

ICD-10 Coordination and Maintenance Committee Meeting
Summary of Diagnosis Presentations
September 22-23, 2015

Donna Pickett, co-chair of the committee, welcomed the members of the audience to the diagnosis portion of the meeting. Ms. Pickett reviewed the timeline and went over key dates and information from the beginning of the topic packet informing the attendees of the deadline for written comments on topics presented at this meeting. All topics are being considered for implementation on October 1, 2016. There will not be any final decisions made at the meeting. The ICD-10-CM 2016 files are posted to the CDC website:
<http://www.cdc.gov/nchs/icd/icd10cm.htm>.

From Donna's announcements:

The ICD-10-PCS 2016 updated files are posted on the CMS website.

<https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-PCS-and-GEMs.html>

In August, an updated expanded list of Present On Admission exempt codes was posted, available from the CDC ICD-10-CM web page above.

It is recognized that there has been a request from Nelly Leon-Chisen, representing the American Hospital Association, to release at least a partial addenda in January 2016 (see 9/22 morning session video, linked below, at 0:18:10). This request will be taken this under consideration.

Written comments for the diagnosis proposals must be received by NCHS by November 13, 2015. Ms. Pickett requested that comments be sent via electronic mail to the following email address: nchsicd10CM@cdc.gov. This email address should be used for all correspondence including new proposals and comments. Telephone contact information for all NCHS staff and the NCHS website are included in the topic packet. Attendees were also reminded that the full topic packet is currently posted on the NCHS website. New proposals for the March 9-10, 2016 meeting must be received by January 15, 2016. The tentative agenda and Federal Register Notice will be posted one month prior to the meeting.

NCHS no longer provides a hard copy continuing education (CE) certificate for this meeting. Attendees were instructed to contact their respective professional association for further information on CE reporting details. NCHS will continue to report, in this summary, the number of hours for each day of the meeting. On September 22, 2015, the meeting convened at 9:00 a.m. and adjourned at about 4:00 p.m. with a 1 hour lunch, for a total of six hours. On September 23, 2015, the meeting convened at 9:10 a.m. and adjourned about 11:45 a.m., for a total of about 2.5 hours. The total for both days was about 8.5 hours. Attendees may be eligible for CE hours.

Video of the meeting is available from the CMS Youtube channel, with links to each session below (<https://www.youtube.com/user/CMSHHSgov>).

2015 Sep 22th, ICD-10 Coordination & Maintenance Committee (Morning Session)

<https://www.youtube.com/watch?v=qQWjxUZFBPw>

2015 Sep 22th, ICD-10 Coordination & Maintenance Committee (Afternoon Session)
<https://www.youtube.com/watch?v=MEwwAZkG1BI>

2015 Sep 23rd, ICD-10 Coordination & Maintenance Committee (Morning Session)
<https://www.youtube.com/watch?v=EfVQtIKXwLc>

Comments and discussion on the topics presented on September 22-23, 2015 were as follows:

Abscess of Anal and Rectal Regions

The clinical presentation for this topic was provided by Dr. Garth H. Utter, MD, MSc, with the Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma; and the proposed coding modifications were presented by Cheryl Bullock. There were no comments on this proposal.

Acquired Hydrocephalus

Donna Pickett presented the clinical background and the proposed coding modifications for this proposal, and noted that this proposal is based on a World Health Organization (WHO) change to ICD-10. Nelly Leon-Chisen, representing the American Hospital Association, expressed concern that it could be hard to tell in a newborn whether this was acquired or not, and wondered if there was an intent to discourage the congenital from being used. She suggested that a default code would be useful.

Amblyopia Suspect

Dr. Michael X Repka, M.D., MBA, representing the American Academy of Ophthalmology, provided the clinical presentation for this topic, and Shannon McConnell Lamptey provided the proposed coding modifications. There were no comments on this proposal.

Amyotrophic Lateral Sclerosis (ALS)

Donna Pickett presented the clinical background and the proposed coding modifications for this proposal. Dr. Laura Powers, representing the American Academy of Neurology (AAN), stated that they were all for this. She expressed talking about this with two neurologists that run ALS clinics. The suggestion from one of them was that both progressive spinal atrophy and primary lateral sclerosis phenotypically turn into ALS, so eventually they will wind up with the ALS code. However, there is room, and so the AAN experts thought that it would be appropriate to provide separate codes for each of these conditions. Dr. Powers agreed to convey this in writing, also.

