ICD-10 Coordination and Maintenance Committee Meeting
September 11-12, 2018
Diagnosis Agenda
Part 1

Welcome and announcements
Donna Pickett, MPH, RHIA
Co-Chair, ICD-10 Coordination and Maintenance Committee

Diagnosis Topics:

Contents

Alcohol Use Unspecified with Withdrawal & Cocaine Use Unspecified with Withdrawal 13

Cheryl Bullock

Atrial Fibrillation..... 15

David Berglund, MD

BRCA 17

Shannon McConnell-Lamptey

Breast Lump in Overlapping Quadrants..... 19

Traci Ramirez

Congenital Deformities of Feet 20

Traci Ramirez
R Dale Blasier, MD, FRCS(C), MBA
Arkansas Children's Hospital
American Academy of Orthopaedic Surgeons (AAOS)

Cyclical Vomiting Syndrome 22

Traci Ramirez

Deficiency of Adenosine Deaminase 2 24

David Berglund, MD

Deep Vein Thrombosis 27

Donna Pickett

Dravet Syndrome 32

Shannon McConnell-Lamptey
Ian Miller, MD
Medical Director of the Comprehensive Epilepsy Program
Nicklaus Children's Hospital

Ehlers-Danlos Syndromes (EDS) 33

Cheryl Bullock
Kay E. Jewell, MD
Vice President Medical Affairs, SMT, Inc

Fetal Anomalies 35

Traci Ramirez

Fetus Number 43

Traci Ramirez

Juvenile Osteochondrosis of Tibia and Fibula 44

Traci Ramirez
R Dale Blasier, MD, FRCS(C), MBA
Arkansas Children's Hospital
American Academy of Orthopaedic Surgeons (AAOS)

Latent Tuberculosis Infection 46

Traci Ramirez

Legal Intervention 48

Shannon McConnell-Lamptey
Dr. John Young
Co-Director, Health Care Quality Program
School of Medicine and Health Sciences
The George Washington University

Legal Intervention Involving Injury of Unspecified Person 50

Shannon McConnell-Lamptey

Neonatal Cerebral Infarction 54

Cheryl Bullock

Osteopenia of the hip 55

Shannon McConnell-Lamptey

Sjogren Syndrome..... 56

Shannon McConnell-Lamptey
Alan N. Baer, MD
Director, Jerome L. Greene Sjogren's Syndrome Center
Professor of Medicine, Johns Hopkins University
Associate Investigator, National Institute of Dental and Craniofacial Research

Slipped Upper Femoral Epiphysis, Unstable 58

Traci Ramirez
R Dale Blasier, MD, FRCS(C), MBA
Arkansas Children's Hospital
American Academy of Orthopaedic Surgeons (AAOS)

Subsegmental Pulmonary Embolism 60

David Berglund, MD

Travel Health Counseling 62

Cheryl Bullock

ICD-10 TIMELINE

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

September 11-12, 2018	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 3, 2018.** 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.
September 2018	Webcast of the September 11-12, 2018 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/meetings.html
October 1, 2018	**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/ic d10cm.htm** **Procedure addendum:** **http://www.cms.gov/Medicare/Coding/ICD10/**

October 12, 2018	**Deadline for receipt of public comments on proposed new codes discussed at the September 11-12, 2018 ICD-10 Coordination and Maintenance Committee meetings for implementation on April 1, 2019.**
November 2018	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, 2019 will be posted on the following websites: http://www.cdc.gov/nchs/icd/icd10cm.htm http://www.cms.gov/Medicare/Coding/ICD10/
November 13, 2018	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the September 11-12, 2018 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2019.**
December 7, 2018	**Deadline for requestors: Those members of the public requesting that topics be discussed at the March 5-6, 2019 ICD-10 Coordination and Maintenance Committee meeting must have their requests submitted to CMS for procedures and NCHS for diagnoses by this date.**
February 2019	Tentative agenda for the Procedure part of the March 5, 2019 ICD-10 Coordination and Maintenance Committee meeting posted on CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials.html Tentative agenda for the Diagnosis part of the March 6, 2019 ICD-10 Coordination and Maintenance Committee meeting posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd/icd10cm_maintenance.htm Federal Register notice of March 5-6, 2019 ICD-10 Coordination and Maintenance Committee Meeting will be published.
February 1, 2019	**On-line registration opens for the March 5-6, 2019 ICD-10 Coordination and Maintenance Committee meeting at: https://www.cms.gov/apps/events/default.asp**

March 2019	Because of increased security requirements, **those wishing to attend the March 5-6, 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 February 22, 2019; failure to do so may result in lack of access to the meeting**.
March 5-6, 2019	ICD-10 Coordination and Maintenance Committee Meeting.
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/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials.html
April 1, 2019	Any new ICD-10 codes to capture new diseases or technology will be implemented on April 1, 2019.
April 5, 2019	**Deadline for receipt of public comments on proposed new 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
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/ICD9ProviderDiagnosticCodes/ICD-9-CM-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 3, 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 3, 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 3, 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/ICD9ProviderDiagnosticCodes/meetings.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 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/
November 8, 2019	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the September 10-11, 2019 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2020.**

- Toll-free WebEx log in information: **Day 1-September 11, 2018**:
    1. Event address for **participants**: https://events-cms.webex.com/events-cms/onstage/g.php?MTID=e15de5ab6e1d20cf9fa7c02829f13f4bf
    2. Event address for **remote presenters**: https://events-cms.webex.com/events-cms/onstage/g.php?MTID=eefc517ca9f0ec858ea4b1877b90034b5
    3. Event number: **908 381 636**
    4. Event password: This event does not require a password for attendees or panelists.
- Toll-free WebEx log in information: **Day 2-September 12, 2018**:
    1. Event address for **participants**: https://events-cms.webex.com/events-cms/onstage/g.php?MTID=e3bf010920f178df3eab041e70e1093da
    2. Event address for **remote presenters**: https://events-cms.webex.com/events-cms/onstage/g.php?MTID=e258aa3de637e69f8f67f5b13dcf17b87
    3. Event number: **909 444 644**
    4. Event password: This event does not require a password for attendees or panelists.

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.

Alcohol Use Unspecified with Withdrawal & Cocaine Use Unspecified with Withdrawal

An important feature of substance 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 when the person with dependence cuts down or stops using the substance.

Clinically, it was originally thought that a withdrawal syndrome could not develop in individuals using alcohol or cocaine unless they also had alcohol or cocaine dependence. However, alcohol withdrawal and cocaine withdrawal can occur in individuals who use alcohol or cocaine regularly and thus might develop withdrawal symptoms if they suddenly stop (but do not have the loss of control or negative consequences required for a diagnosis of dependence).

Currently the only available codes for cases with a diagnosis of alcohol withdrawal or cocaine withdrawal are F10.23, Alcohol dependence with withdrawal and F14.23, Cocaine dependence with withdrawal, which implied dependency.

Withdrawal can also develop in individuals taking prescribed medications that are in the opioid, cannabis, sedative/hypnotic/anxiolytic, other stimulant and other psychoactive substance classes who are not considered to meet criteria for dependence. ICD-10-CM provides codes for these withdrawal syndromes as classified in Substance use, unspecified with withdrawal (i.e., F11.93 Opioid use, unspecified with withdrawal; F12.93 Cannabis use, unspecified with withdrawal; F13.93 Sedative, hypnotic or anxiolytic use, unspecified with withdrawal; F15.93 Other stimulant use, unspecified with withdrawal and F19.93 Other psychoactive substance use, unspecified with withdrawal.)

This proposal is requesting new ICD-10-CM codes for Alcohol use, unspecified with withdrawal and Cocaine use, unspecified with withdrawal in response to an inquiry received from the American Hospital Association (AHA) Coding Clinic Advisory Board. The American Psychiatric Association (APA) proposes the following tabular modifications:

TABULAR MODIFICATIONS

F10 Alcohol related disorders
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 code F10.93 Alcohol use, unspecified with withdrawal

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

F14 Cocaine related disorders

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

Atrial Fibrillation

Previous proposals to expand the codes for atrial fibrillation were presented at the September 2015 and September 2016 ICD-10-CM Coordination and Maintenance meetings, but these have not been implemented. This proposal has been modified from the previous proposals.

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

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

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

Even though based on input from the American College of Cardiology, this term chronic atrial fibrillation is not specific for clinical usage in the U.S., this is a code title in the WHO ICD-10, and for compatibility it is necessary to maintain this term in the clinical modification ICD-10-CM. The tabular changes shown below are being proposed.

