ICD-10 Coordination and Maintenance Committee Meeting
September 13-14, 2016
Diagnosis Agenda

Welcome and announcements
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Co-Chair, ICD-10 Coordination and Maintenance Committee

Diagnosis Topics:

Contents

ICD-10 TIMELINE

A timeline of important dates in the ICD-10 process is described below:

September 13 –14, 2016	ICD-10 Coordination and Maintenance Committee meeting. Those who wish to attend the ICD-10 Coordination and Maintenance Committee meeting **must have registered for the meeting online by September 2, 2016.** You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building.
October 2016	Webcast of the September 13–14, 2016 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/meetings.html The webcast and video of the September 13–14, 2016 ICD-10 Coordination and Maintenance Committee meeting will be posted on CMS Youtube channel, at the link below. https://www.youtube.com/user/CMSHHSgov
October 1, 2016	New and revised ICD-10-CM and ICD-10-PCS codes go into effect along with DRG changes. Final addendum available on web pages as follows: Diagnosis addendum - http://www.cdc.gov/nchs/icd/icd10cm.htm Procedure addendum – http://www.cms.gov/Medicare/Coding/ICD10/
October 16, 2016	**Deadline for receipt of public comments on proposed new codes discussed at the September 13-14, 2016 ICD-10 Coordination and Maintenance Committee meetings for implementation on April 1, 2017.**
November 2016	Any new ICD-10 codes required to capture new technology that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2017 will be posted on the following websites: http://www.cdc.gov/nchs/icd/icd10cm.htm http://www.cms.gov/Medicare/Coding/ICD10/
November 13, 2016	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the September 13-14, 2016 ICD-10**

	Coordination and Maintenance Committee meetings for implementation on October 1, 2017.
January 6, 2017	**Deadline for requestors: Those members of the public requesting that topics be discussed at the March 7–8, 2017 ICD-10 Coordination and Maintenance Committee meeting must have their requests submitted to CMS for procedures and NCHS for diagnoses by this date.**
February 2017	Tentative agenda for the Procedure part of the March 7, 2017 ICD-10 Coordination and Maintenance Committee meeting posted on CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials.html Tentative agenda for the Diagnosis part of the March 8, 2017 ICD-10 Coordination and Maintenance Committee meeting posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd/icd10cm_maintenance.htm Federal Register notice of March 7–8, 2017 ICD-10 Coordination and Maintenance Committee Meeting will be published.
February 3, 2017	**On-line registration opens for the March 7–8, 2017 ICD-10 Coordination and Maintenance Committee meeting at: https://www.cms.gov/apps/events/default.asp**
March 2017	Because of increased security requirements, **those wishing to attend the March 7–8, 2017** ICD-10 Coordination and Maintenance Committee meeting must register for the meeting online at: **https://www.cms.gov/apps/events/default.asp** **Attendees must register online by February 3, 2017; failure to do so may result in lack of access to the meeting**.
March 7 – 8, 2017	ICD-10 Coordination and Maintenance Committee meeting.
March 2017	Webcast of the March 7-8, 2017 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials.html Summary report of the Diagnosis part of the March 8, 2017 ICD-10 Coordination and Maintenance Committee meeting report will be posted on the NCHS webpage as follows: http://www.cdc.gov/nchs/icd/icd10cm_maintenance.htm

April 1, 2017	Any new ICD-10 codes to capture new diseases or technology on April 1, 2017, will be implemented.
April 7, 2017	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the March 7–8, 2017 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2017**.
April 2017	Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This notice will include references to the finalized FY 2018 ICD-10-CM diagnosis and ICD-10-PCS procedure codes to date. It will also include proposed revisions to the MS-DRG system based on ICD-10-CM/PCS codes on which the public may comment. The proposed rule can be accessed at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/IPPS/list.asp
June 2017	Final addendum posted on web pages as follows: Diagnosis addendum – http://www.cdc.gov/nchs/icd/icd10cm.htm Procedure addendum - http://cms.hhs.gov/Medicare/Coding/ICD10/index.html
July 14, 2017	**Deadline for requestors: Those members of the public requesting that topics be discussed at the September 12–13, 2017 ICD-10 Coordination and Maintenance Committee meeting must have their requests submitted to CMS for procedures and NCHS for diagnoses.**
August 1, 2017	Hospital Inpatient Prospective Payment System final rule to be published in the Federal Register as mandated by Public Law 99-509. This rule will also include links to all the final codes to be implemented on October 1, 2017. This rule can be accessed at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/IPPS/list.asp
August 2017	Tentative agenda for the Procedure part of the September 12–13, 2017 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage at – https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials.html Tentative agenda for the Diagnosis part of the September 12-13, 2017 ICD-10 Coordination and Maintenance Committee meeting will be posted on the NCHS webpage at -

	http://www.cdc.gov/nchs/icd/icd10cm_maintenance.htm Federal Register notice for the September 12-13, 2017 ICD-10 Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.
August 4, 2017	**On-line registration opens for the September 12-13, 2017 ICD-10 Coordination and Maintenance Committee meeting at: https://www.cms.gov/apps/events/default.asp**
September 1, 2017	Because of increased security requirements, those wishing to attend the September 12-13, 2017 ICD-10 Coordination and Maintenance Committee meeting must register for the meeting online at: **https://www.cms.gov/apps/events/default.asp** **Attendees must register online by September 1, 2017; failure to do so may result in lack of access to the meeting.**
September 12-13, 2017 (tentative)	ICD-10 Coordination and Maintenance Committee meeting. Those who wish to attend the ICD-10 Coordination and Maintenance Committee meeting **must have registered for the meeting online by September 1, 2017.** You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building.
September 2017	Webcast of the September 12-13, 2017 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/meetings.html Summary report of the Diagnosis part of the September 12-13, 2017 ICD-10 Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd/icd10cm_maintenance.htm
October 1, 2017	New and revised ICD-10-CM and ICD-10-PCS codes go into effect along with DRG changes. Final addendum available on web pages as follows: Diagnosis addendum - http://www.cdc.gov/nchs/icd/icd10cm.htm Procedure addendum – http://www.cms.gov/Medicare/Coding/ICD10/
October 17, 2017	**Deadline for receipt of public comments on proposed new codes discussed at the September 12-13, 2017 ICD-10 Coordination and**

	Maintenance Committee meetings for implementation on April 1, 2018.
November 2017	Any new ICD-10 codes required to capture new technology that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2018 will be posted on the following websites: http://www.cdc.gov/nchs/icd/icd10cm.htm http://www.cms.gov/Medicare/Coding/ICD10/
November 13, 2017	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the September 12-13, 2017 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2018.**

Webcast and Dial-In Information

• The meeting will begin promptly at 9am ET and will be webcast.

Toll-free dial-in access is available for participants who cannot join the webcast: Phone: 1-877-267-1577; Meeting ID: 997 795 269. We encourage you to join early, as the number of phone lines is limited.

• If participating via the webcast or dialing in you do NOT need to register on-line for the meeting.

This meeting is being webcast via CMS at http://www.cms.gov/live/. By your attendance, you are giving consent to the use and distribution of your name, likeness and voice during the meeting. You are also giving consent to the use and distribution of any personally identifiable information that you or others may disclose about you during the meeting. Please do not disclose personal health information.

NOTE: In compliance to The Real ID Act, enacted in 2005, the following states/territories: American Samoa, Louisiana, Minnesota, New Hampshire, and New York **will not** gain access into any Federal Agencies using the **above states** driver's license or ID. This means CMS visitors from these states/territories will need to provide alternative proof of identification (**such as a passport**) to gain entrance into Baltimore-based CMS building.

Contact Information

Mailing address:

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Comments on the diagnosis proposals presented at the ICD Coordination and Maintenance Committee meeting should be sent to the following email address: nchsicd10CM@cdc.gov

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NCHS Classifications of Diseases web page:
http://www.cdc.gov/nchs/icd.htm
Please consult this web page for updated information.

Continuing Education Credits

Continuing education credits may be awarded by the American Academy of Professional Coders (AAPC) or the American Health Information Management Association (AHIMA) for participation in CMS/NCHS ICD-10 Coordination and Maintenance (C&M) Committee Meeting.

Continuing Education Information for American Academy of Professional Coders (AAPC)

If you plan to attend or participate via telephone the ICD-10 Coordination and Maintenance (C&M) Committee Meeting, you should be aware that CMS /NCHS do not provide certificates of attendance for these calls. Instead, the AAPC will accept your printed topic packet as proof of participation. Please retain a your topic packet copy as the AAPC may request them for any conference call you entered into your CEU Tracker if you are chosen for CEU verification. Members are awarded one (1) CEU per hour of participation.

Continuing Education Information for American Health Information Management Association (AHIMA)

AHIMA credential-holders may claim 1 CEU per 60 minutes of attendance at an educational program. Maintain documentation about the program for verification purposes in the event of an audit. A program does not need to be pre-approved by AHIMA, nor does a CEU certificate need to be provided, in order to claim AHIMA CEU credit. For detailed information about AHIMA's CEU requirements, see the Recertification Guide on AHIMA's web site.

Please note: The statements above are standard language provided to NCHS by the AAPC and the AHIMA. If you have any questions concerning either statement, please contact the respective organization, not NCHS.

Abnormality in Fetal Heart Rate or Rhythm

The American Congress of Obstetricians and Gynecologists (ACOG) and The Society for Maternal Fetal Medicine (SM-FM) are requesting new codes to report abnormalities of the fetal heart rate or rhythm during the antepartum period.

It is common to have abnormalities of the fetal heart rate or rhythm during the antepartum period including fetal tachycardia, fetal bradycardia, decelerations of the fetal heart rate, and loss of variability. Abnormalities during antenatal tests such as non-stress tests (NSTs) and contraction stress tests (CSTs) are also reported.

In ICD-9-CM the code 659.73 - Abnormality in fetal heart rate or rhythm, antepartum condition or complication was available. There is no specific code in ICD-10-CM to report these findings when they occur in the antenatal period.

ACOG proposes the following tabular modifications.

TABULAR MODIFICATIONS

O36 Maternal care for other fetal problems

One of the following 7th characters is to be assigned to each code under category O36. 7th character 0 is for single gestations and multiple gestations where the fetus is unspecified. 7th characters 1 through 9 are for cases of multiple gestations to identify the fetus for which the code applies. The appropriate code from category O30, Multiple gestation, must also be assigned when assigning a code from category O36 that has a 7th character of 1 through 9.

0 not applicable or unspecified
1 fetus 1
2 fetus 2
3 fetus 3
4 fetus 4
5 fetus 5
9 other fetus

O36.8 Maternal care for other specified fetal problems

New Sub-subcategory O36.83 Maternal care for abnormalities of the fetal heart rate or rhythm during the antepartum

New code O36.831 Abnormalities of the fetal heart rate or rhythm during the antepartum, first trimester

New code O36.832 Abnormalities of the fetal heart rate or rhythm during the antepartum, second trimester

New code	O36.833 Abnormalities of the fetal heart rate or rhythm during the antepartum, third trimester
New code	O36.839 Abnormalities of the fetal heart rate or rhythm during the antepartum, unspecified trimester

Acute Appendicitis

Acute appendicitis progresses from inflammation of the appendix, then gangrene, followed by perforation. Perforation results in contamination of the peritoneal space with enteric bacteria, which can result in abscess formation or generalized bacterial contamination of the peritoneal space (generalized peritonitis). Perforation, the presence of an abscess, and the presence of generalized peritonitis are key characteristics of appendicitis that physicians use to describe the severity of the disease and determine the most appropriate treatment, such as deciding whether or not to perform an appendectomy or drain abscesses (sometimes percutaneously) and determining the duration of antibiotic treatment.

"Peritonitis" technically refers to inflammation of the peritoneum, and physicians use the term differently in different contexts. In some contexts, the term refers to the quality of tenderness on physical exam; in others, it refers to an inflammatory process involving the peritoneal cavity (e.g., lupus peritonitis). Though "peritonitis" may signify bacterial contamination of the peritoneal space, the term is not necessarily synonymous with this concept. With acute appendicitis, the single most important distinction is between perforation (bacterial contamination of the peritoneal space) and no perforation (no bacterial contamination), rather than the presence or absence of sterile inflammation of the peritoneum. However, the includes terms direct coders to use K35.3 "Acute appendicitis with localized peritonitis" even for cases without perforation or rupture. Thus, the current use of the term "peritonitis" in the classification is potentially misleading.

Acute appendicitis with peritoneal abscess only occurs after the appendix has ruptured, but it does not distinguish whether the perforation involved localized versus generalized contamination. "Acute appendicitis with peritoneal abscess" is currently included with K35.3 "Acute appendicitis with localized peritonitis." However, this entity can occur with either localized or generalized peritonitis.

Thus, beyond the critical distinction between perforation and no perforation, additional distinctions between non-gangrenous and gangrenous appendicitis and between perforation without abscess and perforation with abscess would be helpful.

This proposal was developed by CDC, based on a detailed request from the Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma, to better distinguish the severity of acute appendicitis.

TABULAR MODIFICATIONS

K35 Acute appendicitis

K35.2 Acute appendicitis with generalized peritonitis

Includes: Appendicitis (acute) with generalized (diffuse) peritonitis following rupture or perforation of appendix

Delete Includes: ~~Perforated appendix NOS~~

Delete Includes: ~~Ruptured appendix NOS~~

New code K35.20 Acute appendicitis with generalized peritonitis, without abscess
(Acute) appendicitis with generalized peritonitis NOS
Perforated appendix NOS
Ruptured appendix NOS

New code K35.21 Acute appendicitis with generalized peritonitis, with abscess

K35.3 Acute appendicitis with localized peritonitis

Delete Includes: ~~Acute appendicitis with or without perforation or rupture NOS~~

Delete Includes: ~~Acute appendicitis with or without perforation or rupture with localized peritonitis~~

Delete Includes: ~~Acute appendicitis with peritoneal abscess~~

New code K35.30 Acute appendicitis with localized peritonitis, without perforation or gangrene
Acute appendicitis with localized peritonitis NOS

New code K35.31 Acute appendicitis with localized peritonitis and gangrene, without perforation

New code K35.32 Acute appendicitis with perforation and localized peritonitis, without abscess
(Acute) appendicitis with perforation NOS
Ruptured appendix with localized peritonitis NOS

New code K35.33 Acute appendicitis with perforation and localized peritonitis, with abscess
(Acute) appendicitis with (peritoneal) abscess NOS
Ruptured appendix with localized peritonitis and abscess

K35.8 Other and unspecified acute appendicitis

K35.89 Other acute appendicitis

New code	K35.890	Other acute appendicitis without perforation or gangrene
New code	K35.891	Other acute appendicitis without perforation, with gangrene (Acute) appendicitis with gangrene NOS

Acute Respiratory Distress

Currently in ICD-10-CM the term acute respiratory distress and acute respiratory distress syndrome are both indexed to J80 (Acute respiratory distress syndrome). Effective October 1, 2016, acute respiratory distress will be indexed to R06.00 Dyspnea, unspecified.

The American Academy of Pediatrics is requesting that a new code be created to specifically identify patients with acute respiratory distress. The following tabular modification is being requested.

TABULAR MODIFICATIONS

R06.0 Dyspnea
Excludes1: tachypnea NOS (R06.82)
transient tachypnea of newborn (P22.1)

R06.00 Dyspnea, unspecified

R06.01 Orthopnea

R06.02 Shortness of breath

New code R06.03 Acute respiratory distress

R06.09 Other forms of dyspnea

All-terrain-vehicles (ATVs) and motor-cross/dirt bikes

In 2014, more than 93,700 all-terrain-vehicle (ATV) related injuries were reported to the Consumer Product Safety Commission (CPSC) through the National Electronic Injury Surveillance System (NEISS). [1] NEISS data can be used to estimate the number of ATV injuries for the U.S., but it is unable to provide statewide or local numbers.

Many states, have a large number of rural communities where ATVs are commonly used for recreation and work. The requestor, Dr Peter Masiakos, Assistant Professor of Surgery, Director of Pediatric Trauma Services at Massachusetts General Hospital, noted that every year, more and more families are devastated by deaths and injuries from ATV-related crashes.

Currently ICD-10-CM does not include external cause codes that solely identify ATV or motor-cross/dirt bike vehicle-related injuries. This currently makes the ongoing surveillance of these injuries and evaluating laws, policies, and other prevention efforts related to reducing the burden difficult to assess.

To improve the injury surveillance and evaluation capability for off-road vehicle injuries, the following tabular modifications are being requested for the addition of new codes to capture 3- and 4- wheeled all-terrain vehicles (ATVs) and motor-cross / dirt bikes.

The NCHS Injury Statistics Program has reviewed and supports this proposal.

TABULAR MODIFICATIONS

V86 Occupant of special all-terrain or other off-road motor vehicle, injured in transport accident

Excludes1: special all-terrain vehicle in stationary use or maintenance (W31.-)
sport-utility vehicle (V50-V59)
three-wheeled motor vehicle designed for on-road use (V30-V39)

The appropriate 7th character is to be added to each code from category V86

A initial encounter
D subsequent encounter
S sequela

V86.0 Driver of special all-terrain or other off-road motor vehicle injured in traffic accident

New Code V86.05 Driver of 3- or 4- wheeled all-terrain vehicle (ATV) injured in traffic accident

New Code V86.06 Driver of dirt bike or motor/cross bike injured in traffic accident

V86.1 Passenger of special all-terrain or other off-road motor vehicle injured in

traffic accident

New Code V86.15 Passenger of 3- or 4- wheeled all-terrain vehicle (ATV) injured in traffic accident

New Code V86.16 Passenger of dirt bike or motor/cross bike injured in traffic accident

V86.2 Person on outside of special all-terrain or other off-road motor vehicle injured in traffic accident

New Code V86.25 Passenger of 3- or 4- wheeled all-terrain vehicle (ATV) injured in traffic accident

New Code V86.26 Passenger of dirt bike or motor/cross bike injured in traffic accident

V86.3 Unspecified occupant of special all-terrain or other off-road motor vehicle injured in traffic accident

New Code V86.35 Passenger of 3- or 4- wheeled all-terrain vehicle (ATV) injured in traffic accident

New Code V86.36 Passenger of dirt bike or motor/cross bike injured in traffic accident

V86.4 Person injured while boarding or alighting from special all-terrain or other off-road motor vehicle

New Code V86.45 Person injured while boarding or alighting from a 3- or 4- ATV

New Code V86.46 Person injured while boarding or alighting from a dirt bike or motor/cross bike

V86.5 Driver of special all-terrain or other off-road motor vehicle injured in nontraffic accident

New Code V86.55 Driver of 3- or 4- wheeled all-terrain vehicle (ATV) injured in nontraffic accident

New Code V86.56 Driver of dirt bike or motor/cross bike injured in nontraffic accident

V86.6 Passenger of special all-terrain or other off-road motor vehicle injured in nontraffic accident

New Code V86.65 Passenger of 3- or 4- wheeled all-terrain vehicle (ATV) injured in nontraffic accident

New Code V86.66 Passenger of dirt bike or motor/cross bike injured in nontraffic accident

V86.7 Person on outside of special all-terrain or other off-road motor vehicle injured in nontraffic accident

New Code		V86.75 Person on outside of 3- or 4- wheeled all-terrain vehicle (ATV) injured in nontraffic accident
New Code		V86.76 Person on outside of dirt bike or motor/cross bike injured in nontraffic accident
	V86.9	Unspecified occupant of special all-terrain or other off-road motor vehicle injured in nontraffic accident
New Code		V86.95 Unspecified occupant of 3- or 4- wheeled all-terrain vehicle (ATV) injured in nontraffic accident
New Code		V86.96 Unspecified occupant of dirt bike or motor/cross bike injured in nontraffic accident
		V86.99 Unspecified occupant of other special all-terrain or other off-road motor vehicle injured in nontraffic accident
Delete		~~Unspecified occupant of dirt bike injured in nontraffic accident~~

Amyloidosis

Amyloidosis involves deposition of proteins that have become misfolded, going from a normal soluble state to insoluble amyloid fibrils.[1] These deposits may result in a wide range of clinical manifestations depending upon their type, location, and the amount of deposition. This proposal to update the ICD-10-CM codes for representing amyloidosis is based on a request from GlaxoSmithKline, a biopharmaceutical company.

