CENTERS FOR DISEASE CONTROL AND PREVENTION

ICD-10-CM Coordination and Maintenance Committee Meeting
September 18-19, 2013
Diagnosis Agenda

Welcome and announcements
Donna Pickett, MPH, RHIA
Co-Chair, ICD-9-CM Coordination and Maintenance Committee

Diagnosis Topics:

Contents

ICD-9-CM AND ICD-10-CM/PCS TIMELINE

A timeline of important dates in the ICD-9-CM and ICD-10-CM/PCS process is described below:

September 18 –19, 2013	ICD-9-CM Coordination and Maintenance Committee meeting Those who wish to attend the ICD-9-CM Coordination and Maintenance Committee meeting **must have registered for the meeting online by September 6, 2013.** You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building. **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. If participating via the webcast you do NOT need to register for the meeting.** **Conference lines will also be available for those participants who are unable to view the webcast or attend in person. Toll free dial in access for external participants is as follows:** **Phone: 877-267-1577 Meeting ID: 997-355-278** **If dialing in you do NOT need to register on-line for the meeting.**
October 2013	Summary report of the Procedure part of the September 18 – 19, 2013 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials.html Summary report of the Diagnosis part of the September 18– 19, 2013 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm
October 1, 2013	New and revised ICD-9-CM codes go into effect along with DRG changes. This will be the last update to ICD-9-CM codes as ICD-10 will be implemented on October 1, 2014. Final addendum posted on web pages cas follows: There was no ICD-9-CM diagnosis addenda for October 1, 2013; however, the updated conversion table is posted at the following site: http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm Procedure addendum - http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/addendum.html

November 15, 2013	**Deadline for receipt of public comments on proposed ICD-10-CM/PCS code revisions discussed at the September 18-19, 2013 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2014.**
January 17, 2014	**Deadline for requestors: Those members of the public requesting that topics be discussed at the March 19–20, 2014 ICD-10-CM/PCS Coordination and Maintenance Committee meeting must have their requests submitted to CMS for procedures and NCHS for diagnoses by this date. (Please note that the name of the Committee will change to the ICD-10 Coordination and Maintenance Committee with the March 2014 meeting.)**
February 2014	Draft agenda for the Procedure part of the March 19, 2014 ICD-10 Coordination and Maintenance Committee meeting posted on CMS homepage as follows: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/meetings.html Draft agenda for the Diagnosis part of the March 20, 2014 ICD-10 Coordination and Maintenance Committee meeting posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm Federal Register notice of March 19–20, 2014 ICD-10 Coordination and Maintenance Committee Meeting will be published.
February 14, 2014	**On-line registration opens for the March 19–20, 2014 ICD-10 Coordination and Maintenance Committee meeting at: https://www.cms.gov/apps/events/default.asp**
March 2014	Because of increased security requirements, **those wishing to attend the March 19–20, 2014** 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 14, 2014; failure to do so may result in lack of access to the meeting**.
March 19 – 20, 2014	ICD-10 Coordination and Maintenance Committee meeting.
April 1, 2014	There will be no new ICD-9-CM codes to capture new diseases or technology on April 1, 2014, since the last updates to ICD-9-CM will take place on October 1, 2013.
April 18, 2014	Deadline for receipt of public comments on proposed code

	revisions discussed at the March 19–20, 2014 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2014.
April 2014	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 complete and finalized FY 2015 ICD-10-CM diagnosis and ICD-10-PCS procedure codes. 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
April 2014	Summary report of the Procedure part of the March 19, 2014 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials.html Summary report of the Diagnosis part of the March 20, 2014 ICD-10 Coordination and Maintenance Committee meeting report will be posted on the NCHS webpage as follows: http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm
June 2014	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 19, 2014	**Deadline for requestors: Those members of the public requesting that topics be discussed at the September 23–24, 2014 ICD-10 Coordination and Maintenance Committee meeting must have their requests submitted to CMS for procedures and NCHS for diagnoses.**
August 1, 2014	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, 2014. 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 2014	Tentative agenda for the Procedure part of the September 23–24, 2014 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage at - http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/meetings.html

	Tentative agenda for the Diagnosis part of the September 23 –24, 2014 ICD-10 Coordination and Maintenance Committee meeting will be posted on the NCHS webpage at - http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm
	Federal Register notice for the September 23–24, 2014 ICD-10 Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.
August 15, 2014	**On-line registration opens for the September 23-24, 2014 ICD-10 Coordination and Maintenance Committee meeting at: https://www.cms.gov/apps/events/default.asp**
September 12, 2014	Because of increased security requirements, those wishing to attend the September 23-24, 2014 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 12, 2014; failure to do so may result in lack of access to the meeting.**
September 23 –24, 2014	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 12, 2014.** You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building.
October 2014	Summary report of the Procedure part of the September 23–24, 2014 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials.html Summary report of the Diagnosis part of the September 23–24, 2014 ICD-10-CM/PCS Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm
October 1, 2014	New and revised ICD-10-CM and ICD-10-PCS codes go into effect along with DRG changes. Final addendum posted on web pages as follows: Diagnosis addendum - http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm Procedure addendum - http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/addendum.html

October 17, 2014	**Deadline for receipt of public comments on proposed code revisions discussed at the September 23-24, 2014 ICD-10 Coordination and Maintenance Committee meetings for implementation on April 1, 2015.**
November 2014	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, 2015 will be posted on the following websites: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/addendum.html http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm
November 15, 2014	**Deadline for receipt of public comments on proposed code revisions discussed at the September 23-24, 2014 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2015.**

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: nchsicd9CM@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.

Partial Code Freeze for ICD-9-CM and ICD-10 Finalized

The ICD-9-CM Coordination and Maintenance Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10, which would end one year after the implementation of ICD-10. The implementation of ICD-10 was delayed from October 1, 2013 to October 1, 2014 by final rule CMS-0040-F, issued on August 24, 2012.

Links to this final rule may be found at:
http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html.)

There was considerable support for this partial freeze. The partial freeze will be implemented as follows:

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011.
- On October 1, 2012 and October 1, 2013 there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.
- On October 1, 2014, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.
- On October 1, 2015, regular updates to ICD-10 will begin.

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2015 once the partial freeze has ended.

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-9-CM 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-9-CM 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.

Gastrointestinal Stromal Tumor (GIST)

Gastrointestinal Stromal Tumors (GISTs) are the most common soft tissue sarcoma of mesenchymal origin. GISTs are a kind of tumor of the gastrointestinal tract that is thought to originate from specialized cells (interstitial cells of Cajal, or precursors of them). GISTs are most commonly found in adults between ages 40 to 70 years. Historically it has been thought that GISTs could be malignant or benign, although most experts now consider all GISTs to be malignant.

There are between 4,000 and 5,000 new cases of GISTs each year in the U.S. The most common locations for GISTs are the stomach and the small intestine.

A proposal that specific codes for GIST be created has been received from Novartis. The current beta version of ICD-11 includes specific codes for gastrointestinal stromal tumors.

TABULAR MODIFICATIONS

Malignant neoplasms of digestive organs (C15-C26)

Add Excludes2: gastrointestinal stromal tumors (C49.A-)

C49 Malignant neoplasm of other connective and soft tissue

New subcategory C49.A Gastrointestinal stromal tumor

New Code C49.A0 Gastrointestinal stromal tumor, unspecified site

New Code C49.A1 Gastrointestinal stromal tumor of esophagus

New Code C49.A2 Gastrointestinal stromal tumor of stomach

New Code C49.A3 Gastrointestinal stromal tumor of small intestine

New Code C49.A4 Gastrointestinal stromal tumor of large intestine

New Code C49.A5 Gastrointestinal stromal tumor of rectum

New Code C49.A9 Gastrointestinal stromal tumor of other sites

INDEX MODIFICATIONS

Tumor …
- stromal
- - gastrointestinal
- - - malignant ~~C49.4~~ C49.A0
- - - - colon C49.A4
- - - - duodenum C49.A3
- - - - ileum C49.A3
- - - - jejunum C49.A3
- - - - Meckel diverticulum C49.A3
- - - - omentum C49.A9
- - - - peritoneum C49.A9

Periprosthetic Fractures

Periprosthetic fractures are currently classified in the complication section in ICD-10-CM, T84.0, Mechanical complication of internal joint prosthesis. This placement was based on the approach used when this condition was added to ICD-9-CM in 2005. The ICD-10-CM structure provides the opportunity to appropriately place this concept in Chapter 13, Diseases of the musculoskeletal system and connective tissue. The American Academy of Orthopaedic Surgeons (AAOS) has submitted the following proposal to make these changes.

Fractures occur for one of two reasons. Either there is significant trauma or there is osteoporosis, tumor or other pathological conditions. Fractures around a prosthesis are not complications of the prosthesis, but the result of the same conditions as other fractures, that is, trauma or pathological conditions. Therefore, the AAOS proposes to move periprosthetic fractures from the complications section to the musculoskeletal section. Periprosthetic fractures can occur around any prosthesis, but the most common would be the hip, knee, ankle, shoulder, or elbow.

Based on input from AAOS, it is proposed that specific codes be created for periprosthetic fractures around internal prostheses involving the hip, knee, ankle, shoulder, and elbow joints, with laterality specified as right or left for each joint. Index modifications are also proposed, to enable specific identification of periprosthetic fractures.

The AAOS has requested that these proposed changes be expedited, to be effective with the implementation of ICD-10-CM on October 1, 2014. Comments are due by November 15, 2013.