References:

Chiang CE1, Naditch-Brûlé L, Murin J, et al. Distribution and risk profile of paroxysmal, persistent, and permanent atrial fibrillation in routine clinical practice. Circ Arrhythm Electrophysiol. 2012 Aug 1;5(4):632-9. http://www.ncbi.nlm.nih.gov/pubmed/22787011

Fuster V, Rydén LE, Asinger RW, et al. ACC/AHA/ESC Guidelines for the Management of Patients With Atrial Fibrillation. Circulation. 2001 Oct 23;104(17):2118-50. http://circ.ahajournals.org/content/104/17/2118.full

January CT, Wann LS, Alpert JS, et al.; American College of Cardiology/American Heart Association Task Force on Practice Guidelines. 2014 AHA/ACC/HRS guideline for the management of patients with atrial fibrillation: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol. 2014 Dec 2;64(21):e1-76. doi: 10.1016/j.jacc.2014.03.022. Epub 2014 Mar 28.

TABULAR MODIFICATIONS

	I48	Atrial fibrillation and flutter	
	I48.1	Persistent atrial fibrillation	
New code		I48.11	Longstanding persistent atrial fibrillation
New code		I48.19	Other persistent atrial fibrillation
Add			Chronic persistent atrial fibrillation
Add			Persistent atrial fibrillation, NOS
	I48.2	Chronic atrial fibrillation	
Delete		~~Permanent atrial fibrillation~~	
New code		I48.20	Chronic atrial fibrillation, unspecified
New code		I48.21	Permanent atrial fibrillation

BRCA

BRCA1 and BRCA2 are the best known links to breast cancer risk. People who have a BRCA gene mutation tend to develop breast and ovarian cancers at younger ages than people who do not have these mutations. This proposal has been revised based on public comments received following the March 2018 Coordination and Maintenance meeting.

Given the limitations of current ovarian cancer screening approaches, prophylactic oophorectomy is recommended for patients with the BRCA1 or BRCA2 genetic mutation by the age of 40 or after the conclusion of childbearing. Prophylactic salpingo-oophorectomy reduces the risk of breast cancer by 40-70%. This procedure has been shown to reduce the risk of ovarian, fallopian tube and peritoneal cancer by approximately 85-90% in women with known mutations in BRCA1 or BRCA2. The American College of Obstetricians and Gynecologists Practice Bulletin Number 103, reaffirmed in 2015 on BRCA1 and BRCA2 documents "For a woman with a BRCA1 mutation, the risk of ovarian cancer is 39-46%. For a woman with BRCA2 mutation, the risk ovarian cancer is 65-74%. For women with breast cancer, the 10-year actuarial risk of developing subsequent ovarian cancer is 12.7% for BRCA1 mutation carriers and 6.8% for BRCA2 mutation carriers".

The following new codes are being requested to identify specific BRCA mutations for statistics, tracking and reporting. The changes are shown in bold.

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

TABULAR MODIFICATIONS

Z15 Genetic susceptibility to disease

Z15.0 Genetic susceptibility to malignant neoplasm

New sub-subcategory	Z15.01 Genetic susceptibility to malignant neoplasm of breast
New code	Z15.011 BRCA1 genetic susceptibility to malignancy **of breast**
New code	Z15.012 BRCA2 genetic susceptibility to malignancy **of breast**
New code	Z15.019 Genetic susceptibility to malignant neoplasm **of breast,** unspecified
Add	**BRCA NOS**

New sub-subcategory	**Z15.02**	**Genetic susceptibility to malignant neoplasm of ovary**
New code	**Z15.021**	**BRCA1 genetic susceptibility to malignancy of ovary**
New code	**Z15.022**	**BRCA2 genetic susceptibility to malignancy of ovary**
New code	**Z15.029**	**Genetic susceptibility to malignant neoplasm of ovary unspecified**

Breast Lump in Overlapping Quadrants

The National Center for Health Statistics (NCHS) has received numerous proposals requesting new ICD-10-CM codes for breast lump of overlapping quadrants right and left breast. The proposed codes would align the structure with the current codes for malignant neoplasm of breast (i.e., subcategory C50.8). The proposed codes would allow for proper code assignment when an unspecified lump in the breast overlaps anatomic sites classifiable to different codes.

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

NCHS proposes the following tabular modifications:

TABULAR MODIFICATION

N63 Unspecified lump in breast
Nodule(s) NOS in breast
N63.1 Unspecified lump in the right breast
N63.10 Unspecified lump in the right breast, unspecified quadrant
N63.11 Unspecified lump in the right breast, upper outer quadrant
N63.12 Unspecified lump in the right breast, upper inner quadrant
N63.13 Unspecified lump in the right breast, lower outer quadrant
N63.14 Unspecified lump in the right breast, lower inner quadrant
New code N63.15 Unspecified lump in the right breast, overlapping quadrants

N63.2 Unspecified lump in the left breast
N63.20 Unspecified lump in the left breast, unspecified quadrant
N63.21 Unspecified lump in the left breast, upper outer quadrant
N63.22 Unspecified lump in the left breast, upper inner quadrant
N63.23 Unspecified lump in the left breast, lower outer quadrant
N63.24 Unspecified lump in the left breast, lower inner quadrant
New code N63.25 Unspecified lump in the left breast, overlapping quadrants

Congenital Deformities of Feet

The American Academy of Orthopedic Surgeons (AAOS) is requesting modifications to category Q66. Congenital deformities of feet. Currently in ICD-10-CM there is side specificity for Q66.5 Congenital pes planus and Q66.8 Other congenital deformities of feet. AAOS is requesting consistency across all congenital foot deformities which allows specification of side within ICD-10-CM.

Therefore, the following diagnoses are being requested to be modified to allow specificity of side involved in codes Q66.0- through Q66.9-.

The American Academy of Pediatrics (AAP) has reviewed and supports this proposal. AAOS is requesting the following tabular modifications:

TABULAR MODIFICATIONS

Q66 Congenital deformities of feet
Excludes1: reduction defects of feet
valgus deformities (acquired) (M21.0-)
varus deformities (acquired) (M21.1-)

Q66.0 Congenital talipes equinovarus
New code Q66.00 Congenital talipes equinovarus, unspecified foot
New code Q66.01 Congenital talipes equinovarus, right foot
New code Q66.02 Congenital talipes equinovarus, left foot

Q66.1 Congenital talipes calcaneovarus
New code Q66.10 Congenital talipes calcaneovarus, unspecified foot
New code Q66.11 Congenital talipes calcaneovarus, right foot
New code Q66.12 Congenital talipes calcaneovarus, left foot

Q66.2 Congenital metatarsus (primus) varus
Q66.21 Congenital metatarsus primus varus
New code Q66.211 Congenital metatarsus primus varus, right foot
New code Q66.212 Congenital metatarsus primus varus, left foot
New code Q66.219 Congenital metatarsus primus varus, unspecified foot

Q66.22 Congenital metatarsus adductus
Congenital metatarsus varus
New code Q66.221 Congenital metatarsus adductus, right foot
New code Q66.222 Congenital metatarsus adductus, left foot
New code Q66.229 Congenital metatarsus adductus, unspecified foot

	Q66.3 Other congenital varus deformities of feet
	Hallux varus, congenital
New code	Q66.30 Other congenital varus deformities of feet, unspecified foot
	Q66.31 Other congenital varus deformities of feet, right foot
	Q66.32 Other congenital varus deformities of feet, left foot
	Q66.4 Congenital talipes calcaneovalgus
New code	Q66.40 Congenital talipes calcaneovalgus, unspecified foot
New code	Q66.41 Congenital talipes calcaneovalgus, right foot
New code	Q66.42 Congenital talipes calcaneovalgus, left foot
	Q66.7 Congenital pes cavus
New code	Q66.70 Congenital pes cavus, unspecified foot
New code	Q66.71 Congenital pes cavus, right foot
New code	Q66.72 Congenital pes cavus, left foot
	Q66.9 Congenital deformity of feet, unspecified
New code	Q66.90 Congenital deformity of feet, unspecified, unspecified foot
New code	Q66.91 Congenital deformity of feet, unspecified, right foot
New code	Q66.92 Congenital deformity of feet, unspecified, left foot

Cyclical Vomiting Syndrome

This proposal was originally presented at the September 2017 and again at the March 2018 ICD-10 Coordination and Maintenance (C&M) meeting at the request of the American Hospital Association's Coding Clinic Editorial Advisory Board. Based on comments received at the March 2018 C&M, a revised proposal is being presented for consideration. The American Academy of Pediatrics has reviewed and supports this proposal.

Cyclical vomiting syndrome is described by episodes of severe vomiting that have no identifiable cause. Episodes can last for days or hours and alternate with symptom-free periods of time. Each episode tends to start at the same time of day, last the same length of time and occur with the same symptoms and level of intensity. Cyclical vomiting syndrome may or may not be related to migraines. Treatment usually involves medications, including anti-nausea and migraine therapies, that may help lessen symptoms.

Currently, in ICD-10-CM, Cyclical vomiting is indexed to code G43.AO, Cyclical vomiting, not intractable. These codes fall within the code category of G43-, Migraine. In ICD-9-CM, Cyclical vomiting (not related to migraines) was captured under code 536.2, Persistent vomiting. Code 536.2 crosswalks to ICD-10-CM code R11.10, Vomiting, unspecified. This code does not adequately represent the clinical significance of the disorder and the treatment of cyclical vomiting syndrome not related to migraines.