Asthma Control Status: Controlled and Uncontrolled

The clinical presentation for this topic was provided by Dr. Elizabeth Matsu, MD, MHS, Professor of Pediatrics, Epidemiology, and Environmental Health Sciences at Johns Hopkins University, for the American Academy of Allergy Asthma and Immunology (AAAAI); the proposed coding modifications were presented by Cheryl Bullock, Nelly Leon-Chisen,

representing the American Hospital Association, asked a clinical question as to how you would differentiate an acute exacerbation, from uncontrolled, or how you would tell the difference. Dr. Matsui responded that uncontrolled is over a longer time period. An acute exacerbation often is triggered by something, such as a respiratory infection. Severity and abruptness of onset differentiate it.

Jeanne Yoder, with the military health system stated that as a data analyst, when changing an existing code, it is difficult to flag that the code changed its definition. She suggested that it would be better to change and not re-use the same code, but to start with two new codes instead. Dr. Matsui responded that this is a point that should be well taken; there can be issues with code meaning. She also noted that clinicians do not on a day to day usage talk about uncomplicated diabetes. She said that it does make sense to capture this as a different code.

Sue Bowman, representing AHIMA, stated that she has bad memories related to diabetes, with even doctors being unsure whether something is controlled or uncontrolled. She expressed concerns about how this change is proposed. Dr. Matsui responded that asthma control is the important assessment that needs to happen at every asthma visit, and these have been in the guidelines for 8 years or more, and this is in widely used information. She stated that it is a different scenario than that for diabetes.

Nelly Leon-Chisen, representing the American Hospital Association, recommended having an NOS option, for cases where it is not clear.

Atrial Fibrillation

David Berglund, MD presented the clinical background and the proposed coding modifications for this proposal. Sue Bowman, representing AHIMA, asked whether this proposal was approved by the American Heart Association, or the ACC, and also questioned the level of detail proposed, and whether this would be necessary or clinically used. It was noted that this proposal had been sent to the ACC, together with some others, and while some comments have been received, there was not a definite response as to whether the proposed changes related to atrial fibrillation would be supported by ACC.

Nelly Leon-Chisen, representing the American Hospital Association, commented about the term “first detected,” and questioned how that would be recorded. She stated that unless there is a clinical reason and clear way of handling this, she would recommend not making changes to try to capture first detected cases of atrial fibrillation. It was noted that a code for first detected atrial fibrillation would be an additional code in any case, to be used secondary to one of the other atrial fibrillation codes.

Chronic hepatitis vs. hepatitis carrier

David Berglund, MD presented the clinical background and the proposed coding modifications for this proposal. This proposal is based on WHO changes to ICD-10. There were no comments on this proposal.

Clostridium difficile

The clinical presentation for this topic was provided by Dr. Andy DeRyke, Pharm.D. Scientific Affairs Strategy Lead for the Infectious Disease Scientific Directors, Merck Research Labs, and the proposed coding modifications were presented by Cheryl Bullock. Sue Bowman, representing AHIMA, suggested the two codes could suffice, for recurrent, and not specified as recurrent; she noted that the term initial is also not specified as recurrent.

Contact with knife, sword or dagger

Shannon McConnell Lamptey presented the clinical background and the proposed coding modifications for this proposal. There were no comments on this proposal.

Encounter and Surveillance Codes for Implantable Subdermal Contraceptives

Charles Dubose, representing Merck, Medical Affairs Director, and obstetrician-gynecologist presented clinical information on this proposal, and Donna Pickett presented the proposed coding modifications. It was noted that this proposal affects codes that were proposed to be modified by a previous ACOG proposal. It was also noted that this subdermal contraceptive is not a device. There were no comments on this proposal.

Encounter for examination of eyes and vision with abnormal findings

Dr. Michael X Repka, M.D., MBA, representing the American Academy of Ophthalmology, provided the clinical presentation for this topic, and Shannon McConnell Lamptey provided the proposed coding modifications. There were no comments on this proposal.