Much has been learned about the amyloidosis disease area, and there has been deeper understanding of the various forms of amyloidosis, its unique presentations, chemical characteristics, and patient management techniques. New treatments are currently being developed and tested for various types of amyloidosis, with clinical trials being conducted for certain of these, and certain new medications with expected FDA approvals between 2018-2022. However, the current ICD-10-CM codes and terms do not currently employ the most recent terminology and classification for amyloidosis. It is now usual to classify amyloidosis based on the proteins involved.

Amyloidosis may be localized, with amyloid protein deposited in the organ or tissue where the protein is produced, or systemic, where amyloid protein may be deposited at one or more sites distant from where it was produced.[1] The major systemic types of amyloidosis are light chain amyloidosis (AL), transthyretin-related amyloidosis (ATTR), and serum amyloid A (AA) amyloidosis. AL is associated with a light chain-producing plasma cell dyscrasia, and is the most common type.[1] ATTR may be wild-type ATTR, associated with normal transthyretin and old age), or hereditary ATTR (associated with a transthyretin mutation, or variant) amyloidosis.[1,2] Amyloidosis type AA is associated with longstanding inflammation, usually with an underlying chronic inflammatory disease. Type AA is less common in the U.S. There are a number of other specific types of amyloidosis that are more rare. [1] The types of amyloidosis are all very different from each other with respect to the biochemical nature of the amyloid deposit, clinical manifestation, and treatment guidelines.

Types of Amyloidosis

Transthyretin-related (ATTR) Familial Amyloid Cardiomyopathy

Hereditary amyloidosis is a heterogeneous group of disorders with multiple manifestations. One of the most common manifestations and the major cause of death in this patient population is cardiomyopathic amyloidosis, or familial amyloid cardiomyopathy (FAC), which is caused by deposition of fibrils derived from TTR in the heart.[2] While ATTR FAC has a phenotype similar to wild-type ATTR, there are some differences in patient characteristics; specifically, patients with wild-type ATTR tend to be older at presentation and have longer disease duration than patients with ATTR FAC.[3] When amyloid deposits cause cardiomyopathy, it can result in a stiffening of the heart. Congestive heart failure and atrial fibrillation are the most common symptoms.[4]

Transthyretin-related (ATTR) Familial Amyloid Polyneuropathy

Another example of amyloidosis is ATTR familial amyloid polyneuropathy (FAP). The clinical manifestations of ATTR FAP may include progressive sensory, motor and autonomic neuropathies, as well as visceral organs being affected, depending on the specific subtype of FAP.[2,5] Neuropathic forms of FAP often involve an autonomic, sensory dominant polyneuropathy, often affecting pain and temperature sensation the most severely.[5] Autonomic impairment may involve gastrointestinal symptoms, often with diarrhea alternating with constipation. Other effects may commonly involve dyshidrosis, sexual impotence, orthostatic hypotension, urinary disturbances, ocular involvement, and cardiac and renal dysfunction.[5] Another form of FAP can particularly affect the central nervous system, and may cause cerebral infarction and hemorrhage, hydrocephalus, ataxia, spastic paralysis, convulsion, and dementia.[5]

Wild-type Transthyretin-related (ATTR) Amyloidosis

Wild-type ATTR involving deposition in systemic organs is thought to be underdiagnosed, with such deposition thought to be a common aging-related phenomenon, particularly after age 80.[2] However, it may require a substantial amount of wild-type (normal) TTR deposition to develop clinical symptoms or signs.[2] Wild-type ATTR predominantly affects males, and may typically involve a slowly progressive cardiomyopathy leading to cardiac manifestations, such as congestive heart failure, atrial fibrillation and intractable arrhythmia.[1,2] Carpal tunnel syndrome is another common clinical manifestation, and may often develop as an initial symptom. [1,2] Cardiogenic embolism and mild to moderate renal dysfunction may also frequently be seen.[2] Wild-type ATTR is also known as Senile Systemic Amyloidosis (SSA).[6] Those with wild-type ATTR and cardiac involvement have a better prognosis, with survival averaging a little over 6 years, comparing to those with light chain amyloidosis (AL), which has a much shorter survival with cardiac involvement.[6]

Light Chain Amyloidosis (AL)

In the U.S. and other developed countries, AL amyloidosis is the most common type.[1] It usually affects people from ages 50-80 years old with about two- thirds of the patients being male.[3] AL amyloidosis is generally related to an underlying plasma cell dyscrasia, which leads to deposition of certain immunoglobulin light chains as insoluble amyloid fibrils.[1] AL amyloidosis can occur alone or in association with multiple myeloma or, much less often, Waldenström's macroglobulinemia or non-Hodgkin lymphoma.[1,7,8] The presentation for AL can vary from vague symptoms such as weight loss or fatigue to severe nephrotic syndrome, right-sided heart failure, diarrhea, or liver failure. These may present with edema or hypotension. An enlarged tongue with indentations (glossomegaly) together with periorbital ecchymosis are signs almost pathognomonic of AL amyloidosis.[1]

Serum Amyloid A Amyloidosis (AA)

AA amyloidosis is associated with chronic inflammatory disease or chronic infectious disease, with ongoing or recurring inflammation. Infection or inflammation causes elevation of an acute phase protein, serum amyloid A protein (SAA), part of which (AA protein) deposits as amyloid fibrils. Examples of chronic inflammatory diseases associated with AA amyloidosis include rheumatic diseases, such as rheumatoid arthritis, ankylosing spondylitis, and psoriatic arthritis; inflammatory bowel disease (including Crohn's disease and ulcerative colitis); hematologic malignancies, including Hodgkin's

disease, renal cell carcinoma, and Castleman's disease; and hereditary autoinflammatory disorders such as familial Mediterranean fever (FMF), tumor necrosis factor receptor associated periodic syndrome (TRAPS), the hyperimmunoglobin D syndrome, and cryopyrin-associated periodic syndromes. Chronic infections associated with AA include tuberculosis, AIDS, osteomyelitis bronchiectasis, infections associated with cystic fibrosis, and skin infections with needle-using drug addiction. The most common organ system involved in AA amyloidosis is the kidney, ranging from proteinuria to nephrotic syndrome with loss of renal function. Autonomic dysfunction may occur, and cause gastrointestinal problems, with symptoms such as diarrhea and disturbed gastric emptying; and less often, there can involvement of other organs, such as the liver (e.g., hepatomegaly), the heart (e.g., cardiomyopathy), spleen, or thyroid.[1,9]

Creation of new ICD-10-CM codes are proposed to identify AL and wild-type ATTR amyloidosis. It is also proposed to add inclusion terms for identifying ATTR FAP to code E85.1, Neuropathic heredofamilial amyloidosis, for ATTR FAC, to E85.4, Organ-limited amyloidosis. At this point there has not been a request for any specific identification of AA amyloidosis, although it could map to either code E85.0, Non-neuropathic heredofamilial amyloidosis, or E85.3, Secondary systemic amyloidosis, depending on the specific underlying cause. These proposed new ICD-10-CM codes and revisions to the current amyloidosis codes are anticipated to help clinicians better track and identify patients, ensure treatment options are appropriate, and to enable research analysts to track and study several specific presentations of this disease.

TABULAR MODIFICATIONS

E85 Amyloidosis

E85.0 Non-neuropathic heredofamilial amyloidosis
Hereditary amyloid nephropathy

Add Code also associated disorders, such as:
Autoinflammatory syndromes (M04.-)

Add Excludes2: Transthyretin-related (ATTR) familial amyloid cardiomyopathy

E85.1 Neuropathic heredofamilial amyloidosis
Amyloid polyneuropathy (Portuguese)

Add Transthyretin-related (ATTR) familial amyloid polyneuropathy

	E85.4	Organ-limited amyloidosis Localized amyloidosis	
Add		Transthyretin-related (ATTR) familial amyloid cardiomyopathy	
	E85.8	Other amyloidosis	
New code		E85.81	Light Chain (AL) amyloidosis
New code		E85.82	Wild-type transthyretin-related (ATTR) amyloidosis Senile systemic amyloidosis (SSA)
New code		E85.89	Other amyloidosis

References.

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Amyotrophic Lateral Sclerosis (ALS)

Amyotrophic Lateral Sclerosis (ALS), commonly known as Lou Gehrig's disease, is a progressive and motor neuron disease (MND). The average survival time after onset of symptoms is approximately three years, and only a small proportion of patients survive beyond five years. This updated proposal is based on comments received during the public comment period following the September 2015 presentation, including modifications proposed by the American Academy of Neurology (AAN) recommending unique codes for familial motor neuron disease and progressive spinal muscle atrophy (shown in bold).

As noted in the September 2015 proposal, the Centers for Disease Control and Prevention's Agency for Toxic Substances and Disease Registry (ATSDR) launched the National ALS Registry that identifies ALS cases through the use of existing national datasets including Medicare, Medicaid, and Veterans Health Administration and self-registration. Cases identified through the national databases rely on ICD codes as well as information on type of provider seen and prescription data. The most recent report on ALS prevalence in the United States (2012-2013) was published in the Morbidity and Mortality Weekly Report (MMWR) on August 5, 2016 (http://www.cdc.gov/mmwr/volumes/65/ss/ss6508a1.htm).

The requestors have asked that the new codes be considered for April 1, 2017 expedited implementation. **Therefore, comments on this topic are requested by October 16, 2016.**

TABULAR MODIFICATIONS

	G12		Spinal muscular atrophy and related syndromes
		G12.2	Motor neuron disease
		G12.20	Motor neuron disease, unspecified
		G12.21	Amyotrophic lateral sclerosis
Delete			~~Progressive spinal muscle atrophy~~
		G12.22	Progressive bulbar palsy
New Code		G12.23	Primary lateral sclerosis
New Code		G12.24	Familial motor neuron disease
New Code		G12.25	Progressive spinal muscle atrophy
		G12.29	Other motor neuron disease
Delete			~~Familial motor neuron disease~~
Delete			~~Primary lateral sclerosis~~

Antenatal Screening

The American Congress of Obstetricians and Gynecologists (ACOG) is requesting the expansion of the code category for antenatal screening. Currently in ICD-10-CM, there is a single code for all antenatal screening, Z36 (Encounter for antenatal screening of mother). ACOG is proposing to bring ICD-9-CM antenatal screening specificity to ICD-10-CM for improved data tracking and quality measurement of antenatal screening performance.

Antenatal screening can consist of several layers of screening in the absence of symptoms before a specific diagnosis is determined or ruled out. Lack of specificity for antenatal screening severely limits the clinical information available to treat patients.

ACOG proposes the following tabular modifications.

TABULAR MODIFICATIONS

	Z36 Encounter for antenatal screening of mother
Add	Placental sample (taken vaginally)
New code	Z36.0 Encounter for antenatal screening for chromosomal anomalies
New code	Z36.1 Encounter for screening for raised alphafetoprotein level
New code	Z36.2 Encounter for other screening follow-up
Add	Non-visualized anatomy on a previous scan
New code	Z36.3 Encounter for screening for malformations
Add	Screening for a suspected anomaly
New code	Z36.4 Encounter for screening for fetal growth retardation
Add	Intrauterine growth restriction (IUGR)/small-for-dates
New code	Z36.5 Encounter for antenatal screening for isoimmunization
New subcategory	Z36.8 Encounter for other specified antenatal screening
New code	Z36.80 Encounter for antenatal screening for Hydrops fetalis
New code	Z36.81 Encounter for antenatal screening for nuchal translucency
New code	Z36.82 Encounter for fetal screening for congenital cardiac abnormalities
New code	Z36.83 Encounter for antenatal screening for fetal lung maturity
New code	Z36.84 Encounter for antenatal screening for Streptococcus B
New code	Z36.85 Encounter for antenatal screening for cervical length
Add	Screening for risk of pre-term labor

New code	Z36.86 Encounter for antenatal screening for uncertain dates
New code	Z36.87 Encounter for antenatal screening for fetal macrosomia
Add	Screening for large-for-dates
New code	Z36.88 Encounter for antenatal screening for other specified
New code	Z36.8A Encounter for antenatal screening for other genetic defects
Add	Screening for hemoglobinopathy

Atrial Fibrillation

A previous proposal to expand the codes for atrial fibrillation was presented in September 2015, but was not implemented. This proposal is simplified and modified from that of September 2015.

Atrial fibrillation is a common cause of an abnormal, irregular heartbeat. The heart wall does not move normally in atrial fibrillation, so there is a risk of blood clots forming in the heart, and risk of thromboembolism, including thromboembolic stroke. Atrial fibrillation is generally treated by electrical or pharmacological cardioversion.

Persistent atrial fibrillation describes cases that do not terminate within seven days, or that require repeat pharmacological or electrical cardioversion. Longstanding persistent atrial fibrillation is persistent and continuous atrial fibrillation lasting longer than one year. Permanent atrial fibrillation is persistent or longstanding persistent atrial fibrillation where cardioversion is not indicated, or cannot or will not be performed. The term chronic atrial fibrillation may refer to any of persistent, longstanding persistent, or permanent atrial fibrillation, but in usual clinical practice, use of one of those more specific descriptive terms is preferred.

Atrial fibrillation may be associated with normal pulse rate, atrial tachycardia, or atrial bradycardia (or with alternating appearance of tachycardia and bradycardia, often referred to as tachy-brady syndrome).

Atrial fibrillation is frequently associated with mitral valvular disease, particularly mitral insufficiency. The treatment of those patients with disease of the mitral valve may be significantly different from treatment of patients whose atrial fibrillation is not associated with mitral valvular disease, so the distinction is important to identify and track.

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TABULAR MODIFICATIONS

I48 Atrial fibrillation and flutter

Add Code also, if present:
bradycardia (R00.1)
mitral valve insufficiency (I34.0)
rheumatic mitral insufficiency (I05.1)
tachycardia (I47.1)
tachycardia-bradycardia syndrome (I49.5)

I48.1 Persistent atrial fibrillation

New code I48.11 Longstanding persistent atrial fibrillation

New code I48.19 Other persistent atrial fibrillation
Persistent atrial fibrillation, NOS

I48.2 Chronic atrial fibrillation
Delete ~~Permanent atrial fibrillation~~

New code I48.20 Chronic atrial fibrillation, unspecified

New code I48.21 Permanent atrial fibrillation

Avoidant/Restrictive Food Intake Disorder

The American Psychiatric Association is requesting a new ICD-10-CM code for a disorder added to DSM-5, Avoidant/Restrictive Food Intake Disorder (ARFID).

This condition is characterized by the persistent failure to meet appropriate nutritional and/or energy needs resulting in significant weight loss, significant nutritional deficiency, dependence on enteral feeding or oral nutritional supplements, or marked interference with psychosocial functioning that is related to the eating or feeding disturbance.

Affected individuals may exhibit a range of apparent reasons for the food avoidance, including a lack of interest in eating, avoidance based on the sensory characteristics of foods (e.g., appearance, texture, temperature) and restriction of food intake following a traumatic experience, such as choking. This disorder is not associated with the over concern regarding shape and weight characteristic of anorexia nervosa and bulimia nervosa.

In the DSM-5 predecessor, DSM-IV, Feeding disorder of infancy or early childhood, was rarely used in practice and was criticized for failing to capture the behavioral problems of many very young children presenting with feeding difficulties. ARFID is intended to capture not only individuals who would have been classified in DSM-IV as having Feeding disorder of infancy or early childhood but also a number of other presentations that occur across the age range.

The American Psychiatric Association is requesting the following tabular modifications.

TABULAR MODIFICATIONS

F50 Eating Disorders

F50.8 Other eating disorders

F50.81 Binge eating disorder

New code F50.82 Avoidant/restrictive food intake disorder

F50.89 Other specified eating disorder
Pica in adults
Psychogenic loss of appetite

Add Other specified feeding disorder

Body Integrity Dysphoria

Body Integrity Dysphoria (BID) is a rare mental and behavioral disorder characterized by the persistent desire to have a specific physical disability (e.g., amputation, paraplegia, blindness, deafness) since childhood or early adolescence. The desire for a physical disability can be manifested in a number of ways, including fantasizing about having the desired physical disability, engaging in "pretending" behavior in which the person spends a great deal of time pretending to have the desired disabled (e.g., spending hours in a wheelchair or using leg braces to simulate having leg weakness), and spending time researching how to achieve the desired disability. The preoccupation with the desire to have the physical disability (including time spent pretending) significantly interferes with productivity, with leisure activities, or with social functioning (e.g., person is unwilling to have close relationships because it would make it difficult to pretend). Moreover, for a significant minority of individuals with this desire, their preoccupation goes beyond fantasy and they have pursued actualization of their desires though surgical means (i.e., by procuring an elective amputation of an otherwise healthy limb) or by self-damaging a limb to a degree in which amputation is the only therapeutic option (e.g., freezing a limb in dry ice).

The diagnostic term Body Integrity Dysphoria identifies a distinct group of people who need clinical attention because of the degree of suffering that they endure coupled with the risk of self-harm related to attempts to actualize the desired disability (for example, a recently well-publicized case of a 22 year woman with a desire to be blind arranged to have someone pour drain cleaner in her eyes). Although initially described in single case reports (with the first report going back to 1785 (1)), clinical and research interest in this condition has greatly increased in the past few decades, with papers reporting on its phenomenology and differential diagnosis (2-15), neurobiological underpinnings (16-27), ethical and legal issues (28-35), cross-cultural issues (36), and treatment-related issues (17, 37-40). There has also been a corresponding increase in public awareness of the existence of this condition, with the establishment of web sites that have encouraged individuals who have suffered for years in isolation to reach out and join virtual communities of other sufferers. Moreover, increased media attention both in the form of documentaries (e.g., "Whole"), episodes of popular television programs (e.g., Grey's Anatomy), novels (e.g., Career of Evil, written by J.K. Rowling under the pseudonym Robert Galbraith) and even feature films (e.g., Quid Pro Quo) has heightened awareness of the condition among members of the general public. Although the prevalence of this condition in the general population is unknown, the persistent desire to be disabled may be more common than was originally appreciated given the existence of a number of internet-based "communities" with thousands of members who share such interests.

Although the core feature of BID is the persistent desire to be disabled, individuals suffering from BID experience a variety of component features to varying degrees, which has resulted in this condition being referred to by different names over the past several decades. Similar to individuals with Gender Dysphoria, individuals with BID describe a dysphoric sense of a profound mismatch between their actual able-bodied configuration and their desired disabled body configuration and functionality, a component of the condition emphasized in the term "body integrity identity Disorder." (a term coined in (3)). Some individuals describe a significant sexual component and report intense sexual fantasies involving their desired disability, which is reflected in the term "apotemnophilia." (coined in (41)). Finally, many individuals whose desired disability is amputation report a sense of estrangement from the limb that is the target of the amputation desires, suggesting the possible involvement of the right

cerebral hemisphere given its role in the representation of the bodily self, a fact reflected in the name xenomelia (coined in (16)). The current proposed term, "body integrity dysphoria" is preferred because it is the most descriptive and does not favor any particular etiological theory. All of these alternative terms would be listed as inclusion terms.