TABULAR MODIFICATIONS

M96 Intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhere classified

Excludes2: …

Add — <u>periprosthetic fracture around internal prosthetic joint (M97.-)</u>

New Category — M97 Periprosthetic fracture around internal prosthetic joint

Excludes2: fracture of bone following insertion of orthopedic implant, joint prosthesis or bone plate (M96.6-)
breakage (fracture) of prosthetic joint (T84.01-)

The appropriate 7th character is to be added to each code from category M97
- A initial encounter
- D subsequent encounter
- S sequela

New Subcategory — M97.0 Periprosthetic fracture around internal prosthetic hip joint

New code — M97.01 Periprosthetic fracture around internal prosthetic right hip joint

New code M97.02 Periprosthetic fracture around internal prosthetic left hip joint

New Subcategory M97.1 Periprosthetic fracture around internal prosthetic knee joint

New code M97.11 Periprosthetic fracture around internal prosthetic right knee joint

New code M97.12 Periprosthetic fracture around internal prosthetic left knee joint

New Subcategory M97.2 Periprosthetic fracture around internal prosthetic ankle joint

New code M97.21 Periprosthetic fracture around internal prosthetic right ankle joint

New code M97.22 Periprosthetic fracture around internal prosthetic left ankle joint

New Subcategory M97.3 Periprosthetic fracture around internal prosthetic shoulder joint

New code M97.31 Periprosthetic fracture around internal prosthetic right shoulder joint

New code M97.32 Periprosthetic fracture around internal prosthetic left shoulder joint

New Subcategory M97.4 Periprosthetic fracture around internal prosthetic elbow joint

New code M97.41 Periprosthetic fracture around internal prosthetic right elbow joint

New code M97.42 Periprosthetic fracture around internal prosthetic left elbow joint

New code M97.8 Periprosthetic fracture around other internal prosthetic joint
Periprosthetic fracture around internal prosthetic finger joint
Periprosthetic fracture around internal prosthetic spinal joint
Periprosthetic fracture around internal prosthetic toe joint
Periprosthetic fracture around internal prosthetic wrist joint

Use additional code to identify the joint (Z96.6-)

New code M97.9 Periprosthetic fracture around unspecified internal prosthetic joint

T84 Complications of internal orthopedic prosthetic devices, implants and grafts

T84.0 Mechanical complication of internal joint prosthesis

Delete ~~T84.04 Periprosthetic fracture around internal prosthetic joint~~

~~Excludes2: breakage (fracture) of prosthetic joint (T84.01)~~

Delete ~~T84.040 Periprosthetic fracture around internal prosthetic right hip joint~~
~~T84.041 Periprosthetic fracture around internal prosthetic left hip joint~~

~~T84.042 Periprosthetic fracture around internal prosthetic right knee joint~~
~~T84.043 Periprosthetic fracture around internal prosthetic left knee joint~~
~~T84.048 Periprosthetic fracture around other internal prosthetic joint~~
~~Use additional code to identify the joint (Z96.6-)~~

~~T84.049 Periprosthetic fracture around unspecified internal prosthetic joint~~

INDEX MODIFICATIONS

Fracture, pathological (pathologic) M84.40- see also Fracture, traumatic
- joint prosthesis - see Complications, joint prosthesis, mechanical, breakdown, by site

Revise - - periprosthetic - see Fracture, pathological, periprosthetic ~~Complications, joint prosthesis, mechanical, periprosthesis, fracture, by site~~
Add - periprosthetic M97.9
Add - - ankle M97.2-
Add - - elbow M97.4-
Add - - hip M97.0-
Add - - knee M97.1-
Add - - other specified joint M97.8
Add - - shoulder M97.3-

Fracture, traumatic (abduction) (adduction) (separation) (see also Fracture, pathological) T14.8
- joint prosthesis - see Complications, joint prosthesis, mechanical, breakdown, by site

Revise - - periprosthetic - see Fracture, traumatic, periprosthetic ~~Complications, joint prosthesis, mechanical, periprosthesis, fracture, by site~~
Add - periprosthetic M97.9
Add - - ankle M97.2-
Add - - elbow M97.4-
Add - - hip M97.0-
Add - - knee M97.1-
Add - - other specified joint M97.8
Add - - shoulder M97.3-

Periorbital (Preseptal) Cellulitis

Cellulitis around the orbit of the eye and the preseptal area of the face presents a unique set of diagnostic concerns that are different then a cellulitis of other areas of the face or the orbit. This periorbital cellulitis occurs in front of the orbital septum, which extends from the frontal bone to the tarsal plate of the upper eyelid. It has to be differentiated from orbital cellulitis, or postseptal cellulitis, which affects the orbit, can affect the eye, and is a more severe infection, requiring intravenous antibiotic treatment.

Because periorbital cellulitis may require more intensive evaluation and management then a simple cellulitis of the face, the American Academy of Pediatrics has requested a unique code to better identify and track it.

TABULAR MODIFICATIONS

L03 Cellulitis and acute lymphangitis

L03.2 Cellulitis and acute lymphangitis of face and neck

L03.21 Cellulitis and acute lymphangitis of face

Add — Excludes2: Abscess of orbit (H05.01-)
Cellulitis of orbit (H05.01-)

New Code — L03.213 Periorbital cellulitis
Preseptal cellulitis

Observation and evaluation of newborns for suspected condition not found

Currently in ICD-9-CM there are unique codes to show an encounter for a suspected condition in a newborn that is ruled out, ICD-9-CM category V29, Observation and evaluation of newborns for suspected condition not found. These codes explain a uniquely different set of circumstances than those for a maternal condition as the cause of newborn morbidity or mortality, ICD-9-CM category 760, Fetus or newborn affected by maternal conditions which may be unrelated to present pregnancy.

It is not uncommon for a parent to seek medical care for a perceived problem with their newborn. Very often there isn't any specific condition and reassurance is all that is required. Currently ICD-10-CM does not have any way to uniquely capture suspected conditions ruled out as the reason for the encounter.

In ICD-10-CM this can only be coded using codes in category P00, Newborn (suspected to be) affected by maternal conditions that may be unrelated to present pregnancy. Codes in this category suggest that they may include encounter of newborn for suspected condition not found, however it is felt that category P00.- does not represent the same concerns as ICD-9-CM category V29.

The American Academy of Pediatrics requests that a unique set of codes be added to ICD-10-CM to more clearly capture this information and proposes the following:

The requestor originally suggested use of category Z03; however this category is in use by WHO ICD-10 and cannot be redefined to meet the needs of this request.

TABULAR MODIFICATIONS

Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery (P00-P04)

Revise Note: These codes are for use when the listed maternal conditions are specified as the cause of confirmed morbidity or potential morbidity which have their origin in the perinatal period (before birth through the first 28 days after birth). Codes from these categories are also for use for newborns who are suspected of having an abnormal condition resulting from exposure from the mother or the birth process, but without signs or symptoms~~, and, which after examination and observation, is found not to exist. These codes may be used even if treatment is begun for a suspected condition that is ruled out.~~

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

Add Excludes 1: Encounter for observation of newborn for suspected diseases and conditions proven not to exist (Z05.-)

New category **Z05 Encounter for observation of newborn for suspected diseases and conditions ruled out**

Note: This category is to be used for newborns, within the neonatal period (the first 28 days of life), who are suspected of having an abnormal condition resulting from exposure from the mother or the birth process, but without signs or symptoms, and which, after examination and observation, is found not to exist

Excludes 1: newborn observation for suspected condition, not ruled out (P00-P04)

New code Z05.1 Encounter for observation of newborn for suspected infectious condition

New code Z05.2 Encounter for observation of newborn for suspected neurological condition

New code Z05.3 Encounter for observation of newborn for suspected respiratory condition

New code Z05.4 Encounter for observation of newborn for suspected genetic or metabolic condition

New code Z05.8 Encounter for observation of newborn for other specified suspected condition

New code Z05.9 Encounter for observation of newborn for unspecified suspected condition

Vaccine and prophylactic immunotherapy administration

The American Academy of Pediatrics (AAP) requests that Z23 Encounter for Immunization category be expanded to better identify the reason for the vaccine encounter and include prophylactic immunotherapy. It is noted that one code corresponding to ICD-9-CM categories V03-V06 is present in ICD-10-CM (Z23), however AAP indicates that there is a need to provide greater specificity regarding why an immunization is being administered.

Not all immunizations, vaccines or serums are given as part of a routine preventive health visit. There are many situations where a vaccine or similar component is given as part of an emergent encounter or may be the only reason for the visit. The administration of prophylactic immunotherapy as the reason for an encounter also needs to be monitored.

NCHS has received correspondence from CDC programs and the Department of Defense supporting the need for expansion of this coding category.

TABULAR MODIFICATIONS

Revise	**Z23**	**Encounter for immunization <u>against single bacterial disease</u>**
Revise		Code first any examination, such as routine childhood examination, <u>if applicable</u> (Z00.12-)
		Excludes 1: Encounter for immunization against combinations of infectious diseases (Z27.-) Immunization not carried out and underimmunization status (Z28.-)
New code		Z23.0 Encounter for immunization against cholera
New code		Z23.1 Encounter for immunization against typhoid-paratyphoid alone [TAB]
New code		Z24.2 Encounter for immunization against tuberculosis [BCG]
New code		Z23.3 Encounter for immunization against plague
New code		Z23.4 Encounter for immunization against tularemia
New code		Z23.5 Encounter for immunization against tetanus
New code		Z23.6 Encounter for immunization against diphtheria
New code		Z23.7 Encounter for immunization against pertussis
New subcategory		Z23.8 Encounter for immunization against other specified single bacterial diseases
New code		Z23.81 Encounter for immunization against Hemophilus influenza, type B [Hib]
New code		Z23.82 Encounter for immunization against Streptococcus pneumoniae [pneumococcus]
New code		Z23.83 Encounter for immunization against anthrax
New code		Z23.89 Encounter for immunization against other specified single bacterial disease

New code Z23.9 Encounter for immunization against unspecified single bacterial disease

New category **Z24 Encounter for immunization against certain single viral disease**

Revise Code first any examination, such as routine childhood examination, if applicable (Z00.12-)

Excludes 1: Encounter for immunization against combinations of infectious diseases (Z27.-)
Immunization not carried out and underimmunization status (Z28.-)

New code Z24.0 Encounter for immunization against poliomyelitis
New code Z24.1 Encounter for immunization against arthropod-borne viral encephalitis
New code Z24.2 Encounter for immunization against rabies
New code Z24.3 Encounter for immunization against yellow fever
New code Z24.4 Encounter for immunization against measles
New code Z24.5 Encounter for immunization against rubella
New code Z24.6 Encounter for immunization against viral hepatitis

New category **Z25 Encounter for immunization against other single viral disease**

Revise Code first any examination, such as routine childhood examination, if applicable (Z00.12-)

Excludes 1: Encounter for immunization against combinations of infectious diseases (Z27.-)
Immunization not carried out and underimmunization status (Z28.-)

New code Z25.0 Encounter for immunization against mumps alone
New code Z25.1 Encounter for immunization against influenza
New subcategory Z25.8 Encounter for immunization against other specified single viral diseases
New code Z25.81 Encounter for immunization against Japanese Encephalitis
New code Z25.82 Encounter for immunization against other arthropod-borne viral diseases
New code Z25.83 Encounter for immunization against Varicella

New Code Z25.84 Encounter for immunization against human papillomavirus (HPV)

New code Z25.88 Encounter for immunization against other specified viral disease

New code Z25.9 Encounter for immunization against other unspecified specified single viral diseases

New category **Z26 Encounter for immunization against other single infectious diseases**

Revise Code first any examination, such as routine childhood examination, if applicable (Z00.12-)

Excludes 1: Encounter for immunization against combinations of infectious diseases (Z27.-)
Encounter for immunization, not carried out (Z28.-)

New code Z26.8 Encounter for immunization against other specified single infectious diseases

New code Z26.9 Encounter for immunization against unspecified infectious diseases
Need for immunization NOS

New category **Z27 Encounter for immunization against combinations of infectious diseases**

Revise Code first any examination, such as routine childhood examination, if applicable (Z00.12-)

Excludes2: Encounter for immunization, not carried out (Z28.-)

New code Z27.0 Encounter for immunization against cholera with typhoid-paratyphoid [cholera + TAB]