The following tabular modifications are being proposed and are shown in bold:

TABULAR MODIFICATIONS

G43 Migraine
G43.A Cyclical vomiting

Add — Excludes1: Cyclical vomiting syndrome unrelated to migraine (R11.15)

Revise — G43.A0 Cyclical vomiting~~**, (migraine),**~~ **in migraine**, not intractable
Cyclical vomiting, without refractory migraine

Revise — G43.A1 Cyclical vomiting~~**, (migraine),**~~ **in migraine**, intractable
Cyclical vomiting, with refractory migraine

R11 Nausea and vomiting
R11.1 Vomiting
R11.10 Vomiting, unspecified
Vomiting NOS
R11.11 Vomiting without nausea
R11.12 Projectile vomiting
R11.13 Vomiting of fecal matter
R11.14 Bilious vomiting
Bilious emesis

New code — R11.15 Cyclical vomiting syndrome unrelated to migraine

Add — Cyclic vomiting syndrome **NOS**

Add	Excludes1: Cyclical vomiting **in migraine** (G43.A-)
Add	Excludes2: Diabetes mellitus due to underlying condition (E08.-)
Add	Bulimia nervosa (F50.2)

Deficiency of Adenosine Deaminase 2

A previous proposal to expand the code for adenosine deaminase deficiency was presented in March 2018. This proposal has been modified from the previous proposal, based on comments recieved. The original request to create a specific ICD-10-CM code was received from Dr. Chip Chambers, Vanderbilt University Medical Center, Nashville, TN, and President of the DADA2 Foundation.

Deficiency of Adenosine Deaminase 2 (DADA2), or adenosine deaminase 2 deficiency, is characterized by abnormal inflammation of various tissues, which may be associated with a mottled rash (livedo racemosa), early-onset strokes, other findings of vasculitis (consistent with polyarteritis nodosa), and sometimes immunodeficiency. It is autoinflammatory in nature, and besides the skin and nervous system, may affect the gastrointestinal system or kidneys, and may cause intermittent fevers. It may be associated with hepatosplenomegaly. Onset may be from early childhood to adulthood. Severity of the disorder varies.

While vasculopathy is common with adenosine deacminase 2 deficiency, it is not always present at diagnosis. Although some cases have been described as childhood-onset polyarteritis nodosa, since the diagnosis may be made without vasculopathy being present, this would not be inherent.

Although adenosine deaminase 2 deficiency was relatively recently discovered, researchers suspect that it may not be a rare disease. They are working to determine whether it may underlie other forms of vasculitis and stroke whose causes are now unknown.

Even though adenosine deaminase 2 deficiency may be associated with immunodeficiency, this is usually relatively mild, and it is usually not associated with a significantly increased risk of bacterial and viral infections. This is in contrast with the original adenosine deaminase deficiency (type 1), which causes a severe combined immunodeficiency (SCID); it is commonly referred to as SCID due to ADA deficiency. Despite the similar terms used to identify these disorders, they are quite different clinically. The gene involved in the original ADA deficiency is on chromosome 20, while the gene involved in ADA2 deficiency is on chromosome 22. There can also be cases involving the chromosome on gene 20 that are referred to as partial ADA deficiency, that do not involve SCID; these ideally should not be grouped with either of the other types discussed here, so are being included at the other code in this proposal.

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TABULAR MODIFICATIONS

D81 Combined immunodeficiencies

D81.3 Adenosine deaminase [ADA] deficiency

New code	D81.30	Adenosine deaminase deficiency, unspecified
Add		ADA deficiency NOS
New code	D81.31	Severe combined immunodeficiency due to adenosine deaminase deficiency
Add		ADA with SCID
Add		Adenosine deaminase deficiency with severe combined immunodeficiency
New code	D81.32	Adenosine deaminase 2 deficiency
Add		ADA2 deficiency
Add		Adenosine deaminase deficiency type 2
Add		Code also, if applicable, any associated manifestations, such as:
Add		polyarteritis nodosa (M30.0)
Add		stroke (I63.-)
New code	D81.39	Other adenosine deaminase deficiency
Add		Adenosine deaminase deficiency type 1, NOS (without SCID)

Add	Partial adenosine deaminase deficiency
Add	Partial ADA deficiency

Deep Vein Thrombosis

Calf vein thrombosis refers to any clot affecting the deep veins of the calf, also known as the distal portion of the lower extremity, without extending into the popliteal vein. The calf veins include three paired veins (posterior tibial, peroneal, and anterior tibial) and two sets of muscular veins (soleal and gastrocnemial).[1] Compared to proximal deep vein thrombosis, the clinical significance of distal deep vein thrombosis remains controversial, and there is less consensus about preferred management approaches. [2, 3] According to some studies, anticoagulant treatment may be safely withheld unless there is propagation of the clot into a proximal deep vein. However, evidence in the clinical literature suggests that symptomatic calf vein thrombosis has many of the same risk factors as symptomatic proximal deep vein thrombosis, and can be associated with an increased risk for pulmonary embolism in certain clinical settings.

In ICD-9-CM, a single code (453.42) was created to capture "acute venous embolism and thrombosis of deep veins of the distal lower extremity," and a parallel code (453.52) was created to capture "chronic venous embolism and thrombosis of deep veins of the distal lower extremity." Indexing of these codes included numerous terms relevant to calf vein thromboses, including lower leg, distal, peroneal, and tibial. Coders were educated to use these codes for thromboses involving other specified deep veins of the distal lower extremity, such as the soleal and gastrocnemial muscular branches, in the absence of specific indexing or inclusion terms for these veins. This approach allowed data users to identify all thromboembolic disease involving deep calf veins, and to distinguish this problem from thromboembolic disease involving proximal deep veins, which is a more serious condition associated with a higher risk of pulmonary embolism.

In ICD-10-CM, there are no specific codes to capture thrombophlebitis or thrombosis involving the peroneal vein or muscular branch veins. Coders are referred to nonspecific codes for "phlebitis and thrombophlebitis of other deep vessels of lower extremities" (I80.29-), "acute embolism and thrombosis of other specified deep vein of lower extremity" (I82.49-), and "chronic embolism and thrombosis of other specified deep vein of lower extremity" (I82.59-)." AHRQ believes these codes are not fully satisfactory because they do not distinguish whether the "other specified deep vein" is proximal or distal, a distinction that is readily ascertainable and has substantial clinical significance.

AHRQ notes that this situation is even more confusing because ICD-10-CM lacks any indexing of specific named veins, such as the peroneal, soleal, or gastrocnemial veins (all of which are in the calf), or the external iliac or deep femoral veins (both of which are in the thigh). As a result, users of ICD-10-CM coded data may not be able to distinguish acute thromboses involving deep veins of the proximal lower extremity, which are considered high-risk and thus represent the primary target for surveillance, from acute thromboses involving deep veins of the distal lower extremity, which are considered lower risk and are more likely to be detected on routine surveillance testing, without symptoms.

[1] Caggiati, A., Bergan, J.J., Gloviczki, P., Eklof, B., Allegra, C., and H. Partsch (2005). "Nomenclature of the veins of the lower limb: Extensions, refinements, and clinical application." Journal of Vascular Surgery, 41(4): 719-724.
[2] Antignani, P. L. and L. Aluigi (2013). "The calf vein thrombosis." Reviews in Vascular Medicine 1(1): 1-4.
[3] Lohr, J. M. and A. N. Fellner (2010). "Isolated Calf Vein Thrombosis Should Be Treated With Anticoagulation." Disease-a-Month 56(10): 590-600.

AHRQ notes that there is not a single tibial vein, which makes the terminology in I80.23-, I82.44-, and I82.54- somewhat confusing. Instead, there are paired anterior tibial veins, posterior tibial veins, and peroneal veins in each leg.

Following careful review of latest literature on these issues, AHRQ believes that additional codes for specific vein thrombosis in the distal lower limb would enable improved capture of these diagnoses and avoid current limitations with capturing patient safety-related events. We also believe that adding specific codes for thromboses involving distal calf vein muscular branches would facilitate further research (using coded data) focused on better understanding their clinical significance and management options. AHRQ therefore proposes addition of new codes to identify these important vein categories.

