CENTERS FOR DISEASE CONTROL AND PREVENTION

ICD-10 Coordination and Maintenance Committee Meeting
September 22-23, 2015
Diagnosis Agenda

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:

September 22 –23, 2015	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 11, 2015.** You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building.
October 2015	Webcast of the September 22–23, 2015 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 Summary report of the Diagnosis part of the September 22–23, 2015 ICD-10 Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm
October 1, 2015	ICD-10-CM/PCS codes go into effect along with ICD-10 MS-DRGs
October 1, 2015	New and revised ICD-10-CM and ICD-10-PCS codes go into effect along with DRG changes. Final addendum from previous years are available on web pages as follows: Diagnosis addendum: http://www.cdc.gov/nchs/icd/icd10cm.htm Due to the partial code freeze there are no updates to ICD-10-CM for October 1, 2015. Procedure addendum: https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-PCS-and-GEMs.html
October 16, 2015	**Deadline for receipt of public comments on proposed new codes if any discussed at the September 22-23, 2015 ICD-10 Coordination and Maintenance Committee meetings for implementation on April 1, 2016.**
November 2015	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, 2016 will be posted on the following websites: http://www.cdc.gov/nchs/icd/icd10cm.htm

	https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-PCS-and-GEMs.html
November 13, 2015	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the September 22-23, 2015 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2016.**
January 15, 2016	**Deadline for requestors: Those members of the public requesting that topics be discussed at the March 9–10, 2016 ICD-10 Coordination and Maintenance Committee meeting must have their requests submitted to CMS for procedures and NCHS for diagnoses by this date.**
February 2016	Tentative agenda for the Procedure part of the March 9, 2016 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 10, 2016 ICD-10 Coordination and Maintenance Committee meeting posted on NCHS webpage as follows: http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm Federal Register notice of March 9–10, 2016 ICD-10 Coordination and Maintenance Committee Meeting will be published.
February 1, 2016	**On-line registration opens for the March 9–10, 2016 ICD-10 Coordination and Maintenance Committee meeting at: https://www.cms.gov/apps/events/default.asp**
March 2016	Because of increased security requirements, **those wishing to attend the March 9–10, 2016** 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 29, 2016; failure to do so may result in lack of access to the meeting**.
March 9 – 10, 2016	ICD-10 Coordination and Maintenance Committee meeting.
April 1, 2016	Any new ICD-10 codes to capture new diseases or technology on April 1, 2016, will be implemented.
April 8, 2016	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the March 9–10, 2016 ICD-10 Coordination**

	and Maintenance Committee meetings for implementation on October 1, 2016.
April 2016	Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This notice will include references to the complete and finalized FY 2017 ICD-10-CM diagnosis and ICD-10-PCS procedure codes. It will also include proposed revisions to the MS-DRG system based on ICD-10-CM/PCS codes on which the public may comment. The proposed rule can be accessed at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/IPPS/list.asp
April 2016	Webcast of the March 9-10, 2016 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 Summary report of the Diagnosis part of the March 10, 2016 ICD-10 Coordination and Maintenance Committee meeting report will be posted on the NCHS webpage as follows: http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm
June 2016	Final addendum posted on web pages as follows: Diagnosis addendum: http://www.cdc.gov/nchs/icd/icd10cm.htm Procedure addendum: http://cms.hhs.gov/Medicare/Coding/ICD10/index.html
July 15, 2016	**Deadline for requestors: Those members of the public requesting that topics be discussed at the September 13–14, 2016 ICD-10 Coordination and Maintenance Committee meeting must have their requests submitted to CMS for procedures and NCHS for diagnoses.**
August 1, 2016	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, 2016. 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 2016	Tentative agenda for the Procedure part of the September 13–14, 2016 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 13 –14, 2016 ICD-10 Coordination and Maintenance Committee meeting will be posted on the NCHS webpage at: http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm
	Federal Register notice for the September 13–14, 2016 ICD-10 Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.
August 5, 2016	**On-line registration opens for the September 13-14, 2016 ICD-10 Coordination and Maintenance Committee meeting at: https://www.cms.gov/apps/events/default.asp**
September 2, 2016	Because of increased security requirements, those wishing to attend the September 13-14, 2016 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, 2016; failure to do so may result in lack of access to the meeting.**
September 13 –14, 2016	ICD-10 Coordination and Maintenance Committee 2016 meeting. Those who wish to attend the ICD-10 Coordination and Maintenance Committee meeting **must have registered for the meeting online by September 2, 2016.** You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building.
October 2016	Webcast of the September 13–14, 2016 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 Summary report of the Diagnosis part of the September 13–14, 2016 ICD-10 Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm
October 1, 2016	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 16, 2016	**Deadline for receipt of public comments on proposed new codes discussed at the September 13-14, 2016 ICD-10 Coordination and Maintenance Committee meetings for implementation on April 1, 2017.**
November 2016	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, 2017 will be posted on the following websites: http://www.cdc.gov/nchs/icd/icd10cm.htm http://www.cms.gov/Medicare/Coding/ICD10/
November 13, 2016	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the September 13-14, 2016 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2017.**

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

Donna Pickett (301) 458-4434

David Berglund (301) 458-4095

Cheryl Bullock (301) 458-4297

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

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

The ICD-9-CM Coordination and Maintenance Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10. The partial freeze is scheduled to end one year after the implementation of ICD-10. There was considerable support for this partial freeze. On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, the U.S. Department of Health and Human Services issued a final rule on August 4, 2014 that changed the compliance date for ICD-10 from October 1, 2014 to October 1, 2015. The final rule also requires HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015. Links to the final rule are provided at http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html.

The partial freeze will be implemented as follows:

• The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011.

• On October 1, 2012, October 1, 2013, and October 1, 2014 there were only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.

• On October 1, 2015, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.

• On October 1, 2016 (one year after implementation of ICD-10), regular updates to ICD-10 will begin.

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2016 once the partial freeze has ended.

Continuing Education Credits

Continuing education credits may be awarded by the American Academy of Professional Coders (AAPC) or the American Health Information Management Association (AHIMA) for participation in CMS/NCHS ICD-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.

Abscess of Anal and Rectal Regions

Most experts categorize abscesses of the anal and rectal regions according to their anatomic location: perianal, ischiorectal, intersphincteric, and supralevator. Perianal abscesses are the most common, comprising over half of all anorectal abscesses. They are superficially located adjacent to the anus. Ischiorectal abscesses are the next most common location, located deep to the superficial subcutaneous fascia in the perirectal region, but still superficial to the levator and anal sphincter muscles in the ischiorectal space. Intersphincteric abscesses occur between the external and internal sphincter muscles. Supralevator abscesses are located deep to the levator muscle in the true pelvis. The anatomic details determine appropriate treatment and accurate prognostication. The terms "rectal," "perirectal," and "anorectal"—though less precise—still have a role because they are commonly used by clinicians.

It would be beneficial to characterize the laterality of anorectal abscesses to determine the relationship of a new abscess to prior abscesses or other anatomic conditions. In addition, bilateral abscesses that extend around the posterior aspect of the anal canal represent a special category of severity that warrants identification in the coding classification.

The Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma is requesting the following tabular changes to better distinguish the severity of perirectal abscesses.

TABULAR MODIFICATIONS

K61 Abscess of anal and rectal regions

Includes: Abscess of anal and rectal regions
Cellulitis of anal and rectal regions

K61.0 Anal abscess
Perianal abscess
Excludes1: Intrasphincteric abscess (K61.4)

Add — Intersphincteric abscess (K61.4)

New code — K61.01 Right perianal abscess

New code — K61.02 Left perianal abscess

New Code — K61.03 Bilateral perianal abscess
Horseshoe perianal abscess

New code — K61.09 Perianal abscess, side not specified
Perianal abscess NOS
Midline perianal abscess
Postanal abscess

K61.1 Rectal abscess
Perirectal abscess
Excludes1: Ischiorectal abscess (K61.3)

New code K61.11 Right perirectal abscess

New code K61.12 Left perirectal abscess

K61.13 Bilateral perirectal abscess
Horseshoe perirectal abscess

New code K61.19 Perirectal abscess, side not specified
Perirectal abscess NOS
Midline perirectal abscess

K61.2 Anorectal abscess

New code K61.21 Right anorectal abscess

New code K61.22 Left anorectal abscess

New code K61.23 Bilateral anorectal abscess
Horseshoe anorectal abscess

New code K61.29 Anorectal abscess, side not specified
Anorectal abscess NOS
Midline anorectal abscess

K61.3 Ischiorectal abscess
Abscess of ischiorectal fossa
Add <u>Ischioanal abscess</u>

New code K61.31 Right ischiorectal abscess

New code K61.32 Left ischiorectal abscess

New code K61.33 Bilateral ischiorectal abscess
Horseshoe ischiorectal abscess

New code K61.39 Ischiorectal abscess, side not specified
Ischiorectal abscess NOS

K61.4 Intrasphincteric abscess
Add <u>Intersphincteric</u> abscess

New code K61.41 Right intersphincteric abscess

New code		K61.42	Left intersphincteric abscess
New code		K61.43	Bilateral intersphincteric abscess
New code		K61.49	Intersphincteric abscess, side not specified Intersphincteric abscess NOS
New sub category	K61.5	Supralevator abscess	
New code		K61.51	Right supralevator abscess
New code		K61.52	Left supralevator abscess
New code		K61.53	Bilateral supralevator abscess
New code		K61.59	Supralevator abscess, side not specified Supralevator abscess NOS

Acquired Hydrocephalus

In 2014, the World Health Organization (WHO) updated ICD-10 and added a new code for acquired hydrocephalus of newborn. The new code in ICD-10 has an effective date of January 2016. To address changes made in ICD-10 the following tabular changes are proposed.

TABULAR MODIFICATIONS

	P91	Other disturbances of cerebral status of newborn
New code		P91. 7 Acquired hydrocephalus of newborn Posthemorrhagic hydrocephalus of newborn

ALPHABETIC INDEX

	Hydrocephalus
Revise	-newborn ~~Q03.9~~
Add	- - acquired (post intraventricular hemorrhage) (posthemorrhagic) P91.7
Add	- - congenital Q03.9
Add	- posthemorrhagic, newborn P917

Amblyopia Suspect

Amblyopia is defined as decreased vision in one or both eyes compared with normal vision. The diagnosis of amblyopia can be made at any age. In most cases in older children and adults this is documented with a monocular quantitative visual acuity (eye charts) or qualitative testing (fixation preference testing). In some cases it is hard to be certain of the diagnosis. For instance a young child is unable to read a chart but has refractive, strabismic, or eye structural problems that often are associated with amblyopia. While these conditions can be coded in some instances, the possible presence of amblyopia cannot be coded. The presence of these codes in the medical record and problem list would serve as a reminder that this child has significant risk factors that can be associated with permanent visual loss due to amblyopia. A unique code would serve as a reminder so the child receives ongoing medical observation and timely intervention when required.

The American Academy of Ophthalmology is requesting new codes for amblyopia suspect in order to be able to identify and monitor this condition.

References:

American Academy of Ophthalmology Pediatric Ophthalmology/Strabismus Panel. *Preferred Practic Pattern Guidelines:Pediatric Eye Evaluations.* San Francisco: American Academy of Ophthalmology;2012.

Friedman DS, Katz J, Repka MX, et al. Lack of concordance between fixation preference and HOTV optotype visual acuity in preschool children: the Baltimore pediatric eye disease study. *Ophthalmology.* 2008;115:1796–1799.

TABULAR MODIFICATIONS

H53 Visual disturbances

H53.0 Amblyopia ex anopsia
Excludes: amblyopia due to vitamin A deficiency (E50.5)

New sub-subcategory	H53.04	Amblyopia suspect
New code	H53.041	Amblyopia suspect, right eye
New code	H53.042	Amblyopia suspect, left eye
New code	H53.043	Amblyopia suspect, bilateral
New code	H53.049	Amblyopia suspect, unspecified eye

Amyotrophic Lateral Sclerosis (ALS)

Amyotrophic Lateral Sclerosis (ALS) is the most common motor neuron disease (MND). The onset of ALS is age-related with the highest rate of onset occurring between 55 and 75 years of age. Prognosis also appears to be age-related with slightly better survival occurring among those with a younger age at onset. The average survival time after onset of symptoms is approximately three years, and only a small proportion of patients survive beyond five years. ALS is more common in males than females by a ratio of 1.5 – 2 to 1, but recent studies have suggested that this sex difference is decreasing over time.

In addition to ALS, several other less common conditions are classified under the general term of motor neuron disease, but ALS accounts for 85 percent or more of all motor neuron cases. There are between 5,000 and 6,000 new cases of ALS each year in the U.S.

In 2010, the Centers for Disease Control and Prevention's Agency for Toxic Substances and Disease Registry (ATSDR) launched the National ALS Registry that identifies ALS cases through the use of existing national datasets including Medicare, Medicaid, and Veterans Health Administration and self-registration. Cases identified through the national databases rely on ICD codes as well as information on type of provider seen and prescription data. The pilot project for the National ALS Registry developed an algorithm with sensitivity of 87% and specificity of 85%. All MND codes were evaluated and it was found that MND codes other than the specific code for ALS were often misused, particularly the codes for Progressive Muscular Atrophy and Pseudo Bulbar Palsy. For example, these codes were often used to describe symptoms attributable to other conditions such as Parkinson's disease, stroke, and post-polio syndrome.

