CENTERS FOR DISEASE CONTROL AND PREVENTION

ICD-10 Coordination and Maintenance Committee Meeting
Diagnosis Agenda
March 5-6, 2019
Part 1

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

Diagnosis Topics:

Contents

ICD-10 TIMELINE

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

March 5-6, 2019	ICD-10 Coordination and Maintenance Committee Meeting.
	Those who wish to attend the ICD-10 Coordination and Maintenance Committee meeting **must have registered for the meeting online by February 22, 2019.** You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building.
	In compliance to The Real ID Act, enacted in 2005, (http://www.dhs.gov/real-id-enforcement-brief) the following states/territories: Maine, Minnesota, Missouri, Montana and Washington State **will not** gain access into any Federal Agencies using the **above states** driver's license or ID. This means CMS visitors from these states/territories will need to provide alternative proof of identification (**such as a passport**) to gain entrance into Baltimore-based and Bethesda CMS buildings, as well as the Humphrey Building in Washington.
March 2019	Webcast of the March 5-6, 2019 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD10/C-and-M-Meeting-Materials.html
April 1, 2019	There were no requests for ICD-10 codes to capture new diagnoses or new technology for implementation on April 1, 2019. Therefore, there will be no new ICD-10 diagnosis or procedure codes implemented on April 1, 2019.
April 5, 2019	**Deadline for receipt of public comments on proposed new ICD-10-PCS codes and revisions discussed at the March 5-6, 2019 ICD-10**

	Coordination and Maintenance Committee meetings for implementation on October 1, 2019.
April 2019	Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This notice will include references to the finalized FY 2020 ICD-10-CM diagnosis and ICD-10-PCS procedure codes to date. It will also include proposed revisions to the MS-DRG system based on ICD-10-CM/PCS codes on which the public may comment. The proposed rule can be accessed at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/IPPS/list.asp
May 10, 2019	**Deadline for receipt of public comments on proposed new diagnoses codes and revisions discussed at the March 5-6, 2019 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2020.**
June 2019	Final addendum posted on web pages as follows: Diagnosis addendum - http://www.cdc.gov/nchs/icd/icd10cm.htm Procedure addendum - http://cms.hhs.gov/Medicare/Coding/ICD10/index.html
June 14, 2019	**Deadline for requestors: Those members of the public requesting that topics be discussed at the September 10-11, 2019 ICD-10 Coordination and Maintenance Committee meeting must have their requests submitted to CMS for procedures and NCHS for diagnoses.**
August 1, 2019	Hospital Inpatient Prospective Payment System final rule to be published in the Federal Register as mandated by Public Law 99-509. This rule will also include links to all the final codes to be implemented on October 1, 2019.

	This rule can be accessed at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/IPPS/list.asp
August 2019	Tentative agenda for the Procedure part of the September 10-11, 2019 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage at – https://www.cms.gov/Medicare/Coding/ICD10/C-and-M-Meeting-Materials.html
	Tentative agenda for the Diagnosis part of the September 10-11, 2019 ICD-10 Coordination and Maintenance Committee meeting will be posted on the NCHS webpage at - http://www.cdc.gov/nchs/icd/icd10cm_maintenance.htm
	Federal Register notice for the September 10-11, 2019 ICD-10 Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.
August 2, 2019	**On-line registration opens for the September 10-11, 2019 ICD-10 Coordination and Maintenance Committee meeting at: https://www.cms.gov/apps/events/default.asp**
September 2, 2019	Because of increased security requirements, those wishing to attend the September 10-11, 2019 ICD-10 Coordination and Maintenance Committee meeting must register for the meeting online at: **https://www.cms.gov/apps/events/default.asp** **Attendees must register online by September 2, 2019; failure to do so may result in lack of access to the meeting.**

September 10-11, 2019	ICD-10 Coordination and Maintenance Committee Meeting. Those who wish to attend the ICD-10 Coordination and Maintenance Committee meeting **must have registered for the meeting online by September 2, 2019.** You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building.
September 2019	Webcast of the September 10-11, 2019 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD10/C-and-M-Meeting-Materials.html
October 1, 2019	New and revised ICD-10-CM and ICD-10-PCS codes go into effect along with DRG changes. Final addendum available on web pages as follows: Diagnosis addendum – http://www.cdc.gov/nchs/icd/icd10cm.htm Procedure addendum – http://www.cms.gov/Medicare/Coding/ICD10/
October 11, 2019	**Deadline for receipt of public comments on proposed new ICD-10-CM codes discussed at the September 10-11, 2019 ICD-10 Coordination and Maintenance Committee meetings for implementation on April 1, 2020.**
November 2019	Any new ICD-10 codes required to capture new technology that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2020 will be posted on the following websites: http://www.cdc.gov/nchs/icd/icd10cm.htm http://www.cms.gov/Medicare/Coding/ICD10/

Webcast and Dial-In Information

- Day 1: March 5, 2019: The meeting will begin at 9:00 AM ET and will end promptly at 1:00 PM ET. There will not be a lunch break for this session. The meeting will be webcast via CMS at http://www.cms.gov/live/.
- Day 2: March 6, 2019: The meeting will begin at 9:00 AM ET and will end at 5:00 PM ET. Lunch will be held from 11:30 AM ET to 1:00 PM ET. The meeting will be webcast via CMS at http://www.cms.gov/live/.
- Toll-free dial-in access is available for listen-only participants who cannot join the webcast:
  Day 1-March 5, 2019: Phone: 1-877-267-1577; Meeting 990 668 147.
  Day 2-March 6, 2019: Phone: 1-877-267-1577; Meeting 990 668 147.
  We encourage you to join early, as the number of phone lines is limited.

Contact Information
Mailing address:

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

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Continuing Education Credits

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

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

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

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

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

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

Corneal dystrophy

Corneal dystrophy is a genetic eye condition in which one or more parts of the cornea lose their normal clarity as result of a buildup of cloudy material. While the dystrophies are generally thought to be bilateral conditions, they may be asymmetric and may not require the same interventions. Thus, laterality would improve the value of the ICD-10-CM code set for tracking outcomes. In addition, complications from a corneal transplant would most often apply to a unique eye. This should be coded properly using the correct eye laterality to assist in outcomes and quality assessments.

The American Academy of Ophthalmology is requesting the following tabular changes in order to capture these conditions.

TABULAR MODIFICATIONS

H18 Other disorders of cornea

H18.5 Hereditary corneal dystrophies

H18.50 Unspecified hereditary corneal dystrophies

New code	H18.501	Unspecified hereditary corneal dystrophies, right eye
New code	H18.502	Unspecified hereditary corneal dystrophies, left eye
New code	H18.503	Unspecified hereditary corneal dystrophies, bilateral
New code	H18.509	Unspecified hereditary corneal dystrophies, unspecified eye

H18.51 Endothelial corneal dystrophy
Fuchs' dystrophy

New code	H18.511	Endothelial corneal dystrophy, right eye
New code	H18.512	Endothelial corneal dystrophy, left eye
New code	H18.513	Endothelial corneal dystrophy, bilateral
New code	H18.519	Endothelial corneal dystrophy, unspecified eye

H18.52 Epithelial (juvenile) corneal dystrophy

New code	H18.521	Epithelial (juvenile) corneal dystrophy, right eye
New code	H18.522	Epithelial (juvenile) corneal dystrophy, left eye
New code	H18.523	Epithelial (juvenile) corneal dystrophy, bilateral

New code	H18.529	Epithelial (juvenile) corneal dystrophy, unspecified eye

H18.53 Granular corneal dystrophy

New code	H18.531	Granular corneal dystrophy, right eye
New code	H18.532	Granular corneal dystrophy, left eye
New code	H18.533	Granular corneal dystrophy, bilateral
New code	H18.539	Granular corneal dystrophy, unspecified eye

H18.54 Lattice corneal dystrophy

New code	H18.541	Lattice corneal dystrophy, right eye
New code	H18.542	Lattice corneal dystrophy, left eye
New code	H18.543	Lattice corneal dystrophy, bilateral
New code	H18.549	Lattice corneal dystrophy, unspecified eye

H18.55 Macular corneal dystrophy

New code	H18.551	Macular corneal dystrophy, right eye
New code	H18.552	Macular corneal dystrophy, left eye
New code	H18.553	Macular corneal dystrophy, bilateral
New code	H18.559	Macular corneal dystrophy, unspecified eye

H18.59 Other hereditary corneal dystrophies

New code	H18.591	Other hereditary corneal dystrophies, right eye
New code	H18.592	Other hereditary corneal dystrophies, left eye
New code	H18.593	Other hereditary corneal dystrophies, bilateral
New code	H18.599	Other hereditary corneal dystrophies, unspecified eye

T86 Complications of transplanted organs and tissue

T86.8 Complications of other transplanted organs and tissues

T86.84 Complications of corneal transplant

T86.840 Corneal transplant rejection

New code	T86.8401	Corneal transplant rejection, right eye
New code	T86.8402	Corneal transplant rejection, left eye
New code	T86.8403	Corneal transplant rejection, bilateral
New code	T86.8409	Corneal transplant rejection, unspecified eye

T86.841 Corneal transplant failure

New code	T86.8411	Corneal transplant failure, right eye
New code	T86.8412	Corneal transplant failure, left eye
New code	T86.8413	Corneal transplant failure, bilateral
New code	T86.8419	Corneal transplant failure, unspecified eye

T86.842 Corneal transplant infection

New code	T86.8421	Corneal transplant infection, right eye
New code	T86.8422	Corneal transplant infection, left eye
New code	T86.8423	Corneal transplant infection, bilateral
New code	T86.8429	Corneal transplant infection, unspecified eye

T86.848 Other complications of corneal transplant

New code	T86.8481	Other complications of corneal transplant, right eye
New code	T86.8482	Other complications of corneal transplant, left eye
New code	T86.8483	Other complications of corneal transplant, bilateral
New code	T86.8489	Other complications of corneal transplant, unspecified eye

T86.849 Unspecified complication of corneal transplant

New code	T86.8491	Unspecified complication of corneal transplant, right eye
New code	T86.8492	Unspecified complication of corneal transplant, left eye
New code	T86.8493	Unspecified complication of corneal transplant, bilateral
New code	T86.8499	Unspecified complication of corneal transplant, unspecified eye

Cough

Coughing is part of the body's defense mechanism against inhaled irritants and respiratory infections, serving to clear the airways of foreign material and excess secretions.[6] In physiologic terms, cough arises following activation of a complex sensorimotor reflex arc. In most cases, cough resolves after the inciting factor is eliminated. For some people, however, cough becomes persistent, impacting quality of life and prompting the patient to seek medical attention.

