CENTERS FOR DISEASE CONTROL AND PREVENTION

ICD-9-CM Coordination and Maintenance Committee Meeting
March 9-10, 2011
Diagnosis Agenda

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

Diagnosis Topics:

Contents

ICD-10-CM TOPICS

ICD-9-CM TIMELINE

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

March 9 – March 10 2011	ICD-9-CM Coordination and Maintenance Committee meeting.
April 1, 2011	There will **not** be any new ICD-9-CM codes implemented on April 1, 2011 to capture new technology.
April 1, 2011	**Deadline for receipt of public comments on proposed code revisions discussed at the March 9-10, 2011 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2011.**
April 2011	Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This notice will include the final ICD-9-CM diagnosis and procedure codes for the upcoming fiscal year. It will also include proposed revisions to the DRG system on which the public may comment. The proposed rule can be accessed at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp
April 2011	Summary report of the Procedure part of the March 9, 2011 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Summary report of the Diagnosis part of the March 10, 2011 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd.htm
June 2011	Final addendum posted on web pages as follows: Diagnosis addendum at – http://www.cdc.gov/nchs/icd.htm Procedure addendum at – http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes
July 15, 2011	Those members of the public requesting that topics be discussed at the September 14 – 15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses.
August 1, 2011	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 all the final codes to be implemented on October 1, 2011.

	This rule can be accessed at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp
August 2011	Tentative agenda for the Procedure part of the September 14 – 15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage at - http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Tentative agenda for the Diagnosis part of the September 14 – 15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on NCHS homepage at - http://www.cdc.gov/nchs/icd.htm Federal Register notice for the September 14 –15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.
August 12, 2011	**On-line registration opens for the September 14-15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting at:** http://www.cms.hhs.gov/apps/events
September 9, 2011	Because of increased security requirements, those wishing to attend the September 14 - 15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting must register for the meeting online at: http://www.cms.hhs.gov/apps/events **Attendees must register online by September 9, 2011; failure to do so may result in lack of access to the meeting.**
September 14 –15, 2011	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 9, 2011.** You must bring an official form of picture identification (such as a drivers license) in order to be admitted to the building.
October 2011	Summary report of the Procedure part of the September 14 – 15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Summary report of the Diagnosis part of the September 14– 15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd.htm
October 1, 2011	New and revised ICD-9-CM codes go into effect along

	with DRG changes. Final addendum posted on web pages as follows: Diagnosis addendum - http://www.cdc.gov/nchs/icd.htm Procedure addendum at - http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes
October 7, 2011	**Deadline for receipt of public comments on proposed code revisions discussed at the September 14-15, 2011 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on April 1, 2012.**
November 2011	Any new ICD-9-CM codes required to capture new technology and new diseases that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2012 will be posted on the following websites: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes http://www.cdc.gov/nchs/icd.htm
November 18, 2011	**Deadline for receipt of public comments on proposed code revisions discussed at the September 14-15, 2011 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2012.**

Contact Information

Mailing address:

National Center for Health Statistics
ICD-9-CM Coordination and Maintenance Committee
3311 Toledo Road, Room 2402
Hyattsville, Maryland 20782
Fax: (301) 458-4022

Donna Pickett (301) 458-4434
E-mail: dfp4@cdc.gov

David Berglund (301) 458-4095
E-mail zhc2@cdc.gov

Lizabeth Fisher (301) 458-4091
E-mail llw4@cdc.gov

Traci Ramirez (301) 458-4454
E-mail tfr4@cdc.gov

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

Continuing Education Credits

Continuing education credits may be awarded by the American Academy of Professional Coders (AAPC) or the American Health Information Management Association (AHIMA) for participation in CMS/NCHS ICD-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, <u>not NCHS</u>.

Seclusion status

Seclusion is used for behavioral health purposes to protect the patient against injury to self or others because of an emotional or behavioral disorder. The use of seclusion poses a risk to the patient's physical safety and well-being. Seclusion has the potential to produce serious consequences, such as physical and psychological harm, violation of rights, and even death. Therefore, medical care must maximize safety by allocating sufficient resources that have specialized training. Additionally, the healthcare organization must provide assessment of each encounter.

Patients must be evaluated and monitored more closely when seclusion is used. A health care facility must be able to easily identify patients who had seclusion used during their encounter. During the use of seclusion, the services change as a higher level of monitoring and care is required while a patient is in seclusion. This is a high risk situation which requires special training and patient care. A unique code will assist in giving a better description of the episode of care.

A request was received from Lockheed Martin Health Solutions and Service to create a unique ICD-9-CM diagnosis code for seclusion status.

The following tabular modifications are proposed:

TABULAR MODIFICATIONS

V07 Need for isolation and other prophylactic or treatment measures

V07.0 Isolation
Excludes: seclusion status (V49.88)

V49 Other conditions influencing health status

V49.8 Other specified conditions influencing health status

New code V49.88 Seclusion status

Excludes: need for isolation (V07.0)
seclusion imposed by correction and law enforcement authorities for security purposes – omit code

Vitreomacular adhesion

Vitreomacular adhesion (VMA) is a condition affecting the macula, a small portion of the retina which is important for central vision. VMA may lead to visual impairment or blindness and a variety of complications (macular edema, macular pucker, and macular hole) with similar symptoms. It occurs as a result of the natural process of aging, in which the vitreous gel pulls forward and away from the retina over time. VMA is not a new condition. However, there is a need from a broad health care perspective to be able to track this discrete and potentially sight-threatening condition, understand its true prevalence, and identify it separately from other traction disorders as well as associated or downstream conditions.

In a normal healthy eye, the vitreous gel fills the entire vitreous cavity. However, age-related changes in the vitreous can cause the vitreous gel to collapse. This is called posterior vitreous detachment (PVD), and it occurs when the collagen fibers which make up the vitreous cavity condense, causing the gel to "pull forward".

Within the eye, the macula is the center of the retina, and the center of the macula (much like a “bulls-eye”) is an avascular area called the fovea. The fovea has a high concentration of cone cells responsible for central vision and is therefore the main determinant for visual acuity. Any damage to the macula, and consequently the fovea, is immediately noticed since it affects the central vision.

VMA may occur after PVD, if there is only part, whereby part of the posterior hyaloid (membrane separating the vitreous from the retina) remains attached to the macular area. When adhesion persists at this site, the vitreomacular traction (VMT) generated by the adhesion may become symptomatic (sVMA).

Both researchers and clinicians have recognized VMA as a separately identifiable condition that contributes to serious vision threatening conditions, and warrants its own distinct and unique treatment upon anatomical or visual signs and symptoms of vitreomacular traction. As advanced diagnostic techniques have become universally available in the last decade and new treatments enter the health care marketplace, clinicians and researchers alike would benefit greatly from separately identifiable VMA coding.

The American Academy of Ophthalmology and The American Society of Retina Specialists are requesting a new unique ICD-9-CM diagnosis code for vitreomacular adhesion.

TABULAR MODIFICATIONS

379 Other disorders of eye

379.2 Disorders of vitreous body

New code	379.27	Vitreomacular adhesion
Add		Vitreomacular traction
Add	Excludes:	traction detachment with vitreoretinal organization (361.81)

Partial Tear of Rotator Cuff

The rotator cuff is the network of four muscles and several tendons that form a covering around the top of the upper arm bone (humerus). These muscles form a cover around the head of the humerus. The rotator cuff holds the humerus in place in the shoulder joint and enables the arm to rotate.

Rotator cuff tear is a common cause of pain and disability among adults. Most tears occur in the supraspinatus muscle, but other parts of the cuff may be involved.

The rotator cuff can be torn from a single traumatic injury. Patients often report recurrent shoulder pain for several months and a specific injury that triggered the onset of the pain. A rotator cuff tear may also happen at the same time as another injury to the shoulder, such as a fracture or dislocation.

Most tears, however, are the result of overuse of these muscles and tendons over a period of years. People who are especially at risk for overuse are those who engage in repetitive overhead motions. These include participants in sports such as baseball, tennis, weight lifting, and rowing.

Rotator cuff tears are most common in people who are over the age of 40. Younger people tend to have rotator cuff tears following acute trauma or repetitive overhead work or sports activity. A partial tear of the rotator cuff is an area of damage to the rotator cuff tendons, where the tear does not go all the way through the tendons.

Currently ICD-9-CM has a unique code for the complete tear of the rotator cuff, code 727.61, Complete rupture of rotator cuff, but does not have a unique code for a partial tear of the rotator cuff.

TABULAR MODIFCATION

726 Peripheral enthesopathies and allied syndromes

726.1 Rotator cuff syndrome of shoulder and allied disorders

New code 726.13 Partial tear of rotator cuff

Malnutrition

At the September 2010 ICD-9-CM Coordination and Maintenance Committee meeting the American Dietetic Association (ADA) and the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) requested several new codes and instructional notes be added to the ICD-9-CM to update the current classification of malnutrition. The existing ICD-9-CM codes for malnutrition are outdated and do not reflect the current standard of care or understanding of malnutrition-disease interaction. Thus, the existing ICD-9-CM malnutrition codes are inconsistently applied by clinicians and facilities across health care settings. Inconsistency in the recognition and documentation of malnutrition in adults is of concern and can significantly impact patient health, safety, quality of life, and health care costs.

While public comments received on this proposal agreed in principle with the need for the new codes, commenters noted that certain modifications would be necessary to avoid confusion and conflicts with existing codes and guidelines. The modifications have been incorporated into this revised proposal.

TABULAR MODIFICATIONS

260 Kwashiorkor

Delete ~~Nutritional edema with dyspigmentation of skin and hair~~

Add Excludes: severe malnutrition related to acute injury, illness and other disorders (262.11-262.14, 262.19)

261 Nutritional marasmus

Delete ~~Nutritional atrophy~~

Delete ~~Severe calorie deficiency~~

Delete ~~Severe malnutrition NOS~~

Add Excludes: severe malnutrition related to acute injury, illness and other disorders (262.11-262.14, 262.19)

Revise 262 Other <u>specified</u> severe protein-calorie malnutrition

Delete ~~Nutritional edema without mention of dyspigmentation of skin and hair~~

New subcategory 262.1 Severe malnutrition in injury, illness or other disorders

New code 262.10 Severe malnutrition, unspecified
Severe malnutrition NOS

New code 262.11 Severe malnutrition in acute injury

New code 262.12 Severe malnutrition in acute illness

New code 262.13 Severe malnutrition in chronic illness

New code 262.14 Severe malnutrition in environmental and social circumstances

New code 262.19 Severe malnutrition in other disorders

263 Other and unspecified protein-calorie malnutrition

Add Excludes: severe malnutrition related to acute injury, illness and other disorders (262.11-262.14, 262.19)

782 Symptoms involving skin and other integumentary tissue

782.3 Edema

Delete Excludes: ~~nutritional edema (260, 262)~~

INDEX MODIFICATIONS

Anasarca 782.3
Revise nutritional ~~262~~ – see Malnutrition
Revise Athrepsia ~~261~~ – see Malnutrition
Atrophy,
Revise infantile ~~261~~ – see Disease, motor neuron
Revise nutritional ~~261~~ – see Malnutrition
Cachexia 799.4
Revise due to malnutrition – see Malnutrition
Deficiency, deficient
Revise calorie, severe ~~261~~ – see Malnutrition
Revise edema ~~262~~ – see Malnutrition
Revise multiple, syndrome ~~260~~ – see Malnutrition
Revise protein ~~260~~ – see Malnutrition
Revise syndrome, multiple ~~260~~ – see Malnutrition
Deprivation
Revise protein ~~(familial) (kwashiorkor) 260~~ – see Malnutrition
Development
arrested 783.40
Revise due to malnutrition ~~(protein-calorie) 263.2~~ – see Malnutrition
Diabetes…
Revise Lancereaux's ~~(diabetes mellitus with marked emaciation)~~ 250.8 ~~[261]~~ [263.8]
Revise due to secondary diabetes 249.8 ~~[261]~~ [263.8]
Revise secondary
Revise Lancereaux's ~~(diabetes mellitus with marked emaciation)~~ 249.8 ~~[261]~~ [263.8]
Disease…
wasting NEC 799.4
Revise due to malnutrition ~~261~~ – see Malnutrition
Dwarf, dwarfism 259.4
Revise nutritional ~~263.2~~ – see Malnutrition
Dystrophy…
Revise due to malnutrition ~~263.9~~ – see Malnutrition
Revise nutritional ~~263.9~~ – see Malnutrition
Edema…
Revise famine ~~262~~ – see Malnutrition
Revise inanition ~~262~~ – see Malnutrition
Revise nutritional (newborn) ~~262~~ – see Malnutrition
Revise with dyspigmentation, skin and hair ~~260~~ – see Malnutrition
Revise starvation ~~262~~ – see Malnutrition
Revise Emaciation (due to malnutrition) ~~261~~ – see Malnutrition
Famine 994.2
Revise edema ~~262~~ – see Malnutrition
Hydrops…
Revise nutritional ~~262~~ – see Malnutrition

Revise Hypoproteinosis ~~260~~ – see Malnutrition
Revise Inanition ~~263.9~~ – see Malnutrition
Revise with edema ~~262~~ – see Malnutrition
due to
Revise malnutrition ~~263.9~~ – see Malnutrition
Revise Kwashiorkor ~~(marasmus type)~~ 260
Revise Lancereaux's diabetes ~~(diabetes mellitus with marked emaciation)~~ 250.8 ~~[261]~~ [263.8]
Revise due to secondary diabetes 249.8 ~~[261]~~ [263.8]
Malnutrition (calorie) 263.9
degree
Revise first ~~263.1~~ 263.9
Revise second ~~263.0~~ 263.9
Revise third ~~262~~ 263.9
Revise mild (protein) NEC 263.1
Add due to specified underlying condition – see Malnutrition, related to, by cause
moderate (protein) 263.0
Add due to specified underlying condition – see Malnutrition, related to, by cause
Revise severe ~~261~~ 262.10
Revise protein-calorie NEC 262
Add due to specified underlying condition – see Malnutrition, related to, by cause
Add due to – see Malnutrition, related to
Revise malignant ~~260~~ 263.9
mild (protein) 263.1
Add due to specified underlying condition – see Malnutrition, related to, by cause
moderate (protein) 263.0
Add due to specified underlying condition – see Malnutrition, related to, by cause
Revise protein ~~260~~ 263.9
mild 263.1
Add due to specified underlying condition – see Malnutrition, related to, by cause
moderate 263.0
Add due to specified underlying condition – see Malnutrition, related to, by cause
protein-calorie 263.9
Revise severe NEC 262
specified type NEC 263.8
Add due to specified underlying condition – see Malnutrition, related to, by cause
Add related to (due to)
Add acute illness NEC 262.12
Add acute injury 262.11
Add chronic illness 262.13
Add environmental circumstances 262.14
Add injury, acute 262.11
Add social circumstances 262.14
Add specified NEC 262.19
Revise severe ~~261~~ 263.9
Add due to specified underlying condition – see Malnutrition, related to, by cause
Revise Pedatrophia ~~261~~ – see Malnutrition

Revise Pluricarential syndrome of infancy ~~260~~ – see Malnutrition
Revise Plurideficiency syndrome of infancy ~~260~~ – see Malnutrition
Revise Polycarential syndrome of infancy ~~260~~ – see Malnutrition
Revise Prekwashiorkor ~~260~~ – see Malnutrition
Protein
Revise deficiency ~~260~~ – see Malnutrition
Revise malnutrition ~~260~~ – see Malnutrition
Retardation
growth (physical) in childhood 783.43
Revise due to malnutrition ~~263.2~~ – see Malnutrition
physical 783.43
Revise due to malnutrition ~~263.2~~ – see Malnutrition
Starvation …
Revise edema ~~262~~ – see Malnutrition
Syndrome…
multiple
Revise deficiency ~~260~~ – see Malnutrition
Revise pluricarential of infancy ~~260~~ – see Malnutrition
Revise plurideficiency of infancy ~~260~~ – see Malnutrition
Revise polycarential of infancy ~~260~~ – see Malnutrition
Wasting
disease 799.4
Revise due to malnutrition ~~261~~ – see Malnutrition
Revise extreme (due to malnutrition) ~~261~~ – see Malnutrition

Solitary Pulmonary Nodules

A single pulmonary nodule (SPN) is a round or oval spot (lesion) in the lungs typically deep within and surrounded with the lung parenchyma in a sub-segmental branch of the bronchial tree. On imaging examination more than one single pulmonary nodule may be present on the lung field. The two single pulmonary nodules tend to be distinct and not in close anatomical proximity.

The single pulmonary nodule is detected with chest X-ray, however with enhancements in Computed Tomography (CT) and Positron Emission Tomography (PET) these lesions are found with a higher frequency than with chest X-ray. A SPN, once biopsied, may be benign or malignant, carcinoma in situ, or represent different lung disease.
Twenty five (25%) to thirty five (35%) of SPNs positioned in the sub-segmental branch of the bronchial tree and deep within the lung tissue, upon biopsy using wedge resection or lobectomy are benign. Wedge resection and lobectomy result in increased morbidity and surgical complications, yet provide a viable option for a patient wanting a biopsy confirmation. Five-year survival rates approach 70% when lung cancer is detected and treated at stage 1A of the disease. The peer reviewed medical literature is abundant with articles reporting on techniques to address these peripheral, deep within the lung, lesions using less invasive techniques in support of earlier detection and treatment to save lives.

Currently in ICD-9-CM it is not possible to uniquely identify a patient that has been identified as having a SPN or that following biopsy that the lesion now identified as benign, malignant, or carcinoma in situ was originally identified was linked to a single pulmonary nodule (SPN). The intent of the proposed modifications is to (1) add specificity to the classification to identify a growing number of patients with small peripheral lung lesion(s), also referred to as a single pulmonary nodule and (2) facilitate tracking to support longitudinal research. With the improvement in technologies to detect the SPN improved accuracy of ICD-9-CM diagnosis codes can contribute to clinical decision-making regarding early detection, treatment and management of patients with lung cancer. Current trends in screening patients for lung cancer and SPN identified incident to another medical service represent an opportunity to treat patients with lung cancer earlier and thereby reduce the incidence of death due to lung cancer.

Currently the only reference in the ICD-9-CM non-specific lesions in the lung is “coin lesion” which is indexed to code 793.1, Nonspecific (abnormal) findings on radiological and other examination of lung field. The term “single pulmonary nodule” is not indexed. Proposal 1 recommends an expansion of code 793.1, Nonspecific (abnormal findings on radiological and other examination of body structure, Lung field, to specially identify the unique peripherally located smaller pulmonary lesions, or solitary pulmonary nodule(s).

Proposal 2 recommends the addition of detail for further characterization of the single pulmonary nodule as malignant, benign or carcinoma in situ. Vantage View believes that unique codes should be developed for these prevalent lung lesions to better understand their role in developing into malignant lung cancer, and how the SPN are best staged and treated.

TABULAR MODIFICATIONS

Option 1

793 Nonspecific abnormal findings on radiological and other examination of body structure

793.1 Lung field

Delete ~~Coin lesion lung~~

Delete ~~Shadow, lung~~

New Code 793.11 Solitary pulmonary nodule, sub-segmental branch of the bronchial tree
Coin lesion lung

New Code 793.12 Solitary pulmonary nodule, sub-segmental branch of the bronchial tree, more than one finding on radiological and other examination of lung field

New Code 793.19 Other nonspecific abnormal finding of lung field
Shadow, lung

Optionl 2

162 Malignant neoplasm of trachea, bronchus, and lung

New code 162.7 Malignant neoplasm of sub-segmental branch of bronchial tree, solitary pulmonary nodule(s

New subcategory 212.3 Bronchus and lung

Delete ~~Carina~~

Delete ~~Hilus of lung~~

New code 212.31 Benign neoplasm of sub-segmental branch of bronchial tree, solitary pulmonary nodule(s)

New code 212.39 Benign neoplasm of other site in bronchus and lung
Carina
Hilus of lung

231 Carcinoma in situ of respiratory system

New subcategory 231.2 Carcinoma in situ of bronchus and lung

New code 231.21 Carcinoma in situ sub-segmental branch of bronchial tree, solitary pulmonary nodule(s)

New code 231.29 Carcinoma in situ of other site of bronchus and lung

235 Neoplasm of uncertain behavior of digestive and respiratory systems

New subcategory 235.7 Trachea, bronchus, and lung

New code 235.71 Neoplasm of uncertain behavior of sub-segmental branch of bronchial tree, solitary pulmonary nodule(s)

New code	235.79 Neoplasm of uncertain behavior of other site in bronchus, and lung

Wandering

Autism spectrum disorders (ASDs) affect 1 in 110 children and 1 in 83 children have an intellectual disability in the United States. [1, 2] Children and adults with ASDs and other developmental disabilities (DD) are at higher risk of wandering off than children and adults without these disorders. According to Autism Wandering Awareness Alerts Responder Education AWAARE, in a 2007 National Autism Association Survey, 92% of parents reported that their children with ASD had wandered from a safe environment one or multiple times.[3] A survey of service providers found that 75% of children with intellectual disabilities were reported to have challenging behaviors associated with wandering.[4] Although not every person with ASD/DD or other disorders may have impairments in safety monitoring, for those individuals that are susceptible to wandering into dangerous situations, the consequences can be devastating.

Wandering places children and adults with ASD/DD or other disorders in harmful and potentially life-threatening situations—making this an important safety issue for individuals affected, their families and caregivers. There are reports of tragic deaths of children and adults diagnosed with an ASD associated with wandering off [5,6]. Although available data are very limited, the majority of wandering fatalities associated with autism are attributed to drowning. Wandering occurs among persons with developmental disabilities and may expose a person to dangerous situations (e.g. open bodies of water, traffic).[4,7] Despite reports of concern from caregivers and some studies, there are limited data on population-based estimates and predictors of risk for wandering associated with ASD/DD.[4]

Diagnostic codes for wandering associated with ASDs and wandering associated with other developmental disabilities would promote (1) better data collection for and understanding of this behavior (2) prompt important safety discussions between healthcare providers, caregivers, and the person with the disability to the full extent possible. Better data should help to increase awareness and action among first responders, school administrators and residential facility administrators to recognize and understand the wandering and develop proper emergency protocols and response while supporting self-determination principles.

