CENTERS FOR DISEASE CONTROL AND PREVENTION

ICD-10 Coordination and Maintenance Committee Meeting
September 15-16, 2026
ICD-10-CM Diagnosis Agenda

Register in advance for this webinar: https://cdc.zoomgov.com/webinar/register/WN_18C-Xz4MROugqMEWCew6YA

Welcome and announcements
Dr. Mary Stanfill
Co-Chair, ICD-10 Coordination and Maintenance Committee

Diagnosis Topics:

Contents

September 15, 2026, ICD-10 C & M Diagnosis

Order of presentation Day 1

*Please dial in 45 mins before the topic of interest in the event that the meeting is ahead of schedule, presentation times are subject to change

Topic*	Presenter
Opening Remarks and Welcome, CDC, Diagnosis Day 1 **Time: 9:05-9:10 AM ET**	Mady Hue Mary Stanfill
Topic: Amyloid-related imaging abnormalities (ARIA) **Time: 9:10 AM – 9:25 AM**	David Berglund Danielle Abraham
Topic: Biomarkers Barrett's and Esophageal Cancer **Time: 9:25 AM – 9:40 AM**	David Berglund Felice H. Schnoll-Sussman
Topic: Electric shock drowning (ESD) **Time: 9:40 AM – 9:55 AM**	Traci Ramirez Nicole King
Topic: Extreme Immaturity of Newborn **Time: 9:55 AM – 10:10 AM**	Cheryl Bullock David Kanter
Topic: Encounter for Safety Counseling in the Home **Time: 10:10 AM – 10:25 AM**	Cheryl Bullock Jeff Linzer
Topic: Diabetic foot ulcer **Time: 10:25 AM – 10:40 AM**	Shannon McConnell-Lamptey Caroline Fife
Topic: Limbal stem cell deficiency **Time: 10:40 AM – 10:55 AM**	Shannon McConnell-Lamptey Albert Cheung
Topic: Adverse Effects of Kratom and Related Alkaloids **Time: 10:55 AM – 11:10 AM**	Desiree Abrams Hilary Tesluck Andrew Kolodny - panelist only
Topic: Floppy Eyelid Syndrome - **Time: 11:10 AM – 11:25 AM**	Desiree Abrams Anne Barmettler
Topic: Segmental vitiligo **Time: 11:25 AM – 11:40 AM**	Shannon McConnell-Lamptey Andrea Zaenglein, MD

Topic*	Presenter
Topic: Reactive Infectious Mucocutaneous Eruption **Time: 11:40 AM – 11:55 AM**	Shannon McConnell-Lamptey Reid Oldenburg
Topic: Heart Failure with Improved Ejection Fraction **Time: 11:55 AM – 12:10 PM**	David Berglund Elizabeth Aguirre
Topic: Neonatal Supraventricular Tachycardia` **Time: 12:10 PM – 12:25 PM**	Cheryl Bullock
LUNCH BREAK	12:30-1:30

Topic*	Presenter
Topic: Genitourinary Syndrome of Menopause (GSM) **Time: 1:30 PM – 1:45 PM**	Traci Ramirez Jason Cruff
Topic: Refractory herpes simplex virus (HSV) **Time: 1:45 PM – 2:00 PM**	Traci Ramirez Steven Rizk
Topic: Keratoconus suspect **Time: 2:00 PM – 2:15 PM**	Shannon McConnell-Lamptey Marjan Farid
Topic: Organizing Principles for Classification of Ultra-rare and Genetic Conditions **Time: 2:15 PM – 2:45 PM**	Mary Stanfill
Topic: Genetic Neurodevelopmental Disorders KdVS and OCNDS **Time: 2:45 PM – 3:00 PM**	David Berglund
Topic: Cardiogenic Shock Staging **Time: 3:00 PM – 3:15 PM**	David Berglund
Topic: Heart Failure Stage A and Stage B **Time: 3:15 PM – 3:30PM**	David Berglund
Topic: Carotid Web **Time: 3:30 PM – 3:45 PM**	David Berglund
Topic: Dysphotopsia **Time: 3:45 PM – 4:00 PM**	Shannon McConnell-Lamptey

Topic*	Presenter
Topic: Progressive myopia **Time: 4:00 PM – 4:15 PM**	Shannon McConnell-Lamptey Michael Repka
Topic: Macular telangiectasia **Time: 4:15 PM – 4:30 PM**	Shannon McConnell-Lamptey Michael Repka
Topic: Addenda **Time: 4:30 PM – 4:45 PM**	Traci Ramirez

September 16, 2026, ICD-10 C & M Diagnosis

Order of presentation Day 2

*Please dial in 45 mins before the topic of interest in the event that the meeting is ahead of schedule, presentation times are subject to change

Topic*	Presenter
Opening Remarks and Welcome, CDC, Diagnosis Day 1 **Time: 9:05-9:10 AM ET**	Mary Stanfill
Topic: Chemotherapy-Induced Alopecia (CIA) and Permanent Chemotherapy-Induced Alopecia (pCIA)] **Time: 9:10 AM – 9:25 AM**	Traci Ramirez Elizabeth Kiracofe Airia Comprehensive Dermatology
Topic: Presence of continuous glucose monitoring device **Time: 9:25 AM – 9:40 AM**	Traci Ramirez
Topic: Progressive Pulmonary Fibrosis **Time: 9:40 AM – 9:55 AM**	David Berglund Amy L. Olson
Topic: Tenosynovial Giant Cell Tumor **Time: 9:55 AM – 10:10 AM**	Cheryl Bullock Sydney Stern Alysia Kemp (panelist)
Topic: Keloid or hypertrophic scars **Time: 10:10 AM – 10:25 AM**	Shannon McConnell-Lamptey Donald Glass
Topic: Recurrent respiratory papillomatosis **Time: 10:25 AM – 10:40 AM**	Shannon McConnell-Lamptey Clint Allen
Topic: Titanium Dioxide, Iron Oxide Exposure **Time: 10:40 AM – 10:55 AM**	Desiree Abrams Laree LaPierre
Topic: Hexane and N-Butyl Acetate Exposure **Time: 10:55 AM – 11:10 AM**	Desiree Abrams Laree LaPierre
Topic: Spasticity **Time: 11:10 AM – 11:25 AM**	Cheryl Bullock Lauren Shapiro Carolyn Millett (panelist only)
Topic: Acute posterior vitreous detachment **Time: 11:25 AM – 11:40 AM**	Shannon McConnell-Lamptey Geoffrey G. Emerson

Topic*	Presenter
Topic: Doxy PEP **Time: 11:40 AM – 11:55 AM**	Shannon McConnell-Lamptey Laura Quilter
Topic: Degloving injury **Time: 11:55 AM – 12:10 PM**	Shannon McConnell-Lamptey
Topic: Adverse Childhood Experiences/Toxic Stress **Time: 12:10 PM – 12:25 PM**	Traci Ramirez Sarah DeSilvey Nadine Butke Harris panelist only
LUNCH BREAK	12:30-1:30
Topic*	Presenter
Topic: Laryngopharyngeal reflux disease **Time: 1:30 PM – 1:45 PM**	Shannon McConnell-Lamptey Inna Husain
Topic: Sepsis **Time: 1:45 PM – 2:15 PM**	David Berglund

ICD-10 TIMELINE

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

September 15-16, 2026	The diagnosis code portion of the September 2026 ICD-10 Coordination and Maintenance Committee Meeting will be fully virtual by Zoom and dial-in. Those who wish to attend must participate via Zoom Webinar or by dialing in. The procedure code topics will be open for public comment. **Procedure code topics and related materials–** https://www.cms.gov/medicare/coding-billing/icd-10-codes/icd-10-coordination-maintenance-committee-materials
September 2026	Recordings and slide presentations of the diagnosis code portion of the September 15-16, 2026 ICD-10 Coordination and Maintenance Committee Meeting will be posted on the following web page: **Diagnosis code topics and related materials–** https://www.cdc.gov/nchs/icd/icd-10-maintenance/meetings.html
October 1, 2026	New and revised ICD-10-CM and ICD-10-PCS codes go into effect along with MS-DRG changes. Final addendum available on web pages as follows: **Diagnosis addendum –** https://www.cdc.gov/nchs/icd/icd-10-cm/files.html **Procedure addendum –** https://www.cms.gov/medicare/coding-billing/icd-10-codes
October 16, 2026	**Deadline for receipt of public comments on proposed new codes discussed at the September 15-16, 2026 ICD-10 Coordination and Maintenance Committee Update being considered for implementation on April 1, 2027.**
November 2026	Any new ICD-10 codes that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2027 will be posted on the following websites: https://www.cdc.gov/nchs/icd/icd-10-cm/files.html https://www.cms.gov/medicare/coding-billing/icd-10-codes

November 13, 2026	**Deadline for receipt of public comments on proposed new codes and revisions presented at the September 15-16, 2026 ICD-10 Coordination and Maintenance Committee Meeting being considered for implementation on October 1, 2027.**
December 4, 2026	**Deadline for requestors: Those members of the public requesting that topics be considered for the March 16-17, 2027 ICD-10 Coordination and Maintenance Committee Meeting must have their requests submitted to CMS for procedures and NCHS for diagnoses.** **Procedure code requests should be directed to CMS at:** https://mearis.cms.gov **Diagnosis code requests should be directed to NCHS at:** nchsicd10cm@cdc.gov Requestors should indicate if they are submitting their code request for consideration for an October 1, 2027 implementation date, an April 1, 2028 implementation date, or an October 1, 2028 implementation date. **The ICD-10 Coordination and Maintenance Committee may not be able to consider all requests received for the next Committee code update and will determine if it would be appropriate to postpone consideration of any code requests to a future time. The Committee will make efforts to accommodate the requested implementation date for each request submitted, however, the Committee will determine which requests will be presented for consideration at the March 16-17, 2027 meeting for an October 1, 2027 implementation date, an April 1, 2028 implementation date, or an October 1, 2028 implementation date.** **In addition, requestors indicate whether they have submitted or intend to submit a New Technology Add-on Payment (NTAP) policy application related to the ICD-10-CM diagnosis code request or the ICD-10-PCS procedure code request. If an NTAP application is not submitted as indicated or is withdrawn, the Committee will determine if it would be appropriate to postpone consideration of the code request to a future time.**
January 2027	Federal Register notice for the March 16-17, 2027 ICD-10 Coordination and Maintenance Committee Meeting will be published. This will include the tentative list of code topics.

February 2027	Tentative list of topics for the procedure code portion of the Spring 2027 ICD-10 Coordination and Maintenance Committee Code Update posted on CMS webpage at: https://www.cms.gov/medicare/coding-billing/icd-10-codes/icd-10-coordination-maintenance-committee-materials Tentative agenda for the diagnosis portion of the March 16-17, 2027 ICD-10 Coordination and Maintenance Committee Meeting posted on NCHS homepage at: https://www.cdc.gov/nchs/icd/icd-10-maintenance/meetings.html
February 1, 2027	ICD-10 MS-DRG Grouper software and related materials posted on CMS webpage at: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software
February 1, 2027	Any updates to the ICD-10-CM and ICD-10-PCS Coding Guidelines will be posted on the following websites: https://www.cdc.gov/nchs/icd/icd-10-cm/files.html https://www.cms.gov/medicare/coding-billing/icd-10-codes
February 1, 2027	All ICD-10-CM and ICD-10-PCS code update files (includes April 1 update and full files from prior October 1) will be posted on the following websites: https://www.cdc.gov/nchs/icd/icd-10-cm/files.html https://www.cms.gov/medicare/coding-billing/icd-10-codes
March 16-17, 2027	The diagnosis code portion of the March 2027 ICD-10 Coordination and Maintenance Committee Meeting will be fully virtual by Zoom and dial-in. Those who wish to attend must participate via Zoom Webinar or by dialing in. The procedure code topics will be open for public comment. **Procedure code topics and related materials–** https://www.cms.gov/medicare/coding-billing/icd-10-codes/icd-10-coordination-maintenance-committee-materials
March 2027	Recordings and slide presentations of the diagnosis code portion of the March 16-17, 2027 ICD-10 Coordination and Maintenance Committee Meeting will be posted on the following web page:

	Diagnosis code topics and related materials– https://www.cdc.gov/nchs/icd/icd-10-maintenance/meetings.html
April 1, 2027	Any new or revised ICD-10 codes will be implemented on April 1, 2027.
April 16, 2027	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the March 16-17, 2027 ICD-10 Coordination and Maintenance Committee Meeting being considered for implementation on October 1, 2027**.
April 2027	Notice of Proposed Rulemaking to be published in the Federal Register as mandated by the Omnibus Budget Reconciliation Act of 1986, Public Law 99-509 (Pub. L. 99-509). This notice will include references to the FY 2028 ICD-10-CM diagnosis and ICD-10-PCS procedure codes finalized to date. It will also include proposed revisions to the MS-DRG system based on ICD-10-CM/PCS codes on which the public may comment. The proposed rule can be accessed at: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps.
May 14, 2027	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the March 16-17, 2027 ICD-10 Coordination and Maintenance Committee Meeting being considered for implementation on April 1, 2028.** **Deadline for receipt of public comments on proposed new diagnosis codes and revisions discussed at the March 16-17, 2027 ICD-10 Coordination and Maintenance Committee Meeting being considered for implementation on October 1, 2028**.
June 2027	Final addenda posted on web pages as follows: **Diagnosis addendum -** https://www.cdc.gov/nchs/icd/icd-10-cm/files.html **Procedure addendum -** https://www.cms.gov/medicare/coding-billing/icd-10-codes
June 5, 2027	**Deadline for requestors: Those members of the public requesting that topics be discussed at the September 7-8, 2027 ICD-10 Coordination and Maintenance Committee Meeting must have their requests submitted to CMS for procedures and NCHS for diagnoses.** **Procedure code requests should be directed to CMS at:** https://mearis.cms.gov

Diagnosis code requests should be directed to NCHS at:
nchsicd10cm@cdc.gov

Requestors should indicate if they are submitting their code request for consideration for an April 1, 2028 implementation date or an October 1, 2028 implementation date.

The ICD-10 Coordination and Maintenance Committee may not be able to consider all requests received for the next Committee code update and will determine if it would be appropriate to postpone consideration of any code requests to a future time. The Committee will make efforts to accommodate the requested implementation date for each request submitted, however, the Committee will determine which requests will be presented for consideration at the September 7-8, 2027 meeting for an April 1, 2028 implementation date, or an October 1, 2028 implementation date.

In addition, requestors indicate whether they have submitted or intend to submit a New Technology Add-on Payment (NTAP) policy application related to the ICD-10-CM diagnosis code request or the ICD-10-PCS procedure code request. If an NTAP application is not submitted as indicated or is withdrawn, the Committee will determine if it would be appropriate to postpone consideration of the code request to a future time.

July 2027 — Federal Register notice for the September 7-8, 2027 ICD-10 Coordination and Maintenance Committee Meeting will be published. This will include the tentative list of topics.

August 1, 2027 — Hospital Inpatient Prospective Payment System final rule expected to be published in the Federal Register as mandated by Pub. L. 99-509. This rule will also include links to all the final codes to be implemented on October 1, 2027.

This rule can be accessed at:
https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps

August 2027 — Tentative list of topics for the procedure portion of the Fall 2027 ICD-10 Coordination and Maintenance Committee Code Update will be posted on the CMS webpage at –
https://www.cms.gov/medicare/coding-billing/icd-10-codes/icd-10-coordination-maintenance-committee-materials

	Tentative agenda for the diagnosis portion of the September 7-8, 2027 ICD-10 Coordination and Maintenance Committee Meeting will be posted on the NCHS webpage at – https://www.cdc.gov/nchs/icd/icd-10-maintenance/meetings.html
September 7-8, 2027	The diagnosis code portion of the September 2027 ICD-10 Coordination and Maintenance Committee Meeting will be fully virtual by Zoom and dial-in. Those who wish to attend must participate via Zoom Webinar or by dialing in. The procedure code topics will be open for public comment. **Procedure code topics and related materials–** https://www.cms.gov/medicare/coding-billing/icd-10-codes/icd-10-coordination-maintenance-committee-materials
September 2027	Recordings and slide presentations of the diagnosis code portion of the September 7-8, 2027 ICD-10 Coordination and Maintenance Committee Meeting will be posted on the following web page: **Diagnosis code topics and related materials–** https://www.cdc.gov/nchs/icd/icd-10-maintenance/meetings.html
October 1, 2027	New and revised ICD-10-CM and ICD-10-PCS codes go into effect along with MS-DRG changes. Final addendum available on web pages as follows: **Diagnosis addendum –** https://www.cdc.gov/nchs/icd/icd-10-cm/files.html **Procedure addendum –** https://www.cms.gov/medicare/coding-billing/icd-10-codes

Contact Information
Mailing address:

National Center for Health Statistics
ICD-10-CM Coordination and Maintenance Committee
3311 Toledo Road
Hyattsville, Maryland 20782

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

Mary Stanfill, DHI	(301) 310-9530
Desiree Abrams	(301) 458-4384
David Berglund, MD	(301) 458-4095
Cheryl Bullock	(301) 458-4297
Shannon McConnell-Lamptey	(301) 458-4612
Traci Ramirez	(301) 458-4454

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 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.

Acute posterior vitreous detachment

PVD is a natural, usually age-related process in which the vitreous gel separates from the retina, the light-sensing layer at the back of the eye. Symptoms typically include sudden onset flashes and floaters. While most PVDs are ultimately benign, new-onset acute PVD carries significant short-term risk, including retinal tears, retinal detachment.

A comprehensive dilated retinal examination with scleral depression—or imaging if the retina cannot be visualized—followed by a re-examination within 8 weeks, is the standard of care when acute symptoms first appear. Monitoring during this acute stage allows early detection and treatment of complications, reducing the risk of permanent vision loss.

Distinguishing the acute phase of PVD is clinically critical. It is during this initial onset window that sight-threatening complications are most likely to occur, and when urgent evaluation by a retina specialist is needed. Diagnosis codes that capture the new-onset acute stage of this condition would enable more accurate surveillance, facilitate quality measurement, and support evidence-based care.

New-onset acute PVD represents early disease stages with unique risks and management needs. Peer-reviewed studies indicate that 8–10% of patients with acute symptomatic PVD have a concurrent retinal tear or detachment at presentation, and a measurable proportion experience delayed tears over subsequent months.

Modern imaging technologies, such as optical coherence tomography (OCT) and widefield fundus photography, also allow clinicians to distinguish acute or partial PVD from chronic or complete PVD.

The American Society of Retina Specialists is requesting the following tabular modifications to distinguish acute from chronic disease states, enhance surveillance of sight-threatening complications, and accurate quality reporting for CMS quality measures.

References:
American Academy of Ophthalmology Retina/Vitreous Preferred Practice Pattern Panel. Preferred Practice Pattern® Guidelines. Posterior Vitreous Detachment, Retinal Breaks, and Lattice Degeneration PPP 2024. San Francisco, CA: American Academy of Ophthalmology; 2025. Available at: www.aao.org/ppp.