Despite the clinically distinct nature of this condition and the fact that it is associated with significant morbidity, there is currently no category in the ICD-10-CM (or in any other classification of disorders[1]) applicable to the clinical presentation of individuals with the life-long desire to be physically disabled. Owing to its lack of recognition in ICD-10-CM, clinicians confronted with a patient with a persistent desire to become disabled are likely to misdiagnose such individuals as having a condition that might superficially share some features in common with BID and consequently institute inappropriate treatment. For example, because of the inherent bizarreness of the desire to become physically disabled and the fact that there are case reports of psychotic patients having self-amputated a body part (e.g. ,(42, 43)), clinicians unfamiliar with the existence of BID might assume that such patients are psychotic. In fact, individuals with BID have intact reality testing regarding the source and meaning of their desire for amputation, i.e., at no time do they harbor a belief that the target limb does not actually belong to them (e.g., that it has been possessed by the devil or is under alien control) and they remain fully aware of how bizarre this desire looks to other people, i.e., their insight is intact. Similarly, although individuals with BID, like those with Body dysmorphic disorder (BDD), are dissatisfied with a part or parts of their body, individuals with BDD focus on the appearance of a part of the body, believing that it is defective and a source of shame. In contrast, individuals with the desire for amputation do not believe that there is anything wrong with the appearance of the limb that they wish to be amputated or that the limb is somehow defective; they just believe that it is extraneous and does not belong there.

Many individuals have avoided seeking help from mental health professionals out of concern that their doctor would not be familiar with this condition and possibly label them as "psychotic" and potentially subject to involuntarily commitment. Indeed, in one series (3), the majority of individuals with this condition who were in treatment with a mental health professional have refrained from telling their therapist about this desire, for fear that the therapist might think that he or she is psychotic. Indeed, this concern is more than hypothetical as at least several individuals with BIID have, in fact, been involuntarily hospitalized by physicians because of a misinterpretation of an individual's desire to actualize their desire for amputation as being evidence of suicidal ideation.

Adding a new code for Body Integrity Dysphoria to ICD-10-CM would assist in the identification and management of such individuals and help clinicians make a proper differential diagnosis of patients for presenting with dissatisfaction with their bodies for other reasons (such as body dysmorphic disorder or anorexia nervosa). Furthermore, including this condition into the ICD-10-CM classification would help increase public awareness and acceptance of this condition and would hopefully reduce the extreme societal stigma and consequent shame experienced by individuals with this condition.
Because of the unique phenomenology of this condition, the optimal placement of this disorder within ICD-10-CM is challenging. Given that the primary symptoms involve cognitions, perceptions, and

[1] Body Integrity Identity Disorder was proposed for inclusion in the American Psychiatric Associations' recently revised Diagnostic and Statistical Manual for Mental Disorders, it was ultimately not included as a new disorder because of that manual's high threshold in terms of requiring extensive empirical data which effectively prevents the inclusion of rare conditions into the manual. It is discussed in the DSM text in the context of its differential diagnosis with Body Dysmorphic Disorder (DSM-5, p. 246) and Gender Dysphoria (p. 458).

behaviors, the Mental and Behavioral Disorders chapter is certainly the best initial placement. Because the sections within the Mental and Behavioral Disorders are organized around commonality of presenting symptoms (e.g., Schizophrenia, schizotypal, delusional and other non-psychotic disorder, mood disorders), it is difficult to place Body Integrity Dysphoria inside one of the existing sections in Chapter 5 given that it does not share presenting symptoms with any of these disorders. However, given that the onset of Body Integrity Dysphoria is during childhood or adolescence, it is appropriate to place this condition within the F90-F98 Behavioral and Emotional disorders with onset usually occurring in childhood and adolescence, under F98 Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence. The next available code in this section is F98.6. Thus, it is proposed that a new code, F98.6, be added to ICD-10-CM, with the most common synonyms (Body integrity identity disorder, Apotemnophilia, and Xenomelia) added as inclusion terms. Notably, this proposed placement parallels the proposal to add Body Integrity Dysphoria to the Neurodevelopmental Disorders section of the Mental and Behavioral Disorders chapter in ICD-11.

Michael B. First, M.D., Professor of Clinical Psychiatry, Columbia University, New York, is requesting the following tabular modifications.

TABULAR MODIFICATIONS

F98 Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence

New code	F98.6 Body Integrity Dysphoria
Add	Body Integrity Identity Disorder, Apotemnophilia, Xenomelia

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Cholangitis with Cholecystitis in Cholelithiasis

If cholangitis is present with cholecystitis, that can indicate more severe disease, and may require more urgent surgical intervention. It would be of clinical utility for conveying the entire clinical situation if these could be coded together. Current notes do not allow for this.

It is proposed that these notes be changed, based on input from the Coding Clinic Editorial Advisory Board.

TABULAR MODIFICATIONS

K80 Cholelithiasis

K80.4 Calculus of bile duct with cholecystitis

Revise Any condition listed in K80.5 with cholecystitis ~~(with cholangitis)~~

Add Code also presence of cholangitis (K80.3-)

K80.6 Calculus of gallbladder and bile duct with cholecystitis

Add Code also presence of cholangitis (K80.3-)

K83 Other diseases of biliary tract

K83.0 Cholangitis

Excludes1 …

Revise cholangitis with choledocholithiasis (K80.3-~~, K80.4~~)

INDEX MODIFICATIONS

Calculus, calculi, calculous
- bile duct (common) (hepatic) K80.50
- - with
- - - calculus of gallbladder - see Calculus, gallbladder and bile duct
- - - cholangitis K80.30
- - - - with

Revise - - - - - cholecystitis - see <u>also</u> Calculus, bile duct, with cholecystitis

- - - - - obstruction K80.31

Revise - - - cholecystitis ~~(with cholangitis)~~ K80.40

Add - - - - with

Add - - - - - cholangitis - see also Calculus, bile duct, with cholangitis

Revise - - - - <u>-</u> ~~with~~ obstruction K80.41

- gallbladder K80.20
- - with
- - - bile duct calculus - see Calculus, gallbladder and bile duct
- gallbladder and bile duct K80.70
- - with

- - - cholecystitis K80.60
Add - - - - with
Add - - - - - cholangitis - see also Calculus, bile duct, with cholangitis
Revise - - - - - ~~with~~ obstruction K80.61

Classification of Types of Myocardial Infarction

A proposal to add the types of myocardial infarction to ICD-10-CM was presented at the March 2016 ICD-10 C&M meeting. Based on comments from that meeting and input from experts working with the American Heart Association and the American College of Cardiology, these modifications to the prior proposal are now being proposed.

The 2012 expert consensus document of the Joint European Society of Cardiology / American College of Cardiology Foundation / American Heart Association / World Heart Federation Task Force for the Universal Definition of Myocardial Infarction is the authoritative, world-wide consensus of the professional socieites representing the cardiovascular communities regarding classification of myocardial infarction (MI) (1). By way of background, in 2000, the First Global MI Task Force presented a new definition of MI, specifically that myocardial necrosis as detected by cardiac biomarkers in the setting of myocardial ischemia should be labelled as an MI (2). These principles were further refined by the Second Global MI Task Force, leading to the Universal Definition of Myocardial Infarction Consensus Document in 2007, which emphasized the different conditions which might result in an MI (3). Following the second consensus document, the development of increasingly sensitive assays for the biomarkers of myocardial necrosis mandated further revision, particularly acknowledging that the detection of these biomarkers occurs not infrequently in the setting of the critically ill, after percutaneous coronary intervention and after cardiac surgery. The Third Global MI Task Force was convened to integrate these insights with new clinical outcomes data into a universal classification, particularly the establishment of the diagnosis of MI based on cardiac biomarkers and the prognostic implications of MI in various clinical contexts (1). In 2014, the classification was formally developed by the ACC/AHA Task Force on Data Standards as a controlled terminology for the purposes of interoperability among electronic health information systems (4).

In brief, the classification is as follows (1):

1. Spontaneous myocardial infarction (MI Type 1) is a clinical event typically caused by rupture or erosion of an atherosclerotic plaque resulting in thrombus formation in one or more of the coronary arteries. This is the prototypic “heart attack” for which there are extensive guidelines regarding evaluation and management. ST Elevation MI (STEMI) and Non ST Elevation MI (NSTEMI) share the same pathophysiology, and both are considered Type 1 MIs.

2. Myocardial infarction secondary to ischemic imbalance (myocardial demand exceeding supply) is defined as MI Type 2. This is where a condition other than coronary artery disease results in the imbalance between myocardial oxygen supply and / or demand. Of note, coronary vasospasm and/or endothelial dysfunction also have the potential to cause a Type 2 MI. Of note, the treatment guidelines for Type 1 MI are generally NOT applicable to the management of a Type 2 MI.

3. Patients who present with death from a presumed cardiac etiology (i.e., symptoms or signs suggestive of myocardial ischemia, such as typical chest pain and / or ECG changes) but without confirmatory cardiac biomarkers being available, are classified as having an MI Type 3.

4. Myocardial infarction associated with revascularization procedures are classified as MI Types 4 and 5, with Type 4 MI occurring in the context of percutaneous coronary intervention (PCI) and / or stent

implantation, and Type 5 MI being associated with coronary artery bypasss graft surgery (CABG). There are subclassifications of Type 4 MI reflecting the different contexts in which biomarkers can turn positive in the context of PCI. Critically, the cardiac biomarker reference values for Type 4 and Type 5 MIs are substantively different than Type 1 (and Type 2) MI.

All changes being proposed are shown here, with the content that was not included in the previous proposal and current newly proposed changes shown in bold.

TABULAR MODIFICATIONS

Revise I21 Acute ~~ST elevation (STEMI) and non-ST elevation (NSTEMI)~~ myocardial infarction

I21.0 ST elevation (STEMI) myocardial infarction of anterior wall
Add Type 1 ST elevation myocardial infarction of anterior wall

I21.1 ST elevation (STEMI) myocardial infarction of inferior wall
Add Type 1 ST elevation myocardial infarction of inferior wall

I21.2 ST elevation (STEMI) myocardial infarction of other sites
Add Type 1 ST elevation myocardial infarction of other sites

I21.3 ST elevation (STEMI) myocardial infarction of unspecified site
Delete **~~Myocardial infarction (acute) NOS~~**
Add Type 1 ST elevation myocardial infarction of unspecified site

I21.4 Non-ST elevation (NSTEMI) myocardial infarction
Add **Myocardial infarction (acute) NOS**
Add Type 1 Non-ST elevation myocardial infarction

New subcategory I21.A Other type of myocardial infarction

New code I21.A1 Myocardial infarction type 2
Myocardial infarction due to demand ischemia
Myocardial infarction secondary to ischemic imbalance

Revise Code **first ~~also~~** the underlying cause, if known **and applicable**, such as:
Anemia (D50.0-D64.9)
Chronic obstructive pulmonary disease (J44.-)
Heart failure (I50.-)
Paroxysmal tachycardia (I47.0-I47.9)
Renal failure (N17.0-N19)
Shock (R57.0-R57.9)

New code I21.A9 Other myocardial infarction type
Myocardial infarction associated with revascularization Procedure

Myocardial infarction type 3
Myocardial infarction type 4a
Myocardial infarction type 4b
Myocardial infarction type 4c
Myocardial infarction type 5

Code first, if applicable, postprocedural myocardial infarction following cardiac surgery (I97.190)

Code also complication, **if known and applicable,** such as:
(Acute) stent occlusion (T82.897-)
(Acute) stent stenosis (T82.857-)
(Acute) stent thrombosis (T82.867-)
Cardiac arrest due to underlying cardiac condition (I46.2)
Complication of percutaneous coronary intervention (PCI) (I97.89)
Occlusion of coronary artery bypass graft (T82.218-)

I22 Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction

Includes: acute myocardial infarction occurring within four weeks (28 days) of a previous acute myocardial infarction, regardless of site

Add **Subsequent type 1 myocardial infarction**

Add **Excludes1: Subsequent myocardial infarction, type 2 (I21.A1)**
Subsequent myocardial infarction of other type (type 3) (type 4) (type 5) (I21.A9)

I24 Other acute ischemic heart diseases

I24.8 Other forms of acute ischemic heart disease

Add **Excludes1: myocardial infarction due to demand ischemia (I21.A1)**

I97 Intraoperative and postprocedural complications and disorders of circulatory system, not elsewhere classified

I97.1 Other postprocedural cardiac functional disturbances

I97.19 Other postprocedural cardiac functional disturbances

Use additional code, if applicable, to further specify disorder

I97.190 Other postprocedural cardiac functional disturbances following cardiac surgery

Add **Use additional code, if applicable, for type 4 or type 5 myocardial infarction, to further specify disorder.**

INDEX MODIFICATIONS

Infarct, infarction

Revise **- myocardium, myocardial (acute) (with stated duration of 4 weeks or less) ~~I21.3~~ I21.4**

- - postprocedural

Add **- - - following cardiac surgery (see also Infarct, myocardium, type 4 or type 5, if applicable) I97.190**

Add **- - type 1 – see Infarct, myocardium, by non-ST elevation or ST elevation**

Add **- - type 2 I21.A1**

Add **- - type 3 I21.A9**

Add **- - type 4 I21.A9**

Add **- - type 5 I21.A9**

Ischemia, ischemic I99.8

- demand (coronary) (see also Angina) I24.8

Add **- - with myocardial infarction I21.A1**

Contact with Birds: Psittacines (Parrot)

The W61, Contact with birds (domestic) (wild), identifies injuries associated with various types of birds where the types of bird is denoted at the 4th character (e.g., macaw, turkey, chicken) and types of contact denoted in the 5th character (e.g., bitten by, struck by, pecked by).

In the current classification W61.0 and W61.2 appear to be referring to different types of birds, when in fact they are indistinguishable since parrot and psittacine are synonymous interchangeable terms; parrot, of course is the more common term whereas psittacine is a more technical term for the same type of bird. Moreover, since macaws are a particular type of parrot, it does not make sense to have the term macaw and parrot listed at the same hierarchical level in the classification. In fact, inclusion of both parrot and psittacine as separate categories will result in the collection of nonsensical statistics since it will be leaving the decision as to which term to use up to the random judgment of the coder.

Since macaw is a type of parrot/psittacine and since there appears to be a desire to collect statistics on macaw-related injuries separately from parrot-related injuries by virtue of ICD-10-CM distinguishing macaws from other types of parrots/psittacines, the recommendation is to list macaws first and then to have a single residual category for other parrots/psittacines.

This request to modify these codes was submitted by Michael B. First, M.D.

TABULAR MODIFICATIONS

W61 Contact with birds (domestic) (wild)

Delete ~~W61.0 Contact with parrot~~
Delete ~~W61.01 Bitten by parrot~~
Delete ~~W61.02 Struck by parrot~~
Delete ~~W61.09 Other contact with parrot~~

W61.1 Contact with macaw
W61.11 Bitten by macaw
W61.12 Struck by macaw
W61.19 Other contact with macaw

W61.2 Contact with other psittacines
Add Contact with other parrots

W61.21 Bitten by other psittacines
Add Bitten by other parrots

W61.22 Struck by other psittacines
Add Struck by other parrots

W61.29 Other contact with other psittacines
Add Other contact with other parrots

Disorders of the Gallbladder and Biliary Tract

Disorders of the gallbladder and biliary tract are common and frequently attributable to cholelithiasis. Prolonged obstruction of the cystic duct or stasis of bile in the gallbladder leads to inflammation of the gallbladder, or "cholecystitis." Cholecystitis can be either acute or chronic, though the latter usually represents a finding on pathologic examination and is not frequently used as a clinical diagnosis per se. Pathologic findings of chronic cholecystitis are not unusual even in the absence of attributable symptoms.

Cholecystitis varies in severity from mild inflammation of the gallbladder to severe inflammation resulting in tissue necrosis and eventually perforation of the gallbladder. Distinctions between cholecystitis without gangrene or perforation, cholecystitis with gangrene without perforation, and cholecystitis with perforation would be helpful to more accurately characterize the severity of cholecystitis.

The Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma requests that the classification of disorders of the gallbladder and biliary tract be modified to allow characterization of the severity of cholecystitis.

TABULAR MODIFICATIONS

Option #1

	K80	Cholelithiasis		
		K80.0	Calculus of gallbladder with acute cholecystitis	
			K80.00	Calculus of gallbladder with acute cholecystitis without obstruction
New code			K80.000	Calculus of gallbladder with acute cholecystitis without obstruction, gangrene, or perforation
New code			K80.001	Calculus of gallbladder with acute cholecystitis without obstruction or perforation, with gangrene
New code			K80.002	Calculus of gallbladder with acute cholecystitis without obstruction, with perforation
			K80.01	Calculus of gallbladder with acute cholecystitis with obstruction
New code			K80.010	Calculus of gallbladder with acute cholecystitis with obstruction, without gangrene or perforation

New code		K80.011	Calculus of gallbladder with acute cholecystitis with obstruction and gangrene, without perforation
New code		K80.012	Calculus of gallbladder with acute cholecystitis with obstruction and perforation
	K80.1	Calculus of gallbladder with other cholecystitis	
	K80.10	Calculus of gallbladder with chronic cholecystitis without obstruction	
Delete		~~Cholelithiasis with cholecystitis NOS~~	
New code		K80.100	Calculus of gallbladder with chronic cholecystitis without obstruction, gangrene, or perforation Cholelithiasis with cholecystitis NOS
New code		K80.101	Calculus of gallbladder with chronic cholecystitis without obstruction or perforation, with gangrene
New code		K80.102	Calculus of gallbladder with chronic cholecystitis without obstruction, with perforation
	K80.11	Calculus of gallbladder with chronic cholecystitis with obstruction	
New code		K80.110	Calculus of gallbladder with chronic cholecystitis with obstruction, without gangrene or perforation
New code		K80.111	Calculus of gallbladder with chronic cholecystitis with obstruction and gangrene, without perforation
New code		K80.112	Calculus of gallbladder with chronic cholecystitis with obstruction and perforation
	K80.12	Calculus of gallbladder with acute and chronic cholecystitis without obstruction	
New code		K80.120	Calculus of gallbladder with acute and chronic cholecystitis without obstruction, gangrene, or perforation
New code		K80.121	Calculus of gallbladder with acute and chronic cholecystitis without obstruction or perforation, with gangrene

New code K80.122 Calculus of gallbladder with acute and chronic cholecystitis without obstruction, with perforation

K80.13 Calculus of gallbladder with acute and chronic cholecystitis with obstruction

New code K80.130 Calculus of gallbladder with acute and chronic cholecystitis with obstruction, without gangrene or perforation

New code K80.131 Calculus of gallbladder with acute and chronic cholecystitis with obstruction and gangrene, without perforation

New code K80.132 Calculus of gallbladder with acute and chronic cholecystitis with obstruction and perforation

K80.18 Calculus of gallbladder with other cholecystitis without obstruction

New code K80.180 Calculus of gallbladder with other cholecystitis without obstruction, gangrene, or perforation

New code K80.181 Calculus of gallbladder with other cholecystitis without obstruction or perforation, with gangrene

New code K80.182 Calculus of gallbladder with other cholecystitis without obstruction, with perforation

K80.19 Calculus of gallbladder with other cholecystitis with obstruction

New code K80.190 Calculus of gallbladder with other cholecystitis with obstruction, without gangrene or perforation

New code K80.191 Calculus of gallbladder with other cholecystitis with obstruction and gangrene, without perforation

New code K80.192 Calculus of gallbladder with other cholecystitis with obstruction and perforation

K80.4 Calculus of bile duct with cholecystitis

K80.40 Calculus of bile duct with cholecystitis, unspecified, without obstruction