New code Z27.1 Encounter for immunization against diphtheria-tetanus-pertussis, combined [DTP]

New code Z27.2 Encounter for immunization against diphtheria-tetanus-pertussis with typhoid-paratyphoid [DTP + TAB]

New code Z27.3 Encounter for immunization against diphtheria-tetanus-pertussis with poliomyelitis [DTP + polio]

New code Z27.4 Encounter for immunization against measles-mumps-rubella [MMR]

New subcategory Z27.8 Encounter for immunization against other combinations of infectious diseases
New code Z27.81 Tetanus-diphtheria [TD][DT]
New code Z27.88 Encounter for immunization against other combinations of infectious diseases

New code Z27.9 Encounter for immunization against unspecified combinations of infectious diseases

New category **Z29 Encounter for other prophylactic measures**

Excludes 1: desensitization to allergens (Z51.6)
prophylactic surgery (Z40.-)

New subcategory Z29.1 Encounter for prophylactic immunotherapy
Encounter for administration of immunoglobulin

New code Z29.11 Encounter for prophylactic immunotherapy for respiratory syncytial virus (RSV)
New code Z29.12 Encounter for prophylactic antivenin
New code Z29.13 Encounter for prophylactic Rho(D) immune globulin
New code Z29.14 Encounter for prophylactic rabies immune globin

New code Z29.3 Encounter for prophylactic fluoride administration
New code Z29.8 Encounter for other specified prophylactic measures
New code Z29.9 Encounter for prophylactic measures, unspecified

Encounter for prophylactic or treatment measures

There are many circumstances where an encounter may only be for prophylactic or treatment measures, just as the encounter may only be for immunizations or chemotherapy. The American Academy of Pediatrics (AAP) feels strongly that there needs to be a clear way to track these encounters as they can have a significant effect on the patient's healthcare as well as quality metrics.

The American Academy of Pediatrics proposes the addition of new codes in order to better track these encounters.

TABULAR MODIFICATIONS

Revise Z51 Encounter for other **aftercare and medical care**
Code also condition requiring care
Excludes1: follow-up examination after treatment (Z08-Z09)

Z51.0 Encounter for antineoplastic radiation therapy
Z51.1 Encounter for antineoplastic chemotherapy and immunotherapy
Excludes2: encounter for chemotherapy and immunotherapy for nonneoplastic condition - code to condition

Z51.11 Encounter for antineoplastic chemotherapy
Z51.12 Encounter for antineoplastic immunotherapy
Z51.5 Encounter for palliative care
New code Z51.6 Encounter for desensitization to allergens

Conductive and Sensorineural Hearing Loss

The current coding structure of ICD-10-CM does not allow a mechanism for the reporting of different type of hearing loss conditions in each ear. The codes for unilateral hearing loss (H90.1-, H90.4-, and H90.7-) specify an unrestricted hearing condition on the contralateral side. This only applies to situations where there is either a conductive, sensorineural, or mixed hearing loss in one ear and normal hearing in the other ear.

The development of unique codes is needed for better reporting when the type of hearing loss is different for each ear.

This proposal was submitted by The American Academy of Audiology and is supported by the Academy of Rehabilitative Audiology (ARA), The American Speech-Language-Hearing Association (ASHA), Academy of Doctors of Audiology, and The American Academy of Otolaryngology- Head and Neck Surgery.

The requestor is asking that these changes be implemented during the partial code freeze, before October 1, 2014 ICD-10-CM implementation. Comments regarding the proposal are due to NCHS by November 15, 2013. NCHS is asking commenters on this topic to specifically address whether or not they are in agreement with implementation of it during the partial code freeze.

TABULAR MODIFICATIONS

Other disorders of ear (H90-H94)

H90 Conductive and sensorineural hearing loss
Excludes1: deaf nonspeaking NEC (H91.3)
deafness NOS (H91.9-)
hearing loss NOS (H91.9-)
noise-induced hearing loss (H83.3-)
ototoxic hearing loss (H91.0-)
sudden (idiopathic) hearing loss (H91.2-)

New subcategory H90.A Conductive and sensorineural hearing loss with restricted hearing on the contralateral side

New note Use two codes to show different type of hearing loss on the contralateral side.

New sub-subcategory H90.A1 Conductive hearing loss, unilateral, with restricted hearing on the contralateral side

New code	H90.A11 Conductive hearing loss, unilateral, right ear with restricted hearing on the contralateral side
New code	H90.A12 Conductive hearing loss, unilateral, left ear with restricted hearing on the contralateral side
New sub-subcategory	H90.A2 Sensorineural hearing loss, unilateral, with restricted hearing on the contralateral side
New code	H90.A21 Sensorineural hearing loss, unilateral, right ear, with restricted hearing on the contralateral side
New code	H90.A22 Sensorineural hearing loss, unilateral, left ear, with restricted hearing on the contralateral side
New sub-subcategory	H90.A3 Mixed conductive and sensorineural hearing loss, unilateral with restricted hearing on the contralateral side
New code	H90.A31 Mixed conductive and sensorineural hearing loss, unilateral, right ear with restricted hearing on the contralateral side
New code	H90.A32 Mixed conductive and sensorineural hearing loss, unilateral, left ear with restricted hearing on the contralateral side

Somnolence, stupor and coma

There is an instruction at R40.2 Coma to add a seventh character to R40.21-, R40.22-, and R40.23-, to describe the time when the Glasgow Coma Scale (GCS) test was administered. R40.24- was added to be used when only the total GCS score is recorded, however, these codes were not added to the 7th character instruction. The 7th character is useful to data derived from the new code as with the codes originally listed, and for undocumented times the "unspecified" option is available.

The American Academy of Neurology proposes that R40.24- Glasgow coma scale, total score be added to the list requiring a 7th character.

TABULAR MODIFICATIONS

R40.2 Coma
Code first any associated:
fracture of skull (S02.-)
intracranial injury (S06.-)

Revise — Note: One code from each subcategory, R40.21-R40.23, is required to complete the coma scale

R40.24 Glasgow coma scale, total score

Delete — ~~Use codes R40.21- through R40.23- only when the individual score(s) are documented.~~

Revise — Note: Assign a code from subcategory R40.24, when only the total coma score is documented

Add — The following appropriate 7th character is to be added to subcategory R40.24-:

0 - unspecified time
1 - in the field [EMT or ambulance]
2 - at arrival to emergency department
3 - at hospital admission
4 - 24 hours or more after hospital admission

R40.241	Glasgow coma scale score 13-15
R40.242	Glasgow coma scale score 9-12
R40.243	Glasgow coma scale score 3-8
R40.244	Other coma, without documented Glasgow coma scale score, or with partial score reported

Oral and maxillofacial fractures

Currently, there is no way to specifically report bilateral oral and maxillofacial fractures, where as there are options for reporting fractures of other bilateral bones, joints and ligaments.

The American Association of Oral and Maxillofacial Surgeons (AAOMS) proposes adding codes to ICD-10-CM to specifically report bilateral oral and maxillofacial fractures.

TABULAR MODIFICATIONS

S02.1 Fracture of base of skull

S02.10 Unspecified fracture of base of skull

New code	S02.101	Fracture of base of skull, right side
New code	S02.102	Fracture of base of skull, left side
New code	S02.109	Fracture of base of skull, unspecified side

S02.11 Fracture of occiput

Revise	S02.110	Type I occipital condyle fracture, **unspecified side**
Revise	S02.111	Type II occipital condyle fracture, **unspecified side**
Revise	S02.112	Type III occipital condyle fracture, **unspecified side**
	S02.113	Unspecified occipital condyle fracture
Revise	S02.118	Other fracture or occiput, **unspecified side**
	S02.119	Unspecified fracture of occiput
New code	S02.11A	Type I occipital condyle fracture, right side
New code	S02.11B	Type I occipital condyle fracture, left side
New code	S02.11C	Type II occipital condyle fracture, right side
New code	S02.11D	Type II occipital condyle fracture, left side
New code	S02.11E	Type III occipital condyle fracture, right side
New code	S02.11F	Type III occipital condyle fracture, left side
New code	S02.11G	Other fracture of occiput, right side
New code	S02.11H	Other fracture of occiput, left side

S02.3 Fracture of orbital floor

S02.3 Fracture of orbital floor

New code	S02.30	Fracture of orbital floor, unspecified side
New code	S02.31	Fracture of orbital floor, right side
New code	S02.32	Fracture of orbital floor, left side

S02.4 Fracture of malar, maxillary, and zygoma bones

S02.40 Fracture of malar, maxillary, and zygoma bones, unspecified

Revise S02.400 Malar fracture, **unspecified side**
Revise S02.401 Maxillary fracture, **unspecified side**
Revise S02.402 Zygomatic fracture, **unspecified side**
New code S02.40A Malar fracture, right side
New code S02.40B Malar fracture, left side
New code S02.40C Maxillary fracture, right side
New code S02.40D Maxillary fracture, left side
New code S02.40E Zygomatic fracture, right side
New code S02.40F Zygomatic fracture, left side

S02.6 Fracture of mandible

S02.60 Fracture of mandible, unspecified

Revise S02.600 Fracture of unspecified part of body of mandible, **unspecified side**
New code S02.601 Fracture of unspecified part of body of right mandible
New code S02.602 Fracture of unspecified part of body of left mandible

S02.61 Fracture of condylar process of mandible

New code S02.610 Fracture of condylar process of mandible, unspecified side
New code S02.611 Fracture of condylar process of right mandible
New code S02.612 Fracture of condylar process of left mandible

S02.62 Fracture of subcondylar process of mandible

New code S02.620 Fracture of subcondylar process of mandible, unspecified side
New code S02.621 Fracture of subcondylar process of right mandible
New code S02.622 Fracture of subcondylar process of left mandible

S02.63 Fracture of coronoid process of mandible

New code S02.630 Fracture of coronoid process of mandible, unspecified side
New code S02.631 Fracture of coronoid process of right mandible
New code S02.632 Fracture of coronoid process of left mandible

S02.64 Fracture of ramus of mandible

New code S02.640 Fracture of ramus of mandible, unspecified side
New code S02.641 Fracture of ramus of right mandible
New code S02.642 Fracture of ramus of left mandible

S02.65 Fracture of angle of mandible

New code S02.650 Fracture of angle of mandible, unspecified side
New code S02.651 Fracture of angle of right mandible
New code S02.652 Fracture of angle of left mandible

S02.66 Fracture of symphysis of mandible

S02.67 Fracture of alveolus of mandible

New code	S02.670	Fracture of alveolus of mandible, unspecified side
New code	S02.671	Fracture of alveolus of right mandible
New code	S02.672	Fracture of alveolus of left mandible

S02.69 Fracture of mandible of other specified site

S02.8 Fracture of other specified skull and facial bones

S02.8 Fracture of other specified skull and facial bones

New code	S02.80	Fracture of other specified skull and facial bones, unspecified side
New code	S02.81	Fracture of other specified skull and facial bones, right side
New code	S02.82	Fracture of other specified skull and facial bones, left side

Temporomandibular joint disorders

The temporomandibular joint (TMJ) is located just in front of the lower part of the ear and allows the lower jaw to move. Temporomandibular joint and muscle disorders are problems or symptoms of the chewing muscles and joints. Currently, there is no way to code laterality of the temporomandibular joint, which is a bilateral joint.