In consultation with neurologists specializing in the diagnosis and care of persons with ALS, CDC/ATSDR is proposing the changes to ICD-10-CM to assure that it is possible to distinguish ALS from other motor neuron diseases.

TABULAR MODIFICATIONS

G12.2	Motor neuron disease
	G12.20 Motor neuron disease, unspecified
	G12.21Amyotrophic lateral sclerosis
Delete	~~Progressive spinal muscle atrophy~~
	G12.22Progressive bulbar palsy
New Code	G12.23Primary lateral sclerosis
	G12.29Other motor neuron disease
	Familial motor neuron disease
Delete	~~Primary lateral sclerosis~~
Add	Progressive spinal muscle atrophy

Asthma Control Status: Controlled and Uncontrolled

Current asthma guidelines recommend the assessment of asthma control at every clinical visit and further state that this assessment should result in the health care provider classifying asthma as either well controlled or not well controlled (Joint Task Force on Practice Parameters [JTFPP] 2005). In 1991, the National Heart, Lung and Blood Institute (NHLBI) established the concept of asthma classification based on severity (mild, moderate, and severe) that was tied to a stepwise approach to pharmacotherapy. However, this classification presents limitations in patients already being treated for asthma and does not always correlate with asthma symptoms (JTFPP 2005). Given that asthma has the potential to change significantly over time, classification of asthma control status at each clinical visit is essential in creating an individualized patient management plan.

It is proposed by the American Academy of Allergy Asthma and Immunology (AAAAI) to add new clinical detail by expanding code category J45 to add further specificity to distinguish controlled and uncontrolled asthma. These new codes would better capture a patient's individualized asthma status at the time of the clinical encounter and further provide context as to the treatment goals that resulted.

The American Academy of Allergy Asthma and Immunology (AAAAI) is a professional organization with more than 6,700 members in the United States, Canada and 72 other countries. This membership includes allergist/immunologists (A/I), other medical specialists, allied health and related healthcare professionals, all with a special interest in the research and treatment of patients with allergic and immunologic diseases.

References:

Joint Task Force on Practice Parameters. 2005. "Attaining Optimal Asthma Control: A Practice Parameter." Journal of Allergy and Clinical Immunology 116(5): S3-11.

National Heart Lung and Blood Institute/National Asthma Education and Prevention Program. 2007. "Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma." Washington (DC): National Health Lung and Blood Institute (NHLBI), NIH Publication No. 07-4051. (July 1, 2015) http://wwww.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf.

TABULAR MODIFICATIONS

J45 Asthma

J45.2 Mild intermittent asthma

Revise
J45.20 Mild intermittent asthma, ~~uncomplicated,~~ controlled
J45.21 Mild intermittent asthma with (acute) exacerbation
J45.22 Mild intermittent asthma with status asthmaticus

New Code
J45.23 Mild intermittent asthma, uncontrolled

J45.3 Mild persistent asthma

Revise — J45.30 Mild persistent asthma, ~~uncomplicated,~~ controlled

J45.31 Mild persistent asthma with (acute) exacerbation

J45.32 Mild persistent asthma with status asthmaticus

New code — J45.33 Mild persistent asthma, uncontrolled

J45.4 Moderate persistent asthma

Revise — J45.40 Moderate persistent asthma, ~~uncomplicated,~~ controlled

J45.41 Moderate persistent asthma with (acute) exacerbation

J45.42 Moderate persistent asthma with status asthmaticus

New code — J45.43 Moderate persistent asthma, uncontrolled

J45.5 Severe persistent asthma

Revise code — J45.50 Severe persistent asthma, ~~uncomplicated,~~ controlled

J45.51 Severe persistent asthma with (acute) exacerbation

J45.52 Severe persistent asthma with status asthmaticus

New code — J45.53 Severe persistent asthma, uncontrolled

J45.9 Other and unspecified asthma

J45.90 Unspecified asthma

Asthmatic bronchitis NOS

Childhood asthma NOS

Late onset asthma

J45.901 Unspecified asthma with (acute) exacerbation

J45.902 Unspecified asthma with status asthmaticus

New code — J45.903 Unspecified asthma, uncontrolled

Revise code — J45.909 Unspecified asthma, ~~uncomplicated~~ controlled

Asthma NOS

Atrial Fibrillation

Atrial fibrillation is a common cause of an abnormal, irregular heart beat. 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.

First-detected atrial fibrillation is a case of atrial fibrillation with no available prior history of atrial fibrillation. There is no certainty about the presence or absence of prior episodes or about the duration of the episode. First detected episodes of atrial fibrillation are classified as paroxysmal when they terminate, or persistent when they last for more than seven days.

Paroxysmal atrial fibrillation is an episode that has terminated, either spontaneously or with cardioversion, within seven days of onset. Paroxysmal atrial fibrillation may involve termination of a first episode of atrial fibrillation, or termination of an episode of recurrent paroxysmal atrial fibrillation if there were prior episodes of atrial fibrillation.

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).

Atrial fibrillation is frequently associated with mitral valvular disease, particularly mitral insufficiency. The treatment of those patients with disease of the mitral valve may be significantly different from treatment of patients whose atrial fibrillation is not associated with mitral valvular disease, so the distinction is important to identify and track.

TABULAR MODIFICATIONS

I48 Atrial fibrillation and flutter

I48.0 Paroxysmal atrial fibrillation

Add — Code also, if present:
- bradycardia (R00.1)
- mitral valve insufficiency (I34.0)
- rheumatic mitral insufficiency (I05.1)
- tachycardia (I47.1)
- tachycardia-bradycardia syndrome (I49.5)

I48.1 Persistent atrial fibrillation

Add — Code also, if present:
bradycardia (R00.1)
mitral valve insufficiency (I34.0)
rheumatic mitral insufficiency (I05.1)
tachycardia (I47.1)
tachycardia-bradycardia syndrome (I49.5)

I48.2 Chronic atrial fibrillation

Delete — ~~Permanent atrial fibrillation~~

Add — Code also, if present:
bradycardia (R00.1)
mitral valve insufficiency (I34.0)
rheumatic mitral insufficiency (I05.1)
tachycardia (I47.1)
tachycardia-bradycardia syndrome (I49.5)

New code — I48.20 Chronic atrial fibrillation, unspecified

New code — I48.21 Longstanding persistent atrial fibrillation

New code — I48.22 Permanent atrial fibrillation

I48.8 Other atrial fibrillation and flutter

New code — I48.81 First detected atrial fibrillation

Code first the type of atrial fibrillation, such as:
paroxysmal atrial fibrillation (I48.0)
persistent atrial fibrillation (I48.1)

New code — I48.89 Other atrial fibrillation and flutter

Code also, if present:
bradycardia (R00.1)
mitral valve insufficiency (I34.0)
rheumatic mitral insufficiency (I05.1)
tachycardia (I47.1)
tachycardia-bradycardia syndrome (I49.5)

I48.9 Unspecified atrial fibrillation and atrial flutter

I48.91 Unspecified atrial fibrillation

Add

Code also, if present:
bradycardia (R00.1)
mitral valve insufficiency (I34.0)
rheumatic mitral insufficiency (I05.1)
tachycardia (I47.1)
tachycardia-bradycardia syndrome (I49.5)

Chronic hepatitis vs. hepatitis carrier

The idea of a "healthy carrier" of viral hepatitis is no longer in favor. Instead, this condition is considered a form of chronic viral hepatitis. The change is due to the potential for chronic viral hepatitis to be associated with hepatocellular carcinoma, or with reactivation of hepatitis. Due to this change in clinical understanding, WHO has made changes in ICD-10, effective January 2016, to deactivate the code Z22.5, Carrier of viral hepatitis. It is proposed to eliminate this subcategory in ICD-10-CM, and that such cases should be coded to category B18, Chronic viral hepatitis.

Reference

Martin P. "The Inactive Carrier State in Chronic Hepatitis B Infection." *Medscape.com*. 2009. http://www.medscape.com/viewarticle/702587

TABULAR MODIFICATIONS

B18 Chronic viral hepatitis
Add Includes: Carrier of viral hepatitis

B18.0 Chronic viral hepatitis B with delta-agent

B18.1 Chronic viral hepatitis B without delta-agent
Add Carrier of viral hepatitis B
Chronic (viral) hepatitis B

B18.2 Chronic viral hepatitis C
Add Carrier of viral hepatitis C

B18.8 Other chronic viral hepatitis
Add Carrier of other viral hepatitis

B18.9 Chronic viral hepatitis, unspecified
Add Carrier of unspecified viral hepatitis

Z22 Carrier of infectious disease

Add Excludes2: Carrier of viral hepatitis (B18.-)

Delete subcategory ~~Z22.5 Carrier of viral hepatitis~~

Delete code ~~Z22.50 Carrier of unspecified viral hepatitis~~

Delete code ~~Z22.51 Carrier of viral hepatitis B~~
~~Hepatitis B surface antigen [HBsAg] carrier~~

Delete code ~~Z22.52 Carrier of viral hepatitis C~~

Delete code ~~Z22.59 Carrier of other viral hepatitis~~

INDEX MODIFICATIONS

Carrier (suspected) of …
Revise - HAA (hepatitis Australian-antigen) B18.8 ~~Z22.59~~
Revise - HB(c)(s)-AG B18.1 ~~Z22.51~~
Revise - hepatitis (viral) B18.9 ~~Z22.50~~
Revise - - Australia-antigen (HAA) B18.8 ~~Z22.59~~
Revise - - B surface antigen (HBsAg) B18.1 ~~Z22.51~~
…
Revise - - C B18.2 ~~Z22.52~~
Revise - - specified NEC B18.8 ~~Z22.59~~

Serum …
- hepatitis - see also Hepatitis, viral, type B
Revise - - carrier (suspected) of B18.1 ~~Z22.51~~

Clostridium difficile

Clostridium difficile (C. difficile) is an anaerobic gram-positive, spore-forming, toxin-producing bacillus that is transmitted among humans through the fecal–oral route. *C. difficile* causes antibiotic-associated colitis by colonizing the human intestinal tract after the normal gut flora have been altered due to antibiotic therapy. *C. difficile* infection (CDI) is one of the most common healthcare-associated infections and a significant cause of morbidity and mortality among older adult patients.

Despite the availability of antibiotic treatment, recurrence remains a problem, with 10 to 30 percent of patients developing recurrence within 8 weeks of an initial infection.

Recurrence is defined by complete abatement of CDI symptoms while on appropriate therapy, followed by subsequent reappearance of diarrhea and other symptoms after treatment has been stopped. Recurrence typically occurs within one week after treatment cessation, however recurrence may occur up to 8 weeks later. As such, the American College of Gastroenterology (ACG) 2013 practice guidelines define recurrent CDI as an "episode of CDI that occurs 8 weeks after the onset of a previous episode, provided the symptoms from the previous episode resolved."

Recurrence is associated with greater morbidity and practice guidelines provide distinct recommendations for the management of recurrence, especially in the case of multiple recurrences that differ significantly from treatment of the initial episode.

It is the recommendation of Merck & Company, Inc. that new codes be added under code A04.7, Enterocolitis due to Clostridium, to distinguish between initial cases of enterocolitis due to *C. difficile* from those that are recurrent.

TABULAR MODIFICATIONS

A04 Other bacterial intestinal infections
Excludes1:bacterial foodborne intoxications, NEC (A05.-)
tuberculous enteritis (A18.32)

A04.7 Enterocolitis due to Clostridium difficile
Foodborne intoxication by Clostridium difficile
Pseudomembraneous colitis

New code A04.71 Enterocolitis due to clostridium difficile, recurrent

New code A04.72 Enterocolitis due to clostridium difficile, initial

New code A04.73 Enterocolitis due to clostridium difficile, not specified as recurrent

Contact with knife, sword or dagger

In 2013 the World Health Organization (WHO) Update Reference Committee (URC) approved changes to ICD-10 category W25 (Contact with sharp glass), category W26 (Contact with knife, sword or dagger) and category W45 (Foreign body or object entering through skin). These changes will take effect in ICD-10 January 2016.

At the March 2015 ICD-10 Coordination and Maintenance Committee meeting, NCHS proposed changes to ICD-10-CM that will be made in ICD-10; however, based on public comments the proposal has been revised and is being represented for consideration. The following ICD-10-CM tabular changes are proposed.