New code		K80.400	Calculus of bile duct with cholecystitis, unspecified, without obstruction, gangrene, or perforation
New code		K80.401	Calculus of bile duct with cholecystitis, unspecified, without obstruction or perforation, with gangrene
New code		K80.402	Calculus of bile duct with cholecystitis, unspecified, without obstruction, with perforation
	K80.41		Calculus of bile duct with cholecystitis, unspecified, with obstruction
New code		K80.410	Calculus of bile duct with cholecystitis, unspecified, with obstruction, without gangrene or perforation
New code		K80.411	Calculus of bile duct with cholecystitis, unspecified, with obstruction and gangrene, without perforation
New code		K80.412	Calculus of bile duct with cholecystitis, unspecified, with obstruction and perforation
	K80.42		Calculus of bile duct with acute cholecystitis without obstruction
New code		K80.420	Calculus of bile duct with acute cholecystitis without obstruction, gangrene, or perforation
New code		K80.421	Calculus of bile duct with acute cholecystitis without obstruction or perforation, with gangrene
New code		K80.422	Calculus of bile duct with acute cholecystitis without obstruction, with perforation
	K80.43		Calculus of bile duct with acute cholecystitis with obstruction
New code		K80.430	Calculus of bile duct with acute cholecystitis with obstruction, without gangrene or perforation
New code		K80.431	Calculus of bile duct with acute cholecystitis with obstruction and gangrene, without perforation
New code		K80.432	Calculus of bile duct with acute cholecystitis with obstruction and perforation
	K80.44		Calculus of bile duct with chronic cholecystitis without obstruction

New code		K80.440	Calculus of bile duct with chronic cholecystitis without obstruction, gangrene, or perforation
New code		K80.441	Calculus of bile duct with chronic cholecystitis without obstruction or perforation, with gangrene
New code		K80.442	Calculus of bile duct with chronic cholecystitis without obstruction, with perforation
	K80.45	Calculus of bile duct with chronic cholecystitis with obstruction	
New code		K80.450	Calculus of bile duct with chronic cholecystitis with obstruction, without gangrene or perforation
New code		K80.451	Calculus of bile duct with chronic cholecystitis with obstruction and gangrene, without perforation
New code		K80.452	Calculus of bile duct with chronic cholecystitis with obstruction and perforation
	K80.46	Calculus of bile duct with acute and chronic cholecystitis without obstruction	
New code		K80.460	Calculus of bile duct with acute and chronic cholecystitis without obstruction, gangrene, or perforation
New code		K80.461	Calculus of bile duct with acute and chronic cholecystitis without obstruction or perforation, with gangrene
New code		K80.462	Calculus of bile duct with acute and chronic cholecystitis without obstruction, with perforation
	K80.47	Calculus of bile duct with acute and chronic cholecystitis with obstruction	
New code		K80.470	Calculus of bile duct with acute and chronic cholecystitis with obstruction, without gangrene or perforation
New code		K80.471	Calculus of bile duct with acute and chronic cholecystitis with obstruction and gangrene, without perforation

New code K80.472 Calculus of bile duct with acute and chronic cholecystitis with obstruction and perforation

K80.6 Calculus of gallbladder and bile duct with cholecystitis

K80.60 Calculus of gallbladder and bile duct with cholecystitis, unspecified, without obstruction

New code K80.600 Calculus of gallbladder and bile duct with cholecystitis, unspecified, without obstruction, gangrene, or perforation

New code K80.601 Calculus of gallbladder and bile duct with cholecystitis, unspecified, without obstruction or perforation, with gangrene

New code K80.602 Calculus of gallbladder and bile duct with cholecystitis, unspecified, without obstruction, with perforation

K80.61 Calculus of gallbladder and bile duct with cholecystitis, unspecified, with obstruction

New code K80.610 Calculus of gallbladder and bile duct with cholecystitis, unspecified, with obstruction, without gangrene or perforation

New code K80.611 Calculus of gallbladder and bile duct with cholecystitis, unspecified, with obstruction and gangrene, without perforation

New code K80.612 Calculus of gallbladder and bile duct with cholecystitis, unspecified, with obstruction and perforation

K80.62 Calculus of gallbladder and bile duct with acute cholecystitis without obstruction

New code K80.620 Calculus of gallbladder and bile duct with acute cholecystitis without obstruction, gangrene, or perforation

New code K80.621 Calculus of gallbladder and bile duct with acute cholecystitis without obstruction or perforation, with gangrene

New code		K80.622	Calculus of gallbladder and bile duct with acute cholecystitis without obstruction, with perforation
	K80.63		Calculus of gallbladder and bile duct with acute cholecystitis with obstruction
New code		K80.630	Calculus of gallbladder and bile duct with acute cholecystitis with obstruction, without gangrene or perforation
New code		K80.631	Calculus of gallbladder and bile duct with acute cholecystitis with obstruction and gangrene, without perforation
New code		K80.632	Calculus of gallbladder and bile duct with acute cholecystitis with obstruction and perforation
	K80.64		Calculus of gallbladder and bile duct with chronic cholecystitis without obstruction
New code		K80.640	Calculus of gallbladder and bile duct with chronic cholecystitis without obstruction, gangrene, or perforation
New code		K80.641	Calculus of gallbladder and bile duct with chronic cholecystitis without obstruction or perforation, with gangrene
New code		K80.642	Calculus of gallbladder and bile duct with chronic cholecystitis without obstruction, with perforation
	K80.65		Calculus of gallbladder and bile duct with chronic cholecystitis with obstruction
New code		K80.650	Calculus of gallbladder and bile duct with chronic cholecystitis with obstruction, without gangrene or perforation
New code		K80.651	Calculus of gallbladder and bile duct with chronic cholecystitis with obstruction and gangrene, without perforation
New code		K80.652	Calculus of gallbladder and bile duct with chronic cholecystitis with obstruction and perforation
	K80.66		Calculus of gallbladder and bile duct with acute and chronic cholecystitis without obstruction

New code	K80.660	Calculus of gallbladder and bile duct with acute and chronic cholecystitis without obstruction, gangrene, or perforation
New code	K80.661	Calculus of gallbladder and bile duct with acute and chronic cholecystitis without obstruction or perforation, with gangrene
New code	K80.662	Calculus of gallbladder and bile duct with acute and chronic cholecystitis without obstruction, with perforation

K80.67 Calculus of gallbladder and bile duct with acute and chronic cholecystitis with obstruction

New code	K80.670	Calculus of gallbladder and bile duct with acute and chronic cholecystitis with obstruction, without gangrene or perforation
New code	K80.671	Calculus of gallbladder and bile duct with acute and chronic cholecystitis with obstruction and gangrene, without perforation
New code	K80.672	Calculus of gallbladder and bile duct with acute and chronic cholecystitis with obstruction and perforation

K81 Cholecystitis

K81.0 Acute cholecystitis

Delete	~~Abscess of gallbladder~~
Delete	~~Angiocholecystitis~~
Delete	~~Emphysematous (acute) cholecystitis~~
Delete	~~Empyema of gallbladder~~
Delete	~~Gangrene of gallbladder~~
Delete	~~Gangrenous cholecystitis~~
Delete	~~Suppurative cholecystitis~~

New code		K81.00	Acute cholecystitis without gangrene or perforation Abscess of gallbladder NOS Angiocholecystitis NOS Emphysematous (acute) cholecystitis NOS Empyema of gallbladder NOS Suppurative cholecystitis NOS
New code		K81.01	Acute cholecystitis with gangrene without perforation Gangrene of gallbladder NOS Gangrenous cholecystitis NOS Emphysematous (acute) cholecystitis with gangrene without perforation
New code		K81.02	Acute cholecystitis with perforation Emphysematous (acute) cholecystitis with perforation
	K81.1	Chronic cholecystitis	
New code		K81.10	Chronic cholecystitis without gangrene or perforation
New code		K81.11	Chronic cholecystitis with gangrene without perforation
New code		K81.12	Chronic cholecystitis with perforation
	K81.2	Acute cholecystitis with chronic cholecystitis	
New code		K81.20	Acute cholecystitis with chronic cholecystitis without gangrene or perforation
New code		K81.21	Acute cholecystitis with chronic cholecystitis with gangrene without perforation
New code		K81.22	Acute cholecystitis with chronic cholecystitis with perforation
	K81.9	Cholecystitis, unspecified	
New code		K81.90	Cholecystitis, unspecified, without gangrene or perforation
New code		K81.91	Cholecystitis, unspecified, with gangrene without perforation
New code		K81.92	Cholecystitis, unspecified, with perforation

K82 Other diseases of gallbladder

K82.2 Perforation of gallbladder

Add Excludes1: Cholecystitis with perforation (K80.0-, K80.1-, K80.4-, and K80.6- with sixth character 2; K81.- with fifth character 2)

Option #2

K80 Cholelithiasis

K80.0 Calculus of gallbladder with acute cholecystitis

Add Use additional code for associated gangrene of gallbladder (K82.A1), or perforation of gallbladder (K82.A2).

K80.1 Calculus of gallbladder with other cholecystitis

Add Use additional code for associated gangrene of gallbladder (K82.A1), or perforation of gallbladder (K82.A2).

K80.4 Calculus of bile duct with cholecystitis

Add Use additional code for associated gangrene of gallbladder (K82.A1), or perforation of gallbladder (K82.A2).

K80.6 Calculus of gallbladder and bile duct with cholecystitis

Add Use additional code for associated gangrene of gallbladder (K82.A1), or perforation of gallbladder (K82.A2).

K81 Cholecystitis

Add Use additional code for associated gangrene of gallbladder (K82.A1), or perforation of gallbladder (K82.A2).

K82 Other diseases of gallbladder

K82.2 Perforation of gallbladder
Rupture of cystic duct or gallbladder
Add Excludes1: Perforation of gallbladder in cholecystitis (K82.A2)

New subcategory	K82.A	Disorders of gallbladder in diseases classified elsewhere Code first the type of cholecystitis (K81.-), or cholelithiasis with cholecystitis (K80.00-K80.19, K80.40-K80.47, K80.60-K80.67).	
New code	K82.A1	Gangrene of gallbladder in cholecystitis	
New code	K82.A2	Perforation of gallbladder in cholecystitis	

Diverticular Disease of Intestine

Diverticulosis is a chronic outpouching of the intestine that, once it develops, remains a permanent feature of the involved segment unless it is surgically removed. The vast majority of cases of diverticulosis involve the large intestine, and the sigmoid colon is primarily involved. The main complication of diverticulosis is bleeding. Diverticulitis develops when one of the outpouchings from diverticulosis becomes acutely inflamed. This inflammation can lead to perforation, which can progress to abscess formation and/or generalized peritonitis. Whereas perforation and abscesses do not generally occur as a direct consequence of diverticulosis in the absence of diverticulitis, they occur as a common feature of diverticulitis.

Important distinctions to capture concerning the severity of diverticulitis include the presence of abscess and generalized peritonitis. However, the "excludes notes" for the K65 codes, including K65.0 "Generalized (acute) peritonitis," specifically instruct coders not to use these codes with the K57 "Diverticular disease of intestine" codes. Thus, the codes for diverticulitis with perforation could be improved by distinguishing whether generalized peritonitis occurred.

The Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma requests the following tabular changes to better distinguish the severity of diverticulitis.

TABULAR MODIFICATIONS

K57 Diverticular disease of intestine

K57.0 Diverticulitis of small intestine with perforation and abscess

K57.00 Diverticulitis of small intestine with perforation and abscess without bleeding

New code K57.000 Diverticulitis of small intestine with perforation and abscess without bleeding or generalized peritonitis

New code K57.001 Diverticulitis of small intestine with perforation and abscess without bleeding, with generalized peritonitis

K57.01 Diverticulitis of small intestine with perforation and abscess with bleeding

New code K57.010 Diverticulitis of small intestine with perforation and abscess with bleeding, without generalized peritonitis

New code K57.011 Diverticulitis of small intestine with perforation and abscess with bleeding, with generalized peritonitis

K57.2 Diverticulitis of large intestine with perforation and abscess

K57.20 Diverticulitis of large intestine with perforation and abscess without bleeding

New code K57.200 Diverticulitis of large intestine with perforation and abscess without bleeding or generalized peritonitis

New code K57.201 Diverticulitis of large intestine with perforation and abscess without bleeding, with generalized peritonitis

K57.21 Diverticulitis of large intestine with perforation and abscess with bleeding

New code K57.210 Diverticulitis of large intestine with perforation and abscess with bleeding, without generalized peritonitis

New code K57.211 Diverticulitis of large intestine with perforation and abscess with bleeding, with generalized peritonitis

K57.4 Diverticulitis of both small and large intestine with perforation and abscess

K57.40 Diverticulitis of both small and large intestine with perforation and abscess without bleeding

New code K57.400 Diverticulitis of both small and large intestine with perforation and abscess without bleeding or generalized peritonitis

New code K57.401 Diverticulitis of both small and large intestine with perforation and abscess without bleeding, with generalized peritonitis

K57.41 Diverticulitis of both small and large intestine with perforation and abscess with bleeding

New code K57.410 Diverticulitis of both small and large intestine with perforation and abscess with bleeding, without generalized peritonitis

New code K57.411 Diverticulitis of both small and large intestine with perforation and abscess with bleeding, with generalized peritonitis

K57.8 Diverticulitis of intestine, part unspecified, with perforation and abscess

K57.80 Diverticulitis of intestine, part unspecified, with perforation and abscess without bleeding

New code K57.800 Diverticulitis of intestine, part unspecified, with perforation and abscess without bleeding or generalized peritonitis

New code K57.801 Diverticulitis of intestine, part unspecified, with perforation and abscess without bleeding, with generalized peritonitis

K57.81 Diverticulitis of intestine, part unspecified, with perforation and abscess with bleeding

New code K57.810 Diverticulitis of intestine, part unspecified, with perforation and abscess with bleeding, without generalized peritonitis

New code K57.811 Diverticulitis of intestine, part unspecified, with perforation and abscess with bleeding, with generalized peritonitis

K57.9 Diverticular disease of intestine, part unspecified, without perforation or abscess

K57.92 Diverticulitis of intestine, part unspecified, without perforation or abscess without bleeding

New code K57.920 Diverticulitis of intestine, part unspecified, without perforation or abscess without bleeding or generalized peritonitis

New code K57.921 Diverticulitis of intestine, part unspecified, without perforation or abscess without bleeding, with generalized peritonitis

K57.93 Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding

New code	K57.930	Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding, without generalized peritonitis
New code	K57.931	Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding, with generalized peritonitis

Dyspnea Crisis

The American Thoracic Society (ATS) established an Ad Hoc Committee on Palliative Management of Dyspnea Crisis, the members of which defined dyspnea crisis as "sustained and severe resting breathing discomfort that occurs in patients with advanced, often life-limiting illness and overwhelms the patient and caregivers' ability to achieve symptom relief." It was further noted that, "Dyspnea crisis can occur suddenly and is characteristically without a reversible etiology." While the focus was on dyspnea crisis management for those patients with goals of care aimed toward palliation (e.g., who declined endotracheal intubation and mechanical ventilation), even so, approaches to dyspnea crisis may also be important for those who elect life-sustaining treatment.[1]

It is also noted that, "Dyspnea is a common and often progressively debilitating symptom in advanced chronic disease that is associated with fear, anxiety, activity limitations, and profound suffering." [1]

A specific code for dyspnea crisis has been requested by Dr. Mark Fischer, a member of the Ad Hoc Committee on Palliative Management of Dyspnea Crisis. There has also been support for this expressed from the American Thoracic Society.

TABULAR MODIFICATIONS

R06 Abnormalities of breathing

R06.0 Dyspnea

New code R06.04 Dyspnea crisis

Code also, if applicable, encounter for palliative care (Z51.5).

References

1. Richard A. Mularski, Lynn F. Reinke, Virginia Carrieri-Kohlman, Mark D. Fischer, et al. An Official American Thoracic Society Workshop Report: Assessment and Palliative Management of Dyspnea Crisis. Ann Am Thorac Soc Vol 10, No 5, pp S98–S106, Oct 2013.

Factitious Disorder

Factitious Disorder is characterized by the individual's falsification of medical or psychological signs and symptoms or induction of injury or disease that is associated with identified deception. The current code categories in ICD-10-CM are based on whether the symptoms that are being fabricated, physical, psychological or both. This distinction is not meaningful in terms of differentiating types of patients or treatment.

The American Psychiatric Association (APA) is requesting additional codes for the subtypes of Factitious Disorder that have been included in DSM-5. This distinction is to indicate whether the falsified or intentionally produced signs or symptoms are imposed by the patient on himself (herself) which is Factitious disorder imposed on self, (the most typical variety of factitious disorder) versus imposed on another person, typically a dependent child (Factious disorder imposed on another). The latter form of factitious disorder, which is also referred to as Factitious disorder by proxy or Munchausen's syndrome by proxy, has not previously been given its own code despite the significant morbidity and mortality associated with this condition as well as its forensic implications. It is important to note that the diagnosis is given to the perpetrator of the falsified illness and not the victim, even though it is the victim that displays the signs and symptoms of the falsified illness. The victim is given the appropriate abuse diagnosis.

The following tabular modifications are being requested.

TABULAR MODIFICATIONS

F68 Other disorders of adult personality and behavior

F68.1 Factitious disorder
Compensation neurosis
Elaboration of physical symptoms for psychological reasons
Hospital hopper syndrome
Münchausen's syndrome
Peregrinating patient

Excludes2: Factitial dermatitis (L98.1)
Person feigning illness (with obvious motivation) (Z76.5)

F68.10 Factitious disorder, unspecified

Add Factitious disorder imposed on self

F68.11 Factitious disorder with predominantly psychological signs and symptoms

Add Factitious disorder with predominantly psychological signs and symptoms imposed on self

F68.12 Factitious disorder with predominantly physical signs and symptoms

Add	Factitious disorder with predominantly physical signs and symptoms imposed on self
	F68.13 Factitious disorder with combined psychological and physical signs and symptoms
Add	Factitious disorder with combined psychological and physical signs and symptoms imposed on self
New code	F68.14 Factitious disorder, imposed on another
Add	Münchausen's syndrome by proxy
Add	Factitious disorder by proxy

Gingival recession

In September 2011, the American Academy of Periodontology submitted a proposal for the gingival recession classification to be replaced by the Miller Classification System. The 2011 submission was later withdrawn. Subsequently, this topic was presented at the September 2015 and the March 2016 Coordination and Maintenance meeting. Comments received during both public comment periods cited the need for further clarity on use of the codes.

For a diagnosis related to treatment of gingival recession, there are two entities that are required. The first entity is whether the recession is generalized (multiple teeth in an area that require treatment), or localized (limited to individual teeth in an area of the mouth). The second entity is the degree of recession, which is indicated by minimal, moderate, or severe.

The proposal has been revised following further consultation with the American Dental Association.

TABULAR MODIFICATIONS

	K06	Other disorders of gingiva and edentulous alveolar ridge		
New subcategory	K06.0	Gingival recession		
Delete		Gingival recession ~~(generalized)~~ ~~(localized)~~ (postinfective) (postprocedural)		
New sub-subcategory		K06.01	Gingival recession, localized	
New code			K06.010	Localized gingival recession, unspecified Localized gingival recession, NOS
New code			K06.011	Localized gingival recession, minimal
New code			K06.012	Localized gingival recession, moderate
New code			K06.013	Localized gingival recession, severe
New sub-subcategory		K06.02	Gingival recession, generalized	
New code			K06.020	Generalized gingival recession, unspecified Generalized gingival recession, NOS
New code			K06.021	Generalized gingival recession, minimal
New code			K06.022	Generalized gingival recession, moderate
New code			K06.023	Generalized gingival recession, severe

Heart Failure Classification

There have been a number of previous proposals to create additional codes for different specific types of heart failure. Certain of these or related changes were previously proposed in Sept. 2015, but this current proposal attempts to use a simplified approach to some of these issues where possible.

Heart Failure with Reduced Ejection Fraction, and with Normal Ejection Fraction

It is proposed to add inclusion terms related to ejection fraction, for systolic heart failure, diastolic heart failure, and combined systolic and diastolic heart failure subcategories. The ejection fraction is a measure of the left ventricular function. In systolic heart failure, the ejection fraction is reduced. In diastolic heart failure, there is a normal ejection fraction, or preserved ejection fraction. In combined systolic and diastolic heart failure, there is a reduced ejection fraction, along with diastolic dysfunction. This proposal is based on input from multiple sources.