The American Association of Oral and Maxillofacial Surgeons (AAOMS) proposes adding codes to ICD-10-CM to specifically report laterality of temporomandibular joint disorders.

TABULAR MODIFICATIONS

M26.6 Temporomandibular Joint Disorders

M26.60 Temporomandibular joint disorder, unspecified

New code M26.601 **Right** temporomandibular joint disorder, unspecified
New code M26.602 **Left** temporomandibular joint disorder, unspecified
New code M26.603 **Bilateral** temporomandibular joint disord er, unspecified
New code M26.609 **Unspecified** temporomandibular joint disorder
Temporomandibular joint disorder NOS

M26.61 Adhesions and ankylosis of temporomandibular joint
New code M26.611 Adhesions and ankylosis of **right** temporomandibular joint
New code M26.612 Adhesions and ankylosis of **left** temporomandibular joint
New code M26.613 Adhesions and ankylosis of **bilateral** temporomandibular joint
New code M26.619 Adhesions and ankylosis of temporomandibular joint, **unspecified side**

M26.62 Arthralgia of temporomandibular joint
New code M26.621 Arthralgia of **right** temporomandibular joint
New code M26.622 Arthralgia of **left** temporomandibular joint
New code M26.623 Arthralgia of **bilateral** temporomandibular joint
New code M26.629 Arthralgia of temporomandibular joint, **unspecified side**

M26.63 Articular disc disorder of temporomandibular joint
New code M26.631 Articular disc disorder of **right** temporomandibular joint
New code M26.632 Articular disc disorder of **left** temporomandibular joint
New code M26.633 Articular disc disorder of **bilateral** temporomandibular joint
New code M26.639 Articular disc disorder of temporomandibular joint, **unspecified side**

Dislocation and sprain of joints and ligaments - Jaw

A mandibular dislocation is the separation of your mandible (lower jaw) from your temporomandibular joint (TMJ). When this happens, your lower jaw does not go back in place on its own. Currently, there is no way to specifically report dislocation of the right or left temporomandibular joint, where as there are options for reporting dislocations of other bilateral joints and ligaments.

The American Association of Oral and Maxillofacial Surgeons (AAOMS) proposes adding codes to ICD-10-CM to specifically report dislocation and sprain laterality of the temporomandibular joint.

TABULAR MODIFICATIONS

S03 Dislocation and sprain of joints and ligaments of head

S03.0 Dislocation of jaw
Dislocation of jaw (cartilage) (meniscus)
Dislocation of mandible
Dislocation of temporomandibular (joint)

New code S03.00 Dislocation of jaw, **unspecified side**
New code S03.01 Dislocation of jaw, **right side**
New code S03.02 Dislocation of jaw, **left side**
New code S03.03 Dislocation of jaw, **bilateral**

S03.4 Sprain of jaw
Sprain of temporomandibular (joint) (ligament)

New code S03.40 Sprain of jaw, **unspecified side**
New code S03.41 Sprain of jaw, **right side**
New code S03.42 Sprain of jaw, **left side**
New code S03.43 Sprain of jaw, **bilateral**

Binge Eating Disorder

Binge Eating Disorder is a new disorder in DSM-5. The recognition of Binge Eating Disorder (BED) is supported by the large literature which has emerged since the publication of DSM-IV; a Pub Med search using the phrase "Binge Eating Disorder" identified over 1000 publications. The eating disorders field is very supportive of the inclusion of BED as a distinct diagnostic category, and it is worth noting that there is now a Binge Eating Disorder Association.

A major problem with the categorization in DSM-IV for eating disorders is the very high prevalence of Eating Disorders Not Otherwise Specified (EDNOS), sometimes approaching 50% among individuals presenting to eating disorder clinics. Studies of the characteristics of individuals with EDNOS suggest that a significant fraction, approximately 15-30%, meet criteria for BED. Therefore, the inclusion of BED in DSM-5 is expected to significantly reduce the frequency of unspecified and other specified diagnoses.

The diagnosis of BED has received considerable empirical attention. Many of these studies have addressed research questions that are relevant to assessing the validity and clinical utility of this diagnosis. There has been relatively consistent and strong support for the identification of a latent class resembling BED across a significant number of empirically based classification studies, lending support to the notion that BED can be meaningfully discriminated from other eating disorders. Furthermore, there is evidence that individuals with BED display rates of eating disorder psychopathology, subjective distress, impairments in quality of life, and psychiatric comorbidity at a level that is similar to other eating disorder diagnoses, implying that BED is characterized by clinically significant levels of psychopathology. Moreover, BED displays a clinical course that differs from both Anorexia Nervosa and Bulimia Nervosa and diagnostic crossover between Anorexia Nervosa and BED is extremely low. Thus, in relationship to other eating disorders, the diagnosis of BED represents a diagnostically distinct entity that carries clinically useful information.

It has also been found that BED can be discriminated from obesity and that the presence of BED confers clinically useful information beyond that associated with simple obesity or obesity with nonspecific psychopathology. There is strong evidence that obese subjects with BED experience more psychiatric comorbidity, eating disorder psychopathology, subjective distress, and impairments in quality of life than do obese non-BED subjects. Evidence that BED predicts a clinical course associated with negative medical and psychiatric outcomes is limited and would bolster the clinical utility of the diagnosis. The finding that BED responds to some psychological treatments more completely than to nonspecific treatments provides evidence that the diagnosis has clinical utility for treatment of binge eating behavior, but treatment-related evidence supporting the validity of the diagnosis in relation to other diagnostic groups is rare.

American Psychiatric Association (APA) is recommending that binge eating disorder be added to the Index and in the Tabular List as an inclusion term for F50.8, Other eating disorders for October 1, 2014.

APA recognizes that placing Binge Eating Disorder as an inclusion term with the other eating disorders (F50.8) is less than optimal for differentiating it from the large number of conditions often included in this category. If an alternative code in the F50 series becomes possible for this condition, APA would prefer to modify these codes now or in future revisions.

TABULAR MODIFICATIONS
(OCTOBER 1, 2014)

F50 Eating disorders

F50.8 Other eating disorders

Add	Avoidant/restrictive food intake disorder
Add	Binge eating disorder

INDEX MODIFICATIONS
(OCTOBER 1, 2014)

	Disorder
Add	-binge eating F50.8
	-eating
Add	- -binge F50.8

TABULAR MODIFICATIONS
(OCTOBER 1, 2015)

F50 Eating disorders

F50.8 Other eating disorders

New code	F50.81 Binge eating disorder
New code	F50.82 Avoidant/restrictive food intake disorder
New code	F50.89 Other specified eating disorder

Gender Identity Disorder in Adolescence and Adulthood

When ICD-10-CM was developed, APA recommended assigning F64.1 to the diagnosis of gender identity disorder in adolescence and adulthood. APA now acknowledges that this recommendation is no longer clinically accurate. In the WHO ICD-10, the code F64.1 corresponds to "dual-role transvestism." Transvestism and gender identity disorder are different disorders. APA states that gender identity disorder in adolescence and adulthood corresponds most closely to the ICD-10 description of the WHO code F64.0 Transsexualism, which was deactivated in ICD-10-CM. The DSM-5 has also changed the name of gender identity disorder in adolescents and adult to gender dysphoria in adolescents and adulthood.

APA is requesting that ICD-10-CM change the code for gender identity disorder in adolescents and adulthood to F64.0 and that "gender dysphoria in adolescents and adults" be added as an inclusion term for this entry. Gender dysphoria in adolescents and adults should also be added to the ICD-10-CM index.

TABULAR MODIFICATIONS

	F64	Gender identity disorders
New code	F64.0	Transsexualism Gender identity disorder in adolescence and adulthood Gender dysphoria in adolescents and adults
Revise	F64.1	~~Gender identity disorder in adolescence and adulthood~~ Dual role transvestism
Delete		~~Dual role transvestism~~
Delete		~~Transsexualism~~
	F64.2	Gender identity disorder of childhood
Add		Gender dysphoria in children

Disruptive Mood Dysregulation Disorder

Disruptive mood dysregulation disorder (DMDD) is a new disorder in DSM-5. While some researchers view severe, non-episodic irritability as characteristic of pediatric bipolar disorder (BD), the data have not supported this view. The contention has been that mania manifests in youth, not episodically as in DSM-IV, but instead as severe, non-episodic irritability (Biederman et al 2004; Mick et al 2005). This contention has coincided with an upsurge in the rates of diagnosis of pediatric Bipolar Disorder (BD), which in turn has led to considerable debate about the nosologic status of severe, non-episodic irritability (Blader and Carlson 2007; Moreno et al 2007). Recent epidemiological data (Brotman et al 2006) indicate that non-episodic irritability is far more common among youth than classic BD. As a result, the recent upsurge in the rate of pediatric BD has been attributed to the labeling of non-episodic irritability as a form of pediatric BD.

Given the upsurge in the pediatric BD diagnosis and questions as to whether severe, non-episodic irritability should be viewed as a developmental phenotype of pediatric BD, research over the past eight years has compared youth with such irritability to those with episodic DSM-IV BD. To facilitate this research, a syndrome called severe mood dysregulation (SMD) was defined in 2003. Subsequent research demonstrated that youth with SMD differ from those with DSM-IV BD on important measures of validity. This raises serious questions about the appropriateness of combining children with SMD type syndromes and those with classic BD into a single group and defining them uniformly as suffering from pediatric BD.

The upsurge in the rate of pediatric BD called attention to a problem with DSM-IV that could be addressed only by the creation of a new diagnosis. Other DSM-IV categories do not capture aspects of the clinical presentation of children with severe, non-episodic irritability. Many of these children meet criteria for DSM-IV oppositional defiant disorder (ODD). However, researcher and clinician findings have suggested that this is an inappropriate label for these children, because ODD is a disruptive behavior disorder and the most prominent symptoms in children with severe, non-episodic irritability involve perturbations in mood. Thus, the overall clinical picture suggests that these children suffer from a mood disorder as opposed to a disruptive behavior disorder such as ODD. Additionally, ODD was felt to be insufficiently severe to describe these children.

The American Psychiatric Association is recommending that the new DSM-5 entity, Disruptive mood dysregulation disorder be listed in the Index and as an inclusion term under F34.8: Other persistent mood [affective] disorders.