TABULAR MODIFICATIONS

Exposure to inanimate mechanical forces (W20-W49)

W25 Contact with sharp glass

Add — Excludes2: glass embedded in skin (W45)

Revise — W26 Contact with ~~Knife, sword or dagger~~ <u>other sharp objects</u>

Excludes2: sharp object(s) embedded in skin (W45)

New code — W26.2 Contact with edge of stiff paper
Paper cut

New code — W26.8 Contact with other sharp object(s), not elsewhere classified
Tin can lid

New code — W26.9 Contact with unspecified sharp object(s)

W45 Foreign body or object entering through skin

Add — Includes: foreign body or object embedded in skin: nail

Revise — Excludes2: contact with ~~knife, sword, or dagger~~ <u>other sharp object(s)</u> (W26.-)

Delete — ~~W45.1 Paper entering through skin~~
~~Paper cut~~

Delete — ~~W45.2 Lid of can entering through skin~~

Encounter and Surveillance Codes for Implantable Subdermal Contraceptives

The Merck and Co., is proposing new codes related to encounters for implantable subdermal contraceptive management in order to meet the needs of the needs of the health care provider and patient. It is envisioned that the more specific codes will assist health care providers in more thorough monitoring of patients.

The proposed codes and related changes (shown in bold) modify the proposal of the American Congress of Obstetricians and Gynecologists (ACOG) presented at September 2014 ICD-10 Coordination and Maintenance committee meeting. ACOG proposed new codes for encounters and surveillance codes for vaginal ring hormonal and transdermal patch hormonal contraceptive methods.

TABULAR MODIFICATIONS

Z30 Encounter for contraceptive management

Z30.0 Encounter for general counseling and advice on contraception

Z30.01 Encounter for initial prescription of contraceptives

Add — Encounter for initial prescription of barrier contraception

Add — Encounter for initial prescription of diaphragm

New code — Z30.015 Encounter for initial prescription of vaginal ring hormonal contraceptive

New code — Z30.016 Encounter for initial prescription of transdermal patch hormonal contraceptive device

New code — Z30.017 Encounter for initial prescription of implantable subdermal contraceptive

Z30.4 Encounter for surveillance of contraceptives

Add — Encounter for surveillance of barrier contraception

Add — Encounter for surveillance of diaphragm

New code — Z30.44 Encounter for surveillance of vaginal ring hormonal contraceptive device

New code — Z30.45 Encounter for surveillance of transdermal patch hormonal contraceptive device

New code — Z30.46 Encounter for surveillance of implantable subdermal contraceptive
Encounter for checking, reinsertion or removal of implantable subdermal contraceptive

Z97.5 Presence of (intrauterine) contraceptive device
Excludes1: checking, reinsertion or removal of contraceptive device (Z30.43)

Add — checking, reinsertion or removal of implantable subdermal contraceptive (Z30.46)

Encounter for examination of eyes and vision with abnormal findings

Vision screening is a requirement of well-child primary care as described by Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, third edition, a joint program of the Health Resources and Services Administration (HRSA) and the American Academy of Pediatrics. There is little information on exactly who fails vision screening and with what diagnoses. The addition of two new codes to ICD-10-CM would allow this information to be collected, retrieved and used as needed for performance measurement and reporting. The screening encounter could also be separately retrieved for the presence of abnormal findings. The proposed codes are similar to what currently exists for failed hearing testing.

The American Academy of Ophthalmology is requesting new codes for an encounter for examination of eyes and vision with abnormal findings in order to be able to identify and monitor this condition.

References:

Marsh-Tootle WL, Russ SA, Repka MX, for the National Expert Panel to the National Center for Children's Vision and Eye Health. Vision and Eye Health in Children 36 to <72 Months: Proposed Tracking Definitions. . *Optometry and Visual Science.* 2015;92(1):17-23.

TABULAR MODIFICATIONS

Z01 Encounter for other special examination without complaint, suspected or reported diagnosis

Z01.0 Encounter for examination of eyes and vision

New sub-subcategory	Z01.01 Encounter for examination of eyes and vision with abnormal findings
New code	Z01.010 Encounter for examination of eyes and vision following failed vision screening
New code	Z01.018 Encounter for examination of eyes and vision with other abnormal findings Use additional code to identify abnormal findings

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

It is proposed that there is a need for a way to distinguish right ventricular failure, both chronic and acute (or decompensated) in the adult, and also to identify end stage heart disease. The purposes are to differentiate cases of pure right heart failure from the Core Measures requirements of left heart disease (these patients should not be treated the same way as left heart failure patients overall), as well as to give some way of tracking patients who have right ventricular failure from other than chronic cor pulmonale (which would be coded to I27.81).

The heart failure codes in ICD-10-CM in category I50 parallel the ICD-9-CM codes in category 428. These focus on left heart failure in the adult, and relate to left ventricular disturbances in function. These codes help identify adults with chronic left ventricular failure with systolic dysfunction who are at risk of sudden cardiac death. There are now no specific ICD-10-CM codes for identifying end stage heart disease, right ventricular failure or biventricular failure.

End Stage Heart Failure

Patients with end stage heart failure fall into stage D of the ABCD classification of the American College of Cardiology (ACC)/American Heart Association (AHA), and are characterized by advanced structural heart disease and pronounced symptoms of heart failure at rest or upon minimal physical exertion, despite maximal medical treatment. They frequently develop intolerance to medical therapy and are developing worsening renal function and diuretic resistance according to current guidelines. This patient population has a 1-year mortality rate of approximately 50%, is at highest risk for rehospitalization and requires special therapeutic interventions such as ventricular assist devices, artificial hearts and heart transplantation or hospice care.

TABULAR MODIFICATIONS

I50 Heart failure

Revise	I50.1	Left ventricular failure, unspecified	
	I50.2	Systolic (congestive) heart failure	
Revise		I50.21 Acute (left ventricular) systolic (congestive) heart failure	
Revise		I50.22 Chronic (left ventricular) systolic (congestive) heart failure	
New code		I50.220	Chronic (left ventricular) systolic (congestive) heart failure without mention of end stage
New code		I50.221	End stage (left ventricular) systolic (congestive) heart failure

New code I50.229 Chronic (left ventricular) systolic (congestive) heart failure, undetermined classification

Revise I50.23 Acute on chronic (left ventricular) systolic (congestive) heart failure

New code I50.230 Acute on chronic (left ventricular) systolic (congestive) heart failure without mention of end stage

New code I50.231 Acute on chronic end stage (left ventricular) systolic (congestive) heart failure

New code I50.239 Acute on chronic (left ventricular) systolic (congestive) heart failure, undetermined classification

I50.3 Diastolic (congestive) heart failure

Revise I50.31 Acute (left ventricular) diastolic (congestive) heart failure

Revise I50.32 Chronic (left ventricular) diastolic (congestive) heart failure

New code I50.320 Chronic (left ventricular) diastolic (congestive) heart failure without mention of end stage

New code I50.321 End stage (left ventricular) diastolic (congestive) heart failure

New code I50.329 Chronic (left ventricular) diastolic (congestive) heart failure, undetermined classification

Revise I50.33 Acute on chronic (left ventricular) diastolic (congestive) heart failure

New code I50.330 Acute on chronic (left ventricular) diastolic (congestive) heart failure without mention of end stage

New code I50.331 Acute on chronic end stage (left ventricular) diastolic (congestive) heart failure

New code I50.339 Acute on chronic (left ventricular) diastolic (congestive) heart failure, undetermined classification

I50.4 Combined systolic (congestive) and diastolic (congestive) heart failure

Revise	I50.41		Acute (left ventricular) combined systolic (congestive) and diastolic (congestive) heart failure
Revise	I50.42		Chronic (left ventricular) combined systolic (congestive) and diastolic (congestive) heart failure
New code		I50.420	Chronic (left ventricular) combined systolic (congestive) and diastolic (congestive) heart failure without mention of end stage
New code		I50.421	End stage (left ventricular) combined systolic (congestive) and diastolic (congestive) heart failure
New code		I50.429	Chronic (left ventricular) combined systolic (congestive) and diastolic (congestive) heart failure, undetermined classification
Revise	I50.43		Acute on chronic (left ventricular) combined systolic (congestive) and diastolic (congestive) heart failure
New code		I50.430	Acute on chronic (left ventricular) combined systolic (congestive) and diastolic (congestive) heart failure without mention of end stage
New code		I50.431	Acute on chronic end stage (left ventricular) combined systolic (congestive) and diastolic (congestive) heart failure
New code		I50.439	Acute on chronic (left ventricular) combined systolic (congestive) and diastolic (congestive) heart failure, undetermined classification

Right Heart Failure and Biventricular Heart Failure

Chronic right ventricular failure can have similar characteristics pathologically to left ventricular failure, but the consequences are significantly different. There can be hypertrophy of the right ventricle due to pulmonary hypertension, both primary and secondary causes; there can be dilation of the right ventricle due to ischemic disease or toxicities or alcohol. Chronic right heart failure can be caused by valvular disease (mitral regurgitation and tricuspid and pulmonic valvular disease) and must be differentiated from left heart failure in patients with End Stage Renal Disease. The "cardiomyopathies" are virtually the same in description and many have the same causes. However, where left heart failure causes backup into the lungs and decreased perfusion to the systemic organs, right heart failure causes backup into the venous circulation with resultant chronic passive congestion of the liver and cardiac cirrhosis, secondary hypercoagulable states including increased risk of pulmonary embolism, with signs of jugular venous distension demonstrating this increase in venous pressure.

Chronic cor pulmonale means that the right ventricle has hypertrophied in response to increased resistance to flow through the lungs. In patients with chronic lung diseases these can be linked to right heart failure, but currently none of the other possible causes of chronic right heart disease can be linked this way with right heart failure, as there has not been a code for chronic right heart failure. Right side dominant heart can develop without failure, so the presence of chronic cor pulmonale does not signify that the patient's right ventricle has failed at all, just that it has responded with hypertrophy to chronic lung disease.

Acute cor pulmonale signifies acute dilation of the right ventricle and is usually a response to massive pulmonary embolism or significant Adult Respiratory Distress Syndrome (ARDS); there are codes for these in ICD-10-CM. Acute cor pulmonale is associated with acute right heart failure and can resolve totally at the end of the insult if the patient survives. But there are other causes of acute right heart failure, and we have no way to demonstrate these cases.

As it stands now, in addition to right heart failure, code I50.9 also includes biventricular failure, and this does not allow these to be adequately differentiated. Patients with biventricular failure can have right heart disease due to one cause and left heart disease due to another. Certainly most cardiomyopathies that affect the whole heart will affect both the right and left ventricles, but there is a need to be able to distinguish such cases from those with different causes. Patients with biventricular failure may be eligible for heart transplantation.

TABULAR MODIFICATIONS

I50 Heart failure

New subcategory I50.5 Right ventricular heart failure

New code I50.50 Right ventricular heart failure, unspecified

New subcategory I50.51 Isolated right ventricular failure (code also the causative disease if known)

New code I50.511 Acute isolated right ventricular failure

New code I50.512 Chronic isolated right ventricular failure

New code I50.513 Acute on chronic isolated right ventricular failure
Acute decompensation of chronic isolated right ventricular failure
Acute exacerbation of chronic isolated right ventricular failure

New code I50.52 Right heart failure due to left heart failure
Right ventricular failure secondary to left ventricular failure
Code also the left ventricular failure (I50.1-I50.43)

New code I50.53 Biventricular heart failure
Code also the left ventricular failure (I50.1-I50.43)

I50.9 Heart failure, unspecified
Delete ~~Biventricular (heart) failure NOS~~
Delete ~~Right ventricular failure (secondary to left heart failure)~~

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

Work-related musculoskeletal disorders (MSD) caused by ergonomic hazards are common and costly. In 2012, the U.S. Bureau of Labor Statistics estimated an incidence rate of 37.8 MSDs involving days away from work per 10,000 full-time workers, accounting for 34% of all cases involving days away from work. The National Institute for Occupational Safety and Health (NIOSH) and several state agencies conduct occupational health and safety surveillance activities using external cause codes.

MSDs due to ergonomic hazards are different from other disorders because case definitions include both the diagnosis (nature of injury) and the external cause. Accurate and correct classification of ergonomic related MSDs is impossible without information on both diagnosis and external cause. Overuse (i.e. overexertion, forceful exertion) is the most common external cause for all work-related injuries and MSDs, but there are several other ergonomic physical risk factors— exposure to repetitive movements, awkward postures (includes static postures), vibration and contact stress.

Some state public health departments use external cause codes from hospital discharge and emergency department visit data sources for occupational health and safety surveillance. One state agency in particular, the Ohio Bureau of Workers' Compensation (OHBWC) has been assigning ICD-9-CM external cause codes to all workers' compensation claims since 2011. The OHBWC Division of Safety and Health has been able to use causation data to target safety and health prevention programs and services to Ohio employers. The OHBWC is the largest of four state workers' compensation bureaus that are the exclusive carrier for workers' compensation insurance. The OHBWC insures two-thirds of Ohio workers and insures all Ohio employers with less than 500 employees and all public employers.

An efficient strategy that state health departments have used to increase occupational safety and health surveillance capacity has been to encourage health care providers to use external cause codes regularly. That way, public health practitioners can better utilize existing data sources (i.e. passive surveillance data from hospitals, emergency departments, outpatient surgical centers, trauma registries, and workers' compensation claims) rather than trying to build new databases that could be burdensome for service providers and state health departments. As the use of electronic health records becomes more widespread, opportunities for improving occupational health and safety surveillance systems are increasing. For ICD-10-CM to be useful for these purposes there needs to be a way to track the most common cause of workplace injuries. If the proposed codes are not added to ICD-10-CM then there will not be a way to identify or track MSDs caused by ergonomic hazards using ICD-10-CM.