Currently there are no unique codes to capture wandering associated with ASDs, DDs, or other conditions such as Alzheimer's disease. The concept of wandering was added to ICD-9-CM effective with the October 1, 2000 update as an inclusion term under at code 294.11, Dementia in conditions classified elsewhere with behavioral disturbance. CDC (National Center on Birth Defects and Developmental Disabilities) has requested that new codes be created to better identify children and adults that wander associated with ASDs, DDs, and other conditions. The additional code would not be a component of the ASD or other DD diagnoses, but could be used in conjunction with other applicable codes.

References:

1. CDC. Prevalence of autism spectrum disorders---Autism and Developmental Disabilities Monitoring Network, United States, 2006. In: Surveillance Summaries, December 18, 2009. MMWR 2009; 58(SS10);1-20
2. CDC. How common is intellectual disability? http://www.cdc.gov/ncbddd/dd/mr3.htm
3. Autism Wandering Awareness Alerts Responder Education (AWAARE). www.awaare.org/.
4. Lowe A, Allen D, Jones E, et al.(2007) Challenging behaviours: prevalence and topographies J of Intellectual Disability Res 51(8): 625–636
5. Shavelle RM, Strauss DJ, Pickett J. Causes of death in autism. (2001) Journal of Autism and Developmental Disorders. Volume 31, Number 6, 569-576
6. Gillberg C, Billstedt E, Sundh V, Gillberg IC.(2010) Mortality in Autism: A Prospective Longitudinal Community-Based Study. J Autism Dev Disord 40:352–357
7. Jacobson JW. (1982); Problem Behavior and Psychiatric Impairment Within a Developmentally Disabled Population I: Behavior Frequency Applied Research in Mental Retardation, 3:121 - 139,

TABULAR MODIFICATIONS

Option 1:

799.8 Other ill-defined conditions

799.83 Wandering in diseases classified elsewhere

Code first underlying disorder such as:
autism or pervasive developmental disorder (299.0-299.9)
intellectual disabilities (317-319*)*

Option 2:

V40 Mental and behavioral problems

New subcategory V40.3 Other behavioral problems

New code V40.31 Wandering

Code first underlying disorder such as:
autism or pervasive developmental disorder (299.0-299.9)
intellectual disabilities (317-319)

New code V40.39 Other specified behavioral problem

Acute Kidney Diseases and Related Disorders

Assignment of certain of the existing ICD-9-CM codes for acute renal (kidney) failure requires that providers document a specific pathologic diagnosis in order to assign a diagnosis code. This is contrast to clinical practice, where impairment in kidney function is first recognized, and then a diagnosis is made. Acute kidney disease (AKD) and related disorders are a global problem. It is common and occurs in the community, in the hospital where it is common on medical, surgical, pediatric, and oncology wards, and in ICUs. It imposes a heavy burden of illness, it is a predictor of immediate and long-term adverse outcomes, and has an associated high cost with its requirements for intensive evaluation and management. Individuals with chronic kidney disease (CKD) are especially susceptible to AKD which, in turn, may act as a promoter of progression of the underlying CKD. AKD is amenable to early detection and potential prevention, and therefore important to be recognized by clinicians and health care systems. There is a relationship between CKD, AKD and acute kidney injury (AKI). AKI is a subset of AKD, and both AKI and AKD can occur in patients with CKD. AKI, as well as AKD without AKI, can be superimposed upon CKD. Individuals without AKI, AKD, or CKD have no known kidney disease. AKI is diagnosed based on a specific measured increase in serum creatinine over time, or a specific decrease in urine volume over time.

AKI, AKD and CKD can be identified irrespective of etiology. CKD, AKI and AKD can all encompass various etiologies. For example, a patient may have AKI or AKD that is secondary to acute tubular necrosis, acute interstitial nephritis, acute glomerular diseases, prerenal azotemia, or acute postrenal obstructive nephropathy. The patient may also have an underlying chronic disease, which may have a known etiology, such as diabetes or IgA nephropathy. AKI and AKD can also be secondary to events, such as trauma or obstetric emergencies. The manifestations and clinical consequences of AKI are generally similar regardless of etiology. Even mild, reversible, AKI has important clinical consequences, including increased risk of death. As such, diagnostic codes for AKD and AKI, similar to CKD, should be separated from those for specific etiologies or circumstances.
AKI is classified into stages based on rate of change of kidney function or magnitude of urine output. Each stage has a different clinical action plan associated with it.

The current codes for acute renal failure (584) are primarily based on etiology and pathology. However, as described above, that is in contrast to clinical practice and recent clinical practice guidelines, and is a source of confusion. The National Kidney Foundation has proposed revisions to the ICD-9-CM classification system that reflect the current understanding and definitions of acute kidney disease (AKD) and acute kidney injury (AKI), as extensively reviewed and summarized in the Kidney Disease International Global Outcomes (KDIGO) evidence based guidelines on acute kidney injury (AKI).

TABULAR MODIFICATIONS

Revise 584 Acute ~~renal failure~~ kidney disease and disorders and acute tubular-interstitial diseases

New code 584.1 Acute kidney injury

New code 584.10 Acute kidney injury, unspecified stage
Acute kidney injury (nontraumatic), NOS
Acute renal disease
Acute renal insufficiency

New code 584.11 Acute kidney injury, Stage 1 (mild)

New code 584.12 Acute kidney injury, Stage 2 (moderate)

New code 584.13 Acute kidney injury, Stage 3 (severe)

New code 584.2 Acute kidney disease without AKI

Use additional code for renal dialysis status (V45.11), if applicable

584.5 Acute kidney failure with lesion of tubular necrosis
Add Excludes:
following labor and delivery (669.3)
posttraumatic (958.5)
that complicating:
abortion (634-638 with .3, 639.3)
ectopic or molar pregnancy (639.3)

584.6 Acute kidney failure with lesion of renal cortical necrosis
Add Excludes:
following labor and delivery (669.3)
posttraumatic (958.5)
that complicating:
abortion (634-638 with .3, 639.3)
ectopic or molar pregnancy (639.3)

584.7 Acute kidney failure with lesion of renal medullary [papillary] necrosis
Add Excludes:
following labor and delivery (669.3)
posttraumatic (958.5)
that complicating:
abortion (634-638 with .3, 639.3)
ectopic or molar pregnancy (639.3)

584.8 Acute kidney failure with other specified pathological lesion in kidney

Revise 584.9 Acute ~~renal failure~~ kidney injury or disease, unspecified
Delete ~~Acute kidney injury (nontraumatic)~~

593 Other disorders of kidney and ureter
593.9 Unspecified disorder of kidney and ureter
Delete ~~Acute renal disease~~
Delete ~~Acute renal insufficiency~~

Smoke inhalation

A proposal originally presented at the ICD-9-CM Coordination and Maintenance (C&M) meeting in March 2010 recommended changing the default for smoke inhalation from code 987.9, Toxic effect of unspecified gas, fume, or vapor to a code within either category 506, Respiratory conditions due to chemical fumes and vapors, or 508, Respiratory conditions due to other and unspecified external agents. The axes of classification for these categories are not consistent. Category 506 includes codes for specific types of respiratory conditions, and category 508 is broken down based on the external agent. Both categories require an external cause of injury code (E code) to identify the cause (the source of the fumes and vapors).

Comments received from the March C&M meeting recommended creating a new code in category 508, for smoke inhalation NOS as this category does not identify the type of agent causing the smoke. It was also recommended to have an excludes note for smoke inhalation from a chemical agent (to category 506).

In addition, to be consistent with the sequencing rules for other poisoning and toxic effect codes, we are proposing to add a use additional code note under categories 506 and 508 to help guide coders in use of these codes in conjunction with the associated specific respiratory conditions. This note would apply to all secondary respiratory codes, including acute respiratory failure.

TABULAR MODIFICATIONS

506 Respiratory conditions due to chemical fumes and vapors

Add Use additional code to identify associated respiratory conditions, such as:
Add acute respiratory failure (518.81)

508 Respiratory conditions due to other and unspecified external agents

Add Use additional code to identify associated respiratory conditions, such as:
Add acute respiratory failure (518.81)

New code 508.2 Respiratory conditions due to smoke inhalation

Add Smoke inhalation NOS

Add Excludes: smoke inhalation due to chemical fumes and vapors (506.9)

TOXIC EFFECTS OF SUBSTANCES CHIEFLY NONMEDICINAL AS TO SOURCE (980-989)

Add Excludes: respiratory conditions due to smoke inhalation NOS (508.2)

The above proposal will also require the following index entry to be revised

Inhalation
Revise smoke ~~987.9~~ 508.2

Positive finding for Interferon Gamma Release Assays (IGRA)

Tuberculosis (TB) is caused by the bacteria *Mycobacterium tuberculosis* and is an airborne disease that is spread from person to person via respiratory droplets. Thus identification of TB infected individuals is a major health concern in hospital and community infection control efforts. Many infected individuals remain asymptomatic with latent TB but can develop the disease months or years after exposure to the bacteria. These patients then become a source of TB transmission. The CDC estimates that 9-14 million US residents are infected with TB in its latent (non-symptomatic) phase.

Before 2001, the tuberculin skin test (TST) was the only available immunologic test for *Mycobacterium tuberculosis* infection approved in the United States. These have been used worldwide for more than a century in diagnosing both latent and active tuberculosis. A valid TST requires proper administration method, patients return to a health-care provider for test reading. Inaccuracies and bias exist in reading the test and false-positive TSTs can result from contact with nontuberculous mycobacteria or vaccination with Bacille Calmette-Guerin (BCG).

Recognition that interferon gamma (IFN-γ) played a critical role in regulating cell-mediated immune responses to *M. tuberculosis* infection led to the development of a blood test for the detection of *M. tuberculosis* infection by interferon gamma release assays (IGRAs). IGRAs detect sensitization to *M. tuberculosis* by measuring IFN-γ release in response to antigens representing *M. tuberculosis*. In 2001, the QuantiFERON-TB test (QFT) became the first IGRA approved by the Food and Drug Administration (FDA) as an aid for diagnosing *M. tuberculosis* infection. FDA approval was granted October 10, 2007 (P010033/S011) as a supplement to the original PMA application that was approved in December 2001. Another IGRA, the TSpot TB test, was granted approval by FDA on August 1, 2008.

In June 2010, CDC published *"Updated Guidelines for Using Interferon Gamma Release Assays to Detect Mycobacterium tuberculosis Infection — United States, 2010. Centers for Disease Control and Prevention, MMWR 2010;59/RR-5*. These guidelines stated that "TSTs and IGRAs (QFT-G, QFT-GIT, and T-Spot) may be used as aids in diagnosing *M. tuberculosis* infection. They may be used for surveillance purposes and to identify persons likely to benefit from treatment".

Currently there is no ICD-9-CM diagnosis code for positive finding for interferon gamma release assays (IGRA) for tuberculosis infection. Creating a unique ICD-9-CM diagnosis code for this test would improve diagnosis, increase recognition and ultimately advance the management of tuberculosis. The only ICD-9-CM code available for diagnosis of tuberculosis infection is for the tuberculin skin test, 795.5, Nonspecific reaction to tuberculin skin test without active tuberculosis.

TABULAR MODIFICATIONS

795 Other and nonspecific abnormal cytological, histological, immunological and DNA test findings

795.5 Nonspecific reaction to tuberculin skin test without active tuberculosis
Excludes: nonspecific reaction to cell mediated immunity measurement of gamma interferon antigen response without active tuberculosis (795.72)

795.7 Other nonspecific immunological findings

New code 795.72 Nonspecific reaction to cell mediated immunity measurement of gamma interferon antigen response without active tuberculosis

Add Excludes: nonspecific reaction to tuberculin skin test without active tuberculosis (795.5)

Add positive tuberculin skin test (795.5)

Atypical femoral fracture

The American Society for Bone and Mineral Research (ASBMR) is requesting changes to allow better coding of atypical femoral fractures. In recent years, there have been an increasing number of reports of atypical fractures of the subtrochanteric region of the hip and the femoral shaft in patients receiving long-term bisphosphonate therapy. A multi-disciplinary, international task force convened by the ASBMR to address key questions related to case definition, epidemiology and diagnostic imaging recommended that a specific ICD code be developed to assist in case finding, and advancing optimal surgical and medical management of these fractures.

According to the case definition developed by the ASBMR Task Force, in addition to their location in the subtrochanteric region of the hip or the femoral shaft, atypical femur fractures may be complete and extend across both cortices or incomplete, involving only the lateral cortex. They have several additional distinctive features:

1) transverse or short oblique orientation
2) association with minimal or no trauma
3) lack of comminution
4) cortical thickening that is either generalized or localized at the lateral cortex of the fracture site
5) periosteal reaction of the lateral cortex
6) medial spike when the fracture is complete
7) association with bisphosphonates and other medications, such as glucocorticoids

Currently ICD-9-CM does not have a specific diagnosis code that identifies fractures that have the atypical features, noted above. The term atypical is not used as a descriptor, in either the tabular or index, for fractures. Fractures of the femur are coded to either pathological (733.14-733.15), stress (733.96-733.97) or traumatic (categories 820 or 821). The lack of codes specific to atypical fractures creates difficulty for physicians and researchers trying to determine the true incidence of these fractures and their relationship to medications such as various bisphosphonates and glucocorticoids. The prevailing opinion is that these fractures are a form of stress fracture associated with osteoporosis and are usually non-traumatic or spontaneous or are associated with very minor injuries.

The ASBMR requested a specific ICD code for atypical femur fractures, specifically by expanding or adding to category 733, Other disorders of bone and cartilage rather than in the traumatic fractures category. It was desired to locate this new code with stress fractures, however, there is no room to expand at or near code 733.96 or 733.97, Stress fracture of shaft of femur, as they requested. There is also no room to create codes that reflect the distinctive atypical fracture features.

There is room to add a new code to subcategory 733.1, Pathologic fracture. It should be noted that there is an excludes note at that subcategory for stress and traumatic fractures. Though there is room to create a new code for atypical fractures in category 827, Other, multiple, and ill-defined fractures of lower limb, this option was rejected since these fractures are usually stress or pathologic.

There is also room to create a code for long term (current) use of bisphosphonates at V58.68. This may be useful data for epidemiological analysis. Additionally, external cause of injury codes for adverse effect of bisphosphonates are available (E933-E933.7) if there is any documentation in the record linking the fracture to the therapeutic use of these drugs. These were created a few years ago to allow coding osteonecrosis of the jaw due to use of bisphosphonates.

The proposal was also reviewed by the American Academy of Orthopaedic Surgeons (AAOS) who favored creating a new code at subcategory 733.1, Pathologic fracture. They stated that though these fractures are pathological (e.g.similar to fracture associated with osteomalacia) and/or stress related based on altered mineral-metabolism, the term atypical might be applied to many other, non-simple fracture patterns. This can be reviewed further.

TABULAR MODIFICATIONS

733 Other disorders of bone and cartilage

733.1 Pathologic fracture

New code 733.17 Atypical fracture of the subtrochanteric region and femoral shaft

Add Excludes: pathologic fracture of neck of femur (733.14)

Add pathologic fracture of other specified part of femur (733.15)

V58 Encounter for other and unspecified procedures and aftercare

V58.6 Long-term (current) drug use

New code V58.68 Long term (current) use of bisphosphonates

Severely calcified coronary lesions

Jeff Chambers, M.D. has submitted a proposal requesting a unique diagnosis code, in both ICD-9-CM and ICD-10-CM, to describe severely calcified coronary lesions. This will allow the ability to distinguish this coronary lesion from other ischemic coronary lesions and better track statistics relevant to the surgical and medical management of the disease.

Calcium is sometimes deposited in the coronary arteries and can be detected both by x-ray during coronary angiography and with intravascular ultrasound. Calcified lesions are more difficult to treat with angioplasty and stenting because the calcium deposits may block stents from reaching the desired location and may prevent the stent from fully expanding to the optimal size. Research has also shown that an increased amount of calcium deposits leads to a higher incidence of major adverse cardiac events, in particular the rate of non-Q wave myocardial infarction, when compared to non-calcified (e.g., lipid rich plaque) lesions.

There are no diagnosis codes currently available to describe severely calcified coronary lesions. There are diagnosis codes for chronic total occlusions (414.2, Chronic total occlusion of coronary artery and 440.4, Chronic total occlusion of artery of the extremities) however; chronic total occlusions are different than severely calcified lesions. There is a diagnosis code for coronary atherosclerosis due to lipid rich plaque (414.3,), however lipid rich plaque composition is very different from calcified plaque. Finally, there are two general diagnosis codes for chronic ischemic heart disease, 414.8 (Other specified forms of chronic ischemic heart disease) and 414.9, chronic ischemic heart disease, unspecified, however, these codes are too general to capture disease incidence associated with severely calcified coronary lesions (Type B Lesion classified by ACC/AHA, 1998) comprised of calcium deposits within the artery.

With the advent of interventional coronary techniques, tracking incidence of and other data associated with severely calcified coronary lesions is more important than ever. Additional time (physician, anesthesia, Cath Lab /procedure room) as well as physician skill is required when dealing with severely calcified lesions. Many interventional procedures, such as angioplasty and stent placement are not possible if the severely calcified coronary lesion cannot be crossed. In these cases, the transluminal procedure is discontinued. The patient may then have to be medically managed or a more invasive procedure, such as CABG may be required. Furthermore, most FDA approved drug eluting stent trials specifically exclude patients with severely calcified coronary lesions, further narrowing treatment options for these patients. Without a specific diagnosis code for this condition, hospital and physician coders are not able to identify such a condition that complicates immediate and ongoing patient care.

The requestor indicated that the finding of severely calcified coronary lesion(s) is typically documented by Interventional Cardiologists in their procedure notes and is tracked by the American College of Cardiology national data base, the PCI registry. It is being proposed to introduce a unique code for this condition as follows:

TABULAR MODIFICATIONS

414	Other forms of chronic ischemic heart disease	
New code	414.4	Coronary atherosclerosis due to severely calcified coronary lesion
Add		Code first coronary atherosclerosis (414.00-414.07)

Hepatopulmonary Syndrome

Hepatopulmonary Syndrome (HPS) is a complication of liver disease. It involves pulmonary microvascular dilation, with intrapulmonary shunting resulting in hypoxemia. The diagnosis may be made with contrast echocardiography, injecting agitated saline with microbubbles, that opacify the right ventricle, and if intrapulmonary shunting is present, opacify the left ventricle at least three heartbeats after the right. However, presence of other cardiovascular disease can make diagnosis difficult.

HPS is usually found in patients with chronic liver disease, particularly cirrhosis. Prevalence estimates range from 5 to 32% of chronic liver disease patients. However, it may also occur with acute ischemic hepatitis and with non-cirrhotic portal hypertension. HPS occurs in both pediatric and adult patients.

Patients with HPS and hypoxemia will often require oxygen supplementation. The only treatment effective long term for HPS related to chronic liver disease is liver transplant.

A specific code for HPS would ensure accurate reporting of the condition, provide data for research, and help reflect severity of illness and risk of mortality for this patient population. A request for this has been received from Northwestern Memorial Hospital, in Chicago, IL.

References:

Gaines DI, Fallon MB. Hepatopulmonary syndrome. Liver Int 2004;24:397-401.
Rodriguez-Roisin R, Krowka MJ. Hepatopulmonary syndrome--a liver-induced lung vascular disorder. N Engl J Med 2008;358:2378-2387.
Fuhrmann V, Madl C, Mueller C, Holzinger U, Kitzberger R, Funk GC, Schenk P. Hepatopulmonary syndrome in patients with hypoxic hepatitis. Gastroenterology 2006;131:69-75.

TABULAR MODIFICATIONS

572 Liver abscess and sequelae of chronic liver disease

572.8 Other sequelae of chronic liver disease

Add — Excludes: hepatopulmonary syndrome (573.5)

573 Other disorders of liver

New code — 573.5 Hepatopulmonary synrome

Code first underlying liver disease, such as:
Alcoholic cirrhosis of liver (571.2)
Cirrhosis of liver without mention of alcohol (571.5)

Infection Following Transfusion

Previously, proposals to address infections associated with transfusions at subcategory 999.3 have been presented in Sept. 2009 and Sept. 2010. However, concerns have been raised previously, initially related to the existing use additional code note at 999.3, that it could imply that this code should precede the code for HIV disease. Later concerns were raised about how this code should be used, whether just for acute cases, or for both acute and chronic cases. It was noted that these complication codes are primarily used for acute cases, rather than chronic or longer term.

As previously described, there are a number of infectious organisms (including bacteria, viruses, and parasites, among others) that may be transmitted through transfusion of blood or blood products (which include whole blood, RBCs, plasma, and platelets, among others).

A guideline could be created to specify that this code should be used for acute cases, not for chronic cases. Other notes could also be created to clarify that. One option would be to create a specific code for "Acute infection following transfusion, infusion, or injection of blood and blood products."

Currently there are no specific ICD-9-CM diagnosis codes for infections following transfusion. A request was received from the Food and Drug Administration (FDA) Center for Biologics Evaluation and Research (CBER) to create a unique code for infection following transfusion, as proposed here.

