodology is followed.

Finally, ACDIS requests that the term “vasomotor nephritis” in the Index to Diseases be replaced with “acute ischemic nephritis” as to code to 584.5x; that the term “acute toxic nephritis” be added to the Index to diseases and referenced to 584.5x; and that the term “toxic nephritis” be assigned a suitable code in 583, such as 583.89. Acute interstitial nephritis should not be coded to a glomerular disease; this should instead be referenced to 584.8x, given that the title for 584 will include acute tubular-interstitial diseases.

We ask that our suggested model be adapted to ICD-10-CM or that an exception be made for changing the ICD-10 codes when the next meeting occurs in the fall, given that the KDIGO report will be released this summer.

**Severely calcified coronary lesions (p. 26)**

While ACDIS supports the current proposal, providers, coders, and those involved in clinical documentation and coding integrity must have clear definitions of what differentiates “mild”,
“moderate”, and “severely” calcified coronary lesions so that we may appropriate query providers when this circumstance occurs but is not documented in the clinical record. We recognize that severely calcified coronary lesions may be seen in cardiac fluoroscopy without the addition of dye; however we need definitive references so that all involved may report this condition accurately.

**Hepatopulmonary syndrome (p. 27)**

We support the current proposal.

**Infection following transfusion (p. 28)**

We support the current proposal with one addition: We recommend that any new code for infection following transfusion use the term “due to” instead of “following.” The term “following” is problematic as it does not imply causation.

**Postoperative respiratory failure (p. 30)**

ACDIS recognizes that the postoperative respiratory failure codes require revision as to accurately report AHRQ’s Patient Safety Indicators. Many providers and coders are confused as to when to report codes 518.81, 518.84, or 518.5 when a physician documents respiratory failure in the postoperative period. ACDIS recognizes that 518.81 and 518.84 qualify for PSIs whereas 518.5 does not.

We disagree with the proposed recommendation and recommend that it be taken off the table or amended to address our concerns for the following reasons:

1. Acute respiratory failure as an outcome of trauma is different than acute respiratory failure caused by a surgical procedure. The diseases are different, the pathogenesis are different, and they should be reported with different code sets.

2. Acute respiratory failure that follows a surgical procedure must be distinguished between acute respiratory failure caused by the procedure, caused by adverse reactions to medications (e.g., narcotics or anesthetic agents), or caused by diseases unrelated to the operative procedure. Patient safety for acute respiratory failure after a surgical procedure cannot be impacted at all by the surgeon or anyone dealing with the case if the patient has a hemorrhagic stroke because of a ruptured cerebral aneurysm that causes acute respiratory failure. The code must link the complication directly to or as a result of the operation. For example, if a patient aspirates on intubation and develops ARDS from acute aspiration pneumonitis in the immediate postoperative time period (Mendelson’s syndrome), is the surgeon who is at fault or is it a complication of anesthesia?

3. Inappropriate documentation of postoperative respiratory failure currently leads to overreporting of these conditions when the patient doesn’t have them. For example, current definitions do not distinguish true postoperative respiratory failure from a situation in which a patient is intubated for airway protection or is purposely being maintained on a ventilator prior to returning to the OR after an exploration for ischemic bowel.
In short, acute respiratory failure caused by trauma and acute respiratory failure caused by surgery should *not* be grouped together. We recommend this proposal be tabled and the AHRQ re-examine appropriate groupings of trauma and surgical cases.

Should a series of codes for postoperative respiratory failure be created in the 997.3 category of postoperative respiratory conditions, then the 518.5x series could be appropriately used for causes not distinctly related to the surgical procedure itself. A possible alternative to the proposed changes includes the following:

- **ACDIS** requests that the code set differentiate as to the *cause* of acute or acute on chronic respiratory failure in the postoperative period, rather its *occurrence* in the postoperative period. The term “following” trauma and surgery designates a time frame rather than causation.

- If it is indeed the desire of AHRQ and the CDC to identify acute (on chronic) respiratory failure in the postoperative period, ACDIS suggests that an additional code be added for the nature of the respiratory failure. These would include:
  - 518.81 or 518.84 if due to a medical illness (e.g., COPD, myasthenia gravis, adverse reaction to medications)
  - 997.39 if due to a surgical complication
  - 995.22 if due to an anesthetic agent
  - Others as the C&M committee see fit.

- ACDIS wishes to point out that acute respiratory insufficiency (or distress) and Acute Respiratory Distress Syndrome are not synonymous, even though they share the same code. Acute respiratory insufficiency and acute respiratory distress are symptom of an underlying disease and should be reported as a symptom code, such as 786.09. Given that many physicians equate “acute (nontraumatic) lung injury” with “acute respiratory distress syndrome”, ACDIS believes that this should replace “Acute Respiratory Insufficiency” and “acute respiratory distress” when assigning codes 518.2 or 518.52.

Finally, ACDIS would like to point out that nasotracheal aspiration of the trachea for the purposes of sputum collection codes to 96.04 – Insertion of endotracheal tube, which counts as a PSI if it is performed after surgery. ACDIS believes that aspiration of the trachea would best fit under 96.05 – Other intubation of the respiratory tract, given that 96.04 counts as a PSI.

**Postoperative shock (p. 33)**

We support the current proposal—we agree that there must be a causative link between shock and the procedure performed. We add that the physician must document a causative link between the shock and the procedure performed in order to use these new codes.