During clinical work-up, cough is initially classified by duration. Different categories of cough duration have different diagnostic possibilities and thus different algorithms for evaluation and treatment. The classification of cough by duration was outlined by the world's first cough guideline developed by the American College of Chest Physicians (CHEST) Expert Cough Panel in 1998 and has persisted through the most recent 2018 update.[7,8]

Cough of less than 3 weeks duration is defined as acute cough.[6] Though acute cough can be a sign of a life-threatening condition or an exacerbation of a pre-existing respiratory condition, the majority of acute cough cases are associated with respiratory tract infections. The most common cause of acute cough is acute bronchitis, which is most often viral.[9] Cough associated with respiratory tract infections commonly resolves shortly after the infection itself and does not require targeted therapy. In fact, limited data exist that show any benefit of symptomatic relief for acute cough with traditional cough suppressants like dextromethorphan and codeine.[10] The efficacy of antitussive drugs has been challenged particularly in the case of cough associated with upper respiratory tract infection (URTI); specifically, the American College of Chest Physicians (ACCP) advises against the use of antitussives in the case of URTI.[8]

Subacute cough is quite similar to acute cough as both may be related to URTI and typically resolve after the infection clears. Subacute cough also may be caused by post-infectious cough, pertussis, infection with Mycoplasma or Chlamydia, and – similarly to acute cough – exacerbations of other diseases such as asthma or COPD.[6] The defining difference between subacute and acute is the duration of the cough, subacute being longer, lasting from three to eight weeks.

A significant minority of patients experience chronic cough that persists despite guideline-based treatment of underlying etiologies. This subset of chronic cough is defined as cough that persists after extensive medical investigation and is thus considered a diagnosis of exclusion.[13] While various terms have been used to describe this population, the 2018 CHEST guidelines define Unexplained Chronic Cough (UCC) as cough that occurs under the following circumstances: 1) chronic cough with no diagnosable cause, 2) explained but refractory chronic cough, and 3) unexplained and refractory chronic cough.[12]

Chronic cough can have wide-ranging effects on overall health and well-being. Some of the more severe symptoms include syncope, incontinence, vomiting, and sleep deprivation.[14] Literature indicates that the psychosocial impact of refractory chronic cough can also be profound – studies have demonstrated that 53% of patients with chronic cough exhibit depressive symptoms and are at

risk for developing clinical depression.[15,16] The prevalence of depressive symptoms among patients with refractory chronic cough is comparable to that seen in other chronic disorders, such as chronic obstructive pulmonary disease, chronic heart failure, and diabetes.[17]

Creating new codes for acute, subacute, and chronic cough will ensure the ICD-10-CM is better aligned with the current clinical guidelines for cough.

Merck is requesting the following tabular changes. The American Thoracic Society (ATS), CHEST, American College of Allergy, Asthma and Immunology (ACAAI), American Lung Assocoation, American Academy of Allergy, Asthma and Immunology (AAAI) and the Permanente Federation have reviewed and support the proposal.

References

5 Gibson P, Wang G, et al. Treatment of Unexplained Chronic Cough – CHEST Guideline and Expert Panel Report. Chest. 2016 Jan;149(1): 28-44.
6 Chung KF, Pavord ID. Chronic Cough 1: Prevalence, pathogenesis, and causes of chronic cough. Lancet. 2008; 371:1364-74.
7 Irwin RS, Boulet LP, Cloutier MM, et al. Managing cough as a defense mechanism and as a symptom. A consensus panel report of the American College of Chest Physicians. Chest. 1998;114(2 suppl):133S-181S.
8 Irwin RS, French CL, et al. Classification of Cough as a Symptom in Adults and Management Algorithms; CHEST Guideline and Expert Panel Report. CHEST. 2018; 153(1):196-209.
9 Terasaki G and Paauw DS. Evaluation and Treatment of Chronic Cough. Med Clin N Am. 2014; 98:391-403
10 Bolser DC. Cough suppressant and pharmacologic protussive therapy: ACCP evidence-based clinical practice guidelines. CHEST. 2006;120:238S-49S.
11 Dabrowks M, Grabczak EM, et al. Causes of chronic cough in non-smoking patients. Adv Exp Med Biol. 2015;873:25-33.
12 Irwin RS, French CL, et al. Classification of Cough as a Symptom in Adults and Management Algorithms; CHEST Guideline and Expert Panel Report. CHEST. 2018; 153(1):196-209.
13 Gibson P, Wang G, et al. Treatment of Unexplained Chronic Cough, CHEST Guideline and Expert Panel Report, CHEST 2016 Jan; 149(1): 27-44.
14 Irwin RS. Assessing cough severity and efficacy of therapy in clinical research: ACCP evidence-based clinical practice guidelines. Chest 2006; 129(1 Suppl):232S–237S
15 Dicpinigaitis PV, Tso R, Banauch G. Prevalence of depressive symptoms among patients with chronic cough. Chest 2006; 130:1839–1483
16 McGarvey LPA, Carton C, Gamble LA, Heaney LG, Shepherd R, Ennis M, Macmahon J. Prevalence of psychomorbidity among patients with chronic cough. Cough; 2006; 2:4
17 Brignall K, Jayaraman B, Birring SS. Quality of Life and Psychosocial Aspects of Cough. Lung. 2008; 186(Suppl1):S55-58.

TABULAR MODIFICATIONS

R05 Cough

Excludes1: cough with hemorrhage (R04.2)
smoker's cough (J41.0)

New code	R05.1 Acute cough
Add	Cough of less than 3 weeks duration
New code	R05.2 Subacute cough
Add	Cough of 3-8 weeks duration
New code	R05.3 Chronic cough
Add	Cough of more than 8 weeks duration (> 4 weeks in pediatrics)
Add	Cough, persistent
Add	Cough syncope
Add	Paroxysmal cough
Add	Refractory
Add	Unexplained chronic cough

New code	R05.9 Cough of unspecified duration

Dravet syndrome

The Dravet Syndrome Foundation is proposing the creation of new codes for Dravet syndrome. This proposal was originally presented at the March 2018 Coordination and Maintenance (C&M) meeting and re-presented at the September 2018 C&M meeting. Based on additional comments received following the September 2018 C&M meeting, a revised proposal is being presented for consideration.

Dravet syndrome, previously known as severe myoclonic epilepsy in infancy (SMEI), is a genetic encephalopathy that presents in the first year of life. It is a rare disorder with an incidence estimated between 1:20,000 and 1:40,000 representing about 7% of all severe epilepsies starting before the age of 3 years.

Currently, there is no unique code for Dravet syndrome. It is currently being reported by using code G40.8-, Other epilepsy.

The following new codes are being requested to identify this condition for research and reporting. This proposal has been reviewed and supported by the American Academy of Neurology (AAN).

TABULAR MODIFICATIONS

G40 Epilepsy

G40.8 Other epilepsy and recurrent seizures

G40.83 Dravet syndrome

Add — Polymorphic epilepsy in infancy (PMEI)

Add — Severe myoclonic epilepsy in infancy (SMEI)

New code — G40.831 Dravet syndrome, intractable, with status epilepticus

New code — G40.832 Dravet syndrome, intractable, without status epilepticus

Add — Dravet syndrome NOS

Drowning/submersion occurring in natural bodies of water

Drowning is the third leading cause of unintentional death worldwide.[1] It is also a leading cause of unintentional death in the U.S., resulting in more than 4,500 deaths in 2016.[2] Nonfatal drowning is far more prevalent and can have lifelong, debilitating consequences. In 2015, there were approximately 6,300 emergency department visits and 2,500 hospitalizations for non-fatal drowning/submersions (all ages).[3] This proposal was originally presented at the March 2018 Coordination and Maintenance (C&M) meeting. Based on comments received following the March 2018 C&M, the revised proposal is being presented for consideration.

Prevention is key to reducing the burden of drowning, but drowning prevention receives relatively little attention and few resources. The ability to target resources to prevent drowning could be enhanced by a detailed understanding of where drownings occur. Drowning occurs both in human-made (e.g., bathtubs, pools, fountains, tanks) and natural bodies of water (e.g., lakes, rivers, oceans). More than half of fatal and nonfatal drownings in the U.S. among those 15 years and older (57% and 57% respectively) occurred in natural water settings.[4] Studies have shown that the percentage of drownings in natural settings increases with age.[5]

While ICD-10-CM provides specific external cause of injury codes for drowning/submersion in different types of human-made locations (e.g. W16.011, W16.021, W16.031, W16.211, W16.221, W16.311, W16.321, W16.331, W16.511, W16.521, W16.531, W22.041, W65, W67, W73, X71.0-X71.2, X92.0-X92.2, Y21.0-Y21.3), the codes for drowning/submersion in natural settings are limited (i.e., refer only to "natural water" without greater detail). Y92 'Place of occurrence of external cause' codes are also limited. The only Y92 code that refers to a natural water site is Y92.832: "Beach as the place of occurrence of the external cause." However, a beach could exist at a small pond, a large lake, a river, or the ocean. As well, drowning does not actually occur on a beach, but in offshore water.