NIOSH received a request from OHBWC to add codes in ICD-10-CM that can be used similar to the E927 category. NIOSH established the ICD-10-CM Ergonomic External Causation Coding Workgroup to develop the new codes. The interdisciplinary workgroup included public and private occupational health and safety experts with expertise in the epidemiology, treatment, or prevention of MSDs.

Two external injury codes for ergonomic related cases were available in the International Classifications of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) — E927.0 (Overexertion and strenuous movements) and E928.2 (Exposure to vibration). Based on early input from stakeholders when ICD-10-CM was initially developed, the comparable codes for overexertion in ICD-10-CM were deactivated. Public comments from some external stakeholders supported the deactivation of the category because codes assigned were stated to be highly subjective. The decision

was made to expand the activity code category to indicate the specify activity of the patient seeking healthcare.

NIOSH and other members of the ICD-10-CM Ergonomic External Causation Coding Workgroup propose adding the following external cause codes relevant to MSDs to ICD-10-CM.
References:

Bernard, B. P. (1997). *Musculoskeletal Disorders and Workplace Factors: A critical review of epidemiologic evidence for work-related disorders of the neck, upper extremity, and low back. DHHS (NIOSH) Publication No. 97-141*. Cincinnati, OH: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health; DHHS (NIOSH) Publication No. 97-141. Retrieved from http://www.cdc.gov/niosh/docs/97-141/.

Bureau of Labor Statistics. (November 20, 2012). Occupational safety and health definitions. Retrieved December 28, 2012 from http://www.bls.gov/iif/oshdef.htm.
Bureau of Labor Statistics. (2013). Nonfatal occupational injuries and illnesses requiring days away from work, 2012 *Bureau of Labor Statistics News Release*: U.S. Department of Labor. Retrieved from http://www.bls.gov/news.release/pdf/osh2.pdf.

Dong, R., Krajnak, K., Wirth, O., Wu, J. (Eds). (2006). Proceedings of the First American Conference on Human Vibration. Morgantown, West Virginia: Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health Retrieved from http://www.cdc.gov/niosh/docs/2006-140/pdfs/2006-140.pdf.

Lampl, M. L. (2012, February 9). [2011 Ohio Bureau of Workers' Compensation claims frequency by ICD-9-CM external cause code (personal communication)].
National Research Council - Institute of Medicine. (2001). *Musculoskeletal Disorders and the Workplace*. Washington, DC: National Academy Press.
NORA Musculoskeletal Disorders Team. (2001). National Occupational Research Agenda for Musculoskeletal Disorders: Research Topics for the Next Decade. Cincinnati, OH: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. Retrieved from http://www.cdc.gov/niosh/docs/2001-117/pdfs/2001-117.pdf.

TABULAR MODIFICATIONS

New category X50 Overexertion and strenuous or repetitive movements
The appropriate 7th character is to be added to each code from category X50
A - initial encounter
D - subsequent encounter
S – sequela

New code X50.0 Overuse from strenuous movement or load
Includes: lifting:
- Heavy objects
- Weights

New code X50.1 Overuse from prolonged static or awkward postures
Includes: prolonged or static standing, sitting, twisting, bending, reaching, or kneeling

New code X50.3 Overuse from repetitive movements
Includes: kicking a carpet stretcher with knee
use of a hand as a hammer

Excludes2: Overuse from prolonged static or awkward postures (X50.1)

New code X50.9 Other and unspecified overuse or strenuous movements or postures
Includes: contact stress or contact pressure

Gingival recession

Gingival recession involves the gums receding back, potentially exposing the roots of the teeth. Gingival recession is the apical migration of gingival margin to the cementoenamel junction (CEJ). The distance between the CEJ and gingival margin gives the level of recession. Although it rarely results in tooth loss, gingival recession may effect thermal and tactile sensitivity because of the exposed dentin.

In September 2011, the American Academy of Periodontology submitted a proposal for the gingival recession classification to be replaced by the Miller Classification System. The previous submission has been withdrawn by the requestor.

The American Academy of Periodontology is requesting the specificity which was in ICD-9-CM be added to ICD-10-CM to differentiate the levels of severity.

TABULAR MODIFICATIONS

K06 Other disorders of gingiva and edentulous alveolar ridge

K06.0 Gingival recession

Delete Gingival recession ~~(generalized)~~ ~~(localized)~~ (postinfective) (postprocedural)

Add Note: One code from K06.00-K06.03 and one code from K06.04-K06.05 is required for complete representation of gingival recession

New code	K06.00	Gingival recession, unspecified
New code	K06.01	Gingival recession, minimal
New code	K06.02	Gingival recession, moderate
New code	K06.03	Gingival recession, severe
New code	K06.04	Gingival recession, localized
New code	K06.05	Gingival recession, generalized

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

It is proposed to add inclusion terms related to ejection fraction, for systolic heart failure, diastolic heart failure, and combined systolic and diastolic heart failure subcategories. The ejection fraction is a measure of the left ventricular function. In systolic heart failure, the ejection fraction is reduced. In diastolic heart failure, there is a normal ejection fraction, or preserved ejection fraction. In combined systolic and diastolic heart failure, there is a reduced ejection fraction, along with diastolic dysfunction.

According to the 2013 American College of Cardiology Foundation/American Heart Association (ACCF/AHA) Guidelines, related to definitions of heart failure, the two principal forms of heart failure described are heart failure with reduced ejection fraction (HFrEF), and heart failure with preserved ejection fraction (HFpEF). The guidelines also note that, "Because other techniques may indicate abnormalities in systolic function among patients with a preserved EF, it is preferable to use the terms preserved or reduced EF over preserved or reduced systolic function." It also notes that, "In most patients, abnormalities of systolic and diastolic dysfunction coexist, irrespective of EF." In addition, related to HFrEF, "Those with LV systolic dysfunction commonly have elements of diastolic dysfunction as well."

References:

Yancy CW, M Jessup, B Bozkurt, et al. 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *Circulation*. 2013.

TABULAR MODIFICATIONS

I50 Heart failure

I50.2 Systolic heart failure

Add Heart failure with reduced ejection fraction [HFrEF]

I50.3 Diastolic heart failure

Add Heart failure with normal ejection fraction

Add Heart failure with preserved ejection fraction [HFpEF]

I50.4 Combined systolic and diastolic heart failure

Add Heart failure with reduced ejection fraction and diastolic dysfunction

Hepatic Encephalopathy

Salix Pharmaceuticals, which was acquired this year by Valeant Pharmaceuticals, submitted a request for a unique code for Hepatic Encephalopathy (HE), sometimes referred to as portosystemic encephalopathy or PSE. Hepatic encephalopathy involves altered consciousness and behavior related to insufficient liver function. Hepatic encephalopathy is the loss of brain function that occurs when the liver is unable to remove toxins from the blood. Ammonia, which is produced by your body when proteins are digested, is one of the toxins that's normally made harmless by your liver. When ammonia or other toxic substances build up in the body when your liver isn't working well, it may affect your brain and cause HE.

The most commonly used staging scale of Hepatic Encephalopathy is the West Haven Grading System. The stages of HE span from depression, irritability, sleep disruptions, and forgetfulness in stage 1; lethargy and mild disorientation in stage 2; amnesia and profound confusion in stage 3; to coma in stage 4.

Valeant Pharmaceuticals is requesting a new code for Hepatic Encephalopathy, to differentiate less severe hepatic encephalopathy from cases with hepatic coma.

TABULAR MODIFICATIONS

K72 Hepatic failure, not elsewhere classified

Delete Includes: ~~hepatic encephalopathy NOS~~

K76 Other diseases of liver

K76.8 Other specified diseases of liver

New code K76.82 Hepatic encephalopathy NOS
Portal-systemic encephalopathy

Code also underlying liver disease, such as:
alcoholic hepatic failure without coma (K70.40)
hepatic failure with toxic liver disease without coma (K71.10)
icterus of newborn (P55-P59)
postprocedural hepatic failure (K91.82)
viral hepatitis not specified as to hepatic coma (B17.0, B17.2-B17.9, B18.-)
viral hepatitis without hepatic coma (B15.9, B16.1, B16.9, B17.10, B19.10, B19.20, B19.9)

Excludes1: alcoholic hepatic failure with coma (K70.41)
hepatic failure with toxic liver disease with coma (K71.11)
viral hepatitis with hepatic coma (B15.0, B16.0, B16.2, B17.11, B19.0, B19.11, B19.21)

High Output Heart Failure

High output heart failure generally manifests with warm peripheral extremities, pulmonary congestion, and at times low blood pressure with high cardiac output and usually elevated heart rate. While it is generally due to some other underlying cause (as is the case for all heart failure), high output failure is a specific problem. Its causes differ from most other forms of heart failure. Underlying conditions that may cause high output failure include arrhythmias, anemia, fistulas, thyrotoxicosis, sepsis, carcinoid syndrome, polycythemia vera, and Paget disease of bone, among other things. High output heart failure is now indexed to code I50.9, Heart failure, unspecified.

Based on multiple inputs, it is proposed to add a new code for high output heart failure.

Reference

Mehta PA, Dubrey SW. High output heart failure. QJM. 2009 Apr;102(4):235-41.
http://qjmed.oxfordjournals.org/content/102/4/235.long

TABULAR MODIFICATIONS

	I50	Heart failure	
New subcategory		I50.8	Other heart failure
New code			I50.81 High output heart failure
			Excludes: septic shock (R65.21)

Hypertension in Pregnancy

The American Congress of Obstetricians and Gynecologists (ACOG) is proposing the revision of codes for hypertension in pregnancy. The suggested revisions update the code sections to mirror and standardize the existing language as it is currently reported in code sections O10 and section O15. The requested codes reference conditions complicating childbirth and the puerperium where they currently do not exist.

ACOG proposes the following tabular modifications:

TABULAR MODIFICATIONS

O11 Pre-existing hypertension with pre-eclampsia
Includes: conditions in Ol0 complicated by pre-eclampsia
pre-eclampsia superimposed pre-existing hypertension
Use additional code from O10 to identify the type of hypertension

New code O11.4 Pre-existing hypertension with pre-eclampsia, complicating childbirth
New code O11.5 Pre-existing hypertension with pre-eclampsia, complicating the puerperium

O12 Gestational [pregnancy-induced] edema and proteinuria without hypertension

O12.0 Gestational edema
New code O12.04 Gestational edema, complicating childbirth
New code O12.05 Gestational edema, complicating the puerperium

O12.1 Gestational proteinuria
New code O12.14 Gestational proteinuria, complicating childbirth
New code O12.15 Gestational proteinuria, complicating the puerperium

O12.2 Gestational edema with proteinuria
New code O12.24 Gestational edema with proteinuria, complicating childbirth
New code O12.25 Gestational edema with proteinuria, complicating the puerperium

O13 Gestational [pregnancy-induced] hypertension without significant proteinuria
Includes: gestational hypertension NOS

New code O13.4 Gestational [pregnancy-induced] hypertension without significant proteinuria, complicating childbirth
New code O13.5 Gestational [pregnancy-induced] hypertension without significant proteinuria, complicating the puerperium

O14 Pre-eclampsia

O14.0 Mild to moderate pre-eclampsia

New code O14.04 Mild to moderate pre-eclampsia, complicating childbirth
New code O14.05 Mild to moderate pre-eclampsia, complicating the puerperium

O14.1 Severe pre-eclampsia
New code O14.14 Severe pre-eclampsia complicating childbirth
New code O14.15 Severe pre-eclampsia, complicating the puerperium

O14.2 HELLP syndrome
New code O14.24 HELLP syndrome, complicating childbirth
New code O14.25 HELLP syndrome, complicating the puerperium

O14.9 Unspecified pre-eclampsia
New code O14.94 Unspecified pre-eclampsia, complicating childbirth
New code O14.95 Unspecified pre-eclampsia, complicating the puerperium

Revise O15 Eclampsia complicating pregnancy

Revise O15.0 Eclampsia ~~in pregnancy~~ complicating pregnancy
Revise O15.00 Eclampsia ~~in pregnancy~~ complicating pregnancy, unspecified trimester
Revise O15.02 Eclampsia ~~in pregnancy~~ complicating pregnancy, second trimester
Revise O15.03 Eclampsia ~~in pregnancy~~ complicating pregnancy, third trimester
Revise O15.1 Eclampsia ~~in labor~~ complicating childbirth

Revise O15.2 Eclampsia ~~in~~ complicating the puerperium

O16 Unspecified maternal hypertension

New code O16.4 Unspecified maternal hypertension, complicating childbirth
New code O16.5 Unspecified maternal hypertension, complicating the puerperium

Hypophosphatasia

Hypophosphatasia (HPP) is rare metabolic disease. It is caused by a genetic error affecting production of the enzyme alkaline phosphatase. The error results in impaired phosphate and calcium regulation leading to defective bone mineralization. For this reason, HPP is associated with progressive skeletal deformity, fractures and impaired bone healing, muscle weakness, and gross motor developmental delays. Depending on the age of onset, individuals with HPP commonly develop impaired renal function, seizures and respiratory failure.