End Stage Heart Failure, Right Heart Failure and Biventricular Heart Failure

David Berglund, MD presented the clinical background on end state heart failure, and the proposed coding modifications for this proposal. Sue Bowman, representing AHIMA, raised a question on the term undetermined classification, and how that may seem to be another way of saying unspecified. She stated that the term would seem to imply that the doctor did not know. She also said she would prefer not to add as many codes as were proposed. Without mention of end stage, and end stage, may be sufficient, without adding undetermined classification.

Nelly Leon-Chisen, representing the American Hospital Association, asked what classification this was coming from, and where the proposal had come from. Dr. Berglund noted that the proposal was from a practicing cardiologist, and is under review by the American College of Cardiology (ACC). The classification of heart failure into an ABCD classification is by the American College of Cardiology (ACC) jointly with the American Heart Association (AHA), with end stage heart failure falling into stage D.

Dr. Berglund presented the right heart failure and biventricular heart failure clinical background and proposed coding modifications, following the presentation on high output heart failure. Nelly Leon-Chisen, representing the American Hospital Association, commented that the Code also notes proposed for right and biventricular heart failure would only provide more information if the code referenced was not the unspecified; she suggested that the note be changed, and not include the unspecified, I50.1, but start with I50.2 instead. Dr. Berglund agreed that was reasonable.

External Cause Codes for Work-related Musculoskeletal Disorders Caused by Ergonomic Hazards

The clinical presentation for this topic was provided by Alysha R. Meyers, PhD, CPE; Epidemiologist, Centers for Disease Control and Prevention; National Institute for Occupational Safety and Health (CDC/NIOSH), and the proposed coding modifications were presented by Shannon McConnell Lamptey.

Sue Bowman, representing AHIMA, commented on noticing in the write up that part of why these codes were deactivated and discontinued was people thought the use of the codes was too subjective. She wondered what may have changed, and whether the proposed restored codes would still be too subjective, and whether these might not provide data that would be comparable. Also, she questioned a very specific proposed inclusion term at X50.3, kicking a carpet stretcher with knee.

Dr. Meyers noted that the Ohio Bureau of Workers' Compensation has been using these codes since 2011, and the E927 code is the most commonly used code for their coders. They do not have trouble deciding which involve overexertion. There were some stakeholders not at the table when these codes were retired. As for the carpet, Dr. Meyers stated that this proposal is a much simplified version. Previously in a draft there were six different inclusions. It would be feasible to add a few terms. Repetitive bending over, or grasping or pinching, or other repetitive motion, would be applicable.

Nelly Leon-Chisen, representing the American Hospital Association, noted that these codes seem to refer to exposures. She questioned whether the proposed location was the best place, or whether perhaps something needs to be done to create a new block. Dr. Meyers stated that the X50 category name is one that they would like to change, but understand that the need to be consistent with what WHO uses. Ms. McConnell Lamptey invited comment on what terms are being used in the records seen by coders.

Gingival recession

Shannon McConnell Lamptey presented the clinical background and the proposed coding modifications for this proposal. Jeanne Yoder, with the military health system asked whether gingival recession can be different on each arch, different between the upper and lower teeth? She stated that she would think these could differ, and that even just one ramus could differ. She expressed uncertainty, but concern that this could be an issue. Jeanne Narcissi, representing the American Dental Association (ADA), responded affirmatively, that this could happen. She also noted that AAP (American Academy of Periodontology) was also requesting that terms for postinfective and postprocedural be removed (although these are not shown as removed in the topic packet). She said that there can be a generalized gingival recession and a localized gingival recession, and each of those can be mild, moderate, and severe, so for each there can be three types. For differences in the different parts of the arches, that could be identified elsewhere.

Jeanne Yoder, with the military health system said that it can seem to not make sense if you have different codes showing different severity, but do not have the location to clarify that these are for different places.

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

David Berglund, MD presented the clinical background and the proposed coding modifications for this proposal. Nelly Leon-Chisen, representing the American Hospital Association, asked whether for completeness, wouldn't you want to have the same language, heart failure with reduced ejection fraction (EF) and with preserved EF? Dr. Berglund stated that this is based on a cut off, and so the ejection fraction (EF) has to be either reduced (below the cut off), or normal (above the cut off); it cannot be both. Systolic failure involves a reduced EF, not pumping enough blood that is in the left heart ventricle (at start of systole), and diastolic heart failure usually involves preserved EF, where the percentage of the blood that is pumped (during systole) is OK, but there was not as much blood in the heart to start with (because of a problem with the ventricle filling during diastole).