Ocean beaches are unique in that they feature surf and rip currents, among other hazards. Ocean bays do not feature surf and rip currents, but have unique hazards related to cyclical tidal currents and scouring of the bottom. The Great Lakes are large enough to generate surf and rip currents, but not as reliably as the oceanfront, where surf is generally larger and more prevalent. Rivers feature

[1] Fact Sheet. 2017. World Health Organization. http://www.who.int/mediacentre/factsheets/fs347/en/
[2] WONDER. Accessed January 5, 2018.
[3] WISQARS. Accessed January 5, 2018.
[4] Unintentional drowning: Get the facts. Centers for Disease Control and Prevention. https://www.cdc.gov/homeandrecreationalsafety/water-safety/waterinjuries-factsheet.html. Accessed January 7, 2018.
[5] Nonfatal and Fatal Drownings in Recreational Water Settings -- United States, 2001-2002. MMWR. Morbidity and mortality weekly report, Vol. 53, no. 21, 447-452. June 4, 2004.
[6] Weather related fatalities. 2016. National Weather Service. http://www.nws.noaa.gov/om/hazstats.shtml

relentless currents (typically unaffected by tides) and bottom scouring, along with various obstructions (e.g. rocks, trees, etc.) Ponds and lakes are generally more benign than the foregoing, lacking hazards related to currents or surf, but for this reason tend to attract less accomplished swimmers, and thus appear to be locations for substantial numbers of drownings. Flooding is the second leading cause of weather-related death, most typically due to drowning.[6] Separating deaths during flooded periods can allow specific preventive and response resources to be targeted.

The United States Lifesaving Association and the National Oceanic and Atmospheric Administration joined forces over 10 years ago to attempt to prevent rip current drowning, which occurs in the waters off beaches with surf, since surf is the primary generator of rip currents. The lack of data regarding the number of drowning injuries and deaths in the waters off surf beaches has made it very challenging to affix the magnitude of the problem, set goals, marshal prevention resources, and benchmark injury prevention success. This is equally true for other natural venues.

The United States Lifesaving Association is requesting new codes for drowning/submersion that occur in the following types of natural settings:

- Oceanfront
- Ocean – protected bay or inland waterway
- Great Lakes
- Pond or lake
- River
- Flooded area

TABULAR MODIFICATIONS

Option1

W69 Accidental drowning and submersion while in natural water

Delete ~~Accidental drowning and submersion while in lake~~
Delete ~~Accidental drowning and submersion while in river~~

Delete	~~Accidental drowning and submersion while in stream~~	
New subcategory	W69.1	Accidental drowning and submersion while in ocean water
New code	W69.11	Accidental drowning and submersion while in open sea (off shore)
New code	W69.12	Accidental drowning and submersion while in oceanfront water
New code	W69.13	Accidental drowning and submersion while in ocean bay
New subcategory	W69.2	Accidental drowning and submersion while in lake or pond
New code	W69.21	Accidental drowning and submersion while in Great Lakes
New code	W69.22	Accidental drowning and submersion while in lake or pond
New code	W69.3	Accidental drowning and submersion while in river or stream
New code	W69.4	Accidental drowning and submersion while in flooded area
New code	W69.9	Accidental drowning and submersion while in natural water, unspecified

Option 2

Y92 Place of occurrence of the external cause
The following category is for use, when relevant, to identify the place of Occurrence of the external cause. Use in conjunction with an activity code. Place of occurrence should be recorded only at the initial encounter for treatment

Y92.83 Recreation area as the place of occurrence of the external cause

Y92.832 Beach as the place of occurrence of the external cause
Seashore as the place of occurrence of the external cause

Add — Excludes1: Natural body of water as the place of occurrence of the external cause (Y92.87-)

New subcategory	Y92.87	Natural body of water as the place of occurrence of the external cause
New code	Y92.871	Open sea as the place of occurrence of the external cause
New code	Y92.872	Ocean bay as the place of occurrence of the external cause
New code	Y92.873	Oceanfront water as the place of occurrence of the external cause

New code	Y92.874	Lake or pond as the place of occurrence of the external cause
New code	Y92.875	Great lakes as the place of occurrence of the external cause
New code	Y92.876	River or stream as the place of occurrence of the external cause
New code	Y92.877	Flooded area as the place of occurrence of the external cause
New code	Y92.879	Unspecified natural body of water as the place of occurrence of the external cause

Elevated Liver Enzymes

ICD-10-CM currently classifies non-specific elevation of levels of transaminase and lactic acid dehydrogenase under a single code, R74.0 (Nonspecific elevation of levels of transaminase and lactic acid dehydrogenase [LDH]).

The issue has been raised in that elevations of different enzymes included in this code can result in different a clinical treatment modalities and resource utilization. For example, an elevation in liver transaminases in a trauma patient could indicate the need for at CT scan looking for solid tissue injury; while an elevation in LDH could indicate a neoplastic condition.

Liver transaminases (aspartate aminotransferase [AST] and alanine aminotransferase [ALT]) are often used as a screen for liver injury. Using recursive partitioning retrospective analysis, Cotton et al [5] found that 88% of patients with intraabdominal injury were correctly identified when they had an AST more than 131 U/L with a hematocrit of less than 39% (sensitivity 100% [95% CI, 90%-100%] and specificityof 87% [95% CI, 83%-91%]).

Keller and colleagues found that children with elevated transaminases were more likely to have liver injury compared to children with normal levels (elevated vs normal: AST 12% vs 0%, ALT 17% vs 0%; P b .05). However, it was determined that only levels of more than 400 U/L were predictive of liver injury. Because these levels were associated with patients who had other indications for imaging (eg, physical examination), the value did not influence the decision for imaging studies or other interventions.

It is important to note that in accordance to the Official Coding Guidelines, Section III, B. Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

The American Academy of Pediatrics respectfully request the expansion of R74.0.

Article: Linzer Sr. JF. Do routine laboratory tests add to the care of the pediatric trauma patient? Clinical Pediatric Emergency Medicine. 2010:11(1);18-21

[1.] Keller MS, Coln CE, Trimble JA, et al. The utility of routine trauma laboratories in pediatric trauma resuscitations. Am J Surg 2004;188:671-8.

[5]. Cotton BA, Liao JG, Burd RS. The utility of clinical and laboratory data for predicting intraabdominal injury among children. J Trauma 2005;58:1306-7.

[9]. Holmes JF, Sokolove PE, Brant WE, et al. Identification of children with intra-abdominal injuries after blunt trauma. Ann Emerg Med 2002;39:500-9.

[16]. Chu FY, Lin HJ, Guo HR, et al. A reliable screening test to predict liver injury in pediatric blunt torso trauma. Eur J Trauma Emerg Surg 2009; doi:10.1007/s00068-009-9034-z.

[17.] Holmes JF, Mao A, Awasthi S, et al. Validation of a prediction rule for the identification of children with intra-abdominal injuries after blunt torso trauma. Ann Emerg Med 2009;54: 528-33.

TABULAR MODIFICATIONS

R74 Abnormal serum enzyme levels

R74.0 Nonspecific elevation of levels of transaminase and lactic acid dehydrogenase [LDH]

New code	R74.01	Abnormal levels of liver transaminase
Add		Abnormal level of alanine transaminase (ALT)
Add		Abnormal level of aspartate transaminase (AST)
New code	R74.02	Elevation of levels lactic acid dehydrogenase [LDH]

Esophagitis with bleeding

In ICD-10-CM there is an existing combination code for ulcerative esophagitis with bleeding at code K22.11, however, there are no combination codes for bleeding associated with reflux esophagitis, specified esophagitis NEC, and unspecified esophagitis. Esophageal hemorrhage NOS is an inclusion term under code K22.8, Other specified diseases of esophagus. Therefore, esophageal hemorrhage/bleeding cannot be recognized in data because "Other specified diseases of the esophagus" can potentially encompass a variety of conditions.

Currently, ICD-10-CM provides codes for specified gastritis NEC with bleeding (K29.61) and unspecified gastritis with bleeding (K29.71). In ICD-9-CM, there was a unique code for esophageal hemorrhage. It is requested to expand reflux esophagitis, specified esophagitis NEC, and unspecified esophagitis to reflect presence of bleeding.

A facility-based Health Information Management (HIM) professional is requesting the following new codes to identify the cause and effect relationship with these conditions. This proposal has been reviewed and supported by the American Gastroenterological Association (AGA).

TABULAR MODIFICATIONS

	K20	Esophagitis
New code	K20.1	Esophagitis with bleeding
	K20.8	Other esophagitis
New code	K20.80	Other esophagitis without bleeding
Add		Abscess of esophagus
New code	K20.81	Other esophagitis with bleeding
	K20.9	Esophagitis, unspecified
New code	K20.90	Esophagitis, unspecified without bleeding
Add		Esophagitis NOS
New code	K20.91	Esophagitis, unspecified with bleeding

K21 Gastro-esophageal reflux disease

K21.0 Gastro-esophageal reflux disease with esophagitis

New code K21.00 Gastro-esophageal reflux disease with esophagitis, without bleeding

Add Reflux esophagitis

New code K21.01 Gastro-esophageal reflux disease with esophagitis, with bleeding

Granulomatous Mastitis

Granulomatous mastitis is a rare, chronic, inflammatory condition of the breast with unknown etiology that affects women of child-bearing age. It can be mistaken radiographically and clinically for breast cancer and due to its rarity can cause a delay in establishing a definitive diagnosis and subsequent initiation of treatment. Furthermore, granulomatous mastitis has a progressive clinical course with multiple recurrences.