The incidence and prevalence of HPP is not well established in the United States. In Europe and Japan, the prevalence of the severe forms of HPP are estimated to be approximately 1:300,000 and 1:150,000, respectively. In Canada, the estimated incidence of severe forms of HPP is 1:100,000 live births. However, this estimate is higher than anticipated due to a high prevalence of genetic mutations in the Canadian Mennonite population. In the Canadian Mennonite population, 1 in 2,500 infants is affected and the carrier frequency of the very severe founder
mutation is 1 in 25.

Published classifications of HPP have historically taken into account the age at which clinical manifestation(s) first appear, dividing the disease into the following (or similar) categories: Perinatal-onset (onset in utero or at birth); Infantile-onset (onset between 0-6 months of age); Juvenile-onset (also referred as Childhood-onset; onset between 6 months to 18 years of age); Adult-onset (onset $\geq$ 18 years of age); and Odonto-hypophosphatasia (only dental clinical
symptoms).

Perinatal-onset HPP and infantile-onset are the most severe forms. Perinatal-onset HPP is considered fatal. It can be identified while the individual is still in utero and, in its worst form, can present as stillbirth without mineralized bone. Infantile-onset HPP has a mortality rate of 50%. Juvenile-onset and adult-onset are less severe, but individuals are still subject to skeletal deformities, gait dysfunction, and fractures.

Despite the usefulness of classifying by age at onset, it is increasingly recognized that HPP represents a single disease continuum, with significant variability in the age of onset and morbidity, and considerable clinical overlap amongst the identified phenotypes. There is no cure for HPP. Treatment is directed at supportive care and managing the accompanying conditions. However, enzyme replacement therapy is being developed and has been granted Breakthrough Therapy designation by the FDA. If approved, this would be the first medical treatment specifically for HPP.

Establishing a diagnosis of HPP is straightforward, with minimal false positive tests. Diagnosis is based on the patient's medical history, clinical manifestations including radiographic assessments, and laboratory tests revealing a low serum alkaline phosphatase enzyme level as well as raised levels of enzyme substrates accumulating in blood and/or urine. The serum alkaline phosphatase test is a commonly available and widely used routine blood test and accurately diagnoses HPP in patients with skeletal complications.

All disorders of phosphorus metabolism were classified to a single code in ICD-9-CM. In contrast, ICD-10-CM is more granular and provides specific codes for most of these conditions. However, hypophosphatasia remains classified to a general code for "Other disorders of phosphorus metabolism".

Alexion Pharmaceuticals is requesting the creation of a unique ICD10-CM code for the identification of patients with hypophosphatasia. Recent developments in patient management indicate a need to specifically identify HPP in the encoded data for tracking purposes and to analyze outcomes more precisely.

Because the associated conditions may be life-threatening in their own right and particularly because they may be the focus of treatment, instructional notes are also proposed to code these conditions separately. Depending on the age and presentation of the patient, these codes may be from Chapter 16, Certain conditions originating in the perinatal period, or from other chapters.

TABULAR MODIFICATIONS

E83 Disorders of mineral metabolism

E83.3 Disorders of phosphorus metabolism and phosphatases

New code E83.33 Hypophosphatasia
Code also, if applicable, associated condition such as:
chronic kidney disease and renal failure (N17.-, N18.-, P96.0)
respiratory failure (J96.-, P28.5)
seizure (G40.-, P90, R56.9)

E83.39 Other disorders of phosphorus metabolism

Delete ~~Hypophosphatasia~~

Infection Following a Procedure

Surgical site infections are commonly classified according to their depth: superficial incisional, deep incisional, and organ/space infection. These categories are consistent with the Centers for Disease Control and Prevention criteria for defining a Surgical Site Infection (SSI).

The Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma is requesting the following tabular changes to better distinguish the severity of infections following a procedure.

TABULAR MODIFICATIONS

T81 Complications of procedures, not elsewhere classified

T81.4 Infection following a procedure

Delete Includes: ~~Intra-abdominal abscess following a procedure~~
Delete Includes: ~~Postprocedural infection, not elsewhere classified~~
Delete Includes: ~~Sepsis following a procedure~~
Delete Includes: ~~Stitch abscess following a procedure~~
Delete Includes: ~~Subphrenic abscess following a procedure~~
Includes: Wound abscess following a procedure

Use additional code to identify infection
Use additional code (R65.2-) to identify severe sepsis, if applicable

Excludes1: Obstetric surgical wound infection (O86.0)
Postprocedural fever NOS (R50.82)
Postprocedural retroperitoneal abscess (K68.11)

Excludes2: Bleb associated endophthalmitis (H59.4-)
Infection due to infusion, transfusion and therapeutic injection (T80.2-)
Infection due to prosthetic devices, implants and grafts (T82.6-T82.7, T83.5-T83.6, T84.5-T84.7,T85.7)

New code T81.40 Infection following a procedure, unspecified

New Code T81.41 Infection following a procedure, superficial incisional surgical site
Subcutaneous abscess following a procedure

New code T81.42 Infection following a procedure, deep incisional surgical site
Intra-muscular abscess following a procedure

New code T81.43 Infection following a procedure, organ and space surgical site

		Intra-abdominal abscess following a procedure Subphrenic abscess following a procedure
New code	T81.48	Infection following a procedure, other surgical site infection Stitch abscess following a procedure
New code	T81.49	Infection following a procedure, not elsewhere classified Sepsis following a procedure

Inflammatory Disorders of Breast

Infections of the breast primarily involve mastitis, with or without an abscess. Treatment of these conditions differs in that abscesses frequently require drainage either percutaneously or by incision of the overlying skin, whereas mastitis is treated with antibiotics alone. Category N61, Inflammatory disorders of breast, subsumes both of these diseases. In comparison, category O91, Infections of breast associated with pregnancy, the puerperium and lactation, differentiate breast abscesses from mastitis.

The Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma is requesting the following tabular changes to better distinguish mastitis from breast abscesses.

TABULAR MODIFICATIONS

N61 Inflammatory disorders of breast

Delete ~~Abscess (acute) (chronic) (nonpuerperal) of areola~~
Delete ~~Abscess (acute) (chronic) (nonpuerperal) of breast~~
Delete ~~Carbuncle of breast~~
Delete ~~Infective mastitis (acute) (subacute) (nonpuerperal)~~
Delete ~~Mastitis (acute) (subacute) (nonpuerperal) NOS~~

New code N61.0 Mastitis without abscess
Infective mastitis (acute) (subacute) (nonpuerperal)
Mastitis (acute) (subacute) (nonpuerperal) NOS
Cellulitis (acute) (subacute) (nonpuerperal) of breast NOS
Cellulitis (acute) (subacute) (nonpuerperal) of nipple NOS

New code N61.1 Abscess of the breast and nipple
Abscess (acute) (chronic) (nonpuerperal) of areola
Abscess (acute) (chronic) (nonpuerperal) of breast
Carbuncle of breast
Mastitis with abscess

L03 Cellulitis and acute lymphangitis

L03.3 Cellulitis and acute lymphangitis of trunk

L03.31 Cellulitis of trunk
Excludes2: cellulitis of anal and rectal regions (K61.-)
Revise cellulitis of breast NOS (N61.0)

Intestinal Obstruction

Intestinal obstruction varies in severity, from partial or intermittent obstruction that resolves without intervention to complete obstruction that requires an operation and may lead to intestinal gangrene and perforation. Although other diagnoses capture the concepts of intestinal infarction and perforation, the various intestinal obstruction diagnosis codes differentiate the etiology of the obstruction but not its severity. Physicians frequently describe intestinal obstruction as partial versus complete. These distinctions are relevant because complete obstruction generally requires an operation and partial obstruction usually does not (especially for the small intestine).

The Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma is requesting the following tabular changes to better distinguish the severity of intestinal obstruction.

TABULAR MODIFICATIONS

K56 Paralytic ileus and intestinal obstruction without hernia

New subcategory K56.5 Intestinal adhesions [bands] with obstruction (postprocedural) (postinfection)

New code K56.50 Intestinal adhesions [bands], unspecified as to partial versus complete obstruction
Intestinal adhesions with obstruction NOS

New code K56.51 Intestinal adhesions [bands], with partial obstruction
Intestinal adhesions with incomplete obstruction

New code K56.52 Intestinal adhesions [bands] with complete obstruction

K56.6 Other and unspecified intestinal obstruction

New sub-subcategory K56.60 Unspecified intestinal obstruction
Delete ~~Intestinal obstruction NOS~~

New code K56.600 Partial intestinal obstruction, unspecified as to cause
Incomplete obstruction, NOS

New code K56.601 Complete intestinal obstruction, unspecified as to cause

New code	K56.609	Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction Intestinal obstruction NOS	
New Sub-subcategory	K56.69	Other intestinal obstruction	
New code	K56.690	Other partial intestinal obstruction Other incomplete intestinal obstruction	
New code	K56.691	Other complete intestinal obstruction	
New code	K56.699	Other intestinal obstruction unspecified as to partial versus complete obstruction Other intestinal obstruction, NEC	

K91 Intraoperative and postprocedural complications and disorders of digestive system, not elsewhere classified

New subcategory	K91.3	Postprocedural intestinal obstruction	
New code	K91.30	Postprocedural intestinal obstruction, unspecified as to partial versus complete Postprocedural intestinal obstruction NOS	
New code	K91.31	Postprocedural partial intestinal obstruction Postprocedural incomplete intestinal obstruction	
New code	K91.32	Postprocedural complete intestinal obstruction	

Lysosomal Acid Lipase (LAL) Deficiency

LAL Deficiency is a lysosomal storage disorder (LSD) caused by mutations affecting the LIPA gene resulting in a deficiency of lysosomal acid lipase (LAL) activity. In patients with LAL Deficiency, the enzyme deficiency causes cholesteryl esters and triglycerides to accumulate in the lysosomes across multiple body tissues, leading to progressive and life-threatening organ damage across a clinical continuum from infants to children and adults.

LAL Deficiency has historically been categorized as two different disease states; the infantile presentation has been referred to in published literature as Wolman's disease, while LAL Deficiency presenting in children and adults has been referred to as Cholesteryl Ester Storage Disease (CESD). It has since been determined that Wolman's disease and CESD are the same disease caused by mutations on the LIPA gene. The term LAL Deficiency more accurately characterizes the disease as a clinical continuum with variable phenotypes rather than two different diseases.

LAL Deficiency presenting in infants is a more rare presentation of the disease, usually fatal within the first 6 months of life, and has an incidence rate of 1:704,000. This is the most rapidly progressive presentation of LAL Deficiency, with growth failure as the predominant clinical feature and a key contributor to the early mortality. Rapidly progressive hepatic disease, as evidenced by liver enlargement, elevation of transaminases, hyperbilirubinemia, coagulopathy, and hypoalbuminemia, also occurs in these infants and contributes to mortality.

LAL Deficiency presenting in children and adults is the most common presentation and is an underappreciated cause of cirrhosis, dyslipidemia and accelerated atherosclerosis. LAL Deficiency in children and adults has an estimated prevalence of 1:130,000 individuals; in the majority of reported cases, patients are diagnosed before the age of 20. Although disease presentation can be variable, hepatic manifestations typically dominate the clinical picture. Diagnosis of LAL Deficiency requires a high index of clinical suspicion, since elevated transaminases, fatty liver, and dyslipidemia are also seen in patients with other liver and metabolic diseases. The disease can be easily diagnosed with a simple biochemical enzyme assay that measures the amount of LAL activity in different sample types including dried blood spots, leukocytes and skin fibroblasts.

There is no cure for LAL-D. Treatment is directed at supportive care and managing the accompanying conditions. However, enzyme replacement therapy is being developed and has been granted Breakthrough Therapy designation by the FDA. If approved, this would be the first medical treatment specifically for LAL-D.

In LAL Deficiency, the presence of increased lysosomal cholesteryl esters and triglycerides in the liver is associated with liver fibrosis and progression to cirrhosis. Published cases clearly demonstrate that progression of fibrosis to cirrhosis or clinical complications of chronic liver disease, including bleeding, ascites and esophageal varices, occur across the age spectrum.

Dyslipidemia with elevated total cholesterol, triglycerides, and low-density lipoprotein-cholesterol (LDL-C) and decreased high-density lipoprotein-cholesterol (HDL-C) levels is common and has been shown to be associated with accelerated atherosclerosis. Although textbook descriptions describe elevated LDL-C and triglycerides in affected cases (Type II hyperlipidemia), recent insights suggest that isolated elevation of LDL-C may be present in a number of cases.

In addition to the more common manifestations of LAL Deficiency, other clinical presentations and complications have been described, including pulmonary hypertension, severe hypersplenism, splenic infarcts and mesenteric lipodystrophy. Growth failure, defined as > 2 standard deviations below normal weight and height measurements for age, has been noted in some children and adults with LAL Deficiency. Gastrointestinal involvement occurs in most LAL Deficiency patients. However, infants with LAL Deficiency typically present with chronic diarrhea, emesis, malabsorption and failure to thrive.