According to the 2013 American College of Cardiology Foundation/American Heart Association (ACCF/AHA) Guidelines, related to definitions of heart failure, the two principal forms of heart failure described are heart failure with reduced ejection fraction (HFrEF), and heart failure with preserved ejection fraction (HFpEF). The guidelines also note that, "Because other techniques may indicate abnormalities in systolic function among patients with a preserved EF, it is preferable to use the terms preserved or reduced EF over preserved or reduced systolic function." It also notes that, "In most patients, abnormalities of systolic and diastolic dysfunction coexist, irrespective of EF." In addition, related to HFrEF, "Those with LV systolic dysfunction commonly have elements of diastolic dysfunction as well."

References:

Yancy CW, M Jessup, B Bozkurt, et al. 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *Circulation*. 2013.

Right Heart Failure and Biventricular Heart Failure

It is proposed that there is a need for a way to distinguish right ventricular failure, both chronic and acute (or decompensated) in the adult, and also to identify end stage heart disease. The purposes are to differentiate cases of pure right heart failure from left heart disease (these patients should not be treated the same way as left heart failure patients overall), as well as to give some way of tracking patients who have right ventricular failure.

The heart failure codes in ICD-10-CM in category I50 parallel the ICD-9-CM codes in category 428. These focus on left heart failure in the adult, and relate to left ventricular disturbances in function. These codes help identify adults with chronic left ventricular failure with systolic dysfunction who are at risk of sudden cardiac death. There are now no specific ICD-10-CM codes for identifying right ventricular failure or biventricular failure.

High Output Heart Failure

High output heart failure has different causes and is a different specific clinical entity from other types of heart failure. Currently it is coded in ICD-10-CM to I50.9, Heart failure, unspecified. It is proposed to create a specific code for high output heart failure.

End Stage Heart Failure and Stages of Heart Failure

Heart failure has stages in an ABCD classification of the American College of Cardiology (ACC)/American Heart Association (AHA). Patients with end stage heart failure fall into stage D of this classification, and are characterized by advanced structural heart disease and pronounced symptoms of heart failure at rest or upon minimal physical exertion, despite maximal medical treatment. They frequently develop intolerance to medical therapy and are developing worsening renal function and diuretic resistance according to current guidelines. This patient population has a 1-year mortality rate of approximately 50%, is at highest risk for re-hospitalization and requires special therapeutic interventions such as ventricular assist devices, artificial hearts and heart transplantation or hospice care.

Stage A is the presence of heart failure risk factors but no heart disease and no symptoms. This should not be coded to the regular heart failure codes, but rather to code Z91.89, Other specified personal risk factors, not elsewhere classified. Stage B is where heart disease is present but there are no symptoms; thus there are structural changes in the heart before symptoms occur. Stage C involves structural heart disease, with symptoms.

TABULAR MODIFICATIONS

I50 Heart failure

Revise	I50.1	Left ventricular failure, unspecified
	I50.2	Systolic (congestive) heart failure
Add		Heart failure with reduced ejection fraction [HFrEF]
Add		Systolic left ventricular heart failure
	I50.3	Diastolic (congestive) heart failure
Add		Diastolic left ventricular heart failure
Add		Heart failure with normal ejection fraction
Add		Heart failure with preserved ejection fraction [HFpEF]
	I50.4	Combined systolic (congestive) and diastolic (congestive) heart failure
Add		Combined systolic and diastolic left ventricular heart failure
Add		Heart failure with reduced ejection fraction and diastolic dysfunction
New subcategory	I50.8	Other heart failure

New subcategory	I50.81	Right heart failure Right ventricular failure	
New code	I50.810		Right heart failure, unspecified Right ventricular failure NOS
New code	I50.811		Acute isolated right heart failure Acute isolated right ventricular failure
New code	I50.812		Chronic isolated right heart failure Chronic isolated right ventricular failure
New code	I50.813		Acute on chronic isolated right heart failure Acute on chronic isolated right ventricular failure Acute decompensation of chronic isolated right ventricular failure Acute exacerbation of chronic isolated right ventricular failure
New code	I50.814		Right heart failure due to left heart failure Right ventricular failure secondary to left ventricular failure Code also the type of left ventricular failure, if known (I50.2-I50.43)
New code	I50.82	Biventricular heart failure Code also the type of left ventricular failure, if known (I50.2-I50.43)	
New code	I50.83	High output heart failure	
New code	I50.84	End stage heart failure Code also type of heart failure as systolic or diastolic, if known	
New code	I50.89	Other heart failure	
	I50.9	Heart failure, unspecified	
Delete		~~Biventricular (heart) failure NOS~~	
Delete		~~Right ventricular failure (secondary to left heart failure)~~	

INDEX MODIFICATIONS

Failure…
- heart (acute) (senile) (sudden) I50.9
- - with

Revise - - - decompensation~~ – see Failure, heart, congestive~~ (see also Failure, heart, by type as diastolic or systolic, acute and chronic) I50.9

Revise - - compensated (see also Failure, heart, by type as diastolic or systolic, chronic) I50.9

Revise - - decompensated (see also Failure, heart, by type as diastolic or systolic, acute and chronic) I50.9

Add - - end stage (see also Failure, heart, by type as diastolic or systolic, chronic) I50.84

- - stage A Z91.89
- - stage B (see also Failure, heart, by type as diastolic or systolic) I50.9
- - stage C (see also Failure, heart, by type as diastolic or systolic) I50.9
- - stage D (see also Failure, heart, by type as diastolic or systolic, chronic) I50.84

Hepatic Encephalopathy

This topic was presented at the September 2015 and March 2016 Coordination and Maintenance meeting. Comments received during both the public comment periods cited the proposal seemed complicated. World Health Organization (WHO) made a change to this category in ICD-10 by including the manifestation of hepatic coma to various causes of hepatic failure; thus, creating a challenge with coding hepatic encephalopathy in ICD-10-CM.

Hepatic encephalopathy (HE) involves altered consciousness and behavior related to insufficient liver function. HE is the loss of brain function that occurs when the liver is unable to remove toxins from the blood. Ammonia, which is produced by your body when proteins are digested, is one of the toxins that's normally made harmless by your liver. When ammonia or other toxic substances build up in the body when the liver isn't working well, it may affect the brain and cause HE.

The revised proposal is based on modifications proposed by the American Gastroenterological Association (AGA).

TABULAR MODIFICATIONS

	K70	Alcoholic liver disease	
	K70.4	Alcoholic hepatic failure	
New Sub-subcategory	K70.40	Alcoholic hepatic failure without coma	
New code	K70.401	Alcoholic hepatic failure without coma, without hepatic encephalopathy	
New code	K70.402	Alcoholic hepatic failure without coma, with hepatic encephalopathy	
	K71.1	Toxic liver disease with hepatic necrosis	
New Sub-subcategory	K71.10	Toxic liver disease with hepatic necrosis, without coma	
New code	K71.101	Toxic liver disease with hepatic necrosis, without coma, without hepatic encephalopathy	
New code	K71.102	Toxic liver disease with hepatic necrosis, without coma, with hepatic encephalopathy	
	K72.0	Acute and subacute hepatic failure	
New Sub-subcategory	K72.00	Acute and subacute hepatic failure without coma	
New code	K72.001	Acute and subacute hepatic failure without coma,	

without hepatic encephalopathy

New code K72.002 Toxic liver disease with hepatic necrosis, without coma, with hepatic encephalopathy

K72.1 Chronic hepatic failure

New Sub-subcategory K72.10 Chronic hepatic failure without coma

New code K72.101 Chronic hepatic failure without coma, without hepatic encephalopathy

New code K72.102 Chronic hepatic failure without coma, with hepatic encephalopathy

K72.9 Hepatic failure, unspecified

New Sub-subcategory K72.90 Hepatic failure, unspecified without coma

New code K72.901 Hepatic failure, unspecified without coma, without hepatic encephalopathy

New code K72.902 Hepatic failure, without coma, with hepatic encephalopathy
Hepatic encephalopathy NOS

K91 Intraoperative and postprocedural complications and disorders of digestive system, not elsewhere classified

K91.8 Other intraoperative and postprocedural complications and disorders of digestive system

New Sub-subcategory K91.82 Postprocedural hepatic failure

New code K91.821 Postprocedural hepatic failure, without hepatic encephalopathy

New code K91.822 Postprocedural hepatic failure, with hepatic encephalopathy

B15 Acute hepatitis A

B15.0 Hepatitis A with hepatic coma

New Sub-subcategory B15.9 Hepatitis A without coma

New code B15.90 Hepatitis A without coma, without hepatic encephalopathy

New code B15.91 Hepatitis A without coma, with hepatic encephalopathy

B16 Acute hepatitis B

New
Sub-subcategory B16.1 Acute hepatitis B with delta-agent without coma

New code B16.10 Acute hepatitis B with delta-agent without coma, without hepatic encephalopathy

New code B16.11 Acute hepatitis B with delta-agent without coma, with hepatic encephalopathy

New
Sub-subcategory B16.9 Acute hepatitis B without delta-agent without coma

New code B16.90 Acute hepatitis B without delta-agent without coma, without hepatic encephalopathy

New code B16.91 Acute hepatitis B without delta-agent without coma, with hepatic encephalopathy

B17 Other acute viral hepatitis

B17.1 Acute hepatitis C

New
Sub-subcategory B17.10 Acute hepatitis C without hepatic coma

New code B17.100 Acute hepatitis C without hepatic coma, without hepatic encephalopathy

New code B17.101 Acute hepatitis C without hepatic coma, with hepatic encephalopathy

B19 Unspecified viral hepatitis

B19.0 Unspecified viral hepatitis with hepatic coma

B19.1 Unspecified viral hepatitis B

New
Sub-subcategory B19.10 Unspecified viral hepatitis B without hepatic coma

New code B19.100 Unspecified viral hepatitis B without hepatic coma, without hepatic encephalopathy

New code B19.101 Unspecified viral hepatitis B without hepatic coma, with hepatic encephalopathy

B19.2 Unspecified viral hepatitis C

New
Sub-subcategory B19.20 Unspecified viral hepatitis C without hepatic coma

New code	B19.200	Unspecified viral hepatitis C without hepatic coma, without hepatic encephalopathy
New code	B19.201	Unspecified viral hepatitis C without hepatic coma, with hepatic encephalopathy

Hypoxic ischemic encephalopathy [HIE]

Hypoxic ischemic encephalopathy [HIE] is a clinically defined syndrome of disturbed neurological function in the earliest days of life in an infant, manifested by difficulty with initiating and maintaining respiration, depression of tone and reflexes, subnormal level of consciousness and often seizures.

Previously this diagnosis was made on strictly clinical findings, however with improved diagnostic technology, especially MR imaging and spectroscopy, it is possible to diagnose Hypoxic ischemic encephalopathy [HIE] with much greater precision. Current science has shown that a newborn may meet the criteria for the diagnosis of Hypoxic ischemic encephalopathy [HIE] or may have another underlying cause of the encephalopathy that is not associated with HIE.

Because of its clinical significance which influences the treatment and long term outcome, the American Academy of Pediatric proposes the following ICD-10-CM tabular modifications.

TABULAR MODIFICATIONS

P91.6 Hypoxic ischemic encephalopathy [HIE]
Add — Excludes1: Neonatal cerebral irritability (P91.3)
Add — Neonatal cerebral depression (P91.4)
Add — Neonatal coma (P91.5)

P91.60 Hypoxic ischemic encephalopathy [HIE], unspecified

P91.61 Mild hypoxic ischemic encephalopathy [HIE]

P91.62 Moderate hypoxic ischemic encephalopathy [HIE]

P91.63 Severe hypoxic ischemic encephalopathy [HIE]

P91.8 Other specified disturbances of cerebral status of newborn
New subcategory — P91.81 Neonatal encephalopathy
New code — P91.811 Neonatal encephalopathy in diseases classified elsewhere
Add — Code first underlying condition, if known:
Add — Intracranial nontraumatic hemorrhage of newborn (P52.-)
Add — Kernicterus (P57.-)
Add — Congenital cirrhosis (of liver) (P78.71)
New code — P91.819 Neonatal encephalopathy, unspecified
New code — P91.88 Other specified disturbances of cerebral status of newborn

Infection Following a Procedure

Surgical site infections are commonly classified according to their depth: superficial incisional, deep incisional, and organ/space infection. These categories are consistent with the Centers for Disease Control and Prevention criteria for defining a Surgical Site Infection (SSI).

The Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma is requesting the following tabular modifications to better distinguish the severity of infections following a procedure.

This proposal was originally presented at the March 2016 C&M meeting, however in response to public comment, the proposal has been modified and being represented for further consideration.

TABULAR MODIFICATIONS

T81 Complications of procedures, not elsewhere classified

T81.4 Infection following a procedure

Delete Includes: ~~Intra-abdominal abscess following a procedure~~
Delete Includes: ~~Postprocedural infection, not elsewhere classified~~
Delete Includes: ~~Sepsis following a procedure~~
Delete Includes: ~~Stitch abscess following a procedure~~
Delete Includes: ~~Subphrenic abscess following a procedure~~
Includes: Wound abscess following a procedure

Use additional code to identify infection
Use additional code (R65.2-) to identify severe sepsis, if applicable

Excludes1: Obstetric surgical wound infection (O86.0)
Postprocedural fever NOS (R50.82)
Postprocedural retroperitoneal abscess (K68.11)

Revise Excludes2: Obstetric surgical wound infection (O86.0)
Postprocedural fever NOS (R50.82)
Postprocedural retroperitoneal abscess (K68.11)

New code T81.40 Infection following a procedure, unspecified

New Code T81.41 Infection following a procedure, superficial incisional surgical site
Subcutaneous abscess following a procedure
Add **Stitch abscess following a procedure**

New code T81.42 Infection following a procedure, deep incisional surgical site
Intra-muscular abscess following a procedure

New code	T81.43	Infection following a procedure, organ and space surgical site Intra-abdominal abscess following a procedure Subphrenic abscess following a procedure
New code	T81.44	Sepsis following a procedure
New code	**T81.49**	**Infection following a procedure, other surgical site**

K68 Disorders of retroperitoneum

K68.1 Retroperitoneal abscess

K68.11 Postprocedural retroperitoneal abscess

Add **Excludes2: Infection following procedure (T81.4-)**

Injury of optic tract and visual cortex

An injury to the optic tracts and pathways or to the visual cortex involves neurological connections to both eyes, anywhere beyond the chiasm. The optic nerve coming from each eye contains nerve fibers that go to both sides of the visual cortex. At the optic chiasm, half of the nerve fibers from each optic nerve stay on the same side of the brain, while the other half go to the opposite of the brain.

From the optic chiasm all the way to the visual cortex, the visual pathways include nerve fiber from each eye, both the right eye and the left eye. Thus, if there is an injury in any of these areas, anywhere from the optic chiasm to the visual cortex, it is not appropriate to state right eye or left eye, it will affect vision in both eyes. Thus it is not appropriate to refer to an injury to the optic tract and pathways or to the visual cortex as either right or left eye, but rather right or left side.

This concept is currently captured in the eye-specific diagnosis codes of H47.51 Disorders of visual pathways in (due to) inflammatory disorders, H47.52 Disorders of visual pathways in (due to) neoplasm, and H47.53 Disorders of visual pathways in (due to) vascular disorders.

The requestor submits the following tabular modification to revise the terminology of the code title as it is more clinically accurate to refer to the optic tract and cortex issue is by "side" not “eye.”

The American Academy of Ophthalmology has reviewed and supports this proposal.

TABULAR MODIFICATIONS

S04 Injury of cranial nerve

S04.0 Injury of optic nerve and pathways

S04.03 Injury of optic tract and pathways
Injury of optic radiation

Revise S04.031 Injury of optic tract and pathways, right ~~eye~~ side
Revise S04.032 Injury of optic tract and pathways, left ~~eye~~ side
Revise S04.039 Injury of optic tract and pathways, unspecified ~~eye~~ side
Injury of optic tract and pathways NOS

S04.04 Injury of visual cortex

Revise S04.041 Injury of visual cortex, right ~~eye~~ side
Revise S04.042 Injury of visual cortex, left ~~eye~~ side
Revise S04.049 Injury of visual cortex, unspecified ~~eye~~ side
Injury of visual cortex NOS

Intestinal Obstruction

Intestinal obstruction varies in severity, from partial or intermittent obstruction that resolves without intervention to complete obstruction that requires an operation and may lead to intestinal gangrene and perforation. Although other diagnoses capture the concepts of intestinal infarction and perforation, the various intestinal obstruction diagnosis codes differentiate the etiology of the obstruction but not its severity. Physicians frequently describe intestinal obstruction as partial versus complete. These distinctions are relevant because complete obstruction generally requires an operation and partial obstruction usually does not (especially for the small intestine).

The Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma is requesting tabular changes to better distinguish the severity of intestinal obstruction.

This updated proposal is based on comments received during the public comment period following the September 2015 presentation.

TABULAR MODIFICATIONS

K56 Paralytic ileus and intestinal obstruction without hernia

New subcategory	K56.5	Intestinal adhesions [bands] with obstruction
Delete		~~(postprocedural)~~ (postinfection)
Delete		~~Abdominal hernia due to adhesions with obstruction~~
		Peritoneal adhesions [bands] with intestinal obstruction
Delete		~~(postprocedural)~~ (postinfection)

New code		K56.50	Intestinal adhesions [bands], unspecified as to partial versus complete obstruction Intestinal adhesions with obstruction NOS
New code		K56.51	Intestinal adhesions [bands], with partial obstruction Intestinal adhesions with incomplete obstruction
New code		K56.52	Intestinal adhesions [bands] with complete obstruction
	K56.6		Other and unspecified intestinal obstruction
New sub-subcategory		K56.60	Unspecified intestinal obstruction
Delete			~~Intestinal obstruction NOS~~
New code			K56.600 Partial intestinal obstruction, unspecified as to cause

			Incomplete obstruction, NOS
New code		K56.601	Complete intestinal obstruction, unspecified as to cause
New code		K56.609	Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction Intestinal obstruction NOS
New Sub-subcategory	K56.69	Other intestinal obstruction	
New code		K56.690	Other partial intestinal obstruction Other incomplete intestinal obstruction
New code		K56.691	Other complete intestinal obstruction
New code		K56.699	Other intestinal obstruction unspecified as to partial versus complete obstruction Other intestinal obstruction, NEC

K91 Intraoperative and postprocedural complications and disorders of digestive system, not elsewhere classified

New subcategory	K91.3	Postprocedural intestinal obstruction	
New code	K91.30		Postprocedural intestinal obstruction, unspecified as to partial versus complete Postprocedural intestinal obstruction NOS
New code	K91.31		Postprocedural partial intestinal obstruction Postprocedural incomplete intestinal obstruction
New code	K91.32		Postprocedural complete intestinal obstruction

Intracranial Injury

Category S06, Intracranial injury, has seventh characters to describe initial (A), subsequent (D) encounters and encounters for sequela (S). NCHS has received a request to deactivate the use of seventh character "D" and "S" for codes that identify death since the use of the seventh characters are irrelevant as there would be no encounters following the death of a patient.

The NCHS Injury Statistics Program has reviewed and supports this proposal.

TABULAR MODIFICATIONS

S06 Intracranial injury

The appropriate 7th character is to be added to each code from category S06
A - initial encounter
D - subsequent encounter
S - sequela

Add Note: 7th characters D and S do not apply to codes in category S06 with 6th character 7 – death due to brain injury prior to regaining consciousness, or 8 – death due to other cause prior to regaining consciousness.

S06.1 Traumatic cerebral edema

S06.1X Traumatic cerebral edema

Delete ~~S06.1X7D Traumatic cerebral edema with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, subsequent encounter~~

Delete ~~S06.1X7S Traumatic cerebral edema with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness, sequela~~

Delete ~~S06.1X8D Traumatic cerebral edema with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, subsequent encounter~~

Delete ~~S06.1X8S Traumatic cerebral edema with loss of consciousness of any duration with death due to other cause prior to regaining consciousness, sequela~~

Mastocytosis and Certain Other Mast Cell Disorders

A previous proposal to expand and modify codes related to mastocytosis was presented in Sept. 2014. Based on comments from that time and concerns raised, a simplified version of that proposal is now being presented.