American Society of Retina Specialists. Retina health series: Posterior vitreous detachment. Available at: https://www.asrs.org/content/documents/fact_sheet_1_posterior_vitreous_detachment_new. pdf

TABULAR MODIFICATIONS

H43 Disorders of vitreous body
H43.8 Other disorders of vitreous body

Revise

Excludes~~1~~2: proliferative vitreo-retinopathy with retinal detachment (H33.4-)
Excludes2: vitreous abscess (H44.02-)

New sub-subcategory	H43.83	Acute posterior vitreous detachment	
Add		New onset acute posterior vitreous detachment	
New code		H43.831	Acute posterior vitreous detachment, right eye
New code		H43.832	Acute posterior vitreous detachment, left eye
New code		H43.833	Acute posterior vitreous detachment, bilateral
New code		H43.839	Acute posterior vitreous detachment, unspecified eye
New sub-subcategory	H43.84	Chronic posterior vitreous detachment	
New code		H43.841	Chronic posterior vitreous detachment, right eye
New code		H43.842	Chronic posterior vitreous detachment, left eye
New code		H43.843	Chronic posterior vitreous detachment, bilateral
New code		H43.849	Chronic posterior vitreous detachment, unspecified eye

Adverse Childhood Experiences

This proposal represents a Gravity Project ICD-10-CM submission with terms and codes from the project's consensus, evidence-based analysis of adverse childhood experiences (ACEs). This proposal, revised slightly from a prior version presented at the September 2025 ICD10 Coordination and Maintenance Meeting, aims to support that there are clear paths to documenting each of these core concerns in both current documentation for children toward identification and possible risk mitigation and historical documentation for adults toward understanding and treatment.

The role of ACEs in poor health outcomes are well-documented in the literature. Based on the bedrock of many decades of study, approaches to addressing ACEs are woven into standardized national, state, and clinical efforts. However, to date, there has been insufficient terminology to document the core ten categories of adverse childhood experiences and risk of toxic stress physiology for the purposes of clinical documentation and surveillance.

The foundational Kaiser Permanente and Center for Disease Control Adverse Childhood Experiences study identified ten primary experiences that have the potential to contribute to the development of toxic stress physiology. There are ten categories that are identified, addressed, and studied over time: physical, emotional, and sexual abuse, physical and emotional neglect, and the household challenges of parental separation or divorce, household member mental health issues, household member substance use issues, household member incarceration, and violence and abuse of household members.

This proposal has been revised to incorporate additional consensus feedback. Revisions include edits to the title to reflect the sole focus of adverse childhood experiences and edits to household concepts - changing "household challenge" to "household stressor" - because "stressor" is easier to understand and recognize. In addition, risk stratification elements were removed in response to concern that there is conflicting evidence on the benefits of risk stratification, and concerns about setting a precedent for an influx of additional risk stratification concepts in other domains.

The American Academy of Pediatrics has reviewed and supports the proposal.

References:
https://www.cdc.gov/aces/about/index.html

TABULAR MODIFICATIONS

Z62 Problems related to upbringing
Z62.8 Other specified problems related to upbringing

New sub-subcategory	Z62.84 Personal history of household stressor in childhood
New code	Z62.840 Personal history of household stressor in childhood, parental separation or divorce

New code Z62.841 Personal history of household stressor in childhood, violence or abuse of household member

New code Z62.842 Personal history of household stressor in childhood, household member mental health issue

New code Z62.843 Personal history of household stressor in childhood, household member substance use

New code Z62.844 Personal history of household stressor in childhood, household member incarceration

Z63 Other problems related to primary support group, including family circumstances

Z63.3 Absence of family member

New code Z63.33 Absence of parent or caregiver due to incarceration

New subcategory Z63.5 Disruption of family by separation and divorce

New code Z63.50 Disruption of family by separation or divorce, unspecified

New code Z63.51 Disruption of family by separation or divorce, absence of parent or caregiver

New code Z63.59 Other disruption of family by separation or divorce

Z63.7 Other stressful life events affecting family and household

New sub-subcategory Z63.73 Household member stressor

New code Z63.730 Living in household with violence or abuse of household member

New code Z63.731 Living with a household member with a mental health issue

New code Z63.732 Living with household member with substance abuse

New code Z63.733 Household member incarceration

New code Z63.738 Other household member stressor

New code Z63.739 Household member stressor, unspecified

Adverse Effects of Kratom and Related Alkaloids (Mitragyna speciosa)

Kratom refers to *Mitragyna speciosa*, a tree native to Southeast Asia, and to products derived from its leaves that are marketed as herbal supplements. It contains several alkaloids, particularly mitragynine and 7-hydroxymitragynine, which exhibit opioid-like and other receptor activity. Emerging clinical literature, poison-center surveillance, and pharmacologic evidence have raised concerns regarding adverse effects across multiple organ systems, including neurologic, cardiovascular, endocrine/metabolic, gastrointestinal and renal manifestations.

Reported neurologic findings include seizures (most commonly generalized tonic-clonic seizures), tremors, hallucinations, loss of consciousness, altered mental status, encephalopathic presentations, dizziness, ataxia, weakness, sensory symptoms, and imaging-supported reports of neurotoxicity. Neurologic symptoms may occur during acute intoxication, poisoning, chronic exposure, or withdrawal and are among the most common reasons for emergency evaluation, hospitalization, toxicology consultation, and neurology referral. Cardiovascular findings include tachycardia, hypertension, QTc prolongation, conduction abnormalities, arrhythmias, ventricular fibrillation, and Brugada-pattern electrocardiographic changes.

Endocrine and metabolic findings described in the literature include hyperprolactinemia, secondary hypogonadism, hypothyroidism, weight change, fatigue, hair loss, and dry skin. Gastrointestinal findings include nausea, vomiting, abdominal pain, constipation, and decreased bowel motility. Human evidence regarding kratom-associated bladder or lower urinary tract effects is insufficient. One case report described obstructive uropathy in a patient with kratom dependence and withdrawal but did not establish that kratom caused the obstruction. Renal findings include acute kidney injury, reduced renal function, proteinuria, hematuria, electrolyte abnormalities, flank pain, and edema.

Patients presenting with suspected kratom-related adverse effects are typically adolescents or adults and may report kratom use for pain, mood symptoms, fatigue, self-management of opioid withdrawal, or recreational purposes. Presentations may follow chronic daily use, escalating doses, abrupt cessation, concentrated extracts, or co-ingestion with other substances. The 2026 National Poison Data System report provides more specific current figures: 14,449 reports during 2015–2025, increasing from 258 in 2015 to 3,434 in 2025 (about 1,200%). The report also found that multiple-substance reports were associated with more hospitalizations and serious outcomes.

The current evidence base remains limited and heterogeneous, consisting primarily of case reports, case series, poison-center surveillance, adverse-event reporting, retrospective observational studies, mechanistic investigations, and emerging preclinical data. Common limitations include variable product composition, inconsistent toxicologic confirmation, uncertain dose and duration, concentrated extracts, adulterants, polysubstance exposure, and incomplete exclusion of alternative etiologies. Consequently, the available evidence does not support creation of separate organ-specific kratom disease entities within ICD-10-CM.

Instead, the most appropriate ICD-10-CM approach is a limited revision that preserves documentation of kratom exposure when clinicians identify kratom as a relevant adverse effect, poisoning, or underdosing context while continuing to code the documented clinical manifestations separately. Documentation may also describe intoxication, withdrawal, dependence, harmful use, or use disorder when clinically relevant, with associated manifestations coded in addition to the exposure.

These encounters may be documented in emergency medicine, hospital medicine, primary care, internal medicine, neurology, cardiology, endocrinology, gastroenterology, nephrology, addiction medicine, psychiatry, medical toxicology, and critical care settings. Supporting documentation may include a history of kratom use; exposure to concentrated extracts or alkaloid products; dose, duration, and timing of use; symptom chronology; toxicology findings when available; relevant laboratory, imaging, electrocardiographic, , endocrine, renal, or neurologic findings; co-exposures and concurrent medications; and the clinician's assessment regarding the relevance of kratom exposure after consideration of alternative explanations.

Kratom-associated presentations are not readily identifiable in ICD-10-CM-coded datasets when only the clinical manifestation is coded. As a result, substance-specific information is often lost, limiting the usefulness of coded data for public health surveillance, pharmacovigilance, case identification, claims-based research, utilization review, quality improvement activities, and trend analysis. Such a revision would improve exposure visibility, support surveillance efforts, and maintain compatibility with existing manifestation coding.

The requested revision is intentionally narrow. Rather than establishing new disease categories for individual organ systems or neurologic syndromes, it would preserve the documented exposure within existing ICD-10-CM drug-effect architecture while allowing continued assignment of established manifestation codes. This approach is proportionate to the current evidence base, administratively feasible, and consistent with ICD-10-CM classification principles.

This proposal is submitted by Lisa Frankenfeld and Hilary Tesluck on behalf of the End Kratom Addiction organization.

References:

1. Centers for Medicare & Medicaid Services; National Center for Health Statistics; American Hospital Association; American Health Information Management Association. *ICD-10-CM Official Guidelines for Coding and Reporting, FY 2026*. Updated October 1, 2025. Official guidelines.

2. National Center for Health Statistics. *ICD-10-CM Proposal Process*. Updated April 23, 2026. Proposal process.

3. Turla T, Abele G, Hua M, Paustenbach D. Reported associations between kratom and seizures: a systematic review. *Front Pharmacol*. 2025;16:1632835. doi:10.3389/fphar.2025.1632835. Article.

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TABULAR MODIFICATIONS

T50	Poisoning by, adverse effect of and underdosing of diuretics and other and unspecified drugs, medicaments and biological substances
New subcategory	T50.C Poisoning by, adverse effect of and underdosing of kratom and related alkaloids Poisoning by Mitragyna speciosa Poisoning by Mitragynine Poisoning by kratom alkaloids [7-hydroxymitragynine]
New sub-subcategory	T50.C1 Poisoning by, adverse effect of and underdosing of kratom and related alkaloids
New code	T50.C11 Poisoning by, adverse effect of and underdosing of kratom and related alkaloids, accidental (unintentional)
Add	Poisoning by kratom and related alkaloids NOS
New code	T50.C12 Poisoning by, adverse effect of and underdosing of kratom and related alkaloids, intentional self-harm
New code	T50.C13 Poisoning by, adverse effect of and underdosing of kratom and related alkaloids, assault
New code	T50.C14 Poisoning by, adverse effect of and underdosing of kratom and related alkaloids, undetermined
New code	T50.C15 Adverse effect kratom and related alkaloids
New code	T50.C16 Underdosing of kratom and related alkaloids

Amyloid-Related Imaging Abnormalities

Amyloid-related imaging abnormalities (ARIA) are findings that may be secondary to amyloid beta-directed monoclonal antibody treatment in Alzheimer's Disease (AD). This is a repeat presentation, with prior presentations in September 2024 and September 2025. The Center for Drug Evaluation and Research, U.S. Food and Drug Administration, has proposed new codes for ARIA. This updated proposal has been modified based on previous comments, with fewer codes, certain clinical details for ARIA-hemosiderin deposition (ARIA-H) omitted, and sixth characters rather than seventh proposed.

ARIA is diagnosed based on neuroimaging. It is thought to be the result of reduced vascular integrity due to an inflammatory response and impaired perivascular amyloid beta clearance. ARIA presents in two forms, ARIA-edema/effusion (ARIA-E) and ARIA-H. ARIA-E is the consequence of vascular leakage of proteinaceous fluid and presents as parenchymal vasogenic edema and sulcal effusion in the leptomeningeal/subpial space. ARIA-H is a consequence of blood leakage and deposition of blood degradation products into brain parenchyma and leptomeningeal/subpial space presenting as microhemorrhages and superficial siderosis, respectively.

While similar imaging changes may occur spontaneously in patients with cerebral amyloid angiopathy (CAA), the term ARIA is usually reserved for neuroimaging findings in the context of amyloid beta-directed monoclonal antibody treatment of AD. ARIA may be asymptomatic or associated with a range of neurological findings and symptoms.

The proposed codes for ARIA would allow not only population-based monitoring of this important safety risk in the context of treatment with amyloid beta-directed monoclonal antibodies, but also standardized clinical documentation, real-world evidence generation, and improved patient risk stratification across diverse populations.

Note that modifications to the previous proposal are shown with **bold** text.

TABULAR MODIFICATIONS

	G30	Alzheimer's disease
		Use additional code, if applicable, to identify:
Add		Amyloid-related imaging abnormalities (ARIA) (R90.84-)
	R90	Abnormal findings on diagnostic imaging of central nervous system
		R90.8 Other abnormal findings on diagnostic imaging of central nervous system
New sub-subcategory		**R90.84** Amyloid-related imaging abnormalities [ARIA]
Add		**Code first, if applicable:**
Add		**Alzheimer's disease (G30.-)**
Add		Use additional code, if applicable, for:
Add		adverse effect of immunoglobin (T50.Z15)

Add	**Excludes2:**	**cerebral amyloid angiopathy (I68.0)**
New code	**R90.840**	**Amyloid-related imaging abnormalities with edema/effusion [ARIA-E]**
New code	**R90.841**	**Amyloid-related imaging abnormalities with hemosiderin deposition [ARIA-H]**
New code	**R90.849**	**Amyloid-related imaging abnormalities, unspecified**

Biomarkers for the detection of Barrett's esophagus and esophageal adenocarcinoma

Barrett's esophagus (BE) is a metaplastic condition that is a precursor to, and the most significant risk factor for, development of esophageal adenocarcinoma (EAC).[1] EAC has a 5-year survival of 20%, while endoscopic treatment of BE can eradicate the disease in up to 90% of cases.[2-4] Because the metaplasia–dysplasia–carcinoma sequence in BE is well established, BE is a key target for endoscopic screening and surveillance aimed at early detection and treatment of dysplasia to prevent progression to EAC.[5, 6] Major U.S. gastroenterology societies, including the American College of Gastroenterology (ACG) and American Gastroenterological Association (AGA), recommend screening in high-risk individuals with multiple risk factors, including chronic gastroesophageal reflux disease (GERD), age >50 years, male sex, White race, tobacco use, obesity, and a family history of BE or EAC in a first-degree relative.[7, 8]

Upper endoscopy (EGD) with biopsies has traditionally been the diagnostic gold standard for BE. However, both the ACG and AGA recognize and include in current guidelines the use of non-endoscopic, biomarker-based tests that are easily administered, well tolerated, and feasible in standard office settings as a triage to EGD to improve screening uptake.

Biomarker testing plays a critical role in detecting early molecular-level changes that are associated with BE and EAC, and these tests function as a non-endoscopic, in-office triage prior to diagnostic EGDs. Patients with a positive biomarker result are referred to EGD for direct esophageal visualization and biopsies to obtain histologic confirmation and disease staging. In contrast, patients with negative results are unlikely to have BE or EAC and may defer EGD, with ongoing management of reflux symptoms and risk factors guided by clinical judgment.

Use of biomarker testing in this triage framework has been shown in a large, randomized, controlled study to increase disease detection rates. more than 10-fold.[9] In addition, a study conducted at the Cleveland Veterans Affairs Medical Center demonstrated that a screening strategy using positive biomarker results to determine which patients undergo EGD can detect the same number of cases while requiring 60% fewer endoscopies compared with standard screening approaches.[10] Finally, it has also been demonstrated that use of biomarker-based triage can improve the diagnostic yield of EGD up to 3-fold.[10, 11]

Given the clinical value of biomarkers as a triage tool, positive results should be distinctly identifiable in coding data to accurately document the rationale for subsequent diagnostic evaluation. As BE screening increasingly shifts toward biomarker-based strategies, it will become essential to track test results within the medical record to support high-quality care and ensure clear communication among providers. A specific ICD-10-CM code to denote a positive biomarker test for BE is therefore essential to support patient identification and enable accurate provider reporting.

This proposal is based on a submission from Lucid Diagnostics, a medical diagnostics technology company, with the support of the American Foregut Society (AFS).

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TABULAR MODIFICATIONS

R85 Abnormal findings in specimens from digestive organs and abdominal cavity
R85.8 Other abnormal findings in specimens from digestive organs and abdominal cavity

New Code	R85.83	Esophageal methylated DNA biomarker positive for metaplasia, dysplasia, or neoplasia
Add		Abnormal methylated DNA findings in esophageal cell specimens for intestinal metaplasia, dysplasia, and neoplasia test positive
Add		Elevated level of vimentin (mVIM) and CyclinA1 (mCCNA1)
Add		Excludes1: Barrett’s esophagus (K22.70-K22.719)
Add		benign neoplasm of esophagus (D13.0)
Add		carcinoma in situ of esophagus (D00.1)
Add		gastrointestinal stromal tumor of esophagus (C49.A1)
Add		malignant neoplasm of esophagus (adenocarcinoma and other carcinomas) (C15.3-C15.9)
Add		malignant neoplasm of connective and soft tissue involving esophagus (esophageal sarcomas and other mesenchymal malignancies) (C49.3-C49.4)

Cardiogenic Shock Staging

Cardiogenic shock (CS) is a complex, high-acuity, and hemodynamically heterogeneous state associated with significant morbidity and mortality, with a staging system published in 2022. New specific codes for CS were proposed at the March 2026 ICD-10 Coordination and Maintenance Committee Meeting based on a proposal received from the Society for Cardiovascular Angiography and Interventions (SCAI) with input and support from the American College of Cardiology. Revisions based on previous comments are shown in **bold**.

Traditional definitions of CS in trials and registries relied primarily on hypotension, reduced cardiac output, and signs of end-organ hypoperfusion.[1] However, these definitions oversimplify a dynamic clinical syndrome that exists on a continuum of severity and fail to recognize the well-documented poor outcomes associated with normotensive cardiogenic shock.[2]

Current expert consensus statements from the Society for Cardiovascular Angiography and Interventions (SCAI) recommend classifying CS using a five-stage schema (A–E) that more accurately characterizes severity and prognostic risk.[3–4] SCAI stages B–E have been strongly correlated with in-hospital mortality and are now widely used to guide clinical decision-making, triage, resource allocation, and advanced therapies.

Currently ICD-10-CM has a single code R57.0, Cardiogenic shock, which is used for all levels of CS severity. Since this ranges from early or normotensive CS (SCAI B) to refractory shock (SCAI E), it combines a wide range of severity. Adding specific ICD-10-CM codes for the stages of cardiogenic shock will reflect current clinical practice and consensus-based definitions endorsed by major professional societies, improve diagnostic accuracy and consistency across institutions, and enable researchers and health systems to track outcomes and resource utilization across clinically meaningful CS subgroups. This will also enable better tracking for patients requiring high-complexity care, particularly for those needing escalation to mechanical circulatory support. These codes align with the validated SCAI classification framework and will allow clinicians and coders to accurately represent patient severity in administrative and claims data. Given the widespread clinical adoption and prognostic importance of SCAI cardiogenic shock staging, the addition of stage-specific ICD-10-CM codes is essential to improve diagnostic accuracy and enhance the reliability of national research and quality improvement efforts.

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TABULAR MODIFICATIONS

R57 Shock, not elsewhere classified

R57.0 Cardiogenic shock

Add — Excludes1: Cardiogenic shock, SCAI Stage A (at risk for cardiogenic shock) (R5A.0)

New code — R57.00 Cardiogenic shock, unspecified

New code — R57.01 **Beginning** cardiogenic shock **[**SCAI Stage B**]**
Add — Cardiogenic shock, SCAI Stage B
Add — Society for Cardiovascular Angiography & Interventions cardiogenic shock stage B

New code — R57.02 **Classic** cardiogenic shock **[**SCAI Stage C**]**
Add — Cardiogenic shock, SCAI Stage C
Add — Society for Cardiovascular Angiography & Interventions cardiogenic shock stage C

New code — R57.03 **Deteriorating** cardiogenic shock **[**SCAI Stage D**]**
Add — Cardiogenic shock, SCAI Stage D
Add — Society for Cardiovascular Angiography & Interventions cardiogenic shock stage D

New code — R57.04 **Extremis from** cardiogenic shock **[**SCAI Stage E**]**
Add — Cardiogenic shock, SCAI Stage E
Add — Society for Cardiovascular Angiography & Interventions cardiogenic shock stage E

[Note: The following proposed new category is being proposed to directly follow category R57.]