Hepatic Encephalopathy

The clinical presentation for this topic was provided by Dr. Joe Harper, PharmD, Senior Director, Medical Affairs, Valeant Pharmaceuticals North America LLC, and the proposed coding modifications were presented by Shannon McConnell Lamptey. Linda Holtzman, Clarity Coding, asked about the distinction between hepatic encephalopathy, and hepatic coma. It was noted that hepatic encephalopathy only occurs when there is some stage of liver failure.

Dr. Laura Powers, representing the American Academy of Neurology, noted that there is a disconnect here, with the terms hepatic encephalopathy and hepatic coma previously combined in coding with ICD-9-CM. Separating them did not matter, until treatment was developed. For ICD-10-CM, the presumption could be made that the terms with coma would include cases that were encephalopathic; without coma can mean no encephalopathy. I could see adding encephalopathy to codes that are with coma. However, this proposal is to separate out the degree of encephalopathy. Although there are four stages, it is only proposed to separate into two; that does not make sense.

Sue Bowman, representing the American Health Information Management Association (AHIMA), expressed concern that this approach seems confusing. With the separate K72 and K76 codes, it seems this could set up a way to code it in two different ways. Ms. Bowman also asked where the medical specialty societies stand on this proposal, noting that it came from a pharmaceutical company, and whether there could be ways to improve the proposal. Ms. McConnell Lamptey noted that the proposal has been sent to the American Society for the Study of Liver Disease for review, with feedback being awaited.

Linda Holtzman also expressed concern that this could be confusing, and although separate codes for hepatic encephalopathy could be useful, expressed uncertainty as to whether this would be the best structure for it.

High Output Heart Failure

David Berglund, MD presented the clinical background and the proposed coding modifications for this proposal. During the presentation, Dr. Berglund also raised the question of whether it would be useful to also create a new code at I50.89, for Other heart failure, that is not elsewhere classified; comment on that possibility is invited.

A question was raised about coding of septic shock with high output heart failure, since sepsis can be a cause of high output heart failure. It was noted that the proposal referenced an excludes note for septic shock that gave an ICD-9-CM code; that was an error that should be corrected (to reference code R65.21, Severe sepsis with septic shock). Jeanne Yoder, with the military health system, suggested considering a code also note, or possibly an Excludes2 note. Sue Bowman, representing AHIMA, stated that she did not think an Excludes note was needed, since if a case is documented as septic shock, then you would not be at that code.

Hypertension in Pregnancy

Traci Ramirez presented the clinical background and the proposed coding modifications for this proposal. Nelly Leon-Chisen, representing the American Hospital Association, commented that there appeared to be a typo, with O15.0 and O15.1 both showing the same title, with the term “complicating pregnancy;” she asked if one could be complicating childbirth. Ms. Ramirez noted that will be checked.

Sue Bowman, representing AHIMA, stated that she thought there had been an EAB question on secondary pulmonary hypertension complicating pregnancy, and wondered whether ACOG had commented on that. Ms. Ramirez noted that this issue will be sent to ACOG for a response.

Hypophosphatasia

The clinical presentation for this topic was provided by Dr. Uchenna Iloeje from Alexion Pharmaceuticals, and the proposed coding modifications were presented by Donna Pickett. There were no comments on this proposal.

Infection Following a Procedure

The clinical presentation for this topic was provided by Dr. Garth H. Utter, MD, MSc, with the Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma; and the proposed coding modifications were presented by Cheryl Bullock.

Nelly Leon-Chisen, representing the American Hospital Association, had a clinical question as to whether the same patient could have a postprocedural retroperitoneal abscess with any of the proposed new T81.4 codes for infection following a procedure, since now there is an existing Excludes1 type of note, and that would mean that they could not occur together. Dr. Utter stated that is a good point, as those could occur together, so that should probably be corrected.

Ms. Leon-Chisen also noted that obstetrical wounds are in a separate chapter, and asked if there is interest in tracking those also. Dr. Utter noted that while it is a much smaller population, he would not be opposed to having a similar expansion for that also.