References
U.S. Biovigilance Network (http://www.cdc.gov/nhsn/PDFs/hemovigModuleProtocol_current.pdf)
Canadian transfusion safety surveillance system
(http://www.phac-aspc.gc.ca/hcai-iamss/tti-it/index-eng.php)

TABULAR MODIFICATIONS

Option 1

042 Human immunodeficiency virus [HIV] disease

Add Use additional code, if applicable, to identify infection following transfusion, infusion, or injection of blood and blood products (999.33)

999 Complications of medical care, not elsewhere classified

999.3 Other infection

Add Code first, if applicable, human immunodeficiency virus (HIV) disease (042)

New code 999.33 Infection following transfusion, infusion, or injection of blood and blood products

Revise 999.39 Infection following other infusion, injection, ~~transfusion,~~ or vaccination

Option 2

999 Complications of medical care, not elsewhere classified

999.3 Other infection

New code 999.33 Acute infection following transfusion, infusion, or injection of blood and blood products

Postoperative Respiratory Failure

Respiratory failure—frequently defined by the need for intubation or prolonged mechanical ventilation—is a relatively common postoperative complication, affecting an estimated 0.8 to 1.2% of all patients undergoing elective non-thoracic surgical procedures,[1] or approximately 32,000 cases annually in the US. Postoperative respiratory failure (PRF) also is associated with increased use of resources (e.g., hospitalization costs[2] and length of stay) and a seven-fold increase in mortality.[3] The risk of PRF can be reduced, but not eliminated, through evidence-based interventions such as preoperative smoking cessation and perioperative lung expansion exercises.[4] As a result, PRF has become a focus of several organizations that measure quality of care, including the Agency for Healthcare Research and Quality, the Surgical Quality Improvement Program and proposed by the Center for Medicare & Medicaid Services for its programs.

AHRQ identifies PRF based on existing diagnosis code 518.81 ("acute respiratory failure") or 518.84 ("acute and chronic respiratory failure"), or procedure codes for endotracheal intubation (96.04, dated one or more days after a major operating room [OR] procedure) or continuous mechanical ventilation (96.70 [unspecified duration] dated two or more days after a major OR procedure, or 96.72 [duration 96 consecutive hours or more] dated one or more days after a major OR procedure).

Respiratory failure that is specifically described as "due to trauma, surgery or shock" is indexed to 518.5 ("pulmonary insufficiency following trauma and surgery"). However, this code is much less specific than the codes for "acute respiratory failure" (518.81) and "acute and chronic respiratory failure" (518.84). For example, other conditions indexed to 518.5 include "shock lung," "drowned lung," "acute pulmonary (respiratory) insufficiency following shock (surgery)(trauma),"wet lung syndrome (adult)," "adult respiratory distress syndrome following trauma or surgery," and "acute idiopathic pulmonary congestion." Therefore, this code identified many patients who do not have acute respiratory failure, but instead have less severe respiratory complications that may only require supplemental oxygen or intensified observation.

AHRQ proposes that unique codes be added at 518.5 to distinguish postoperative acute respiratory failure from less severe respiratory complications of surgery or trauma, within the existing axis of ICD-9-CM codes. Additionally, current indexing of "shock lung" to 518.5, when the shock in question is unrelated to trauma or surgery, is confusing and contradicts the title of code 518.5 ("…following trauma and surgery"). In common usage, the term "shock lung" is used interchangeably with "adult respiratory distress syndrome" or "ARDS" in patients with nontraumatic shock, such as hemorrhagic shock due to gastrointestinal bleeding.

[1] McAlister FA, Bertsch K, Man J, et al. Incidence of and risk factors for pulmonary complications after nonthoracic surgery. Am J Respir Crit Care Med. 2005;171:514-7.
[2] Dimick JB, Chen SL, Taheri PA, et al. Hospital costs associated with surgical complications: a report from the private-sector National Surgical Quality Improvement Program. J Am Coll Surg. 2004;199:531-7.
[3] Money SR, Rice K, Crockett D, et al. Risk of respiratory failure after repair of thoracoabdominal aortic aneurysms. Am J Surg. 1994;168:152-5.
[4] Qaseem A, Snow V, Fitterman N, et al. Risk assessment for and strategies to reduce perioperative pulmonary complications for patients undergoing noncardiothoracic surgery: a guideline from the American College of Physicians. Ann Intern Med 2006;144:575–580.

TABULAR MODIFICATIONS

518 Other diseases of lung

518.5 Pulmonary insufficiency following trauma and surgery

New code 518.51 Acute respiratory failure following trauma and surgery
Respiratory failure, not otherwise specified, following trauma and surgery

Excludes:
Acute respiratory failure in other conditions (518.81)

New code trauma 518.52 Other pulmonary insufficiency, not elsewhere classified, following and surgery
Adult respiratory distress syndrome
Pulmonary insufficiency following:
surgery
trauma
Shock lung related to trauma and surgery

Excludes: adult respiratory distress syndrome associated with other conditions (518.82)
pneumonia:
aspiration (507.0)
hypostatic (514)
shock lung, not related to trauma or surgery (518.82)

New code surgery 518.53 Acute and chronic respiratory failure following trauma and

Excludes:
Acute and chronic respiratory failure in other conditions (518.84)

518.8 Other diseases of lung

Revise 518.81 Acute respiratory failure
Respiratory failure NOS
Excludes: acute and chronic respiratory failure (518.84)
acute respiratory distress (518.82)
chronic respiratory failure (518.83)
respiratory arrest (799.1)
respiratory failure, newborn (770.84)
acute respiratory failure following trauma and surgery (518.51)

Revise 518.82 Other pulmonary insufficiency, not elsewhere classified
Acute respiratory distress
Acute respiratory insufficiency
Adult respiratory distress syndrome NEC
Excludes: adult respiratory distress syndrome associated with trauma or surgery (518.52)
pulmonary insufficiency following trauma or surgery (518.52)
respiratory distress:
NOS (786.09)
newborn (770.89)
syndrome, newborn (769)
~~shock lung (518.5)~~

Revise

518.84 Acute and chronic respiratory failure
Acute on chronic respiratory failure
Excludes: acute and chronic respiratory failure following trauma or surgery (518.54)

Postoperative Shock

Shock is a complication that often arises after major surgery, and is therefore referred to as "postoperative shock" in this setting. Shock is not a disease, but a physiologic state characterized by decreased perfusion (i.e., hypoperfusion) of body tissues, resulting in decreased oxygen delivery and local imbalance between oxygen delivery and consumption. The effects of oxygen deprivation are initially reversible, but rapidly become irreversible: cell death, end-organ injury, multi-system organ failure, death. Manifestations of shock include low mean blood pressure (hypotension), tachycardia (in response to hypotension), cool and clammy (poorly perfused) skin, altered mental status, and decreased urine output (oliguria).[5]

In both surgical and nonsurgical patients, shock has several fundamentally different causes or mechanisms:

1. Hypovolemic shock (785.59) is attributable to loss of intravascular volume, which can result from either hemorrhage or severe dehydration. In the setting of trauma, the term "traumatic shock" (985.4) is commonly used.

2. Cardiogenic shock (785.51) is attributable to cardiac pump failure, which can result from myocardial infarction or systolic heart failure.

3. Distributive shock is attributable to dilation of systemic arterioles (vasodilation) with decreased vascular resistance. The most common subtypes are septic shock (785.52), due to severe infection with end-stage systemic inflammatory response syndrome, and anaphylactic shock (995.0), due to a severe allergic reaction.

Postoperative patients can experience any of these phenomena. For example, internal bleeding from poor surgical technique or disseminated intravascular coagulation may lead to hemorrhagic shock, which is treated with blood products. Postoperative volume shifts, also known as "third spacing," may lead to nonhemorrhagic hypovolemic shock, which is treated with intravenous fluids. Postoperative myocardial infarction may lead to cardiogenic shock, which is treated with inotropic agents to improve cardiac output. Postoperative infections originating in the wound, lungs, or blood/vascular catheter may lead to septic shock, which is treated with antibiotics and supportive care. In addition, different types of shock can coexist in postoperative patients. For example, patients with septic shock often have a hypovolemic component (due to vomiting and diarrhea), a cardiogenic component (due to myocardial dysfunction), and a distributive component (due to inflammation-related changes in vascular resistance and permeability).

Despite this complex clinical picture, most forms of postoperative shock are included at code 998.0 which interferes with national and regional efforts to identify patients who experience postoperative sepsis with shock, which is a particularly important postoperative complication. AHRQ has requested that unique codes be created to describe specific types or mechanisms of postoperative shock. The proposed coding structure is exactly parallel to the existing coding structure for "shock without mention of trauma" (785.5x). A less preferred option would be to add a "use additional code" note at 998.0 to require a code from subcategory 785.5x to describe the type of postoperative shock.

References:
1. Galeski D. Shock in adults: Types, presentation, and diagnostic approach. In www.uptodate.com , Section Editor
2. Parsons PE, Deputy Editor Wilson KC. Last literature review version 18.2: May 2010.
3. Moore LJ, Moore FA, Todd SR, Jones SL, Turner KL, Bass BL. Sepsis in general surgery. The 2005-2007 National Surgical Quality Improvement Program Perspective. *Arch Surg* 2010; 145(7):695-700.
4. Khuri SF, Henderson WG, DePalma RG, Mosca C, Healey NA, Kumbhani DJ, and the participants in the VA National Surgical Quality Improvement Program. Determinants of long-term survival after major surgery and the adverse effect of postoperative complications. *Ann Surg* 2005; 242(3):326-41.
5. Ghaferi AA, Birkmeyer JD, Dimick JB. Variation in hospital mortality associated with inpatient surgery. *N Engl J Med* 2009; 361:1368-1375

TABULAR MODIFICATIONS

Option 1:

998 Other complications of procedures, not elsewhere classified

New Subcategory

998.0 Postoperative shock

~~Collapse, not otherwise specified, during or resulting from a surgical procedure~~
Shock ~~(endotoxic)(hypovolemic)(septic),~~ during or resulting from a surgical procedure

New code

998.00 Postoperative shock, unspecified
Collapse, not otherwise specified, during or resulting from a surgical procedure

Failure of peripheral circulation (postoperative)

New code

998.01 Postoperative shock, cardiogenic

New code

998.02 Postoperative shock, septic

Endotoxic (postoperative)

Gram-negative (postoperative)

Code first systemic inflammatory response syndrome due to infectious process with organ dysfunction (995.92)

New code

998.09 Postoperative shock, other
Postoperative hypovolemic shock

Drug-Induced Pancytopenia

There have been a number of changes related to pancytopenia in ICD-9-CM. However, the issue has been raised that at this time, drug induced pancytopenia would be coded to 284.89, Other specified aplastic anemias. However, pancytopenia related to drugs would not necessarily by related to aplastic anemia. To better handle such cases, it is proposed to create a specific code, 284.11, Drug induced pancytopenia, although aplastic anemia due to drugs should still be excluded to code 284.89. At the same time, it is proposed to create a code 284.19, Other pancytopenia. This issue was raised related to questions to the Editorial Advisory Board for Coding Clinic.

TABULAR MODIFICATIONS

284 Aplastic anemia and other bone marrow failure syndromes

284.1 Pancytopenia

Excludes: pancytopenia (due to) (with):

Delete ~~drug induced (284.89)~~

New code 284.11 Drug induced pancytopenia

Excludes: aplastic anemia due to drugs (284.89)

New code 284.19 Other pancytopenia

Hypertrophic Cardiomyopathy

Hypertrophic cardiomyopathy can have two levels of manifestation, obstructive or nonobstructive. Whether or not it is obstructive can impact the need for different medical or surgical treatments.

In ICD-9-CM, code 425.1 is Hypertrophic obstructive cardiomyopathy. Hypertrophic cardiomyopathy that is nonobstructive, or not described as obstructive, is currently coded to 425.4, Other primary cardiomyopathies.

Jerre F. Lutz, MD, of the Emory Clinic, has proposed restructuring 425.1 as a subcategory, and moving hypertrophic cardiomyopathy not specified as obstructive to this subcategory, giving it a new code.

TABULAR MODIFICATIONS

425 Cardiomyopathy

Revise 425.1 Hypertrophic ~~obstructive~~ cardiomyopathy
Delete ~~Hypertrophic subaortic stenosis (idiopathic)~~

Add Excludes: ventricular hypertrophy (429.3)

New code 425.11 Hypertrophic obstructive cardiomyopathy
Hypertrophic subaortic stenosis (idiopathic)

New code 425.12 Other hypertrophic cardiomyopathy
Nonobstructive hypertrophic cardiomyopathy

425.4 Other primary cardiomyopathies
Cardiomyopathy:
Delete ~~hypertrophic~~
Delete ~~nonobstructive~~

Acute Interstitial Pneumonitis

Acute interstitial pneumonitis (AIP) is a rapidly progressive form of interstitial pneumonia, with a distinct histopathology described as an organizing diffuse alveolar damage, identical to the pattern found in acute respiratory distress syndrome (ARDS) caused by sepsis and shock. The term acute interstitial pneumonitis is reserved for cases of unknown cause. Some of the cases described by Hamman and Rich in 1944 probably represented AIP; Hamman-Rich syndrome is now considered to be synonymous with AIP.

Acute interstitial pneumonitis may also be referred to as “acute interstitial pneumonia.” This topic was presented previously in September 2010 with that title. However, concerns were raised about the potential use of the term “acute interstitial pneumonia” when referring to certain bacterial pneumonias, with atypical appearance on x-rays that might be described as an interstitial process.

The term “acute interstitial pneumonia” is indexed in ICD-9-CM to code 136.3, Pneumocystosis. The histologic pattern in AIP of diffuse alveolar damage may also occur due to Pneumocystis carinii pneumonia, as well as due to a number of other potential causes. However, at this time, based on the 2001 consensus s statement of the American Thoracic Society and the European Respiratory Society, the term “acute interstitial pneumonia” should be reserved for cases of unknown cause, and thus represents a specific idiopathic interstitial pneumonia. To avoid confusion, the indexing for the term “acute interstitial pneumonia” will be updated, to reflect the various possible meanings.

The American Thoracic Society (ATS) and the American College of Chest Physicians (ACCP) have requested creation of a specific code for AIP, as well as for a number of other interstitial lung diseases. AIP has a different course, and a less favorable prognosis than other idiopathic interstitial pneumonias, and thus needs to be distinguished from them. A specific code will facilitate epidemiological, clinical, comparative effectiveness and cost effectiveness research.

References

Bouros D, Nicholson AC, Polychronopoulos V, du Bois RM. Acute interstitial pneumonia. Eur Respir J. 2000 Feb;15(2):412-8. (Available here: http://erj.ersjournals.com/cgi/reprint/15/2/412.)

"American Thoracic Society/European Respiratory Society International Multidisciplinary Consensus Classification of the Idiopathic Interstitial Pneumonias" http://ajrccm.atsjournals.org/cgi/content/full/165/2/277.

TABULAR MODIFICATIONS

516 Other alveolar and parietoalveolar pneumonopathy

Revise 516.3 Idiopathic ~~fibrosing alveolitis~~ interstitial pneumonia

New code 516.33 Acute interstitial pneumonitis
Hamman Rich syndrome

Excludes: Pneumocystis pneumonia (136.3)

518 Other diseases of lung

518.8 Other diseases of lung

518.82 Other pulmonary insufficiency, not elsewhere classified

Add Excludes: acute interstitial pneumonitis (516.33)

INDEX MODIFICATIONS

Pneumonia…
…
interstitial 516.8
…
Revise acute ~~136.3~~
Add due to Pneumocystis (carinii) (jiroveci) 136.3
meaning:
acute interstitial pneumonitis (516.33)
atypical pneumonia – see Pneumonia, atypical
bacterial pneumonia – see Pneumonia, bacterial

Pneumothorax and Air Leak

The term “postoperative air leak” is currently indexed in ICD-9-CM to code 512.1, iatrogenic pneumothorax. However, concern has been raised about this, as one can have a postoperative air leak without significant air in the pleural space, since chest tubes are often placed following procedures where this is a risk. A specific code for postoperative air leak has been proposed by the American College of Surgeons, as well as additional specific codes as further described.

There is also the issue of a persistent air leak which is not postoperative, such as when a chest tube has been placed for a primary spontaneous pneumothorax and the lung re-expands but the air leak persists. That is a relatively frequent occurrence, but the leak usually shuts off in a few days. When it persists, that is an indication for a surgical intervention, usually thoracoscopic.

Spontaneous pneumothorax may be primary, or secondary and thus related to various other conditions. It was proposed to differentiate these. Some causes of secondary pneumothorax include cystic fibrosis, spontaneous rupture of the esophagus, Marfan’s syndrome, lymphangioleiomyomatosis, metastatic cancer, primary lung cancer, catamenial, pneumocystis carinii pneumonia, and eosinophilic pneumonia.

TABULAR MODIFICATIONS

Revise 512 Pneumothorax and air leak

New code 512.2 Postoperative air leak

Revise 512.8 Other spontaneous pneumothorax and air leak
Delete ~~Pneumothorax:~~
Delete ~~NOS~~
Delete ~~acute~~
Delete ~~chronic~~

New code 512.81 Primary spontaneous pneumothorax

New code 512.82 Secondary spontaneous pneumothorax

Code first underlying condition, such as:
cancer metastatic to lung (197.0)
catamenial pneumothorax due to endometriosis (617.8)
cystic fibrosis (277.02)
eosinophilic pneumonia (518.3)
lymphangioleiomyomatosis (516.4)
Marfan syndrome (759.82)
pneumocystis carinii pneumonia (136.3)
primary lung cancer (162.3-162.9)
spontaneous rupture of the esophagus (530.4)

New code 512.83 Other air leak
Persistent air leak

New code 512.89 Other pneumothorax
acute pneumothorax
chronic pneumothorax
pneumothorax NOS
spontaneous pneumothorax NOS

Thalassemia

Thalassemia is a family of inherited hemoglobinopathies which in severest form require life-long blood transfusions for survival. The subsequent iron overload can lead to multisystem complications. It is a complex disease with multiple genotype combinations leading to a wide spectrum of phenotypes. There have been many recent advances in the care of these patients including new iron chelators and new technology for the management of the complications (e.g., MRI assessment of iron burden). However, because transfusion-dependent anemias are rare in the US, disseminating this new information to providers across the U.S. is often very slow. For 2010, there is no accurate estimate of the number of symptomatic thalassemia patients in the U.S. Key groups involved in care of patients with severe thalassemia (CDC, NHLBI, and the patient advocacy group, the Cooley's Anemia Foundation) recognize that there is probably a significant number of patients scattered all over the U.S. that have not been accounted for and may be receiving care by non-expert-center providers. Attempts to locate these patients have been made through the Cooley's Anemia Foundation and informal networks but has not yielded large numbers of new patients.

Currently there is a single ICD-9-CM code (242.49) to capture all non-sickle cell related thalassemias. This one code includes the entire spectrum from asymptomatic patients (silent carrier or thalassemia trait) to patients with severe disease (thalassemia major).

Attempts to search large administrative databases (e.g., hospital systems, state or federal systems) would be fruitless using the single code, as the vast majority of patients with that code would be asymptomatic thalassemia trait patients. There is a new network of several states funded under the RuSH grant through the CDC and NIH trying to determine the true number of patients in the U.S. affected by hemoglobinopathies, including thalassemia. Having ICD-9-CM codes that more accurately describe these patients would help tremendously toward this important aim. Identifying who has trait vs disease has important public health implications for surveillance of populations and genetics for future generations. There is currently no way to disentangle the millions of asymptomatic thalassemia trait persons from the thousands of patients with disease. These patients represent both high public health and research utilization, because they require life-long monthly blood transfusions, iron overload monitoring, chelation therapy, and they are candidates for hematopoetic stem cell transplant. Tracking those who have real disease will help blood banks, hospitals, state insurance programs, and others to plan for use of health care resources.

The Thalassemia Clinical Research Group/Cooley's Anemia Foundation and the American Academy of Pediatrics have requested expedited consideration for expansion of the codes for Thalassemia in ICD-9-CM. While this problem is addressed in ICD-10-CM, concern is raised that the delay in having these codes in place in the existing ICD-9-CM would have a deleterious effect in the tracking and study of this condition.

TABULAR MODIFICATIONS

282 Hereditary hemolytic anemias

282.4 Thalassemias

New code	282.40	Thalassemia, unspecified
	282.41	Sickle-cell thalassemia without crisis
Add		Microdrepanocytosis

New code

282.43 Alpha thalassemia
Alpha thalassemia major
Hemoglobin H disease
Hemoglobin H Constant Spring
Severe alpha thalassemia
Triple gene defect alpha thalassemia

Excludes:
Alpha thalassemia trait or minor (282.46)
Hydrops fetalis due to isoimmunization (773.3)
Hydrops fetalis not due to immune hemolysis (778.0)

New code

282.44 Beta thalassemia
Beta thalassemia major
Cooley's anemia
Homozygous beta thalassemia
Severe beta thalassemia
Thalassemia intermedia
Thalassemia major

Excludes
Beta thalassemia minor (282.46)
Beta thalassemia trait (282.46)
Delta-beta thalassemia (282.45)
Hemoglobin E beta thalassemia (282.47)
Sickle-cell beta thalassemia (282.41, 282.42)

New code

282.45 Delta-beta thalassemia
Homozygous delta-beta thalassemia

Excludes:
Delta-beta thalassemia trait (282.46)

New code 282.46 Thalassemia minor
Alpha thalassemia minor
Alpha thalassemia trait
Alpha thalassemia silent carrier
Beta thalassemia minor
Beta thalassemia trait
Delta-beta thalassemia trait
Thalassemia trait NOS
Excludes:
Alpha thalassemia (282.43)
Beta thalassemia (282.44)
Delta beta thalassemia (282.45)
Hemoglobin E-beta thalassemia (282.47)
Sickle-cell trait (282.5)

New code 282.47 Hemoglobin E-beta thalassemia
Excludes:
Beta thalassemia (282.44)
Beta thalassemia minor (282.46)
Beta thalassemia trait (282.46)
Delta-beta thalassemia (282.45)
Delta-beta thalassemia trait (282.46)
Hemoglobin E disease (282.7)
Other hemoglobinopathies (282.7)
Sickle-cell beta thalassemia (282.41, 282.42)

282.49 Other thalassemia
Delete ~~Cooley's anemia~~
Add Dominant thalassemia
Add Hemoglobin Bart's Disease
Add Hemoglobin C thalassemia
Delete ~~Microdrepanocytosis~~
Add Mixed thalassemia
Revise Thalassemia ~~(alpha) (beta) (intermedia) (major) (minima) (minor) (mixed) (trait) (~~with other hemoglobinopathy~~)~~
Delete ~~Thalassemia NOS~~
Add Excludes:
Add Hemoglobin C disease (282.7)
Add Hemoglobin E disease (282.7)
Add Other hemoglobinopathies (282.7)
Add Sickle cell anemias (282.6)
Add Sickle-cell beta thalassemia (282.41-282.42)

282.7 Other hemoglobinopathies

Add Excludes: hemoglobin E-beta thalassemia (282.47)
Add other hemoglobinopathies with thalassemia (282.49)

INDEX MODIFICATIONS

Anemia …
Revise microdrepanocytosis 282.41 ~~282.49~~

Disease …
Revise microdrepanocytic 282.41 ~~282.49~~

Revise Microdrepanocytosis (thalassemia-Hb-S disease) 282.41 ~~282.49~~
Add with sickle cell crisis 282.42

Infection Due to Central Venous Catheter

Central line-associated bloodstream infections (CLABSI) are common, with an estimated 250,000 cases occuring in hospitals in the United States. These cause significantly longer hospitalizations and resource use. Such infections are currently indexed to 999.31, “Infection due to central venous catheter.” However, there are two major categories of infections due to central venous catheters: local and systemic. The existing code does not distinguish between central line-associated bloodstream infections, which are systemic, and local infections. These
have very different clinical and epidemiologic implications.