New Category R5A Other cardiac signs, symptoms, and findings, not elsewhere classified

New code R5A.0 At risk for cardiogenic shock [SCAI Stage A]
Add — Cardiogenic shock, SCAI Stage A
Add — Society for Cardiovascular Angiography & Interventions cardiogenic shock stage A
Add — Code first, if applicable, any current acute specific conditions that convey risk for cardiogenic shock, such as:
Add — acute myocardial infarction (I21.-)
Add — heart failure (I50.-)
Add — Code also, if applicable, any specific history of conditions that convey risk for cardiogenic shock, such as:
Add — old myocardial infarction (I25.2)

New code R5A.8 Other cardiac signs, symptoms, and findings

Carotid Web

This proposal to add specific codes for carotid web is modified from a prior proposal presented at the March 2026 ICD-10 Coordination and Maintenance Committee Meeting based on public comments received. The original proposal was based on a request received from Diogo C. Haussen, MD, Grady Memorial Hospital, Emory University.

Carotid web is characterized by a shelf-like projection into the lumen of the proximal internal carotid artery bulb [1]. It is increasingly recognized as an important cause of ischemic stroke, being recently incorporated into the American Heart Association guidelines for secondary stroke prevention as a discrete cause of stroke [2]. Carotid web related strokes occur particularly in younger patients without traditional atherosclerotic risk factors. These lesions generate flow disruption, with a large area of flow stasis and recirculation and thus subsequent thrombus formation. This can lead to artery-to-artery embolism. Stroke recurrence rates are high, reaching nearly 20% in 2 years [3, 4]. The diagnosis is made by vascular imaging, with CT angiography, MR angiography, or catheter angiography demonstrating the classic shelf-like intraluminal bulb protrusion [5].

Carotid web is underrecognized in clinical practice but is being reported with greater frequency in recent years [6]. In some series, it accounts for up to 20% of recurrent cryptogenic ischemic strokes in young and middle-aged adults [7, 8].

At this time carotid web has been coded to either I77.3, Arterial fibromuscular dysplasia, or to I77.8, Other specified disorders of arteries and arterioles. Code I77.3 is used for all types of fibromuscular dysplasia, including that involving the renal artery, vertebral artery, and mesenteric artery, as well as the carotid artery, among others. Carotid web has been referred to as an atypical variant of fibromuscular dysplasia. In contrast, typical fibromuscular dysplasia has a classic imaging appearance described as a "string of beads," and it does not have a direct association with ischemic stroke in contrast with carotid web [7, 8]. However, renal artery fibromuscular dysplasia has often been related to hypertension, and hypertension can be associated with stroke risk. Clinical consensus at this time is that carotid web "is likely distinct from the clinical syndrome of FMD." [9] Differentiating carotid web from fibromuscular dysplasia with separate ICD-10-CM coding will be of clinical value and epidemiological utility.

A unique ICD-10-CM code for carotid web would improve clinical recognition and enable documentation and tracking, allow for accurate epidemiologic surveillance, facilitate ongoing and future research, and support the collection of standardized data for clinical trials and registries. It would also improve the precision of documentation in support of interventions such as stenting or endarterectomy in patients with this condition [10, 11]. This would also promote improved communication among healthcare providers, researchers, and others, which is critical for improving patient care.

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TABULAR MODIFICATIONS

I77 Other disorders of arteries and arterioles
I77.8 Other specified disorders of arteries and arterioles

New sub-subcategory	I77.83	Carotid web
New code	I77.830	Carotid web, right carotid artery
New code	I77.831	Carotid web, left carotid artery
New code	I77.839	Carotid web, unspecified

INDEX MODIFICATIONS

Web, webbed (congenital)
Add - carotid (artery) I77.839
Add - - left I77.831
Add - - right I77.830

Chemotherapy-Induced Alopecia (CIA) and Persistent Chemotherapy-Induced Alopecia (pCIA)

The National Center for Health Statistics received a proposal for alopecia induced by chemotherapy. Hair loss remains one of the most distressing side effects of chemotherapy, reported by up to 65% of patients undergoing cancer treatment[1]. For many, this alopecia is temporary and reversible, aligning with what would be classified as chemotherapy-induced alopecia (CIA).

However, for a subset of patients, particularly those treated with taxanes or other cytotoxic agents, hair loss may be prolonged or even permanent[2]. This form of hair loss is also known as persistent chemotherapy-induced alopecia (pCIA), some may use the term permanent CIA, but persistent is preferred because some patients may show delayed regrowth or respond to treatments over time. Persistent chemotherapy-induced alopecia results from irreversible damage to the hair follicle[3], a phenomenon that is increasingly documented in medical literature yet inadequately addressed in ICD-10-CM diagnostic coding. Without a way to distinguish pCIA from CIA or other forms of alopecia, providers are limited in their ability to deliver individualized care and advocate for essential support services.

Cancer survivors frequently report that hair loss, especially when persistent (permanent), is among the most psychologically traumatic aspects of their cancer journey[4,5]. This proposal seeks to establish two specific ICD-10-CM diagnostic codes: chemotherapy-induced alopecia (CIA) and persistent chemotherapy-induced alopecia (pCIA). Currently, there are no specific codes within ICD-10-CM to distinguish temporary or persistent hair loss secondary to chemotherapy. The most commonly used codes include L64.0 (Drug-induced androgenic alopecia) and L65.1 Anagen Effluvium fail to adequately capture the distinct etiology, clinical presentation, and psychosocial impact of CIA and pCIA. These gaps in classification have real-world consequences for cancer patients and survivors.

The availability of separate codes for CIA and pCIA would allow for improved data collection, epidemiological tracking, and participation in clinical trials. Understanding the prevalence, duration, and risk factors associated with these conditions is critical for the development of new therapies and patient-centered care models. This clarity is essential for determining the most appropriate course of treatment, planning for long-term follow-up, and referring patients for specialized oncologic, dermatologic and/or psychosocial care. Furthermore, these codes would help health systems better allocate resources, design survivorship programs, and advocate for policies that support quality of life for those affected.

The proposal was reviewed and is supported by the American Academy of Dermatology (AAD).

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TABULAR MODIFICATIONS

L64 Androgenic alopecia
L64.0 Drug-induced androgenic alopecia
Add Excludes1: other specified nonscarring hair loss (L65.8-)

L66 Cicatricial alopecia [scarring hair loss]
Add Excludes1: other specified nonscarring hair loss (L65.8-)

L65 Other nonscarring hair loss
L65.8 Other specified nonscarring hair loss
Add Excludes1:cicatricial alopecia (L66.-)
Add androgenic alopecia (L64.-)

New code L65.81 Chemotherapy-Induced Alopecia (CIA)
Add Reversible chemotherapy hair loss

New code L65.82 Persistent chemotherapy-induced alopecia (pCIA)
Add Irreversible chemotherapy-related alopecia

New code L65.88 Other specified nonscarring hair loss

Degloving injury

Degloving is often associated with high-energy injuries. It occurs when the skin surface is subjected to forces, including torsion, crush, avulsion, or a combination of these. The soft tissues are sheared along single or multiple tissue layers, depending on the severity of the injury. These injuries can involve any part of the body but are most common on the lower limbs and trunk.

Degloving injuries can be open or closed and complete or partial. Open degloving injury may be partial injuries with an attached skin flap that exposes the underlying musculoskeletal structures. In partial degloving injuries the attached skin may or may not be viable. Open degloving injuries often have significant contamination and pose a risk for infection. In a complete open degloving injury, the skin and tissue have been completely detached.

Closed or internal degloving injuries leave the skin intact but still involve the internal shearing of the skin and subcutaneous tissue from the fascia and muscle. This results in significant damage to the lymphatic and vascular systems and creates a space for hematoma and/or fluid collections. Due to internal damage, the intact skin may or may not be viable, leading to skin necrosis.

Currently, there is no unique code in ICD-10-CM for these injuries. Following the American Hospital Association (AHA) Coding Clinic Editorial Advisory Board (EAB) discussion, NCHS is requesting the following tabular modifications to report degloving injuries.

References:

1. Degloving Injuries - StatPearls - NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK557707/
2. Traumatic degloving injuries: a prospective study to assess injury patterns, management, and outcomes at a single center in northern India. https://www.jtraumainj.org/journal/view.php?viewtype=pubreader&number=1270

TABULAR MODIFICATIONS

S49 Other and unspecified injuries of shoulder and upper arm
S49.8 Other specified injuries of shoulder and upper arm
The appropriate 7th character is to be added to each code in subcategory S49.8
A - initial encounter
D - subsequent encounter
S – sequela

S49.80 Other specified injuries of shoulder and upper arm, unspecified arm
S49.81 Other specified injuries of right shoulder and upper arm
S49.82 Other specified injuries of left shoulder and upper arm

New sub-subcategory	S49.83 Partial open degloving injury of shoulder and upper arm
Add	An open degloving injury not identified as partial or complete should be coded to partial
New code	S49.831 Partial open degloving injury of right shoulder and upper arm
New code	S49.832 Partial open degloving injury of left shoulder and upper arm
New code	S49.839 Partial open degloving injury of shoulder and upper arm, unspecified arm
New sub-subcategory	S49.84 Complete open degloving injury of shoulder and upper arm
Add	An open degloving injury not identified as partial or complete should be coded to partial
New code	S49.841 Complete open degloving injury of right shoulder and upper arm
New code	S49.842 Complete open degloving injury of left shoulder and upper arm
New code	S49.849 Complete open degloving injury of shoulder and upper arm, unspecified arm
New sub-subcategory	S49.85 Closed degloving injury of shoulder and upper arm
New code	S49.851 Closed degloving injury of right shoulder and upper arm
New code	S49.852 Closed degloving injury of left shoulder and upper arm
New code	S49.859 Closed degloving injury of shoulder and upper arm, unspecified arm

S59 Other and unspecified injuries of elbow and forearm

S59.8 Other specified injuries of elbow and forearm

The appropriate 7th character is to be added to each code in subcategory S59.8

A - initial encounter

D - subsequent encounter

S – sequela

S59.80 Other specified injuries of elbow
S59.801 Other specified injuries of right elbow
S59.802 Other specified injuries of left elbow
S59.809 Other specified injuries of unspecified elbow

S59.81 Other specified injuries of forearm
S59.811 Other specified injuries right forearm
S59.812 Other specified injuries left forearm
S59.819 Other specified injuries unspecified forearm

New sub-subcategory
S59.82 Partial open degloving injury of elbow
Add An open degloving injury not identified as partial or complete should be coded to partial

New code S59.821 Partial open degloving injury of right elbow
New code S59.822 Partial open degloving injury of left elbow
New code S59.829 Partial open degloving injury of elbow, unspecified arm

New sub-subcategory
S59.83 Complete open degloving injury of elbow
Add An open degloving injury not identified as partial or complete should be coded to partial

New code S59.831 Complete open degloving injury of right elbow
New code S59.832 Complete open degloving injury of left elbow
New code S59.839 Complete open degloving injury of elbow, unspecified arm

New sub-subcategory
S59.84 Closed degloving injury of elbow

New code S59.841 Closed degloving injury of right elbow
New code S59.842 Closed degloving injury of left elbow
New code S59.849 Closed degloving injury of elbow, unspecified arm

New sub-subcategory
S59.85 Partial open degloving injury of forearm
Add An open degloving injury not identified as partial or complete should be coded to partial

New code S59.851 Partial open degloving injury of right forearm
New code S59.852 Partial open degloving injury of left forearm
New code S59.859 Partial open degloving injury of elbow, unspecified forearm

New sub-subcategory
S59.86 Complete open degloving injury of forearm
Add: An open degloving injury not identified as partial or complete should be coded to partial

New code S59.861 Complete open degloving injury of right forearm
New code S59.862 Complete open degloving injury of left forearm
New code S59.869 Complete open degloving injury of elbow, unspecified forearm

New sub-subcategory
S59.87 Closed degloving injury of forearm

New code S59.871 Closed degloving injury of right forearm
New code S59.872 Closed degloving injury of left forearm
New code S59.879 Closed degloving injury of forearm, unspecified arm

S69 Other and unspecified injuries of wrist, hand and finger(s)
The appropriate 7th character is to be added to each code from category S69
A - initial encounter
D - subsequent encounter
S – sequela

S69.8 Other specified injuries of wrist, hand and finger(s)
S69.80 Other specified injuries of unspecified wrist, hand and finger(s)
S69.81 Other specified injuries of right wrist, hand and finger(s)
S69.82 Other specified injuries of left wrist, hand and finger(s)

New sub-subcategory
S69.83 Partial open degloving injury of wrist, hand and finger(s)
Add: An open degloving injury not identified as partial or complete should be coded to partial

New code S69.831 Partial open degloving injury of right wrist, hand and finger(s)
New code S69.832 Partial open degloving injury of left wrist, hand and finger(s)
New code S69.839 Partial open degloving injury of wrist, hand and finger(s), unspecified arm

New sub-subcategory — S69.84 Complete open degloving injury of wrist, hand and finger(s)

Add — An open degloving injury not identified as partial or complete should be coded to partial

New code — S69.841 Complete open degloving injury of right wrist, hand and finger(s)

New code — S69.842 Complete open degloving injury of left wrist, hand and finger(s)

New code — S69.849 Open degloving injury of wrist, hand and finger(s), unspecified arm

New sub-subcategory — S69.85 Closed degloving injury of wrist, hand and finger(s)

New code — S69.851 Closed degloving injury of right wrist, hand and finger(s)

New code — S69.852 Closed degloving injury of left wrist, hand and finger(s)

New code — S69.859 Closed degloving injury of wrist, hand and finger(s), unspecified arm

S79 Other and unspecified injuries of hip and thigh

S79.8 Other specified injuries of hip and thigh

The appropriate 7th character is to be added to each code in subcategory S79.8

A - initial encounter
D - subsequent encounter
S - sequela

S79.81 Other specified injuries of hip
- S79.811 Other specified injuries of right hip
- S79.812 Other specified injuries of left hip
- S79.819 Other specified injuries of unspecified hip

S79.82 Other specified injuries of thigh
- S79.821 Other specified injuries of right thigh
- S79.822 Other specified injuries of left thigh
- S79.829 Other specified injuries of unspecified thigh

New sub-subcategory — S79.83 Partial open degloving injury of hip

Add — An open degloving injury not identified as partial or complete should be coded to partial

New code — S79.831 Partial open degloving injury of right hip

New code — S79.832 Partial open degloving injury of left hip

New code	S79.839 Partial open degloving injury of unspecified hip
New sub-subcategory	S79.84 Complete open degloving injury of hip
Add	An open degloving injury not identified as partial or complete should be coded to partial
New code	S79.831 Complete open degloving injury of right hip
New code	S79.832 Complete open degloving injury of left hip
New code	S79.839 Complete open degloving injury of unspecified hip
New sub-subcategory	S79.85 Closed degloving injury of hip
New code	S79.851 Closed degloving injury of right hip
New code	S79.852 Closed degloving injury of left hip
New code	S79.859 Closed degloving injury of unspecified hip
New sub-subcategory	S79.86 Partial open degloving injury of thigh
Add	An open degloving injury not identified as partial or complete should be coded to partial
New code	S79.861 Partial open degloving injury of right thigh
New code	S79.862 Partial open degloving injury of left thigh
New code	S79.869 Partial open degloving injury of unspecified thigh
New sub-subcategory	S79.87 Complete open degloving injury of thigh
Add	An open degloving injury not identified as partial or complete should be coded to partial
New code	S79.871 Complete open degloving injury of right thigh
New code	S79.872 Complete open degloving injury of left thigh
New code	S79.879 Complete open degloving injury of unspecified thigh
New sub-subcategory	S79.88 Closed degloving injury of thigh
New code	S79.881 Closed degloving injury of right thigh
New code	S79.882 Closed degloving injury of left thigh
New code	S79.889 Closed degloving injury of unspecified thigh

S89 Other and unspecified injuries of lower leg

S89.8 Other specified injuries of lower leg

The appropriate 7th character is to be added to each code in subcategory S89.8

A - initial encounter
D - subsequent encounter
S - sequela

S89.80 Other specified injuries of unspecified lower leg
S89.81 Other specified injuries of right lower leg
S89.82 Other specified injuries of left lower leg

New sub-subcategory — S89.83 Partial open degloving injury of knee
Add — An open degloving injury not identified as partial or complete should be coded to partial

New code — S89.831 Partial open degloving injury of right lower knee
New code — S89.832 Partial open degloving injury of left lower knee
New code — S89.839 Partial open degloving injury of unspecified knee

New sub-subcategory — S89.84 Complete open degloving injury of knee
Add — An open degloving injury not identified as partial or complete should be coded to partial

New code — S89.841 Complete open degloving injury of right lower knee
New code — S89.842 Complete open degloving injury of left lower knee
New code — S89.849 Complete open degloving injury of unspecified knee

New sub-subcategory — S89.85 Closed degloving injury of knee
Add — Morel-Lavallee lesion

New code — S89.851 Complete degloving injury of right knee
New code — S89.852 Complete degloving injury of left knee
New code — S89.859 Complete degloving injury of unspecified knee

New sub-subcategory — S89.86 Partial open degloving injury of lower leg
Add — An open degloving injury not identified as partial or complete should be coded to partial

New code S89.861 Partial open degloving injury of right lower leg
New code S89.862 Partial open degloving injury of left lower leg
New code S89.869 Partial open degloving injury of unspecified lower leg

New sub-subcategory S89.87 Complete open degloving injury of lower leg
Add An open degloving injury not identified as partial or complete should be coded to partial

New code S89.851 Complete open degloving injury of right lower leg
New code S89.852 Complete open degloving injury of left lower leg
New code S89.859 Complete open degloving injury of unspecified lower leg

New sub-subcategory S89.88 Closed degloving injury of lower leg

New code S89.881 Closed degloving injury of right lower leg
New code S89.882 Closed degloving injury of left lower leg
New code S89.889 Closed degloving injury of unspecified lower leg

S99 Other and unspecified injuries of ankle and foot

S99.8 Other specified injuries of ankle and foot

The appropriate 7th character is to be added to each code from subcategory S99.8
A - initial encounter
D - subsequent encounter
S - sequela

S99.81 Other specified injuries of ankle
S99.811 Other specified injuries of right ankle
S99.812 Other specified injuries of left ankle
S99.819 Other specified injuries of unspecified ankle
S99.82 Other specified injuries of foot
S99.821 Other specified injuries of right foot
S99.822 Other specified injuries of left foot
S99.829 Other specified injuries of unspecified foot

New sub-subcategory S99.83 Partial open degloving injury of ankle
Add An open degloving injury not identified as partial or complete should be coded to partial

New code S99.831 Partial open degloving injury of right ankle
New code S99.832 Partial open degloving injury of left ankle
New code S99.839 Partial open degloving injury of unspecified ankle

New sub-subcategory S99.84 Complete open degloving injury of ankle
Add An open degloving injury not identified as partial or complete should be coded to partial

New code S99.841 Complete open degloving injury of right ankle
New code S99.842 Complete open degloving injury of left ankle
New code S99.849 Complete open degloving injury of unspecified ankle

New sub-subcategory S99.85 Closed degloving injury of ankle

New code S99.851 Closed degloving injury of right ankle
New code S99.852 Closed degloving injury of left ankle
New code S99.859 Closed degloving injury of unspecified ankle

New sub-subcategory S99.86 Partial open degloving injury of foot
Add An open degloving injury not identified as partial or complete should be coded to partial

New code S99.861 Partial open degloving injury of right foot
New code S99.852 Partial open degloving injury of left foot
New code S99.869 Partial open degloving injury of unspecified foot

New sub-subcategory S99.87 Complete open degloving injury of foot
Add An open degloving injury not identified as partial or complete should be coded to partial

New code S99.871 Complete open degloving injury of right foot
New code S99.872 Complete open degloving injury of left foot
New code S99.879 Complete open degloving injury of unspecified foot

New sub-subcategory	S99.88	Closed degloving injury of foot
New code	S99.881	Closed degloving injury of right foot
New code	S99.882	Closed degloving injury of left foot
New code	S99.889	Closed degloving injury of unspecified foot

Diabetic foot ulcer

Diabetic foot ulcers (DFUs) are chronic wounds of the foot in persons with diabetes mellitus arising from the interaction of peripheral neuropathy, peripheral artery disease, and repetitive mechanical stress, frequently complicated by infection and osteomyelitis.[1,2] Lifetime incidence among persons with diabetes is 19% to 34%, with approximately 18.6 million people affected worldwide each year;[1,2] in the United States, diabetic foot disease accounts for an estimated 6.7 million ambulatory care cases annually.[4] At presentation, roughly half of ulcers are clinically infected and half occur in the setting of peripheral artery disease, most often in older adults with substantial comorbidity.[6] DFUs precede the majority of nontraumatic lower-extremity amputations, and five-year mortality after ulceration (approximately 30%) rivals that of many common cancers.[2,5] Current coding cannot separate new from recurrent ulcers or stratify by clinically meaningful severity, obscuring true incidence, healing, recurrence, and amputation outcomes.[3,4,14]

DFUs follow a relapsing-remitting course — roughly 40% recur within one year of healing and 65% within five years — so a healed patient is best characterized as "in remission" and requires ongoing surveillance and offloading to prevent relapse.[1,13] In addition, outcome is driven by wound depth and the structures involved: progression to tendon, muscle, or bone independently predicts infection, hospitalization, and amputation, and bone exposure confers a markedly elevated risk of osteomyelitis, changing diagnostic workup and management.[7,9,12] The validated systems used at the bedside (University of Texas, SVS WIfI, IWGDF) all grade ulcers by exposed structure, and the proposed exposed-structure terms align coded data with these systems for risk stratification and prioritization of high-risk patients.[7,8,10,11]

The Wound Care Collaborative Community (WCCC) is requesting the following new codes to more specifically describe wound depth, location, progression and severity.