TABULAR MODIFICATIONS

I80 Phlebitis and thrombophlebitis

I80.1 Phlebitis and thrombophlebitis of femoral vein

Add — Phlebitis and thrombophlebitis of common femoral vein

Add — Phlebitis and thrombophlebitis of deep femoral vein

I80.2 Phlebitis and thrombophlebitis of other and unspecified deep vessels of lower extremities

I80.21 Phlebitis and thrombophlebitis of iliac vein

Add — Phlebitis and thrombophlebitis of common iliac vein

Add — Phlebitis and thrombophlebitis of external iliac vein

Add — Phlebitis and thrombophlebitis of internal iliac vein

I80.23 Phlebitis and thrombophlebitis of tibial vein

Add — Phlebitis and thrombophlebitis of anterior tibial vein

Add — Phlebitis and thrombophlebitis of posterior tibial vein

New subcategory — I80.24 Phlebitis and thrombophlebitis of peroneal vein

New code — I80.241 Phlebitis and thrombophlebitis of right peroneal vein

New code — I80.242 Phlebitis and thrombophlebitis of left peroneal vein

New code I80.243 Phlebitis and thrombophlebitis of peroneal vein, bilateral

New code I80.249 Phlebitis and thrombophlebitis of unspecified peroneal vein

New subcategory I80.25 Phlebitis and thrombophlebitis of calf muscular vein

Add Phlebitis and thrombophlebitis of soleal vein

Add Phlebitis and thrombophlebitis of gastrocnemial vein

Add Phlebitis and thrombophlebitis of calf muscular vein, NOS

New code I80.251 Phlebitis and thrombophlebitis of right calf muscular vein

New code I80.252 Phlebitis and thrombophlebitis of left calf muscular vein

New code I80.253 Phlebitis and thrombophlebitis of calf muscular vein, bilateral

New code I80.259 Phlebitis and thrombophlebitis of unspecified calf muscular vein

I80.29 Phlebitis and thrombophlebitis of other deep vessels of lower extremity

I82 Other venous embolism and thrombosis

I82.4 Acute embolism and thrombosis of deep veins of lower extremity

I82.41 Acute embolism and thrombosis of femoral vein

Add Acute embolism and thrombosis of common femoral vein

Add Acute embolism and thrombosis of deep femoral vein

I82.42 Acute embolism and thrombosis of iliac vein

Add Acute embolism and thrombosis of common iliac vein

Add Acute embolism and thrombosis of external iliac vein

Add Acute embolism and thrombosis of internal iliac vein

I82.44 Acute embolism and thrombosis of tibial vein

Add Acute embolism and thrombosis of anterior tibial vein

Add Acute embolism and thrombosis of posterior tibial Vein

New subcategory	I82.45 Acute embolism and thrombosis of peroneal vein
New code	I82.451 Acute embolism and thrombosis of right peroneal vein
New code	I82.452 Acute embolism and thrombosis of left peroneal vein
New code	I82.453 Acute embolism and thrombosis of peroneal vein, bilateral
New code	I82.459 Acute embolism and thrombosis of unspecified peroneal vein
New subcategory	I82.46 Acute embolism and thrombosis of calf muscular vein
Add	Acute embolism and thrombosis of soleal vein
Add	Acute embolism and thrombosis of gastrocnemial vein
Add	Acute embolism and thrombosis of calf muscular vein, NOS
New code	I82.461 Acute embolism and thrombosis of right calf muscular vein
New code	I82.462 Acute embolism and thrombosis of left calf muscular vein
New code	I82.463 Acute embolism and thrombosis of calf muscular vein, bilateral
New code	I82.469 Acute embolism and thrombosis of unspecified calf muscular vein
	I82.49 Acute embolism and thrombosis of other specified deep vein of lower extremity
	I82.5 Chronic embolism and thrombosis of deep veins of lower extremity
	I82.51 Chronic embolism and thrombosis of femoral vein
Add	Chronic embolism and thrombosis of common femoral vein
Add	Chronic embolism and thrombosis of deep femoral vein
	I82.52 Chronic embolism and thrombosis of iliac vein
Add	Chronic embolism and thrombosis of common iliac vein
Add	Chronic embolism and thrombosis of external iliac vein
Add	Chronic embolism and thrombosis of internal iliac vein
	I82.54 Chronic embolism and thrombosis of tibial vein
Add	Chronic embolism and thrombosis of anterior tibial vein

Add	Chronic embolism and thrombosis of posterior tibial vein
New subcategory	I82.55 Chronic embolism and thrombosis of peroneal vein
New code	I82.551 Chronic embolism and thrombosis of right peroneal vein
New code	I82.552 Chronic embolism and thrombosis of left peroneal vein
New code	I82.553 Chronic embolism and thrombosis of peroneal vein, bilateral
New code	I82.559 Chronic embolism and thrombosis of unspecified peroneal vein
New subcategory	I82.56 Chronic embolism and thrombosis of calf muscular vein
Add	Chronic embolism and thrombosis of soleal vein
Add	Chronic embolism and thrombosis of gastrocnemial vein
Add	Chronic embolism and thrombosis of calf muscular vein NOS
New code	I82.561 Chronic embolism and thrombosis of right calf muscular vein
New code	I82.562 Chronic embolism and thrombosis of left calf muscular vein
New code	I82.563 Chronic embolism and thrombosis of calf muscular vein, bilateral
New code	I82.569 Chronic embolism and thrombosis of unspecified calf muscular vein

I82.59 Chronic embolism and thrombosis of other specified deep vein of lower extremity

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 meeting. The revised proposal is based on public comments received following the meeting.

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.

Dravet syndrome is a part of a group of diseases known as SCN1A related seizure disorders. Mutations of the SCN1A gene are the cause of 79% of diagnosed cases. This intractable (uncontrollable) epilepsy is characterized by unilateral clonic or tonic clonic (grand mal) seizures that may progress to status epilepticus.

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.

TABULAR MODIFICATIONS

G40	Epilepsy	
G40.8	Other epilepsy and recurrent seizures	
New sub-subcategory	G40.83	Dravet syndrome
New code	G40.831	Dravet syndrome, intractable, with status epilepticus
New code	G40.832	Dravet syndrome, intractable, without status epilepticus
New code	G40.839	Dravet syndrome, unspecified
Add		Polymorphic epilepsy in infancy (PMEI)
Add		Severe myoclonic epilepsy in infancy (SMEI)
Add		Dravet syndrome NOS

Ehlers-Danlos Syndromes (EDS)

A proposal to create thirteen new codes for Ehlers-Danlos Syndrome (EDS) was presented at the March 2018 Coordination and Maintenance Meeting. The new codes that were proposed were in recognition of the thirteen specific types of EDS that were published by the International Consortium on EDS. The classification and manuscripts about EDS were published in the March 2017 Part C Seminars in Medical Genetics issue of the American Journal of Medical Genetics and are all available through the Ehlers-Danlos Society (http://bit.ly/EDS2017papers).

However, based on public comment and the low prevalence of some types of EDS, a revised proposal to expand the more common and more severe types of EDS is being resubmitted for consideration.

Ehlers-Danlos syndromes are a clinically and genetically heterogeneous group of heritable connective tissue disorders characterized by articular hypermobility, skin hyperextensibility or laxity, and tissue fragility affecting virtually every organ system: skin, ligaments, joints, bone, muscle, blood vessels and various organs.

The prevalence and most common types of EDS cited in the GeneReview articles are: hypermobile (hEDS) - 1:5000 https://www.ncbi.nlm.nih.gov/books/NBK1279; classical (cEDS) - 1:20,000 https://www.ncbi.nlm.nih.gov/books/NBK1244 and vascular (vEDS) - 1:200,000 based on identification of 1500 affected individuals https://www.ncbi.nlm.nih.gov/books/NBK1494/.

The most severe in presentation and the only one associated with early mortality is vascular (vEDS). "The long-term outlook (prognosis) for people with vascular Ehlers-Danlos syndrome is generally poor. It is typically considered the most severe form of EDS and is often associated with a shortened lifespan. Among affected people diagnosed as the result of a complication, 25% have experienced a significant medical complication by age 20 and more than 80% by age 40. The median life expectancy for people affected by vascular EDS is 48 years.[4][2]" https://rarediseases.info.nih.gov/diseases/2082/ehlers-danlos-syndrome-vascular-type.

A specific ICD-10-CM code for the most common and severe types will be of value to the patient and the clinician. Regardless of the type experienced, EDS is a life- long progressive condition that has a major impact on the lives and daily function of most living with EDS.

This proposal is resubmitted jointly by Brad Tinkle, MD PHD, Division Chief of Clinical Genetics at Advocate Children's Hospital and member of the Steering Committee of the International Consortium on EDS and Kay Jewell, MD Consultant, Acer Therapeutics Pharmaceutical Company.

TABULAR MODIFICATIONS

New/Revise subcategory	Q79.6 Ehlers-Danlos Syndrome**s**
New code	Q79.60 Ehlers-Danlos Syndrome, unspecified
New code	Q79.61 Classical Ehlers-Danlos Syndrome
Add	Classical EDS (cEDS)
New code	Q79.62 Hypermobile Ehlers-Danlos Syndrome
Add	Hypermobile EDS (hEDS)
New code	Q79.63 Vascular Ehlers-Danlos Syndrome
Add	Vascular EDS (vEDS)
New code	Q79.69 Other Ehlers-Danlos Syndromes

Fetal Anomalies

The American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) are proposing that code category O35, Maternal care for known or suspected fetal abnormality and damage, be expanded to provide specificity for appropriate diagnosis and to assist in measuring the incidence of these specific anomalies. This will enable better tracking, measurement, and ultimately treatment for identified fetal anomalies.