To date, there is no universally accepted treatment. The treatment is unknown at this time and many women are treated inappropriately for long periods of time with antibiotics. This disease remains a diagnostic and therapeutic challenge. Since 2008, the number of cases reported has increased in the literature. There are active clinical trials looking for therapeutic options.

The condition is discreetly different from other types of mastitis currently listed in ICD-10-CM and warrants a separate code. Due to the lack of an ICD-10-CM code that specifically captures the diagnosis of granulomatous mastitis, it has been hard to develop a tracking database that would allow providers/researchers access to incidence and prevalence data.

The Permanente Medical Group is requesting a unique code for this condition. The American College of Obstetricians and Gynecologists (ACOG) has reviewed and supports this proposal.

References

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2. Study: Granulomatous Mastitis Current Approach and Treatment
Study link: https://clinicaltrials.gov/ct2/show/NCT02667132

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3. Granulomatousmastitis: a 10 year experience from a large inner city county hospital.
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TABULAR MODIFICATIONS

N61 Inflammatory disorders of breast
Excludes1: inflammatory carcinoma of breast (C50.9)
inflammatory disorder of breast associated with childbirth (O91.-)
neonatal infective mastitis (P39.0)
thrombophlebitis of breast [Mondor's disease] (I80.8)

New subcategory	N61.2 Granulomatous mastitis
New code	N61.21 Granulomatous mastitis, right breast
New code	N61.22 Granulomatous mastitis, left breast
New code	N61.23 Granulomatous mastitis, bilateral breast
New code	N61.29 Granulomatous mastitis, unspecified breast

Immunodeficiency Status

The American Academy of Pediatrics (AAP) proposes that new codes be created to indicate when a patient is immunocompromised. This topic was presented at the March 2017 and March 2018 Coordination and Maintenance meeting. After a lengthy discussion and in response to public comments received, the Academy submits this revised proposal for reconsideration.

An immunocompromised status is a state in which a person's immune system is immunosuppressed or weakened. Individuals who are immunocompromised are less capable of battling infections because the immune system response is not functioning properly. Treating a patient who is immunocompromised poses more risks and challenges, therefore, it is very important to be able to identify a patient with this status.

These individuals are more prone to serious infections, opportunistic infections and other types of complications. A patient may be immunocompromised due to a specific clinical condition such as HIV, AIDS, certain cancers and genetic disorders. There are also external factors such as treatment with certain medications or exposure to radiation therapy, or a combination of both clinical conditions and external factors.

There are circumstances where a patient may be immune competent because of improvement of an underlying condition that can affect the immune system, but become immunocompromised because of an acute illness, new treatment or medication, e.g. bone marrow transplant with a fever.
A patient whose immune system is suppressed because of illness or external factors generally requires greater resource utilization. These patients are at increased risk because of fevers, non-environmental hypothermia, or injury thus requiring more interventions such as laboratory testing and medications than those with normally functioning immune systems.

Clinicians routinely document in the medical record when a patient's immune system may be compromised by using terms such as "immunodeficiency," "immunosuppressed" or "immunocompromised." Conditions within category D80-D89, Certain disorders involving the immune mechanism, do not indicate that a patient is immunocompromised and are generally specific to the type of immune deficiency. The codes D84.8, Other specified immunodeficiencies and D89.89,Other specified disorders involving the immune mechanism, not elsewhere classified, are not specific enough to capture the details as to why a patient's immune system status is compromised and which places the patient at greater health risks.

The following tabular modifications are being proposed:

TABULAR MODIFICATIONS

D84 Other immunodeficiencies

D84.8 Other specified immunodeficiencies

New code D84.81 Immunodeficiency due to conditions classified elsewhere

Add Code first underlying condition, if known, such as:
Add acquired absence of spleen (Z90.81)
Add chromosomal abnormalities (Q90-Q99)
Add congenital absence and malformations of spleen (Q89.0)
Add diabetes mellitus (E08-E13)
Add malignant neoplasms (C00-C96)
Add transplanted organ and tissue (Z94)

Add Excludes1: combined immunodeficiencies (D81.-)
Add common variable immunodeficiency (D83.-)
Add defects in the complement system (D84.1)
Add immunodeficiency associated with other major defects (D82.-)
Add immunodeficiency with predominantly antibody defects (D80.-)
Add lymphocyte function antigen-1 [LFA-1] defect (D84.0)

New sub-subcategory D84.82 Immunodeficiency due to drugs and external causes

New code D84.821 Immunodeficiency due to drugs

Add Excludes2: adverse effect of drug (T36-T50 with fifth or six character 5)

Add — Code also drug or medication such as:
Add — encounter for antineoplastic chemotherapy and immunotherapy (Z51.1)
Add — long term (current) drug therapy (Z79.-)

New code — D84.822 Immunodeficiency due to external causes

Add — Code also external cause such as:
Add — encounter for antineoplastic radiation therapy (Z51.0)
Add — exposure to ionizing radiation (W88) other contact with and (suspected)exposures hazardous to health (Z77)

New code — D84.89 Other immunodeficiencies

D84.9 Immunodeficiency, unspecified
Add — Immunocompromised NOS
Add — Immunodeficient NOS
Add — Immunosuppressed NOS

Chapter 19

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

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

Excludes2: abuse and dependence of psychoactive substances (F10-F19)
abuse of non-dependence-producing substances (F55.-)
drug reaction and poisoning affecting newborn (P00-P96)
Add — immunodeficiency due to drugs (D84.821)
pathological drug intoxication (inebriation) (F10-F19)

Joint related disorders

The American Association of Oral and Maxillofacial Surgeons (AAOMS) is proposing the creation of new codes for various joint-related disorders affecting a large cross section of patients. A prior proposal to expand ICD-10-CM codes specific to the temporomandibular joint was presented at the September 2017 Coordination and Maintenance (C&M) meeting. Based on comments received following the September 2017 C&M, the revised proposal is being presented for consideration.

The AAOMS is requesting the following tabular changes in order to better identify these conditions.

TABULAR MODIFICATIONS

M05 Rheumatoid arthritis with rheumatoid factor

M05.7 Rheumatoid arthritis with rheumatoid factor without organ or systems involvement

New code M05.7A Rheumatoid arthritis with rheumatoid factor of other specifie site without organ or systems involvement

M05.8 Other rheumatoid arthritis with rheumatoid factor

New code M05.8A Other rheumatoid arthritis with rheumatoid factor of other specified site

M06 Other rheumatoid arthritis

M06.0 Rheumatoid arthritis without rheumatoid factor

New code M06.0A Rheumatoid arthritis without rheumatoid factor, other specified site

M06.8 Other specified rheumatoid arthritis

New code M06.8A Other specified rheumatoid arthritis, other specified site

M08 Juvenile arthritis

M08.0 Unspecified Juvenile rheumatoid arthritis

New code M08.0A Unspecified juvenile rheumatoid arthritis, other specified site

M08.2 Juvenile rheumatoid arthritis with systemic onset

New code M08.2A Juvenile rheumatoid arthritis with systemic onset,

other specified site

M08.4 Pauciarticular juvenile rheumatoid arthritis

New code M08.4A Pauciarticular juvenile rheumatoid arthritis, other specified site

M08.9 Juvenile arthritis, unspecified

New code M08.9A Juvenile arthritis, unspecified, other specified site

M19 Other and unspecified osteoarthritis

M19.0 Primary osteoarthritis of other joints

New code M19.09 Primary osteoarthritis, other specified site

M19.1 Post-traumatic osteoarthritis of other joints

New code M19.19 Post-traumatic osteoarthritis, other specified site

M19.2 Secondary osteoarthritis of other joints

New code M19.29 Secondary osteoarthritis, other specified site

M24 Other specific joint derangement

M24.1 Other articular cartilage disorders

New code M24.19 Other articular cartilage disorders, other specified site

M24.2 Disorder of ligament

New code M24.29 Disorder of ligament, other specified site

M24.3 Pathological dislocation of joint, not elsewhere classified

New code M24.39 Pathological dislocation of other specified joint, not elsewhere classified

M24.4 Recurrent dislocation of joint

New code M24.49 Recurrent dislocation, other specified joint

M24.5 Contracture of joint

New code M24.59 Contracture, other specified joint

M24.6 Ankylosis of joint

New code M24.69 Ankylosis, other specified joint

M24.8 Other specified joint derangement, not elsewhere classified
New code M24.89 Other specified joint derangement of other specified joint, not elsewhere classified

M25 Other joint disorder, not elsewhere classified

M25.3 Other instability of joint
New code M25.39 Other instability, other specified joint

M25.5 Pain in joint
New code M25.59 Pain in other specified joint

M25.6 Stiffness of joint, not elsewhere classified
New code M25.69 Stiffness of other specified joint, not elsewhere classified

M26 Dentofacial anomalies [including malocclusion]

M26.6 Temporomandibular joint disorders
New sub-subcategory M26.64 Arthritis of temporomandibular joint

New code M26.641 Arthritis of right temporomandibular joint
New code M26.642 Arthritis of left temporomandibular joint
New code M26.643 Arthritis of bilateral temporomandibular joint
New code M26.649 Arthritis of unspecified temporomandibular joint

New sub-subcategory M26.65 Arthropathy of temporomandibular joint

New code M26.651 Arthropathy of right temporomandibular joint
New code M26.652 Arthropathy of left temporomandibular joint
New code M26.653 Arthropathy of bilateral temporomandibular joint
New code M26.659 Arthropathy of unspecified temporomandibular joint

New sub-subcategory M26.66 Disorder of ligament of temporomandibular joint

New code M26.661 Disorder of ligament of right temporomandibular joint
New code M26.662 Disorder of ligament of left temporomandibular joint

New code	M26.663	Disorder of ligament of bilateral temporomandibular joint
New code	M26.669	Disorder of ligament of unspecified temporomandibular joint

Juvenile Osteochondrosis of Tibia and Fibula

This proposal was originally presented at the September 2018 Coordination and Maintenance (C&M) meeting and is being represented with recommendations received from public comments. The American Academy of Orthopedic Surgeons (AAOS) is requesting modifications to the category M92.5 Juvenile osteochondrosis of tibia and fibula to adequately represent the clinical significance of this disorder.