References

1. Armstrong DG, Boulton AJM, Bus SA. Diabetic foot ulcers and their recurrence. N Engl J Med. 2017;376(24):2367-2375.

2. Armstrong DG, Tan TW, Boulton AJM, Bus SA. Diabetic foot ulcers: a review. JAMA. 2023;330(1):62-75.

3. Zhang P, Lu J, Jing Y, Tang S, Zhu D, Bi Y. Global epidemiology of diabetic foot ulceration: a systematic review and meta-analysis. Ann Med. 2017;49(2):106-116.

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11. Monteiro-Soares M, Russell D, Boyko EJ, et al. Guidelines on the classification of diabetic foot ulcers (IWGDF 2019). Diabetes Metab Res Rev. 2020;36(suppl 1):e3273.

12. Lipsky BA, Berendt AR, Cornia PB, et al. 2012 Infectious Diseases Society of America clinical practice guideline for the diagnosis and treatment of diabetic foot infections. Clin Infect Dis. 2012;54(12):e132-e173.

13. Bus SA, Sacco ICN, Monteiro-Soares M, et al. Guidelines on the prevention of foot ulcers in persons with diabetes (IWGDF 2023 update). Diabetes Metab Res Rev. 2024;40(3):e3651.

14. Fife CE, Eckert KA, Carter MJ. Publicly reported wound healing rates: the fantasy and the reality. Adv Wound Care (New Rochelle). 2018;7(3):77-94.

TABULAR MODIFICATIONS

L97.4 Non-pressure chronic ulcer of heel and midfoot

Non-pressure chronic ulcer of plantar surface of midfoot

L97.40 Non-pressure chronic ulcer of unspecified heel and midfoot

L97.401 Non-pressure chronic ulcer of unspecified heel and midfoot limited to breakdown of skin

L97.402 Non-pressure chronic ulcer of unspecified heel and midfoot with fat layer exposed

Add Non-pressure chronic ulcer of unspecified heel and midfoot with subcutaneous exposed

L97.403 Non-pressure chronic ulcer of unspecified heel and midfoot with necrosis of muscle

L97.404 Non-pressure chronic ulcer of unspecified heel and midfoot with necrosis of bone

L97.405 Non-pressure chronic ulcer of unspecified heel and midfoot with muscle involvement without evidence of necrosis

Add Non-pressure chronic ulcer of unspecified heel and midfoot with muscle or fascia or tendon exposed

L97.406 Non-pressure chronic ulcer of unspecified heel and midfoot with bone involvement without evidence of necrosis

Add Non-pressure chronic ulcer of unspecified heel and midfoot with bone exposed

L97.408 Non-pressure chronic ulcer of unspecified heel and midfoot with other specified severity

Add Non-pressure chronic ulcer of unspecified heel and midfoot with dermis exposed

L97.409 Non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity

L97.41 Non-pressure chronic ulcer of right heel and midfoot

L97.411 Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin

L97.412 Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed

Add Non-pressure chronic ulcer of right heel and midfoot with subcutaneous exposed

L97.413 Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle

L97.414 Non-pressure chronic ulcer of right heel and midfoot with necrosis of bone

L97.415 Non-pressure chronic ulcer of right heel and midfoot with muscle involvement without evidence of necrosis

Add Non-pressure chronic ulcer of right heel and midfoot with muscle or fascia or tendon exposed

L97.416 Non-pressure chronic ulcer of right heel and midfoot with bone involvement without evidence of necrosis

Add Non-pressure chronic ulcer of right heel and midfoot with bone exposed

L97.418 Non-pressure chronic ulcer of right heel and midfoot with other specified severity

Add Non-pressure chronic ulcer of right heel and midfoot with dermis exposed

L97.419 Non-pressure chronic ulcer of right heel and midfoot with unspecified severity

L97.42 Non-pressure chronic ulcer of left heel and midfoot

L97.421 Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin

L97.422 Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed

Add — Non-pressure chronic ulcer of left heel and midfoot with subcutaneous exposed

L97.423 Non-pressure chronic ulcer of left heel and midfoot with necrosis of muscle

L97.424 Non-pressure chronic ulcer of left heel and midfoot with necrosis of bone

L97.425 Non-pressure chronic ulcer of left heel and midfoot with muscle involvement without evidence of necrosis

Add — Non-pressure chronic ulcer of left heel and midfoot with muscle or fascia or tendon exposed

L97.426 Non-pressure chronic ulcer of left heel and midfoot with bone involvement without evidence of necrosis

Add — Non-pressure chronic ulcer of left heel and midfoot with bone exposed

L97.428 Non-pressure chronic ulcer of left heel and midfoot with other specified severity

Add — Non-pressure chronic ulcer of left heel and midfoot with dermis exposed

L97.429 Non-pressure chronic ulcer of left heel and midfoot with unspecified severity

New sub-subcategory — L97.4A Recurrent non-pressure chronic ulcer of unspecified heel and midfoot

New code — L97.4A1 Recurrent non-pressure chronic ulcer of unspecified heel and midfoot limited to breakdown of skin

New code — L97.4A2 Recurrent non-pressure chronic ulcer of unspecified heel and midfoot with fat layer exposed

Add — Recurrent non-pressure chronic ulcer of unspecified heel and midfoot with subcutaneous exposed

New code — L97.4A3 Recurrent non-pressure chronic ulcer of unspecified heel and midfoot with necrosis of muscle

New code	L97.4A4 Recurrent non-pressure chronic ulcer of unspecified heel and midfoot with necrosis of bone
New code	L97.4A5 Recurrent non-pressure chronic ulcer of unspecified heel and midfoot with muscle involvement without evidence of necrosis
Add	Recurrent non-pressure chronic ulcer of unspecified heel and midfoot with muscle or fascia or tendon exposed
New code	L97.4A6 Recurrent non-pressure chronic ulcer of unspecified heel and midfoot with bone involvement without evidence of necrosis
Add	Recurrent non-pressure chronic ulcer of unspecified heel and midfoot with bone exposed
New code	L97.4A8 Recurrent non-pressure chronic ulcer of unspecified heel and midfoot with other specified severity
Add	Recurrent non-pressure chronic ulcer of unspecified heel and midfoot with dermis exposed
New code	L97.4A9 Recurrent non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity
New sub-subcategory	L97.4B Recurrent non-pressure chronic ulcer of right heel and midfoot
New code	L97.4B1 Recurrent non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin
New code	L97.4B2 Recurrent non-pressure chronic ulcer of right heel and midfoot with fat layer exposed
Add	Recurrent non-pressure chronic ulcer of right heel and midfoot with subcutaneous exposed
New code	L97.4B3 Recurrent non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle
New code	L97.4B4 Recurrent non-pressure chronic ulcer of right heel and midfoot with necrosis of bone

New code	L97.4B5 Recurrent non-pressure chronic ulcer of right heel and midfoot with muscle involvement without evidence of necrosis
Add	Recurrent non-pressure chronic ulcer of right heel with muscle or fascia or tendon exposed
New code	L97.4B6 Recurrent non-pressure chronic ulcer of right heel and midfoot with bone involvement without evidence of necrosis
Add	Recurrent non-pressure chronic ulcer of right heel and midfoot with bone exposed
New code	L97.4B8 Recurrent non-pressure chronic ulcer of right heel and midfoot with other specified severity
Add	Recurrent non-pressure chronic ulcer of right heel and midfoot with dermis exposed
New code	L97.4B9 Recurrent non-pressure chronic ulcer of right heel and midfoot with unspecified severity
New sub-subcategory	L97.4C Recurrent non-pressure chronic ulcer of left heel and midfoot
New code	L97.4C1 Recurrent non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin
New code	L97.4C2 Recurrent non-pressure chronic ulcer of left heel and midfoot with fat layer exposed
Add	Recurrent non-pressure chronic ulcer of left heel and midfoot with subcutaneous exposed
New code	L97.4C3 Recurrent non-pressure chronic ulcer of left heel and midfoot with necrosis of muscle
New code	L97.4C4 Recurrent non-pressure chronic ulcer of left heel and midfoot with necrosis of bone

New code L97.4C5 Recurrent non-pressure chronic ulcer of left heel and midfoot with muscle involvement without evidence of necrosis

Add Recurrent non-pressure chronic ulcer of left heel and midfoot with muscle or fascia or tendon exposed

New code L97.4C6 Recurrent non-pressure chronic ulcer of left heel and midfoot with bone involvement without evidence of necrosis

Add Recurrent non-pressure chronic ulcer of left heel and midfoot with bone exposed

New code L97.4C8 Recurrent non-pressure chronic ulcer of left heel and midfoot with other specified severity

Add Recurrent non-pressure chronic ulcer of left heel and midfoot with dermis exposed

New code L97.4C9 Recurrent non-pressure chronic ulcer of left heel and midfoot with unspecified severity

New sub-subcategory L97.4D Non-pressure chronic ulcer of heel and midfoot, in remission

New code L97.4D1 Non-pressure chronic ulcer of right heel and midfoot, in remission

New code L97.4D2 Non-pressure chronic ulcer of left heel and midfoot in remission

New code L97.4D9 Non-pressure chronic ulcer of unspecified heel and midfoot, in remission

L97.5 Non-pressure chronic ulcer of other part of foot

Non-pressure chronic ulcer of toe

L97.50 Non-pressure chronic ulcer of other part of unspecified foot

L97.501 Non-pressure chronic ulcer of other part of unspecified foot limited to breakdown of skin

L97.502 Non-pressure chronic ulcer of other part of unspecified foot with fat layer exposed

Add Non-pressure chronic ulcer of other part of unspecified foot with subcutaneous exposed

L97.503 Non-pressure chronic ulcer of other part of unspecified foot with necrosis of muscle

L97.504 Non-pressure chronic ulcer of other part of unspecified foot with necrosis of bone

L97.505 Non-pressure chronic ulcer of other part of unspecified foot with muscle involvement without evidence of necrosis

Add Non-pressure chronic ulcer of other part of unspecified foot with muscle or fascia or tendon exposed

L97.506 Non-pressure chronic ulcer of other part of unspecified foot with bone involvement without evidence of necrosis

Add Non-pressure chronic ulcer of other part of unspecified foot with bone exposed

L97.508 Non-pressure chronic ulcer of other part of unspecified foot with other specified severity

Add Non-pressure chronic ulcer of other part of unspecified foot with dermis exposed

L97.509 Non-pressure chronic ulcer of other part of unspecified foot with unspecified severity

L97.51 Non-pressure chronic ulcer of other part of right foot

L97.511 Non-pressure chronic ulcer of other part of right foot limited to breakdown of skin

L97.512 Non-pressure chronic ulcer of other part of right foot with fat layer exposed

Add Non-pressure chronic ulcer of other part of right foot with subcutaneous exposed

L97.513 Non-pressure chronic ulcer of other part of right foot with necrosis of muscle

L97.514 Non-pressure chronic ulcer of other part of right foot with necrosis of bone

L97.515 Non-pressure chronic ulcer of other part of right foot with muscle involvement without evidence of necrosis

Add Non-pressure chronic ulcer of other part of right foot with muscle or fascia or tendon exposed

L97.516 Non-pressure chronic ulcer of other part of right foot with bone involvement without evidence of necrosis

Add Non-pressure chronic ulcer of other part of right foot with bone exposed

L97.518 Non-pressure chronic ulcer of other part of right foot with other specified severity

Add Non-pressure chronic ulcer of other part of right foot with dermis exposed

L97.519 Non-pressure chronic ulcer of other part of right foot with unspecified severity

L97.52 Non-pressure chronic ulcer of other part of left foot

L97.521 Non-pressure chronic ulcer of other part of left foot limited to breakdown of skin

L97.522 Non-pressure chronic ulcer of other part of left foot with fat layer exposed

Add Non-pressure chronic ulcer of other part of left foot with subcutaneous exposed

L97.523 Non-pressure chronic ulcer of other part of left foot with necrosis of muscle

L97.524 Non-pressure chronic ulcer of other part of left foot with necrosis of bone

L97.525 Non-pressure chronic ulcer of other part of left foot with muscle involvement without evidence of necrosis

Add Non-pressure chronic ulcer of other part of left foot with muscle or fascia or tendon exposed

L97.526 Non-pressure chronic ulcer of other part of left foot with bone involvement without evidence of necrosis

Add Non-pressure chronic ulcer of other part of left foot with bone exposed

L97.528 Non-pressure chronic ulcer of other part of left foot with other specified severity

Add — Non-pressure chronic ulcer of other part of left foot with dermis exposed

L97.529 Non-pressure chronic ulcer of other part of left foot with unspecified severity

New sub-subcategory — L97.5A Recurrent non-pressure chronic ulcer of other part of unspecified foot

New code — L97.5A1 Recurrent non-pressure chronic ulcer of other part of unspecified foot limited to breakdown of skin

New code — L97.5A2 Recurrent non-pressure chronic ulcer of other part of unspecified foot with fat layer exposed

Add — Recurrent non-pressure chronic ulcer of other part of unspecified foot with subcutaneous exposed

New code — L97.5A3 Recurrent non-pressure chronic ulcer of other part of unspecified foot with necrosis of muscle

New code — L97.5A4 Recurrent non-pressure chronic ulcer of other part of unspecified foot with necrosis of bone

New code — L97.5A5 Recurrent non-pressure chronic ulcer of other part of unspecified foot with muscle involvement without evidence of necrosis

Add — Recurrent non-pressure chronic ulcer of other part of unspecified foot with muscle or fascia or tendon exposed

New code — L97.5A6 Recurrent non-pressure chronic ulcer of other part of unspecified foot with bone involvement without evidence of necrosis

Add — Recurrent non-pressure chronic ulcer of other part of unspecified foot with bone exposed

New code	L97.5A8 Recurrent non-pressure chronic ulcer of other part of unspecified foot with other specified severity
Add	Recurrent non-pressure chronic ulcer of other part of unspecified foot with dermis exposed
New code	L97.5A9 Recurrent non-pressure chronic ulcer of other part of unspecified foot with unspecified severity
New sub-subcategory	L97.5B Recurrent non-pressure chronic ulcer of other part of right foot
New code	L97.5B1 Recurrent non-pressure chronic ulcer of other part of right foot limited to breakdown of skin
New code	L97.5B2 Recurrent non-pressure chronic ulcer of other part of right foot with fat layer exposed
Add	Recurrent non-pressure chronic ulcer of other part of right foot with subcutaneous exposed
New code	L97.5B3 Recurrent non-pressure chronic ulcer of other part of right foot with necrosis of muscle
New code	L97.5B4 Recurrent non-pressure chronic ulcer of other part of right foot with necrosis of bone
New code	L97.5B5 Recurrent non-pressure chronic ulcer of other part of right foot with muscle involvement without evidence of necrosis
Add	Recurrent non-pressure chronic ulcer of other part of right foot with muscle or fascia or tendon exposed
New code	L97.5B6 Recurrent non-pressure chronic ulcer of other part of right foot with bone involvement without evidence of necrosis
Add	Recurrent non-pressure chronic ulcer of other part of right foot with bone exposed

New code	L97.5B8 Recurrent non-pressure chronic ulcer of other part of right foot with other specified severity
Add	Recurrent non-pressure chronic ulcer of other part of right foot with dermis exposed
New code	L97.5B9 Recurrent non-pressure chronic ulcer of other part of right foot with unspecified severity
New sub-subcategory	L97.5C Recurrent non-pressure chronic ulcer of other part of left foot
New code	L97.5C1 Recurrent non-pressure chronic ulcer of other part of left foot limited to breakdown of skin
New code	L97.5C2 Recurrent non-pressure chronic ulcer of other part of left foot with fat layer exposed
Add	Recurrent non-pressure chronic ulcer of other part of left foot with subcutaneous exposed
New code	L97.5C3 Recurrent non-pressure chronic ulcer of other part of left foot with necrosis of muscle
New code	L97.5C4 Recurrent non-pressure chronic ulcer of other part of left foot with necrosis of bone
New code	L97.5C5 Recurrent non-pressure chronic ulcer of other part of left foot with muscle involvement without evidence of necrosis
Add	Recurrent non-pressure chronic ulcer of other part of left foot with muscle or fascia or tendon exposed
New code	L97.5C6 Recurrent non-pressure chronic ulcer of other part of left foot with bone involvement without evidence of necrosis
Add	Recurrent non-pressure chronic ulcer of other part of left foot with bone exposed

New code	L97.5C8 Recurrent non-pressure chronic ulcer of other part of left foot with other specified severity
Add	Recurrent non-pressure chronic ulcer of other part of left foot with dermis exposed
New code	L97.5C9 Recurrent non-pressure chronic ulcer of other part of left foot with unspecified severity
New sub-subcategory	L97.5D Non-pressure chronic ulcer of other part of foot, in remission
New code	L97.5D1 Non-pressure chronic ulcer of other part of right foot, in remission
New code	L97.5D2 Non-pressure chronic ulcer of other part of left foot, in remission
New code	L97.5D9 Non-pressure chronic ulcer of other part of unspecified foot, in remission

Doxycycline post-exposure prophylaxis

This topic was presented at the September 2025 ICD-10 Coordination and Maintenance meeting. Based on public comments, revisions to the proposal have been made for reconsideration.