LAL deficiency is currently classified to a broadly defined ICD-10-CM diagnosis code. This proposal requests new clinical detail by expanding E75.5, Other lipid storage disorders, as a subcategory. A specific code for LAL deficiency would facilitate more accurate identification of underlying causes of cirrhosis and other conditions as well as other epidemiological research and outcomes analysis. Additionally, the creation of a unique ICD-10 diagnosis code for LAL-D would align with existing ICD-10 coding for other rare lysosomal storage disorders that have unique diagnosis codes, including: Pompe disease (E74.02); Sandhoff disease (E75.01); TaySachs disease (E75.02); Gaucher disease (E75.22); Fabry (-Anderson) disease (E75.21) among many other LSDs.

Alexion Pharmaceuticals is requesting the creation of a specific ICD-10-CM code for identification of patients with LAL Deficiency with support from the North American Society of Pediatric Gastroenterology, Hepatology and Nutrition, the Lysosomal Disease Network and LAL Solace (a patient advocacy organization).

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TABULAR MODIFICATIONS

E75 Disorders of sphingolipid metabolism and other lipid storage disorders

E75.5 Other lipid storage disorders

Delete ~~Cerebrotendinous cholesterosis [van Bogaert-Scherer-Epstein]~~

Delete ~~Wolman's disease~~

New code E75.51 Lysosomal acid lipase deficiency
Cholesteryl ester storage disease
Wolman's disease
Code also, if applicable, associated condition such as:
atherosclerosis (I25.-, I70.-)
fibrosis and cirrhosis of liver (K74.-)
hepatic failure (K72.-)

Excludes1: disorders of lipoprotein metabolism and other lipidemias (E78.-)

New code E75.59 Other specified lipid storage disorders
Cerebrotendinous cholesterosis [van Bogaert-Scherer-Epstein]

Mediastinitis

"Mediastinitis" refers to inflammation of the mediastinum—almost always involving bacterial infection—typically as a result of esophageal perforation, extension of a neck infection into the thorax, or a postoperative infection following a procedure involving the mediastinum.

Mediastinitis warrants its own code because it is usually a quite severe infection, whether as an indicator of the severity of a disease process or as a complication of care. Further, mediastinitis is arguably a more important and salient entity to capture than an abscess of the mediastinum, which is a relatively unusual manifestation of an infection in this region.

The Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma is requesting the following tabular changes to better identify mediastinitis.

TABULAR MODIFICATIONS

J98 Other respiratory disorders

J98.5 Diseases of mediastinum, not elsewhere classified

Delete	~~Fibrosis of mediastinum~~
Delete	~~Hernia of mediastinum~~
Delete	~~Retraction of mediastinum~~
	Excludes2: Abscess of mediastinum (J85.3)
New code	J98.51 Mediastinitis
	Code first: Underlying condition, if applicable, such as postoperative mediastinitis (T81.-)
New code	J98.59 Other diseases of mediastinum, not elsewhere classified
	Fibrosis of mediastinum
	Hernia of mediastinum
	Retraction of mediastinum

Megacolon

Megacolon is significant dilation of the colon. It may be chronic or acute, and toxic megacolon is a form of acute toxic colitis that can be potentially lethal. Patients with toxic megacolon are generally very sick, and in addition to the dilated colon, will usually have fever, tachycardia, leukocytosis, and/or anemia (generally at least three of these four findings are present). Also, there will generally be at least one finding of dehydration, altered mental status, electrolyte abnormality, or hypotension.

A number of things can cause toxic megacolon, including these causes of an inflammatory colitis: ulcerative colitis, Crohn colitis, and pseudomembranous colitis. Also, a number of types of infections colitis may cause toxic megacolon, including species of Salmonella, Shigella, Campylobacter, and Yersinia, and also Clostridium difficile, Entamoeba histolytica, Cytomegalovirus, Rotavirus, and invasive aspergillosis. Toxic megacolon may also be caused by radiation colitis, ischemic colitis, nonspecific colitis secondary to chemotherapy, as a complication of collagenous colitis (but rarely), and as a complication of Behçet syndrome (again, rarely.) Certain drugs or toxins may also cause either an acute or a chronic megacolon. It is proposed that a new code be created for toxic megacolon.

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TABULAR MODIFICATIONS

K59 Other functional intestinal disorders

K59.3 Megacolon, not elsewhere classified
Dilatation of colon

Delete ~~Toxic megacolon~~

Revise Code first if applicable (T51-T65) to identify toxic agent

Excludes1: congenital megacolon (aganglionic) (Q43.1)
megacolon (due to) (in) Chagas' disease (B57.32)
megacolon (due to) (in) Clostridium difficile (A04.7)
megacolon (due to) (in) Hirschsprung's disease (Q43.1)

New code K59.31 Toxic megacolon

New code K59.39 Other megacolon
Megacolon NOS

Non-Exudative AMD

In September 2012, a working group of the American Academy of Ophthalmology (AAO) submitted a code proposal for age related macular degeneration (AMD) to the Coordination and Maintenance committee. These codes were tentatively accepted for the tabular addenda following ICD-10-CM implementation. An unrelated group called the Beckman Initiative for Macular Research Committee was finalizing a consensus publication to update the AMD clinical classification. Among the disease-area-expert authors on the Beckmann committee publication were the original Age-Related Eye Disease Study (AREDS) authors on which the AMD code expansion was based, Drs. Frederick Ferris III and Emily Chew.

The new proposed classification below aligns the ICD-10-CM non-exudative AMD codes with the updated Beckman classification for geographic atrophy. Intermediate AMD and geographic atrophy have been completely separated per Beckman. This code proposal also incorporates other expert input that recommended a further division of advanced AMD (geographic atrophy) into foveal-sparing and foveal-involvement.

The new proposed classification also builds upon the earlier change presented in 2012. The advanced AMD staging has become important in the last few years as treatment of atrophic AMD has become possible. The proposed change is based on the Beckman AMD clinical classification but modified slightly, dividing geographic atrophy between foveal-sparing and foveal-involvement as key stages in the disease process.

The American Academy of Ophthalmology (AAO) is requesting the following proposed tabular modifications to better distinguish the stages of non-exudative AMD.

TABULAR MODIFICATIONS

H35 Other retinal disorders

H35.3 Degeneration of macula and posterior pole

H35.31 Nonexudative age-related macular degeneration
Dry age-related macular degeneration

One of the following 7th characters is to be assigned to codes in subcategory H35.31 to designate the stage of the disease:
0 stage unspecified
1 early dry stage
2 intermediate dry stage
Revise 3 advanced ~~dry stage~~ atrophic without subfoveal involvement
Add 4 advanced atrophic with subfoveal involvement

H35.311 Nonexudative age-related macular degeneration, right eye
H35.312 Nonexudative age-related macular degeneration, left eye

H35.313 Nonexudative age-related macular degeneration, bilateral
H35.319 Nonexudative age-related macular degeneration, unspecified eye

Observation and evaluation of newborns for suspected conditions ruled out

The American Academy of Pediatrics (AAP) has developed modifications of its initial proposal presented at the September 2013 C&M meeting. These modifications are based on submitted comments and working with various stakeholders over the last two years.

Currently ICD-10-CM does not have any way to uniquely capture suspected conditions ruled out as the reason for the encounter. The Academy originally submitted a proposal for a unique set of codes be added to ICD-10-CM to more clearly capture this information for epidemiological and health resource utilization for tracking of newborns who present to the healthcare system with significant parental concerns but who are found not to have a clinical condition.

AAP determined that the P00-P04 code series was not robust enough to capture this information and did not show that the condition was not present ("ruled out"). The American Academy of Pediatrics is again requesting that a unique set of codes be added to ICD-10-CM to more clearly capture this information; hence the proposed development of the new code category Z05, Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out. In addition, this revised proposal has additional modifications to include revise code titles, inclusions terms and clarification of Excludes2 notes.

TABULAR MODIFICATIONS

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

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

Add Excludes 2: Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out (Z05.-)

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

Code first any current condition in newborn

Revise Excludes2: newborn ~~(suspected to be)~~ affected by maternal complications of pregnancy (P01.-)

Revise P00.0 Newborn ~~(suspected to be)~~ affected by maternal hypertensive disorders
Newborn ~~(suspected to be)~~ affected by maternal conditions classifiable to O10-O11, O13-O16

Revise P01 Newborn ~~(suspected to be)~~ affected by maternal complications of pregnancy

Revise P02 Newborn ~~(suspected to be)~~ affected by complications of placenta, cord and membranes

Revise P03 Newborn ~~(suspected to be)~~ affected by other complications of labor and delivery

Revise P04 Newborn ~~(suspected to be)~~ affected by noxious substances transmitted via placenta or breast milk

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

This category is to be used for newborns, within the neonatal period (the first 28 days of life), who are suspected of having an abnormal condition but without signs or symptoms, and which, after examination and observation, is ruled out.

Excludes 2: Newborn affected by maternal factors and by complications of pregnancy labor, and delivery (P00-P04)

New Code Z05.0 Observation and evaluation of newborn for suspected cardiac condition ruled out

New code Z05.1 Observation and evaluation of newborn for suspected infectious condition ruled out

New code Z05.2 Observation and evaluation of newborn for suspected neurological condition ruled out

New code Z05.3 Observation and evaluation of newborn for suspected respiratory condition ruled out

New subcategory Z05.4 Observation and evaluation of newborn for suspected genetic, metabolic or immunologic condition ruled out

New Code Z05.41 Observation and evaluation of newborn for suspected genetic condition ruled out

New Code Z05.42 Observation and evaluation of newborn for suspected metabolic condition ruled out

New Code Z05.43 Observation and evaluation of newborn for suspected immunologic condition ruled out

New Code	Z05.5	Observation and evaluation of newborn for suspected gastrointestinal condition ruled out
New Code	Z05.6	Observation and evaluation of newborn for suspected genitourinary condition ruled out
New subcategory	Z05.7	Observation and evaluation of newborn for suspected skin, subcutaneous, musculoskeletal and connective tissue condition ruled out
New Code	Z05.71	Observation and evaluation of newborn for suspected skin and subcutaneous tissue condition ruled out
New Code	Z05.72	Observation and evaluation of newborn for suspected musculoskeletal condition ruled out
New Code	Z05.73	Observation and evaluation of newborn for suspected connective tissue condition ruled out
New code	Z05.8	Observation and evaluation of newborn for other specified suspected condition ruled out
New code	Z05.9	Observation and evaluation of newborn for unspecified suspected condition ruled out

Proposal to change Excludes Designations for Epilepsy

In ICD-10-CM there are multiple conditions listed in an Excludes1 note for G40, Epilepsy and recurrent seizures. Some of these conditions listed as Excludes1 is clinically inaccurate.

Mesial temporal sclerosis, hippocampal sclerosis and temporal sclerosis are conditions that are most often considered etiologies for symptomatic epilepsy, but by themselves are not always associated with epilepsy. The presence of these conditions makes epilepsy surgery a viable option for some patients whose epilepsy is refractory to medication. It is important to capture both conditions when present in one patient for specificity.

Todd's paralysis is a manifestation occurring after a seizure. It does have some predictive and physiologic significance. It is not a manifestation that is considered inherent to all epilepsy syndromes. It would be useful to capture both the epilepsy code and the Todd's paralysis code for specificity.

The American Academy of Neurology (AAN) proposes that mesial temporal sclerosis, hippocampal sclerosis, temporal sclerosis, and Todd's paralysis be included in an Excludes2 note under G40. In addition there is a typographical error for the code for Todd's paralysis.

TABULAR MODIFICATIONS

G40 Epilepsy and recurrent seizures

	Excludes1	conversion disorder with seizures (F44.5)
		convulsions NOS (R56.9)
Delete		~~hippocampal sclerosis (G93.81)~~
Delete		~~mesial temporal sclerosis (G93.81)~~
		post traumatic seizures (R56.1)
		seizure (convulsive) NOS (R56.9)
		seizure of newborn (P90)
Delete		~~temporal sclerosis (G93.81)~~
Delete		~~Todd's paralysis (G83.8)~~
Add	Excludes2	hippocampal sclerosis (G93.81)
Add		mesial temporal sclerosis (G93.81)
Add		temporal sclerosis (G93.81)
Add		Todd's paralysis (G83.84)

Pulmonary Hypertension

Pulmonary hypertension (PH) is now classified into five groups, based on categories that share similar pathological findings, hemodynamic characteristics and management. This was established at the Second World Symposium on Pulmonary Hypertension in 1998, and maintained through the most recent Fifth World Symposium in 2013.

> Five groups of disorders that cause PH were identified: pulmonary arterial hypertension (Group 1); pulmonary hypertension due to left heart disease (Group 2); pulmonary hypertension due to chronic lung disease and/or hypoxia (Group 3); chronic thromboembolic pulmonary hypertension (Group 4); and pulmonary hypertension due to unclear multifactorial mechanisms (Group 5). During the successive world meetings, a series of changes were carried out, reflecting some progresses in the understanding of the disease. However, the general architecture and the philosophy of the clinical classification were unchanged. (Simonneau 2013)

The ICD-9-CM and ICD-10-CM codes are based on an earlier classification of PH. It has been requested by Bayer HealthCare Pharmaceuticals that new codes be created to better represent the current clinical classification of PH. This coding proposal is based on input from Bayer.