The two conditions, Blount Disease and Osgood-Schlatter are very dissimilar both in character, prognosis and treatment. Blount disease is a growth disorder of the tibia (shin bone) that causes the lower leg to angle inward, resembling a bowleg which occurs in growing children. Osgood-Schlatter is a characteristic of soreness and swelling at the tibial tuberosity, which occurs in adolescence.

AAOS is requesting modifications to better distinguish the difference between these conditions.

TABULAR MODIFICATIONS

M92	Other juvenile osteochondrosis
Revise	M92.5 Juvenile osteochondrosis of tibia and fibula [Blount]
Delete	~~Osteochondrosis (juvenile) of proximal tibia [Blount]~~
Delete	~~Osteochondrosis (juvenile) of tibial tubercle [Osgood-Schlatter]~~
Delete	~~Tibia vara~~
Revise	M92.50 Juvenile osteochondrosis of proximal tibia and fibula [Blount], unspecified leg
Add	Tibia vara
Revise	M92.51 Juvenile osteochondrosis of proximal tibia and fibula [Blount], right leg
Add	Tibia vara
Revise	M92.52 Juvenile osteochondrosis of tibia and fibula [Blount], left leg
Add	Tibia vara
New code	M92.53 Juvenile osteochondrosis of tibia and fibula [Blount], bilateral
Add	Tibia vara
	M92.8 Other specified juvenile osteochondrosis
New code	M92.81 Juvenile osteochondrosis of tibia and fibula [Osgood-Schlatter]
New code	M92.810 Osteochondrosis (juvenile) of tibial tubercle [Osgood-Schlatter], unspecified leg

New code		M92.811 Osteochondrosis (juvenile) of tibial tubercle [Osgood-Schlatter], right leg
New code		M92.812 Osteochondrosis (juvenile) of tibial tubercle [Osgood-Schlatter], left leg
New code		M92.813 Osteochondrosis (juvenile) of tibial tubercle [Osgood-Schlatter], bilateral
New code	M92.89	Other specified juvenile osteochondrosis
Add		Calcaneal apophysitis

Neonatal Cerebral Infarction

The American Academy of Pediatrics (AAP) submitted a proposal requesting modifications for neonatal cerebral infarction that was presented at the September 2018 Coordination and Maintenance Meeting. However based on public comments, the proposal has been modified and being resubmitted for reconsideration.

Neonatal cerebral infarction (or stroke) is a cerebrovascular condition that occurs between 20 weeks of fetal life through to the 28th postnatal day. This condition is defined as a severe disorganization or even a complete disruption of the gray matter of the developing brain caused by embolic, thrombotic or ischemic events.

This condition results in ischemic and hemorrhagic injury around focal or multifocal cerebral vessels in which there is disruption of cerebral blood flow secondary to arterial or cerebral venous thrombosis or embolization. A neonatal cerebral infarction is confirmed by neuroimaging or neuropathological studies.

It is frequently diagnosed by CT scan or MRI in neonates with neurologic findings such as seizures or asymmetric neurologic tone. It is most often found in the right or left middle cerebral artery distribution, and is most often, but not exclusively unilateral. Laterality is important to document for epidemiology, prognosis, and follow-up.

The following tabular modifications are being requested:

TABULAR MODIFICATION

P91.8 Other specified disturbances of cerebral status of newborn

New subcategory	P91.82 Neonatal cerebral infarction
Add	Neonatal stroke
Add	Perinatal arterial ischemic stroke
Add	Perinatal cerebral infarction
Add	Excludes1: cerebral infarction (I63.-)
Add	Excludes2: intracranial hemorrhage of newborn (P52.-)
New code	P91.821 Neonatal cerebral infarction, right side
New code	P91.822 Neonatal cerebral infarction, left side
New code	P91.823 Neonatal cerebral infarction, bilateral
New code	P91.829 Neonatal cerebral infarction, unspecified side

I63 Cerebral infarction

Includes: occlusion and stenosis of cerebral and precerebral arteries, resulting in cerebral infarction

Add Excludes1: neonatal cerebral infarction (P91.82-)
Excludes2: sequelae of cerebral infarction (I69.3-)

P91 Other disturbances of cerebral status of newborn

P91.0 Neonatal cerebral ischemia

Add Excludes 1: neonatal cerebral infarction (P91.82-)

Ogilvie syndrome

Ogilvie syndrome is a rare, acquired disorder characterized by abnormalities affecting the involuntary, rhythmic muscular contractions within the colon. Ogilvie syndrome is also known as acute colonic pseudo-obstruction (ACPO). Symptoms of Ogilvie syndrome are similar to other forms of intestinal pseudo-obstruction and can include nausea, vomiting, abdominal colic and constipation. The symptoms mimic those of mechanical blockage of the colon, but no such physical obstruction is present. Distention of the colon in Ogilvie syndrome can potentially lead to serious, life-threatening complications including the formation of a hole in the wall of the colon or lack of blood flow to the colon.

Ogilvie syndrome is usually associated with an underlying disorder, trauma or surgery. Non-operative trauma, infection and heart disease are common conditions associated with Ogilvie syndrome. Ogilvie syndrome can be managed with conservative treatment, but if unrecognized and untreated can lead to serious, potentially life-threatening complications. It is not the same as chronic intestinal pseudo-obstruction (CIP), a similar, but distinct disorder.

A facility-based Health Information Management (HIM) professional is requesting the following new codes to accurately identify this condition. This proposal has been reviewed and supported by the American Gastroenterological Association (AGA).

TABULAR MODIFICATIONS

	K59	Constipation	
		K59.8	Other specified functional intestinal disorders
Delete			~~Atony of colon~~
Delete			~~Pseudo-obstruction (acute) (chronic) of intestine~~
New code		K59.81	Ogilvie syndrome
Add			Acute colonic pseudo-obstruction (ACPO)
New code		K59.89	Other specified functional intestinal disorders
Add			Atony of colon
Add			Pseudo-obstruction (acute) (chronic) of intestine

Osteoporosis Related Pathological Fractures

The American Association of Oral and Maxillofacial Surgeons (AAOMS) is proposing the creation of new codes for pathological fracture of "other specified site" due to age-related osteoporosis and pathological fracture of "other specified site" due to drug-induced osteoporosis**.** While there is a code for multiple types of fractures within each subcategory, there is no listing to report such fractures when they occur in the maxilla or mandible or a site that is not elsewhere classified. The closest entry is directed to code M80.00, Age-related osteoporosis with current pathological fracture, unspecified site and code M80.80, Other osteoporosis with current pathological fracture, unspecified site.

The AAOMS is requesting the following tabular changes in order to identify these conditions.

TABULAR MODIFICATIONS

M80 Osteoporosis with current pathological fracture
M80.0 Age-related osteoporosis with current pathological fracture

M80.08 Age-related osteoporosis with current pathological fracture, vertebrae

New code M80.0A Age-related osteoporosis with current pathological fracture, other site

M80.8 Other osteoporosis with current pathological fracture

M80.88 Other osteoporosis with current pathological fracture, vertebrae

New code M80.8A Other osteoporosis with current pathological fracture, other site

Other Type of Uterine Scar

Currently in ICD-10-CM Category O34, subcategory O34.2 there are existing codes for maternal care due to uterine scar from previous surgery. A code for "Maternal care for other type scar from previous cesarean delivery" was requested. The American Hospital Association's (AHA) Editorial Advisory Board (EAB) for coding clinic has received inquiries on how to code a mid-transverse T incision. The EAB supported the need to bring a proposal to the ICD-10 Coordination and Maintenance meeting.

The American College of Obstetricians and Gynecologists (ACOG) has reviewed and supports this proposal.

TABULAR MODIFICATIONS

O34 Maternal care for abnormality of pelvic organs

Includes: the listed conditions as a reason for hospitalization or other obstetric care of the mother, or for cesarean delivery before onset of labor

Code first any associated obstructed labor (O65.5)

Use additional code for specific condition

O34.2 Maternal care due to uterine scar from previous surgery

O34.21 Maternal care for scar from previous cesarean delivery

O34.211 Maternal care for low transverse scar from previous cesarean delivery

O34.212 Maternal care for vertical scar from previous cesarean delivery

Maternal care for classical scar from previous cesarean delivery

New code O34.218 Maternal care for other type scar from previous cesarean delivery

Add Mid-transverse T incision

O34.219 Maternal care for unspecified type scar from previous cesarean delivery

Polyps and angiodysplasia of jejunum and ileum

ICD-10-CM has specific codes for non-adenomatous polyps and angiodysplasia of the stomach and duodenum as well as the colon. However, there are currently no unique codes for polyps and angiodysplasia of the jejunum and ileum. This topic was presented originally at the September 2018 Coordination and Maintenance meeting. Based on public comments received, a revised proposal is being presented for consideration.