A variety of local catheter infections can occur, including exit or insertion site infections, port or reservoir infections, and tunnel infections. Signs of infection may involve purulent discharge, and localized findings such as pain, erythema, or tenderness may also be present. In exit site infections, these are found at the catheter exit or insertion site. Port or reservoir infections are associated with implantable venous access devices, with signs involving the skin over the reservoir; there also may be a purulent exudate within the reservoir or in the subcutaneous pocket around it. A tunnel infection involves the area where the catheter runs underneath the skin. Signs of exit site inflammation or infection may or may not be present.

The Central Line Associated Bloodstream Infections have been carefully defined by the Centers for Disease Control and Prevention as part of its National Healthcare Safety Network (NHSN), as laboratory-confirmed bloodstream infections (LCBI) that are not secondary to an infection at another site (see reference for Central Line-Associated Bloodstream Infection (CLABSI) Event).

The primary target of current surveillance and prevention efforts is catheter-related bloodstream infection. However, use of the same code (999.31) for local catheter infections and bloodstream infections interferes with national and regional efforts to identify patients who experience central line-associated bloodstream infections, which are a particularly important complication of health care.

In addition, the current ICD-9-CM tabular language does not use the currently preferred term “central line-associated bloodstream infection.” This term has a broader, more surveillance-oriented meaning than previous terms. The surveillance definition includes all BSIs that occur in patients with CVCs, when other sites of infection have been excluded. This overestimates the true incidence of catheter-related BSI, because not all BSIs originate from a catheter.

This proposal from AHRQ is intended to address these issues.

References:

Guidelines for the Prevention of Intravascular Catheter-Related Infections, MMWR, August 9, 2002 / 51(RR10);1-26.

Reduction in Central Line--Associated Bloodstream Infections Among Patients in Intensive Care Units --- Pennsylvania, April 2001--March 2005, MMWR, October 14, 2005 / 54(40);1013-1016.

Central Line-Associated Bloodstream Infection (CLABSI) Event, Device-Associated Module, CLABSI.
http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf

TABULAR MODIFICATIONS

996 Complications peculiar to certain specified procedures

996.6 Infection and inflammatory reaction due to internal prosthetic device, implant, and graft

996.62 Due to vascular device, implant and graft

Excludes: infection due to:

Revise central venous catheter (999.31-999.32)
Revise Hickman catheter (999.31-999.32)
Revise peripherally inserted central catheter (PICC) (999.31-999.32)
Revise portacath (port-a-cath) (999.31-999.32)
Revise triple lumen catheter (999.31-999.32)
Revise umbilical venous catheter (999.31-999.32)

999 Complications of medical care, not elsewhere classified

999.3 Other infection

Revise 999.31 Bloodstream infection ~~Infection~~ due to central venous catheter
Revise bloodstream infection due to:
Hickman catheter
Revise ~~Peripherally~~ peripherally inserted central catheter (PICC)
portacath (port-a-cath)
Delete ~~Portacath~~
Revise ~~Triple~~ triple lumen catheter
umbilical venous catheter
Add central line-associated bloodstream infection
Add infection due to central venous catheter, unspecified

New code	999.32	Local infection due to central venous catheter exit or insertion site infection local infection due to: Hickman catheter peripherally inserted central catheter (PICC) portacath (port-a-cath) triple lumen catheter umbilical venous catheter port or reservoir infection tunnel infection

Atrial Fibrillation and Flutter

Atrial fibrillation is an abnormal irregularly irregular heart rhythm in which the atria do not have the regular, coordinated contractions they normally do. On electrocardiogram (ECG), there is an absence of P waves, with irregular oscillations instead, and ventricular response is often rapid. Blood clots can form in the atria, and then embolize, potentially causing a stroke or other vascular problem. Atrial fibrillation is the most common abnormal heart rhythm.

In 2001, the American College of Cardiology (ACC), the American Heart Association (AHA), and the European Society of Cardiology (ESC) released guidelines for treatment of patients with atrial fibrillation. This also described classification of atrial fibrillation. It recommended distinguishing first-detected episodes of atrial fibrillation from those that are recurrent. Paroxysmal atrial fibrillation involves episodes that terminate spontaneously within 7 days (most less than one day). Persistent atrial fibrillation is sustained generally for over 7 days; it may be terminated by drug therapy or electrical cardioversion. Long standing persistent atrial fibrillation is persistent atrial fibrillation that has been present for a year or more, but that is still susceptible to being terminated by cardioversion or other procedures such as ablation. Permanent atrial fibrillation is long standing (over a year), with attempts to terminate it unsuccessful or not indicated or attempted. These terms apply for atrial fibrillation that is not related to a reversible cause. If it is secondary to a treatable underlying condition, then it would be considered separately, as such treatment will usually eliminate the arrhythmia. Causes of secondary atrial fibrillation may include acute myocardial infarction, cardiac surgery, pericarditis, myocarditis, hyperthyroidism, pulmonary embolism, pneumonia, and acute pulmonary disease.

Atrial flutter is a reentrant heart rhythm, where the wave of activation through the atria makes a circuit (typically in the right atrium) that re-activates a region that has just shortly before contracted, and this continues at a fast rate. On ECG, this shows up as a saw tooth pattern with a rate of close to 300 beats per minute, instead of normal P waves. The ventricular response is usually regular, often in a ratio of 2 atrial beats to one ventricular beat, although it may range to 4 to 1. The ventricular rate may be close to 150 beats per minute, or lower if the conduction ratio is higher. In typical atrial flutter, the reentrant circuit involves conduction around the tricuspid annulus, usually in a counterclockwise direction. Atypical atrial flutter involves a reentrant circuit in some other atrial location.

Atrial fibrillation and atrial flutter may frequently coexist, and either one may spontaneously convert to the other in some cases.

A request was received from Medtronic to create specific codes for the specific types of atrial fibrillation, based on the classification used by the ACC/AHA/ESC. Also, WHO will be making changes in ICD-10, that will overlap with these changes.

References:

ACC/AHA/ESC Guidelines for the Management of Patients With Atrial Fibrillation, JACC 38 (4) 2001, 1266i-lxx.

Braunwald's Heart Disease - A Textbook of Cardiovascular Medicine, 9th ed., 2011. F Morady, DP Zipes; Chapter 40 – Atrial Fibrillation : Clinical Features, Mechanisms, and Management.

TABULAR MODIFICATIONS for ICD-9-CM

427 Cardiac dysrhythmias

427.3 Atrial fibrillation and flutter

Revise	427.31	Atrial fibrillation, unspecified
	427.32	Atrial flutter
New code	427.33	Paroxysmal atrial fibrillation
New code	427.34	Persistent atrial fibrillation
New code	427.35	Long standing persistent atrial fibrillation
New code	427.36	Permanent atrial fibrillation
New code	427.39	Other atrial fibrillation acute atrial fibrillation first episode atrial fibrillation secondary atrial fibrillation

Code first, if applicable, underlying etiology

TABULAR MODIFICATIONS for ICD-10-CM

I48 Atrial fibrillation and flutter

Revise	I48.0		<u>Paroxysmal</u> Atrial fibrillation
Revise	I48.1		Persistent atrial fibrillation ~~Atrial flutter~~
New code		I48.11	Long standing persistent atrial fibrillation
New code		I48.19	Other persistent atrial fibrillation
New subcategory	I48.2		Chronic and permanent atrial fibrillation
New code		I48.20	Chronic atrial fibrillation Long standing atrial fibrillation
			Excludes: long standing persistent atrial fibrillation (I48.11)
New code		I48.21	Permanent atrial fibrillation
New code	I48.3		Typical atrial flutter
New code	I48.4		Atypical atrial flutter
New code	I48.8		Other atrial fibrillation acute atrial fibrillation first episode atrial fibrillation secondary atrial fibrillation
			Code first, if applicable, underlying etiology
New subcategory	I48.9		Atrial fibrillation and atrial flutter, unspecified
New code		I48.90	Atrial fibrillation, unspecified
New code		I48.91	Atrial flutter, unspecified

Novel Influenza

Influenza causes significant morbidity and mortality worldwide. New forms can threaten to spread widely, with little existing immunity in populations. Novel influenza A is a nationally reportable disease. It includes all human infections with influenza A viruses that are different from currently circulating human influenza viruses. These include viruses subtyped as nonhuman in origin, and those that are unsubtypable with standard laboratory methods. The 2009 pandemic influenza is now regularly referred to as 2009 H1N1 influenza, rather than novel H1N1 influenza. Changes to ICD-9-CM for novel influenza have been recommended by the CDC National Center For Immunization and Respiratory Diseases (NCIRD).

TABULAR MODIFICATIONS for ICD-9-CM

488 Influenza due to certain identified influenza viruses

Revise Excludes: influenza caused by unspecified or seasonal influenza viruses (487.0-487.8)

Revise 488.1 Influenza due to identified ~~novel~~ 2009 H1N1 influenza virus
Revise 2009 H1N1 ~~[swine]~~ swine influenza virus
Revise ~~Novel~~ (Novel) 2009 influenza H1N1
Delete ~~Swine flu~~

Add Excludes: bird influenza virus infection (488.01-488.09)
Add swine influenza virus infection (488.81-488.89)
Add influenza A/H5N1 (488.01-488.09)
Add other human infection with influenza virus of animal origin (488.81-488.89)

Revise 488.11 Influenza due to identified ~~novel~~ 2009 H1N1 influenza virus with pneumonia
Revise Influenza due to identified ~~novel~~ (novel) 2009 H1N1 with pneumonia, any form
Revise ~~Novel~~ (Novel) 2009 H1N1 influenzal:
bronchopneumonia
pneumonia

Revise 488.12 Influenza due to identified ~~novel~~ 2009 H1N1 influenza virus with other respiratory manifestations
Revise ~~Novel~~ (Novel) 2009 H1N1 influenza NOS
Revise ~~Novel~~ (Novel) 2009 H1N1 influenzal:
laryngitis
pharyngitis
respiratory infection (acute) (upper)

Revise 488.19 Influenza due to identified ~~novel~~ 2009 H1N1 influenza virus with other manifestations

Revise — Encephalopathy due to identified (novel) 2009 H1N1 influenza

Revise — (Novel) 2009 H1N1 influenza with involvement of gastrointestinal tract

New subcategory 488.8 Influenza due to novel influenza A
Influenza due to animal origin influenza virus
Infection with influenza viruses occurring in pigs or other animals
Other novel influenza A viruses not previously found in humans

Excludes: bird influenza virus infection (488.01-488.09)
influenza due to identified 2009 H1N1 influenza virus (488.11-488.19)

New code 488.81 Influenza due to identified novel influenza A virus with pneumonia
Influenza due to animal origin influenza virus with pneumonia, any form
Novel influenza A:
- bronchopneumonia
- pneumonia

Use additional code to identify the type of pneumonia (480.0-480.9, 481, 482.0-482.9, 483.0-483.8, 485)

New code 488.82 Influenza due to identified novel influenza A virus with other respiratory manifestations
Influenza due to animal origin influenza A virus with other respiratory manifestations
Novel influenza A:
- laryngitis
- pharyngitis
- respiratory infection (acute) (upper)

New code 488.89 Influenza due to identified novel influenza A virus with other manifestations
Encephalopathy due to novel influenza A
Influenza due to animal origin influenza virus with encephalopathy
Influenza due to animal origin influenza virus with involvement of gastrointestinal tract
Novel influenza A with involvement of gastrointestinal tract

Excludes: "intestinal flu" [viral gastroenteritis] (008.8)

TABULAR MODIFICATIONS for ICD-10-CM

J09 Influenza due to certain identified influenza viruses

Add Excludes1: seasonal influenza due to other identified influenza virus (J10.-)
Add seasonal influenza due to unidentified influenza virus (J11.-)

Delete ~~J09.0 Influenza due to identified avian influenza virus~~
Delete ~~Avian influenza~~
Delete ~~Bird flu~~
Delete ~~Influenza A/H5N1~~

Delete ~~J09.01 Influenza due to identified avian influenza virus with pneumonia~~
Delete ~~Code also associated lung abscess, if applicable (J85.1)~~

Delete ~~J09.010 Influenza due to identified avian influenza virus with identified avian influenza pneumonia~~

Delete ~~J09.018 Influenza due to identified avian influenza virus with other specified type of pneumonia~~
Delete ~~Code also the specified type of pneumonia~~

Delete ~~J09.019 Influenza due to identified avian influenza virus with unspecified type of pneumonia~~

Delete ~~J09.02 Influenza due to identified avian influenza virus with other respiratory manifestations~~
Delete ~~Influenza due to identified avian influenza virus NOS~~
Delete ~~Influenza due to identified avian influenza virus with laryngitis~~
Delete ~~Influenza due to identified avian influenza virus with pharyngitis~~
Delete ~~Influenza due to identified avian influenza virus with upper respiratory symptoms~~
Delete ~~Use additional code for associated pleural effusion, if applicable (J91.8)~~
Delete ~~Use additional code for associated sinusitis, if applicable (J01.-)~~

Delete ~~J09.03 Influenza due to identified avian influenza virus with gastrointestinal manifestations~~
Delete ~~Influenza due to identified avian influenza virus gastroenteritis~~
Delete ~~Excludes1: "intestinal flu" [viral gastroenteritis] (A08.-)~~

Delete ~~J09.09 Influenza due to identified avian influenza virus with other manifestations~~

Delete ~~J09.090 Influenza due to identified avian influenza virus with encephalopathy~~

Delete ~~J09.091 Influenza due to identified avian influenza virus with myocarditis~~

Delete ~~J09.092 Influenza due to identified avian influenza virus with otitis media~~

Delete ~~Use additional code for any associated perforated tympanic membrane (H72.-)~~

Delete ~~J09.098 Influenza due to identified avian influenza virus with other manifestations~~

Delete ~~Use additional codes to identfy the manifestations~~

Delete ~~J09.1 Influenza due to identified novel H1N1 influenza virus~~

Delete ~~2009 H1N1 [swine] influenza virus~~

Delete ~~Novel 2009 influenza H1N1~~

Delete ~~Novel H1N1 influenza~~

Delete ~~Novel influenza A/H1N1~~

Delete ~~Swine flu~~

Delete ~~J09.11 Influenza due to identified novel H1N1 influenza virus with pneumonia~~

Delete ~~Code also associated lung abscess, if applicable (J85.1)~~

Delete ~~J09.110 Influenza due to identified novel H1N1 influenza virus with identified novel H1N1 influenza pneumonia~~

Delete ~~J09.118 Influenza due to identified novel H1N1 influenza virus with other specified type of pneumonia~~

Delete ~~J09.119 Influenza due to identified novel H1N1 influenza virus with unspecified type of pneumonia~~

Delete ~~J09.12 Influenza due to identified novel H1N1 influenza virus with other respiratory manifestations~~

Delete ~~Influenza due to identified novel H1N1 influenza virus NOS~~

Delete ~~Influenza due to identified novel H1N1 influenza virus with laryngitis~~

Delete ~~Influenza due to identified novel H1N1 influenza virus with pharyngitis~~

Delete ~~Influenza due to identified novel H1N1 influenza virus with upper respiratory symptoms~~

Delete ~~Use additional code for associated pleural effusion, if applicable (J91.8)~~

Delete ~~Use additional code for associated sinusitis, if applicable (J01.-)~~

Delete ~~J09.13 Influenza due to identified novel H1N1 influenza virus with gastrointestinal manifestations~~
Delete ~~Influenza due to identified novel H1N1 influenza virus gastroenteritis~~
Delete ~~Excludes1: "intestinal flu" [viral gastroenteritis] (A08.)~~

Delete ~~J09.19 Influenza due to identified novel H1N1 influenza virus with other manifestations~~
Delete ~~J09.190 Influenza due to identified novel H1N1 influenza virus with encephalopathy~~
Delete ~~J09.191 Influenza due to identified novel H1N1 influenza virus with myocarditis~~
Delete ~~J09.192 Influenza due to identified novel H1N1 influenza virus with otitis media~~
Delete ~~Use additional code for any associated perforated tympanic membrane (H72.)~~

Delete ~~J09.198 Influenza due to identified novel H1N1 influenza virus with other manifestations~~
Delete ~~Use additional codes to identify the manifestations~~

New subcategory J09.X Influenza due to identified novel influenza A virus
Avian influenza
Bird influenza
Influenza A/H5N1
Influenza of other animal origin, not bird or swine
Swine influenza virus (viruses that normally cause infections in pigs)

New code J09.X1 Influenza due to identified novel influenza A virus with pneumonia
Code also, if applicable, associated:
lung abscess (J85.1)
other specified type of pneumonia

New code J09.X2 Influenza due to identified novel influenza A virus with other respiratory manifestations
Influenza due to identified novel influenza A virus NOS
Influenza due to identified novel influenza A virus with laryngitis
Influenza due to identified novel influenza A virus with pharyngitis
Influenza due to identified novel influenza A virus with upper respiratory symptoms
Use additional code , if applicable, for associated:
pleural effusion (J91.8)
sinusitis (J01.-)

New code J09.X3 Influenza due to identified novel influenza A virus with gastrointestinal manifestations
Influenza due to identified novel influenza A virus gastroenteritis
Excludes1: "intestinal flu" [viral gastroenteritis] (A08.-)

New code J09.X9 Influenza due to identified novel influenza A virus with other manifestations
Influenza due to identified novel influenza A virus with encephalopathy
Influenza due to identified novel influenza A virus with myocarditis
Influenza due to identified novel influenza A virus with otitis media
Influenza due to identified novel influenza A virus with other manifestations
Use additional codes to identify the manifestations

ICD-9-CM TABULAR LIST OF DISEASES
PROPOSED ADDENDA (Effective October 1, 2011)

099 Other venereal diseases

099.3 Reiter's disease

Add Reactive arthritis

209 Neuroendocrine tumors

209.7 Secondary neuroendocrine tumors

209.71 Secondary neuroendocrine tumor of distant lymph nodes

Delete ~~Mesentery metastasis of neuroendocrine tumor~~

209.74 Secondary neuroendocrine tumor of peritoneum

Add Mesentery metastasis of neuroendocrine tumor

294 Persistent mental disorders due to conditions classified elsewhere

294.1 Dementia in conditions classified elsewhere

Code first any underlying physical condition as:

Delete ~~dementia in:~~

Add Parkinson's disease (332.0)

Revise Category Title ~~MENTAL RETARDATION~~ INTELLECTUAL DISABILITIES (317-319)

Revise 317 ~~Mild mental retardation~~Mild intellectual disabilities

Revise 318 Other specified ~~mental retardation~~intellectual disabilities

Revise 318.0 Moderate ~~mental retardation~~intellectual disabilities

Revise 318.1 Severe ~~mental retardation~~intellectual disabilities

Revise 318.2 Profound ~~mental retardation~~intellectual disabilities

Revise 319 Unspecified ~~mental retardation~~intellectual disabilities

345 Epilepsy and recurrent seizures

345.8 Other forms of epilepsy and recurrent seizures

Delete ~~Seizure disorder NOS~~

345.9 Epilepsy, unspecified

Delete ~~Recurrent seizures NOS~~

514 Pulmonary congestion and hypostasis

Revise Excludes: hypostatic pneumonia due to or specified as a specific type of pneumonia - code to the type of pneumonia (480.0-480.9, 481, 482.0-482.9, 483.0-483.8, 485, ~~486,~~ 487.0, 488.01, 488.11)

ICD-9-CM INDEX TO DISEASES AND INJURIES
PROPOSED ADDENDA (Effective October 1, 2011)

Aplasia - see also Agenesis
Revise — red cell (with thymoma) ~~(adult)~~ 284.81
acquired (secondary) 284.81
Add — due to drugs 284.81
Add — adult 284.81
pure 284.01
Add — due to drugs 284.81

Add — Aversion
Add — oral 783.3
Add — newborn 779.31
Add — nonorganic origin 307.59

Revise — Bruck-de Lange disease or syndrome (Amsterdam dwarf, intellectual disabilities, and brachycephaly) 759.89

Revise — Coprostasis 560.32

Dementia 294.8
due to or associated with condition(s) classified elsewhere
Add — Parkinson's disease
Add — with behavioral disturbance 332.0 [294.11]
Add — without behavioral disturbance 332.0 [294.10]

Dilatation
Revise — bile duct (common) ~~(cystic)~~ (congenital) 751.69

Revise — Disability, disabilities
Add — intellectual 319
Add — borderline V62.89
Add — mild, IQ 50-70 317
Add — moderate, IQ 35-49 318.0
Add — profound, IQ under 20 318.2
Add — severe, IQ 20-34 318.1

Add — Factor V Leiden mutation 289.81

Impaction, impacted
bowel, colon, rectum 560.30
by

Revise calculus 560.32
Revise specified type NEC 560.32
intestine(s) 560.30
by
Revise calculus 560.32
Revise specified type NEC 560.32

Metastasis, metastatic
Revise mesentery, of neuroendocrine tumor ~~209.71~~ 209.74

Migraine
Add complicated 346.0

Mutation
Revise factor V Leiden 289.81

Obstruction…
intestine … 560.9
Revise impaction 560.32

Retardation
mental – see Disability, intellectual
Delete ~~borderline V62.89~~
Delete ~~mild, IQ 50-70 317~~
Delete ~~moderate, IQ 35-49 318.0~~
Delete ~~profound, IQ under 20 318.2~~
Delete ~~severe, IQ 20-34 318.1~~
[NOTE: All existing entries with the term "mental retardation" will be revised to "intellectual disabilities]

Tuberculosis… 011.9
Add latent 795.5
Virilism (adrenal) E25.9

with
Delete ~~3-beta-hydroxysteroid dehydrogenase defect 255.2~~
Delete ~~11-hydroxylase defect 255.2~~
Delete ~~21-hydroxylase defect 255.2~~
Add 3-beta-hydroxysteroid dehydrogenase defect 255.2
Add 11-hydroxylase defect 255.2
Add 21-hydroxylase defect 255.2

Wound, open

Revise	anus 863.89
Delete	~~complicated 879.7~~

Place of Occurrence

NCHS has received a request to expand Y92.00,Unspecifed non-institutional (private) residence as the place of occurrence of the external cause, to include the same level of detail included at Y92.01-through Y92.8-. It was noted that documentation may often contain information about the room in which the injury occurred but that the type of dwelling may only be specified as house. Given that the term "house" is used to describe, depending on the geographic area, an apartment, a single family dwelling, or townhouse, creating a default would not be appropriate.