Group 1: Pulmonary Arterial Hypertension (PAH)
PAH is the most widely recognized category of PH, and includes the previously designated Primary Pulmonary Hypertension (PPH). PAH includes idiopathic PAH (IPAH) without an identifiable family history or risk factor, heritable PAH due to mutations in the bone morphogenetic protein receptor type 2 (BMPR2) gene. This BMPR2 mutation is attributable to 80 percent of cases with heritable PAH and 11 to 40 percent of IPAH. PAH also includes drug- and toxin-induced PH, and PH associated with other chronic conditions such as HIV infection, and congenital heart diseases.

Group 2: PH due to left heart disease
This subgroup, due to left heart systolic dysfunction, left heart diastolic dysfunction, and left heart valvular disease that may produce increase in left atrial pressure, represents the most frequent cause of PH. Some patients with left heart valvular disease or left heart dysfunction can develop PH as severe as that seen in PAH.

Group 3: PH due to lung diseases and/or hypoxia
In this subgroup, the predominant cause of PH is alveolar hypoxia as a result of lung disease, impaired control of breathing, or residence at high altitude. The prevalence of PH in this subtype remains large unknown. Among those with pulmonary fibrosis and emphysema, the prevalence of PH is almost 50 percent.

Group 4: Chronic Thromboembolic PH (CTEPH)
Obstruction of pulmonary arterial vessels by thromboemboli, tumors, or foreign bodies can lead to CTEPH. In the U.S., approximately 600,000 individuals have an acute pulmonary embolism (PE) each year, and cumulative incidence of CTEPH is estimated to range from 0.57 to 3.8 percent after acute PE. These incidence rates may be underestimated as postembolism observational studies often do not include patients referred for pulmonary endarterectomy (PEA) and favor inclusion of survivors.

Group 5: PH with unclear multifactorial mechanisms
This group includes multiple forms of PH for which the etiology is unclear or multifactorial. The subgroups include hematologic disorders such as myeloproliferative disorders and splenectomy; systemic disorders such as sarcoidosis and pulmonary Langerhans cell histiocytosis; metabolic disorders such as glycogen storage disease, Gaucher disease and thyroid disorders; and other conditions that lead to PH.

References

Simonneau G, Gatzoulis MA, Adatia I, et al. Updated clinical classification of pulmonary hypertension. J Am Coll Cardiol. 2013;62(25 Suppl):D34–41. http://www.sciencedirect.com/science/article/pii/S0735109713058725

Simonneau G, Robbins I, Beghetti M, et al. Updated clinical classification of pulmonary hypertension. J Am Coll Cardiol 2009;54:S43–54. doi:10.1016/j.jacc.2009.04.012. http://www.sciencedirect.com/science/article/pii/S0735109709012169

TABULAR MODIFICATIONS

I27 Other pulmonary heart diseases

Revise I27.0 Primary pulmonary hypertension and other pulmonary arterial hypertension

Add Group 1 pulmonary hypertension
Add Pulmonary arterial hypertension (drug-induced) (heritable) (idiopathic) (toxin-induced)
Add Pulmonary arterial hypertension, associated with other conditions
Add Pulmonary arterial hypertension due to mutation in bone morphogenetic protein receptor type 2 (BMPR2) gene
Add Pulmonary arterial hypertension with pulmonary veno-occlusive disease [PVOD]
Add Pulmonary arterial hypertension with pulmonary capillary hemangiomatosis [PCH]

Code also associated conditions if applicable, or adverse effects of drugs or toxins, such as:
Adverse effect of appetite depressants (T50.5X5)
Congenital heart disease (Q20-Q28)
Human immunodeficiency virus [HIV] disease (B20)
Polymyositis (M33.2-)
Portal hypertension (K76.6)
Rheumatoid arthritis (M05.-)
Schistosomiasis (B65.-)
Sjögren syndrome (M35.0-)
Systemic sclerosis (M34.-)

Add Excludes1: Persistent pulmonary hypertension of newborn (P29.30)
Revise Pulmonary hypertension NOS (I27.20)
Revise Secondary pulmonary hypertension (I27.29)

I27.2 Other secondary pulmonary hypertension

New code I27.20 Pulmonary hypertension NOS

New code I27.21 Pulmonary hypertension due to left heart disease
Group 2 pulmonary hypertension
Pulmonary hypertension due to left heart diastolic dysfunction
Pulmonary hypertension due to left heart systolic dysfunction
Pulmonary hypertension due to left heart valvular disease
Code also associated left heart disease, if known, such as:
Diastolic heart failure (I50.3-)
Nonrheumatic aortic valve disorders (I35.-)
Nonrheumatic mitral valve disorders (I34.-)
Rheumatic mitral valve diseases (I05.-)
Rheumatic aortic valve diseases (I06.-)
Systolic heart failure (I50.2-)

New code I27.22 Pulmonary hypertension due to lung diseases and hypoxia
Group 3 pulmonary hypertension
Pulmonary hypertension due to chronic obstructive pulmonary disease
Pulmonary hypertension due to interstitial lung disease
Pulmonary hypertension due to sleep related breathing disorders
Pulmonary hypertension due to alveolar hypoventilation

Code also associated lung disease, if known, such as:
Chronic bronchitis (J41-J42)
Chronic obstructive pulmonary disease (J44.-)
Emphysema (J43.-)
Interstitial lung disease (J84.-)
Morbid (severe) obesity with alveolar hypoventilation (E66.2)
Sleep apnea (G47.3-)

New code I27.23 Pulmonary hypertension due to chronic thromboembolic pulmonary hypertension
Group 4 pulmonary hypertension
Code also associated pulmonary embolism, if applicable (I26.-)

New code I27.24 Pulmonary hypertension due to other unclear multifactorial mechanisms
Group 5 pulmonary hypertension

Pulmonary hypertension due to hematologic disorders
Pulmonary hypertension due to metabolic disorders
Pulmonary hypertension due to other systemic disorders
Code also other associated disorders, if known, such as:
Chronic myeloid leukemia (C92.10- C92.22)
Chronic myeloproliferative disease (D47.1)
Essential thrombocythemia (D47.3)
Gaucher disease (E75.22)
Glycogen storage disease (E74.0-)
History of splenectomy (Z90.81)
Myelodysplastic syndromes (D46.-)
Polycythemia vera (D45)
Pulmonary Langerhans cell histiocytosis (J84.82)
Sarcoidosis (D86.-)
Thyroid disorders (E00-E07)

New code I27.29 Secondary pulmonary hypertension, not elsewhere classified

Code also associated underlying condition

P29 Cardiovascular disorders originating in the perinatal period

P29.3 Persistent fetal circulation

Delete ~~Delayed closure of ductus arteriosus~~
~~(Persistent) pulmonary hypertension of newborn~~

New code P29.30 Pulmonary hypertension of newborn
Persistent pulmonary hypertension of newborn

New code P29.38 Other persistent fetal circulation
Delayed closure of ductus arteriosus

Risk Level for Dental Carries

The American Dental Association (ADA) is proposing the creation of new codes that will assist dentistry with the reporting of detailed caries risk assessment diagnoses. These codes are needed to determine disease etiological factors, effective treatment modalities, clinical data collection and population monitoring and research. The ADA is requesting the new codes for consistency with other recognized terminologies and to uniquely identify caries risk levels that are not currently represented in ICD 10-CM.

The ADA is proposing the following tabular modifications:

TABULAR MODIFICATIONS

Z87 Personal history of other diseases and conditions

Z87.1 Personal history of diseases of the digestive system
Conditions classifiable to K00-K93

New Sub-subcategory	Z87.12	Personal history of other dental conditions
New code	Z87.120	Personal history of low risk for dental caries
New code	Z87.121	Personal history of moderate risk for dental caries
New code	Z87.122	Personal history of high risk for dental caries

Subarachnoid hemorrhage

In ICD-10-CM, category I60 is Nontraumatic subarachnoid hemorrhage. In creation of the clinical modification, a number of codes have been expanded to identify laterality. One of these is for the anterior communicating artery. It connects between the left and right anterior cerebral arteries. While it has a left and right side, it is relatively short, and it has been suggested that the expansion to include laterality for the anterior communicating artery is not needed, and thus it has been proposed that the specific codes for this be deleted. After such a change, there will still continue to be a four character code I60.2 for Nontraumatic subarachnoid hemorrhage from anterior communicating artery, corresponding to a WHO ICD-10 code.

TABULAR MODIFICATIONS

I60 Nontraumatic subarachnoid hemorrhage

I60.2 Nontraumatic subarachnoid hemorrhage from anterior communicating artery

Delete code ~~I60.20 Nontraumatic subarachnoid hemorrhage from unspecified anterior communicating artery~~

Delete code ~~I60.21 Nontraumatic subarachnoid hemorrhage from right anterior communicating artery~~

Delete code ~~I60.22 Nontraumatic subarachnoid hemorrhage from left anterior communicating artery~~

Vascular Disorders of Intestine

Acute intestinal ischemia is a morbid and sometimes fatal condition common to several different etiologies of vascular disease. ICD-10-CM classifies all such cases with one code, K55.0 "Acute vascular disorders of intestine," but the spectrum of this condition ranges from self-resolving reversible ischemia affecting only a single, small lesion of the intestine to gangrene of the entire small and large intestine, which is almost universally fatal.

Acute intestinal ischemia occurs in a wide variety of patterns that defy easy categorization. Nonetheless, physicians routinely describe such cases according to the broad anatomic region involved (small or large intestine), reversibility (ischemia versus infarction), and extent ("limited," "focal," or "segmental" versus "diffuse," i.e., affecting most or all of the affected region). These distinctions are important for a variety of reasons: (1) the prognosis varies markedly across different permutations of these characteristics; (2) treatment varies quite dramatically since reversible ischemia generally does not warrant resection (though it may warrant a procedure to improve blood flow to the intestine) whereas infarction frequently requires resection; and (3) different patterns of ischemia involve differences in resource use and have different implications for quality measurement.

The Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma is requesting the following tabular changes to better distinguish the severity of intestinal ischemia. Instances involving ischemia affecting both the small and large intestine would warrant separate codes for both the small and large intestine.

TABULAR MODIFICATIONS

K55 Vascular disorders of intestine

K55.0 Acute vascular disorders of intestine

Delete ~~Acute fulminant ischemic colitis~~
Delete ~~Acute intestinal infarction~~
Delete ~~Acute small intestine ischemia~~
Infarction of appendices epiploicae
Mesenteric (artery) (vein) embolism
Mesenteric (artery) (vein) infarction
Mesenteric (artery) (vein) thrombosis
Delete ~~Necrosis of intestine~~
Delete ~~Subacute ischemic colitis~~

New subcategory K55.01 Acute (reversible) ischemia of small intestine

New code K55.011 Focal (segmental) acute (reversible) ischemia of small intestine

New code		K55.012	Diffuse acute (reversible) ischemia of small intestine
New code		K55.019	Acute (reversible) ischemia of small intestine, extent unspecified
New subcategory	K55.02	Acute infarction of small intestine	
New code		K55.021	Focal (segmental) acute infarction of small intestine
New code		K55.022	Diffuse acute infarction of small intestine
New code		K55.029	Acute infarction of small intestine, extent unspecified
New subcategory	K55.03	Acute (reversible) ischemia of large intestine Acute fulminant ischemic colitis Subacute ischemic colitis	
New code		K55.031	Focal (segmental) acute (reversible) ischemia of large intestine
New code		K55.032	Diffuse acute (reversible) ischemia of large intestine
New code		K55.039	Acute (reversible) ischemia of large intestine, extent unspecified
New subcategory	K55.04	Acute infarction of large intestine	
New code		K55.041	Focal (segmental) acute infarction of large intestine
New code		K55.042	Diffuse acute infarction of large intestine
New code		K55.049	Acute infarction of large intestine, extent unspecified
New subcategory	K55.05	Acute (reversible) ischemia of intestine, part unspecified	
New code		K55.051	Focal (segmental) acute (reversible) ischemia of intestine, part unspecified

New code		K55.052	Diffuse acute (reversible) ischemia of intestine, part unspecified
New code		K55.059	Acute (reversible) ischemia of intestine, part and extent unspecified
New subcategory	K55.06	Acute infarction of intestine, part unspecified Necrosis of intestine Gangrene of intestine Acute intestinal infarction	
New code		K55.061	Focal (segmental) acute infarction of intestine, part unspecified
New code		K55.062	Diffuse acute infarction of intestine, part unspecified
New code		K55.069	Acute infarction of intestine, part and extent unspecified

ICD-10-CM TABULAR OF DISEASES - PROPOSED ADDENDA
All proposed effective October 1, 2016

D46 Myelodysplastic syndromes
Revise D46.2 Refractory anemia with excess of blasts [RAEB]

D64.8 Other specified anemias
D64.81 Anemia due to antineoplastic chemotherapy
Delete Excludes1: ~~anemia in neoplastic disease (D63.0)~~
Add Excludes2: anemia in neoplastic disease (D63.0)