Upper gastrointestinal endoscopy (EGD) has long been able to visualize polyps and angiodysplasia of the stomach and duodenum. Likewise, lower GI endoscopy (colonoscopy) has long been able to visualize polyps and angiodysplasia of the large intestine. However, it was not possible to directly identify polyps and angiodysplasia of the intervening segments of the small intestine, because the jejunum and ileum generally cannot be reached or surveyed via conventional endoscopy due to their location, mobility, and length.

More recently, the advent and routine use of capsule endoscopy and deep (balloon-assisted) enteroscopy to examine the distal small intestine now enables polyps and angiodysplasia of the jejunum and ileum to be regularly identified and documented. When performing capsule endoscopy, the physician does not know the specific histology of the polyp (i.e., it includes adenomatous polyps, but does not exclude any other histology) he/she is visualizing at the time of the procedure.

Though less common than angiodysplasia of the esophagus, stomach, duodenum and colon, angiodysplasia of the jejunum and ileum is an important cause of obscure gastrointestinal bleeding. Since these diagnoses are now being established with increasing frequency in the jejunum and ileum, it would be beneficial to have specific codes for the jejunum and ileum.

Medtronic is requesting the following new codes to capture this condition and differentiate the jejunum and ileum. The changes are in **bold**.

TABULAR MODIFICATIONS

D13 Benign neoplasm of other and ill-defined parts of digestive system
D13.3 Benign neoplasm of other and unspecified parts of small intestine
D13.39 Benign neoplasm of other parts of small intestine

New code	D13.391	Benign neoplasm of jejunum
Add		Adenomatosis of jejunum
Add		**Excludes1: hyperplastic polyp of jejunum (K63.6)**
New code	D13.392	Benign neoplasm of ileum
Add		Adenomatosis of ileum
Add		**Excludes1: hyperplastic polyp of ileum (K63.7)**

K63 Other diseases of intestine

New code **K63.6 Polyp of jejunum**

Add **Hyperplastic polyp of jejunum**
Add **Excludes1: adenomatous polyp of jejunum (D13.391)**

New code **K63.7 Polyp of ileum**

Add **Hyperplastic polyp of ileum**
Add **Excludes1: adenomatous polyp of ileum (D13.392)**

K63.8 Other specified diseases of intestine

New code K63.82 Angiodysplasia of jejunum and ileum without bleeding

New code K63.83 Angiodysplasia of jejunum and ileum with bleeding

Pressure ulcer of mucosal membrane by site

This topic was presented originally at the September 2017 Coordination and Maintenance (C&M) meeting and at the September 2018 C&M meeting. This revised proposal is based on public comments received and further discussions with the Agency for Healthcare Research and Quality (AHRQ). Currently, there is no indexing for pressure ulcers or sores involving mucosal membranes.

AHRQ reports that some coders are using "specified site NEC" (L89.89-) to describe pressure sores involving mucous membranes, but other coders are concerned that this code is in Chapter 12, Diseases of the skin and subcutaneous tissue, which may not be an appropriate for conditions involving mucous membrane.

AHRQ is requesting new codes to identify mucosal membrane pressure ulcers of specific sites.

TABULAR MODIFICATIONS

J34 Other and unspecified disorders of nose and nasal sinuses

J34.0 Abscess, furuncle, and carbuncle of nose
Delete ~~Cellulitis of nose~~
Delete ~~Necrosis of nose~~
Delete ~~Ulceration of nose~~

New code J34.01 Ulceration of nose
New code J34.011 Pressure ulcer of nasal mucosa
New code J34.019 Other ulceration of nose

New code J34.09 Other abscess, furuncle, and carbuncle of nose
Add Cellulitis of nose
Add Necrosis of nose

J38 Diseases of vocal cords and larynx, not elsewhere classified

J38.3 Other diseases of vocal cords
Delete ~~Abscess of vocal cords~~
Delete ~~Cellulitis of vocal cords~~
Delete ~~Granuloma of vocal cords~~
Delete ~~Leukokeratosis of vocal cords~~
Delete ~~Leukoplakia of vocal cords~~

New code J38.31 Ulceration of vocal cords
New code J38.311 Pressure ulcer of vocal cords
New code J38.319 Other ulcer of vocal cords

New code J38.39 Other diseases of vocal cords
Add Abscess of vocal cords
Add Cellulitis of vocal cords
Add Granuloma of vocal cords
Add Leukokeratosis of vocal cords
Add Leukoplakia of vocal cords

J39 Other diseases of upper respiratory tract

J39.2 Other diseases of pharynx
Delete ~~Cyst of pharynx~~
Delete ~~Edema of pharynx~~

New code J39.21 Ulcer of pharynx
New code J39.211 Pressure ulcer of pharynx
New code J39.219 Other ulceration of pharynx

New code J39.29 Other diseases of pharynx
Add Cyst of pharnyx
Add Edema of pharynx

K06 Other disorders of gingiva and edentulous alveolar ridge

K06.8 Other specified disorders of gingiva and edentulous alveolar ridge
Delete ~~Fibrous epulis~~
Delete ~~Flabby alveolar ridge~~
Delete ~~Giant cell epulis~~
Delete ~~Peripheral giant cell granuloma of gingiva~~
Delete ~~Pyogenic granuloma of gingiva~~
Delete ~~Vertical ridge deficiency~~

New code K06.81 Ulcer of gingiva and edentulous alveolar ridge
New code K06.811 Pressure ulcer of gingiva and edentulous alveolar ridge
New code K06.819 Other ulceration of gingiva and edentulous alveolar ridge

New code K06.89 Other specified disorders of gingiva and edentulous alveolar ridge
Add Fibrous epulis
Add Flabby alveolar ridge
Add Giant cell epulis
Add Peripheral giant cell granuloma of gingiva

Add Pyogenic granuloma of gingiva
Add Vertical ridge deficiency

K12 Stomatitis and related lesions

K12.1 Other forms of stomatitis
Delete ~~Stomatitis NOS~~
Delete ~~Denture stomatitis~~
Delete ~~Ulcerative stomatitis~~
Delete ~~Vesicular stomatitis~~

New code K12.11 Ulcer of oral mucosa
New code K12.111 Pressure ulcer of oral mucosa
New code K12.119 Other ulcer of oral mucosa

New code K12.19 Other forms of stomatitis
Add Stomatitis NOS
Add Denture stomatitis
Add Vesicular stomatitis

K13 Other diseases of lip and oral mucosa

K13.0 Diseases of lips
Delete ~~Abscess of lips~~
Delete ~~Angular cheilitis~~
Delete ~~Cellulitis of lips~~
Delete ~~Cheilitis NOS~~
Delete ~~Cheilodynia~~
Delete ~~Cheilosis~~
Delete ~~Exfoliative cheilitis~~
Delete ~~Fistula of lips~~
Delete ~~Glandular cheilitis~~
Delete ~~Hypertrophy of lips~~
Delete ~~Perleche NEC~~

New code K13.01 Ulcer of lips
New code K13.011 Pressure ulcer of lips
New code K13.019 Other ulcer of lips

New code K13.09 Other diseases of lips
Add Abscess of lips
Add Angular cheilitis
Add Cellulitis of lips
Add Cheilitis NOS

Add Cheilodynia
Add Cheilosis
Add Exfoliative cheilitis
Add Fistula of lips
Add Glandular cheilitis
Add Hypertrophy of lips
Add Perleche NEC

K14 Diseases of tongue

K14.0 Glossitis
Delete ~~Abscess of tongue~~
Delete ~~Ulceration (traumatic) of tongue~~

New code K14.01 Ulcer of tongue
New code K14.011 Pressure ulcer of tongue
New code K14.019 Other ulceration (traumatic) of tongue

New code K14.09 Other glossitis
Add Abscess of tongue

K62 Other diseases of anus and rectum

K62.6 Ulcer of anus and rectum
Delete ~~Solitary ulcer of anus and rectum~~
Delete ~~Stercoral ulcer of anus and rectum~~

New code K62.61 Pressure ulcer of anus and rectum
New code K62.69 Other ulcer of anus and rectum
Add Solitary ulcer of anus and rectum
Add Stercoral ulcer of anus and rectum

N34 Urethritis and urethral syndrome

N34.2 Other urethritis
Delete ~~Meatitis, urethral~~
Delete ~~Postmenopausal urethritis~~
Delete ~~Ulcer of urethra (meatus)~~
Delete ~~Urethritis NOS~~

New code N34.21 Ulcer of urethra (meatus)
New code N34.211 Pressure ulcer of urethra
New code N34.219 Other ulcer of urethra

New code	N34.29	Other urethritis
Add		Meatitis, urethral
Add		Postmenopausal urethritis
Add		Urethritis NOS

N48 Other disorders of penis

N48.5 Ulcer of penis

New code	N48.51	Pressure ulcer of penis
New code	N48.59	Other ulcer of penis

N76 Other inflammation of vagina and vulva

N76.5 Ulceration of vagina

New code	N76.51	Pressure ulcer of vagina
New code	N76.59	Other ulceration of vagina

N76.6 Ulceration of vulva

New code	N76.61	Pressure ulcer of vulva
New code	N76.69	Other ulceration of vulva

Progressive Fibrotic Interstitial Lung Disease

Interstitial lung disease (ILD) encompasses a large group of pulmonary disorders. Although the ILDs are heterogeneous in etiology, pathophysiology and clinical course, the major abnormality in ILDs is disruption of the distal lung parenchyma. While the pathogenesis remains unknown, especially for Idiopathic Interstitial Pneumonias (IIPs), it is generally agreed that some form of injury of the alveolar epithelial cells initiates an inflammatory response coupled with repair mechanisms. The injury-repair process is reflected pathologically as inflammation, fibrosis or a combination of both. The resulting alteration of the interstitial space leads to clinical symptoms, including dyspnea, cough, and physiologic abnormalities consistent with restrictive ventilatory deficit on pulmonary function testing.

