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Updating and Validating the Rheumatic Disease Comorbidity Index to ICD-10-CM

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U.S. Department of Veterans Affairs

Updating and Validating the Rheumatic Disease Comorbidity Index to ICD-10-CM

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Summer Undergraduate Research Program

Introduction

- Comorbidities such as lung disease, stroke, and diabetes have been shown to contribute to increased mortality and disability risk in individuals with rheumatoid arthritis (RA)^{1,2}
- The Rheumatic Disease Comorbidity Index (RDCI) assesses 11 comorbidity categories and produces a weighted score (0-9) to predict several health outcomes³
- The RDCI was developed with self-report data and later validated using ICD-9-CM codes to collect administrative comorbidity data^{3,4}
- In October 2015, the United States healthcare systems transitioned to ICD-10-CM, which resulted in a nearly five-fold increase in the number of codes available for classifying health conditions⁵
- Objective: update and validate the RDCI by translating it into ICD-10-CM

Methods

- Cohort study using Veterans Affairs Rheumatoid Arthritis Registry (VARA)
- ICD-10 codes generated by converting ICD-9 codes using tools that provide suggested crosswalks, and the codes were reviewed by a physician to assess clinical relevance
- National VA administrative databases were sources for ICD-9 and ICD-10 comorbidity data

Figure 1. Study design overview

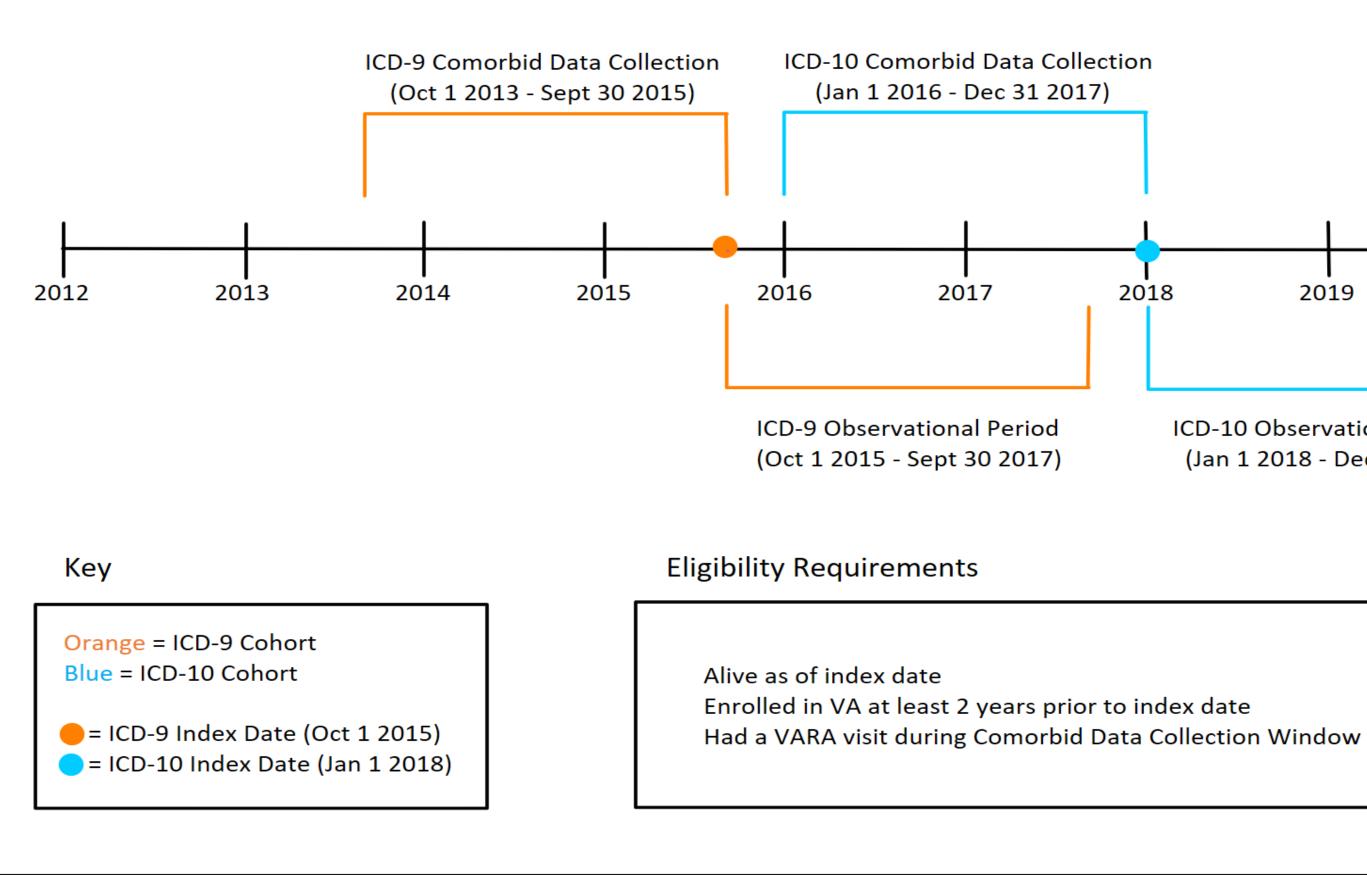


	Table 1. Example of ICD-9 to ICD-10 mapping for comorbid category (Diabetes Mellitus)				
Comorbid Condition		id Condition	ICD-9 Diagnosis Code	L.	
				E08	
		Secondary diabetes mellitus	249.x (Secondary diabetes mellitus)	E09.	
	Diabetes Mellitus			E13.x (O	
		Diabetes mellitus	250.x (Diabetes mellitus)	E10. E11.	

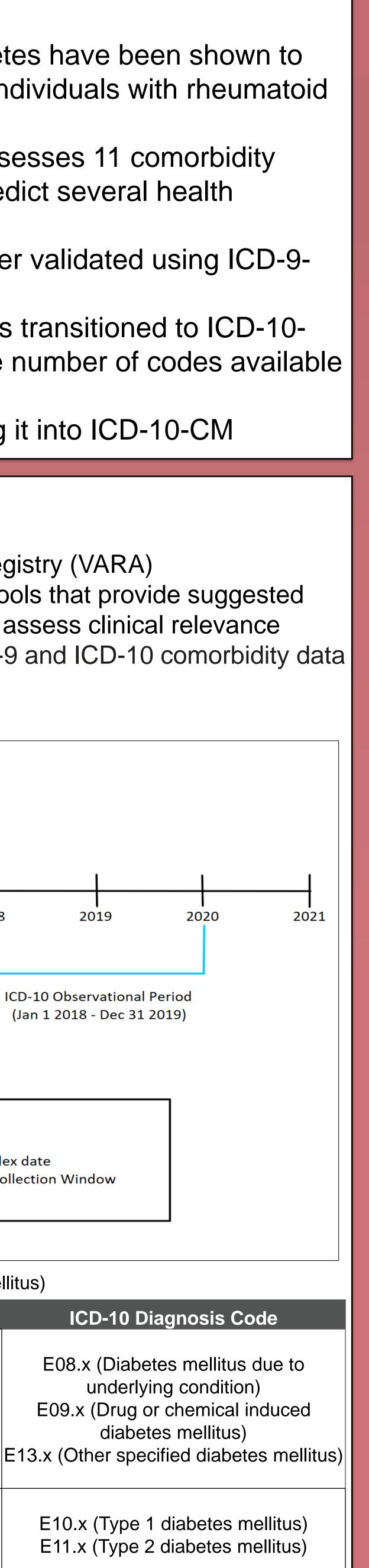


Table 2. Characteristics of ICD-9 and ICD-10 cohorts from VARA registry				
Characteristics	ICD-9-CM Cohort	ICD-10-CM Cohort		
	(N = 1,082)	(N = 1,446)		
Age, years	67.3 ± 10.2	68.2 ± 10.0		
Male, no. (%)	965 (89.2)	1260 (87.1)		
White, no. (%)	823 (76.1)	1060 (73.3)		
Smoking Status, no. (%)				
Current	263 (24.3)	341 (23.6)		
Former	548 (50.6)	739 (51.1)		
Never	229 (21.2)	293 (20.3)		
DAS28	3.28 ± 1.38	3.15 ± 1.35		
Duration of RA Disease, years	15.24 ± 11.00	16.38 ± 11.16		
RA Treatment, no. (%)				
csDMARDs	566 (52.3)	758 (52.4)		
b/tsDMARDs	260 (24.0)	359 (24.8)		
Glucocorticoids	284 (26.2)	315 (21.8)		
Anti-CCP antibody, no. (%)	756 (69.9)	1066 (73.7)		