Due to the many recent advances in mast cell disorder research, the American Academy of Allergy, Asthma, and Immunology (AAAAI) Mast Cell Disorders Committee, together with The Mastocytosis Society, Inc., recognized the urgency of developing an updated code hierarchy for mastocytosis. Revised and cohesive codes for these disease conditions are not only warranted, but necessary and vital to patients whose disease could otherwise go unrecognized or untreated.

Broadly, mastocytosis can be divided into cutaneous and systemic forms. Symptoms can be due to release of substances such as histamine, and can include headaches, dizziness, flushing, tachycardia, hypotension, syncope, nausea, vomiting, abdominal pain, and diarrhea.

As a result of significant advances in the study of neoplastic mast cells and their morphology, phenotype and genetic characteristics, a consensus classification for Mastocytosis was proposed and adopted by the World Health Organization (WHO) in 2001. Mastocytosis comprises a set of disorders involving abnormal proliferation and accumulation of clonal mast cells in one or multiple organ systems.

Cutaneous Mastocytosis (CM) is diagnosed by the presence of typical skin lesions and a positive skin biopsy demonstrating characteristic clusters of mast cells. This category includes Urticaria Pigmentosa (UP)/Maculopapular Cutaneous Mastocytosis (MPCM), Telangiectasia Macularis Eruptiva Perstans (TMEP), Diffuse Cutaneous Mastocytosis (DCM), and Solitary Mastocytoma. Most cases of Pediatric Mastocytosis fall into one of these categories and may or may not include symptoms of systemic mast cell activation as a result of mediators released from the skin. In children, cutaneous lesions can be expected to spontaneously regress before or at puberty 70-75% of the time, while the remaining 25-30% will develop into Indolent Systemic Mastocytosis or another variant of Systemic Mastocytosis.

Mastocytosis and mast cell neoplasms have been classified to a few different categories in ICD. Certain types are malignant. Code C96.2, Malignant mast cell tumor, includes aggressive systemic mastocytosis and mast cell sarcoma. It is proposed to expand and create specific codes for these disorders. Also, it is proposed to change the title for C96.2, to Malignant mast cell neoplasm. Mast cell leukemia is classified to C94.3.

The default for mastocytosis has been Q82.2, Mastocytosis, in category Q82, Other congenital malformations of skin. However, certain types of mastocytosis and mast cell neoplasms are classified in the ICD with neoplasms of uncertain behavior. It is proposed to create new subcategories and codes for certain of these at category D47, Other neoplasms of uncertain behavior of lymphoid, hematopoietic and related tissue, and subcategory D47.0, along with changing the title of D47.0 to Mast cell neoplasms of uncertain behavior (replacing “tumors” with “neoplasms,” and moving histiocytic neoplasms elsewhere).

It is proposed to create new separate subcategories for cutaneous and systemic mastocytosis, along with new default codes for mastocytosis, at D47.

It is proposed that code Q82.2, Mastocytosis, be retitled, and expanded. Cases with onset in the newborn or neonatal period will be classified here. For clarity, that the title be changed to Congenital cutaneous mastocytosis.

TABULAR MODIFICATIONS

C96 Other and unspecified malignant neoplasms of lymphoid, hematopoietic and related tissue

Revise C96.2 Malignant mast cell neoplasm ~~tumor~~
Delete ~~Aggressive systemic mastocytosis~~
~~Mast cell sarcoma~~

New code C96.20 Malignant mast cell neoplasm, unspecified

New code C96.21 Aggressive systemic mastocytosis

New code C96.22 Mast cell sarcoma

New code C96.29 Other malignant mast cell neoplasm

D47 Other neoplasms of uncertain behavior of lymphoid, hematopoietic and related tissue

Revise D47.0 ~~Histiocytic and mast~~ Mast cell neoplasms ~~tumors~~ of uncertain behavior
Delete ~~Indolent systemic mastocytosis~~
~~Mast cell tumor NOS~~
~~Mastocytoma NOS~~
Add Excludes1: congenital cutaneous mastocytosis (Q82.2-)
Add histiocytic neoplasms of uncertain behavior (D47.Z9)
Revise malignant mast cell neoplasm ~~tumor~~ (C96.2-)
Delete ~~mastocytosis (congenital) (cutaneous) (Q82.2)~~

New code D47.01 Cutaneous mastocytosis
Diffuse cutaneous mastocytosis
Maculopapular cutaneous mastocytosis
Solitary mastocytoma
Telangiectasia macularis eruptiva perstans
Urticaria pigmentosa

Excludes1: congenital (diffuse) (maculopapular) cutaneous mastocytosis (Q82.2)
congenital urticaria pigmentosa (Q82.2)
extracutaneous mastocytoma (D47.09)

New code D47.02 Systemic mastocytosis
Indolent systemic mastocytosis
Isolated bone marrow mastocytosis
Smoldering systemic mastocytosis
Systemic mastocytosis, with an associated hematological non mast cell lineage disease (SM-AHNMD)
Code also if applicable any associated hematological non-mast cell lineage disease, such as:
acute myeloid leukemia (C92.6-, C92.A-)
chronic myelomonocytic leukemia (C93.1-)
essential thrombocytosis (D47.3)
hypereosinophilic syndrome (D72.1)
myelodysplastic syndrome (D46.9)
myeloproliferative syndrome (D47.1)
non-Hodgkin lymphoma (C82-C85)
plasma cell myeloma (C90.0-)
polycythemia vera (D45)

Excludes1: aggressive systemic mastocytosis (C96.21)
mast cell leukemia (C94.3-)

New code D47.09 Other mast cell neoplasms of uncertain behavior
Extracutaneous mastocytoma
Mastocytoma NOS
Mastocytosis NOS
Mast cell tumor NOS

Q82 Other congenital malformations of skin

Revise Q82.2 Congenital cutaneous mastocytosis
Add Congenital diffuse cutaneous mastocytosis
Add Congenital maculopapular cutaneous mastocytosis
Revise Congenital ~~Urticaria~~ urticaria pigmentosa

Add Excludes1: cutaneous mastocytosis NOS (D47.01)
diffuse cutaneous mastocytosis (with onset after newborn period) (D47.01)
Revise malignant mastocytosis (C96.2-)
Add systemic mastocytosis (D47.02)
Add urticaria pigmentosa (non-congenital) (with onset after newborn period) (D47.01)

D89.4 Mast cell activation syndrome and related disorders

Revise	Excludes1:	aggressive systemic mastocytosis (C96.21)
Revise		congenital cutaneous mastocytosis (Q82.2)
Add		(non-congenital) cutaneous mastocytosis (D47.01)
Revise		(indolent) systemic mastocytosis (D47.02)
Add		malignant mast cell neoplasm (C96.2-)
Revise		malignant mastocytoma (C96.29)
Add		mast cell sarcoma (C96.22)
Add		mastocytoma NOS (D47.09)
Add		other mast cell neoplasms of uncertain behavior (D47.09)
Revise		systemic mastocytosis associated with a clonal hematologic non-mast cell lineage disease (SM-AHNMD) (D47.02)

INDEX MODIFICATIONS

	Mastocytoma D47.0
Revise	- malignant C96.29
Revise	Mastocytosis ~~Q82.2~~ D47.09
Add	- cutaneous (diffuse) (maculopapular) D47.01
Add	- - congenital Q82.2
Add	- - of neonatal onset Q82.2
Add	- - of newborn onset Q82.2
Revise	Nettleship's syndrome ~~Q82.2~~ – see Urticaria pigmentosa
	Urticaria L50.9
Revise	- pigmentosa ~~Q82.2~~ D47.01
Add	- - congenital Q82.2
Add	- - of neonatal onset Q82.2
Add	- - of newborn onset Q82.2
Revise	- xanthelasmoidea ~~Q82.2~~ – see Urticaria pigmentosa

Multiple Pregnancy - Triplets and Above - Amnion and Chorion Equal to Fetus Number

Unique diagnosis codes in subcategories O30.1 (Triplet pregnancy), O30.2 (Quadruplet pregnancy), and O30.8 (Other specified multiple gestation) are being requested to report the most common type of presentation in which number of chorions is equal to number of amnions or fetuses.
In multiple pregnancy, two or more fetuses may share a placenta (monochorionic) and may also share an amniotic sac (monoamniotic). Multiple pregnancies with monochorionic pairs have much greater risk of perinatal mortality; therefore, diagnosis of multiple gestation type should be determined as early as possible in the pregnancy.

With the increased use of assisted reproductive technology (ART) there has also been an increase in multiple birth pregnancies. In the majority of these cases, each fetus has its own placenta. However, there has also been an increase in monochorionic presentations. There is an incidence of monozygotic twins after natural conception of approximately 0.4%, and following ART it is around 0.9%. About two thirds of these monozygotic twins will have a monochorionic presentation.

Current ICD-10-CM codes in these categories reflect the conditions potentially associated with higher morbidity and fetal loss, where there are monochorionic or monoamniotic pairs in triplets, quadruplets, or other multiple pregnancies. However, the codes do not reflect the more common cases, where each fetus has its own amniotic sac and placenta. Therefore, new codes in the category of multiple gestation (O30) are requested.

This proposal was presented and supported at the March 2016 C&M meeting. However after further review, it was determined that additional clarity was needed at code category O30.8 Other specified multiple gestation. This additional modification has been reviewed and supported by the American College of Obstetrics and Gynecology (ACOG).

References
Obstetric outcomes of monochorionic pregnancies conceived following assisted reproductive technology: A retrospective study. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4150138/
The risk of monozygotic twins after assisted reproductive technology: a systematic review and meta-analysis. http://www.ncbi.nlm.nih.gov/pubmed/18927071/

O30 Multiple gestation

O30.1 Triplet pregnancy

New sub-subcategory	O30.13 Triplet pregnancy, trichorionic/triamniotic
New code	O30.131 Triplet pregnancy, trichorionic/triamniotic, first trimester
New code	O30.132 Triplet pregnancy, trichorionic/triamniotic, second trimester
New code	O30.133 Triplet pregnancy, trichorionic/triamniotic, third trimester
New code	O30.139 Triplet pregnancy, trichorionic/triamniotic, unspecified trimester

O30.2 Quadruplet pregnancy

New sub-subcategory	O30.23 Quadruplet pregnancy, quadrachorionic/quadra-amniotic
New code	O30.231 Quadruplet pregnancy, quadrachorionic/quadra-amniotic, first trimester
New code	O30.232 Quadruplet pregnancy, quadrachorionic/quadra-amniotic, second trimester
New code	O30.233 Quadruplet pregnancy, quadrachorionic/quadra-amniotic, third trimester
New code	O30.239 Quadruplet pregnancy, quadrachorionic/quadra-amniotic, unspecified trimester

O30.8 Other specified multiple gestation

New sub-subcategory	O30.83 Other specified multiple gestation, **number of chorions and amnions are both equal to the number of fetuses**
Add	Pentachorionic, penta-amniotic pregnancy (quintuplets)
Add	Hexachorionic, hexa-amniotic pregnancy (sextuplets)
Add	Heptachorionic, hepta-amniotic pregnancy (septuplets)

New code	O30.831 Other specified multiple gestation, **number of chorions and amnions are both equal to the number of fetuses,** first trimester
New code	O30.832 Other specified multiple gestation, **number of chorions and amnions are both equal to the number of fetuses**, second trimester
New code	O30.833 Other specified multiple gestation, **number of chorions and amnions are both equal to the number of fetuses**, third trimester
New code	O30.839 Other specified multiple gestation, **number of chorions and amnions are both equal to the number of fetuses,** unspecified trimester

Myopic Choroidal Neovascularization

Myopic choroidal neovascularization is among the most vision-threatening complications in pathologic myopia. Degenerative (Pathologic) myopia is a condition where the eye continues to grow, becoming much longer than it should be. Degenerative myopia can be associated with the growth of leaky blood vessels in the macula, which is called myopic choroidal neovascularization (mCNV), and is associated with serious impairment of vision and, in some cases, blindness if left untreated.

Myopic CNV appears as a flat, small, greyish subretinal membrane beneath or in close proximity to fovea with or without macular hemorrhage. Individuals with degenerative myopia also have increased risks of macular atrophy such as choroidal atrophy, myopic foveoschisis and myopic macular hole. In the USA, the prevalence of degenerative myopia in people older than 18 years is estimated at 818,000 and those with mCNV is estimated to be 41,000, [1] respectively.

Currently, patients with Myopic Choroidal Neovascularization are coded using H44.2, Degenerative Myopia and/or H35.05, Retinal Neovascularization, unspecified. In some cases, when mCNV presents in elderly patients they may even be coded as macular degeneration (H35.32, Exudative age-related macular degeneration or H35.30, Unspecified macular degeneration).

The American Academy of Ophthalmology proposes the following new codes in order to better identify these conditions.

Reference:
Willis JR, Vitale S, Morse L, et al. The prevalence of Myopic Choroidal Neovascularization in the United States. Ophthalmology 2016; :1-12.

TABULAR MODIFICATIONS

H44 Disorders of globe

H44.2 Degenerative myopia

New sub-subcategory Add	H44.2A	Degenerative myopia with choroidal neovascularization Use additional code for any associated choroid disorders (H31.-)	
New code	H44.2A1	Degenerative myopia with choroidal neovascularization, right eye	
New code	H44.2A2	Degenerative myopia with choroidal neovascularization, left eye	
New code	H44.2A3	Degenerative myopia with choroidal neovascularization, bilateral eye	

New code	H44.2A9	Degenerative myopia with choroidal neovascularization, unspecified eye
New sub-subcategory	H44.2B	Degenerative myopia with macular hole
New code	H44.2B1	Degenerative myopia with macular hole, right eye
New code	H44.2B2	Degenerative myopia with macular hole, left eye
New code	H44.2B3	Degenerative myopia with macular hole, bilateral eye
New code	H44.2B9	Degenerative myopia with macular hole, unspecified eye
New sub-subcategory	H44.2C	Degenerative myopia with retinal detachment
Add		Use additional code to identify the retinal detachment (H33.-)
New code	H44.2C1	Degenerative myopia with retinal detachment, right eye
New code	H44.2C2	Degenerative myopia with retinal detachment, left eye
New code	H44.2C3	Degenerative myopia with retinal detachment, bilateral eye
New code	H44.2C9	Degenerative myopia with retinal detachment, unspecified eye
New sub-subcategory	H44.2D	Degenerative myopia with foveoschisis
New code	H44.2D1	Degenerative myopia with foveoschisis, right eye
New code	H44.2D2	Degenerative myopia with foveoschisis, left eye
New code	H44.2D3	Degenerative myopia with foveoschisis, bilateral eye

New code	H44.2D9	Degenerative myopia with foveoschisis, unspecified eye
New sub-subcategory	H44.2E	Degenerative myopia with other maculopathy
New code	H44.2E1	Degenerative myopia with other maculopathy, right eye
New code	H44.2E2	Degenerative myopia with other maculopathy, left eye
New code	H44.2E3	Degenerative myopia with other maculopathy, bilateral eye
New code	H44.2E9	Degenerative myopia with other maculopathy, unspecified eye

Obsessive-Compulsive Disorders

The American Psychiatric Association (APA) is proposing the following tabular modifications to better align the Mental, Behavioral and Neurodevelopmental Disorders in ICD-10-CM with those in DSM-5, the standard manual used in the United States to diagnose mental disorders.

APA had previously requested the addition of a 4th character for code category F42 Obsessive-Compulsive Disorder in order to accommodate newly added diagnoses in DSM-5. Those changes have been included in the addenda effective October 1, 2016.

With respect to this coding implementation, after further review from APA, concerns were raised that by having F42 Obsessive-Compulsive Disorder (OCD) as a code category this would imply that hoarding disorder is not a distinct diagnosis from OCD. This concern was previously noted in comments received during the previous comment period.

In fact, as listed in the APA Diagnostic and Statistical Manual, Obsessive-compulsive disorder, Hoarding disorder, and Excoriation disorder are considered distinct but related conditions that are part of a larger diagnostic grouping called "Obsessive-Compulsive and Related Disorders."

APA is requesting that code category F42 Obsessive-compulsive disorders be revised to reflect the change to Obsessive-Compulsive and Related Disorders and F42.2 be revised to clarify that it is to be used for Obsessive-Compulsive Disorder as most cases of OCD are characterized by both obsessional thoughts and acts. These ICD-10-CM tabular modifications will become effective October 1, 2017.

TABULAR MODIFICATIONS

Revise	F42 Obsessive-compulsive and related disorders
Revise	F42.2 ~~Mixed obsessional thoughts and acts~~ Obsessive-compulsive disorder
Add	Mixed obsessional thoughts and acts
Revise	F42.8 Other obsessive-compulsive and related disorder
Revise	F42.9 Obsessive-compulsive and related disorder, unspecified

Post Endometrial Ablation Syndrome

The American Congress of Obstetricians and Gynecologists (ACOG) is requesting a new code to report post endometrial ablation syndrome.

Global endometrial ablation is a procedure that is commonly performed for reproductive-aged women with menstrual disorders to include menorrhagia and menometrorrhagia. This procedure has been used in clinical practice for over two decades. Post endometrial ablation syndrome is a condition that may occur in up to 10% of women who undergo endometrial ablation that includes cyclic pain and hematometra. This condition occurs most commonly in women who have previously had fallopian tube occlusion performed for sterilization purposes.

Although ICD-10-CM allows one to code for the signs and symptoms related to this condition (e.g. pelvic pain, hematometra), post endometrial ablation syndrome occurs frequently enough that a separate code is warranted for better coding specificity and tracking purposes.

ACOG proposes the following tabular modification.

TABULAR MODIFICATIONS

N94 Pain and other conditions associated with female genital organs and menstrual cycle

N94.8 Other specified conditions associated with female genital organs and menstrual cycle

New code N94.82 Post endometrial ablation syndrome

Pulmonary Hypertension

Pulmonary hypertension (PH) is clinically classified into five groups, based on categories that share similar pathological findings, hemodynamic characteristics and management. This was first established at the Second World Symposium on Pulmonary Hypertension in 1998, and maintained through the most recent Fifth World Symposium in 2013. Recommendations related to updating of the ICD-10-CM codes for pulmonary hypertension have been received from a number of organizations, including the American Thoracic Society, the Pulmonary Hypertension Association, and the Society of Thoracic Surgeons. The current proposal is based on this input, but the specific proposed changes have been modified from external proposals, for consistency with ICD structure and conventions. A previous proposal related to this was presented in Sep. 2015, and this is updated from that original proposal based on input from multiple organizations.

Group 1: Pulmonary Arterial Hypertension (PAH)
PAH is the most widely recognized category of PH, and includes the previously designated Primary Pulmonary Hypertension (PPH). PAH includes idiopathic PAH (IPAH) without an identifiable family history or risk factor, and heritable PAH such as that due to mutations in the bone morphogenetic protein receptor type 2 (BMPR2) gene. PAH also includes a number of secondary causes of PH: drug- and toxin-induced PH, and PH associated with other chronic conditions such as HIV infection, and congenital heart diseases. PAH due to congenital heart disease can be related to defects that cause a left to right shunt. However, over time with PAH, a right to left shunt may develop, in what is referred to as Eisenmenger's syndrome.

Group 2: PH due to left heart disease
This subgroup may be due to left heart failure (systolic or diastolic), or left heart valvular disease that may produce increase in left atrial pressure. Some patients with left heart valvular disease or left heart dysfunction can develop PH as severe as that seen in PAH.