Assignment of trimesters is not applicable and the fetus specific codes can be deleted from this code section. A separate Z code identifying the fetus number is also being proposed in a separate code proposal.

The proposed codes would be reported if the condition is suspected or has been confirmed. If the condition is not found, the appropriate encounter for suspected maternal and fetal conditions ruled out code (Z03.7-) would be assigned.

The American Academy of Pediatrics (AAP) has reviewed and supports the proposal. ACOG is proposing the following tabular modifications:

TABULAR MODFICTIONS

O35 Maternal care for known or suspected fetal abnormality and damage
Includes: the listed conditions in the fetus as a reason for hospitalization or other obstetric care to the mother, or for termination of pregnancy
Code also any associated maternal condition
Excludes1**:** encounter for suspected maternal and fetal conditions ruled out (Z03.7-)

Delete ~~One of the following 7th characters is to be assigned to each code under category O35. 7th character 0 is for single gestations and multiple gestations where the fetus is unspecified. 7th characters 1 through 9 are for cases of multiple gestations to identify the fetus for which the code applies. The appropriate code from category O30, Multiple gestation, must also be assigned when assigning a code from category O35 that has a 7th character of 1 through 9.~~

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

O35.0 Maternal care for (suspected) central nervous system malformation in fetus

Delete ~~Maternal care for fetal anencephaly~~
Delete ~~Maternal care for fetal hydrocephalus~~

Delete	~~Maternal care for fetal spina bifida~~ Excludes2: chromosomal abnormality in fetus (O35.1)
New code	O35.00 Maternal care for (suspected) central nervous system malformation in fetus, unspecified
New Code	O35.01Maternal care for (suspected) central nervous system malformation in fetus; agenesis of the callosum
New code	O35.02 Maternal care for (suspected) central nervous system malformation in fetus; anencephaly
New code	O35.03 Maternal care for (suspected) central nervous system malformation in fetus; central nervous system malformation marker, choroid plexus cysts
New code	O35.04 Maternal care for (suspected) central nervous system malformation in fetus, encephalocele
New code	O35.05 Maternal care for (suspected) central nervous system malformation in fetus, holoprosencephaly
New code	O35.06 Maternal care for (suspected) central nervous system malformation in fetus, hydrocephaly
New code	O35.07 Maternal care for (suspected) central nervous system malformation in fetus, microcephaly
New code	O35.08 Maternal care for (suspected) central nervous system malformation in fetus, spina bifida
New code	O35.09 Maternal care for (suspected) central nervous system malformation in fetus, other specified
	O35.1 Maternal care for (suspected) chromosomal abnormality in fetus
New code	O35.10 Maternal care for (suspected) chromosomal abnormality in fetus, unspecified
New code	O35.11 Maternal care for (suspected) chromosomal abnormality in fetus, Trisomy 13
New code	O35.12 Maternal care for (suspected) chromosomal abnormality in fetus, Trisomy 18
New code	O35.13 Maternal care for (suspected) chromosomal abnormality in fetus, Trisomy 21
New code	O35.14 Maternal care for (suspected) chromosomal abnormality in fetus, Turner Syndrome
New code	O35.15 Maternal care for (suspected) chromosomal abnormality in fetus, sex chromosome abnormality
New code	O35.19 Maternal care for (suspected) chromosomal abnormality in fetus, other specified

O35.2 Maternal care for (suspected) hereditary disease in fetus
Excludes2: chromosomal abnormality in fetus (O35.1)

New code O35.20 Maternal care for (suspected) hereditary disease in fetus, unspecified

New code O35.21 Maternal care for (suspected) hereditary disease in fetus; inherited metabolic disorder

New code O35.29 Maternal care for (suspected) hereditary disease in fetus, other specified

New category O35.A Maternal care for (suspected) cardiovascular anomalies in fetus

New subcategory O35.A1 Maternal care for (suspected) congenital malformations of cardiac chambers and connections, in fetus

New code O35.A10 Maternal care for (suspected) congenital malformations of cardiac chambers and connections in fetus, common arterial trunk

New code O35.A11 Maternal care for (suspected) congenital malformations of cardiac chambers and connections in fetus, double outlet right ventricle

New code O35.A12 Maternal care for (suspected) congenital malformations of cardiac chambers and connections in fetus, double outlet left ventricle

New code O35.A14 Maternal care for (suspected) congenital malformations of cardiac chambers and connections in fetus, discordant ventriculoarterial connection

Add Maternal care for (suspected) congenital malformations of cardiac chambers and connections in fetus, dextrotransposition of aorta

Add Maternal care for (suspected) congenital malformations of cardiac chambers and connections in fetus, transposition of great vessels (complete)

New code O35.A18 Maternal care for (suspected) fetal congenital cardiac malformations of cardiac chambers and connections in fetus, other specified

New code	O35.A19 Maternal care for (suspected) fetal congenital cardiac malformations in fetus, unspecified
New subcategory	O35.A2 Maternal care for (suspected) fetal congenital malformations of cardiac septa
New code	O35.A20 Maternal care for (suspected) congenital malformations of cardiac septa in fetus, atrioventricular septal defect
New code	O35.A21 Maternal care for (suspected) fetal congenital malformations of cardiac septa in fetus, Tetralogy of Fallot
New code	O35.A28 Maternal care for (suspected) fetal congenital malformations of cardiac septa in fetus, other specified
New code	O35.A29 Maternal care for (suspected) congenital malformations of cardiac septa in fetus, unspecified
New subcategory	O35.A3 Maternal care for (suspected) congenital malformation of pulmonary and tricuspid valves in fetus
New code	O35.A30 Maternal care for (suspected) fetal congenital malformation of pulmonary and tricuspid valves in fetus, Ebstein's anomaly
New code	O35.A31 Maternal care for (suspected) fetal congenital malformation of pulmonary and tricuspid valves in fetus, Hypoplastic right heart syndrome
New code	O35.A38 Maternal care for (suspected) fetal congenital malformation of pulmonary and tricuspid valves in fetus, other specified
New code	O35.A39 Maternal care for (suspected) fetal congenital malformation of pulmonary and tricuspid valves in fetus, unspecified
New subcategory	O35.A9 Maternal care for other (suspected) congenital malformation of cardiovascular system in fetus
New code	O35.A90 Maternal care for other (suspected) congenital malformation of cardiovascular system in fetus, hypoplastic left heart syndrome with intact/restrictive atrial septum

New code	O35.A91 Maternal care for other (suspected) congenital malformation of cardiovascular system in fetus, total anomalous pulmonary venous connection
	O35.A92 Maternal care for other (suspected) congenital malformation of cardiovascular system in fetus, heterotaxy syndrome
New code	O35.A98 Maternal care for other (suspected) congenital malformation of cardiovascular system in fetus, other specified
New code	O35.A99 Maternal care for other (suspected) congenital malformation of cardiovascular system in fetus, unspecified
New subcategory	O35.B Maternal care for (suspected) pulmonary anomalies in fetus
New code	O35.B0 Maternal care for (suspected) pulmonary anomalies in fetus, unspecified
New code	O35.B1 Maternal care for (suspected) pulmonary anomalies in fetus, congenital cystic lung
New code	O35.B2 Maternal care for (suspected) pulmonary anomalies in fetus, sequestration of lung
New code	O35.B3 Maternal care for (suspected) pulmonary anomalies in fetus, agenesis of lung
New code	O35.B4 Maternal care for (suspected) pulmonary anomalies in fetus, congenital diaphragmatic hernia
New code	O35.B9 Maternal care for (suspected) pulmonary anomalies in fetus, Other specified
New subcategory	O35.C Maternal care for (suspected) fetal musculoskeletal anomalies in fetus
New code	O35.C0 Maternal care for (suspected) fetal musculoskeletal anomalies in fetus, unspecified
New code	O35.C1 Maternal care for (suspected) fetal musculoskeletal

		anomalies in fetus, exomphalos
Add		Omphalocele
New code	O35.C2	Maternal care for (suspected) fetal musculoskeletal anomalies in fetus, gastroschisis
New code	O35.C3	Maternal care for (suspected) fetal musculoskeletal anomalies in fetus, upper extremities
New code	O35.C4	Maternal care for (suspected) fetal musculoskeletal anomalies in fetus, lower extremities
New code	O35.C9	Maternal care for (suspected) fetal musculoskeletal anomalies in fetus, other specified
New subcategory	O35.D	Maternal care for (suspected) genitourinary anomalies in fetus
New code	O35.D0	Maternal care for (suspected) genitourinary anomalies in fetus, unspecified
New code	O35.D1	Maternal care for (suspected) genitourinary anomalies in fetus; renal agenesis and other reduction defects of kidney
New code	O35.D2	Maternal care for (suspected) genitourinary anomalies in fetus, cystic kidney disease
New code	O35.D3	Maternal care for (suspected) genitourinary anomalies in fetus, congenital obstructive defects of renal pelvis and congenital malformations of ureter
New code	O35.D4	Maternal care for (suspected) genitourinary anomalies in fetus, congenital megaureter
New code	O35.D5	Maternal care for (suspected) genitourinary anomalies in fetus, exstrophy of urinary bladder Cloacal extrophy
New code	O35.D9	Maternal care for (suspected) genitourinary anomalies in fetus, other specified
New subcategory	O35.8	Maternal care for (suspected) other fetal abnormality and damage
New code	O35.80	Maternal care for (suspected) other abnormality and damage; non-central nervous system markers or anomalies in fetus,