TABULAR MODIFICATION

	Y92	Place of Occurrence of External Cause
New subcategory		Y92.00 Unspecified non-institutional (private) residence as the place of occurrence of the external cause
New code		Y92.000 Kitchen of unspecified non-institutional (private) residence as the place of occurrence of the external cause
New code		Y92.001 Dining room of unspecified non-institutional (private) residence as the place of occurrence of the external cause
New code		Y92.002 Bathroom of unspecified non-institutional (private) residence single-family (private) house as the place of occurrence of the external cause
New code		Y92.003 Bedroom of Unspecified non-institutional (private) residence as the place of occurrence of the external cause
New code		Y92.008 Other place in unspecified non-institutional (private) residence as the place of occurrence of the external cause
New code		Y92.009 Unspecified place in unspecified non-institutional (private) residence as the place of occurrence of the external cause

Other Chronic Pain

In 2006, several ICD-9-CM diagnosis codes were implemented in a newly created category 338, Pain, not elsewhere classified. Subcategory 338.2, Chronic pain, includes four codes: chronic pain due to trauma, chronic post-thoracotomy pain, other chronic postoperative pain, and other chronic pain. ICD-10-CM mirrors this structure with category G89, Pain, not elsewhere classified, and subcategory G89.2, Chronic pain, not elsewhere classified. However, G89.2 includes only three codes: chronic pain due to trauma, chronic post-thoracotomy pain, and other chronic postoperative pain. While ICD-9-CM assigns 338.29 for other chronic pain, ICD-10-CM does not have a specific code for other chronic pain.

The current 2011 draft of ICD-10-CM indexes chronic pain NOS to code R52, Pain unspecified. The term 'other chronic pain' is not specifically indexed. Although G89.2 is classified as nervous system code, R52 is classified as a symptom code.

While acute pain is usually self-limited and serves as a warning to the body of injury other chronic pain serves no such function. It typically results from damage to nervous tissue itself (e.g. chronic arachnoiditis, post-herpetic neuralgia, pathological vertebral fracture in osteoporosis) and can persist after the tissue is healed. For these reasons, chronic pain can be seen as a neurologic disease process in its own right and is treated as a distinct condition, for example by implantation of a spinal neurostimulator or an intrathecal infusion pump. It is necessary to acknowledge this clinical perspective on other chronic pain with its own unique code in subcategory G89.2 and not at code R52 which also classifies acute pain NOS, generalized pain NOS, and pain NOS.

Classifying 'other chronic pain' to R52 also disrupts the pain code guidelines currently in the draft ICD-10-CM Official Guidelines for Coding and Reporting. These state that codes in category G89 are assigned and sequenced as the principal diagnosis when the reason for the encounter is pain control or pain management, as in an encounter for steroid injection or admission for neurostimulator implantation. That will work for chronic pain that is post-traumatic, post-thoracotomy and post-procedural, since those conditions are classified to category G89. But since 'other chronic pain' is not specifically indexed it will be coded to R52 as a symptom. Therefore, the underlying cause will need to be sequenced as the principal diagnosis and it's questionable if pain will be coded at all. Encounters for pain management and control will likely be coded and sequenced inconsistently, depending on how the chronic pain is characterized and then coded in ICD-10-CM.

It is proposed to create a unique ICD-10-CM diagnosis code for other chronic pain, in subcategory G89.2, Chronic pain, not elsewhere classified.

TABULAR MODIFICATIONS

G89 Pain, not elsewhere classified

G89.2 Chronic pain, not elsewhere classified

New code G89.29 Other chronic pain

Migraines

The American Headache Society (AHS) is requesting changes to category G43, Migraine and G44, Other headache syndromes. The proposed changes were developed with and are supported by the American Academy of Neurology (AAN).

Three of the four terms included in ICD-9-CM subcategory 346.2X, Variants of migraine, not elsewhere classified were given unique codes in ICD-10-CM: G43A-, Cyclical vomiting; G43B- Ophthalmologic migraine; and G43C- Periodic headache syndromes in child or adult. The fourth term, abdominal migraine, also listed under variants of migraine in ICD-9-CM, was not included in ICD-10-CM. The AHS proposes that a unique code be established for abdominal migraine. In the 2011 version of ICD-10-CM, menstrual migraine is assigned to subcategory G43D, however, it is requested that the new codes for abdominal migraine be assigned to G43D to allow keeping the variants of migraine conditions together. The codes for menstrual migraine are being proposed to be moved to new subcategories in G43.8, Other migraine.

The AHS is also proposing to delete the codes for "with and without status migrainosus" under G43A-, G43B-, and G43C-. Status migrainosus refers to a prolonged headache lasting more than 72 hours. Status migrainosus would not apply to these codes because they describe disorders other than the pain associated with migraines; e.g. abdominal migraine is abdominal pain, not headache, and Ophthalmologic migraine is palsy of the third cranial nerve and not migraine. The default (NOS) for each of these conditions would be the codes for not intractable and the index will reflect this.

TABULAR MODIFICATIONS

G43 Migraine

G43.A Cyclical vomiting

G43.A0 Cyclical vomiting, not intractable

Delete ~~G43.A01 Cyclical vomiting, not intractable, with status migrainosus~~

Delete ~~G43.A09 Cyclical vomiting, not intractable, without status migrainosus~~

Delete ~~Cyclical vomiting NOS~~

G43.A1 Cyclical vomiting, intractable

Delete ~~G43.A11 Cyclical vomiting, intractable, with status migrainosus~~

Delete ~~G43.A19 Cyclical vomiting, intractable, without status migrainosus~~

G43.B Ophthalmoplegic migraine

G43.B0 Ophthalmoplegic migraine, not intractable

Delete ~~G43.B01 Ophthalmoplegic migraine, not intractable, with status migrainosus~~

Delete ~~G43.B09 Ophthalmoplegic migraine, not intractable, without status migrainosus~~

Delete ~~Ophthalmoplegic migraine NOS~~

G43.B1 Ophthalmoplegic migraine, intractable

Delete ~~G43.B11 Ophthalmoplegic migraine, intractable, with status migrainosus~~

Delete ~~G43.B19 Ophthalmoplegic migraine, intractable, without status migrainosus~~

G43.C Periodic headache syndromes in child or adult

G43.C0 Periodic headache syndromes in child or adult, not intractable

Delete ~~G43.C01 Periodic headache syndromes in child or adult, not intractable, with status migrainosus~~

Delete ~~G43.C09 Periodic headache syndromes in child or adult, not intractable, without status migrainosus~~

Delete ~~Periodic headache syndromes in child or adult NOS~~

G43.C1 Periodic headache syndromes in child or adult, intractable

Delete ~~G43.C11 Periodic headache syndromes in child or adult, intractable, with status migrainosus~~

Delete ~~G43.C19 Periodic headache syndromes in child or adult, intractable, without status migrainosus~~

Delete ~~G43.d Menstrual migraine~~
Delete ~~Menstrual headache~~
Delete ~~Menstrually related migraine~~
Delete ~~Pre-menstrual headache~~
Delete ~~Pre-menstrual migraine~~
Delete ~~Pure menstrual migraine~~

Delete ~~Code also associated premenstrual tension syndrome (N94.3)~~

Delete ~~G43.d0 Menstrual migraine, not intractable~~

Delete ~~G43.d01 Menstrual migraine, not intractable, with status migrainosus~~
Delete ~~G43.d01 Menstrual migraine, not intractable, with status migrainosus~~

Delete ~~G43.d09 Menstrual migraine, not intractable, without status migrainosus~~
Delete ~~Menstrual migraine NOS~~

Delete ~~G43.d1 Menstrual migraine, intractable~~

Delete ~~G43.d11 Menstrual migraine, intractable, with status migrainosus~~

Delete			~~G43.d19 Menstrual migraine, intractable, without status migrainosus~~
New subcategory	G43.D	Abdominal migraine	
New code		G43.D0	Abdominal migraine, not intractable
New code		G43.D1	Abdominal migraine, intractable
New subcategory		G43.82	Menstrual migraine, not intractable
Add			Menstrual headache, not intractable
Add			Menstrually related migraine, not intractable
Add			Pre-menstrual headache, not intractable
Add			Pre-menstrual migraine, not intractable
Add			Pure menstrual migraine, not intractable
Add		Code also associated premenstrual tension syndrome (N94.3)	
New code			G43.821 Menstrual migraine, not intractable, with status migrainosus
New code			G43.829 Menstrual migraine, not intractable, without status migrainosus
Add			Menstrual migraine NOS
New subcategory		G43.83	Menstrual migraine, intractable
Add			Menstrual headache, intractable
Add			Menstrually related migraine, intractable
Add			Pre-menstrual headache, intractable
Add			Pre-menstrual migraine, intractable
Add			Pure menstrual migraine, intractable
Add		Code also associated premenstrual tension syndrome (N94.3)	
New code			G43.831 Menstrual migraine, intractable, with status migrainosus
New cod			G43.839 Menstrual migraine, intractable, without status migrainosus

Landau- Kleffner Syndrome

Currently, in ICD-10-CM, Landau-Kleffner Syndrome is coded to F80.3, Acquired aphasia with epilepsy [Landau-Kleffner]. Additionally, category G40, Epilepsy and recurrent seizures, has an Excludes1 note for Landau-Kleffner Syndrome (directing to use code F80.3). In ICD-9-CM, Landau-Kleffner Syndrome was indexed to code 345.8x, Other forms of epilepsy and recurrent seizures.

Landau-Kleffner Syndrome is a neurologic condition with evidence of abnormality on an EEG. The International League Against Epilepsy (ILAE) defines Landau-Kleffner Syndrome as an electro-clinical syndrome, that is, the diagnosis is based on the EEG and not the clinical presentation. The ILAE's full published "Revised terminology and concepts for organization of seizures and epilepsies: Report of the ILAE Commission on Classification and Terminology, 2005 - 2009 *(Epilepsia, 51(4):676–685, 2010)* is available at: http://www.ilae-epilepsy.org/Visitors/Centre/ctf/ctfoverview.cfm

The American Academy of Neurology (AAN) proposes to deactivate code F80.3, and revise the index to direct Landau-Kleffner Syndrome to be coded to subcategories G40.80- or G40.81-, Other epilepsy (4th character dependant on intractability) with appropriate 5th characters applied for status epilepticus. In addition appropriate exclusion notes in Chapter 5 and at category G40 would be revised to direct using codes at subcategories G40.80- and G40.81-.

TABULAR MODIFICATIONS

F80 Specific developmental disorders of speech and language

F80.1 Expressive language disorder

Revise Excludes2: acquired aphasia with epilepsy [Landau-Kleffner] ***(G40.80-, G40.81-)***

F80.2 Mixed receptive-expressive language disorder

Revise Excludes2: acquired aphasia with epilepsy [Landau-Kleffner] ***(G40.80-, G40.81-)***

Delete ~~F80.3 Acquired aphasia with epilepsy [Landau-Kleffner]~~
Delete ~~Excludes1: aphasia NOS (R47.01)~~
Delete ~~Excludes2: pervasive developmental disorders (F84.-)~~

G40 Epilepsy and recurrent seizures

Delete Excludes1: ~~Landau-Kleffner syndrome (F80.3)~~

G40.8 Other epilepsy and seizures
Add Landau-Kleffner syndrome

INDEX MODIFICATIONS

Aphasia…
Revise - acquired, with epilepsy (Landau-Kleffner syndrome) ***G40.80-***
Add - - intractable G40.81-

Revise Landau-Kleffner syndrome ***G40.80-***
Add - - intractable G40.81-

Syndrome …
Revise - Landau-Kleffner ***G40.80-***
Add - - intractable G40.81-

Epilepsy and recurrent seizures

The American Academy of Neurology (AAN) is proposing several revisions to better group the disorders and syndromes at category G40, Epilepsy and Recurrent Seizures. The AAN found that many inclusion terms at subcategories G40.3, Generalized idiopathic epilepsy and epileptic syndromes, and G40.4, Other generalized epilepsy and epileptic syndromes are dissimilar. Some terms are not syndromes and, for others, it often is not clear if the epilepsy is generalized or localized. The AAN is proposing that some of these inclusion terms be moved to other existing codes in this category, while others would be better classified with unique codes. These proposals are consistent with the International League Against Epilepsy (ILAE) published "Revised terminology and concepts for organization of seizures and epilepsies: Report of the ILAE Commission on Classification and Terminology, 2005 - 2009 *(Epilepsia, 51(4):676–685, 2010)* whose full published report is available at:
http://www.ilae-epilepsy.org/Visitors/Centre/ctf/ctfoverview.cfm

G40.3, Generalized idiopathic epilepsy and epileptic syndromes- The AAN proposes to remove all inclusion terms at this subcategory and do the following:

Benign myoclonic epilepsy in infancy, and Benign neonatal convulsions (familial): Index these terms to direct to the use of G40.8- Other epilepsy and seizures. The basis of assignment to the generalized epilepsy category is based upon the consistent onset of a seizure from both hemispheres simultaneously. This is not the case with either of these syndromes. Thus it would be more accurate to put each in a category in which ictal onset can be either focal or generalized. Furthermore, in the past the term "benign" has frequently been associated with "idiopathic". Per the 2010 Revision of the classification of seizures and epilepsies by the ILAE, the term "benign" is being discouraged as these syndromes do not always result in seizure freedom and normal cognition. Thus, these disorders should be dissociated from the term 'idiopathic' wherever possible.

Absence epilepsy syndromes: These syndromes constitute distinct entities with differing inclusion criteria, and thus should be coded separately so as not be "lost" within the other generalized syndromes. The AAN recommends creating a new code, G40.A-, Absence Epileptic Syndromes. They also propose moving the following three inclusion terms to the proposed new code: Childhood absence epilepsy [pyknolepsy], Juvenile absence epilepsy, Absence epilepsy NOS.

Juvenile myoclonic epilepsy [impulsive petit mal]: Since this epilepsy syndrome is distinct and relatively common in the population a separate code is indicated so that it can be tracked independently from other different and/or less common syndromes. Thus it is proposed to remove this term from G40.3 and create a new subcategory G40.B, Juvenile myoclonic epilepsy [impulsive petit mal].

Nonspecific - atonic, clonic, myoclonic, tonic, tonic-clonic, and grand mal seizures and epilepsy with grand mal seizures upon awakening: These terms refer to seizures and only when these seizures occur consistently in an individual is the term "epilepsy" appropriate. These epilepsies are very frequently not idiopathic and should be put in a classification that is less specific. It is therefore recommended to move these seven terms to subcategory G40.4, Other generalized epilepsy and epileptic syndromes.

G40.4, Other generalized epilepsy and epileptic syndromes- In addition to moving the nonspecific terms, mentioned above from G40.3 to this subcategory, the following changes are proposed:

Lennox-Gastaut Syndrome: This is a distinct syndrome from the other disorders included under G40.4 with specific pharamaco sensitivities and prognosis. In order to assess epidemiology in the future, a separate code is needed. It is recommended to delete this inclusion term and create two new codes: G40.82 Lennox-Gastaut Syndrome, not intractable and G40.83 Lennox-Gastaut Syndrome, intractable.

Infantile spasms, Salaam attacks, and West's syndrome: These three terms are essentially equivalent. It is recommended to delete these inclusion terms at G40.4 and create two new codes: G40.84 Epileptic Spasms, not intractable and G40.85 Epileptic Spasms, intractable and include these terms with the new codes. This will be consistent with the ILAE classification which recognizes this seizure type and the fact that spasms can occur beyond infancy (as noted on page 678 of the referenced ILAE article).

G40.8, Other Epilepsy and Seizures-
In ICD-9-CM, Other forms of epilepsy and recurrent seizures is coded as 345.8. Recurrent seizures NOS is included at that code. The term “recurrent” was not included in ICD-10-CM subcategory G40.8, Other epilepsy and seizures. Recurrent seizures NOS is currently listed as an inclusion term at code G40.909, Epilepsy, unspecified, not intractable, without status epilepticus. In an effort to conform G40.8 with the ICD-9-CM AAN proposes that the term "recurrent" be added to subcategory G40.8, Other epilepsy and seizures. In addition the term recurrent seizures NOS, should be deleted from code G40.909 and added as an inclusion term to subcategory G40.8.

TABULAR MODIFICATIONS

G40 Epilepsy and recurrent seizures

G40.3 Generalized idiopathic epilepsy and epileptic syndromes

Delete	~~Benign myoclonic epilepsy in infancy~~
Delete	~~Benign neonatal convulsions (familial)~~
Delete	~~Childhood absence epilepsy [pyknolepsy]~~
Delete	~~Epilepsy with grand mal seizures on awakening~~
Delete	~~Grand mal seizure NOS~~
Delete	~~Juvenile absence epilepsy~~
Delete	~~Juvenile myoclonic epilepsy [impulsive petit mal]~~
Delete	~~Nonspecific atonic epileptic seizures~~
Delete	~~Nonspecific clonic epileptic seizures~~
Delete	~~Nonspecific myoclonic epileptic seizures~~
Delete	~~Nonspecific tonic epileptic seizures~~
Delete	~~Nonspecific tonic-clonic epileptic seizures~~
Delete	~~Petit mal seizure NOS~~

New subcategory	G40.A	Absence epileptic syndrome
Add		Childhood absence epilepsy [pyknolepsy]
Add		Juvenile absence epilepsy
Add		Absence epileptic syndrome, NOS

New subcategory	G40.A0	Absence Epileptic Syndrome, not intractable
New code	G40.A01	Absence Epileptic Syndrome, not intractable, with status epilepticus
New code	G40.A09	Absence Epileptic Syndrome, not intractable, without status epilepticus

New subcategory	G40.A1	Absence Epileptic Syndrome, intractable
New code	G40.A11	Absence Epileptic Syndrome, intractable, with status epilepticus

New code		G40.A19	Absence Epileptic Syndrome, intractable, without status epilepticus
New subcategory	G40.B	Juvenile myoclonic epilepsy [impulsive petit mal]	
New subcategory		G40.B0	Juvenile myoclonic epilepsy, not intractable
New code		G40.B01	Juvenile myoclonic epilepsy, not intractable, with status epilepticus
New code		G40.B09	Juvenile myoclonic epilepsy, not intractable, without status epilepticus
New subcategory		G40.B1	Juvenile myoclonic epilepsy, intractable
New code		G40.B11	Juvenile myoclonic epilepsy, intractable, with status epilepticus
New code		G40.B19	Juvenile myoclonic epilepsy, intractable, without status epilepticus
	G40.4	Other generalized epilepsy and epileptic syndromes	
Add		Epilepsy with grand mal seizures on awakening	
Add		Grand mal seizure NOS	
Delete		~~Infantile spasms~~	
Delete		~~Lennox-Gastaut syndrome~~	
Add		Nonspecific atonic epileptic seizures	
Add		Nonspecific clonic epileptic seizures	
Add		Nonspecific myoclonic epileptic seizures	
Add		Nonspecific tonic epileptic seizures	
Add		Nonspecific tonic-clonic epileptic seizures	
Delete		~~Salaam attacks~~	
Delete		~~West's syndrome~~	
Revise	G40.8	Other epilepsy and <u>recurrent</u> seizures	
Add		Recurrent seizures NOS	
New subcategory		G40.82	Lennox-Gastaut Syndrome, not intractable
New code		G40.821	Lennox-Gastaut Syndrome, not intractable, with status epilepticus
New code		G40.829	Lennox-Gastaut Syndrome, not intractable, without status epilepticus

New subcategory	G40.83	Lennox-Gastaut Syndrome, intractable
New code		G40.831 Lennox-Gastaut Syndrome, intractable, with status epilepticus
New code		G40.839 Lennox-Gastaut Syndrome, intractable, without status epilepticus
New subcategory	G40.84	Epileptic spasms, not intractable
Add		Infantile spasms, not intractable
Add		Salaam attacks, not intractable
Add		West's syndrome, not intractable
New code		G40.841 Epileptic spasms, not intractable, with status epilepticus
New code		G40.849 Epileptic spasms, not intractable, without status epilepticus
New subcategory	G40.85	Epileptic spasms, intractable
Add		Infantile spasms, intractable
Add		Salaam attacks, intractable
Add		West's syndrome, intractable
New code		G40.851 Epileptic spasms, intractable, with status epilepticus
New code		G40.859 Epileptic spasms, intractable, without status epilepticus
	G40.9	Epilepsy, unspecified
		G40.90 Epilepsy, unspecified, not intractable
		G40.909 Epilepsy, unspecified, not intractable, without status epilepticus
Delete		~~Recurrent seizures NOS~~

INDEX MODIFICATIONS

Note: The following index modifications were submitted with the AAN proposal. Complete modifications, including re-directing terms mentioned above and indexing any new codes will be listed in the complete ICD-10-CM index addenda.