Idiopathic pulmonary fibrosis (IPF) is the classic fibrosing ILD, with poor prognosis. However, clinical data suggest that a larger group of patients with differing clinical ILD diagnoses can develop a progressive fibrosing phenotype, with similarities to IPF, during the course of their disease. In this group of patients, the natural history appears to follow a course similar to Idiopathic Pulmonary Fibrosis (IPF) with worsening of respiratory symptoms, lung function, quality of life and functional status, as well as early mortality, despite treatment with currently available (but non-approved) immunomodulatory therapies.

While there is limited data in the literature on this patient subgroup, the scientific working hypothesis is that the response to lung injury in these ILDs includes the development of fibrosis which becomes progressive, self-sustaining and independent of the original clinical association or trigger. These patients are considered to represent a distinct phenotype, with a strong need for further characterization and treatment options.

This proposal is based on a request for a new code for interstitial lung disease with progressive fibrotic phenotype in diseases classified elsewhere, received from Boehringer Ingelheim (a pharmaceutical company).

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TABULAR MODIFICATIONS

J84 Other interstitial pulmonary diseases

New subcategory

J84.1 Other interstitial pulmonary diseases with fibrosis

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

Delete

~~Interstitial pneumonia (nonspecific) (usual) due to collagen vascular disease~~
~~Interstitial pneumonia (nonspecific) (usual) in diseases classified elsewhere~~
~~Organizing pneumonia due to collagen vascular disease~~
~~Organizing pneumonia in diseases classified elsewhere~~

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

New Code

J84.170 Interstitial lung disease with progressive fibrotic phenotype in diseases classified elsewhere
Progressive fibrotic interstitial lung disease

Add

Code first underlying disease, such as:
lung diseases due to external agents (J60-J70)
rheumatoid arthritis (M05.00-M06.9)
systemic connective tissue disorders (M30-M36)
sarcoidosis (D86)

New Code

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

Add

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

Sickle Cell Disease

The American Academy of Pediatrics (AAP) requests tabular modifications for sickle cell disorders to identify patients without major complications but who are in crisis. This proposal was presented at the September 2016 and March 2018 Coordination & Maintenance (C&M) meeting. However based on additional public comments, the proposal has been revamped and being presented for reconsideration.

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

There is currently no adequate means to track patients with other types of complications in addition to acute chest syndrome and splenic sequestration. Other complication include but not limited to acute gall bladder involvement, priapism or fever. Cerebral infarcts are a major complication in patients with sickle cell disease. According to the CDC, about 10% of children with sickle cell disease will have a symptomatic stroke.

TABULAR MODIFICATIONS

D57 Sickle-cell disorders
Use additional code for any associated fever (R50.81)
Excludes1: other hemoglobinopathies (D58.-)

D57.0 Hb-SS disease with crisis
Revise Sickle-cell disease ~~NOS~~ with crisis
Hb-SS disease with vasooclusive pain

D57.00 Hb-SS disease with crisis, unspecified
Add Hb-SS disease with crisis NOS
Add Hb-SS disease with vasoocclusive pain NOS

D57.01 Hb-SS disease with acute chest syndrome

D57.02 Hb-SS disease with splenic sequestration

New code D57.03 Hb-SS disease with cerebral vascular involvement
Add Code also, if applicable: cerebral infarction (I63)

New code D57.09 Hb-SS disease with crisis with other specified complication
Add Code also manifestations, such as:
Add cholelithiasis (K80)
Add fever presenting with conditions classified elsewhere (R50.81)
Add priapism (N48.32)

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

D57.20 Sickle-cell/Hb-C disease without crisis

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

D57.211 Sickle-cell/Hb-C disease with acute chest syndrome

D57.212 Sickle-cell/Hb-C disease with splenic sequestration

New code D57.213 Sickle-cell/Hb-C disease with cerebral vascular involvement
Add Code also, if applicable: cerebral infarction (I63)

New code D57.218 Sickle-cell/Hb-C disease with crisis with other specified complication
Add Code also manifestations, such as:
cholelithiasis (K80)
Add fever presenting with conditions classified elsewhere (R50.81)
Add priapism (N48.32)

D57.219 Sickle-cell/Hb-C disease with crisis, unspecified
Sickle-cell/Hb-C disease with crisis NOS
Add Sickle-cell/Hb-C disease with crisis with vasoocclusive pain NOS

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

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

D57.411 Sickle-cell thalassemia with acute chest syndrome

D57.412 Sickle-cell thalassemia with splenic sequestration

New code D57.413 Sickle-cell/Hb-C disease with cerebral vascular involvement
Add Code also, if applicable cerebral infarction (I63)

New code D57.418 Sickle-cell thalassemia with crisis with other specified complication

Add Code also manifestations, such as:
cholelithiasis (K80)
Add fever presenting with conditions classified elsewhere (R50.81)
Add priapism (N48.32)

D57.419 Sickle-cell thalassemia with crisis, unspecified
Sickle-cell thalassemia with crisis NOS
Add Sickle-cell thalassemia with crisis with vasoocclusive pain

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

D57.81 Other sickle-cell disorders with crisis

D57.811 Other sickle-cell disorders with acute chest syndrome
D57.812 Other sickle-cell disorders with splenic sequestration

New code D57.813 Other sickle-cell disorders with cerebral vascular involvement
Add Code also, if applicable: cerebral infarction (I63)

New code D57.818 Other sickle-cell disorders with crisis with other specified complication

Add		Code also manifestations, such as: cholelithiasis (K80)
Add		fever presenting with conditions classified elsewhere (R50.81)
Add		priapism (N48.32)
	D57.819	Other sickle-cell disorders with crisis, unspecified Other sickle-cell disorders with crisis NOS

Sjogren syndrome

This is a representation of a proposal presented at the September 2018 Coordination and Maintenance meeting. Sjogren is a systemic autoimmune disease that affects the entire body. Its two most comon symptoms are dry eyes and a dry mouth. In Sjogren syndrome, the immune system targets the mucous membranes and moisture secreting glands of your eyes and mouth resulting in decreased tears and saliva. Along with symptoms of extensive dryness, other serious complications include profound fatigue, chronic pain, major organ involvement, neuropathies and lymphomas. Women are more likely than men to have Sjogren syndrome.

With Sjogren syndrome, the most common form of peripheral nervous system involvement is small fiber neuropathies, which can cause numbness and pain. Autonomic neuropathies, which can lead to a drop in blood pressure and subsequent dizziness and fainting and affect heart rate, sweating, digestion and the bowel and bladder, are frequently reported. Cranial neuropathies; axonal or sensory motor or sensory neuropathies; ataxic sensory neuropathies/large fiber ganglionopathies; and mononeuritis multiplex/multiple mononeuropathies also occur.

Central nervous system involvement includes cognitive dysfunction, impaired sleep, vasculitis, symptoms of vestibular/auditory/olfactory and taste, myelitis and other demyelinating syndromes, and psychiatric manifestations (anxiety, depression, and, less frequently, psychosis). The most common pulmonary manifestations of Sjogren is interstitial lung disease and it can lead to recurring pneumonia and fibrosis. Upper airway disease in Sjogren includes difficulty swallowing and talking, reflux and obstructive sleep apnea. Lower airway disease includes bronchiectasis, bronchiolitis and obstructive lung diseases including COPD and asthma. Lymphoproliferative disease can occur and lead to the development of non-Hodgkin lymphoma, amyloidosis and nodular lymphoid hyperplasia. Vascular lung disease also can occur.

The existing code M35.0, Sicca syndrome [Sjogren], is misleading and appears that sicca syndrome was intended to reflect the Sjogren disease. The term “sicca syndrome” was an alternative for the eponym “Sjogren syndrome” used in the past, by Henrik Sjogren and others. The term has been abandoned over the past 35 or more years in favor of the eponymic Sjogren syndrome. Sjogren’s patients might or might not present with dryness symptoms.

Sjogren’s Syndrome Foundation and the American College of Rheumatology are requesting the following ICD-10-CM tabular modifications. The changes are shown in **bold**.

TABULAR MODIFICATIONS

M35 Other systemic involvement of connective tissue

Revise	M35.0	~~Sicca syndrome [Sjogren]~~ Sjogren syndrome
Add		Sicca syndrome
Add		**Excludes1: Dry mouth, unspecified (R68.2)**
Revise	M35.00	~~Sicca~~ Sjogren syndrome, unspecified
Revise	M35.01	~~Sicca~~ Sjogren syndrome with keratoconjunctivitis
Revise	M35.02	~~Sicca~~ Sjogren syndrome with lung involvement
Revise	M35.03	~~Sicca~~ Sjogren syndrome with myopathy
Revise	M35.04	~~Sicca~~ Sjogren syndrome with tubulo-interstitial nephropathy
New code	**M35.05**	**Sjogren syndrome with inflammatory arthritis**
New code	**M35.06**	**Sjogren syndrome with peripheral nervous system involvement**
New code	**M35.07**	**Sjogren syndrome with central nervous system involvement**
New code	**M35.08**	**Sjogren syndrome with gastrointestinal involvement**
New code	**M35.0A**	**Sjogren syndrome with glomerular disease**
New code	**M35.0B**	**Sjogren syndrome with vasculitis**
New code	**M35.0C**	**Sjogren syndrome with dental involvement**
Revise	M35.09	~~Sicca~~ Sjogren syndrome with other organ involvement

Substance Abuse with Withdrawal, Alcohol Use Unspecified with Withdrawal and Cocaine Use Unspecified with Withdrawal

A proposal submitted by the American Psychiatric Association (APA) for new codes for alcohol use unspecified with withdrawal and cocaine use unspecified with withdrawal was presented at the September 2018 Coordination and Maintenance (C&M) meeting. However based on public comments and reevaluation of the proposal by the submitter, modifications have been made and being submitted for consideration.