TABULAR MODIFICATIONS
(OCTOBER 1, 2014)

F34 Persistent mood [affective] disorders

F34.8 Other persistent mood [affective] disorders

Add Disruptive mood dysregulation disorder

INDEX MODIFICATIONS
(OCTOBER 1, 2014)

Disorder
Add - disruptive mood dysregulation F34.8

TABULAR MODIFICATIONS
(OCTOBER 1, 2015)

F34 Persistent mood [affective] disorders

F34.8 Other persistent mood [affective] disorders

New code F34.81 Disruptive mood dysregulation disorder
New code F34.89 Other specified persistent mood disorders

Social (Pragmatic) Communication Disorder

The American Psychiatric Association recommends the addition of Social (Pragmatic) Communication Disorder as an inclusion term under F80.89, Other developmental disorders of speech and language. The APA has included this condition in DSM-5, because clinically significant impairments in social-communication skills (commonly referred to as pragmatic language deficits) are often neglected as a specific type of communication disorder. Additionally under DSM-IV, these disorders were often lumped under Pervasive Developmental Disorder NOS (PDD-NOS) with individuals who have "atypical" autism, missed the age of onset requirement for autism, or have subthreshold symptoms, even though they lacked the repetitive behaviors and fixated interests that were required for all other Pervasive Developmental Disorders.

When Autism Spectrum Disorder (ASD) was redefined in DSM-5, it captured many of those who would have been identified as PDD-NOS under a broader definition of autism. As in DSM-IV, ASD is characterized by the presence of both deficits in social communication and reciprocity and excessive fixated interests and repetitive behaviors. Scientific literature and clinical experience provides strong support that individuals lacking the characteristic repetitive behaviors and fixated interests of an Autism Spectrum Disorder are better served by having a more specific and accurate diagnosis of Social (Pragmatic) Communication Disorder.

Social (Pragmatic) Communication Disorder is not intended to split a group away from Autism Spectrum Disorder. Individuals with only social communication deficits are different from those meeting criteria for Autism Spectrum Disorder and require different services. It is essential that this term be added so that those who would previously have met criteria for PDD-NOS with only social communication deficits continue to have a diagnostic "home" and continue to receive services. Additionally, it is hoped that individuals with other conditions, such as severe ADHD or schizophrenia, may have these specific deficits in social communication recognized and treated.

TABULAR MODIFICATIONS
(OCTOBER 1, 2014)

F80 Specific developmental disorders of speech and language
F80.8 Other developmental disorders of speech and language

F80.89 Other developmental disorders of speech and language
Add Social (pragmatic) communication disorder

INDEX MODIFICATIONS
(OCTOBER 1, 2014)

Disorder
Add - social (pragmatic) communication F80.89

TABULAR MODIFICATIONS
(OCTOBER 1, 2015)

F80 Specific developmental disorders of speech and language
F80.8 Other developmental disorders of speech and language

New code F80.82 Social pragmatic communication disorder
Excludes1: Asperger's syndrome (F84.5)
Autistic disorder (F84.0)

Hoarding Disorder

Hoarding Disorder (HD) is a new diagnosis added to the DSM-5, under the Obsessive-Compulsive and Related Disorders chapter.

In the DSM-5, hoarding disorder is characterized as "persistent difficulty discarding or parting with possessions, regardless of their actual value" that "results in the accumulation of possessions that congest and cluster active living areas and substantially compromises their intended use." Available data and research show that clinically significant hoarding has significant prevalence and can vary from mild to severe and life threatening. The personal and public health consequences of hoarding can be substantial, putting people at risk for fire, falling (especially elderly people), poor sanitation and health risks. Pathological hoarding also represents a profound public health burden in terms of occupational impairment, poor physical health and social service utilization. Hoarding also has a substantial impact on the family members of the sufferers.

Research shows that hoarding disorder is related to obsessive-compulsive disorder (OCD) but is a distinct disorder in that: 1) the main characteristics of OCD, obsessions and/or compulsions, are absent in hoarding disorder; 2) clinically significant hoarding is possible but rare in OCD; 3) OCD symptoms can wax and wane while hoarding disorder can be stable but worsen over time; 4) Exposure and ritual prevention (ERP) is a good treatment for OCD while ERP alone is not sufficient to treat hoarding disorder and hoarding requires a somewhat different psychosocial treatment approach than OCD.

Considering its clinical and public health importance as an independent disorder and its distinction from OCD, the American Psychiatric Association (APA) is recommending that hoarding disorder be added to the Index and as an inclusion term to F42 Obsessive Compulsive Disorder (for October 1, 2014).

APA recognizes that placing Hoarding Disorder in the same code section with obsessive compulsive F42 disorder category is less than optimal for differentiating it from Obsessive Compulsive Disorder—in which there are no fourth digit diagnoses. However, this does place it in the appropriate mental disorder section. For October 1, 2015 it is proposed that code be created at F42 to include a unique code for F42.2 for OCD and F42.3 for Hoarding Disorder in future revisions.

Reference:
American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Arlington, VA, 2013.
Mataix-Cols D, Frost RO, Pertusa1 A, Clark LA, Saxena S, Leckman JF, Stein DJ, Matsunaga H, Wilhelm S. Hoarding Disorder: A New Diagnosis for DSM-V? Depression & Anxiety, 2010; 27:556-572.

TABULAR MODIFICATIONS
(OCTOBER 1, 2014)

F42 Obsessive compulsive disorder

Add Hoarding disorder

INDEX MODIFICATIONS
(OCTOBER 1, 2014)

Disorder
Add - hoarding F42

TABULAR LIST
(OCTOBER 1, 2015)

F42 Obsessive compulsive disorder

New code F42.2 Mixed obsessional thoughts and acts
New code F42.3 Hoarding disorder
New code F42.8 Other obsessive compulsive disorder
New code F42.9 Obsessive-compulsive disorder, unspecified

Excoriation (Skin-Picking) Disorder

American Psychiatric Association (APA) recommends that the inclusion term excoriation (skin-picking) disorder be added to L98.1. Excoriation (skin-picking) disorder is a new diagnoses added to the DSM-5. It is defined as "recurrent skin picking resulting in skin lesions" despite "repeated attempts to decrease or stop skin picking." Skin picking also leads to clinically significant distress or disability, and that patients with skin picking disorder can have important medical sequelae.

Excoriation (skin picking) disorder primarily benefits from psychiatric treatments. The disorder is often accompanied by other mental disorders. Particularly, studies show comorbidity and increased familiarity between excoriation (skin-picking) disorder and obsessive-compulsive disorder, which suggests a common underlying psychobiological dysfunction across the disorders. Coding excoriation (skin-picking) disorder in the mental health chapter of ICD-10-CM would emphasize the underlying etiology and appropriate treatment for the disorder.

APA recognizes that placing Excoriation (skin-picking) Disorder outside the obsessive compulsive F42 disorder category is less than optimal for differentiating it from the factitial excoriation disorder associated with the L98.1 code in the dermatology section. If an alternative code in the F42 series becomes possible for subcategories of body focused repetitive behavior disorders such as this condition and trichotillomania, APA would prefer to modify these codes in future revisions. F98.8, Other specified behavioral and emotional disorders with onset usually occurring in early childhood and adolescence, would an unsatisfactory placement for this disorder. This residual, "other specified" category appears to be devoted mainly to problems and habits seen in children, problems that are not considered to be mental disorders in DSM-5. Although it has onset in adolescence, as many mental disorders do, the course of excoriation disorder is chronic, commonly persisting into adulthood, so it is not considered to be specifically a disorder of childhood/adolescence. Excoriation disorder is a well-defined, discrete disorder in DSM-5, unlike conditions such as "nail biting," "excessive masturbation," and "nose-picking" that are listed under F98.8. Finally, as noted above, excoriation is closely related to obsessive-compulsive disorder and should be classified to reflect this relationship, if at all possible.

Reference:
American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Arlington, VA, 2013.
Stein DJ, Grant JE, Franklin ME, Keuthen N, Lochner C, Singer HS, Woods DW. Trichotillomania (Hair Pulling Disorder), Skin Picking Disorder, and Stereotypic Movement Disorder: Toward DSM-V. Depression & Anxiety 2010;27:611-626.
Bienvenu, O. J., Samuels, J. F., Wuyek, L. A., Liang, K. Y., Wang, Y., Grados, M. A. et al. (2011). Is obsessive compulsive disorder an anxiety disorder, and what, if any, are spectrum conditions? A family study perspective. Psychological Medicine, FirstView, 1-13.

TABULAR MODIFICATIONS
(OCTOBER 1, 2014)

L98 Other disorders of skin and subcutaneous tissue, not elsewhere classified

L98.1 Factitial dermatitis

Add Excoriation (skin-picking) disorder

INDEX MODIFICATIONS
(OCTOBER 1, 2014)

Disorder
Add - excoriation (skin-picking) L98.1

TABULAR MODIFICATIONS
(OCTOBER 1, 2015)

F42 Obsessive-compulsive disorder
New code F42.4 Excoriation (skin-picking) disorder
Excludes1: Factitial dermatitis (L98.1)
Other specified behavioral and emotional disorders with onset usually occurring in early childhood and adolescence (F98.8)

L98 Other disorders of skin and subcutaneous tissue, not elsewhere classified

L98.1 Factitial dermatitis

Excludes1: Excoriation (skin-picking) disorder (F42.4)

Premenstrual Dysphoric Disorder

Premenstrual Dysphoric Disorder (PMDD) is a new disorder in DSM-5. The disorder may affect more than two million women in the United States alone. A number of studies find that women with PMDD experience impaired functioning in a various domains, which improves with treatment. Such impairment among those suffering from the condition argues for the need to detect and treat women who experience PMDD.

Without clear diagnostic boundaries for PMDD, the diagnosis may be missed by providers. Clinicians may assume, for example, that the patient suffers from milder premenstrual syndrome or, alternatively, an ongoing mood disorder such as Major Depressive Disorder or Persistent Depressive Disorder (Dysthymic Disorder). The treatments for these various conditions are distinct, thus arguing for accurate diagnosis and documentation. Thus, APA is recommending that an inclusion term of "Premenstrual Dysphoric Disorder" be added to the Index and the Tabular List under N94.3 Premenstrual Tension Syndrome.

APA recognizes that placing PMDD outside the recurrent depressive disorder category is less than optimal for differentiating it from N94.3 Premenstrual Tension Syndrome, which is generally less severe than PMDD, and does not require psychiatric treatment. If an alternative code in the F32 series is possible, APA would prefer to modify the code in that section in future revisions.