Epilepsy, epileptic, epilepsia (attack) (cerebral) (convulsion) (fit) (seizure) G40.909

Revise	- benign myoclonic in infancy - ~~*see* Epilepsy, generalized, idiopathic~~
Add	- - intractable G40.819
Add	- - - with status epilepticus G40.811
Add	- - - without status epilepticus G40.819

Add - - not intractable G40.809
Add - - - with status epilepticus G40.801
Add - - - without status epilepticus G40.809

Convulsions (idiopathic) (*see also* Seizure(s)) R56.9
Revise - benign neonatal (familial) - ~~*see* Epilepsy, generalized, idiopathic~~
Add - - intractable G40.819
Add - - - with status epilepticus G40.811
Add - - - without status epilepticus G40.819
Add - - not intractable G40.809
Add - - - with status epilepticus G40.801
Add - - - without status epilepticus G40.809

Seizure(s) (see also Convulsions) R56.9
Revise - recurrent G40.8-

Epileptic Seizures Related to External Causes

The descriptor for G40.5 "Special epileptic syndromes" does not accurately define the disorders included under this code. Epileptic seizures related to alcohol, drugs, hormonal changes, sleep deprivation and stress are really not syndromes, rather the seizures are symptomatic of the underlying related cause. (See pages 680 - 681 of the attached article for a discussion of epileptic syndromes) For this reason we propose revising the code descriptor for G40.5 to read Epileptic seizures related to external causes. We also propose to delete the intractable/non-intractable reference for these codes because as symptomatic seizures (those due to an external cause), they would not be intractable. However, they could still lead to status epilepticus. We also propose to add an Excludes2 note to ask that when applicable the appropriate epilepsy syndrome be coded first.

In addition, we are proposing to delete the inclusion term epilepsia partialis continua [Kozhevnikof] from G40.5. Epilepsia partialis continua [Kozhevnikof] by definition is a localization-related focal partial epilepsy with simple partial seizures and therefore should be coded to G40.1, Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures.

TABULAR MODIFICATIONS

G40.1 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures

Add — Epilepsia partialis continua [Kozhevnikof

Revise — G40.5 ~~Special epileptic syndromes~~ Epileptic seizures related to external causes

Delete — ~~Epilepsia partialis continua [Kozhevnikof]~~

Add — Excludes2: epilepsy and recurrent seizures (G40.0 - G40.9)

Revise — G40.50 ~~Special epileptic syndromes~~ Epileptic seizures related to external causes, not intractable

Delete — ~~Special epileptic syndromes without intractability~~

Revise — G40.501 ~~Special epileptic syndromes~~ Epileptic seizures related to external causes, not intractable, with status epilepticus

Revise — G40.509 ~~Special epileptic syndromes~~ Epileptic seizures related to external causes, not intractable, without status epilepticus

Delete — ~~Special epileptic syndromes NOS~~

Add — Epileptic seizures related to external causes, NOS

Delete — ~~G40.51 Special epileptic syndromes, intractable~~

Delete — ~~G40.511 Special epileptic syndromes, intractable, with status epilepticus~~

Delete — ~~G40.519 Special epileptic syndromes, intractable, without status epilepticus~~

Vascular Headaches

The American Headache Society (AHS) is requesting changes to category G44, Other headache syndromes. The proposed changes were developed with and are supported by the American Academy of Neurology (AAN).

The 2011 draft version of ICD-10-CM includes codes for vascular headache. In the International Classification of Headache Disorders, 2nd edition the term vascular headache is no longer specifically used. ICHD does include a code defined as headache attributed to cranial or cervical vascular disorder and states that "when a new headache occurs … in close temporal relation to a vascular disorder it is coded as a secondary headache attributed to the vascular disorder." The AHS is proposing that G44.1 be used in a similar fashion. For that reason it is proposed to delete codes G44.10 and G44.11 (see below) as intractability will not apply to this. Code G44.1 will, in almost all cases, be coded as a secondary diagnosis. The Excludes2 note is proposed to assure that a more specific migraine or headache code is used when that information is available.

TABULAR MODIFICATIONS

G44 Other headache syndromes

G44.1 Vascular headache, not elsewhere classified

Add Excludes2: cluster headache (G44.0)
Add complicated headache syndromes (G44.5-)
Add drug-induced headache (G44.4-)
Add migraine (G43.-)
Add other specified headache syndromes (G44.8-)
Add post-traumatic headache (G44.3-)
Add tension-type headache (G44.2-)

Delete ~~G44.10 Vascular headache, not elsewhere classified, not intractable~~

Delete ~~Vascular headache NOS~~

Delete ~~G44.11 Vascular headache, not elsewhere classified, intractable~~

Post-traumatic Headache

Currently, ICD-10-CM has an instruction at subcategory G44.3, Post-traumatic headache to “Code first postconcussional syndrome (F07.81)". This instructional note is not listed at the equivalent ICD-9-CM subcategory 339.2X Post-traumatic headache. Additionally, ICD-10-CM code F07.81, Postconcussional syndrome has an instructional note to "Use additional code to identify associated post-traumatic headache (G44.3-)". In ICD-9-CM, the instructional note at code 310.2, Post-concussion syndrome states "Use additional code to identify associated post-traumatic headache, **if applicable**".

Chronic post-traumatic headache can occur independent of post-concussion syndrome, and therefore a "Code first" instruction is not appropriate. In addition, post-concussion syndrome requires the presence of three symptoms of which headache can be only one symptom. Also, this diagnosis requires that the symptoms be present for three months after the injury. The American Headache Society (AHS) proposes that the “Code first” instruction be removed from subcategory G44.3 and a revision be made to the instructional note for code F07.81 to include the phrase "if applicable".

TABULAR MODIFICATION

F07 Personality and behavioral disorders due to known physiological condition

F07. 8 Other personality and behavioral disorders due to known physiological condition

F07.81 Postconcussional syndrome

Revise — Use additional code to identify associated post-traumatic headache, if applicable (G44.3-)

G44 Other headache syndromes

G44.3 Post-traumatic headache

Delete — ~~Code first: postconcussional syndrome (F07.81)~~

Ventral hernia

In 2009 the World Health Organization (WHO) Update Reference Committee (URC) revised ICD-10 category K43, Ventral hernia. These changes will take effect, for ICD-10, in January 2013. Therefore they are proposed here as changes to ICD-10-CM so that they will be available when it is implemented October 1, 2013.

TABULAR MODIFICATIONS

K43 Ventral hernia

Revise	K43.0	~~Ventral~~ Incisional hernia with obstruction, without gangrene
Revise		~~Ventral~~ Incisional hernia causing obstruction, without gangrene
Revise		Incarcerated ~~ventral~~ incisional hernia, without gangrene
Revise		Irreducible ~~ventral~~ incisional hernia, without gangrene
Revise		Strangulated ~~ventral~~ incisional hernia, without gangrene
Delete		~~K43.00 Ventral hernia, unspecified, with obstruction, without gangrene~~
Delete		~~K43.01 Incisional hernia, with obstruction, without gangrene~~
Delete		~~K43.09 Other ventral hernia, with obstruction, without gangrene~~
Delete		~~Epigastric hernia~~
Revise	K43.1	~~Ventral~~ Incisional hernia with gangrene
Revise		Gangrenous ~~ventral~~ incisional hernia
Delete		~~K43.10 Ventral hernia, unspecified, with gangrene~~
Delete		~~K43.11 Incisional hernia, with gangrene~~
Delete		~~K43.19 Other ventral hernia, with gangrene~~
Delete		~~Epigastric hernia~~
New code	K43.2	Incisional hernia without obstruction or gangrene
Add		Incisional hernia NOS
New code	K43.3	Parastomal hernia with obstruction, without gangrene
Add		Parastomal hernia causing obstruction, without gangrene
Add		Incarcerated parastomal hernia, without gangrene
Add		Irreducible parastomal hernia, without gangrene
Add		Strangulated parastomal hernia, without gangrene
New code	K43.4	Parastomal hernia with gangrene
Add		Gangrenous parastomal hernia
New code	K43.5	Parastomal hernia without obstruction or gangrene
Add		Parastomal hernia NOS
New code	K43.6	Other and unspecified ventral hernia with obstruction, without gangrene
Add		Epigastric hernia causing obstruction, without gangrene
Add		Hypogastric hernia causing obstruction, without gangrene
Add		Incarcerated epigastric hernia without gangrene
Add		Incarcerated hypogastric hernia without gangrene
Add		Incarcerated midline hernia without gangrene
Add		Incarcerated spigelian hernia without gangrene
Add		Incarcerated subxiphoid hernia without gangrene
Add		Irreducible epigastric hernia without gangrene
Add		Irreducible hypogastric hernia without gangrene

Add		Irreducible midline hernia without gangrene
Add		Irreducible spigelian hernia without gangrene
Add		Irreducible subxiphoid hernia without gangrene
Add		Midline hernia causing obstruction, without gangrene
Add		Spigelian hernia causing obstruction, without gangrene
Add		Strangulated hypogastric hernia without gangrene
Add		Strangulated midline hernia without gangrene
Add		Strangulated spigelian hernia without gangrene
Add		Strangulated subxiphoid hernia without gangrene
Add		Subxiphoid hernia causing obstruction, without gangrene
New code	K43.7	Other and unspecified ventral hernia with gangrene
Add		Any condition listed under K43.6 specified as gangrenous
Revise	K43.9	Other and unspecified ventral ~~Ventral~~ hernia without obstruction or gangrene
Add		Ventral hernia NOS
Delete		~~K43.90 Ventral hernia, unspecified, without obstruction or gangrene~~
Delete		~~Ventral hernia NOS~~
Delete		~~K43.91 Incisional hernia, without obstruction or gangrene~~
Delete		~~K43.99 Other ventral hernia, without obstruction or gangrene~~
Delete		~~Epigastric hernia~~

Methicillin Resistant Staphylococcus Aureus (MRSA) and Drug Resistance

In 2008 codes for Methicillin resistant Staphylococcus aureus (MRSA) were implemented, in several ICD-9-CM categories (038, 041, 482 and some V codes). This was in response to a request from the Centers for Disease Control and Prevention (CDC) to allow better tracking of these specific drug resistant infections.

In ICD-10-CM one code was created to capture drug resistance, Z16 Infection with drug resistant microorganisms. Therefore, more than one code is required to indicate a condition with drug resistance (example -- A41.0, Sepsis due to Staphylococcus aureus and Z16, Infection with drug resistant microorganisms). Additionally, if a patient has multiple drug resistant conditions, it may be difficult to match code Z16 with the appropriate code for the condition. Therefore, it has been suggested to add unique codes for MRSA, to ICD-10-CM, similar to those that were created in ICD-9-CM.

In addition, in 2009 and 2010 the World Health Organization (WHO) created and modified ICD-10 codes for drug resistance to antimicrobials and antineoplastic drugs. This further detail must also be added to ICD-10-CM before it is officially implemented on 10/1/2013. This can be accomplished by expanding category Z16.

NCHS is therefore proposing the following changes:

TABULAR MODIFICATIONS

CHAPTER 1 Certain infectious and parasitic diseases (A00-B99)

Revise Use additional code for any associated drug resistance ***(Z16-)***

A41 Other sepsis

A41.0 Sepsis due to Staphylococcus aureus

New code A41.01 Sepsis due to Methicillin susceptible Staphylococcus aureus
Add MSSA sepsis
Add Staphylococcus aureus sepsis NOS

New code A41.02 Sepsis due to Methicillin resistant Staphylococcus aureus

A49 Bacterial infection of unspecified site

A49.0 Staphylococcal infection, unspecified site

New code A49.01 Methicillin susceptible Staphylococcus aureus infection, unspecified site
Add Methicillin susceptible Staphylococcus aureus (MSSA) infection
Add Staphylococcus aureus infection NOS

New code A49.02 Methicillin resistant Staphylococcus aureus infection, unspecified site
Add Methicillin resistant Staphylococcus aureus (MRSA) infection

B95 Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified elsewhere

B95.6 Staphylococcus aureus as the cause of diseases classified elsewhere

New code B95.61 Methicillin susceptible Staphylococcus aureus infection in diseases classified elsewhere
Add Methicillin susceptible Staphylococcus aureus (MSSA) infection in diseases classified elsewhere
Add Staphylococcus aureus infection NOS in diseases classified elsewhere

New code B95.62 Methicillin resistant Staphylococcus aureus infection in diseases classified elsewhere
Add Methicillin resistant staphylococcus aureus (MRSA) infection in diseases classified elsewhere

Malignant neoplasms (C00-C96)

Add Use additional code (Z16.4) to identify resistance, non-responsiveness and refractive properties of the neoplasm to antineoplastic drugs

J15 Bacterial pneumonia, not elsewhere classified

J15.2 Pneumonia due to staphylococcus

J15.21 Pneumonia due to staphylococcus aureus

New code J15.211 Pneumonia due to Methicillin susceptible Staphylococcus aureus
Add MSSA pneumonia
Add Pneumonia due to Staphylococcus aureus NOS

New code J15.212 Pneumonia due to Methicillin resistant Staphylococcus aureus

Revise section ***Resistance to antimicrobial and antineoplastic drugs*** (Z16)

Delete code ~~Z16 Infection with drug resistant microorganisms~~

Add category Z16 Resistance to antimicrobial and antineoplastic drugs

Delete ~~This category is intended for use as an additional code for infectious conditions classified elsewhere to indicate the presence of drug-resistance of the infectious organism~~

Add note Note: The codes in this category are provided for use as additional codes to identify the resistance, non-responsiveness and refractive properties of a condition to antimicrobials and antineoplastic drugs.

Code first the infection

Add Excludes1: Methicillin resistant Staphylococcus aureus pneumonia (J15.212)
Add Methicillin resistant Staphylococcus aureus infection (A49.02)

Add			Methicillin resistant Staphylococcus aureus infection in diseases classified elsewhere (B95.62)
Add			Sepsis due to Methicillin resistant Staphylococcus aureus (A41.02)
New subcategory	Z16.1	Resistance to beta lactam antibiotics	
New code		Z16.10	Resistance to unspecified beta lactam antibiotics
New code		Z16.11	Resistance to penicillins Resistance to amoxicillin Resistance to ampicillin
New code		Z16.12	Extended spectrum beta lactamase (ESBL) resistance
New code		Z16.19	Resistance to other specified beta lactam antibiotics Resistance to cephalosporins
New subcategory	Z16.2	Resistance to other antibiotics	
New code		Z16.20	Resistance to unspecified antibiotic Resistance to antibiotics NOS
New code		Z16.21	Resistance to vancomycin
New code		Z16.22	Resistance to vancomycin related antibiotics
New code		Z16.23	Resistance to quinolones and fluoroquinolones
New code		Z16.24	Resistance to multiple antibiotics
New code		Z16.29	Resistance to other single specified antibiotic
Add			Resistance to aminoglycosides
Add			Resistance to macrolides
Add			Resistance to sulfonamides
Add			Resistance to tetracyclines
New subcategory	Z16.3	Resistance to other antimicrobial drugs	
Add		Excludes1: resistance to antibiotics (Z16.1-, Z16.2-)	
New code		Z16.30	Resistance to unspecified antimicrobial drugs
Add			Drug resistance NOS
New code		Z16.31	Resistance to antiparasitic drug(s) Resistance to quinine and related compounds
New code		Z16.32	Resistance to antifungal drug(s)
New code		Z16.33	Resistance to antiviral drug(s)

New subcategory
Z16.34 Resistance to antimycobacterial drug(s)

Add
Resistance to tuberculostatics

New code
Z16.341 Resistance to single antimycobacterial drug
Resistance to antimycobacterial drug NOS

New code
Z16.342 Resistance to multiple antimycobacterial drugs

New code
Z16.35 Resistance to multiple antimicrobial drugs

Add
Excludes1: Resistance to multiple antibiotics only (Z16.23)

New code
Z16.39 Resistance to other specified antimicrobial drug

New code
Z16.4 Resistance to antineoplastic drugs

Add
Includes: Non-responsiveness to antineoplastic drugs
Add
Refractory cancer

Z22 Carrier of infectious disease

Z22.3 Carrier of other specified bacterial diseases

Z22.32 Carrier of bacterial disease due to staphylococci

New code
Z22.321 Carrier or suspected carrier of Methicillin susceptible Staphylococcus aureus

Add
MSSA colonization

New code
Z22.322 Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus

Add
MRSA colonization

Z86 Personal history of certain other diseases

Z86.1 Personal history of infectious and parasitic diseases

Z86.19 Personal history of other infectious and parasitic diseases

New code
Z86.191 Personal history of Methicillin resistant Staphylococcus aureus infection

Add
Personal history of MRSA infection

Underdosing

Comments received following the September 2010 ICD-9-CM Coordination and Maintenance (C&M) Committee presentation of a proposal for modification to codes for opioids included concerns about the use of the term/concept of underdosing.

Discussion is needed to review the need for this concept in ICD-10-CM. This concept was added with the intent to be able to track incidents where a person did not receive adequate dose of a given medication.

There could be several reasons for underdosing, some of which include:

1. Prescription error – especially with medications where there is no established dose for a drug, such as a pediatric patient receiving a medication usually given to adults.
2. Patient/caretaker error – This could be either intentional, perhaps due to financial constraint or noncompliance issues, or unintentional such as misunderstanding dosage instructions or cognitive issues.
3. Dose adjustment needed based on blood level testing.
4. Dosage titration problems.

Underdosing can result in the disease not being properly treated or controlled which can lead to additional medical care and treatment.

The concept of underdosing does not exist in ICD-10 as released by the World Health Organization (WHO). The following changes are proposed in order to retain the concept of underdosing in ICD-10-CM:

- The definitions currently shown at the beginning of section "Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances" (T36-T50) were originally stated as inclusion statements in ICD-10 and it is recommended to return them to that format. Any definition or further instruction of these could be handled in the official coding guidelines.

- It was overwhelmingly recommended, in the comments received after the September 2010 C&M meeting, to remove any codes where the concept of underdosing is not clinically appropriate. This was especially true of codes in category T40, Poisoning by, adverse effect of and underdosing of narcotics and psychodysleptics [hallucinogens]. These are shown in the proposed modifications.

- There are also proposed changes to related codes for reason or intent for underdosing in the Chapters 20 and 21.

TABULAR MODIFICATIONS

Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances (T36-T50)

Delete ~~Includes: poisoning is defined as:~~
Delete ~~overdose of substances wrong substance given or taken in error~~
Delete ~~adverse effect is defined as:~~
Delete ~~"hypersensitivity", "reaction", etc. of correct substance properly administered~~
Delete ~~underdosing is defined as:~~
Delete ~~taking less of a medication than is prescribed or instructed by the manufacturer, whether inadvertently or deliberately~~

Add Includes: overdose of these substances
Add taking less substance than prescribed
Add wrong substance given or taken in error

Revise T40 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ narcotics and psychodysleptics [hallucinogens]

Revise T40.0 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ opium
Revise T40.0x Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ opium
Delete ~~T40.0x6 Underdosing of opium~~

Revise T40.1 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ heroin
Revise T40.1x Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ heroin
Delete ~~T40.1x6 Underdosing of heroin~~

Revise T40.2 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ other opioids
Revise T40.2x Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ other opioids
Delete ~~T40.2x6 Underdosing of other opioids~~

Revise T40.3 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ methadone
Revise T40.3x Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ methadone
Delete ~~T40.3x6 Underdosing of methadone~~

Revise T40.4 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ other synthetic narcotics
Revise T40.5x Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ cocaine
Delete ~~T40.5x6 Underdosing of cocaine~~

Revise T40.6 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ other and unspecified narcotics
Revise T40.60 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ unspecified narcotics
Delete ~~T40.606 Underdosing of unspecified narcotics~~

Revise T40.69 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ other narcotics
Delete ~~T40.696 Underdosing of other narcotics~~

Revise T40.7 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ cannabis (derivatives)
Revise T40.7x Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ cannabis (derivatives)
Delete ~~T40.7x6 Underdosing of cannabis (derivatives)~~

Revise T40.8 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ lysergide [LSD]
Revise T40.8x Poisoning by and adverse effect of lysergide [LSD]
Delete ~~T40.8x6 Underdosing of lysergide [LSD]~~

Revise T40.9 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ other and unspecified psychodysleptics [hallucinogens]
Revise T40.90 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ unspecified psychodysleptics [hallucinogens]
Delete ~~T40.906 Underdosing of unspecified psychodysleptics~~

Revise T40.99 Poisoning by~~,~~ ***and*** adverse effect of ~~and underdosing of~~ other psychodysleptics [hallucinogens]
Delete ~~T40.996 Underdosing of other psychodysleptics~~

Y63 Failure in dosage during surgical and medical care
Y63.6 Underdosing and nonadministration of necessary drug, medicament or biological substance

Delete ~~Y63.61 Underdosing of necessary drug, medicament or biological substance~~
Delete ~~Y63.62 Nonadministration of necessary drug, medicament or biological substance~~
Y63.8 Failure in dosage during other surgical and medical care
Y63.9 Failure in dosage during unspecified surgical and medical care

Z91 Personal risk factors, not elsewhere classified
Z91.1 Patient's noncompliance with medical treatment and regimen
Delete ~~Z91.12 Patient's intentional underdosing of medication regimen~~
Delete ~~Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship~~
Delete ~~Z91.128 Patient's intentional underdosing of medication regimen for other reason~~
Delete ~~Z91.13 Patient's unintentional underdosing of medication regimen~~
Delete ~~Z91.130 Patient's unintentional underdosing of medication regimen due to age-related debility~~
Delete ~~Z91.138 Patient's unintentional underdosing of medication regimen for other reason~~
Delete ~~Z91.14 Patient's other noncompliance with medication regimen~~
Delete ~~Patient's underdosing of medication NOS~~

Orthopedic deformities

ICD-9-CM has unique codes for several orthopedic conditions but there are no parallel codes for those conditions in ICD-10-CM. The conditions are acquired valgus and varus deformities of the hip (codes 736.31 and 736.32), vertical talus as deformity (754.61) and congenital valgus and varus deformities of the hip (codes 755.61 and 755.62).