**Drug-induced pancytopenia (p. 35)**
ACDIS supports the restriction of the term “aplastic anemia” to circumstances in which the physician explicitly documents “aplastic anemia”. For this reason, ACDIS supports the addition of the new code for drug-induced pancytopenia for the purpose of data integrity, recognizing that hospitals will likely lose the “MCC” that they used to be allowed with drug-induced pancytopenia coded to 284.89 – Aplastic anemia. For this reason, ACDIS asks that the term “toxic anemia” likewise not code to 284.89 – Aplastic anemia, unless the provider explicitly documents it.

ACDIS believes that ICD-9-CM should be consistent with other entries. For this reason, given that there is a differentiation between anemia due to cancer chemotherapy (285.3) and anemia due to other drugs, ACDIS believes that there should be likewise a differentiation between pancytopenia due to chemotherapy and pancytopenia due to other conditions and drugs.

ACDIS strongly urges the ICD-9-CM Coordination and Maintenance Committee to add a reference to code, in addition, any associated anemia, neutropenia, or thrombocytopenia, given that these may have varying causes and that sequencing of these will be dependent upon the circumstances of admission. This would be congruent with advice given in Coding Clinic, 3rd Quarter, 2005, pp. 11-12 which states the following:

**Question:**

The patient is a 69-year-old female with breast cancer receiving weekly Taxol therapy. She developed a high-grade fever at home, presented to the emergency department and was found to have neutropenic fever. The patient was admitted for treatment of neutropenic fever. The physician documented that the patient also had pancytopenia. How should this be coded? Coding Clinic has previously stated that pancytopenia is a deficiency of all three elements of the blood and includes anemia (deficiency of red cells), neutropenia (deficiency of white cells), and thrombocytopenia (deficiency of platelets). Is this advice true when the final diagnosis is neutropenic fever?

**Answer:**

*Note from 3M:*
As of October 1, 2007, code 284.8 has been expanded to identify acquired red cell aplasia (284.81) and other specified aplastic anemia (284.89).

*Note from 3M:*
As of October 1, 2006, code 288.0 has been revised and expanded to further specify type/cause of neutropenia. A "Use additional code for any associated fever (780.6)" directive has been added. Code 284.1 has been created to report pancytopenia.

Assign code 288.0, Agranulocytosis, for the neutropenic fever, as the principal diagnosis. Assign code 174.9, Malignant neoplasm of female breast, Breast (female), unspecified, for the breast cancer, code 284.8, Other specified aplastic anemias, for the pancytopenia and code E933.1, Drugs, medicinal and biological substances causing adverse effects in therapeutic use, Primarily systemic agents, Antineoplastic and immunosuppressive drugs, as additional diagnoses.
In this case, the reason for the admission was the neutropenic fever. The pancytopenia was due to the chemotherapy. Neutropenia is a nonspecific abnormal laboratory finding of less than 3500 neutrophils on a white blood count (WBC). Neutropenic fever is a potentially serious clinical condition, in which the white blood count (WBC) is very low. At this point, the body's defense mechanisms to fight infection are impaired. The fever may imply a serious infectious process, which requires immediate evaluation and therapeutic intervention. When a patient presents with fever and an absolute neutrophil count (ANC) of less than 500/mm3-1000/mm3, a diagnosis of neutropenic fever is established. However, neutropenic fever should be documented by the provider and should not be assigned on the basis of lab findings alone. The clinical work-up is very similar to the work-up for septicemia. The focus is generally twofold: to identify the source of infection if present and prevent progression to sepsis. The work-up includes culturing any potential sources of infection, such as blood, sputum, catheter sites, skin, urine, cerebrospinal fluid, and wound cultures when appropriate, as well as radiological imaging. In order to prevent progression to sepsis, blood counts are continually monitored, patients are aggressively treated with IV antibiotics, neupogen may be administered to increase white blood cell count, and in some cases ICU isolation may be required.

**Hypertrophic cardiomyopathy (p. 36)**

We support the current proposal.

**Acute interstitial pneumonitis (p. 37)**

We support the current proposal.

**Atrial fibrillation and flutter (p. 48)**

While ACDIS does not oppose the proposal for atrial fibrillation and flutter, ACDIS does ask that the control of these rhythms be taken into account, especially as it impacts the reason for inpatient admission and the use of resources during that admission. Adding terms like “uncontrolled” or “rapid ventricular response” are most helpful, given that many times these patients must be admitted to intensive care to receive intravenous medications in order to control their ventricular rate or perhaps undergo cardioversion. Given that patients with uncontrolled atrial fibrillation or flutter may have acute exacerbations of their systolic or diastolic heart failure, having the option to diagnose, document, and code their uncontrolled atrial fibrillation allows justification for it to be sequenced as the principal diagnosis, especially if considerable resources were expended in addressing this condition.

There appears no option for adding a fifth digit in this circumstance. For this reason, we ask that the following codes be added:

- 427.37 – Atrial fibrillation with rapid ventricular response
- 427.38 – Atrial flutter with rapid ventricular response

These will be temporary placeholders until appropriate classifications are made in ICD-10.
Thank you for the opportunity to comment. If you have any questions about our commentary, do not hesitate to e-mail or call.

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