TABULAR MODIFICATIONS
(OCTOBER 1, 2014)

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

N94.3 Premenstrual tension syndrome

Add Premenstrual dysphoric disorder

INDEX MODIFICATIONS
(OCTOBER 1, 2014)

Disorder
Add - premenstrual dysphoric N94.3

TABULAR MODIFICATIONS (OCTOBER 1, 2015)

F32 Major depressive disorder, single episode

F32.8 Other depressive episodes

New code F32.81 Premenstrual dysphoric disorder
Excludes1: premenstrual tension syndrome (N94.3)

New code F32.89 Other specified depressive episodes

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

N94.3 Premenstrual tension syndrome

Add Excludes1: Premenstrual dysphoric disorder

Additional Tabular List Inclusion Terms for ICD-10-CM

F01 Vascular dementia
F01.5 Vascular dementia
F01.50 Vascular dementia without behavioral disturbance
Add Major neurocognitive disorder without behavioral disturbance
F01.51 Vascular dementia with behavioral disturbance
Add Major neurocognitive disorder with aggressive behavior
Add Major neurocognitive disorder with combative behavior
Add Major neurocognitive disorder with violent behavior

F02 Dementia in other diseases classified elsewhere
F02.8 Dementia in other diseases classified elsewhere
F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance
Add Major neurocognitive disorder in other diseases classified elsewhere
F02.81 Dementia in other diseases classified elsewhere with behavioral disturbance
Add Major neurocognitive disorder in other diseases classified elsewhere with aggressive behavior
Add Major neurocognitive disorder in other diseases classified elsewhere with combative behavior
Add Major neurocognitive disorder in other diseases classified elsewhere with violent behavior

F34 Persistent mood [affective] disorders
F34.1 Dysthymic disorder
Add Persistent depressive disorder

F44 Dissociative and conversion disorders
F44.0 Dissociative amnesia
Add Excludes1: Dissociative amnesia with dissociative fugue (F44.1)

F45 Somatoform disorders
F45.1 Undifferentiated somatoform disorder
Add Somatic symptom disorder
F45.2 Hypochondriacal disorders
F45.21 Hypochondriasis
Add Illness anxiety disorder

F52 Sexual dysfunction not due to a substance or known physiological condition
F52.3 Orgasmic disorder
F52.32 Male orgasmic disorder
Add Delayed ejaculation

F52.6 Dyspareunia not due to a substance or known physiological condition
Add Genito-pelvic pain/penetration disorder

F80 Specific developmental disorders of speech and language
F80.0 Phonological disorder
Add Speech-sound disorder

F84 Pervasive developmental disorders
F84.0 Autistic disorder
Add Autism spectrum disorder

F88 Other disorders of psychological development
Add Global developmental delay

Unintended awareness under general anesthesia

In extremely rare cases, a patient can become conscious during surgery and subsequently recall what occurred. This experience, referred to as "intraoperative awareness," or anesthesia awareness, is estimated to occur about 1 to 2 times per every 1,000 uses of general anesthesia. Most patients do not experience any pain due to intraoperative awareness, but it can be disturbing and some patients may need counseling following surgery to ease their anxiety.

The American Society of Anesthesiologists defines awareness during surgery as applying only to patients who are under general anesthesia, and that intraoperative awareness does not include:

- The period of time just prior to the anesthetic completely taking effect or as the patient is emerging from anesthesia.
- When sedatives are administered during a local or regional anesthetic (such as a nerve block, spinal or epidural). In these cases, it is expected that patients will have some recollection of the procedure.
- Patients who receive sedation, and not general anesthesia, for procedures outside of the operating room. This can include dental procedures, upper GI endoscopies, and colonoscopies. Awareness is not unusual for these procedures.

The American Society of Anesthesiologists is requesting the establishment of an ICD-10-CM code to describe the uncommon instance in which a patient experiences unintended awareness under general anesthesia as well as a code to track a history of this unintended awareness. Availability of these codes will further research into the factors that contribute to unintended awareness, including methods to reduce its occurrence and to correctly identify patients who experience the condition thus facilitating both acute management and appropriate care during future anesthetics.

The following ICD-10-CM modifications are proposed:

TABULAR MODIFICATIONS

T88 Other complications of surgical and medical care, not elsewhere classified

T88.5 Other complications of anesthesia

New code T88.53 Unintended awareness under general anesthesia during procedure

Excludes2: personal history of unintended awareness under general anesthesia (Z92.84)

Z92 Personal history of medical treatment

Z92.8 Personal history of other medical treatment

New code Z92.84 Personal history of unintended awareness under general anesthesia

Excludes2: unintended awareness under general anesthesia during procedure (T88.53)

Intracranial injury (TBI)

In 2013 the *Report to Congress on Traumatic Brain Injury in the United States: Understanding the Public Health Problem among Current and Former Military Personnel*[1] was published by the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Department of Defense (DoD), and the Department of Veterans Affairs (VA). The report stated that "Federal stakeholders have been concerned regarding the need for a better classification for TBI symptoms using ICD codes as acute or persistent (or chronic) for both epidemiologic and clinical uses. CDC, NIH, DoD, VA, and other federal agencies are reviewing proposed codes of ICD-10-CM classification and making suggestions for changes that would improve TBI reporting in the United States." One of the reports recommendations was to "Improve the coding and classification of TBI by working across agencies. All four participating agencies should continue to meet with professional, academic, health care, and coding organizations to discuss improvements in ICD-10-CM and TBI severity measures that can allow comparison of cases and outcomes." Specifically, the report recommended revision of the intracranial injury code set in ICD-10-CM to improve the accuracy of disease coding consistent with accepted case definitions before ICD-10-CM implementation on October 1, 2014.

Currently, ICD-10-CM classifies concussion in subcategory S06.0, Concussion. The codes use loss of consciousness (LOC) to differentiate the severity of the concussion with the range extending from no loss of consciousness to greater than 24 hours including that with death.

A proposal has been received from the VA requesting that codes representing concussion with LOC greater than 30 minutes be removed (deleted) indicating that mild TBI is synonymous with concussion and more severe forms of TBI are inappropriately labeled as concussion. In addition their proposal stated that moderate and severe TBI are neither classifiable as concussion nor post-concussive syndrome. They propose the revisions to subcategory S06.0, Concussion to delete codes for concussion with LOC greater than 30 minutes. In addition they propose additional coding instructional notes in this category to better direct coders to use of the specified intracranial injury codes when a concussion occurs with these injuries.

As indicated above, the requestor is asking that these changes be implemented during the partial code freeze, before October 1, 2014 ICD-10-CM implementation. Comments regarding the proposal are due to NCHS by November 15, 2013. NCHS is asking commenters on this topic to specifically address whether or not they are in agreement with implementation of it during the partial code freeze.

[1]The CDC, NIH, DoD, and VA Leadership Panel. Report to Congress on Traumatic Brain Injury in the United States: Understanding the Public Health Problem among Current and Former Military Personnel. Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Department of Defense (DoD), and the Department of Veterans Affairs (VA). 2013.
http://www.cdc.gov/TraumaticBrainInjury/factsheets_reports.html

PDF available at:
http://www.cdc.gov/traumaticbraininjury/pdf/Report_to_Congress_on_Traumatic_Brain_Injury_2013-a.pdf

TABULAR MODIFICATIONS

S06 Intracranial injury
Includes: traumatic brain injury
Code also any associated:
open wound of head (S01.-)
skull fracture (S02.-)
Excludes1: head injury NOS (S09.90)
The appropriate 7th character is to be added to each code from category S06
A initial encounter
D subsequent encounter
S sequela

S06.0 Concussion
Commotio cerebri

Add Mild traumatic brain injury

Revise Excludes1: concussion with ~~other~~ intracranial injuries classified in subcategories S06.1- to S06.6-, S06.81- , S06.82- code to specified intracranial injury

S06.0X Concussion
S06.0X0 Concussion without loss of consciousness
S06.0X1 Concussion with loss of consciousness of 30 minutes or less
~~Delete S06.0X2 Concussion with loss of consciousness of 31 minutes to 59 minutes~~
~~Delete S06.0X3 Concussion with loss of consciousness of 1 hour to 5 hours 59 minutes~~
~~Delete S06.0X4 Concussion with loss of consciousness of 6 hours to 24 hours~~
~~Delete S06.0X5 Concussion with loss of consciousness greater than 24 hours with return to pre-existing conscious level~~
~~Delete S06.0X6 Concussion with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving~~
~~Delete S06.0X7 Concussion with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness~~
~~Delete S06.0X8 Concussion with loss of consciousness of any duration with death due to other cause prior to regaining consciousness~~
S06.0X9 Concussion with loss of consciousness of unspecified duration
Concussion NOS

S06.8 Other specified intracranial injuries

S06.89 Other specified intracranial injury

Add Excludes1: concussion (S06.0X-)

S06.890 Other specified intracranial injury without loss of consciousness
S06.891 Other specified intracranial injury with loss of consciousness of 30 minutes or less
S06.892 Other specified intracranial injury with loss of consciousness of 31 minutes to 59 minutes
S06.893 Other specified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes
S06.894 Other specified intracranial injury with loss of consciousness of 6 hours to 24 hours
S06.895 Other specified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level
S06.896 Other specified intracranial injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving
S06.897 Other specified intracranial injury with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness
S06.898 Other specified intracranial injury with loss of consciousness of any duration with death due to other cause prior to regaining consciousness
S06.899 Other specified intracranial injury with loss of consciousness of unspecified duration

S06.9 Unspecified intracranial injury

Add Traumatic brain injury NOS

Add Excludes1: conditions classifiable to S06.0- to S06.8- code to specified intracranial injury

INDEX MODIFICATIONS

In addition to index modifications required if codes are deleted the following other changes are also proposed to clarify coding traumatic brain injury NOS.

	Injury (see also specified injury type) T14.90
	- brain (traumatic) S06.9
Delete	~~- - traumatic - see category S06~~
Revise	TBI (traumatic brain injury) S06.9
	Traumatic - see also condition
Revise	- brain injury S06.9

Placenta Previa vs Low Lying Placenta

Currently, in ICD-10-CM, placenta previa and low lying placenta are both classified to category O44, Placenta previa. This category is further subdivided to indicate whether or not the condition is with or without hemorrhage. The American Congress of Obstetricians and Gynecologists (ACOG) is proposing a code expansion at this category to allow differentiation between complete placenta previa, partial placenta previa and low lying placenta.

Placenta previa is a condition that occurs when some portion of the placenta is covering the internal cervical os. It may be either complete, where the internal cervical os is completely covered by the placenta, or partial where the internal cervical os is partially covered by the placenta. Both of these conditions may result in hemorrhage and both require close monitoring often requiring delivery by cesarean section. ACOG indicates that from a clinical standpoint complete placenta previa is a more serious condition that leads to greater morbidity and earlier delivery whereas a partial placenta previa is more likely to resolve as a pregnancy progresses.

Low lying placenta is a condition where the placenta implants low in the uterus but does not cover the cervix. A low lying placenta will typically require less follow-up or fewer visits to assess the condition and often resolves prior to delivery. This condition may also result in hemorrhage but it is more likely that conservative therapy will be prescribed and the condition is less likely to result in early delivery.