Sue Bowman, representing AHIMA, commented about stitch abscess being an inclusion term at proposed new code T81.48; that she would have thought it would be more like a superficial incisional site; she was unclear what would differentiate it from things at T81.41 and T81.42. Dr. Utter stated that the question is whether it is an infection at all. However, it has been included there, so it seems to need to be included somewhere. Thus, this was an attempt to keep it in the same category as WHO placed it, and yet have the other codes be specific to clinical usage.

Inflammatory Disorders of Breast

The clinical presentation for this topic was provided by Dr. Garth H. Utter, MD, MSc, with the Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma; and the proposed coding modifications were presented by Shannon McConnell Lamptey. There were no comments on this proposal.

Intestinal Obstruction

The clinical presentation for this topic was provided by Dr. Garth H. Utter, MD, MSc, with the Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma; and the proposed coding modifications were presented by Shannon McConnell Lamptey

Nelly Leon-Chisen, representing the American Hospital Association, commented that some other instructional notes would be needed. She also stated that some of the other codes say “with obstruction,” and that could be intestinal obstruction. Thus, she asked whether Dr. Utter would envision needing to code both a new code, and an existing one. He responded that he would have to review specific instances, but expressed uncertainty about whether there would be instructions on coding other things also, such as hernia. He stated that on the face of it, allowing the coding of both would seem to be reasonable. He stated that use of obstruction for hernia is awkward, because it does not say if there is an intestinal obstruction. He expressed being open to either approach, adding more codes to the hernia classification, or adding one of these codes if appropriate, to account for this distinction.

Ms. Leon-Chisen also noted that she and Sue Bowman were discussing code K91.3, Postprocedural intestinal obstruction, and whether it could potentially overlap with code K56.5, Intestinal adhesions with obstruction, and within parentheses, “(postprocedural).” Ms. McConnell Lamptey stated that this will be reviewed, and it will be determined whether the nonessential modifiers need updating.

Lysosomal Acid Lipase (LAL) Deficiency

The clinical presentation for this topic was provided by Dr. Uchenna Iloeje from Alexion Pharmaceuticals, and the proposed coding modifications were presented by Donna Pickett. There were no comments on this proposal.

Mediastinitis

The clinical presentation for this topic was provided by Dr. Garth H. Utter, MD, MSc, with the Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma; and the proposed coding modifications were presented by Shannon McConnell Lamptey. There were no comments on this proposal.

Megacolon

David Berglund, MD presented the clinical background and the proposed coding modifications for this proposal. Nelly Leon-Chisen, representing the American Hospital Association, asked about radiation and whether that would be from radiation therapy, or from external radiation; she noted that it would make a difference in the codes to use (which are outside the code first note

range). It was noted that either type of radiation should be possible causes, so that will be something to consider. The proposal also would add the term “if applicable” to the code first note. It could be reasonable to add the radiation codes to the code first note.

Non-Exudative AMD (Age-related Macular Degeneration)

Dr. Michael X Repka, M.D., MBA, representing the American Academy of Ophthalmology, provided the clinical presentation for this topic, and Shannon McConnell Lamptey provided the proposed coding modifications. Nelly Leon-Chisen, representing the American Hospital Association, asked whether the term advanced dry stage would never be used, or would some people still use such a term? Dr. Repka stated that he would be agreeable with that term being included or kept as an index entry, although he would not make it the parent term or code title. Another expert, Dr. Daniela Ferrara, a retina specialist, commented that dry means not exudative, and that this refers to presence of druzen, so this differentiates the form of degeneration. Dr. Repka stated that an index entry might be the perfect way to handle this.

Observation and evaluation of newborns for suspected conditions ruled out

Cheryl Bullock presented the clinical background and the proposed coding modifications for this proposal. Sue Bowman, representing AHIMA, commented that the second to last sentence, right above the one shown as being deleted, should also be deleted, that states newborns suspected as having abnormal conditions resulting from exposures to the mother or the birth process. She stated that this will address the point of the changes, as originally the category mixed those babies with a suspected condition that was ruled out with those that actually have a condition.

Proposal to change Excludes Designations for Epilepsy

Cheryl Bullock presented the clinical background and the proposed coding modifications for this proposal. Corwyn Williams, representing American Academy of Neurology (AAN), commented to acknowledge that as stated, this proposal was submitted by AAN for the reasons outlined. He also expressed that these changes were shared with the National Association of Epilepsy Centers, and they were in agreement as well.