	unspecified
New code	O35.81 Maternal care for (suspected) other abnormality and damage, facial anomalies in fetus
Add	Maternal care for (suspected) other abnormality and damage, micrognathia
Add	Maternal care for (suspected) other abnormality and damage, cleft lip
New sub-subcategory	O35.82 Maternal care for (suspected) other abnormality and damage, gastrointestinal anomalies in fetus
New code	O35.820 Maternal care for (suspected) other abnormality and damage, gastrointestinal anomalies in fetus, tracheo-esophageal fistula
New code	O35.821 Maternal care for (suspected) other abnormality and damage, gastrointestinal anomalies in fetus; congenital atresia and stenosis of small intestine
Add	Maternal care for (suspected) other abnormality and damage, duodenal obstruction or congenital atresia
Add	Maternal care for (suspected) other abnormality and damage, jejunal obstruction or congenital atresia
Add	Maternal care for (suspected) other abnormality and damage, ileal obstruction or congenital atresia
	O35.828 Maternal care for (suspected) other abnormality and damage, gastrointestinal anomalies in fetus; other specified
Add	Maternal care for (suspected) other abnormality and damage, colonic obstruction congenital atresia
Add	Maternal care for (suspected) other abnormality and damage, intrauterine bowel perforation
Add	Maternal care for (suspected) other abnormality and damage, meconium ileus
New code	O35.829 Maternal care for (suspected) other abnormality and damage, gastrointestinal anomalies in fetus; unspecified

	O35.8	Maternal care for other (suspected) fetal abnormality and damage Maternal care for damage to fetus from maternal listeriosis Maternal care for damage to fetus from maternal toxoplasmosis
New code	O35.89	Maternal care for (suspected) other fetal abnormality and damage; other non-central nervous system markers or anomalies, unspecified
Add		Maternal care for (suspected) other fetal abnormality and damage; congenial cystic hygroma

Fetus Number

The American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) are proposing to add a new code section to identify fetus number in order condense pending and future obstetrical diagnosis code proposals to the specific applicable condition or illness, with an additional code to be added for fetus number when multiple gestations are involved.

The American Academy of Pediatrics (AAP) has reviewed and supports the proposal. ACOG is proposing the following tabular modifications:

TABULAR MODIFICATIONS

New Category	Z3B	Fetus number affected by fetal anomalies
New Code		Z3B.1 Fetus 1
New Code		Z3B.2 Fetus 2
New Code		Z3B.3 Fetus 3
New Code		Z3B.4 Fetus 4
New Code		Z3B.5 Fetus 5
New Code		Z3B.8 Other specified fetus
New code		Z3B.0 Unspecified fetus number

Juvenile Osteochondrosis of Tibia and Fibula

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
M92.5 Juvenile osteochondrosis of tibia and fibula
Delete ~~Osteochondrosis (juvenile) of proximal tibia [Blount]~~
Delete ~~Osteochondrosis (juvenile) of tibial tubercle [Osgood-Schlatter]~~
Delete ~~Tibia vara~~
M92.50 Juvenile osteochondrosis of tibia and fibula, unspecified leg
M92.51 Juvenile osteochondrosis of tibia and fibula, right leg
M92.52 Juvenile osteochondrosis of tibia and fibula, left leg

M92.8 Other specified juvenile osteochondrosis
Delete ~~Calcaneal apophysitis~~
New subcategory M92.81 Juvenile osteochondrosis of proximal tibia [Blount]
Add Tibia vara
New code M92.811 Juvenile osteochondrosis of proximal tibia [Blount], right leg
New code M92.812 Juvenile osteochondrosis of proximal tibia [Blount], left leg
New code M92.819 Juvenile osteochondrosis of proximal tibia [Blount], unspecified leg

New Subcategory M92.82 Juvenile osteochondrosis of tibia tubercle [Osgood-Schlatter]
New code M92.821 Juvenile osteochondrosis of tibia tubercle [Osgood-Schlatter], right leg
New code M92.822 Juvenile osteochondrosis of tibia tubercle [Osgood-

	Schlatter], left leg
New code	M92.829 Juvenile osteochondrosis of tibia tubercle [Osgood-Schlatter], unspecified leg
New code	M92.89 Other specified juvenile osteochondrosis
Add	Calcaneal apophysitis

Latent Tuberculosis Infection

Latent tuberculosis infection (LTBI) occurs when a person is infected with the bacteria Mycobacterium tuberculosis, but does not have active tuberculosis (TB) disease. The only sign of a tuberculosis infection is a positive reaction to the tuberculin skin test or tuberculosis blood test. Compared to active tuberculosis disease, persons with latent tuberculosis infection are not infectious, cannot spread tuberculosis infection to others and normally do not develop TB disease. But persons who have a weak immune system, the bacteria can become active, multiply and cause tuberculosis disease.

Treatment for latent tuberculosis infection and active tuberculosis is very different and the cost for treatment of active tuberculosis can be as much as thirty times more than treatment of latent tuberculosis. Cost and clinical care can also be increased even more with the development of a drug resistant infection and a longer treatment period.

CDC's Division of Tuberculosis Elimination data indicate that tuberculosis cannot be eliminated in the United States without addressing latent tuberculosis infection. Up to thirteen million people in the United States have latent tuberculosis and live with the potential of developing tuberculosis disease at some point in their lives. More than eighty percent of the United States tuberculosis cases are estimated to be associated with reactivation of longstanding, untreated latent tuberculosis.

The U.S. Preventive Services Task Force (USPSTF) issued a recommendation encouraging providers to test for latent tuberculosis in populations at increased risk, aligning with CDC recommendations to provide targeted testing. This expands latent tuberculosis testing beyond traditional public health service into the private sector. With medical improvements in testing and treatment, including an improved blood test and shorter courses of antibiotics, addressing latent tuberculosis infection is now greatly facilitated for physicians and patients and is expected to expand.

Currently, ICD-10 CM codes do not differentiate between latent tuberculosis and active tuberculosis disease. However, distinguishing between these two conditions is important since they have very different short-term and long-term consequences for both the patient and for public health. This will enable providers to accurately characterize patients' risk for developing TB disease, assist in correct classification and help determine the true frequency of latent tuberculosis.

The National Tuberculosis Controllers Association (NTCA) and the CDC are respectfully request the following tabular modification:

TABULAR MODICIFATIONS

Z11 Encounter for screening for infectious and parasitic diseases
Z11.1 Encounter for screening for respiratory tuberculosis
Add Encounter for screening for active tuberculosis disease

New code Z11.7 Encounter for testing for latent tuberculosis infection

Z22 Carrier of infectious disease

New code Z22.7 Latent tuberculosis
Add Latent tuberculosis infection (LBTI)

Add Excludes1: nonspecific reaction to cell mediated immunity measurement of gamma interferon antigen response without active tuberculosis (R76.12)
nonspecific reaction to tuberculin skin test without active tuberculosis (R76.11)

Z86 Personal history of certain other diseases
Z86.1 Personal history of infectious and parasitic diseases
Conditions classifiable to A00-B89, B99
Excludes1: personal history of infectious diseases specific to a body system
sequelae of infectious and parasitic diseases (B90-B94)
Z86.11 Personal history of tuberculosis
New code Z86.15 Personal history of latent tuberculosis infection

Legal Intervention

Surveillance technologies have facilitated national and international awareness of an upward trend in the rate of injuries to law enforcement officials, bystanders, and suspects resulting from a legal intervention. However, the ICD-10-CM coding schema do not appropriately describe modern-day mechanisms of injury to a suspect, bystander, or law enforcement official. The lack of concise data is a barrier to fully understanding the origin and downstream effects of injury from a legal intervention.

Currently ICD-10-CM category, Y35 Legal intervention, does not completely capture mechanisms of injury in modern-day encounters between civilians and law enforcement. As a result, some legal intervention codes fail to provide the necessary specificity to track for public information, law enforcement, and morbidity and mortality data collection and reporting purposes.

The current ICD-10-CM coding system describes and classifies legal intervention mechanism under code Y35.81, Legal intervention involving manhandling. The submitter is requesting new codes to differentiate the cause of injury involving “manhandling” versus “bodily force”.

Improving public health monitoring of law-enforcement-related morbidity and mortality is a critical part of efforts to ensure public accountability for these incidents.