Values are reported as mean ± standard deviation unless stated otherwise VARA = Veterans Affairs Rheumatoid Arthritis Registry; DAS28 = Disease Activity Score; RA = Rheumatoid Arthritis; csDMARDs = conventional synthetic disease-modifying antirheumatic drug; b/tsDMARDs = biologic or targeted synthetic disease-modifying antirheumatic drug; Anti-CCP = Anti-cyclic citrullinated peptide

- had lower agreement

Hanifah Ali², Punyasha Roul MS², Yangyuna Yang MBBS, Ph.D², Kaleb Michaud, Ph.D², Ted Mikuls, MD, MSPH^{1,2}, and Bryant England MD, Ph.D^{1,2}

Results

Table 3. RDCI scores and agreement for ICD-9 and ICD-10 Cohorts					
	All Patients		Patient in both cohorts (N=862)		
	ICD-9-CM (N=1,082)	ICD-10-CM (N=1,446)	ICD-9-CM	ICD-10-CM	ICC Value ⁶ (95% CI)
RDCI Score	2.95 ± 1.73	2.93 ± 1.75	2.89 ± 1.70	3.02 ± 1.76	0.71 (0.68-0.74)

	All Patients		Patient i	Patient in both cohorts (N=862)		
	ICD-9-CM (N=1,082)	ICD-10-CM (N=1,446)	ICD-9-CM	ICD-10-CM	ICC Value ⁶ (95% CI)	
RDCI Score	2.95 ± 1.73	2.93 ± 1.75	2.89 ± 1.70	3.02 ± 1.76	0.71 (0.68-0.74)	

Table 4. Comorbidity frequency and agreement for ICD-9 and ICD-10 cohorts

	All Patents		Patients in both cohorts (N=862)		
Comorbid Condition	ICD-9-CM % (N=1,082)	ICD-10-CM % (N=1,446)	ICD-9-CM %	ICD-10-CM %	Cohen's Kappa ^{7,8}
Myocardial Infarction	7.2	5.0	6.5	5.6	0.47
Hypertension	65.3	63.5	65.1	63.2	0.71
Diabetes Mellitus	29.1	28.5	27.8	31.2	0.84
Depression	27.6	23.7	28.3	25.8	0.61
Ulcer or Stomach Problem	8.2	8.0	6.8	8.0	0.27
Stroke	5.2	6.5	4.5	6.3	0.49
Fracture spine, hip, or leg	1.8	2.7	1.3	2.0	0.13
Other Cardiovascular	35.0	36.9	32.1	37.8	0.63
Lung Disease	29.9	32.4	29.4	33.1	0.62
Cancer	20.9	20.1	20.3	21.8	0.58

Conclusions

Mapping RDCI from ICD-9 to ICD-10 generates comparable scores

More chronic conditions (e.g. diabetes and hypertension) had higher

agreement, while more acute conditions (e.g. fractures and ulcers)

Updated RDCI can be used in research with ICD-10-CM era data

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Creen = moderate agreement of migher (K = 0.71), Key = 1633 than moderate agreement (K = 0.70)

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Veterans Affairs **Rheumatoid Arthritis** Registry

References

- nte, A., & del Rincón, I. (1999). How much disability in rheumatoid arthritis is explained by rheumatoid arthritis? Arthritis and Rheumatism, 42(8), 1712-1721. r, H., Smolen, J. S., & Aletaha, D. (2010). Impact of comorbidity on physical function in patients with rheumatoid arthritis. Annals of the Rheumatic es, 69(3), 536-541
- d, K., & Wolfe, F. (2007). Comorbidities in rheumatoid arthritis. Best Practice & Research.Clinical Rheumatology, 21(5), 885-906. I, B. R., Sayles, H., Mikuls, T. R., Johnson, D. S., & Michaud, K. (2015). Validation of the rheumatic disease comorbidity index. Arthritis Care &
- ch, 67(6), 865-872 for Disease Control and Prevention. (2015). International Classification of Diseases, (ICD-10-CM/PCS) transition -
- *pund*. www.cdc.gov/nchs/icd/icd10cm_pcs_background.htm. K., & Li, M. Y. (2016). A Guideline of Selecting and Reporting Intraclass Correlation Coefficients for Reliability Research. Journal of Chiropractic ne, 15(2), 155-163.
- , J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics, 33*(1), 159-174. . J., & Garrett, J. M. (2005). Understanding interobserver agreement: the kappa statistic. *Family Medicine*, 37(5), 360-363.