Group 3: PH due to lung diseases and/or hypoxia
In this subgroup, the predominant cause of PH is alveolar hypoxia as a result of lung disease, impaired control of breathing, or residence at high altitude. Among those with pulmonary fibrosis and emphysema, the prevalence of PH is almost 50 percent.

Group 4: Chronic Thromboembolic PH (CTEPH)
Obstruction of pulmonary arterial vessels by thromboemboli, tumors, or foreign bodies can lead to CTEPH.

Group 5: PH with unclear multifactorial mechanisms
This group includes multiple forms of PH for which the etiology is unclear or multifactorial. The subgroups include hematologic disorders such as myeloproliferative disorders and splenectomy; systemic disorders such as sarcoidosis and pulmonary Langerhans cell histiocytosis; metabolic disorders such as glycogen storage disease, Gaucher disease and thyroid disorders; and other conditions that lead to PH.

Reference

Simonneau G, Gatzoulis MA, Adatia I, et al. Updated clinical classification of pulmonary hypertension. J Am Coll Cardiol. 2013;62(25 Suppl):D34–41. http://www.sciencedirect.com/science/article/pii/S0735109713058725

TABULAR MODIFICATIONS

I27 Other pulmonary heart diseases

I27.0 Primary pulmonary hypertension
Add Primary group 1 pulmonary hypertension
Add Heritable pulmonary arterial hypertension
Add Idiopathic pulmonary arterial hypertension
Add Primary pulmonary arterial hypertension

Add Excludes1: Persistent pulmonary hypertension of newborn (P29.30)
Revise Pulmonary hypertension NOS (I27.20)
Add Secondary pulmonary arterial hypertension (I27.21)
Revise Secondary pulmonary hypertension (I27.29)

I27.2 Other secondary pulmonary hypertension

Excludes1: Eisenmenger's syndrome (I27.83)

New code I27.20 Pulmonary hypertension, unspecified

New code I27.21 Secondary pulmonary arterial hypertension
(Associated) (drug-induced) (toxin-induced) pulmonary arterial hypertension NOS
(Associated) (drug-induced) (toxin-induced) (secondary) group 1 pulmonary hypertension

Code also associated conditions if applicable, or adverse effects of drugs or toxins, such as:
Adverse effect of appetite depressants (T50.5X5)
Congenital heart disease (Q20-Q28)
Human immunodeficiency virus [HIV] disease (B20)
Polymyositis (M33.2-)
Portal hypertension (K76.6)
Rheumatoid arthritis (M05.-)
Schistosomiasis (B65.-)
Sjögren syndrome (M35.0-)
Systemic sclerosis (M34.-)

New code I27.22 Pulmonary hypertension due to left heart disease

Group 2 pulmonary hypertension
Code also associated left heart disease, if known, such as:
Multiple valve disease (I08.-)
Rheumatic mitral valve diseases (I05.-)
Rheumatic aortic valve diseases (I06.-)

New code I27.23 Pulmonary hypertension due to lung diseases and hypoxia
Group 3 pulmonary hypertension

Code also associated lung disease, if known, such as:
Bronchiectasis (J47.-)
Cystic fibrosis with pulmonary manifestations (E84.0)
Interstitial lung disease (J84.-)
Pleural effusion (J90)
Sleep apnea (G47.3-)

New code I27.24 Chronic thromboembolic pulmonary hypertension
Group 4 pulmonary hypertension
Code also associated pulmonary embolism, if applicable (I26.-, I27.82)

New code I27.29 Other secondary pulmonary hypertension
Group 5 pulmonary hypertension
Pulmonary hypertension with unclear multifactorial mechanisms
Pulmonary hypertension due to hematologic disorders
Pulmonary hypertension due to metabolic disorders
Pulmonary hypertension due to other systemic disorders
Code also other associated disorders, if known, such as:
Chronic myeloid leukemia (C92.10- C92.22)
Essential thrombocythemia (D47.3)
Gaucher disease (E75.22)
Hypertensive chronic kidney disease with end stage renal disease (I12.0, I12.11, I13.2)
Hyperthyroidism (E05.-)
Hypothyroidism (E00-E03)
Polycythemia vera (D45)
Sarcoidosis (D86.-)

I27.8 Other specified pulmonary heart diseases

New code
I27.83 Eisenmenger's syndrome
Eisenmenger's complex
(Irreversible) Eisenmenger's disease
Pulmonary hypertension with right to left shunt related to congenital heart disease
Code also underlying heart defect, such as:
Atrial septal defect (Q21.1)
Eisenmenger's defect (Q21.8)
Patent ductus arteriosus (Q25.0)
Ventricular septal defect (Q21.0)

I27.89 Other specified pulmonary heart diseases
Delete ~~Eisenmenger's complex~~
~~Eisenmenger's syndrome~~
~~Excludes1:Eisenmenger's defect (Q21.8)~~

P29 Cardiovascular disorders originating in the perinatal period

P29.3 Persistent fetal circulation
Delete ~~Delayed closure of ductus arteriosus~~
Delete ~~(Persistent) pulmonary hypertension of newborn~~

New code
P29.30 Pulmonary hypertension of newborn
Persistent pulmonary hypertension of newborn

New code
P29.38 Other persistent fetal circulation
Delayed closure of ductus arteriosus

Q21 Congenital malformations of cardiac septa

Q21.8 Other congenital malformations of cardiac septa
Eisenmenger's defect
Pentalogy of Fallot
Delete ~~Excludes1:Eisenmenger's complex (I27.8)~~
Delete ~~Eisenmenger's syndrome (I27.8)~~
Add Code also if applicable:
Add Eisenmenger's complex (I27.83)
Add Eisenmenger's syndrome (I27.83)

Sickle Cell without Acute Chest Syndrome or Splenic Sequestration

Currently in ICD-10-CM, patients with sickle cell vasoocclusive crisis not associated with acute chest syndrome or splenic sequestration are coded as "with crisis, unspecified". In the majority of these encounters, the vasoocclusive pain crisis is the problem that requires medical intervention as other major complications may not be present.

The American Academy of Pediatrics requests tabular modifications for sickle cell disorders with crisis to identify patients without major complications but who are in crisis.

TABULAR MODIFICATIONS

D57 Sickle-cell disorders

D57.0 Hb-SS disease with crisis
Sickle-cell disease NOS with crisis
Hb-SS disease with vasoocclusive pain

D57.00 Hb-SS disease with crisis, unspecified
D57.01 Hb-SS disease with acute chest syndrome
D57.02 Hb-SS disease with splenic sequestration
New code D57.03 Hb-SS disease with crisis without acute chest syndrome or splenic sequestration
New code D57.08 HB-SS disease with crisis with other specified complication
New code D57.09 HB-SS disease with crisis, unspecified
Add HB-SS disease with crisis NOS

D57.2 Sickle-cell/Hb-C disease
Hb-SC disease
Hb-S/Hb-C disease

D57.21 Sickle-cell/Hb-C disease with crisis

D57.211 Sickle-cell/Hb-C disease with acute chest syndrome
D57.212 Sickle-cell/Hb-C disease with splenic sequestration
New code D57.213 Sickle-cell/Hb-C disease with crisis without acute chest syndrome or splenic sequestration
New code D57.218 Sickle-cell/Hb-C disease with crisis with other specified complication

D57.4 Sickle-cell thalassemia
Sickle-cell beta thalassemia
Thalassemia Hb-S disease

D57.41 Sickle-cell thalassemia with crisis
Sickle-cell thalassemia with vasoocclusive pain

D57.411 Sickle-cell thalassemia with acute chest syndrome
D57.412 Sickle-cell thalassemia with splenic sequestration
New Code D57.413 Sickle-cell thalassemia with crisis without acute chest syndrome or splenic sequestration
New code D57.418 Sickle-cell thalassemia with crisis with other specified complication

D57.8 Other sickle-cell disorders
Hb-SD disease
Hb-SE disease

D57.81 Other sickle-cell disorders with crisis

D57.811 Other sickle-cell disorders with acute chest syndrome
D57.812 Other sickle-cell disorders with splenic sequestration
New code D57.813 Other sickle-cell disorders with crisis without acute chest syndrome or splenic sequestration
New code D57.818 Other sickle-cell disorders with crisis with other specified complication

Spinal Stenosis with Neurogenic Claudication

Neurogenic claudication is a commonly used term for a syndrome associated with significant lumbar spinal stenosis leading to compression of the cauda equina (lumbar nerves). Symptoms typically are buttock and lower extremity cramping, pain, and fatigue. The symptoms are exacerbated by standing erect and extension of the lumbar spine and often subside with sitting or bending forward at the waist. Moving the spine forward (flexion) naturally widens the spinal canal. Neurogenic claudication symptoms can be similar to vascular claudication symptoms but are instead due to nerve root compression rather than vascular insufficiency.

ICD-9-CM code 724.03, Lumbar region, with neurogenic claudication, was implemented in 2010 for reporting spinal stenosis of the lumbar region with neurogenic claudication. Currently, there is no code in ICD-10-CM to capture lumbar spinal stenosis with neurogenic claudication.

The requestor is recommending the following new codes to parallel what was in ICD-9-CM in order to identify these conditions. This recommendation is supported by the American Academy of Neurology (AAN).

TABULAR MODIFICATIONS

M48 Other Spondylopathies

M48.0 Spinal stenosis

New sub-subcategory	M48.06	Spinal stenosis, lumbar region	
New code	M48.061	Spinal stenosis, lumbar region without neurogenic claudication Spinal stenosis, lumbar region NOS	
New code	M48.062	Spinal stenosis, lumbar region with neurogenic claudication	

Umbilical Granuloma in the Perinatal Period

An umbilical granuloma is a very common condition that affects roughly 1 in 500 newborns. This condition presents as a small round growth in center of navel after the umbilical cord has fallen off.

Its appearance is red, can be on a stalk and may be covered with clear mucus. Without treatment, the granuloma will usually grow in size and can become an entry point for umbilical infections. The routine treatment is application of a silver nitrate stick, usually repeated two or three times over a number of clinic visits.

Currently the condition is indexed to L92.9 Granulomatous disorder of the skin and subcutaneous tissue, unspecified.

The American Academy of Pediatrics is requesting the following tabular modifications.

TABULAR MODIFICATIONS

L92 Granulomatous disorders of skin and subcutaneous tissue

L92.9 Granulomatous disorder of the skin and subcutaneous tissue, unspecified

Add — Excludes 1: Umbilical granuloma (P83.81)

P83 Other conditions of integument specific to newborn

New subcategory — P83.8 Other specified conditions of integument specific to newborn

New code — P83.81 Umbilical granuloma

Add — Excludes1: Granulomatous disorder of the skin and subcutaneous tissue, unspecified (L92.9)

New code — P83.88 Other specified conditions of integument specific to newborn

Bronze baby syndrome
Neonatal scleroderma
Urticaria neonatorum

Zika Related Newborn Conditions

The American Academy of Pediatrics is requesting the addition of new codes related to Zika virus infection.

The Academy and the CDC convened a work group consisting of representatives of the CDC, along with physicians representing fetal and newborn medicine, infectious disease pediatrics, developmental and behavioral pediatrics, neurology, and disaster preparedness who are dealing with this emerging public health issue.

CDC has published recommendations for the evaluation and testing of infants with possible congenital Zika virus infection (http://www.cdc.gov/mmwr/volumes/65/wr/mm6503e3.htm). These recommendations state that all infants be tested regardless of presentation at birth (e.g., with or without microcephaly) who have been exposed in-utero to the virus, or who have been suspected to be exposed to the virus. Currently, there is not any way to identify and monitor this specific screening or identifying infants who are infected with Zika virus.

Given the potentially enormous public health impact of the Zika virus, the work group states that it is critical that we accurately capture infected in utero or manifesting clinical findings of Zika virus infection. It is clear that this virus has the potential to rapidly spread though out parts of the US. The CDC-American Academy of Pediatrics Zika Workgroup are requesting that specific codes be created and **implemented April 1, 2017** in order to identify and monitor these infants who are at risk or infected with the virus and who may require additional resources in their care. **Therefore, comments on this topic are requested by October 16, 2016.**

TABULAR MODIFICATIONS

P00 Newborn affected by maternal conditions that may be unrelated to present pregnancy

P00.2 Newborn affected by maternal infectious and parasitic diseases
Newborn affected by maternal infectious disease classifiable to A00-B99, J09 and J10

New code
Add
P00.21 Newborn affected by maternal infection with Zika virus
Code also any manifestations

New code
P00.29 Newborn (suspected to be) affected by other maternal infection

P35 Congenital viral diseases
Includes: infections acquired in utero or during birth

New code
P35.4 Congenital Zika virus infection
Code also any manifestations

Z20 Contact with and (suspected) exposure to communicable diseases
Z20.8 Contact with and (suspected) exposure to other communicable diseases
Z20.82 Contact with and (suspected) exposure to other viral communicable diseases
New code Z20.821 Contact with and (suspected) exposure to Zika virus

ICD-10-CM TABULAR LIST OF DISEASES - PROPOSED ADDENDA

B81 Other intestinal helminthiases, not elsewhere classified
Revise Excludes1: angiostrongyliasis due to: ~~Parastrongylus cantonensis (B83.2)~~
Add Angiostrongylus cantonensis (B83.2)
Add Parastrongylus cantonensis (B83.2)

B81.3 Intestinal angiostrongyliasis
Revise Angiostrongyliasis due to: ~~Parastrongylus costaricensis~~
Add Angiostrongylus cantonensis (B83.2)
Add Parastrongylus cantonensis (B83.2)

C79 Secondary malignant neoplasm of other and unspecified site
Delete Excludes 1: ~~lymph node metastases (C77.0)~~

C79.1 Secondary malignant neoplasm of bladder and other and unspecified urinary organs
C79.11 Secondary malignant neoplasm of bladder
Add Excludes 2: lymph node metastases (C77.0)

C86 Other specified types of T/NK-cell lymphoma
C86.4 Blastic NK-cell lymphoma
Add Blastic Plasmacytoid Dendritic Cell Neoplasm (BPDCN)

E13 Other specified diabetes mellitus
Delete Excludes1~~: type 2 diabetes mellitus (E11.-)~~
E13.0 Other specified diabetes mellitus with hyperosmolarity
E13.00 Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
Add Excludes2: type 2 diabetes mellitus (E11.-)

E16 Other disorders of pancreatic internal secretion
E16.0 Drug-induced hypoglycemia without coma
Revise Excludes1: diabetes with hypoglycemia without coma ~~(E09.692)~~ (E09.649)

F31 Bipolar disorder
F31.9 Bipolar disorder, unspecified
Add Manic depression

G00 Bacterial meningitis, not elsewhere classified
Revise Excludes1: ~~bacterial:~~
Revise bacterial meningoencephalitis (G04.2)
Revise bacterial meningomyelitis (G04.2)

G10 Huntington's disease
Huntington's chorea
Huntington's dementia
Add Code also Dementia in other diseases classified elsewhere without behavioral disturbance (F02.80)

H02 Other disorders of eyelid
Revise H02.05Trichiasis without ~~entropian~~ entropion
Revise H02.051 Trichiasis without ~~entropian~~ entropion right upper eyelid
Revise H02.052 Trichiasis without ~~entropian~~ entropion right lower eyelid
Revise H02.053 Trichiasis without ~~entropian~~ entropion right eye, unspecified eyelid
Revise H02.054 Trichiasis without ~~entropian~~ entropion left upper eyelid
Revise H02.055 Trichiasis without ~~entropian~~ entropion left lower eyelid
Revise H02.056 Trichiasis without ~~entropian~~ entropion left eye, unspecified eyelid
Revise H02.059 Trichiasis without ~~entropian~~ entropion unspecified eye, unspecified eyelid

I25 Chronic ischemic heart disease
I25.7 Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris
Delete Excludes1: ~~embolism or thrombus of coronary artery bypass graft(s) (T82.8-)~~
I25.71 Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris
I25.710 Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris
Add Excludes2: embolism or thrombus of coronary artery bypass graft(s) (T82.8-)

I30 Acute pericarditis
Excludes1: Dressler's syndrome (I24.1)
rheumatic pericarditis (acute) (I01.0)
Add viral pericarditis due to Coxsakie virus (B33.23)

I34 Nonrheumatic mitral valve disorders
Revise Excludes 1:mitral valve disorder specified as congenital (Q23.2, ~~Q23.3~~ Q23.9)

I49 Other cardiac arrhythmias
Delete Excludes1:~~bradycardia NOS (R00.1)~~
Add Excludes2:bradycardia NOS (R00.1)

I49.8 Other specified cardiac arrhythmias
Add Brugada syndrome
Add Long QT syndrome

I50 Heart Failure
Delete Excludes1: ~~cardiac arrest (I46.-)~~
Add Excludes2: cardiac arrest (I46.-)

Cerebrovascular diseases (I60-I69)
Delete Excludes1: ~~transient cerebral ischemic attacks and related syndromes (G45.-)~~

I60 Nontraumatic subarachnoid hemorrhage
Delete ~~ruptured cerebral aneurysm~~

I63 Cerebral infarction
Delete Excludes1: ~~sequelae of cerebral infarction (I69.3-)~~
Add Excludes2: sequelae of cerebral infarction (I69.3-)

I63.9 Cerebral infarction, unspecified
Add Excludes2: transient cerebral ischemic attacks and related syndromes (G45.-)

I67 Other cerebrovascular diseases
I67.4 Hypertensive encephalopathy
Add Excludes2: insufficiency, NOS, of precerebral arteries (G45.-) (G45.2)

I69 Sequelae of cerebrovascular disease
Delete Excludes1: ~~transient ischemic attack (TIA) (G45.9)~~
I69.3 Sequelae of cerebral infarction
I69.32 Speech and language deficits following cerebral infarction
I69.322 Dysarthria following cerebral infarction
Add Excludes2: transient ischemic attack (TIA) (G45.9)
I69.35 Hemiplegia and hemiparesis following cerebral infarction
I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
Add Excludes2: transient ischemic attack (TIA) (G45.9)

I72 Other aneurysm
Add Excludes 2: Precerebral artery, congenital (nonruptured) (Q28.1)

I96 Gangrene, not elsewhere classified
Delete Excludes1: ~~gangrene in diabetes mellitus (E08-E13)~~
Add Excludes2: gangrene in diabetes mellitus (E08-E13)

J15 Bacterial pneumonia, not elsewhere classified
Revise J15.6 Pneumonia due to other ~~aerobic~~ Gram-negative bacteria
Add Pneumonia due to other aerobic Gram-negative bacteria

J44 Other chronic obstructive pulmonary disease
Delete Excludes1: ~~lung diseases due to external agents (J60-J70)~~

J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
Add Excludes2: lung diseases due to external agents (J60-J70)

J44.9 Chronic obstructive pulmonary disease, unspecified
Add Excludes2: lung diseases due to external agents (J60-J70)

J45 Asthma
Delete Excludes1: ~~lung diseases due to external agents (J60-J70)~~
J45.9 Other and unspecified asthma
J45.90 Unspecified asthma
J45.909 Unspecified asthma, uncomplicated
Add Excludes2: lung diseases due to external agents (J60-J70)

J84 Other interstitial pulmonary diseases
Delete Excludes1: ~~lung diseases due to external agents (J60-J70)~~
Add Excludes2: lung diseases due to external agents (J60-J70)
J84.1 Other interstitial pulmonary diseases with fibrosis
J84.10 Pulmonary fibrosis, unspecified
Add Excludes2: lung diseases due to external agents (J60-J70)

K52 Other and unspecified noninfective gastroenteritis and colitis
K52.8 Other specified noninfective gastroenteritis and colitis
K52.81 Eosinophilic gastritis or gastroenteritis
Delete ~~Excludes 1 eosinophilic esophagitis (K20.0)~~
Add Excludes 2 eosinophilic esophagitis (K20.0)

K56 Paralytic ileus and intestinal obstruction without hernia
Delete Excludes1: ~~intestinal obstruction with hernia (K40-K46)~~
K56.7 Ileus, unspecified
Add Excludes2: intestinal obstruction with hernia (K40-K46)