Bacterial sexually transmitted infections (STIs) are common in the United States, with over 1.6 million cases of chlamydia, over 600,000 cases of gonorrhea, and over 200,000 cases of syphilis reported in 2023.[1] Gonorrhea and chlamydia can cause long-term health consequences such as pelvic inflammatory disease, chronic pelvic pain, or infertility and ectopic pregnancy, particularly when left untreated.[2] Syphilis can also cause serious clinical complications, including central nervous system disease and adverse pregnancy outcomes.[3] In June 2024, the Centers for Disease Control and Prevention (CDC) released its guidelines on the use of doxycycline as post-exposure prophylaxis (doxy PEP) for the prevention of bacterial STIs.[4] These guidelines detail how providers can prescribe doxycycline 200mg, taken once after sex, to significantly reduce the risk of acquiring a bacterial STI among certain populations disproportionately affected by STIs.

Doxy PEP represents the first new biomedical prevention tool for the prevention of bacterial STIs in decades. In three randomized controlled trials, doxy PEP demonstrated efficacy in reducing acquisition of bacterial STIs (syphilis, chlamydia, and gonorrhea).[5-7]

Doxy PEP has been well received, with interest from patients and uptake in a number of jurisdictions across the United States.[8-11] To date, at least 17 state and county public health departments have released guidance supporting the use of doxy PEP.[12] Early evidence also points to the efficacy of doxy PEP as a public health intervention to reduce STI rates. At the same time, evidence from clinicals trials shows that use of doxy PEP may be associated with increased antimicrobial resistance (AMR) among sexually transmitted pathogens such as gonorrhea and other pathogens, such as *Staphylococcus aureus*.[13] In both clinical trials and population studies, doxy PEP has been associated with increased high-level tetracycline resistance in gonorrhea.[6, 14]

Currently, there is no unique ICD-10-CM code addressing an indication for doxy PEP prescription. The use of ICD-10-CM code Z20.2, Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission, is not specific to the use of doxycycline as STI prophylaxis. The existing code Z20.2 is for a wide array of purposes related to screening, prevention, and treatment of STIs limits any interpretation of its use.

CDC Division of Sexually Transmitted Disease Prevention is requesting a new code to better capture prescription of doxycycline specifically for post-exposure prophylaxis to prevent the acquisition of bacterial STIs and to track the use of doxy PEP to understand its public health benefits and potential consequences for antimicrobial resistance.

References:

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TABULAR MODIFICATIONS

Z29 Encounter for other prophylactic measures

Z29.8 Encounter for other specified prophylactic measures

New code	Z29.82	Encounter for post-exposure prophylaxis for bacterial sexually transmitted infections prevention
Add		Encounter for post-exposure prophylaxis for bacterial sexually transmitted infections prevention using a patient administered antimicrobial after sex

Dysphotopsia

This topic was presented at the 2026 March ICD 10 Coordination and Maintenance Comittee Meeting. Based on public comments received during the public comment period, the proposal has been revised for reconsideration.

Dysphotopsias are unwanted visual phenomena. They can occur naturally, after many ocular surgeries, and following otherwise-successful cataract surgery. Positive Dysphotopsia (PD) includes phenomena such as light streaks, arcs, flashes, rings and halos, or glare caused by external light sources. Negative Dysphotopsia is a dark arc-shaped shadow or line in the peripheral vision. [1,2] PD is associated with light entering the eye, often caused by changes such as IOL implantation, where ND may stem from other intrinsic factors independent of the cataract surgery. [2] The most common factors affecting occurrence of PD are characteristics of the intraocular lens (IOL), such as the IOL shape, edge design, and size. [1,2] Causes of ND are less well-understood and believed to be multi-factorial. ND can occur regardless of the type of IOL [3] and can be affected by placement and orientation of the IOL as well as the patient's anatomy. [4,5,6] Both PD and ND are transient symptoms in most patients but may persist for at least one year in 2-3% of patients.[2] Knowing the type of dysphotopsia is important when evaluating a patient and leads to a different treatment pathway both pre and intra operatively. [2] Surgical interventions may be appropriate as a second line treatment for patients with persistent dysphotopsia. For PD, such intervention would be an IOL exchange. For ND, possible interventions include reverse optic capture technique, secondary (piggy back) IOL implantation, or IOL exchange.

Currently, both Positive Dysphotopsia (PD) and Negative Dysphotopsia (ND) are captured under ICD-10-CM code H53.19, Other subjective visual disturbances.

Johnson and Johnson Vision is requesting the following tabular modifications to support effective disease tracking of the condition and to facilitate research.

References:

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TABULAR MODIFICATIONS

H53 Visual disturbances
H53.1 Subjective visual disturbances

New sub-subcategory	H53.17 Dysphotopsia	
New code	H53.171	Dysphotopsia, right eye
New code	H53.172	Dysphotopsia, left eye
New code	H53.173	Dysphotopsia, bilateral
New code	H53.179	Dysphotopsia, unspecified eye

Electric Shock Drowning

Electric shock drowning (ESD) is an injury mechanism in which a person immersed in water is exposed to low-voltage alternating current (AC), typically originating from electrical systems associated with docks, marinas, or watercraft. Exposure to low levels of AC can cause sustained skeletal muscle tetany, resulting in immediate loss of voluntary motor control and inability to maintain airway position above the water surface. At higher current levels, electrical exposure may induce ventricular fibrillation and cardiac arrest.

The drowning component involves respiratory impairment following submersion, leading to hypoxemia, loss of consciousness, and potential cardiac arrest. Survivors may experience aspiration pneumonitis, ARDS, and hypoxic neurologic injury.

ESD represents a combined and sequential mechanism of electrical incapacitation followed by drowning that is not captured by existing ICD-10-CM codes. ESD is often diagnosed based on a combination of clinical presentation and investigative findings rather than definitive physical evidence.

Electrical injury in water frequently leaves no external burns or entry/exit wounds, and autopsy findings are often consistent with nonspecific drowning. Nonfatal cases may present with transient paralysis, weakness, arrhythmias, or near-drowning complications.

Lack of a specific ICD-10-CM code results in inconsistent documentation and code assignment. Cases are misclassified under drowning or electrocution codes, limiting epidemiologic surveillance and prevention efforts.

This proposal was submitted by the Electric Shock Drowning Prevention Association (ESDPA) and requests creation of a new ICD-10-CM code to identify electric shock drowning as a distinct mechanism of injury.

The American Academy of Pediatrics (AAP) has reviewed and supports this proposal.

References:
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12. DockSafe. Electric shock drowning: the hidden crisis in America's freshwater marinas. Research Brief; 2026. https://docksafevoltage.com

TABULAR MODIFICATIONS

T75.4 Electrocution

Delete	~~Shock from electric current~~
Delete	~~Shock from electroshock gun (taser)~~
New code	T75.41 Electrocution
Add	Shock from electric current
Add	Shock from electroshock gun (taser)
New code	T75.42 Electric shock drowning
Add	Use additional external cause code for place of occurrence (Y92.-)

Encounter for safety counseling in the home

According to the National Safety Council, 1 in 11 persons will seek medical advice because of an injury. The number of home-related injuries exceeds the total number of injuries that occur in other locations, including schools, parks, workplaces, and motor vehicle collisions. The number of preventable home-related injury deaths has increased 190% since 1999. This increase is mostly driven by increases in unintentional falls and poisoning. Also, according to the National Safety Council, the highest risk of preventable deaths is from poisonings (17.1 per 100,000 population, followed by falls (9.6), and choking (0.9). Other unidentified deaths have a rate of 1.9 per 100,000 population.

The principal cause of home-related injuries and deaths is poisoning (>50%), followed by falls. The overall death rate in 2024 from home-related incidents was 31.7 per 100,000 population. Infants and toddlers had a rate of 10.8, while adolescents had a rate of 6.9. The group with the highest death rate is adults 75 and older, with a rate of 122.4 per 100,000 population.

Homes contain both visible and hidden risks that may lead to serious injury or death. While the AAP mainly addresses children and teens, these dangers also impact older adults and people with disabilities.

Any age child, adolescent, or adult can be at risk from home injuries that could be prevented with appropriate safety counseling. These risks can range from an injury caused by a poorly installed and secure bookcase, cooking in the kitchen, backyard barbecue to a poorly protected pool.

Home-related injuries are becoming an increasingly important public health issue, impacting people of all ages. Children, older adults, and individuals with disabilities face especially high risks. Dangers in the home—such as unstable furniture, drowning hazards, poisoning, falls, and unsafe play areas—can result in severe injury or even death. Fortunately, many of these incidents can be prevented with targeted counseling.

Currently, there are counselling codes to capture several important health issues, i.e., Z71.84 Encounter for health counseling related to travel; Z71.85 Encounter for immunization safety counseling and Z71.88 Encounter for counseling for socioeconomic factors. However, current ICD-10-CM codes do not adequately distinguish home safety counseling from other types of counseling. Existing code, Z71.89, Other specified counseling, is too nonspecific to capture home safety-related counseling.

The American Academy of Pediatrics are requesting a unique code to capture home safety counseling. The proposed new code would improve the ability to document, track, and analyze home safety interventions, supporting better public health surveillance and resource allocation. Given that home-related injuries account for a large proportion of preventable injuries and deaths and have increased substantially over time, this new code would help close a critical data gap and strengthen prevention efforts across populations.

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At Home. American Academy of Pediatrics. HealthyChildren.Org. https://www.healthychildren.org/english/safety-prevention/at-home/Pages/default.aspx.

National Safety Council. https://injuryfacts.nsc.org/home-and-community/deaths-in-the-home/introduction/

TABULAR MODIFICATIONS

Z71 Persons encountering health services for other counseling and medical advice, not elsewhere classified

Z71.8 Other specified counseling
Excludes2: counseling for contraception (Z30.0-)

New code	Z71.8A Encounter for home safety counseling
Add	Encounter for home safety counseling for fall risk
Add	Encounter for home safety counseling for drowning prevention
Add	Encounter for home safety counseling for poisoning prevention
Add	Encounter for home safety counseling for safe home guidance
Add	Encounter for home safety counseling for safe play guidance
Add	Encounter for home safety counseling to prevent wandering
Add	Code also if applicable:
Add	encounter for general adult medical examination (Z00.0-)
Add	encounter newborn, infant and child health examinations (Z00.1-)

Extreme Immaturity of Newborn

US hospitals participating in the Vermont Oxford Network Database Research Repository (VON), indicate the rate of treatment for infants born at 22 weeks have more than doubled since 2014.

Most infants born at 22 weeks in VON hospitals received active treatment in 2019. During the same period, the rate of survival after birth at 22 weeks of gestation tripled, with 17% of liveborn 22-week infants in 2019 surviving to hospital discharge or one postnatal year. At the University of Iowa between 2010 and 2025, there were 22 infants born alive at 21 weeks gestational age. 77% of those were resuscitated, of whom 35% were discharged home from the NICU.

With the increasing rates of resuscitation and clinical management for newborns at 21 and 22 weeks gestation, enhanced diagnostic specificity is crucial to facilitate prospective data collection and accurate reporting of infant outcomes.

Due to the evolving care patterns that provide newborn support at these lowest gestational ages, multiple factors have collectively shifted the viability limit to gestational ages as low as 21 weeks. Advancements in medical technology, updated clinical guidelines, and an increasing number of relevant publications underline the expansion of resuscitation and NICU management for gestational ages less than 23 weeks.

This data is essential for counselling pregnant patients and families expecting delivery at early gestational ages. This approach aligns with the American Academy of Pediatrics Neonatal Resuscitation Program, which highlights shared decision-making and aims to give parents thorough, relevant, and current information about prognosis.

The enhanced ICD-10-CM codes for 21- and 22-week gestations facilitate more accurate sharing of medical information and support for caregivers. These revisions also underscore the ongoing requirements of infants and their families.

ICD-10-CM is essential for healthcare support, planning, quality, safety, and research, but it lacks specific diagnostic codes for 21- and 22-week newborns. More detailed classification would allow for improved identification of cases in administrative data and support more precise tabulation of outcomes and utilization patterns. Greater code specificity would improve the accuracy of data capture and better reflect clinically meaningful differences in outcomes and resource utilization at the lowest gestational ages.

Gestational age and extreme immaturity are routinely documented in standard perinatal and neonatal records, including delivery notes, newborn admission documentation, NICU records, and discharge summaries. Obstetric, neonatal, and pediatric providers consistently record gestational age as part of routine clinical care. The proposed new codes are consistent with current documentation practices, as gestational age in complete weeks is routinely recorded in the medical record and available to support code assignment.

The proposal also includes a request to end date P07.21 to allow for additional gestational age less than 23 weeks. This change would allow ICD-10-CM classification structure to align with current clinical

practices and enable consistent data collection. Greater specificity would aid statistical reporting, research, and public health by allowing cases to be stratified at lower gestational ages.

Distinct ICD-10-CM codes for gestational ages below 23 weeks would fill a gap in the classification, improve accuracy, and support better data use in clinical and research settings.

The American Academy of Pediatrics requests new codes to for extreme immaturity of newborn (gestational age under 23 weeks) to accurately capture and analyze data related to this population.

References:

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TABULAR MODIFICTIONS

P07 Disorders of newborn related to short gestation and low birth weight, not elsewhere classified

P07.2 Extreme immaturity of newborn
Less than 28 completed weeks (less than 196 completed days) of gestation

P07.20 Extreme immaturity of newborn, unspecified weeks of gestation
Gestational age less than 28 completed weeks NOS

P07.21 Extreme immaturity of newborn, gestational age less than 23 completed weeks
Extreme immaturity of newborn, gestational age less than 23 weeks, 0 days

Add **Note: Effective October 1, 2027, P07.21, Extreme immaturity of newborn, gestational age less than 23 completed weeks will no longer be effective due to increase in clinical management and need for further specificity for extreme immaturity newborn gestational age. The code P07.21 will remain in the tabular for surveillance purposes.**

New code P07.2A Extreme immaturity of newborn, gestational age less than 21 completed weeks
Add Extreme immaturity of newborn, gestational age less than 21 weeks, 0 days

New code P07.2B Extreme immaturity of newborn, gestational age 21 completed weeks
Add Extreme immaturity of newborn, gestational age 21 weeks, 0 days through 21 weeks, 6 days

New code P07.2C Extreme immaturity of newborn, gestational age 22 completed weeks
Add Extreme immaturity of newborn, gestational age 22 weeks, 0 days through 22 weeks, 6 days

P07.22 Extreme immaturity of newborn, gestational age 23 completed weeks
Extreme immaturity of newborn, gestational age 23 weeks, 0 days through 23 weeks, 6 days

P07.23 Extreme immaturity of newborn, gestational age 24 completed weeks
Extreme immaturity of newborn, gestational age 24 weeks, 0 days through 24 weeks, 6 days

P07.24 Extreme immaturity of newborn, gestational age 25 completed weeks
Extreme immaturity of newborn, gestational age 25 weeks, 0 days through 25 weeks, 6 days

P07.25 Extreme immaturity of newborn, gestational age 26 completed weeks
Extreme immaturity of newborn, gestational age 26 weeks, 0 days through 26 weeks, 6 days

P07.26 Extreme immaturity of newborn, gestational age 27 completed weeks
Extreme immaturity of newborn, gestational age 27 weeks, 0 through 27 weeks, 6 days

Floppy Eyelid Syndrome

This topic was presented at the March 2026 ICD-10 Coordination and Maintenance meeting. Based on comments received during the public comments period and additional clinical consultations, changes have been made for reconsideration and noted in **bold**.

Floppy eyelid syndrome (FES) is a frequently underdiagnosed cause of eye irritation and discharge, often seen in the presence of obstructive sleep apnea. FES is defined by hyperlaxity of the upper and lower eyelids, lack of rigidity in the underlying tarsus, easy or spontaneous lid eversion, and associated chronic reactive papillary conjunctivitis.[1] Estimated prevalence of FES is 3.8-8.0% of the adult population, with the majority of cases going undiagnosed.[2,3]

Floppy eyelid syndrome is strongly correlated with obstructive sleep apnea, with studies showing 75-95% of patients with FES have obstructive sleep apnea.[1,4,5] There is a positive correlation between FES and obstructive sleep apnea severity, and treatment of sleep apnea with CPAP has even been linked to improvement in FES symptoms.[2,6] Proper documentation of FES is therefore crucial for sleep apnea surveillance and screening, enabling timely treatment. Treatment of obstructive sleep apnea has been shown to decrease cardiovascular events, and motor vehicle accidents, resulting in a 40% relative reduction in all-cause mortality.[7–10] FES is also associated with other conditions, such as ectropion, entropion, keratoconus, and obesity, heightening the importance of proper FES documentation.[1,5,11]

The hyperlaxity in FES is caused by a weakening of the tarsal plate due to elastin breakdown.[12] Symptoms include tearing, redness, photosensitivity, foreign body sensation, dryness, and decreased vision.[11,13,14] The mechanism of conjunctival and corneal irritation in FES is thought to be secondary to a combination of three factors: 1) lid eversion during sleep with direct mechanical irritation of the ocular surface, 2) inadequate tear film contact, 3) and/or underlying ischemia-reperfusion damages.[14] FES can lead to ocular surface damage and in severe cases corneal ulcers and scarring.[4,13,15] Treatments for FES include eye shields during sleep to prevent mechanical irritation, lubricating ointments, and surgery to tighten the eyelids.[13,14]

Current ICD-10-CM coding does not capture FES as a distinct syndrome. An ICD-10-CM code designation for FES would enable more consistent diagnosis of this underdiagnosed condition. Furthermore, a FES ICD-10-CM code would facilitate obstructive sleep apnea surveillance and screening for patients with FES, resulting in earlier diagnosis and treatment of this life-threatening disease. A FES ICD-10-CM code would also allow for improved research into FES pathophysiology, treatment, and its association with other disorders. **Since FES is a distinct, specified eyelid disorder characterized by tarsal hyperlaxity secondary to elastic fiber degradation and decreased tarsal elastin, the new codes should be placed as a new sub-subcategory (H02.8A) under H02.8 – "Other specified disorders of eyelid."[12]**

This proposal is submitted by oculoplastic surgeons Anne Barmettler, MD, and Lalita Gupta, MD.

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TABULAR MODIFICATIONS

H02 Other disorders of eyelid

H02.8 Other specified disorders of eyelid

New sub-subcategory **H02.8A Floppy eyelid syndrome (FES)**

New code **H02.8A1 Floppy eyelid syndrome, right eye**
New code **H02.8A2 Floppy eyelid syndrome, left eye**
New code **H02.8A3 Floppy eyelid syndrome, bilateral**
New code **H02.8A9 Floppy eyelid syndrome, unspecified eye**

Genetic Neurodevelopmental Disorders Koolen-de Vries Syndrome (KdVS) and Okur-Chung Neurodevelopmental Syndrome (OCNDS)

Koolen-de Vries Syndrome (KdVS) and Okur-Chung Neurodevelopmental Syndrome (OCNDS) were both previously presented at the September 2025 ICD-10 Coordination and Maintenance Committee Meeting. The proposals for both conditions were placed on hold while NCHS obtained input on principles for organizing genetic conditions. Comments from the previous presentation were generally positive but recommended classifying these conditions within subcategories previously created. This proposal incorporates that recommendation as possible, with KdVS being classified to a subcategory for genes associated with transcription. A new subcategory is proposed for OCNDS.