The proposal requests to create additional subcategories at category O44 to allow unique codes to track these conditions separately and to continue the ability to indicate whether or not hemorrhage is present with each. It should also be noted that as proposed below the default for this condition will change from the WHO ICD-10 default of "with hemorrhage" to "without hemorrhage". ACOG has indicated that most of the time, in today's practice, these conditions (especially either type of placenta previa) are diagnosed and delivered before hemorrhage. Therefore, their proposal is to have the default point to without hemorrhage for each of these conditions. Additionally, they indicated that the default for "placenta previa NOS" should indexed to and included at complete placenta previa without hemorrhage. The proposal below indicates these defaults and the index would be modified to reflect this.

TABULAR MODIFICATIONS

O44 Placenta previa

Revise	O44.0		Complete placenta previa ~~specified as~~ NOS or without hemorrhage
Delete			~~Low implantation of placenta specified as without hemorrhage~~
Add			Placenta previa NOS
Revise		O44.00	Complete placenta previa ~~specified as~~ NOS or without hemorrhage, unspecified trimester
Revise		O44.01	Complete placenta previa ~~specified as~~ NOS or without hemorrhage, first trimester
Revise		O44.02	Complete placenta previa ~~specified as~~ NOS or without hemorrhage, second trimester
Revise		O44.03	Complete placenta previa ~~specified as~~ NOS or without hemorrhage, third trimester

Revise	O44.1		Complete placenta previa with hemorrhage
Delete			~~Low implantation of placenta, NOS or with hemorrhage~~
Delete			~~Marginal placenta previa, NOS or with hemorrhage~~
Delete			~~Partial placenta previa, NOS or with hemorrhage~~
Delete			~~Total placenta previa, NOS or with hemorrhage~~
			Excludes1: labor and delivery complicated by hemorrhage from vasa previa (O69.4)
Revise		O44.10	Complete placenta previa with hemorrhage, unspecified trimester
Revise		O44.11	Complete placenta previa with hemorrhage, first trimester
Revise		O44.12	Complete placenta previa with hemorrhage, second trimester
Revise		O44.13	Complete placenta previa with hemorrhage, third trimester
New subcategory	O44.2		Partial placenta previa without hemorrhage Marginal placenta previa, NOS or without hemorrhage
New code		O44.20	Partial placenta previa NOS or without hemorrhage, unspecified trimester
New code		O44.21	Partial placenta previa NOS or without hemorrhage, first trimester
New code		O44.22	Partial placenta previa NOS or without hemorrhage, second trimester
New code		O44.23	Partial placenta previa NOS or without hemorrhage, third trimester
New subcategory	O44.3		Partial placenta previa with hemorrhage
New code		O44.30	Partial placenta previa with hemorrhage, unspecified trimester
New code		O44.31	Partial placenta previa with hemorrhage, first trimester
New code		O44.32	Partial placenta previa with hemorrhage, second trimester
New code		O44.33	Partial placenta previa with hemorrhage, third trimester
New subcategory	O44.4		Low lying placenta NOS or without hemorrhage Low implantation of placenta NOS or without hemorrhage
New code		O44.40	Low lying placenta NOS or without hemorrhage, unspecified trimester
New code		O44.41	Low lying placenta NOS or without hemorrhage, first trimester
New code		O44.42	Low lying placenta NOS or without hemorrhage, second trimester
New code		O44.43	Low lying placenta NOS or without hemorrhage, third trimester
New subcategory	O44.5		Low lying placenta with hemorrhage Low implantation of placenta with hemorrhage
New code		O44.50	Low lying placenta with hemorrhage, unspecified trimester
New code		O44.51	Low lying placenta with hemorrhage, first trimester
New code		O44.52	Low lying placenta with hemorrhage, second trimester
New code		O44.53	Low lying placenta with hemorrhage, third trimester

Dental Terms

The Harvard School of Dental Medicine has submitted a proposal to add a number of dental terms to ICD-10-CM. The foremost rationale for this proposal is to help improve the granularity and contemporaneity of the ICD-10-CM oral health-related terms. This will not only enhance the clinical relevance of the ICD terms for dentists, but also increase its utilization. Further rationales for the specific groups of terms suggested for addition are briefly discussed.

Periodontology related terms

Terms related to dental plaque induced gingival disease are proposed to be added at K05.00, Acute gingivitis, plaque induced, including: "Plaque induced gingival disease without local contributing factors," and "Plaque induced gingival disease with local contributing factors."

It is proposed that the term "Pregnancy associated gingivitis," related to a specific type of gingivitis found commonly in pregnant women, be added at subcategory K05.1, Chronic gingivitis.

It is proposed that a number of terms be added to code K05.5, Other periodontal diseases. These include the following: "Combined periodontic-endodontic lesion," which occurs when an infection involves both pulp and periodontal ligament space simultaneously; "Primary occlusal trauma," resulting from abnormal occlusal forces on teeth with normal periodontium; and "Secondary occlusal trauma," resulting from normal/excessive occlusal forces on teeth with abnormal (compromised) periodontium. Another term is "Insufficient biological width," which is the dimension of the soft tissue attached to the portion of the tooth coronal to the alveolar crest, which is essential for preservation of periodontal health and removal of irritation that might damage the periodontium; when this width is insufficient, it is a strong indication for crown lengthening.

It is proposed to add terms at K06.8, Other specific disorders of gingiva and edentulous alveolar ridge. The additional terms are "Vertical ridge deficiency" or "Horizontal ridge deficiency," which are deficiencies in the height or width of the alveolar ridge (respectively).

TABULAR MODIFICATIONS

K05 Gingivitis and periodontal diseases

K05.0 Acute gingivitis

K05.00 Acute gingivitis, plaque induced
Add Plaque induced gingival disease (with local contributing factors)
(without local contributing factors)

K05.1 Chronic gingivitis
Add Pregnancy associated gingivitis

K05.5 Other periodontal diseases
Add Combined periodontic-endodontic lesion
Add Primary occlusal trauma
Add Secondary occlusal trauma
Add Insufficient biological width (of periodontal soft tissue)

K06 Other disorders of gingiva and edentulous alveolar ridge

K06.8 Other specified disorders of gingiva and edentulous alveolar ridge

Add Horizontal ridge deficiency
Add Vertical ridge deficiency

Endodontology-related terms

Endodontology classification is done on two dimensions – symptomaticity and reversibility – both of which have implications for the clinical management of patient presentation. Currently in ICD-10-CM, the same code (K04.0) is used for both reversible and irreversible pulpitis. It is proposed to differentiate these two concepts, creating separate codes for them, since these diagnoses have significantly different treatment implications.

Reversible pulpitis is a condition where the pulp is inflamed and is actively responding to an irritant. The pulp is still considered to be vital, so once the irritant is eliminated and there is placement of a restoration, the pulp will return to its normal, healthy state. Symptomatic reversible pulpitis involves pain, while asymptomatic reversible pulpitis involves no symptoms.

Irreversible pulpitis is a condition where the pulp is irreversibly damaged. The pulp is still alive, but the introduction of bacteria into the pulp will not allow the pulp to heal and it will ultimately result in necrosis, or death, of the pulp tissue. Treatment is usually extraction or endodontic treatment. There can be asymptomatic irreversible pulpitis, or symptomatic irreversible pulpitis.

TABULAR MODIFICATIONS

K04 Diseases of pulp and periapical tissues

	K04.0	Pulpitis
Delete		~~Irreversible pulpitis~~
		~~Reversible pulpitis~~
New code	K04.01	Reversible pulpitis Asymptomatic reversible pulpitis Symptomatic reversible pulpitis
New code	K04.02	Irreversible pulpitis Asymptomatic irreversible pulpitis Symptomatic irreversible pulpitis

Caries terms

Recent trends in caries diagnoses require an indication of the extent of decay. Following the principles of the International Caries Detection and Assessment System (ICDAS, a detection & assessment system, classifying stages of the caries process) the Harvard School of Dental Medicine has recommended addition of a number of terms related to dental caries, that are in line with the current thinking in the field, and more robust in their description of dental caries diagnoses.

Arrested incipient caries in enamel are non-cavitated and inactive caries, which can involve white spots, or brown spots, with pits and fissures of the enamel. These may be separated based on depth, into those less than 1/2 way to the dentino-enamel junction (DEJ), and those greater than 1/2 way to DEJ. Arrested incipient carries may also involve caries lesion regression, or remineralized caries lesions.

Active incipient caries in enamel are non-cavitated progressive caries, which can involve white spots, or brown spots, with pits and fissures of enamel. Again, these may be separated based on depth, into those less than 1/2 way to the DEJ, and those greater than 1/2 way to DEJ.

Primary caries (at DEJ) are initial caries extending to the dentino-enamel junction. Recurrent caries are caries around an existing restoration, which may have depth into enamel, to DEJ, or to the pulp. Early childhood caries is occurrence of any sign of dental caries on any tooth surface during the first three years of life. Rampant caries is advanced or severe decay on multiple surfaces of many teeth. Caries of dentine is dental caries extending into dentine. Pre-eruptive caries are defects on the crowns of developing permanent teeth which are evident radiographically, even though no infection of the primary tooth is apparent.

TABULAR MODIFICATIONS

K02 Dental caries
Includes: …
Add Caries of dentine
Add Early childhood caries
Add Pre-eruptive caries
Add Rampant caries
Add Recurrent caries (DEJ) (Enamel) (to the pulp)

K02.3 Arrested dental caries
Add Arrested incipient caries in enamel (less than 1/2 way to DEJ) (greater than 1/2 way to DEJ)

K02.5 Dental caries on pit and fissure surface

K02.52 Dental caries on pit and fissure surface penetrating into dentin
Add Primary caries (at DEJ)

K02.6 Dental caries on smooth surface

K02.61 Dental caries on smooth surface limited to enamel
Add Active incipient caries in enamel (less than 1/2 way to DEJ) (greater than 1/2 way to DEJ)

Other Dental Terms

There are additional dental terms being submitted for inclusion that do not fall under any of the above categories. The rationale for submitting them includes the fact that no matching term exists for them in the ICD and they are fairly frequently used terms. Also, these conditions can be common indications for some of the more popular surgical procedures carried out in dentistry, such as crown lengthening and tooth extraction.

Insufficient anatomic crown height is when the part of a tooth that is covered with enamel extending from the cemento-enamel junction to the cusp tips or incisal edge is shortened. Insufficient clinical crown length is when an insufficient portion of the tooth is above the gingival margin. A nonfunctional tooth is a tooth that is not in occlusion with any opposing teeth.

