



April 5, 2023

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Via email ([ICDProcedureCodeRequest@cms.hhs.gov](mailto:ICDProcedureCodeRequest@cms.hhs.gov))

Ms. Hue:

On behalf of the American Thoracic Society (ATS) and American College of Chest Physicians (CHEST), we offer comments on coding proposals to be considered at the March, 2023 ICD-10 Coordination and Maintenance Committee meeting. Jointly, the ATS and CHEST represent over 20,000 pulmonary, critical care and sleep clinicians serving patients across the U.S., and around the globe. It is with our shared clinical expertise in pulmonary, critical care and sleep medicine that we provide the following comments:

**Social Determinants of Health: Z59.7 Insufficient social insurance and welfare support**

The proposal to separate insufficient health insurance coverage from insufficient welfare support into two separate diagnosis codes is understandable. However, the separation creates artificial specificity, when the existing single code remains nonspecific, regardless of the distinction between health insurance and welfare support. As currently defined, Z59.7 potentially applies to everything from unaffordable copays for visits or prescriptions to payment/coverage policies for diagnostic tests or therapeutic procedures. The code could conceivably be used when an expensive imaging modality such as CT or MR does not meet the Medicare-required appropriate use criteria. Finally, practicing clinicians are extremely unlikely to make distinctions between welfare and health insurance in both practice and clinical documentation.

**Gulf War Illness: Z77.3 Contact with and (suspected) exposure to Persian Gulf theater**

The proposal to create a diagnosis code for participation in the Persian Gulf theater of war seems reasonable on face value, as a marker of mere exposure and not disease. However, this potentially creates a bad precedent for a diagnosis code to mark participation in every individual was theater, regardless of the duration of a tour of duty.

We oppose the addition of any specific disease, disorder or condition (such as the proposed Gulf War illness and Gulf War syndrome) to this mere marker of exposure. We note that the Kansas Gulf War Illness case definition included in the rationale for the proposal is based upon completely subjective symptoms, rather than objective criteria (diagnostic tests and validated rating scales). As proposed, patients with a

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variety of conditions such as fibromyalgia, systemic lupus erythematosus (SLE), myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), post-intensive care unit syndrome (PICS), post-acute COVID syndrome (PASC), and even somatic symptom disorder or other psychological conditions such as depression could meet such criteria, leading to diagnostic confusion rather than clarity.

### **Classification codes E66.8**

We recognize and agree with the need for alignment of the current classification of obesity (classes 1-3) based upon body mass index (BMI) with specific diagnosis codes in ICD-10. However, reflecting discussion at the 3/8/23 meeting, we support the need for education among providers and coders alike given widespread current use of severe and morbid obesity without specific reference to BMI. We support option 2, distinguishing obesity in adults with E66.81 from obesity in children and adolescents with E66.82.

### **Post-exertional malaise/post-exertional symptom exacerbation R68.A**

We oppose assignment of R68.A to post-exertional malaise/post-exertional symptom exacerbation. This symptom is nonspecific, and duplicative of existing diagnosis codes for symptoms such as exertional dyspnea (R06.9), fatigue (R53.83), and malaise (R53.81). Symptomatic patients with syndromes following COVID and other illnesses can effectively be identified using existing diagnosis codes and other electronic health data, evidenced by the two attached papers from Pfaff et al (one of which was cited by the presenters). Addition of such a code would merely add to the coding burden of providers and coders, without advancing the science.

### **Encounter for Sepsis Aftercare Z51.A**

We continue to support, as reflected in our separate letter of support previously submitted as part of the application by Dr. Mikkelsen, Dr. Bowles, and the University of Colorado.

### **Single specific genetic disorders**

Finally, we share the concerns effectively expressed at the meeting by several individuals regarding the proliferation of requests for unique diagnosis codes assigned to a single specific genetic disorder (e.g., KCNQ2-related epilepsy, Kleefstra syndrome, monogenic forms of obesity, SCN2A-related disorders, SLC13A5 citrate transporter disorder, SLC6A1-related disorder, STXBP1-related disorders). The assignment of specific ICD-10 diagnosis codes to these disorders, often present in extremely low frequency in the population, represents an undue burden upon providers and coders alike. The rapid identification of numerous genetic diseases, disorders, and conditions will only accelerate in the near future, and the identification of a genetic defect is not synonymous with disease due to many factors, such as phenotypic variation and variable penetrance. However, we recognize and appreciate the importance of identifying such patients in order to obtain accurate epidemiological and population based data, which can apply to rare genetic respiratory disorders as well. While we believe assigning a potentially infinite number of unique ICD-10 diagnosis codes does not represent

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an adequate solution, we would be happy to participate in discussions or meetings to consider alternative, effective solutions to this diagnosis coding controversy.

Please let us know if you have questions or need additional information.

Sincerely,



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Joint ATS/CHEST Clinical Practice Committee



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