KdVS is a genetic disorder caused by pathogenic variants in the KANSL1 gene, leading to haploinsufficiency of the KAT8 Regulatory NSL Complex Subunit One protein.[1] KdVS is characterized by a distinct set of neurological and non-neurological symptoms, including psychomotor developmental delays, intellectual disability, hypotonia, unique facial features, communication disorders, epilepsy, congenital heart defects, and compromised immune function.[1–7] The syndrome affects multiple organ systems, with hypotonia and motor impairment often presenting early and causing feeding and speech difficulties. Prevalence estimates suggest up to 1 in 30,000 individuals, with over 11,000 affected in the U.S. alone. Establishing a specific ICD-10-CM code for KdVS will improve tracking, data collection, and clinical care, facilitate research, and help identify patients for future clinical trials, especially given the risks associated with anesthesia due to airway complications. Creation of a specific code for KdVS was requested by Bert B.A. de Vries, MD, PhD; David A. Koolen, MD, PhD; Heather Mefford, MD, PhD; Angela Morgan, PhD; Kenneth Myers, MD; Anna Pfalzer, PhD; Kellan P Weston, PhD; Terry Jo Bichell, PhD; and the KdVS Foundation, a patient advocacy organization.

OCNDS is a rare, autosomal-dominant genetic disorder caused by mutations in the CSNK2A1 gene, which encodes the alpha subunit of protein kinase CK2, crucial for neuronal development and synaptic transmission.[8-11] The syndrome is characterized by developmental delays, mild-to-moderate intellectual impairment, hypotonia, distinctive facial features, speech delay or inability to speak, cortical malformations, and frequent gastrointestinal and feeding difficulties; less common features include kyphoscoliosis, short stature, sleep disturbances, seizures, and poor coordination.[12-15] Language development is typically more impaired than motor skills, and affected individuals may also present with learning disabilities, autism spectrum disorder, and unusual primary teeth.[13,16] Diagnosis relies on molecular genetic testing, most often via Whole Exome or Whole Genome Sequencing.[17] Prevalence estimates, based on incidence estimated from mutation rate analysis,[18,19] suggest over 5,000 affected individuals in the U.S., with diagnoses rising as genetic testing becomes more widespread. Currently, there is no cure, and treatment focuses on managing symptoms through therapies and pharmacologic interventions; ongoing drug repurposing studies aim to identify OCNDS-specific treatments.

Establishing a unique diagnosis code is critical for tracking patients, facilitating research, and supporting clinical breakthroughs, as well as enabling effective surveillance and management of the disorder. Creation of a specific code for OCNDS was requested by the CSNK2A1 Foundation, a not-for-profit organization.

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TABULAR MODIFICATIONS

QA0 Neurodevelopmental disorders related to specific genetic pathogenic variants

QA0.0 Neurodevelopmental disorders related to pathogenic variants in specific genes

QA0.01 Neurodevelopmental disorders related to pathogenic variants in certain specific genes

	QA0.015	Neurodevelopmental disorders, related to genes associated with transcription and gene expression
New code	QA0.0152	Koolen-de Vries Syndrome
New sub-sub-subcategory	QA0.018	Neurodevelopmental disorders related to pathogenic variants in certain specific genes associated with proteins with other and multiple functions
New code	QA0.0181	Okur-Chung neurodevelopmental syndrome
New code	QA0.0189	Neurodevelopmental disorders related to pathogenic variants in certain other specific genes associated with proteins with other and multiple functions

Genitourinary Syndrome of Menopause (GSM)

Genitourinary syndrome of menopause (GSM) is a collection of symptoms and signs associated with decreased estrogen and other sex steroids involving changes to the labia, vestibule/introitus, vagina, urethra, and bladder. Symptoms may include (but are not limited to) vulvovaginal symptoms (vaginal dryness, burning, irritation); sexual symptoms (lubrication difficulties, dyspareunia); and lower urinary tract symptoms (dysuria, urgency, frequency, and recurrent urinary tract infections).

GSM is an established, consensus clinical diagnosis, not simply "atrophic vaginitis." GSM is very common, affecting more than half of postmenopausal women. The term "GSM" was introduced via consensus to replace narrower or less accurate terminology (e.g., "atrophic vaginitis" / "vulvovaginal atrophy") and is intended to capture the three related clinical domains, including genital, sexual, and urinary. GSM is covered in urologic/urogynecologic guidance (AUA/SUFU/AUGS) as a defined syndrome with a spectrum of symptoms/changes resulting from declining sex steroids.

Current ICD-10-CM options fragment a single syndrome into multiple codes, reducing data quality. In typical practice, clinicians often code N95.2 (postmenopausal atrophic vaginitis) plus separate urinary symptom codes. This approach:

- Underrepresents urinary manifestations as part of the same menopausal syndrome
- Makes outcomes research, quality measurement, and population tracking less reliable
- Increases variability across coders/clinicians and complicates longitudinal analytics

A dedicated GSM ICD-10-CM code would improve clinical documentation, research, and public health reporting. A specific GSM code would also allow for:

- More accurate measurement of GSM prevalence and treatment patterns
- Cleaner research cohorts (e.g., GSM vs isolated OAB vs recurrent UTI)
- Better tracking of guideline-concordant management

Jason Cruff, DO, FACOG, URPS, a board-certified urogynecologist from Sanford Health/Marshfield Clinic submitted the proposal to create a new code for GSM. The American College of Obstetricians and Gynecologists (ACOG) and the American Urogynecologic Society (AUGS) have reviewed and support the proposal.

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TABULAR MODIFICATIONS

N95 Menopausal and other perimenopausal disorders

New subcategory N95.8 Other specified menopausal and perimenopausal disorders

New code N95.81 Genitourinary syndrome of menopause
Add Code also, any associated conditions such as:
Add dyspareunia (N94.1-)
Add dysuria (R30.0)
Add Excludes1: acute cystitis (N30.0-)
Add acute vaginitis (N76.0)

New code N95.89 Other specified menopausal and perimenopausal disorders

Heart Failure Stage A and Stage B

Heart failure can develop and progress in stages, with a detailed staging system with stages A through D developed by the American College of Cardiology (ACC) and American Heart Association (AHA).[1] This proposal to add certain specific codes has been developed based on internal review and extending from input and review on other related issues, but without a specific external request.

Heart failure stages start with stage A, "At risk" of heart failure. At this stage there are no symptoms, nor structural heart disease, or cardiac biomarkers present. This will include people with hypertension, atherosclerotic heart disease, diabetes, metabolic syndrome, obesity, exposure to cardiotoxic agents, genetic variants of cardiomyopathy, or family history of cardiomyopathy.[1]

Heart failure stage B can be identified as "Pre-heart failure." It includes people with no symptoms or signs of heart failure, but with evidence for one of structural heart disease, increased filling pressures, or risk factors together with elevated cardiac enzymes (including BNP or troponin) without other explanatory diagnoses.[1] The structural heart disease can be ventricular hypertrophy, chamber enlargement, wall motion abnormalities, valvular heart disease, reduced left or right ventricular systolic function, reduced ejection fraction, or reduced strain (in this case, the strain is a measure of how much the heart muscle shortens during contraction).[1] Measurement of filling pressures can be assessed invasively (such as during angiogram) or noninvasively (such as with echocardiogram).

Heart failure stage C is symptomatic heart failure. Heart failure stage D is advanced heart failure.[1]

It is being proposed to add new codes for heart failure stage A and heart failure stage B.

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	I51		Complications and ill-defined descriptions of heart disease
		I51.8	Other ill-defined heart diseases
New code			I51.82 Pre-heart failure
Add			Heart failure stage B
Add			Code also, if known, any specific cardiac abnormalities, such as:
Add			cardiomegaly (I51.7)
Add			congenital heart disease (Q20.0-Q24.9)
Add			valvular heart disease (I05.0-I08.9; I34.0-I39)
Add			Excludes1: heart failure (I50.-)

Z91 Personal risk factors, not elsewhere classified
Z91.8 Other specified personal risk factors, not elsewhere classified

New code	Z91.86	At risk for heart failure
Add		Heart failure stage A
Add		Code first, if known, any conditions associated with risk for heart failure, such as:
Add		atherosclerotic heart disease (I25.1)
Add		diabetes mellitus (E08-E13)
Add		hypertension (I10)

Heart Failure with Improved Ejection Fraction (HFimpEF)

Heart Failure with Improved Ejection Fraction (HFimpEF) is formally recognized in the 2022 AHA/ACC/HFSA Heart Failure Guideline as a separate subcategory of Heart Failure with Reduced Ejection Fraction (HFrEF), defined by prior left ventricular ejection fraction (LVEF) ≤40% with subsequent improvement to >40%. Although associated with better outcomes, improvement in LVEF does not mean full myocardial recovery or normalization of LV function, and these patients retain a significant risk of relapse, warranting continued guideline-directed medical therapy. HFimpEF may also be referred to as Heart Failure with Recovered Ejection Fraction (HFrecEF).

Current ICD-10-CM guidance directs coding of HFrecEF as chronic diastolic heart failure (I50.32) when documentation by providers indicate that the patient has HFimpEF. However, patients with HFimpEF represent a distinct clinical phenotype and do not necessarily have diastolic dysfunction. Defaulting these patients to diastolic HF misrepresents underlying pathophysiology and diminishes data accuracy.

While EF normalization removes criteria for Heart Failure with Reduced Ejection Fraction (HFrEF), absence of systolic dysfunction does not establish diastolic dysfunction; therefore, default reassignment to I50.32 lacks physiologic and clinical justification when abnormal filling pressures or relaxation abnormalities are not documented.

A specific ICD-10-CM code for HFimpEF would improve diagnostic precision, align coding with contemporary clinical practice, and prevent inappropriate classification as diastolic heart failure solely based on EF normalization. In alignment with ICD-10-CM structure, the proposed code fits logically under I50 Heart failure. This structure maintains ICD-10-CM conventions while modernizing classification to reflect current guideline-based terminology for this condition.

The anticipated impact for creation of a distinct HFimpEF code (to include HFrecEF) would ensure accurate classification of heart failure based on the underlying pathophysiology, enhance public health surveillance, quality measurement, and research accuracy. It would support valid epidemiologic analyses and ensure that administrative data reflects modern heart failure phenotyping. This is based on a proposal received from Baylor Scott & White Health, a not-for-profit healthcare system.

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TABULAR MODIFICATIONS

I50 Heart failure

I50.2 Systolic (congestive) heart failure

Add — Excludes1: combined heart failure with improved ejection fraction [HFimpEF] and diastolic (congestive) heart failure (I50.B-)

Add — heart failure with improved ejection fraction (I50.A-)

I50.3 Diastolic (congestive) heart failure

Add — Excludes1: combined heart failure with improved ejection fraction [HFimpEF] and diastolic (congestive) heart failure (I50.B-)

Add — heart failure with improved ejection fraction (I50.A-)

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

Add — Excludes1: combined heart failure with improved ejection fraction [HFimpEF] and diastolic (congestive) heart failure (I50.B-)

New subcategory — I50.A Heart failure with improved ejection fraction [HFimpEF]

Add — Heart failure with recovered ejection fraction [HFrecEF]

New code — I50.A0 Unspecified heart failure with improved ejection fraction [HFimpEF]

New code — I50.A2 Chronic heart failure with improved ejection fraction [HFimpEF]

New code — I50.A3 Acute on chronic heart failure with improved ejection fraction [HFimpEF]

New subcategory — I50.B Combined heart failure with improved ejection fraction [HFimpEF] and diastolic (congestive) heart failure

Add — Combined heart failure with recovered ejection fraction [HFrecEF] and diastolic (congestive) heart failure

Add — Heart failure with improved ejection fraction [HFimpEF] and diastolic dysfunction

Add — Heart failure with recovered ejection fraction [HFrecEF] and diastolic dysfunction

Add — Code also end stage heart failure, if applicable (I50.84)

New code	I50.B0	Unspecified combined heart failure with improved ejection fraction [HFimpEF] and diastolic (congestive) heart failure
New code	I50.B2	Chronic combined heart failure with improved ejection fraction [HFimpEF] and diastolic (congestive) heart failure
New code	I50.B3	Acute on chronic combined heart failure with improved ejection fraction [HFimpEF] and diastolic (congestive) heart failure

Hexane and N-Butyl Acetate Exposure

This topic was presented at the March 2026 ICD-10 Coordination and Maintenance Committee meeting. At the submitter's request, additional new Z codes in Chapter 21 have been submitted for consideration.

Hexane and n-butyl acetate are organic solvents to which humans are commonly exposed in everyday life and at elevated levels in many occupational settings. Both substances are tracked within the Individual Longitudinal Exposure Record (ILER), which monitors toxic exposures for the Department of Defense (DoD) and Department of Veterans Affairs (VA): n-hexane ranked 35th and n-butyl acetate ranked 37th most common hazard out of 767, based on data pulled in January 2023.

Hexane

Hexane is a hydrocarbon found in gasoline and produced as a byproduct of burning plastic water bottles and Styrofoam trays — a common exposure route for military service members in close proximity to burn pit smoke and other airborne hazards while serving in Iraq, Afghanistan, Djibouti, Saudi Arabia, UAE, Kuwait, and Qatar (Olsen et al., 2022). Among civilian workers, exposure to n-hexane is common in the manufacturing of leather, glues and adhesives, shoemaking, laboratories, and as an extractant in cooking oil production (Faroon et al., 2024).

Since hexane is highly volatile, the most common and most studied route of exposure is inhalation. Common symptoms include lung injury and airway dysfunction (Olsen et al., 2022). Those exposed through inhalation have also been known to experience peripheral neuropathy, particularly in occupational settings, though nerve function can return after toxic exposure ends (Faroon et al., 2024; Kutlu et al., 2009). Other effects include damage to the eyes, heart, and liver, and long-term exposure can cause motor and sensory dysfunction (Zhang et al., 2021).

N-Butyl Acetate

N-butyl acetate is an important solvent in the chemical industry, primarily used in paint and coating manufacturing and the lacquer industry. The chemical is rapidly hydrolyzed to n-butanol and acetic acid following inhalation or dermal exposure, with n-butanol responsible for many of its systemic effects (Segal et al., 2020). Exposure typically occurs through inhalation of vapors or accidental dermal contact during industrial or maintenance applications (Caro & Gallego, 2009). U.S. military personnel may have been exposed to n-butyl acetate through maintenance of military vehicles, cleaning operations, or from use of paints, varnishes, paint removers, and degreasing products. Acute inhalation exposure has been associated with eye, nose, and throat irritation at concentrations as low as 300 ppm (Health Canada, 2023; n-Butyl acetate MAK Value Documentation, 2003).

Currently, no ICD-10-CM codes exist that specifically record exposures to hexane or n-butyl acetate. Documentation of toxic substances and exposures during or associated with military service is a high priority for both the DoD and the VA due to their potential long-term health consequences. Both

Departments are directed under the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act of 2022 to improve identification and documentation of service-related toxic exposures (United States Congress, 2022).

The proposed new codes will enable easier documentation to capture exposure to these substances in electronic health record. This will benefit active-duty service members and Veterans within the DoD and VA, their beneficiaries, including family members, as well as members of the general public who might encounter these chemicals.

This proposal is submitted by Laree LaPierre, MPH on behalf of the DoD, VA, and the Federal Electronic Health Record Modernization (FEHRM) Office.

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TABULAR MODIFICATIONS

Note: The tabular modifications below were presented and supported at March 2026 C&M Meeting.

T52 Toxic effect of organic solvents

New subcategory T52.A Toxic effect of n-butyl acetate

New sub-subcategory T52.AX Toxic effect of n-butyl acetate

New code T52.AX1 Toxic effect of n-butyl acetate, accidental (unintentional)
Toxic effect of n-butyl acetate, NOS

New code T52.AX2 Toxic effect of n-butyl acetate, intentional self-harm

New code T52.AX3 Toxic effect of n-butyl acetate, assault

New code T52.AX4 Toxic effect of n-butyl acetate, undetermined

T52 Toxic effect of organic solvents

T52.B Toxic effect of other organic solvents

New sub-subcategory T52.BX Toxic effects of hexane
Use additional code(s) for all associated manifestations, such as:
contact with and (suspected) exposure to other war theater

New code T52.BX1 Toxic effects of hexane, accidental (unintentional)

New code T52.BX2 Toxic effects of hexane, intentional self-harm

New code T52.BX3 Toxic effects of hexane, assault

New code T52.BX4 Toxic effects of hexane, undetermined

TABULAR MODIFICATIONS

Z77 Other contact with and (suspected) exposures hazardous to health

Includes: contact with and (suspected) exposures to potential hazards to health

Excludes2: contact with and (suspected) exposure to communicable diseases (Z20.-)

Add — contact with and (suspected) exposure to war theater (Z77.3-)

Z77.0 Contact with and (suspected) exposure to hazardous, chiefly nonmedicinal, chemicals

New sub-subcategory — Z77.03 Contact with and (suspected) exposure to hazardous organic solvents

New code — Z77.030 Contact with and (suspected) exposure to n-butyl acetate

New code — Z77.031 Contact with and (suspected) exposure to hexane

New code — Z77.038 Contact with and (suspected) exposure to other hazardous organic solvents

Keloid or hypertrophic scars

Advances in wound healing science and clinical care have clarified meaningful distinctions among pathologic scar phenotypes, including hypertrophic scars and keloids, the two most clinically significant fibroproliferative scar disorders.[1] However, the current ICD-10-CM category L91, Hypertrophic disorders of the skin, does not differentiate between these two clinically distinct disorders. The lack of a granular classification framework contributes to diagnostic ambiguity, limits data accuracy, and constrains research infrastructure.[2]

Pathologic scars represent a heterogeneous group of fibroproliferative disorders that arise following cutaneous injury, surgery, burns, inflammation, and trauma. Hypertrophic scars and keloids represent the two primary pathologic fibroproliferative scar phenotypes and demonstrate distinct biological behavior, growth patterns, treatment responses, and recurrence risk.[1,3] Hypertrophic scars and keloids are not variants along a single continuum but represent biologically distinct disease processes with divergent molecular pathways, fibroblast subtypes, and inflammatory signaling mechanisms.[4,5]

Hypertrophic scars are characterized by excessive collagen deposition that remains confined within the boundaries of the original wound.[1,3] Histologically, hypertrophic scars exhibit well organized collagen fibers oriented parallel to the epidermal surface and prominent α-smooth muscle actin-expressing myofibroblasts.[5] While they may cause discomfort, pruritus, and cosmetic concerns, hypertrophic scars do not exhibit the invasive growth pattern characteristic of keloids, are more likely to spontaneously regress over time, and have significantly lower recurrence rates following excision.[3]

Keloids are fibroproliferative disorders that extend beyond the original wound margins and exhibit locally aggressive growth behaviors. They rarely spontaneously regress and exhibit high recurrence rates following treatment.[1,3,6] Histologically, keloids exhibit haphazardly arranged whorls of thickened hyalinized collagen bundles, which is pathognomonic for this condition. Keloids cause substantial patient suffering, including pain (allodynia, hyperalgesia, or both), severe pruritus, restricted mobility due to contractures, and profound psychosocial distress.[7,8,9] Recurrence rates following surgical excision alone range from 45% to 100%, necessitating multimodal treatment approaches and prolonged follow-up.[3,10] Even with combination therapies, recurrence remains a persistent clinical challenge.