D61 Other aplastic anemias and other bone marrow failure syndromes
D61.8 Other specified aplastic anemias and other bone marrow failure syndromes
Delete Excludes1: ~~pancytopenia (due to) (with) myelodysplastic syndromes (D46.-)~~
Add Excludes2: pancytopenia (due to) (with) myelodysplastic syndromes (D46.-)

E29 Testicular dysfunction
Revise Excludes1: Klinefelter's syndrome (Q98.0-~~Q98.2~~ Q98.1, Q98.4)

E66 Overweight and obesity

E66.2 Morbid (severe) obesity with alveolar hypoventilation
Add Obesity hypoventilation syndrome (OHS)

F52 Sexual dysfunction not due to a substance or known physiological condition

F52.0 Hypoactive sexual desire disorder
Revise Anhedonia ~~(~~sexual~~)~~

G00 Bacterial meningitis, not elsewhere classified
G00.1 Pneumococcal meningitis
Add Meningtitis due to Streptococcal pneumoniae

H42 Glaucoma in diseases classified elsewhere
Excludes1: glaucoma (in):
Delete ~~diabetes mellitus (E08.39, E09.39, E10.39, E11.39, E13.39)~~
Add Excludes 2: glaucoma (in): diabetes mellitus (E08.39, E09.39, E10.39, E11.39,E13.39)

I20 Angina pectoris
I20.8 Other forms of angina pectoris
Add Stable angina

L70 Acne
Delete L70.5 Acné excoriée ~~des jeunes filles~~
Add Acné excoriée des jeunes filles

L82 Seborrheic keratosis
Add Basal cell papilloma

L89 Pressure ulcer
L89.5 Pressure ulcer of ankle
L89.52 Pressure ulcer of left ankle
L89.521 Pressure ulcer of left ankle, stage 1
Revise Pressure pre-ulcer skin changes limited to
~~persistnt~~ persistent focal edema, left ankle

R00 Abnormalities of heart beat
Revise Excludes1: abnormalities originating in the perinatal period (P29.1-)
~~specified arrhythmias (I47-I49)~~
Add Excludes 2: specified arrhythmias (I47-I49)

R01 Cardiac murmurs and other cardiac sounds

R01.1 Cardiac murmur, unspecified
Add Systolic murmur NOS

Symptoms and signs involving the digestive system and abdomen (R10-R19)

Revise Excludes 1: ~~signs and symptoms involving the urinary system (R30-R39)~~
Add Excludes 2: signs and symptoms involving the urinary system (R30-R39)

Symptoms and signs involving cognition, perception, emotional state and behavior (R40-R46)

Revise Excludes1: ~~intestinal obstruction (K56.-)~~
Revise ~~symptoms and signs constituting part of a pattern of mental disorder(F01F99)~~

Add Excludes2: intestinal obstruction (K56.-)
Add symptoms and signs constituting part of a pattern of mental disorder (F01-F99)

T80.6 Other serum reactions
Revise Excludes2: serum hepatitis ~~(B16.-)~~ (B16-B19)

Transport accidents (V00-V99)
Revise Note: Definitions ~~of~~ related to transport vehicles:

V47 Car occupant injured in collision with fixed or stationary object
Delete ~~V47.01 Driver of sport utility vehicle injured in collision with fixed or stationary object in nontraffic accident~~

V47.1 Car passenger injured in collision with fixed or stationary object in nontraffic accident
Delete ~~V47.11Passenger of sport utility vehicle injured in collision with fixed or stationary object in nontraffic accident~~

V47.3 Unspecified car occupant injured in collision with fixed or stationary object in nontraffic accident
Delete ~~V47.31 Unspecified occupant of sport utility vehicle injured in collision with fixed or stationary object in nontraffic accident~~

V47.5 Car driver injured in collision with fixed or stationary object in traffic accident
Delete ~~V47.51 Driver of sport utility vehicle injured in collision with fixed or stationary object in traffic accident~~

V47.6 Car passenger injured in collision with fixed or stationary object in traffic accident
Delete ~~V47.61 Passenger of sport utility vehicle injured in collision with fixed or stationary object in traffic accident~~

V47.9 Unspecified car occupant injured in collision with fixed or stationary object in traffic accident
Delete ~~V47.91 Unspecified occupant of sport utility vehicle injured in collision with fixed or stationary object in traffic accident~~

Revise Assault (X92-~~Y08~~ Y09)

Misadventures to patients during surgical and medical care (Y62-Y69)

Delete ~~Excludes2: surgical and medical procedures as the cause of abnormal reaction of the patient, without mention ofmisadventure at the time of the procedure (Y83-Y84)~~

Add Excludes1: surgical and medical procedures as the cause of abnormal reaction of the patient, without mention of misadventure at the time of the procedure (Y83-Y84)

Medical devices associated with adverse incidents in diagnostic and therapeutic use (Y70-Y82)

Delete ~~Excludes1: misadventure to patients during surgical and medical care, classifiable to (Y62-Y69)~~
~~later complications following use of medical devices without breakdown or malfunctioning of device (Y83-Y84)~~

Add Excludes2: misadventure to patients during surgical and medical care, classifiable to (Y62-Y69)
later complications following use of medical devices without breakdown or malfunctioning of device (Y83-Y84)

Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure (Y83-Y84)

Add Excludes2: breakdown or malfunctioning of medical device (during procedure) (after implantation) (ongoing use) (Y70-Y82)

Z04 Encounter for gynecological examination

Z01.41 Encounter for routine gynecological examination
Z01.41 Encounter for gynecological examination (general) (routine) with abnormal findings
Add Use additional code to identify abnormal findings

Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings
Delete ~~Use additional code to identify abnormal findings~~

Z12.4 Encounter for screening for malignant neoplasm of cervix

Revise Excludes1: ~~encounter for screening for human papillomavirus (Z11.51)~~

Add Excludes2: encounter for screening for human papillomavirus (Z11.51)

Z3A Weeks of gestation

Revise Use additional code: Codes from category Z3A are for use, only on the maternal record, to indicate the weeks of gestation of the pregnancy <u>if applicable</u>.

Z79 Long term (current) drug therapy

Z79.8 Other long term (current) drug therapy

Z79.89 Other long term (current) drug therapy

Revise Excludes1: methodone use NOS ~~(F11.2-)~~ (F11.9-)

Z99.2 Dependence on renal dialysis

Delete ~~Excludes1: noncompliance with renal dialysis (Z91.15)~~

Add Excludes2: noncompliance with renal dialysis (Z91.15)

ICD-10-CM INDEX OF DISEASES - PROPOSED ADDENDA
All proposed effective October 1, 2016

	Anemia
	- in (due to) (with)
Delete	- - ~~failure, kidney (renal) D63.1~~
	Angina pectoris
Revise	-Stable angina ~~I20.9~~ I20.8
	Complication (s) (from) (of)
	- coronary artery (bypass) graft
Revise	- - specified type NEC ~~T82.897~~ T82.898
	- vaccination T88.1
Revise	- - myelitis ~~G04.89~~ G04.02
	Diabetes, diabetic (mellitus) (sugar)
	-with
Add	-gastroparalysis E11.43
	- due to drug or chemical E09.9
	- - with
Add	---gastroparalysis E09.43
	- due to underlying condition E08.9
	- - with
Add	---gastroparalysis E08.43
	- - with
Add	---gastroparalysis E13.43
	- type 1 E10.9
	- - with
Add	---gastroparalysis
	- type 2
	--with
Add	---gastroparalysis E11.43
Add	--uncontrolled E11.65
	Disorder
Revise	- attention-deficit without hyperactivity (adolescent) (adult) (child) ~~F90.0~~ F98.8
Revise	- dysmorphic body ~~F45.~~1 F45.22
	Dissection
	- artery
Add	--precerebral congenital (nonruptured)

	Ear - see also condition
Revise	- tropical ~~B36.8~~ NEC B36.9 [H62.40]
Add	- - in
Add	- - - aspergillosis B44.89
Add	- - - candidiasis B37.84
Add	- - - moniliasis B37.84
Delete	Enteritis (acute) (diarrheal) (hemorrhagic) (noninfective) (~~septic~~) K52.9
	Fracture, pathological (pathologic) M84.40- see also Fracture, traumatic
	-due to
Revise	--osteoporosis ~~M80.80~~ M80.00
	Hypopituitarism (juvenile)
Revise	- postpartum O99.285, E23.0
	Laennec's cirrhosis ~~K74.69~~ K70.30
Add	- with ascites K70.31
	- alcoholic K70.30
	- - with ascities K70.31
Add	- nonalcoholic K74.69
	Meningitis
Revise	- pneumococcal streptococcus pneumoniae G00.1
Add	- Streptococcal pneumoniae G00.1
	Meningoencephalitis
	- in (due to)
Revise	- - Hemophilus influenzae (H .influenzae) ~~G04.2~~ G00.0
Revise	- influenzal (H. influenzae) ~~G04.2~~ G00.0
Revise	Methadone use ~~F11.20~~ - see Use, opioid
	Morbid (severe) obesity with alveolar hypoventilation
Add	- Obesity hypoventilation syndrome (OHS) E66.2
	Mycosis, mycotic
Revise	- ear ~~B36.8~~ B36.9
Add	- - in
Add	- - - aspergillosis B44.89
Add	- - - candidiasis B37.84
Add	- - - moniliasis B37.84
	Necrosis, necrotic
Revise	- pituitary (gland) ~~(postpartum) (Sheehan)~~ E23.0
Add	- - postpartum O99.285, E23.0

Add - - Sheehan O99.285, E23.0

Newborn (infant) (liveborn) (singleton)
Revise - apnea ~~P28.3~~ NEC P28.4
- - primary P28.3
- - obstructive P28.4
Add - - sleep (central) (obstructive) (primary) P28.3
Delete ~~- - specified P28.4~~

Nontraumatic subarachnoid hemorrhage from unspecified intracranial artery
Revise - ruptured cerebral aneurysm I60.7

Obesity E66.9
- with alveolar hyperventilation E66.2

Revise Osteomyelofibrosis ~~D75.89~~ D47.4

Otitis (acute)
-ear
- externa
- - in (due to)
Revise - - - mycotic NEC B36.9
- - mycotic
Add - - in
Add - - - aspergillosis B44.89
Add - - - candidiasis B37.84
Add - - - moniliasis B37.84
Revise - - tropical ~~B36.8~~ NEC B36.9 [H62.40]
Add - - in
Add - - - aspergillosis B44.89
Add - - - candidiasis B37.84
Add - - - moniliasis B37.84

Peritonitis (adhesive) (bacterial) (fibrinous) (hemorrhagic) (idiopathic) (localized) (perforative) (primary) (with adhesions)
(with effusion) K65.9
- with or following
Revise - - appendicitis ~~K35.2~~ K35.3

Reaction
-toxic, to local anesthesia ~~T81.89~~ T88.59

Strabismus
Revise - cyclotropia ~~H50.1~~ H50.41

Terrorism (involving)
-hot substances ~~Y38.5X~~ Y38.3X

Tobacco (nicotine)
Add - abuse – see Tobacco, use
- use Z72.0
Add --history Z87.891

Urgency
Revise - urinary ~~N39.41~~ R39.15

Use (of)
- alcohol F10.99
Add - - with intoxication F10.929
Revise - methadone ~~F11.20~~ – see Use, opioid

ICD-10-CM Table of Drugs and Chemicals

T38.0 Poisoning by, adverse effect of and underdosing of glucocorticoids and synthetic analogues
Excludes1: glucocorticoids, topically used (T49.-)

Delete Hydrocortisone (derivatives) ~~T49.0X1 T49.0X2 T49.0X3 T49.0X4 T49.0X5 T49.0X6~~

Add Hydrocortisone (derivatives) T38.0X1 T38.0X2 T38.0X3 T38.0X4 T38.0X5 T38.0X6

ICD-10-CM External Cause of Injuries Index

Accident (to)

- transport

Revise - - motor vehicle NEC occupant (traffic) ~~V86.39~~ V89.2
Delete ~~- - - driver V86.09~~
Delete ~~- - - hanger-on V86.29~~
Revise - - - nontraffic ~~V86.99~~ V89.0
Delete ~~- - - - driver V86.59~~
Delete ~~- - - - hanger-on V86.79~~
Delete ~~- - - - passenger V86.69~~
Delete ~~- - - passenger V86.19~~
Delete ~~- - - while boarding~~
Revise - - sport utility vehicle occupant – ~~see also Accident, transport, car occupant~~ – see Accident transport, van occupant
Delete ~~- - - collision (with)~~
Delete ~~- - - - stationary object (traffic) V47.91~~
Delete ~~- - - driver~~
Delete ~~- - - - collision (with)~~
Delete ~~- - - - - stationary object (traffic) V47.51~~
Delete ~~- - - - - nontraffic V47.01~~
Delete ~~- - - passenger~~
Delete ~~- - - - collision (with)~~
Delete ~~- - - - - stationary object (traffic) V47.61~~
Delete ~~- - - - - nontraffic V47.11~~