The submitter is requesting the following new codes to identify these specific encounters:

TABULAR MODIFICATIONS

Y35 Legal intervention

Y35.8 Legal intervention involving other specified means

New sub-subcategory	Y35.82 Legal intervention involving bodily force
New code	Y35.821 Legal intervention involving bodily force, law enforcement official injured
New code	Y35.822 Legal intervention involving bodily force, bystander injured
New code	Y35.823 Legal intervention involving bodily force, suspect injured
New sub-subcategory	Y35.83 Legal intervention involving a conducted energy device
Add	Electroshock device (taser)
Add	Stun gun

New code	Y35.831	Legal intervention involving a conducted energy device, law enforcement official injured
New code	Y35.832	Legal intervention involving a conducted energy device, bystander injured
New code	Y35.833	Legal intervention involving a conducted energy device, suspect injured

Legal Intervention Involving Injury of Unspecified Person

The Massachusetts Injury Surveillance Program (ISP) within the Massachusetts Department of Public Health is requesting new ICD-10-CM codes related to injuries resulting from legal intervention. In the current ICD-10-CM, the legal intervention codes, Y35, include specific codes to identify the person injured. Options include law enforcement officer injured, suspect injured, or bystander injured. However, there is currently no ICD-10-CM legal intervention code when the injured person is not specified in the health record. In addition, a new ICD-10-CM code designated for "Legal intervention involving a conducted energy device (including tasers)" would enhance the ability to track injuries related to these devices.

According to the U.S. Department of Justice, Tasers, the most common Conducted Energy Device (CED), are used by more than 15,000 law enforcement and military agencies across the U.S.[1] Tasers use 50,000 volts of electricity and have been associated with injuries and in rare cases, death.[1]

ICD-10-CM has legal intervention codes for unspecified firearm, machine gun, handgun, rifle pellet, rubber bullet, other firearm, dynamite, unspecified explosives, explosive shell, unspecified gas, tear gas, other gas, unspecified blunt objects, baton, other blunt objects, unspecified sharp, bayonet, other sharp objects, manhandling, other specified means, and means unspecified. However, there is no ICD-10-CM code designated for CED use. Currently injuries that result from CED use would be coded as "Legal Intervention involving other specified means (Y35.89X).

The following new codes are being requested to track injuries related to these legal interventions.

References:
1). U.S. Department of Justice. NIJ Research in Brief. Police use of force, tasers and other less-lethal weapons. May 2011. (https://www.ncjrs.gov/pdffiles1/nij/232215.pdf)

TABULAR MODIFICATIONS

Y35 Legal intervention

Y35.0 Legal intervention involving firearm discharge

Y35.00 Legal intervention involving unspecified firearm discharge

New code Y35.009 Legal intervention involving unspecified firearm discharge, unspecified person injured

Y35.01 Legal intervention involving injury by machine gun

New code Y35.019 Legal intervention involving injury by machine gun, unspecified person injured

Y35.02 Legal intervention involving injury by handgun

New code Y35.029 Legal intervention involving injury by handgun, unspecified person injured

Y35.03 Legal intervention involving injury by rifle pellet

New code Y35.039 Legal intervention involving injury by rifle pellet, unspecified person injured

Y35.04 Legal intervention involving injury by rubber bullet

New code Y35.049 Legal intervention involving injury by rubber bullet, unspecified person injured

Y35.09 Legal intervention involving other firearm discharge

New code Y35.099 Legal intervention involving other firearm discharge, unspecified person injured

Y35.1 Legal intervention involving explosives

Y35.10 Legal intervention involving unspecified explosives

New code Y35.109 Legal intervention involving unspecified explosives, unspecified person injured

Y35.11 Legal intervention involving injury by dynamite

New code Y35.119 Legal intervention involving injury by dynamite, unspecified person injured

Y35.12 Legal intervention involving injury by explosive shell

New code Y35.129 Legal intervention involving injury by explosive shell, unspecified person injured

Y35.19 Legal intervention involving other explosives

New code Y35.199 Legal intervention involving other explosives, unspecified person injured

Y35.2 Legal intervention involving gas

Y35.20 Legal intervention involving unspecified gas

New code Y35.209 Legal intervention involving unspecified gas, unspecified person injured

Y35.21 Legal intervention involving injury by tear gas

New code Y35.219 Legal intervention involving injury by tear gas, unspecified person injured

Y35.29 Legal intervention involving other gas

New code Y35.299 Legal intervention involving other gas, unspecified person injured

Y35.3 Legal intervention involving blunt objects

Y35.30 Legal intervention involving unspecified blunt objects

New code Y35.309 Legal intervention involving unspecified blunt objects, unspecified person injured

Y35.31 Legal intervention involving baton

New code Y35.319 Legal intervention involving baton, unspecified person injured

Y35.39 Legal intervention involving other blunt objects

New code Y35.399 Legal intervention involving other blunt objects, unspecified person injured

Y35.4 Legal intervention involving sharp objects

Y35.40 Legal intervention involving unspecified sharp objects

New code Y35.409 Legal intervention involving unspecified sharp objects,

unspecified person injured

Y35.41 Legal intervention involving bayonet

New code Y35.419 Legal intervention involving bayonet, unspecified person injured

Y35.49 Legal intervention involving other sharp objects

New code Y35.499 Legal intervention involving other sharp objects, unspecified person injured

Y35.8 Legal intervention involving other specified means

Y35.81 Legal intervention involving manhandling

New code Y35.819 Legal intervention involving manhandling, unspecified person injured

New sub-subcategory Y35.83 Legal intervention involving a conducted energy device

Add Electroshock device (taser)

Add Stun gun

New code Y35.831 Legal intervention involving a conducted energy device, law enforcement official injured

New code Y35.832 Legal intervention involving a conducted energy device, bystander injured

New code Y35.833 Legal intervention involving a conducted energy device, suspect injured

New code Y35.839 Legal intervention involving a conducted energy device, unspecified person injured

Y35.9 Legal intervention, means unspecified

New code Y35.99 Legal intervention, means unspecified, unspecified person injured

Neonatal Cerebral Infarction

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 American Academy of Pediatrics request the following tabular modifications:

TABULAR MODIFICATION

P91.8 Other specified disturbances of cerebral status of newborn

New subcategory	P91.88 Other specified disturbances of cerebral status of newborn
New sub-sub category	P91.881 Neonatal cerebral infarction
Add	Excludes1:cerebral infarction (I63.-)
Add	Excludes2:intracranial (nontraumatic) hemorrhage of newborn (P52.-)
Add	Neonatal stroke
Add	Perinatal cerebral infarction
Add	Perinatal arterial ischemic stroke
New code	P91.8811 Neonatal cerebral infarction, right side
New code	P91.8812 Neonatal cerebral infarction, left side
New code	P91.8813 Neonatal cerebral infarction, bilateral
New code	P91.8819 Neonatal cerebral infarction, unspecified side

Osteopenia of the hip

Osteopenia is decreased bone density but not to the extent of osteoporosis. Someone with osteopenia is more likely to fracture a bone than someone with a normal bone density but is less likely to fracture a bone than someone with osteoporosis. Aging is the most common risk factor for osteopenia. The goal of treatment is to keep osteopenia from progressing into osteoporosis.

Osteopenia is diagnosed using measures of bone mineral density (BMD). The dual energy X-ray absorptiometry, called DEXA or DXA usually measures bone density levels in the spine, hip, wrist, finger and sometimes the heel. These locations are frequent sites of bone fracture.

There is currently no unique code for reporting osteopenia of the hip. The coding option at this time is M85.88, Other specified disorders of bone density and structure, other site.

The submitter is requesting the following tabular modifications in order to capture these conditions.

The American Academy of Orthopedic Surgeons has reviewed and supports this proposal.

TABULAR MODIFICATIONS

M85 Other disorders of bone density and structure

M85.8 Other specified disorders of bone density and structure

M85.88 Other specified disorders of bone density and structure, other site
M85.89 Other specified disorders of bone density and structure, multiple sites

New sub-subcategory
M85.8A Other specified disorders of bone density and structure, hip

Add
Osteopenia of hip

New code
M85.8A1 Other specified disorders of bone density and structure, right hip

New code
M85.8A2 Other specified disorders of bone density and structure, left hip

New code
M85.8A9 Other specified disorders of bone density and structure, unspecified hip

Sjogren Syndrome

Sjögren is a systemic autoimmune disease that affects the entire body. Its two most common 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 Sjögren is interstitial lung disease and it can lead to recurring pneumonia and fibrosis. Upper airway disease in Sjögren 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's disease. The term "sicca syndrome" was an alternative for the eponym "Sjögren 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 Sjögren syndrome. Sjögren 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.