An important feature of dependence on alcohol, opioids, cannabis, sedatives/hypnotics/ anxiolytics, cocaine, other stimulants, nicotine, and some of the other psychoactive substances is the potential development of a withdrawal syndrome that occurs when the person with dependence reduces or ceases use of the substance.

Clinically, it was originally thought that a withdrawal syndrome only developed in individuals with a diagnosis of substance dependence; however, substance withdrawal can occur in clinical situations involving individuals who use substances regularly and then suddenly stop using them, but who do not have a diagnosis of substance dependence. Such situations include (1) individuals taking prescribed medication daily exactly as directed who are physiologically addicted to the substance but who do not have the behavioral elements required for a diagnosis of substance dependence and (2) individuals who abuse substances regularly (which qualifies for a diagnosis of substance abuse) but lack the loss of control required for a diagnosis of substance dependence.

APA is requesting new ICD-10-CM codes for substance abuse with withdrawal for those classes that can cause physiological addiction (i.e., alcohol, opioids, cannabis, sedatives, cocaine, other stimulants, and other psychoactive substance). Additional proposed codes are in response to an inquiry received from the American Hospital Association (AHA) Coding Clinic.

TABULAR MODIFICATIONS

F10 Alcohol related disorders

F10.1 Alcohol abuse
F10.12 Alcohol abuse with intoxication
F10.120 Alcohol abuse with intoxication, uncomplicated
F10.121 Alcohol abuse with intoxication delirium
F10.129 Alcohol abuse with intoxication, unspecified

New subcategory F10.13 Alcohol abuse, with withdrawal

New code F10.130 Alcohol abuse with withdrawal, uncomplicated

New code F10.131 Alcohol abuse with withdrawal delirium
New code F10.132 Alcohol abuse with withdrawal with perceptual disturbance
New code F10.139 Alcohol abuse with withdrawal, unspecified

F10.9 Alcohol use, unspecified
F10.92 Alcohol use, unspecified, with intoxication
F10.920 Alcohol use, unspecified with intoxication, uncomplicated
F10.921 Alcohol use, unspecified with intoxication delirium
F10.929 Alcohol use, unspecified with intoxication, unspecified

New subcategory F10.93 Alcohol use, unspecified with withdrawal
New code F10.930 Alcohol use, unspecified with withdrawal, uncomplicated
New code F10.931 Alcohol use, unspecified with withdrawal delirium
New code F10.932 Alcohol use, unspecified with withdrawal with perceptual disturbance
New code F10.939 Alcohol use, unspecified with withdrawal, unspecified

F10.94 Alcohol use, unspecified with alcohol-induced mood disorder
F10.95 Alcohol use, unspecified with alcohol-induced psychotic disorder
F10.96 Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
F10.97 Alcohol use, unspecified with alcohol-induced persisting dementia
F10.98 Alcohol use, unspecified with other alcohol-induced disorders

F10.99 Alcohol use, unspecified with unspecified alcohol-induced disorder

F11 Opioid related disorders
F11.1 Opioid abuse
F11.12 Opioid abuse with intoxication
F11.120 Opioid abuse with intoxication, uncomplicated

F11.121 Opioid abuse with intoxication delirium
F11.122 Opioid abuse with intoxication with perceptual disturbance
F11.129 Opioid abuse with intoxication, unspecified

New code F11.13 Opioid abuse with withdrawal

F12 Cannabis related disorders
F12.1 Cannabis abuse
F12.12 Cannabis abuse with intoxication
F12.120 Cannabis abuse with intoxication, uncomplicated
F12.121 Cannabis abuse with intoxication delirium
F12.122 Cannabis abuse with intoxication with perceptual disturbance
F12.129 Cannabis abuse with intoxication, unspecified

New code F12.13 Cannabis abuse with withdrawal

F13 Sedative, hypnotic, or anxiolytic related disorders
F13.1 Sedative, hypnotic or anxiolytic-related abuse
F13.12 Sedative, hypnotic or anxiolytic abuse with intoxication
F13.120 Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13.121 Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13.129 Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified

New subcategory F13.13 Sedative, hypnotic or anxiolytic dependence with withdrawal
New code F13.130 Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
New code F13.131 Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
New code F13.132 Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
New code F13.139 Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified

F14 Cocaine related disorders
F14.1 Cocaine abuse
F14.12 Cocaine abuse with intoxication

F14.120 Cocaine abuse with intoxication, uncomplicated
F14.121 Cocaine abuse with intoxication with delirium
F14.122 Cocaine abuse with intoxication with perceptual disturbance
F14.129 Cocaine abuse with intoxication, unspecified

New code F14.13 Cocaine abuse, unspecified with withdrawal

F14.9 Cocaine use, unspecified
F14.90 Cocaine use, unspecified, uncomplicated
F14.92 Cocaine use, unspecified with intoxication
F14.920 Cocaine use, unspecified with intoxication, uncomplicated
F14.921 Cocaine use, unspecified with intoxication delirium
F14.922 Cocaine use, unspecified with intoxication with perceptual disturbance
F14.929 Cocaine use, unspecified with intoxication, unspecified
New code F14.93 Cocaine use, unspecified with withdrawal
F10.94 Cocaine use, unspecified with cocaine-induced mood disorder
F10.95 Cocaine use, unspecified with cocaine-induced psychotic disorder
F10.98 Cocaine use, unspecified with other cocaine-induced disorders

F10.99 Cocaine use, unspecified with unspecified cocaine-induced disorder

F15 Other stimulant related disorders
F15.1 Other stimulant abuse
F15.12 Other stimulant abuse with intoxication
F15.120 Other stimulant abuse with intoxication, uncomplicated
F15.121 Other stimulant abuse with intoxication delirium
F15.122 Other stimulant abuse with intoxication with perceptual disturbance
F15.129 Other stimulant abuse with intoxication, unspecified

New code F15.13 Other stimulant abuse with withdrawal

F19 Other psychoactive substance related disorders
F19.1 Other psychoactive substance abuse
F19.12 Other psychoactive substance abuse with intoxication

F19.120 Other psychoactive substance abuse with intoxication, uncomplicated
F19.121 Other psychoactive substance abuse with intoxication delirium
F19.122 Other psychoactive substance abuse with intoxication with perceptual disturbances
F19.129 Other psychoactive substance abuse with intoxication, unspecified

New subcategory	F19.13 Other psychoactive substance dependence with withdrawal
New code	F19.130 Other psychoactive substance dependence with withdrawal, uncomplicated
New code	F19.131 Other psychoactive substance dependence with withdrawal, with delirium
New code	F19.132 Other psychoactive substance dependence with withdrawal with perceptual disturbance
New code	F19.139 Other psychoactive substance dependence with withdrawal, unspecified

Suspected Foreign Body Ingestion

Foreign bodies can gain entry into the human body through a variety of methods, including ingestion, aspiration, and purposeful insertion. Foreign bodies are a common cause for seeking medical care.

In the pediatric population, there are times when the presence of a foreign body may be suspected and a clinical evaluation is required to determine the presence of a foreign object. As the child is often not able to communicate the actual event (incident), this often requires some form of radiographic imaging and or other diagnostic test. At times, the evaluation will show that no foreign body is present.

Currently, there is no way to identify and track these types of encounters and justification of resource utilization.

The American Academy of Pediatrics (AAP) respectfully requests a new code to identify patients who seek care for suspected foreign body ingestion, not found.

TABULAR MODIFICATIONS

Z03 Encounter for medical observation for suspected diseases and conditions ruled out

This category is to be used when a person without a diagnosis is suspected of having an abnormal condition, without signs or symptoms, which requires study, but after examination and observation, is ruled out. This category is also for use for administrative and legal observation status.

Z03.8 Encounter for observation for other suspected diseases and conditions ruled out

New subcategory Z03.82 Encounter for observation for suspected foreign body ruled out

Add Excludes1: Retained foreign body (Z18.-)
Add Retained foreign body in eyelid (H02.81)
Add Residual foreign body in soft tissue (M79.5)

Add Excludes 2: Confirmed foreign body ingestion or aspiration including
Add Foreign body on external eye (T15)

Add	Foreign body in ear (T16)
Add	Foreign body in respiratory tract (T17)
Add	Foreign body in alimentary tract (T18)

New code	Z03.821 Encounter for observation for suspected ingested foreign body ruled out
New code	Z03.822 Encounter for observation for suspected aspirated (inhaled) foreign body ruled out
New code	Z03.823 Encounter for observation for suspected inserted (injected) foreign body ruled out
Add	Encounter for observation for suspected inserted (injected) foreign body in skin ruled out
Add	Encounter for observation for suspected inserted (injected) foreign body in eye ruled out
Add	Encounter for observation for suspected inserted (injected) foreign body in orifice ruled out

Z03.89 Encounter for observation for other suspected diseases and conditions ruled out