Tabular modifications to differentiate keloid and hypertrophic conditions are being requested by the following individuals:

- Donald Glass, MD, PhD — Associate Professor of Dermatology, University of Texas Southwestern Medical Center
- Morinola Shobajo, MD — Dermatology Resident, University of Minnesota
- Lamont R. Jones, MD, MBA — Henry Ford Health; Keloid Academy
- Jessica Brown-Korsah, MD — Dermatology Resident, University of Pennsylvania
- Itisha Jefferson — Medical Student, Loyola University Stritch School of Medicine
- Shanica Jefferson — Nursing Student, NYU Rory Meyers College of Nursing

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TABULAR MODIFICATIONS

Revise	L91	Hypertrophic <u>or keloid</u> disorders of skin
	L91.0	Hypertrophic scar
Delete		~~Keloid~~
Delete		~~Keloid scar~~
Add		Excludes2: acne keloid (L73.0) scar NOS (L90.5)
New code	L91.A	Keloid
Add		Keloid scar

Keratoconus suspect

Keratoconus is a progressive, bilateral, asymmetric corneal ectatic disorder characterized by focal corneal thinning, steepening, and loss of biomechanical integrity, resulting in irregular astigmatism, higher-order aberrations, visual distortion, and progressive visual impairment.[1-3]

Keratoconus suspect is a clinically recognized condition describing patients with structural corneal findings suggestive of early keratoconus who do not yet meet diagnostic criteria for confirmed disease. Advances in corneal topography, tomography, epithelial thickness mapping, optical coherence tomography, biomechanical assessment, and artificial intelligence-assisted imaging analysis now permit identification of subtle corneal abnormalities long before classic clinical signs or significant visual impairment develop.[3,5,9] These patients may demonstrate abnormal corneal curvature, posterior corneal elevation, abnormal pachymetric distribution, epithelial thickness abnormalities, irregular astigmatism, or other findings consistent with early ectatic disease.[5,9]

Keratoconus is widely recognized as a multifactorial disease influenced by genetic, environmental, and behavioral factors. Established risk factors include family history, habitual eye rubbing, atopy, allergic eye disease, Down syndrome, connective tissue disorders, and other conditions associated with increased mechanical stress on the cornea.[5,6,7,8] Multiple studies have demonstrated that early detection enables timely intervention, particularly corneal collagen cross-linking, which can halt or significantly slow disease progression and preserve long-term visual function.[2,3,5] Conversely, delayed diagnosis may result in progression to more advanced disease, greater visual impairment, reduced treatment benefit, and increased likelihood of requiring invasive procedures such as corneal transplantation.[3] Patients classified as keratoconus suspects therefore represent a clinically meaningful surveillance population requiring ongoing monitoring, repeat imaging, risk-factor counseling, and assessment for progression.[5]

Currently, there is no unique ICD-10-CM code to identify this condition. Clinicians may document keratoconus suspect in the medical record but are generally limited to assigning codes for confirmed keratoconus, nonspecific corneal disorders, or refractive abnormalities. These coding options do not accurately distinguish keratoconus suspects from either normal patients or patients with established keratoconus. As a result, a clinically important patient population cannot be reliably identified within administrative databases, electronic health records, clinical registries, or public health surveillance systems.

The absence of a dedicated code creates a significant information gap. Recent advances in diagnostic technology have expanded the ability to identify patients at risk for developing keratoconus, resulting in a growing population of individuals requiring longitudinal monitoring.[3,5] Researchers reported a prevalence of keratoconus suspect of approximately 1 in 669 children in a Chicago-based pediatric population and noted that the combined prevalence of keratoconus and keratoconus suspect was approximately 1 in 223 children, suggesting that early disease states may be more common than historically appreciated.[2] Keratoconus diagnosed in children and adolescents is frequently more aggressive and progresses more rapidly than disease diagnosed later in life.[2,3,10,11]

The National Keratoconus Foundation is proposing the new codes to facilitate identification of patients with suspected keratoconus, support epidemiologic and outcomes research, improve characterization of disease progression and healthcare utilization.

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TABULAR MODIFICATIONS

H18 Other disorders of cornea

H18.6 Keratoconus

New sub-subcategory	H18.63	Keratoconus suspect
Add		Forme fruste keratoconus
Add		Subclinical keratoconus
Add		Suspected keratoconus
New code	H18.631	Keratoconus suspect, right eye
New code	H18.632	Keratoconus suspect, left eye
New code	H18.633	Keratoconus suspect, bilateral
New code	H18.639	Keratoconus suspect, unspecified eye

Laryngopharyngeal reflux disease

Laryngopharyngeal reflux disease is commonly referred to as laryngopharyngeal reflux, laryngeal reflux, silent reflux, or extra-esophageal reflux. Laryngopharyngeal Reflux Disease (LPRD) is characterized as the retrograde movement of gastric contents – particularly pepsin and other non-acid components – into the larynx and pharynx, where they cause mucosal irritation, inflammation, and associated upper-airway symptoms including dysphonia, chronic cough, throat clearing, globus sensation, and dysphagia[1-4]. These symptoms often dramatically impact quality of life and can be associated with serious health consequences such as airway stenosis, reactive airway disease, and laryngeal cancer [5-7]. LPRD is estimated to affect 34-102 million adults in the United States [4,8,9.]

The pathogenesis of LPRD reflects the interaction of reflux composition, target-organ susceptibility, and neurosensory processing rather than reflux burden alone. Direct chemical injury may occur when gastroduodenal refluxate reaches the laryngopharyngeal mucosa, where weakly acidic or non-acid reflux containing bile salts and pepsin can induce inflammation despite neutral pH[10]. Laryngeal tissues lack the protective mechanisms of esophageal epithelium, rendering them vulnerable to injury even with brief or infrequent exposure[11]. In addition, reflux events confined to the distal esophagus may trigger vagally mediated laryngeal symptoms without detectable laryngopharyngeal exposure, helping explain negative reflux testing and poor response to acid-suppressive therapy in some patients. Esophageal and sphincter dysfunction, including impaired peristalsis, transient lower esophageal sphincter relaxation, or upper esophageal sphincter dysfunction, may further permit reflux ascent.

Unlike classic GERD, LPRD commonly occurs during upright, daytime conditions and may involve small-volume or aerosolized reflux poorly detected by standard diagnostics. Collectively, these mechanisms indicate that tissue susceptibility, rather than reflux burden alone, determines disease expression and distinguishes LPRD from acid-mediated GERD[11-13], with important implications for diagnosis and treatment strategies.

LPRD is a prevalent and clinically significant condition yet it is routinely miscoded as GERD without esophagitis (K21.9), despite clear differences in affected anatomy, reflux composition, diagnostic evaluation, and treatment response[14,16]. LPRD is predominantly associated with weakly acidic or non-acidic reflux containing pepsin and bile salts, limiting the utility of conventional acid-targeting GERD diagnostics [11,16]. Subclassification will be useful to identify clinically meaningful distinctions in LPRD pathophysiology and presentation. Acid versus non-acid -predominant LPRD differs in mechanism, diagnostic detection, and treatment response[15,17]. Direct LPRD (i.e. documented laryngeal exposure) and indirect LPRD (i.e. inflammatory phenotype without observed exposure) represent established clinical patterns[17].

The multidisciplinary team of faculty, providers and staff representing otolaryngology, gastroenterology, and laryngology departments and clinical practices at the Medical College of Wisconsin and Powers Health, is requesting new codes to enhance data quality, support research, epidemiologic tracking, and patient management and outcomes for these conditions.

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TABULAR MODIFICATIONS

J38 Diseases of the vocal cords and larynx, not elsewhere classified

New subcategory
Add

J38.A Laryngopharyngeal reflux disease
Code also, if applicable, associated conditions such as:
laryngitis (J04.-)
pharyngitis (J31.-)

New code
Add

J38.A0 Laryngopharyngeal reflux disease, unspecified
Laryngopharyngeal reflux disease NOS

New sub-subcategory
Add
Add

J38.A1 Direct laryngopharyngeal reflux disease
Laryngopharyngeal reflux disease reflux-mediated
Extraesophageal exposure subtype, direct

New code		J38.A10	Direct laryngopharyngeal reflux disease, acidic
New code		J38.A11	Direct laryngopharyngeal reflux disease, non-acidic
New code		J38.A19	Direct laryngopharyngeal reflux disease, unspecified
New code	J38.A2	Indirect laryngopharyngeal reflux disease,	
Add		Laryngopharyngeal reflux disease reflex-mediated	
Add		Esophagovagal subtype, indirect	
New code	J38.A9	Other laryngopharyngeal reflux disease	

Limbal stem cell deficiency

Limbal stem cell deficiency (LSCD) is a distinct and serious disorder affecting the cornea characterized by dysfunction or insufficient quantity of the limbal epithelial stem cells, which are located along the limbus, the transitional zone between the cornea and sclera where the bulbar conjunctiva terminates. The limbal stem cells are essential for maintaining corneal transparency and responsible for the normal weekly replacement of the entire superficial, barrier cell layer of the cornea, the epithelium. When the limbal epithelial stem cells are depleted or impaired, epithelial renewal becomes inadequate and conjunctival epithelial cells migrate onto the corneal surface, replacing native corneal epithelium in a process known as conjunctivalization. This results in corneal surface instability, pain, chronic inflammation, neovascularization, recurrent epithelial defects, progressive corneal opacification, and ultimately vision loss, including blindness. Although the initiating LSCD dysfunction originates in the limbus, the clinical expression of the condition is a progressive corneal disorder.

The conjunctiva covers the ocular surface from the upper and lower lid margins to the limbus with mucous membrane. It protects the ocular surface via its important role in tear film production, immunology, and antimicrobial effects. Healthy conjunctiva is necessary for maintaining proper tear film, eyelid, and limbal stem cell function. Conjunctival inflammatory disorders and/or trauma can lead to conjunctival abnormalities or deficiency and its sequelae (forniceal foreshortening and symblepharon/ankyloblepharon; limbal stem cell deficiency; decreased mucin and aqueous tear production; and ultimately ocular surface keratinization). The degree of conjunctival deficiency that accompanies LSCD often determines the prognosis of an eye following rehabilitation. Although conjunctival abnormalities can contribute to LSCD, LSCD can be present without conjunctival abnormalities, and conjunctival abnormalities can be present without LSCD. Therefore, LSCD is a histopathologically unique disorder of the cornea.

LSCD represents a clinically and pathophysiologically distinct entity that warrants its own ICD-10-CM code separate from the current classifications under H18.899 (Other specified disorders of cornea, unspecified eye) and H11.24 (Conjunctival scarring). This condition has unique diagnostic criteria that have been well defined by an international consensus group, specific treatment pathways, and distinct outcomes that differ substantially from other corneal disorders currently grouped under H18.899.

LSCD affects an estimated 33,500 to 167,500 individuals in the United States although true prevalence remains uncertain due to insufficient disease awareness and coding limitations. Etiologies may be categorized as non-acquired or acquired. Non-acquired causes include genetic diseases such as aniridia, ectodermal dysplasia, xeroderma pigmentosum, and dyskeratosis congenita. Acquired LSCD encompasses immune-mediated and non-immune-mediated mechanisms. Immune-mediated etiologies most commonly arise from local and systemic chronic inflammation including mucous membrane pemphigoid, Stevens Johnson Syndrome, atopic/allergic ocular surface disease, Sjögren's syndrome, ocular rosacea, graft versus-host disease, and chronic keratouveitis. Non-immune-mediated acquired causes result from etiologies involving chemical/toxic, thermal, or mechanical trauma to the limbus such as iatrogenic damage from multiple limbal surgeries, infectious ocular diseases, chronic lid margin disease, drug-induced injury, toxic exposure, and long-term contact lens use. Severe cases of LSCD are often associated with conjunctival deficiency where chronic conjunctival inflammation causes mucin deficiency (from loss of goblet cells), symblepharon, and lid malpositioning which causes further damage to the limbal stem cells.

Diagnosis of LSCD requires a detailed medical history and clinical examination. Slit-lamp biomicroscopy with fluorescein staining demonstrates the hallmark features including conjunctivalization of the corneal surface, corneal neovascularization, corneal surface irregularity, and recurrent epithelial defects. Recognizing associated abnormalities of the conjunctiva can be useful in clinically diagnosing LSCD. These include conjunctival injection/inflammation, bulbar or palpebral conjunctival fibrosis, forniceal foreshortening, symblepharon/ankyloblepharon, and keratin.

Medical management of LSCD is distinct from other corneal disorders and remains largely palliative, focused on symptom relief, improving ocular surface lubrication, preserving epithelial integrity, and controlling underlying inflammation. Interventions may include topical ocular lubricants, systemic or local anti-inflammatory therapy, autologous serum tears, amniotic membrane applications, and treatment/control of ocular surface or relevant systemic comorbidities. There are no approved pharmacologic therapies for LSCD.

Once the conjunctival inflammation is stabilized systemically, conjunctival abnormalities may need to be addressed with a mucous membrane graft or contralateral conjunctival autograft. This will prepare the ocular surface for addressing the associated LSCD. Superficial keratectomy (with or without amniotic membrane transplantation) is a surgical option for less severe LSCD albeit with short-term benefit and uncertain outcomes and repeatability. For severe LSCD, surgical transplantation of limbal stem cells (with or without conjunctiva) is a treatment option. A keratoprosthesis may be another option for refractory or end-stage LSCD.

Ophthalmologists, Dr. Albert Cheung and Dr. Joshua Hou, are requesting new ICD-10-CM codes to better identify and track these patients.

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TABULAR MODIFICATIONS

H18 Other disorders of cornea

H18.8 Other specified disorders of cornea

New sub-subcategory	H18.84	Corneal limbal stem cell deficiency
New code	H18.841	Corneal limbal stem cell deficiency, right eye
New code	H18.842	Corneal limbal stem cell deficiency, left eye
New code	H18.843	Corneal limbal stem cell deficiency, bilateral
New code	H18.849	Corneal limbal stem cell deficiency, unspecified eye

Macular Telangiectasia

This topic was presented at the March 2026 ICD-10 Coordination and Maintenance meeting. Based on public comments, revisions have been made for reconsideration.

Macular telangiectasia is an uncommon disease affecting the macula. Macular telangiectasia causes vessel abnormalities, neovascularization, and microaneurysms around the fovea resulting in leakage and degeneration of the macula with loss of central vision. There are currently three types of macular telangiectasia identified.

Type 1 is congenital, typically unilateral, and uncommon. Blood vessels dilate, creating aneurysms that leak fluid damaging macular cells.[1]

Type 2 is bilateral and acquired. [1,2] Blood vessels around the fovea become abnormal and may dilate and leak, but the finding is also associated with neurodegeneration of the retina. Type 2 affects approximately 0.1% of the global population.[3] There is a gene therapy treatment of Type 2 with an implant producing ciliary neurotrophic factor to prevent retinal degeneration.

Type 3 is very rare, poorly understood, and primarily occlusive.

The American Academy of Ophthalmology is requesting the following tabular modifications to facilitate accurate data collection and proper tracking of this condition. The condition is frequently misdiagnosed[4] and development of an ICD-10 CM code could improve awareness by physicians and public health advocates, and such awareness could possibly improve access to timely intervention.

References:
1 Contento, R., Polo, R., Ahmed, H., Festok, M., Abu Sbeit, R., Mahrous, A., Mozayan, E., Shah, V., Kim, L., Mammo, D., Bhagat, N., Lim, J., Karth, P., Kitchen, D., Georges Coussa, R., & Akula, S. (2025, August 24). *Macular Telangiectasia - EyeWiki*. EyeWiki. https://eyewiki.org/Macular_Telangiectasia
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3 Klein R, Blodi BA, Meuer SM, Myers CE, Chew EY, Klein BE. The prevalence of macular telangiectasia type 2 in the Beaver Dam eye study. Am J Ophthalmol. 2010 Jul;150(1):55-62.e2. doi: 10.1016/j.ajo.2010.02.013. PMID: 20609708; PMCID: PMC2901890.
4 Raming, Kristin Rodriguez Garcia, Jose Luis; Steffens, Nele; Nadal, Jennifer; Herrmann, Philipp; Holz, Frank G; Pfau, Kristina; Goerdt, Lukas. FREQUENCY OF MISDIAGNOSES AND ASSOCIATED RISK FACTORS IN MACULAR TELANGIECTASIA TYPE 2. Retina 46(2):p 301-308, February 2026. | DOI: 10.1097/IAE.0000000000004681

TABULAR MODIFICATIONS

H35 Other retinal disorders
H35.0 Background retinopathy and retinal vascular changes

New sub-subcategory	H35.08 Macular telangiectasia
Add	Congenital macular telangiectasia
Add	Macular telangiectasia, Type 1
Add	Macular telangiectasia, Type 2
Add	Macular telangiectasia, Type 3
New code	H35.081 Macular telangiectasia, right eye
New code	H35.082 Macular telangiectasia, left eye
New code	H35.083 Macular telangiectasia, bilateral
New code	H35.089 Macular telangiectasia, unspecified eye

Neonatal Supraventricular Tachycardia

NCHS received a request from a HIM professional from Mercy Medical Center, for a unique code for Neonatal Supraventricular Tachycardia (NSVT). This proposal was presented at the March 2026 Coordination Maintenance meeting. In response to public comments, changes have been made and noted in **bold.**

Neonatal supraventricular tachycardia is a serious and most common arrhythmia encountered in the newborn that is characterized by an abnormally rapid heart rate originating above the ventricles. Neonatal supraventricular tachycardia typically presents within the first few days or weeks of life, can cause symptoms ranging from subtle to severe, making prompt diagnosis and management critical to prevent complications.

Neonatal supraventricular tachycardia is a more serious condition than mild tachycardia. It commonly requires assessment through ECG or ECHO, may need more intensive treatments, and can lead to ongoing medical evaluations or care in the future.

The heart rate in neonatal supraventricular tachycardia generally exceeds 220 beats per minute, often with a narrow QRS complex and a regular rhythm. Infants may present with signs such as irritability, poor feeding, lethargy, or even respiratory distress. In some cases, the tachycardia may be asymptomatic and discovered incidentally during routine examinations. The rapid heart rate can compromise cardiac function and diminish cardiac output, potentially leading to congestive heart failure if left untreated.

NSVT often proves challenging to control and may necessitate medication or even interventional ablation. Although it typically starts during the neonatal period, it can persist far past the first 28 days of life. Additionally, NSVT may develop *in utero,* sometimes resulting in fetal cardiac failure and hydrops fetalis.

Existing ICD-10-CM code P29.11, Neonatal tachycardia, does not fully represent the clinical severity of the neonate when supraventricular tachycardia is present, which may represent a congenital issue and have additional future healthcare needs

The request has been reviewed and supported by the American Academy of Pediatrics.

TABULAR MODIFICATIONS

P29 Cardiovascular disorders originating in the perinatal period
Excludes2: congenital malformations of the circulatory system (Q20-Q28)

P29.1 Neonatal cardiac dysrhythmia

New sub-category	**P29.11 Neonatal tachycardia**
Add	**Code also, specified type of tachycardia, if known (I47.1- , I47.2-., I47.9)**

New code	**P29.111 Neonatal supraventricular tachycardia**
New code	**P29.118 Other neonatal tachycardia**
New code	**P29.119 Neonatal tachycardia, unspecified**
Add	**Neonatal tachycardia , NOS**

P29.12 Neonatal bradycardia

Organizing Principles for Classification of Ultra-rare and Genetic Conditions

Background

This topic was first presented at the March 2026 ICD-10 Coordination and Maintenance (C&M) Committee meeting (see previous presentation for additional context). ICD-10-CM does not have defined organizing principles for ultra-rare and genetic conditions that would determine what conditions warrant unique classification or how genetic disorders and susceptibility to a disease are consistently represented and reported. The lack of organizing principles to guide code maintenance efforts has caused delays for new code requests and could lead to inadvertent inconsistencies in code structure or coded data over time. This is a growing problem as the number of requests for unique ICD-10-CM codes to represent ultra-rare conditions, often including gene-level specificity, continues to grow. The problem is compounded by structural constraints, for example, ICD-10-CM was designed to represent broad characterizations to organize and aggregate clinical morbidity data and codes are limited to seven characters within a single hierarchy.