The American Academy of Orthopedic Surgeons (AAOS) supports the addition of new codes for these conditions.

TABULAR MODIFICATIONS

New subcategory	M21.05	Valgus deformity, not elsewhere classified, hip
New code	M21.051	Valgus deformity, not elsewhere classified, right hip
New code	M21.052	Valgus deformity, not elsewhere classified, left hip
New code	M21.059	Valgus deformity, not elsewhere classified, unspecified hip
New subcategory	M21.15	Varus deformity, not elsewhere classified, hip
New code	M21.151	Varus deformity, not elsewhere classified, right hip
New code	M21.152	Varus deformity, not elsewhere classified, left hip
New code	M21.159	Varus deformity, not elsewhere classified, unspecified hip
Q65		Congenital deformities of hip
New subcategory	Q65.8	Other congenital deformities of hip
New code	Q65.81	Congenital coxa valga
New code	Q65.82	Congenital coxa vara
Q66		Congenital deformities of feet
	Q66.5	Other congenital deformities of feet
New code	Q66.50	Congenital pes planus, unspecified foot
New code	Q66.51	Congenital pes planus, right foot
New code	Q66.52	Congenital pes planus, left foot
	Q66.8	Other congenital deformities of feet
New code	Q66.80	Congenital vertical talus deformity, unspecified foot
	Q66.81	Congenital vertical talus deformity, right foot
	Q66.82	Congenital vertical talus deformity, left foot
New code	Q66.89	Other congenital deformity of feet

Hidden or buried penis

Buried penis was described in the early 20th century as a penis of normal size that lacks an appropriate sheath of skin and is located beneath the integument of the abdomen, thigh, or scrotum. This condition is more common in children, usually presenting in neonates or obese prepubertal boys; however, it can also be seen in adults and has been observed in both circumcised and uncircumcised individuals. Marginal cases may not be diagnosed until adulthood, when increased fat deposition accentuates the problem in patient who may not be considered obese. The reason that the condition may be seen in adults is a result of balanitis xerotica obliterans (BXO) that leads to scarring and tightness of the foreskin, or phimosis (inability to pull the foreskin back behind the glans. The skin of the lower abdomen and pubis descends or sags with age, causing the penis of some men to hide under excess skin and fat deposits. Several classification systems of buried penis have been proposed, although none has been universally adopted in the literature. In most congenital pediatric cases, the buried penis is self-limited. In untreated adults, however, the condition tends to worsen as the abdominal pannus continues to grow.

The code for congenital buried penis was presented at the September 2010 ICD-9-CM Coordination and Maintenance meeting. The American Urological Association believes that it is necessary to add a code for acquired buried penis to be able to track the occurrence of buried penis that is not a congenital defect.

TABULAR MODIFICATION

N48 Other disorders of penis

New code N48.7 Buried penis, acquired

Glasgow Coma Scale

The Glasgow Coma Scale (GCS) was introduced in 1974 by Drs. Teasdale and Jennett. This scale is composed of a score of 3 observations: status of eye opening, best verbal response and best motor response. The highest possible score is 15. The GCS is easily performed by many levels of medical personnel. Though the GCS was initially developed to measure coma and predict outcome in traumatic brain injury, it has been found a useful predictor of outcome in many other types of acute neurological impairment. It is widely used in emergency medicine, intensive care medicine, neurological, neurosurgical and trauma medicine assessments.

There are situations in which the full GCS assessment is difficult to perform. In the case of a sedated ventilator patient only the motor responses might be assessed, yet this limited score still has predictive value. Pediatric patients may require a variation of the GCS (the Pediatric Glasgow Coma Scale) that is also scored and on a 15-point basis with good predictive value.

In ICD-10-CM, coma requires three codes, each reflecting the score of one of the three areas of measurement of the GCS, and the specific time the test is administered. This is useful for trauma registries, but the more common entry into the medical record will be a total GCS score or no score at all, and the timing may not be available. The predictive value of the data is better associated with the total score than the individual variables. In the case of the sedated ventilator patient, only a best motor score might be documented. The timing of the test will have different predictive value depending on the situation.

For data coming from trauma registries, full reporting could be captured by separating coma associated with trauma from all other coma. The GCS total score stratification can be associated with other and unspecified coma as long as there is an option for instances when the GCS is not documented.

The American Academy of Neurology has proposed adding codes to ICD-10-CM to capture the GSC assessment when the detailed components are not included in the medical record documentation.

TABULAR MODIFICATION

R40.2 Coma

R40.20 Unspecified coma
Add Coma NOS
Add Unconsciousness NOS

New subcategory R40.24 Glasgow ~~Coma~~ coma scale, Total score
Use codes R40.21- - R40.23- only when the individual score(s) are documented

New code R40.241 Glasgow Coma Scale score 13-15
New code R40.242 Glasgow Coma Scale score 9-12
New code R40.243 Glasgow Coma Scale score 3-8
New code R40.244 Glasgow Coma Scale score less than 3
New code R40.245 Other coma, without documented Glasgow Coma Scale score, or with partial score reported.

Femoroacetabular impingement

Over the last ten years, orthopedists have identified a pathologic entity, femoroacetabular impingement (FAI) that is the cause of hip pain and dysfunction. It develops in young patients and is thought to be a condition that contributes to the ultimate development of osteoarthritis of the hip. FAI occurs when there is recurrent abutment of the anterolateral femoral head and neck upon the anterolateral rim of the acetabulum. FAI can be associated with tears of the acetabular labrum. The lesions are classified as femoral (cam) or acetabular-based (pincer) deformities. Both may occur at once.

Surgical approaches to FAI have included both open dislocations of the hip and arthroscopic approaches to this problem. The American Academy of Orthopedic Surgeons (AAOS) has requested that new codes be created for this condition.

TABULAR MODIFICATIONS

M24.8 Other specific joint derangements, not elsewhere classified

Note: The appropriate 7th character is to be added to each code from subcategory M24.A5:
- A cam lesion (femoral side)
- B pincer lesion (acetabular side)
- C with labral tear
- D with hip arthritis

New subcategory	M24.A5	Impingement
New code		M24.A51 Femoroacetabular impingement, right side
New code		M24.A52 Femoroacetabular impingement, left side
New code		M24.A53 Femoroacetabular impingement, bilateral
New code		M24.A59 Femoroacetabular impingement, unspecified side

Dehiscence of amputation stump

Questions have been raised related to coding for a dehiscence of an amputation stump. While it is a type of disruption of an operation wound, it is also a complication of an amputation. Thus, it is coded in ICD-10-CM to T87.8, Other complications of amputation stump. It is proposed to provide a specific code for dehiscence of an amputation stump. This issue was raised related to questions to the Editorial Advisory Board for Coding Clinic.

TABULAR MODIFICATIONS

T81 Complications of procedures, not elsewhere classified

T81.3 Disruption of wound, not elsewhere classified

T81.31 Disruption of external operation (surgical) wound, not elsewhere classified

Add: Excludes: dehiscence of amputation stump (T87.81)

T87 Complications peculiar to reattachment and amputation

T87.8 Other complications of amputation stump
~~Amputation stump contracture~~
~~Amputation stump contracture of next proximal joint~~
~~Amputation stump flexion~~
~~Amputation stump edema~~
~~Amputation stump hematoma~~

New code T87.81 Dehiscence of amputation stump

New code T87.89 Other complications of amputation stump
Amputation stump contracture
Amputation stump contracture of next proximal joint
Amputation stump flexion
Amputation stump edema
Amputation stump hematoma

Benign Shuddering Attacks

Benign shuddering attacks are a paroxysmal nonepileptic condition found in infants and toddlers. These may resemble seizures, and require evaluation to differentiate. In ICD-9-CM this condition had its own code at 333.93. This condition is not currently indexed nor does it have a specific code in ICD-10-CM.

The American Academy of Neurology (AAN) has requested changes to ICD-10-CM to provide a code for benign shuddering attacks.

TABULAR MODIFICATIONS

G25.8 Other specified extrapyramidal and movement disorders

New code G25.83 Benign shuddering attacks

Pulmonary conditions

Certain pulmonary conditions are represented by specific codes in ICD-9-CM, but do not have specific codes in ICD-10-CM. It has been proposed by Dr. Frank McCormack and Dr. Alan Plummer, in coordination with the American College of Chest Physicians, to add specific codes for certain of these specific conditions. These include alveolar proteinosis (516.0) and pulmonary alveolar microlithiasis (516.2), which had been included together at J84.0, Alveolar and parieto-alveolar conditions.

Idiopathic pulmonary hemosiderosis (516.1) is currently indexed in ICD-10-CM to E83.19 [J99]. It is proposed to create a new subcategory, J84.17, Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere, and a new code within that for Idiopathic pulmonary hemosiderosis, that would be used together with code E83.19, Other disorders of iron metabolism.

Postinflammatory pulmonary fibrosis (515) in ICD-9-CM includes pulmonary fibrosis NOS, and a number of additional terms. Related terms in ICD-10-CM go to code J84.1, Other interstitial pulmonary diseases with fibrosis. Consistent with prior ICD-9-CM proposals, that will be expanded. It is proposed to also add a code for pulmonary fibrosis, unspecified, and include postinflammatory pulmonary fibrosis and additional relevant terms there.

TABULAR MODIFICATIONS

E83 Disorders of mineral metabolism

E83.1 Disorders of iron metabolism

E83.19 Other disorders of iron metabolism

Add — Use additional code, if applicable, forIdiopathic pulmonary hemosiderosis (J84.171)

J84 Other interstitial pulmonary diseases

J84.0 Alveolar and parieto-alveolar conditions

Delete — ~~Alveolar proteinosis~~
~~Pulmonary alveolar microlithiasis~~

New code — J84.01 Alveolar proteinosis

New code — J84.02 Pulmonary alveolar microlithiasis

New code — J84.09 Other alveolar and parieto-alveolar conditions

J84.1 Other interstitial pulmonary diseases with fibrosis

Delete ~~Cirrhosis of lung~~
Delete ~~Diffuse pulmonary fibrosis~~
Delete ~~Fibrosing alveolitis (cryptogenic)~~
Delete ~~Hamman-Rich syndrome~~
Delete ~~Idiopathic pulmonary fibrosis~~
Delete ~~Induration of lung~~
Delete ~~Usual interstitial pneumonia~~

New code J84.10 Pulmonary fibrosis, unspecified
Postinflammatory pulmonary fibrosis
Cirrhosis of lung (chronic or unspecified)
Fibrosis of lung (atrophic) (confluent) (massive) (perialveolar) (peribronchial) chronic or unspecified
Induration of lung chronic or unspecified

New subcategory J84.17 Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere

New code J84.171 Idiopathic pulmonary hemosiderosis
Essential brown induration of lung
Code first underlying disease (E83.10-E83.19)
Excludes: acute idiopathic pulmonary hemorrhage in infants [AIPHI] (R04.81)

New code J84.178 Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere
Interstitial pneumonia (desquamative) (lymphocytic) (nonspecific) (usual) in diseases classified elsewhere
Interstitial pneumonia (desquamative) (lymphocytic) (nonspecific) (usual) due to collagen vascular disease
Organizing pneumonia in diseases classified elsewhere
Organizing pneumonia due to collagen vascular disease

Code first underlying disease, such as:
progressive systemic sclerosis (M34.0)
rheumatoid arthritis (M05.00-M06.9)
systemic lupus erythematosis (M32.0-M32.9)

Complications of genitourinary devices, implants and grafts

In reviewing the ICD-10-CM section for genitourinary prosthetic devices, grafts and implants (T83.--), the American Urological Association believes this section needs to be revised to incorporate appropriate terminology and current urological medical practice. There are certain occurrences for urological devices and prosthetics that should be included in this section and other instances where refinements are needed to remove references to specific complications that do not occur for a particular device, implant or graft.

TABULAR MODFICATIONS

T83 Complications of genitourinary prosthetic devices, implants and grafts

Revise T83.0 Mechanical complication of urinary ~~(indwelling)~~ catheter or stent

Revise	T83.01 Breakdown (mechanical) of urinary ~~(indwelling)~~ catheter or stent
New code	T83.011 Breakdown (mechanical) of indwelling urethral catheter
New code	T83.012 Breakdown (mechanical) of indwelling ureteral stent
Revise	T83.018 Breakdown (mechanical) of other ~~indwelling urethral~~ urinary catheter
Revise	T83.02 Displacement of urinary ~~(indwelling)~~ catheter or stent
Revise	Malposition of urinary ~~(indwelling)~~ catheter
New code	T83.021 Displacement of indwelling urethral catheter
New code	T83.022 Displacement of indwelling ureteral stent
Revise	T83.028 Displacement of other ~~indwelling urethral~~ urinary catheter
Revise	T83.03 Leakage of urinary ~~(indwelling)~~ catheter
New code	T83.031 Leakage of indwelling urethral catheter
Revise	T83.038 Leakage of other ~~indwelling urethral~~ urinary catheter
Revise	T83.09 Other mechanical complication of urinary ~~(indwelling)~~ catheter or stent
Revise	Obstruction (mechanical) of urinary ~~(indwelling)~~ catheter or stent
Revise	Perforation of urinary ~~(indwelling)~~ catheter or stent
Revise	Protrusion of urinary ~~(indwelling)~~ catheter or stent
New code	T83.091 Other mechanical complication of indwelling urethral catheter
New code	T83.092 Other mechanical complication of indwelling ureteral stent
Revise	T83.098 Other mechanical complication of other ~~indwelling urethral~~ urinary catheter

Revise T83.4 Mechanical complication of devices, prosthetics, implants and grafts of ~~genital~~ genitourinary tract

Revise T83.41 Breakdown (mechanical) of other prosthetic devices, implants and grafts of ~~genital~~ genitourinary tract

New code T83.411 Breakdown (mechanical) of urinary electronic (implanted) device

Includes: breakdown of pulse generator or receiver for sacral nerve neurostimulation

New code T83.412 Breakdown (mechanical) of urinary sphincter (implanted)

Revise T83.418 Breakdown (mechanical) of other prosthetic devices, implants and grafts of ~~genital~~ genitourinary tract

Revise T83.42 Displacement of other prosthetic devices, implants and grafts of ~~genital~~ genitourinary tract

Revise Malposition of other prosthetic devices, implants and grafts of genitourinary tract

New code T83.421 Displacement of urinary sphincter implant

New code T83.422 Displacement of urinary device (implanted)

Includes: breakdown of pulse generator or receiver for sacral nerve neurostimulation

Revise T83.428 Displacement of other prosthetics devices, implants and grafts of ~~genital~~ genitourinary tract

Revise T83.49 Other mechanical complication of other prosthetics devices, implants and grafts of ~~genital~~ genitorurinary tract

Revise Leakage of other prosthetic devices, implants and grafts of genitourinary ~~genital~~ tract

Revise Obstruction, mechanical of other prosthetic devices, implants and grafts of genitourinary ~~genital~~ tract

Revise Perforation of other prosthetic devices, implants and grafts of genitourinary ~~genital~~ tract

Revise Protrusion of other prosthetic devices, implants and grafts of genitourinary ~~genital~~ tract

New code T83.491 Other mechanical complication of urinary sphincter (implanted)

New code T83.492 Other mechanical complication of urinary electronic device

Includes: breakdown of pulse generator or receiver for sacral nerve neurostimulation

T83.498 Other mechanical complication of other prosthetic devices, implants and grafts of genital tract

T83.5 Infection and inflammatory reaction due to device, prosthetic, implant and graft in urinary system

Revise T83.51 Infection and inflammatory reaction due to ~~indwelling~~ urinary catheter

New code	T83.510	Infection and inflammatory reaction due to cystostomy cathether
New code	T83.511	Infection and inflammatory reaction due to indwelling uretheral cathether
New code	T83.512	Infection and inflammatory reaction due to other urinary cathether

New code T83.52 Infection and inflammatory reaction due to other urinary devices and implants

New code T83.53 Infection and inflammatory reaction due to graft of urinary organ

New code T83.54 Infection and inflammatory reaction due to penile (implanted) prosthesis

New code T83.55 Infection and inflammatory reaction due to urinary sphincter (implanted)

New code T83.56 Infection and inflammatory reaction due to indwelling ureteral stent

New code T83.57 Infection and inflammatory reaction due to urinary electronic device (implanted)

Revise T83.59 Infection and inflammatory reaction due to <u>other</u> prosthetic device, implant and graft in urinary system

T85 Complications of other internal prosthetic devices, implants and grafts

T85.1 Mechanical complication of implanted electronic stimulator of nervous system

T85.11 Breakdown (mechanical) of implanted electronic stimulator of nervous system

T85.110 Breakdown (mechanical) of implanted electronic neurostimulator of brain

Add Includes: pulse generator and/or electrode array of brain

T85.111 Breakdown (mechanical) of implanted electronic neurostimulator of peripheral nerve

Add Includes: pulse generator and/or electrode array of peripheral nerve

T85.112 Breakdown (mechanical) of implanted electronic neurostimulator of spinal cord

Add Includes: pulse generator and/or electrode array of spinal cord

T85.113 Breakdown (mechanical) of implanted electronic neurostimulator sacral nerve

Add Includes: pulse generator and/or electrode of sacral nerve

T85.12 Displacement of implanted electronic stimulator of nervous system

T85.120 Displacement of implanted electronic neurostimulator of brain

Add Includes: pulse generator and/or electrode array of brain

T85.121 Displacement of implanted electronic neurostimulator of peripheral nerve

Add	Includes: pulse generator and/or electrode array of peripheral nerve
	T85.122 Displacement of implanted electronic neurostimulator of spinal cord
Add	Includes: pulse generator and/or electrode array ~~(electrode)~~ of spinal cord
	T85.123 Displacement of implanted electronic neurostimulator of sacral nerve
Add	Includes: pulse generator and/or electrode array of sacral nerve
	T85.19 Other mechanical complication of implanted electronic stimulator of nervous system
	T85.190 Other mechanical complication of implanted electronic neurostimulator (electrode) of brain
Add	Includes: pulse generator and/or electrode array of brain
	T85.191 Other mechanical complication of implanted electronic neurostimulator electrode of peripheral nerve
Add	Pulse generator and/or electrode array of peripheral nerve
	T85.192 Other mechanical complication of implanted electronic neurostimulator (electrode) of spinal cord
Add	Includes: pulse generator and/or electrode array of spinal cord
New code	T85.193 Other mechanical complication of implanted electronic neurostimulator (electrode) of sacral nerve
	Inculdes: pulse generator and/or electrode array of sacral nerve

Posterior Reversible Encephalopathy Syndrome (PRES) and Cerebral Vasoconstriction

Posterior Reversible Encephalopathy Syndrome (PRES) is a syndrome of vasogenic edema that can be associated with eclampsia (and preeclampsia), severe or acute hypertension, immunosuppressants, renal disease and autoimmune disease. The clinical presentation includes headaches, seizures, vision changes and encephalopathy. Brain MRI's of these patients will show focal (and later reversible) vasogenic edema. There is not one consistent arterial abnormality on radiography. Proposed pathophysiologies include a breakdown of cerebral regulation, endothelial dysfunction, and vasospasm.

Currently PRES is indexed in ICD-10-CM to G93.49, Other encephalopathy. Since all of the proposed mechanisms are vascular, PRES would better be represented with cerebrovascular diseases. Also, PRES is a widely recognized syndrome which warrants its own ICD-10-CM code.

Cerebral vasoconstriction syndromes are different than PRES, though both are reversible and have similar presentations. There is some overlap between the two. These patients present with the sudden onset of headache (sometimes a "Thunderclap" headache syndrome), nausea, vomiting, confusion, and visual change. They may develop focal neurologic deficits. Generalized seizures may be present. The symptoms improve over days to weeks. Cerebral vasoconstriction may be focal or diffuse, and by definition angiography will be abnormal, usually with segmental constriction and dilatation ("string of beads"). The MRI may be normal, or may show ischemic or hemorrhagic, single or multifocal strokes. Besides the earlier clinical improvement, this syndrome is differentiated from the more serious primary angiitis of the central nervous system (PACNS) by angiographic reversibility of the vasoconstriction. The Call-Fleming syndrome is one of the reversible cerebral vasoconstriction syndromes. This type of vasoconstriction is also separate from that associated with aneurysmal subarachnoid hemorrhage and other similar conditions. Reversible cerebrovascular vasoconstriction can also be associated with eclampsia and preeclampsia, as well as migraine, illicit vasoactive drugs such as Ecstasy, vasoactive medications, and some chemotherapeutic agents. There have been other reported associations.

ICD-10-CM indexes Cerebral (artery) vasospasm to G45.9, Transient cerebral ischemic attack, unspecified. This is incorrect placement, as vasospasm is not always transient and not always ischemic.

The American Academy of Neurology (AAN) has requested changes to ICD-10-CM to address these issues.