TABULAR MODIFICATIONS

M35 Other systemic involvement of connective tissue

Revise	M35.0	~~Sicca syndrome [Sjogren]~~ Sjogren syndrome
Add		Sicca syndrome
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 subcategory		
Revise	M35.09	~~Sicca~~ Sjogren syndrome with other organ or system involvement
New code	M35.091	Sjogren syndrome with inflammatory arthritis
New code	M35.092	Sjogren syndrome with peripheral nervous system involvement
New code	M35.093	Sjogren syndrome with central nervous system involvement
New code	M35.094	Sjogren syndrome with gastrointestinal involvement
New code	M35.095	Sjogren syndrome with glomerular disease
New code	M35.096	Sjogren syndrome with vasculitis
New code	M35.097	Sjogren syndrome with dental involvement
New code	M35.098	Sjogren syndrome with other organ or system involvement

Slipped Upper Femoral Epiphysis, Unstable

The American Academy of Orthopedic Surgeons (AAOS) is requesting expansion of code category M93.0, Slipped upper femoral epiphysis to add codes to slipped upper femoral epiphysis. It is proposed to add new codes to reflect acute- and acute-on-chronic slips which reflect whether the hip is stable or unstable. Slipped capital femoral epiphysis (SCFE) is a failure through the growth plate (physis), which results in slippage of the overlying end of the proximal femur (epiphysis). Normally, the head of the femur (the capital femoral epiphysis) should sit squarely on the femoral neck. Abnormal shear failure through the growth plate results in the slip. The capital femoral epiphysis remains in the acetabulum (hip socket), while the metaphysis (upper end of the femur) moves in an anterior direction with external rotation. The condition usually develops gradually over time. Slips may present as stable or unstable:.

A stable SCFE causes some stiffness or pain in the knee or groin area, and possibly a limp that causes a child to walk with a foot outward. The pain and the limp usually tend to come and go, worsening with activity and getting better with rest. With a stable SCFE, a child still can walk, even if crutches are needed. The prognosis is relatively good for functional recovery.

An unstable SCFE is a more severe slip that usually happens suddenly, and is usually much more painful. A child will not be able to bear weight on the affected side. An unstable SCFE is also more serious because it can restrict blood flow to the hip joint, leading to tissue death in the head of the femur. For this reason the prognosis is much more guarded.

Because the prognosis is strongly related to the stability of the slip (stable versus unstable) it should be reflected in the relevant diagnosis codes. Generally chronic slips are stable and only acute or acute-on-chronic slips can be unstable.

AAOS is requesting the following tabular modifications:

TABULAR MODIFICATIONS

M93 Other osteochondropathies

Excludes2: osteochondrosis of spine (M42.-)

M93.0 Slipped upper femoral epiphysis (nontraumatic)

Use additional code for associated chondrolysis (M94.3)

M93.00 Unspecified slipped upper femoral epiphysis (nontraumatic)

M93.001Unspecified slipped upper femoral epiphysis (nontraumatic), right hip

M93.002 Unspecified slipped upper femoral epiphysis (nontraumatic), left hip

Revise ~~M93.003~~ M93.009 Unspecified slipped upper femoral epiphysis (nontraumatic), unspecified hip

M93.01 Acute slipped upper femoral epiphysis (nontraumatic)
M93.011 Acute slipped upper femoral epiphysis (nontraumatic), right hip
M93.012 Acute slipped upper femoral epiphysis (nontraumatic), left hip

Revise ~~M93.013~~ M93.019 Acute slipped upper femoral epiphysis (nontraumatic), unspecified hip

M93.02 Chronic slipped upper femoral epiphysis (nontraumatic)
M93.021 Chronic slipped upper femoral epiphysis (nontraumatic), right hip
M93.022 Chronic slipped upper femoral epiphysis (nontraumatic), left hip

Revise ~~M93.023~~ M93.029 Chronic slipped upper femoral epiphysis (nontraumatic), unspecified hip

M93.03 Acute on chronic slipped upper femoral epiphysis (nontraumatic)
M93.031 Acute on chronic slipped upper femoral epiphysis (nontraumatic), right hip
M93.032 Acute on chronic slipped upper femoral epiphysis (nontraumatic), left hip

Revise ~~M93.033~~ M93.039 Acute on chronic slipped upper femoral epiphysis (nontraumatic), unspecified hip

New subcategory M93.04 Acute slipped upper femoral epiphysis, unstable (nontraumatic)

New code M93.041 Acute slipped upper femoral epiphysis, unstable (nontraumatic), right hip

New code M93.042 Acute slipped upper femoral epiphysis, unstable (nontraumatic), left hip

New code M93.049 Acute slipped upper femoral epiphysis, unstable (nontraumatic), unspecified hip

New subcategory M93.05 Acute on chronic slipped upper femoral epiphysis, unstable (nontraumatic)

New code M93.051 Acute on chronic slipped upper femoral epiphysis, unstable (nontraumatic), right hip

New code M93.052 Acute on chronic slipped upper femoral epiphysis, unstable (nontraumatic), left hip

New code M93.059 Acute on chronic slipped upper femoral epiphysis, unstable (nontraumatic), unspecified hip

Subsegmental Pulmonary Embolism

Subsegmental pulmonary emboli (SSPE) can be detected with CT, but studies have suggested that the optimal clinical treatment for these may differ from other pulmonary emboli (PE). It has been proposed by the Hospital for Special Surgery (HSS) in New York that specific ICD-10-CM codes be created for certain types of subsegmental pulmonary emboli.

Although the incidence of PE diagnosis is increasing, case fatality rates have declined and mortality rates are unchanged (1). This may be explained by the use of increasingly sensitive imaging tools that can detect small subsegmental pulmonary emboli (SSPE) that may not be clinically significant. A 2010 meta-analysis demonstrated a lower rate of SSPE (4.7%) detected using single-detector computed tomography pulmonary angiogram (CTPA), compared to using multidetector CTPA (9.4%), but that the use of multidetector CTPA did not reduce the rate of venous thromboembolism (VTE) among untreated patients during 3 months of follow up (2). This suggests that ascertaining more pulmonary emboli with more sensitive scanners does not improve outcomes and may subject some patients to unnecessary anticoagulation. Studies also suggest that there is low inter-reader agreement in the diagnosis of SSPE among radiologists reading CTPA (4).

There is also evidence, however, that SSPE are in fact clinically significant and should be treated. For example, in an analysis of 3769 patients with suspected PE, the rate of recurrent PE and death was actually higher in the treated patients with SSPE compared to those with larger clots, suggesting that SSPE are not a benign phenomenon (5).

There are no prospective trials testing the hypothesis that isolated SSPE in the absence of deep vein thrombosis (DVT) can safely go untreated, although one such trial is under way. Nonetheless, the most recent guidelines from the American College of Chest Physicians (ACCP) recommend that patients with isolated SSPE and no proximal DVT undergo surveillance rather than anticoagulation (3). The rate of proximal DVT in patients with SSPE on CTPA is 7.1%, demonstrating the importance of performing bilateral lower extremity ultrasound in patients with isolated SSPE if withholding of anticoagulation is being considered (2).

SSPE would now be coded to I26.99, Other pulmonary embolism without acute cor pulmonale. It is recommended that two new codes be created, one code for single subsegmental pulmonary embolism without larger clots without acute cor pulmonale, and one code for multiple subsegmental pulmonary emboli without larger clots without acute cor pulmonale. This will enable important clinical differentiation, which will be important, given the guideline from ACCP that those with SSPE and without DVT should not receive anticoagulation. This differentiation will also be helpful for quality measures for hospitals, since this differing clinical treatment for a type of PE might otherwise negatively impact hospital performance on quality measures. Specific codes for SSPE will also benefit research to further evaluate treatment safety.

References

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TABULAR MODIFICATIONS

I26 Pulmonary embolism

I26.9 Pulmonary embolism without acute cor pulmonale

New code I26.93 Single subsegmental pulmonary embolism without acute cor pulmonale

Add Subsegmental pulmonary embolism NOS

New code I26.94 Multiple subsegmental pulmonary emboli without acute cor pulmonale

Travel Health Counseling

At the request of the American Academy of Pediatrics (AAP), a proposal for new codes for Travel Counseling was presented at the March 2018 C&M meeting. However, in response to public comment, a revised proposal is being resubmitted for consideration.

While there are codes for a variety of counseling services, currently there is no unique ICD-10-CM code for health counseling related to travel. Patients and caregivers often seek travel health counseling services (i.e. health risks), and whom do not present with any signs or symptoms and the encounter may be unrelated to a related to preventive medical care encounter.

For example, when planning a trip to a particular country or region, the parent (or caregiver) may want to review with the physician potential risk factors such as safe drinking water or disease prevention.

The American Academy of Pediatrics reports that there have been an increase in the number of patients seen for these services. The Academy is again requesting a specific new code to identify travel health related encounters.

TABULAR MODIFICATIONS

Z71.8 Other specified counseling

New Code	Z71.84 Encounter for health counseling related to travel
Add	Health risk and safety counseling for (international) travel
Add	Excludes2: encounter for administrative examination (Z02.-)
Add	encounter for other special examination without complaint, suspected or reported diagnosis (Z01.-)