K76 Other diseases of liver
K76.7 Hepatorenal syndrome
Revise Excludes1: postprocedural hepatorenal syndrome (~~K91.82~~) (K91.83)

K90 Intestinal malabsorption
K90.0 Celiac disease
Revise Celiac ~~G~~gluten-sensitive enteropathy

K90.4 Malabsorption due to intolerance, not elsewhere classified
Revise Excludes2: celiac gluten-sensitive enteropathy (K90.0)

L57 Skin changes due to chronic exposure to nonionizing radiation
Revise Use additional code to identify the source of the ultraviolet radiation (W89~~, X32~~)

N18 Chronic kidney disease (CKD)

N18.9 Chronic kidney disease, unspecified
Add Chronic uremia NOS
Add Diffuse sclerosing glomerulonephritis NOS

N25 Disorders resulting from impaired renal tubular function
Delete ~~Excludes1: metabolic disorders classifiable to E70-E88~~
N25.0 Renal osteodystrophy
Add Excludes2: metabolic disorders classifiable to E70-E88
N25.8 Other disorders resulting from impaired renal tubular function
N25.81 Secondary hyperparathyroidism of renal origin
Add Excludes2: metabolic disorders classifiable to E70-E88

N28 Other disorders of kidney and ureter, not elsewhere classified
N28.1 Cyst of kidney, acquired
Revise Cyst (multiple) (solitary) of kidney, (acquired)

N80 Endometriosis
N80.8 Other endometriosis
Add Endometriosis of thorax

N99 Intraoperative and postprocedural complications and disorders of genitourinary system, not elsewhere classified
N99.1 Postprocedural urethral stricture
N99.11 Postprocedural urethral stricture, male
Add N99.111 Postprocedural bulbous urethral stricture, male
Add N99.112 Postprocedural membranous urethral stricture, male
Add N99.113 Postprocedural anterior urethral stricture, male

O99 Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium

O99.1 Other diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism complicating pregnancy, childbirth and the puerperium
Delete Excludes2: hemorrhage with coagulation defects (O45.-, O46.0-, O67.0, O72.3)
Add Excludes1: hemorrhage with coagulation defects (O45.-, O46.0-, O67.0, O72.3)

P00 Newborn (suspected to be) affected by maternal conditions that may be unrelated to present pregnancy
P00.2 Newborn (suspected to be) affected by maternal infectious and parasitic diseases
Delete Excludes1: ~~infections specific to the perinatal period (P35-P39)~~
Add Excludes2: infections specific to the perinatal period (P35-P39)

P27 Chronic respiratory disease originating in the perinatal period
Delete Excludes1: ~~respiratory distress of newborn (P22.0-P22.9)~~
Add Excludes2: respiratory distress of newborn (P22.0-P22.9)

Q25 Congenital malformations of great arteries
Q25.4 Other congenital malformations of aorta
Q25.49 Other congenital malformations of aorta
Add Aortic arch
Add Bovine arch

R00 Abnormalities of heart beat
Delete Excludes1: ~~specified arrhythmias (I47-I49)~~
R00.1 Bradycardia, unspecified
Add Excludes2: specified arrhythmias (I47-I49)

R09 Other symptoms and signs involving the circulatory and respiratory system
R09.0 Asphyxia and hypoxemia
Revise Excludes1: hypercapnia ~~(R06.4)~~ (R06.89)

R42 Dizziness and giddiness
Add Excludes2: symptoms and signs constituting part of a pattern of mental disorder (F01-F99)

R45 Symptoms and signs involving emotional state
R45.8 Other symptoms and signs involving emotional state
R45.85 Homicidal and suicidal ideations
R45.851 Suicidal ideations
Add Excludes2: symptoms and signs constituting part of a pattern of mental disorder (F01-F99)

R53 Malaise and fatigue
R53.8 Other malaise and fatigue
Delete Excludes1: ~~exhaustion and fatigue due to depressive episode (F32.)~~

R53.83 Other fatigue

Add — Excludes2: exhaustion and fatigue due to depressive episode (F32.-)

R57 Shock, not elsewhere classified

Delete — Excludes1: ~~septic shock (R65.21)~~

R57.0 Cardiogenic shock

Add — Excludes2: septic shock (R65.21)

R60 Edema, not elsewhere classified

Delete — Excludes1: ~~nutritional edema (E40-E46)~~

R60.1 Generalized edema

Add — Excludes2: nutritional edema (E40-E46)

R68 Other general symptoms and signs

R68.1 Nonspecific symptoms peculiar to infancy

R68.13 Apparent life threatening event in infant (ALTE)

Add — Brief Resolved Unexplained Event (BRUE)

R79 Other abnormal findings of blood chemistry

Delete — Excludes1: ~~abnormality of fluid, electrolyte or acid-base balance (E86-E87)~~

R79.1 Abnormal coagulation profile

Add — Excludes2: abnormality of fluid, electrolyte or acid-base balance (E86-E87)

S72 Fracture of femur

Revise — Excludes2: periprosthetic fracture of prosthetic implant of hip ~~(T84.040, T84.041)~~ (M97.0-)

Injury, poisoning and certain other consequences of external causes (S00-T88)

Delete — ~~T20-T32 Burns and corrosions~~

T07 Unspecified multiple injuries

Add — The appropriate 7th character is to be added to code T07
A - initial encounter
D - subsequent encounter
S - sequela

T14 Unspecified multiple injuries

Add — The appropriate 7th character is to be added to each code from category T14

A - initial encounter
D - subsequent encounter
S - sequela

T14.8 Other injury of unspecified body region
Add Wound NOS

T84 Complications of internal orthopedic prosthetic devices, implants and grafts
T84.0 Mechanical complication of internal joint prosthesis T84.01 Broken
Revise Excludes1: periprosthetic joint implant fracture ~~(T84.04)~~ (M97-

W29 Contact with other powered hand tools and household machinery
Revise W29.8 Contact with other powered ~~powered~~ hand tools and household machinery

Contact with heat and hot substances (X10-X19)

Revise Excludes1: exposure to fire and flames (X00-~~X09~~X08)

X32 Exposure to sunlight
Delete Excludes1: ~~radiation-related disorders of the skin and subcutaneous tissue (L55-L59)~~
Add Excludes2: radiation-related disorders of the skin and subcutaneous tissue (L55-L59)

Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure (Y83-Y84)

Add Excludes2: breakdown or malfunctioning of medical device (during procedure (after implantation) (ongoing use) (Y70-Y82)

Z01 Encounter for other special examination without complaint, suspected or reported diagnosis
Z01.4 Encounter for gynecological examination
Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings
Add Use additional code to identify abnormal findings
Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings
Delete ~~Use additional code to identify abnormal findings~~

Z16 Resistance to antimicrobial drugs
Delete Excludes1: Methicillin resistant Staphylococcus aureus infection in diseases classified elsewhere (B95.62)

Z16.1 Resistance to beta lactam antibiotics
Z16.12 Extended spectrum beta lactamase (ESBL) resistance
Add — Excludes2: Methicillin resistant Staphylococcus aureus infection in diseases classified elsewhere (B95.62)

Z31 Encounter for procreative management
Z31.5 Encounter for genetic counseling
Add — Encounter for nonprocreative genetic counseling

Z43 Encounter for attention to artificial openings
Delete — Excludes1: ~~artificial opening status only, without need for care (Z93.-)~~
Z43.1 Encounter for attention to gastrostomy
Excludes2: artificial opening status only, without need for care (Z93.-)

Z45 Encounter for adjustment and management of implanted device
Delete — Excludes1: presence of prosthetic and other devices (Z95-Z97)
Z45.0 Encounter for adjustment and management of cardiac device
Z45.018 Encounter for adjustment and management of other part of cardiac pacemaker
Add — Excludes1: presence of prosthetic and other devices (Z95-Z97)

Z48 Encounter for other postprocedural aftercare
Add — Excludes1: Encounter for aftercare following injury – code to Injury, by site, with 7th character D

Z68 Body mass index [BMI]
Revise — Z68.1 Body mass index (BMI) 19.9 or less, adult

Z79 Long term (current) drug therapy
Z79.8 Other long term (current) drug therapy
Z79.89 Other long term (current) drug therapy
Revise — Z79.890 Hormone replacement therapy ~~(postmenopausal)~~

Z83 Family history of other specific disorders
Z83.7 Family history of diseases of the digestive system
Z83.71 Family history of colonic polyps
Delete — Excludes1: ~~family history of malignant neoplasm of digestive organs (Z80.0)~~

Add — Excludes2: family history of malignant neoplasm of digestive organs (Z80.0)

Z91 Personal risk factors, not elsewhere classified

Add — Excludes 2: Female genital mutilation status (N90.81-)

Z95 Presence of cardiac and vascular implants and grafts

Delete — Excludes1: ~~complications of cardiac and vascular devices, implants and grafts (T82.-)~~

Add — Excludes2: complications of cardiac and vascular devices, implants and grafts (T82.-)

Z95.1 Presence of aortocoronary bypass graft

Add — Presence of coronary artery bypass graft

ICD-10-CM INDEX LIST OF DISEASES - PROPOSED ADDENDA

Adenitis - see also Lymphadenitis
Revise - due to Pasteurella multocida (~~p~~P. septica) A28.0

Arrest, arrested
- cardiac I46.9
Add - - personal history, successfully resuscitated Z86.74

Atresia, atretic
- vein NEC Q27.8
Revise - - pulmonary ~~Q26.3~~ Q26.4
Add - - - partial Q26.3
Add - - - total Q26.2

Bleeding - see also Hemorrhage
- uterus, uterine NEC N93.9
Revise - - dysfunctional o~~f~~r functional N93.8

Body, bodies
- mass index (BMI)
- - adult
Revise - - - 19.9 or less Z68.1

Bursitis
Revise - collateral ligament, tibial —see Bursitis, tibial collateral M76.04 M76.4-
Revise - tibial collateral —see Bursitis, tibial collateral M76.04 M76.4-

Cardiomyopathy
- due to
Revise - - progressive muscular dystrophy G71.0 [I43]

Checking (of)
Add -wound – Z48.0-
Add - -due to injury – code to Injury, by site, with 7th character D

Cleft (congenital) - see also Imperfect, closure
Revise - branchial ~~(cyst)~~ (persistent) Q18.2
Add - cyst Q18.0
Add - -fistula Q18.0
Add - -sinus Q18.0

Coma R40.20
Add -ketoacidotic (diabetic) - see Diabetes, by type, with ketoacidosis, with coma

Cord - see also condition
Revise - around neck ~~(tightly) (with compression)~~
- - complicating delivery ~~O69.~~1 O69.81
Add - - -with compression O69.1

Complication(s) (from) (of)
- prosthetic device or implant T85.9
- - mesh
Revise - - - erosion (to surrounding organ or tissue) ~~T83.718~~ T83.718
Revise - - - exposure (into surrounding organ or tissue) ~~T83.728~~ T83.728

Compression
-cranial nerve G52.9
Revise --seventh ~~G52.8~~ G51.8

Defect
- coagulation
Revise - - postpartum O72.3 O99.13
Add - - - with hemorrhage O72.3

Delivery (childbirth) (labor)
Revise - obstructed - see Delivery, complicated by, ~~obstruction~~ obstructed labor

Dementia
- - Huntington's disease or chorea G10
Add - - - with dementia G10 [F02.80]

Diabetes, diabetic (mellitus) (sugar) E11.9
- with
Add - -osteomyelitis

Disease
- Huntington's G10
Add - -with dementia G10 [F02.80]
- lung J98.4
- - obstructive (chronic) J44.9
-pulmonary
- - heart I27.9
- - - specified NEC I27.89
Revise - - hypertensive (vascular) ~~I27.0~~
Add - - - NEC I27.2
Add - - - primary (idiopathic) I27.0

Disorder (of) - see also Disease
- autoimmune D89.89

Disorder (of) - see also Disease
- anxiety F41.9
- - due to (secondary to)
- - - alcohol F10.980

Add - - - -in

Add - - - - -abuse F10.180

Add - - - - -dependence F10.280

Revise - disruptive behavior ~~F98.9~~ - see Disorder, conduct

-stress

Add - - acute (F53.0)

Dissection
- artery

Add - precerbral artery, congenital (nonruptured) (Q28.1)

Add - - Heartland A93.8

Endocarditis

Add -viral

Embolism
- artery

Add - - choroidal (anterior) ~~I66.8~~ I65.8

Add - - communicating posterior ~~I66.8~~ I65.8

Add - - hypophyseal ~~I66.8~~ I65.8

Add - - pontine ~~I66.8~~ I65.8

Enlargement, enlarged - see also Hypertrophy

Add vestibular aqueduct Q16.5

Entanglement

Revise - umbilical cord(s) O69.82

- - with compression O69.2

Delete ~~- - - without compression O69.82~~

Add - - without compression O69.82

Revise - - around neck (with compressionO69.81

Add - - - with compression O69.1

Fibroid (tumor) - see also Neoplasm, connective tissue, benign

Revise - uterus (see also Leiomyoma, uterus) D25.9

Foreign body

Revise ~~-felling~~ feeling of, in throat R09.89

Revise Fracture, chronic - see Fracture, pathological, by site

Revise Fracture, insufficiency - see Fracture, ~~pathologic~~ pathological, by site

Fracture, traumatic, tibia,
Revise - - spine - see Fracture, tibia upper end, spine

Add Heartland virus disease A93.8

History
-personal (of) —see also History, family (of)
Revise - - - ear (corrected) ~~Z87.720~~ Z87.721
Revise - - - eye (corrected) ~~Z87.721~~ Z87.720
Revise - - substance abuse NEC F10-F19 ~~with fifth character 1~~

Hygroma (congenital) (cystic) D18.1
Add - subdural I62.03

Hypoglycemia (spontaneous) E16.2
- coma E15
Revise - - diabetic - see Diabetes, by type, with hypoglycemia with coma

Hypothyroidism (acquired) E03.9
Add - autoimmune- See Thyroiditis autoimmune

Ileocolitis (see also Enteritis) K52.9
Add - ulcerative K51.9-

Ileus
Add -postoperative K91.89

Imperfect
- closure (congenital)
Revise - - branchial cleft ~~or sinus~~ NOS Q18.~~0~~2
Add - - -cyst Q18.0
Add - - -fistula Q18.0
Add - - -sinus Q18.0

Infection, infected, infective (opportunistic) B99.9
- due to or resulting from
- - device, implant or graft (see also Complications, by site and type, infection or inflammation) T85.79
- - - electronic (electrode) (pulse generator) (stimulator)
Revise - - - - urinary ~~(~~indwelling~~)~~ T83.51

Insufficiency, Insufficient
Revise -valve, valvular (heart) - ~~see Endocarditis~~ I38
Add - - aortic – see Insufficiency, aortic (valve)
Add - - mitral – see Insufficiency, mitral (valve)
Add - - pulmonary – see Insufficiency, pulmonary, valve
Add - - tricuspid – see Insufficiency, tricuspid (valve)

Lymphoma (of) (malignant) C85.90
Add -Blastic Plasmacytoid Dendritic Cell Neoplasm (BPDCN) C86.4

Obstruction and Occlusion
Revise - artery ~~(see also Embolism, artery) I74.9~~ (see also Atherosclerosis, artery) I70.9

Occlusion, occluded
Revise - artery ~~(see also Embolism, artery) I74.9~~ (see also Atherosclerosis, artery) I70.9
Revise - - communicating posterior – see Occlusion, artery, ~~cerebral~~ precerebral, specified NEC
Revise - - pontine – see Occlusion, artery, ~~cerebral~~ precerebral, specified NEC
- - precerebral
- - - specified NEC
- - - - due to
Revise - - - - - thrombosis ~~I63.00~~ I63.09

Osteoarthritis
Revise - hip ~~M16.1-~~ M16.9-
Revise -knee ~~M17.9~~ M17.1-

Osteomyelofibrosis ~~D75.~~89 D47.4

Add PANDAS D89.89

Persistence, persistent (congenital)
Revise -branchial cleft NOS Q18.2
Add - -cyst Q18.0
Add - -fistula Q18.0
Add - -sinus Q18.0

Pregnancy
- complicated by (care of) (management affected by)
Revise - - genital herpes (asymptomatic) (history of) (inactive) ~~O98.51-~~ O98.3-

Puerperal
Revise - coagulopathy (any) ~~O72.3~~ O99.13
Add - - with hemorrhage O72.3

	Recession, receding
	- gingival (generalized) (localized) (postinfective) (postoperative) K06.0
Delete	~~- - Miller Class I K06.01~~
Delete	~~- - Miller Class II K06.02~~
Delete	~~- - Miller Class III K06.03~~
Delete	~~- - Miller Class IV K06.04~~
Revise	Scarlatina (anginosa) (maligna) ~~(ulcerosa)~~ A38.9
Add	- Ulcerosa A38.8
Revise	Sheehan's disease or syndrome O99.285 E23.0
	Shock
Revise	- hemorrhagic R57.8
	Status (post) - see also Presence (of)
Add	-coronary artery bypass graft Z95.1
Add	Sundowning F05
	Syndrome - see also Disease
Add	-Brugada I49.8
Revise	- postpartum panhypopituitary (Sheehan) O99.285 E23.0
Add	-Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) D89.89
Revise	-Wright's (hyperabduction) ~~I77.89~~ G54.0
	Thrombophlebitis I80.9
	- leg ~~I80.299~~ I80.3
	Thrombosis, thrombotic
	- artery, arteries
Revise	- - choroidal (anterior) – see Occlusion, artery, ~~cerebral~~ precerebral, specified NEC
Revise	- - communicating posterior – see Occlusion, artery, ~~cerebral~~ precerebral, specified NEC
Revise	- - hypophyseal – see Occlusion, artery, ~~cerebral~~ precerebral, specified NEC
Revise	- -pontine – see Occlusion, artery, ~~cerebral~~ precerebral, specified NEC
	-atrium, auricular
Add	--old I51.3
	–cardiac
Add	--old I51.3
	–heart
Add	--old I51.3
	–intramural
Add	--old I51.3
	–mural

Add	--old I51.3 –ventricle
Add	--old I51.3
	Tinea (intersecta) (tarsi) B35.9
Add	- specified ~~site~~ NEC B35.8
	Twin (newborn) - see also Newborn, twin
Revise	- pregnancy - see Pregnancy, twin~~, conjoined~~
	Varix -leg - -bilateral (asymptomatic) I83.93 - - -with
Revise	- - - -ulcer ~~I83.009~~ I83.0-
Add	Wound check – Z48.0-
Add	-due to injury – code to Injury, by site, with 7th character D
Add	Wound, open T14.8

Table of Drugs and Chemicals

	Substance	Poisoning Accidental (unintentional)	Poisoning Intentional self harm	Poisoning Assault	Poisoning Undetermined	Adverse affect	Underdosing
Add	Antithrombotic	T45.521	T45.522	T45.523	T45.524	T45.525	T45.526
Delete	~~Fluticasone propionate~~	~~T49.0X1~~	~~T49.0X2~~	~~T49.0X3~~	~~T49.0X4~~	~~T49.0X5~~	~~T49.0X6~~
Add	Fluticasone propionate	T38.0X1	T38.0X2	T389.0X3	T38.0X4	T38.0X5	T38.0X6
Delete	~~Triamcinolone~~	~~T49.0X1~~	~~T49.0X2~~	~~T49.0X3~~	~~T49.0X4~~	~~T49.0X5~~	~~T49.0X6~~
Add	Triamcinolone	T38.0X1	T38.0X2	T389.0X3	T38.0X4	T38.0X5	T38.0X6
Delete	Warfarin ~~– sodium~~	~~T60.4X1~~	~~T60.4X2~~	~~T60.4X3~~	~~T60.4X4~~		
Add	- sodium	T45.511	T45.512	T45.513	T45.514	T45.515	T45.516