Pulmonary Hypertension

The clinical presentation for this topic was provided by Dr. David Platt, MD, representing Bayer HealthCare Pharmaceuticals, and the proposed coding modifications were presented by David Berglund, MD. Dr. Berglund remarked that on the proposed new code I27.29, Secondary pulmonary hypertension, NEC, it would be possible to instead create one fewer code, and combine the I27.29 along with the proposed new code I27.24, Group 5 pulmonary hypertension. Input public is sought on whether this would be preferable. Dr. Platt agreed that could be a reasonable approach.

Nelly Leon-Chisen, representing the American Hospital Association, commented that with the new codes we have and concerns from many about there being too many codes, along with not having any previous requests for new codes for this until now, she would recommend that before going forward with this proposal, input be obtained from the relevant medical societies. She also stated that the existing ICD-10-CM structure could convey the clinical condition already with two codes, as you would have the underlying condition separately anyway.

Sue Bowman, representing AHIMA, also called for input from relevant specialty groups on whether this expansion would be desired for clinical purposes. She further noted that under the Excludes1 note that is present, for “secondary pulmonary hypertension,” it would go to an NEC or NOS code. Dr. Berglund stated that another option for the Excludes note would be to use I27.2- (with a dash or hyphen at the end, intended to match any fifth character).

Dr. Platt stated that current coding for pulmonary hypertension diverges greatly from current accepted clinical classification of this disorder. Just because a request has not come in does not mean it is not recognized as a problem. Dr. Platt illustrated this by referring to a paper looking at deaths through the NCHS US death database, and noted that when a new code was added for secondary pulmonary hypertension, the number of deaths reported as primary pulmonary hypertension plummeted, even though the overall number of deaths related to pulmonary hypertension remained the same and continued to increase. He interpreted this as showing that the added detail in the coding system enabled more accurate coding, and also as very clearly showing that the current coding system is deficient when it comes to the pulmonary hypertension. He recognized the need to maintain simplicity. However, he concluded that the proposed changes would not be burdensome for the physicians who are treating the disease, but would be very intuitive to experts in this field.

Dr. Berglund confirmed that input will be sought from ACC and pulmonologists, and any other medical specialty groups with an interest in this.

Risk Level for Dental Carries

Traci Ramirez presented the clinical background and the proposed coding modifications for this proposal. Jeanne Narcissi, representing the American Dental Association (ADA), stated that these codes are necessary for quality measurement and the meaningful use program. She further stated that ADA originally proposed these codes for the dental caries section, and were considering that these may often be found in young children, some of whom may not have a personal history, so she was wondering if the proposed code structure location was the best place for these to fit. It was noted that typically such codes as risk factors are in the “Z” code chapter in ICD-10 and ICD-10-CM, so that is for consistency with the classification.

Sue Bowman, representing AHIMA, noted that she found this proposal confusing. She stated that from the wording, it sounds like they no longer have the risk, just a personal history of it, as well as having it in the personal history section. However, it is a current risk factor, not a history of a risk factor.

Subarachnoid hemorrhage

David Berglund, MD presented the clinical background and the proposed coding modifications for this proposal. There were no comments on this proposal.

Vascular Disorders of Intestine

The clinical presentation for this topic was provided by Dr. Garth H. Utter, MD, MSc, with the Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma; and the proposed coding modifications were presented by Shannon McConnell Lamptey.

Nelly Leon-Chisen, representing the American Hospital Association, expressed that she likes the inclusion terms at K55.06, necrosis of intestine, and gangrene of intestine. The terms will help the coders, if that is documented. She also suggested adding those same inclusion terms to the other acute infarction codes for the small intestine and large intestine at K55.02 and K55.04.

Tabular Addenda

Traci Ramirez presented the tabular addenda. Sue Bowman, representing AHIMA, asked about codes being deleted for SUVs, and noted that she understands they are considered a truck rather than a car. She said she was expecting the code to show up somewhere else, and asked where it would go. Ms. Ramirez noted that will be reviewed. Also, Ms. Bowman asked about the potential to have situations where you could have different codes from two ranges, and expressed concern about changing an Excludes2 to an Excludes1 note. Ms. Ramirez noted that this was based on a request from 3M, and that it will be reviewed.

Index Addenda

Traci Ramirez presented the index addenda. There were no comments.