TABULAR MODIFICATIONS

K08 Other disorders of teeth and supporting structures

K08.8 Other specified disorders of teeth and supporting structures

Add	Insufficient anatomic crown height
Add	Insufficient clinical crown length
Add	Nonfunctional tooth

ICD-10-CM TABULAR OF DISEASES - PROPOSED ADDENDA
All proposed effective October 1, 2014

A41 Other sepsis
Delete Excludes1: ~~sepsis NOS (A41.9)~~

B17 Other acute viral hepatitis
B17.9 Acute viral hepatitis, unspecified
Add Acute infectious hepatitis NOS

D76 Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue
Add Excludes1: histiocytic medullary reticulosis (C96.9)
Delete ~~malignant histiocytosis (C96.A)~~
Revise leukemic reticuloendotheliosis ~~or reticulosis~~ (C91.4-)
Revise lipomelanotic ~~reticuloendotheliosis or~~ reticulosis (I89.8)
Add malignant histiocytosis (C96.A)
Add malignant reticulosis (C86.0)
Add nonlipid reticuloendotheliosis (C96.0)

E13 Other specified diabetes mellitus
Add Excludes1: type 1 (E10.-)

E88 Other and unspecified metabolic disorders
E88.4 Mitochondrial metabolism disorders
E88.42 MERRF syndrome
Myoclonic epilepsy associated with ragged-red fibers
Revise Code also: <u>progressive</u> myoclonic epilepsy (G40.3-)

F02 Dementia in other diseases classified elsewhere
Code first the underlying physiological condition, such as:
Add dementia with Parkinsonism (G31.83)
Delete ~~Excludes1: dementia with Parkinsonism (G31.83)~~

I50 Heart failure
I50.9 Heart failure, unspecified
Revise <u>Excludes2</u>: fluid overload (E87.70)

I69 Sequelae of cerebrovascular disease
I69.1 Sequelae of nontraumatic intracerebral hemorrhage
I69.12 Speech and language deficits following nontraumatic intracerebral hemorrhage
I69.123 Fluency disorder following nontraumatic intracerebral hemorrhage
Revise Stuttering following nontraumatic intracerebral hemorrhage

[Note: Same revisions will be made at codes I69.223, I69.323, I69.823, and I69.923]

I97 Intraoperative and postprocedural complications and disorders of circulatory system, not elsewhere classified
I97.8 Other intraoperative and postprocedural complications and disorders of the circulatory system, not elsewhere classified
I97.82 Postprocedural cerebrovascular infarction
Revise I97.820 Postprocedural cerebrovascular infarction following cardiac surgery
Revise I97.821 Postprocedural cerebrovascular infarction following other surgery

K52 Other and unspecified noninfective gastroenteritis and colitis
K52.8 Other specified noninfective gastroenteritis and colitis
K52.81 Eosinophilic gastritis or gastroenteritis
Revise Excludes2: eosinophilic esophagitis (K20.0)

M90 Osteopathies in diseases classified elsewhere
Excludes1: osteochondritis, osteomyelitis, and osteopathy (in):
Revise diabetes mellitus (E08-E13 with .69)

O13 Gestational [pregnancy-induced] hypertension without significant proteinuria
Add Includes: transient hypertension of pregnancy

O24 Diabetes mellitus in pregnancy, childbirth, and the puerperium
Revise O24.0 Pre-existing type 1 diabetes mellitus, in pregnancy, childbirth and the puerperium
Revise O24.01 Pre-existing type 1 diabetes mellitus, in pregnancy
Revise O24.011 Pre-existing type 1 diabetes mellitus, in pregnancy, first trimester
Revise O24.012 Pre-existing type 1 diabetes mellitus, in pregnancy, second trimester
Revise O24.013 Pre-existing type 1 diabetes mellitus, in pregnancy, third trimester
Revise O24.019 Pre-existing type 1 diabetes mellitus, in pregnancy, unspecified trimester
Revise O24.02 Pre-existing type 1 diabetes mellitus, in childbirth
Revise O24.03 Pre-existing type 1 diabetes mellitus, in the puerperium
Revise O24.1 Pre-existing type 2 diabetes mellitus in pregnancy, childbirth and the puerperium
Revise O24.11 Pre-existing type 2 diabetes mellitus, in pregnancy
Revise O24.111 Pre-existing type 2 diabetes mellitus, in pregnancy, first trimester

Revise O24.112 Pre-existing type 2 diabetes mellitus, in pregnancy, second trimester
Revise O24.113 Pre-existing type 2 diabetes mellitus, in pregnancy, third trimester
Revise O24.119 Pre-existing type 2 diabetes mellitus, type 2, in pregnancy, unspecified trimester
Revise O24.12 Pre-existing type 2 diabetes mellitus, in childbirth
Revise O24.13 Pre-existing type 2 diabetes mellitus, in the puerperium

O34 Maternal care for abnormality of pelvic organs
O34.0 Maternal care for congenital malformation of uterus
Add Maternal care for double uterus
Add Maternal care for uterus bicornis

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

O99.6 Diseases of the digestive system complicating pregnancy, childbirth and the puerperium
Add Excludes 2: hemorrhoids in pregnancy (O22.4-)

O99.8 Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium
O99.82 Streptococcus B carrier state complicating pregnancy, childbirth and the puerperium
Add Excludes1: Carrier of streptococcus group B (GBS) in a nonpregnant woman (Z22.330)

Symptoms and signs involving cognition, perception, emotional state and behavior (R40-R46)
Revise Excludes2: symptoms and signs constituting part of a pattern of mental disorder (F01-F99)

Abnormal findings on examination of blood, without diagnosis (R70-R79)

Revise Excludes2: ~~abnormalities (of)(on):~~
Revise abnormal findings on antenatal screening of mother (O28.-)
Delete ~~coagulation hemorrhagic disorders (D65-D68)~~
Revise abnormalities of lipids (E78.-)
Revise abnormalities of platelets and thrombocytes (D69.-)
Revise abnormalities of white blood cells classified elsewhere (D70-D72)
Add coagulation hemorrhagic disorders (D65-D68)

W89 Exposure to man-made visible and ultraviolet light
Revise Excludes1:exposure to sunlight (X32)

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

X39 Exposure to other forces of nature
X39.0 Exposure to natural radiation

Revise
Excludes1: contact with and (suspected) exposure to radon and other naturally occuring radiation (Z77.123)

Z22 Carrier of infectious disease
Z22.3 Carrier of other specified bacterial diseases
Z22.33 Carrier of bacterial disease due to streptococci
Z22.330 Carrier of Group B streptococcus

Add
Excludes1: Carrier of streptococcus group B (GBS) complicating pregnancy, childbirth and the puerperium (O99.82-)

ICD-10-CM INDEX OF DISEASES - PROPOSED ADDENDA
All proposed effective October 1, 2014

Adenoma - see also Neoplasm, benign, by site
- microcystic
Revise - - pancreas D13.6
- - specified site NEC - see Neoplasm, benign, by site
Revise - - unspecified site D13.6

Burn
Revise - hip(s) - see Burn, thigh

Carrier (suspected) of
- bacterial disease NEC Z22.39
- - streptococcal Z22.338
- - - group B Z22.330
Add - - - - complicating pregnancy or delivery O99.82-
- streptococci Z22.338
- - group B Z22.330
Add - - - - complicating pregnancy or delivery O99.82-

Coma
Revise - hyperglycemic (diabetic) - see Diabetes, by type, with hyperosmolarity, with coma
Revise - hyperosmolar (diabetic) - see Diabetes, by type, with hyperosmolarity, with coma
Revise - hypoglycemic (diabetic) - see Diabetes, by type, with hypoglycemia, with coma
Revise - in diabetes - see Diabetes, by type

Convulsions (idiopathic) (see also Seizure(s) R56.9
Delete ~~- benign neonatal (familial) - see Epilepsy, generalized, idiopathic~~
Delete ~~- neonatal, benign (familial) - see Epilepsy, generalized, idiopathic~~

Revise Cyst (colloid) (mucous) (retention) (simple) ~~(retention)~~
Revise - cervical lateral Q18.0

Dehydration E86.0
Add - with
Add - - hypernatremia E87.0
Add - - hyponatremia E87.1

Delivery (childbirth) (labor)
- cesarean (for)
Revise - - streptococcus group B (GBS) carrier state O99.824
- complicated O75.9
- - by
Revise - - - streptococcus group B (GBS) carrier state O99.824

Diabetes, diabetic (mellitus) (sugar) E11.9
- with
Add - - osteomyelitis E11.69
[Note: Same entry is proposed to be added under each type of diabetes in the index]

Add - brittle - see Diabetes, type 1
Add - due to
Add - - autoimmune process - see Diabetes, type 1
Add - - immune mediated pancreatic islet beta-cell destruction - see Diabetes, type 1
Add - idiopathic - see Diabetes, type 1

Distress
Revise - acute respiratory ~~(adult) (child) J80~~ R06.00
Add - - syndrome (adult) (child) J80
Revise - respiratory (adult) (child) R06.00
Delete ~~- - adult J80~~
Delete ~~- - child J80~~

Effect, adverse
- anesthesia (see also Anesthesia) T88.59
Delete ~~- - in pregnancy NEC O29.3-~~
- - local, toxic
- - - in labor and delivery O74.4
Add - - - in pregnancy NEC O29.3-

Epilepsy…
Revise - myoclonus, myoclonic ~~(progressive)~~ - see Epilepsy, generalized, specified NEC
Add - - progressive – See Epilepsy, generalized, idiopathic

Hepatitis K75.9
- acute B17.9
Revise - - infectious B17.9
Delete ~~- - - with hepatic coma B15.0~~
- infectious, infective
Revise - - acute (subacute) B17.9
- - chronic B18.9
Delete ~~- - - with hepatic coma B15.0~~

Injury (see also specified injury type) T14.90
- gland
Revise - - salivary S09.93

Revise Melanocytoma, eyeball D31.9-

Necrosis, necrotic (ischemic) - see also Gangrene
Revise - cornea H18.89-

Osteomyelitis …
Add - in diabetes mellitus - see E08-E13 with .69

Pregnancy (single) (uterine) - see also Delivery and Puerperal
- complicated by (care of) (management affected by)
Revise - - streptococcus group B (GBS) carrier state O99.820

Puerperal, puerperium (complicated by, complications)
- infection O86.4
- - maternal O98.93
Revise - - - streptococcus group B (GBS) carrier state O99.825

Resistance, resistant (to)
- organism(s)
- - to
Revise - - - drug Z16.30
Revise - - - - antimycobacterial (single) Z16.341
- - - - multiple drugs (MDRO)
Add - - - - - antimicrobial Z16.35
Add - - - - - antimycobacterials Z16.342

Reticuloendotheliosis
Delete ~~- malignant C96.9~~

Reticulosis (skin)
Revise - histiocytic medullary C96.A
Delete ~~- nonlipid C96.0~~

Sequestration - see also Sequestrum
Add - disk – see Displacement, intervertebral disk

Virus, viral
Revise - swine influenza (viruses that normally cause infections in pigs) (see also Influenza, due to, identified novel influenza A virus) J09.X2

Table of Drugs

Prilocaine …
Revise - nerve block (peripheral) (plexus) T41.3X1…

Revise Propionaldehyde (medicinal) T42.6X1…