TABULAR MODIFICATIONS

I67 Other cerebrovascular diseases

I67.8 Other specified cerebrovascular diseases

Delete ~~Acute cerebrovascular insufficiency NOS~~

Delete ~~Cerebral ischemia (chronic)~~

New code I67.80 Cerebrovascular disease, unspecified

New code I67.81 Acute cerebrovascular insufficiency
Acute cerebrovascular insufficiency unspecified as to location or reversibility

New code I67.82 Cerebral ischemia (chronic)

New code I67.83 Posterior reversible encephalopathy syndrome (PRES)

New subcategory I67.84 Cerebral vasospasm and vasoconstriction

New code I67.841 Reversible cerebrovascular vasoconstriction syndrome
Call-Fleming syndrome

Code first underlying condition if applicable, such as:
eclampsia (O15.00-O15.9)

New code I67.848 Other cerebrovascular vasospasm and vasoconstriction

New code I67.89 Other cerebrovascular disease

INDEX MODIFICATIONS

Revise PRES (Posterior Reversible Encephalopathy Syndrome) ~~G93.49~~ <u>I67.83</u>

Revise Vasospasm <u>(vasoconstriction)</u> I73.9
Revise - cerebral (artery) ~~G45.9~~ <u>I67.848</u>
Add - - reversible I67.841

Acute Necrotizing Hemorrhagic Encephalopathy

Acute necrotizing hemorrhagic encephalopathy (ANHE), also known as acute hemorrhagic leukoencephalitis or acute hemorrhagic encephalomyelitis is a relatively rare disorder with a high rate of mortality and morbidity. In contrast to acute disseminated encephalomyelitis (ADEM), ANHE has a hyper acute course and is characterized by prominent necrotizing cerebral vasculitis and hemorrhage. As with ADEM, ANHE made be due to post infectious or post immunization etiologies, however some cases have been associated with ulcerative colitis, septicemia, other underlying conditions, or the etiology may not be determined. In ICD-10, ANHE in these other cases would default to G04.30, Post infectious acute necrotizing hemorrhagic encephalopathy, which would not correctly reflect their etiology.

The American Academy of Neurology (AAN) has requested addition of a new code to ICD-10-CM to enable more accurately representing this disorder.

TABULAR MODIFICATIONS

G04 Encephalitis, myelitis and encephalomyelitis

G04.3 Acute necrotizing hemorrhagic encephalopathy

Revise	G04.30	Acute necrotizing hemorrhagic encephalopathy, unspecified ~~Post infectious acute necrotizing hemorrhagic encephalopathy~~
Delete		~~Acute necrotizing hemorrhagic encephalopathy NOS~~
Revise	G04.31	Postinfectious acute necrotizing hemorrhagic encephalopathy ~~Postimmunization acute necrotizing hemorrhagic encephalopathy~~
Delete		~~Use additional code to identify the vaccine (T50.A-, T50.B-, T50.Z-)~~
New code	G04.32	Postimmunization acute necrotizing hemorrhagic encephalopathy Use additional code to identify the vaccine (T50.A-, T50.B-, T50.Z-)
New code	G04.39	Other acute necrotizing hemorrhagic encephalopathy Code also underlying etiology, if applicable

Acute disseminated encephalitis and encephalomyelitis (ADEM)

Acute disseminated encephalitis and encephalomyelitis (ADEM) is an acute neurological disorder occurring in persons of all ages, although most often in children. Widespread availability of MRI has facilitated diagnosis of ADEM, which is associated with multiple inflammatory lesions in the white matter and gray matter of the brain and spinal cord, due to autoimmune demyelination. Symptoms are variable and may include coma, seizures, loss of vision, and other cranial nerve palsies.

ADEM has occurred after immunizations or infections, but in many cases no such association can be made. In ICD-10, such cases would default to G04.00 (post infectious ADEM), or present the possibility of classification as G04.81, Other encephalitis and encephalomyelitis, Noninfectious acute disseminated encephalomyelitis (noninfectious ADEM). In reality, all cases included in G04.0x are also "noninfectious," but rather are post infectious or postimmunization. Cases of ADEM not determined to be post infectious or post immunization belong in the ADEM code family, appropriately designated.

The American Academy of Neurology (AAN) has requested addition of a new code to ICD-10-CM to enable better representation for this disorder.

TABULAR MODIFICATIONS

G04 Encephalitis, myelitis and encephalomyelitis

G04.0 Acute disseminated encephalitis and encephalomyelitis (ADEM)

Add — Excludes1: Other noninfectious acute disseminated encephalomyelitis (noninfectious ADEM) (G04.81)

Revise — G04.00 Acute disseminated encephalitis and encephalomyelitis, unspecified ~~Post infectious acute disseminated encephalitis and encephalomyelitis (post infectious ADEM)~~

Delete — ~~Acute disseminated encephalitis and encephalomyelitis NOS~~

Delete — ~~Excludes1: noninfectious acute disseminated encephalomyelitis (noninfectious ADEM) (G04.81)~~

Delete — ~~post chickenpox encephalitis (B01.1)~~

Delete — ~~post measles encephalitis (B05.0)~~

Delete — ~~post measles myelitis (B05.1)~~

Revise — G04.01 Postinfectious acute disseminated encephalitis and encephalomyelitis (postinfectious ADEM) ~~Postimmunization acute disseminated encephalitis, myelitis and encephalomyelitis~~

Delete — ~~Encephalitis, post immunization~~

Delete — ~~Encephalomyelitis, post immunization~~

Delete — ~~Use additional code to identify the vaccine (T50.A-, T50.B-, T50.Z)~~

Add	Excludes1:	post chickenpox encephalitis (B01.1)
Add		post measles encephalitis (B05.0)
Add		post measles myelitis (B05.1)

New code	G04.02	Postimmunization acute disseminated encephalitis, myelitis and encephalomyelitis
		Encephalitis, post immunization
		Encephalomyelitis, post immunization
		Use additional code to identify the vaccine (T50.A-, T50.B-, T50.Z-)

Cerebellar Ataxia in Diseases Classified Elsewhere

In ICD-9-CM there is a code 334.4, Cerebellar ataxia in diseases classified elsewhere, which is useful and specific. It includes a note to code first underlying disease. This specific concept is not currently present in ICD-10-CM, because the main ataxia heading is "hereditary", and some of the secondary ataxias are indexed elsewhere (e.g., alcoholic ataxia to G31.2).

The American Academy of Neurology (AAN) has requested changes to ICD-10-CM to provide a code for cerebellar ataxia in diseases classified elsewhere, since such a code would be useful.

TABULAR MODIFICATIONS

G13 Systemic atrophies primarily affecting central nervous system in diseases classified elsewhere

New code
G13.2 Systemic atrophy primarily affecting the central nervous system in myxedema
Code first underlying disease, such as:
hypothyroidism (E03.-)
myxedematous congenital iodine deficiency (E00.1)

G13.8 Systemic atrophy primarily affecting central nervous system in other diseases classified elsewhere
Delete ~~Code first underlying disease, such as:~~
Delete ~~cerebellar ataxia (in):~~
Delete ~~hypothyroidism (E03.)~~
Delete ~~myxedematous congenital iodine deficiency (E00.1)~~

G32 Other degenerative disorders of nervous system in diseases classified elsewhere

G32.8 Other specified degenerative disorders of nervous system in diseases classified elsewhere
Delete ~~Degenerative encephalopathy in diseases classified elsewhere~~

New code
G32.81 Cerebellar ataxia in diseases classified elsewhere
Code first underlying disease, such as:
cerebellar ataxia (in):
neoplastic disease (paraneoplastic cerebellar degeneration)
Excludes1: systemic atrophy primarily affecting the central nervous system in myxedema (G13.2)
alcoholic cerebellar ataxia (G31.2)

New code
G32.89 Other specified degenerative disorders of nervous system in diseases classified elsewhere
Degenerative encephalopathy in diseases classified elsewhere

Reclassification of hemorrhoids in ICD-10

ICD-10 (and ICD-10-CM) currently classifies hemorrhoids at I84 in the vascular disease chapter. The current classification of hemorrhoids in ICD-10 as a venous disease is outdated. It is also suggested that the concept of internal and external hemorrhoids is outdated. Modern medical literature classifies hemorrhoids as an anal disease and further classifies it into four stages or degrees. The distinction of these stages is clear and affects the therapy given.

As of October 2010, the World Health Organization (WHO) has approved changes to ICD-10 (effective January 2013), that will move the hemorrhoids to a new category in Chapter 11, Diseases of the Digestive System and add new codes to the classification to reflect staging for this condition. The codes at I84 in the vascular chapter are being deleted. The scope of the new category has been expanded and will also include perianal venous thrombosis as well as the hemorrhoids.

NCHS is bringing this WHO approved proposal forward to seek input on the indexed terms that are being deleted from ICD-10 particularly internal and external hemorrhoids as well as thrombosed and prolapsed hemorrhoids. If the terms are still in active use in health care records they would be retained and re-indexed in ICD-10-CM.

TABULAR MODIFICATIONS

Delete **~~I84 Hemorrhoids~~**

Delete ~~Includes: piles~~
Delete ~~varicose veins of anus and rectum~~
Delete ~~Excludes1: hemorrhoids complicating childbirth and the puerperium (O87.2)~~
Delete ~~hemorrhoids complicating pregnancy (O22.4)~~
Delete **~~I84.0 Thrombosed hemorrhoids~~**
Delete **~~I84.00 Unspecified thrombosed hemorrhoids~~**
Delete ~~Thrombosed hemorrhoids, unspecified whether internal or external~~
Delete **~~I84.01 Internal thrombosed hemorrhoids~~**
Delete **~~I84.02 External thrombosed hemorrhoids~~**
Delete **~~I84.03 Internal and external thrombosed hemorrhoids~~**
Delete **~~I84.1 Hemorrhoids with other complications~~**
Delete **~~I84.10 Unspecified hemorrhoids with other complications~~**
Delete **~~I84.101 Unspecified bleeding hemorrhoids~~**
Delete **~~I84.102 Unspecified prolapsed hemorrhoids~~**
Delete **~~I84.103 Unspecified strangulated hemorrhoids~~**
Delete **~~I84.104 Unspecified ulcerated hemorrhoids~~**
Delete **~~I84.11 Internal hemorrhoids with other complications~~**
Delete **~~I84.111 Internal bleeding hemorrhoids~~**
Delete **~~I84.112 Internal prolapsed hemorrhoids~~**
Delete **~~I84.113 Internal strangulated hemorrhoids~~**
Delete **~~I84.114 Internal ulcerated hemorrhoids~~**
Delete **~~I84.12 External hemorrhoids with other complications~~**
Delete **~~I84.121 External bleeding hemorrhoids~~**
Delete **~~I84.122 External prolapsed hemorrhoids~~**
Delete **~~I84.123 External strangulated hemorrhoids~~**
Delete **~~I84.124 External ulcerated hemorrhoids~~**
Delete **~~I84.13 Internal and external hemorrhoids with other complications~~**
Delete **~~I84.131 Internal and external bleeding hemorrhoids~~**
Delete **~~I84.132 Internal and external prolapsed hemorrhoids~~**

Delete ~~**I84.133 Internal and external strangulated hemorrhoids**~~
Delete ~~**I84.134 Internal and external ulcerated hemorrhoids**~~
Delete ~~**I84.2 Hemorrhoids without complication**~~
Delete ~~**I84.20 Unspecified hemorrhoids without complication**~~
Delete ~~Hemorrhoids NOS~~
Delete ~~**I84.21 Internal hemorrhoids without complication**~~
Delete ~~Internal hemorrhoids NOS~~
Delete ~~**I84.22 External hemorrhoids without complication**~~
Delete ~~External hemorrhoids NOS~~
Delete ~~**I84.23 Internal and external hemorrhoids without complication**~~
Delete ~~Internal and external hemorrhoids NOS~~
Delete ~~**I84.6 Residual hemorrhoidal skin tags**~~
Delete ~~Skin tags of anus or rectum~~

New category K64 Hemorrhoids and perianal venous thrombosis
Includes: piles
Excludes*:* hemorrhoids complicating childbirth and the puerperium (O87.2)
hemorrhoids complicating pregnancy (O22.4)

New code K64.0 First degree hemorrhoids
Grade/stage I hemorrhoids
Hemorrhoids (bleeding) without prolapse outside of anal canal

New code K64.1 Second degree hemorrhoids
Grade/stage II hemorrhoids
Hemorrhoids (bleeding) that prolapse with straining, but retract spontaneously

New code K64.2 Third degree hemorrhoids
Grade/stage III hemorrhoids
Hemorrhoids (bleeding) that prolapse with straining and require manual replacement back inside anal canal

New code K64.3 Fourth degree hemorrhoids
Grade/stage IV hemorrhoids
Hemorrhoids (bleeding) with prolapsed tissue that cannot be manually replaced

New code K64.4 Residual hemorrhoidal skin tags
External hemorrhoids, NOS
Skin tags of anus or rectum

New code K64.5 Perianal venous thrombosis
External hemorrhoids with thrombosis
Perianal hematoma

New code K64.8 Other haemorrhoids
Internal hemorrhoids, degree not specified

New code K64.9 Unspecified hemorrhoids
Hemorrhoids (bleeding) NOS
Hemorrhoids (bleeding) without mention of degree

Concussion Codes

The codes for concussion in ICD-10-CM reflect a continuum of duration of loss of consciousness (LOC) matching that used for every brain injury code. In civilian settings concussion will most often be coded when the duration of LOC is shorter than 24 hours, as LOC longer than 24 hours is generally associated with moderate to severe traumatic brain injury. Because of the unfortunate increase in traumatic brain injury due to current military conflicts and the increased attention to sports-related concussion, the science is rapidly developing that will be better able to identify meaningful traumatic brain injury parameters in the future, and a more useful classification can be derived from that information. Therefore, at this time, the American Academy of Neurology believes it makes sense to eliminate the codes for concussion with loss of consciousness greater than 24 hours and leave the placeholder "x". When consistent scientific evidence for the parameters (duration of LOC or otherwise) that affect outcome of brain injury is available, the classification can be restructured to meet the needs of meaningful data collection.

TABULAR MODIFICATION

S06.0 Concussion
Commotio cerebri
Excludes1: concussion with other intracranial injuries classified in category S06- 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

S06.0x2 Concussion with loss of consciousness of 31 minutes to 59 minutes

S06.0x3 Concussion with loss of consciousness of 1 hour to 5 hours 59 minutes

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~~

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

ICD-10-CM TABULAR LIST OF DISEASES
PROPOSED ADDENDA (Effective October 1, 2011)

A41 Other sepsis

Revise A41.9 Sepsis, unspecified organism

CHAPTER 2
Neoplasms (C00-D49)

Notes:

Delete ~~Morphology [Histology]~~
~~Chapter 2 classifies neoplasms primarily by site (topography), with broad groupings for behavior, malignant, in situ, benign, etc. The Table of Neoplasms should be used to identify the correct topography code. In a few cases, such as for malignant melanoma and certain neuroendocrine tumors, the morphology (histologic type) is included in the category and codes. To identify the morphology for the majority of Chapter 2 codes that do not include the histologic type, comprehensive separate morphology codes are provided. These morphology codes are derived from the International Classification of Diseases for Oncology (ICD-O).~~

Malignant neoplasms (C00-C96)

Delete ~~Use additional morphology codes with behavior code /3~~

Malignant neoplasm of bone and articular cartilage (C40-C41)

Revise Excludes1:malignant neoplasm of bone marrow NOS (C96.9)

In situ neoplasms (D00-D09)

Delete ~~Use additional morphology codes with behavior code /2~~

Benign neoplasms, except benign neuroendocrine tumors (D10-D36)

Delete ~~Use additional morphology codes with behavior code /0~~

Neoplasms of uncertain behavior, polycythemia vera and myelodysplastic syndromes (D37-D48)

Revise Note: Categories D37-D44, and D48 classify by site neoplasms of uncertain behavior, i.e., histologic confirmation whether the neoplasm is

malignant or benign cannot be made. ~~Use additional morphology codes with behavior code /1.~~

G71 Primary disorders of muscles

G71.0 Muscular dystrophy

Add — Congenital muscular dystrophy NOS

Add — Congenital muscular dystrophy with specific morphological abnormalities of the muscle fiber

Delete — ~~Excludes1:congenital muscular dystrophy NOS (G71.2)~~

Delete — ~~congenital muscular dystrophy with specific morphological abnormalities of the muscle fiber (G71.2)~~

G71.2 Congenital myopathies

Delete — ~~Congenital muscular dystrophy NOS~~

Delete — ~~Congenital muscular dystrophy with specific morphological abnormalities of the muscle fiber~~

J84 Other interstitial pulmonary diseases

J84.2 Lymphoid interstitial pneumonia

Delete — ~~Endogenous lipoid pneumonia~~

Delete — ~~Excludes1:exogenous lipoid pneumonia (J69.1)~~

Delete — ~~unspecified lipoid pneumonia (J69.1)~~

J84.8 Other specified interstitial pulmonary diseases

Add — Endogenous lipoid pneumonia

Add — Excludes1:exogenous lipoid pneumonia (J69.1)

Add — unspecified lipoid pneumonia (J69.1)

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

Delete — ~~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.~~

Add Includes: the listed maternal conditions only when specified as a cause of mortality or morbidity of fetus or newborn

J84 Other interstitial pulmonary diseases

J84.2 Lymphoid interstitial pneumonia

Delete ~~Endogenous lipoid pneumonia~~

Delete ~~Excludes1:exogenous lipoid pneumonia (J69.1)~~
Delete ~~unspecified lipoid pneumonia (J69.1)~~

J84.8 Other specified interstitial pulmonary diseases

Add Endogenous lipoid pneumonia

Add Excludes1:exogenous lipoid pneumonia (J69.1)
Add unspecified lipoid pneumonia (J69.1)

Q28 Other congenital malformations of circulatory system

Q28.3 Other malformations of cerebral vessels
Add Developmental venous anomaly

S83 Dislocation and sprain of joints and ligaments of knee

S83.8 Sprain of other specified parts of knee

S83.8x Sprain of other specified parts of knee

Revise S83.8x2 Sprain of other specified parts of left knee

Revise S83.8x9 Sprain of other specified parts of unspecified knee

T14 Injury of unspecified body region

T14.8 Other injury of unspecified body region

Add Abrasion NOS

Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances (T36-T50)

Delete ~~Use additional code(s) for all manifestations of poisoning and adverse effects~~

Add Use additional code to specify the effects of the poisoning

Add Excludes: adverse effects ["hypersensitivity", "reaction", etc.] of correct substance properly administered; such cases are to be classified according to the nature of the adverse effect, such as:
aspirin gastritis (K29.-)
blood disorders (D50-D76)
contact dermatitis (L23-L25)
nephropathy (N14.0-N14.2)
unspecified adverse effect of drug (T88.7)

Add Note: The drug giving rise to the adverse effect may be identified by use of appropriate codes in categories T36-T50

Z86 Personal history of certain other diseases

Z86.5 Personal history of mental and behavioral disorders

Delete ~~Excludes2:substance abuse and dependence (F10-F19 with final character 1, in remission)~~

ICD-10-CM INDEX OF DISEASES

PROPOSED ADDENDA (Effective October 1, 2011)

Revise	Abrasion T14.8
Add	- skin NEC T14.8
	Adenocarcinoma - see also Neoplasm, malignant, by site
Delete	~~- with~~
	Adhesions, adhesive…
Add	- ear
Add	- - middle H74.1-
	Aneurysm (anastomotic) (artery)… I72.9
Add	- celiac I72.8
Add	- gastroduodenal I72.8
Add	- gastroepiploic I72.8
Add	- hepatic I72.8
Add	- pancreaticoduodenal I72.8
Add	- specified NEC I72.8
Add	- superior mesenteric I72.8
Add	- visceral NEC I72.8
	Angioma - see also Hemangioma, by site
Add	venous Q28.3
Revise	Anisocoria (pupil) *H57.02*
	Arteriosclerosis, arteriosclerotic… I70.90
Add	-carotid (see also Occlusion, artery, carotid) I65.2-
	Arthritis, arthritic…
	- in (due to)
Revise	- - bacterial disease (see also category M01) A49.9
Revise	- - Hemophilus influenzae M00.8 [B96.3]
	Carcinoma (malignant) - see also Neoplasm, by site, malignant
	- infiltrating
Revise	- - ductular
Revise	Contusion T14.8

Revise Crush, crushed, crushing T14.8

Dementia…
- in (due to)
Revise - - Parkinson's disease ~~(parkinsonism)~~ G20 [F02.80]
Delete ~~- - with behavioral disturbance G31.83 [F02.81]~~
- Lewy body G31.83 [F02.80]
Add - - with behavioral disturbance G31.83 [F02.81]

Disorder (of)…
- ear
- - middle H74.9-
Add - - - adhesive H74.1-

Migraine
Add - complicated G43.109

Neoplasm

Revise	- lumbosacral plexus	C47.5	C79.89	-	D36.16	D48.2 D49.2
Revise	- subpleural	C34.9-	C78.0-	D02.2	D14.3-	D38.1 D49.1

Delete ~~Pneumonia (acute) (Alpenstich) (benign) (bilateral) (brain) (cerebral) (circumscribed) (congestive) (creeping) (delayed resolution) (double) (epidemic) (fever) (flash) (fulminant) (fungoid) (granulomatous) (hemorrhagic) (incipient) (infantile) (infectious) (infiltration) (insular) (intermittent) (latent) (migratory) (organized) (overwhelming) (primary (atypical) progressive) (pseudolobar) (purulent) (resolved) (secondary) (senile) (septic) (suppurative) (terminal) (true) (unresolved) (vesicular) J18.9~~

Add Pneumonia (acute) (double) (migratory) (purulent) (septic) (unresolved) J18.9

Revise Recklinghausen disease Q85.01

Sequelae (of) - see also condition
- disease
- - cerebrovascular I69.90
Revise - - - cognitive deficits I69.91
- - - specified type NEC I69.80
Revise - - - - cognitive deficits I69.81
- hemorrhage
- - intracerebral I69.10
Revise - - - cognitive deficits I69.11
- - intracranial, nontraumatic NEC I69.20

Revise	- - - cognitive deficits I69.21
	- - subarachnoid I69.00
Revise	- - - cognitive deficits I69.11
	- infarction
	- - cerebral I69.30
Revise	- - - cognitive deficits I69.31
	- stroke NOS I69.30
Revise	- - - cognitive deficits I69.31
	Telangiectasia, telangiectasis (verrucous) I78.1
Add	- juxtafoveal H35.07-
Add	- macular H35.07-
Add	- parafoveal H35.07-
Revise	- retinal (idiopathic) (juxtafoveal) (macular) (parafoveal) H35.07-
	Thickening
Add	- endometrium R93.8
	Von Recklinghausen
Revise	- disease (neurofibromatosis) Q85.01