At the March 2026 C&M meeting, NCHS requested input to guide development of principles that will provide clarification on the ICD-10-CM scope and process for incorporating, applying, and maintaining codes for ultra-rare and genetic conditions. Input following the March meeting underscores both the urgency and complexity of developing such principles, while maintaining ICD-10-CM's structural integrity. There was broad input recognizing ICD-10-CM cannot indefinitely expand and a framework is needed to determine disease-level and gene-level representation that is carried out in a manner that incorporates external expert input and industry efforts. There is also agreement that unique ICD-10-CM codes should correspond to clinically recognizable and stable disease entities, conditions with established diagnostic criteria or strong gene-disease validity, and disorders for which accurate identification materially affects care pathways, surveillance, or outcomes. Furthermore, gene-specific codes require even higher evidentiary thresholds due to the pace at which knowledge of genotypes and phenotypes is evolving. Such thresholds, however, cannot be based on prevalence alone since the absence of a code itself may hinder accurate prevalence measurement.

While there is agreement that visibility of patients with rare diseases is essential, there are varying perspectives on what data standards, alone or in combination, are best suited to identify these patients, scalable approaches, and the level of detail that should be represented in ICD-10-CM. This diverse input is being considered. In the meantime, several action items will enable the current ICD-10-CM maintenance process to advance proposals currently on hold, in addition to new submissions. Such actions include, for example, establishing eligibility criteria and clarifying coding guidelines and conventions.

Proposed Eligibility Criteria

A condition may be considered for unique representation in ICD-10-CM (in one or more unique codes) when it meets criteria in the following table. In this table, criteria 1 through 4 are high priority. To be considered for a unique code(s), a condition must meet the criteria in section A (i.e. meet both 1

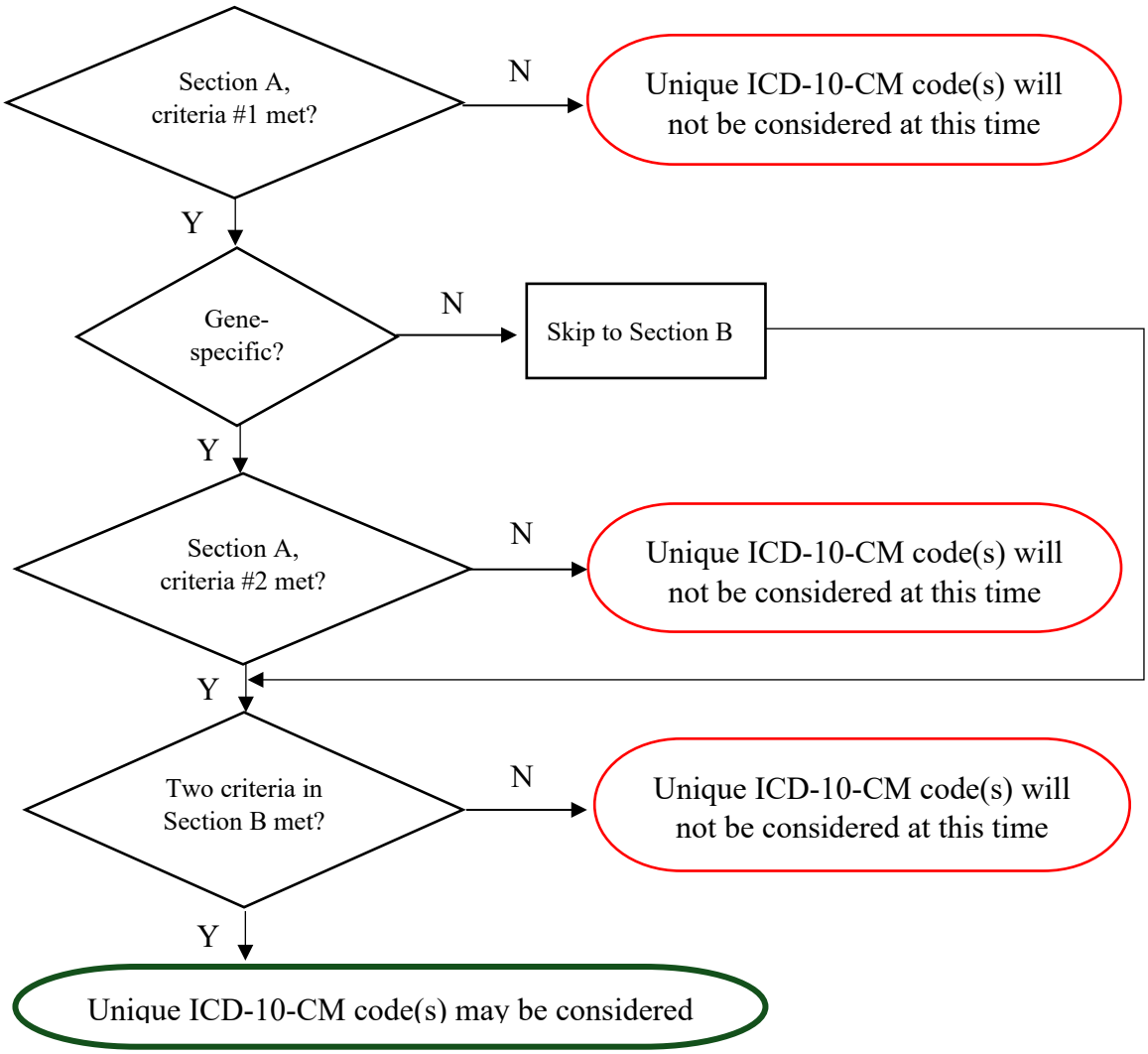
and 2, when 2 is applicable). A condition must also meet at least two of the three criteria in section B. Criteria in Section C represent additional considerations that further support the need for a unique code(s) but are insufficient alone.

NOTE: Health care coverage (health insurance) and reimbursement for healthcare services are intentionally not included in the eligibility criteria.

Criteria	Description
A. Required to warrant consideration of unique ICD-10-CM code(s)	
1. Established clinically distinct, stable entity	A condition should have a stable, coherent phenotype that clinicians can reliably identify. This might be evidenced by published diagnostic criteria and well-described clinical features recognized by relevant professional societies and supported in peer-reviewed scientific literature. The disease should remain meaningful over time and not be based on transient or poorly validated findings. This may be evidenced by recognition as a durable disease concept across multiple resources or the existence of an identifier in other terminologies (e.g. SNOMED, OMIM, Orphanet, MONDO, ClinGen, NORD, GARD).
2. Strong gene-disease evidence (if gene-specific)	To ensure ICD-10-CM avoids premature or unstable gene-level codes, there must be clinical validity for the gene-disease relationship before creating gene-based or gene-specific codes. There should be multiple, replicated human observations supporting the association. Supporting evidence may include a stable identifier in a related terminology or ClinGen designation as “definitive” or “strong.”
B. At least two also required to warrant consideration of unique ICD-10-CM code(s)	
3. Distinct meaningful clinical management implications	Unique ICD-10-CM code(s) may be considered when the diagnosis directly affects how patient care is delivered, such as treatment choices or prognostic significance. This might include, for example, medication contraindications or the need for preventative screening (e.g. cancer risk, organ-specific monitoring).
4. Other compelling implications, such as care coordination or patient safety	Unique ICD-10-CM code(s) may be considered when there are other compelling implications, such as care coordination across multiple disciplines or an opportunity to enable patient safety. This might include, for example, instances when non-specific classification has consequences for care pathways or may lead to increased clinical risk (e.g. transplant donor selection).
5. Disease prevalence in the United States	Prevalence or incidence should be considered based on U.S. data, not global data. The Orphan Drug Act defines a rare disease as a condition that affects less than 200,000 people in the U.S.[1,2] An ultra-rare disease is a condition that affects fewer than 1 in 50,000,[3] which is fewer than 7,000 people affected in the U.S. Given that ICD-10-CM was designed to categorize (or group) diseases, generally, a condition should affect at least 1,000 people in the U.S. to be uniquely classified within the limited classification structure.
C. Additional considerations (not required)	
6. Multisystem involvement requiring unified classification	A unique code may be important when a condition affects multiple organ systems, making body-system codes insufficient. Consider a unifying disease-level code in this circumstance to avoid fragmentation.

7. Holds value for research, surveillance, or epidemiological tracking	Unique codes should be considered when non-specific code groupings may obscure public-health tracking of disease burden or outcomes. Research needs include clinical trial recruitment, registry participation, and natural-history study enrollment.

CDC/NCHS proposes applying the eligibility criteria according to the following decision tree.



Action Items

Initial CDC/NCHS action items for the current ICD-10-CM maintenance process include:

- Clarify guidance on multiple coding and sequencing, for example clarify use of codes in the QA0 category with chapter specific codes for developmental disorders (F80-F82), intellectual disabilities (F70-F73), or epilepsy (G40) or developmental and epileptic encephalopathy (G93.45).

- Clarify interaction between genetic disorder codes, manifestations, and Z15 susceptibility codes, including when co-reporting is prohibited, redundant, or inappropriate; Identify and improve related instructional notes and Official Guidelines for Coding and Reporting.
- Clarify the approach going forward for placement of single and multi-system genetic or chromosomal disorders within the existing ICD-10-CM structure. For example, some genetic neurodevelopmental disorders were categorized in body system chapters but more recently many are organized in the newer subcategory QA0.0 based on broad groupings by gene function according to Guerrini et al., 2023,[4] to better represent variability in presentation.
- Establish consistent approaches for determining when to include or not include gene variant names in code titles and when combination (pre-coordinated) codes may be warranted to ensure code titles are unique and descriptive of the condition, without combinatorial explosion. For instance, there must be evidence of the need for a unique code at the level of specificity requested. Examples of how a unique code will be used should illustrate why the proposed level of specificity is needed, by whom, and how likely it is that necessary information will be documented in the health record.
- Evaluate utilization of relevant ICD-10-CM codes to inform improvements and minimize coding burden.

Next Steps

The CDC/NCHS invites commenters to provide input in the 60-day comment period following this September 2026 ICD-10 Coordination and Maintenance Committee meeting. Please submit comments to this inbox: nchsicd10cm@cdc.gov.

We will use this input and conversations with subject matter experts as we proceed on action items and to confirm and refine the eligibility criteria that will be applied to proposals currently on hold and future submissions. CDC/NCHS anticipates applying eligibility criteria to resume consideration of ultra-rare and genetic proposals currently on hold in preparation for the March 2027 C&M meeting. Please submit your comments to the inbox. We welcome your suggestions and feedback on the eligibility criteria and initial action items.

References

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3. Undiagnosed Diseases Network Foundation (UDNF), "What are ultra-rare diseases" https://udnf.org/what-are-ultra-rare-diseases/
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Presence of continuous glucose monitoring device

Continuous Glucose Monitors (CGMs) are wearable medical devices that track your glucose levels in real-time, 24 hours a day. The sensor is a tiny fine thread inserted just under the skin (usually on the back of the arm or abdomen) that measures glucose in the interstitial fluid. This eliminates the need for constant fingersticks, provide a comprehensive look at glucose trends and send immediate alerts if blood sugar is rising or falling dangerously. Viewing the blood sugar levels in real time can help make informed decisions about food, physical activity and medications for the patient.

Diabetic patients can benefit from using a CGM. Especially patients with type 1 diabetes, type 2 diabetes with insulin use and patients that have problems with managing blood sugar levels. Maintaining blood glucose level in target range can help prevent other health problems caused by diabetes.

Currently, there is no unique ICD-10-CM code for these monitoring devices. Following the American Hospital Association (AHA) Coding Clinic Editorial Advisory Board (EAB) discussion, NCHS is requesting the following tabular modifications to report continuous glucose monitoring devices.

References:
https://diabetes.org/about-diabetes/devices-technology/choosing-cgm
https://www.niddk.nih.gov/health-information/diabetes/overview/managing-diabetes/continuous-glucose-monitoring
https://www.cdc.gov/diabetes/treatment/continuous-glucose-monitors.html

TABULAR MODIFICATIONS

	Z97	Presence of other devices
New subcategory	Z97.8	Presence of other specified devices
New code		Z97.81 Presence of continuous glucose monitoring device
New code		Z97.89 Presence of other specified devices

Progressive myopia

This topic was originally presented at the March 2026 ICD-10 Coordination and Maintenance meeting. Based on comments received during the public comments period, a revised proposal is being presented for consideration. Changes are indicated in **BOLD**.

Myopia is one of the most common ocular conditions worldwide and its prevalence has been increasing in both children and adults. Global projections suggest that nearly half of the world's population could be myopic by 2050, with a rise in high myopia and associated visual impairment from abnormal enlargement of the eye.[1] Population-based data from the United States demonstrate growing prevalence of myopic refractive error across age groups.[2] Higher degrees of myopia are associated with structural changes of the entire eye and a substantially increased risk of sight-threatening complications including myopic maculopathy, choroidal neovascularization, retinal detachment, glaucoma, and cataract. Pathologic myopia is estimated to affect 1–3% of the global population with its prevalence expected to rise as myopia prevalence increases.[3]

This request is submitted in response to the growing body of literature evaluating the use of optical and pharmacologic strategies to slow myopia progression in children (termed myopia control). These publications include randomized clinical trials demonstrating varied degrees of efficacy of dual-focus soft contact lenses,[4] specialized spectacle lens designs,[5] and low-concentration atropine[6] designed to slow myopia progression. There has been a large uptake of such treatment strategies in the US and around the world. There are now two FDA-authorized treatments in the US. For these reasons there is a public health need to understand how many eligible children there are in United States and how many are being treated.

Currently, myopia as a refractive error is coded in ICD-10-CM using H52.1 Myopia, in the "Disorders of refraction and accommodation" chapter. This code describes the refractive state of the eye but does not identify whether the myopia is progressing, and which children could benefit from myopia control treatment to slow progression. While myopia progression indicates that there are increases in the refractive error and the eyeglasses prescription, it is more serious related to abnormal eye growth including abnormal changes in the structure of globe and retina. Codes in ICD-10-CM reporting ocular changes associated with abnormal myopia progression are included in codes H44.2A through H44.2E, Degenerative Myopia with the most severe complications including retinal detachment, macular hole and neovascularization. There is no code in either section of ICD-10-CM, H44.2- or H52.1, noting whether there is ongoing progression of the myopia.

The American Academy of Ophthalmology is requesting the following tabular modifications to facilitate accurate data collection of patients with progressive myopia and progressive high myopia at risk for degenerative complications of the retina.

References:
1. Holden BA, Fricke TR, Wilson DA, et al. Global prevalence of myopia and high myopia and temporal trends from 2000 through 2050. Ophthalmology. 2016;123(5):1036-1042.
2. Vitale S, Ellwein L, Cotch MF, Ferris FL, Sperduto RD. Prevalence of refractive error in the United States, 1999-2004. Arch Ophthalmol. 2008;126:1111-9.

3. Flitcroft DI, He M, Jonas JB, et al. IMI – Defining and Classifying Myopia: A Proposed Set of Standards for Clinical and Epidemiologic Studies. Investigative Ophthalmology & Visual Science. 2019;60(3):M20-M30. doi:10.1167/iovs.18-25957.
4. Chamberlain P, Peixoto-de-Matos SC, Logan NS, Ngo C, Jones D, Young G. A 3-year Randomized Clinical Trial of MiSight Lenses for Myopia Control. Optometry and Vision Science. 2019;96(8):556-567. doi:10.1097/opx.0000000000001410
5. Ma J-X, Tian S-W, Liu Q-P. Effectiveness of peripheral defocus spectacle lenses in myopia control: a Meta-analysis and systematic review. International Journal of Ophthalmology. 2022;15(10):1699.
6. Yam JC, Jiang Y, Tang SM, et al. Low-concentration atropine for myopia progression (LAMP) study: a randomized, double-blinded, placebo-controlled trial of 0.05%, 0.025%, and 0.01% atropine eye drops in myopia control. Ophthalmology. 2019;126(1):113-124.

TABULAR MODIFICATIONS

H44 Disorders of globe
H44.2 Degenerative myopia
Malignant myopia

New sub- subcategory	H44.2F	Degenerative myopia with progression **of refractive error**
Add		Progressive degenerative myopia
Add		Progressive high myopia
Add		Progressive myopia
New code	H44.2F1	Degenerative myopia with progression **of refractive error**, right eye
New code	H44.2F2	Degenerative myopia with progression **of refractive error**, left eye
New code	H44.2F3	Degenerative myopia with progression **of refractive error**, bilateral
New code	H44.2F9	Degenerative myopia with progression **of refractive error**, unspecified eye

Progressive Pulmonary Fibrosis

Interstitial lung disease (ILD) encompasses a heterogeneous group of pulmonary disorders characterized by inflammation, fibrosis, or both of the alveolar interstitium.[1] Although fibrotic ILDs arise from diverse and sometimes uncertain etiologies, a subset of patients develop a similar pattern of progressive fibrosis characterized by worsening respiratory symptoms, declining lung function, and increasing fibrosis on imaging. With recognition of this shared clinical trajectory, in 2022, the American Thoracic Society (ATS), European Respiratory Society (ERS), Japanese Respiratory Society (JRS), and the Asociación Latino Americana de Tórax (ALAT) published updated guidelines that introduced a distinct phenotype: Progressive Pulmonary Fibrosis (PPF).[2]

PPF is defined by progression criteria rather than etiology, requiring at least two of the following within one year, with no alternative explanation[2]:

- worsening respiratory symptoms;
- physiological evidence of disease progression, including an absolute decline in forced vital capacity (FVC) ≥5% or absolute decline in Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) (corrected for hemoglobin) ≥10%; and
- radiological evidence of disease progression, including increasing fibrosis on high-resolution computed tomography

This definition is agnostic to underlying ILD diagnosis, marking a paradigm shift in how health care professionals identify and manage fibrotic lung disease. The updated guidelines have influenced regulatory labeling and payer coverage policies, all of which now recognize PPF as a distinct phenotype with widely adopted nomenclature.

As a manifestation code, J84.170 (Interstitial lung disease with progressive fibrotic phenotype in diseases classified elsewhere) requires an underlying disease to be coded first and cannot serve as the principal diagnosis. This structure depends on identifying an underlying etiology, whereas PPF is defined by disease progression and may be recognized before, or even without, a definitive underlying diagnosis.

Emerging evidence supports this concern. A 2026 analysis of TriNetX data (2021-2024) found that J84.170 coding identified far fewer patients than proxy-based algorithms for progression. This study highlights substantial undercapture by diagnosis coding, limited overlap between coded and proxy populations, and potential unmet treatment need among uncoded patients.[4] Results from the analysis included:

- J84.170 ICD-10 coding identified far fewer patients than proxy-based progression algorithms, suggesting substantial undercapture (3.7/100,000 prevalence).
- Only 1.4–10.0% of proxy-based progression patients had J84.170 code, and less than half of coded patients met proxy criteria, indicating limited overlap and possible miscoding.

Underreporting of PPF also obscures epidemiologic tracking, and can affect health outcomes research, and resource planning. A dedicated code will enable accurate reporting and population health management. This proposal is based on a request to create a new code received from Boehringer Ingelheim.

References
1 Maher TM et al. Nerandomilast in Patients with Progressive Pulmonary Fibrosis. *N Engl J Med*. 2025 Jun 12;392(22):2203-2214. https://doi.org/10.1056/NEJMoa2503643
2 Raghu G. et al. Idiopathic Pulmonary Fibrosis (an Update) and Progressive Pulmonary Fibrosis in Adults: An Official ATS/ERS/JRS/ALAT Clinical Practice Guideline. AJRCCM. 2022 May 1, Vol 205, issue 09. https://doi.org/10.1164/rccm.202202-0399st
3 Cigna. Pulmonary Antifibrotics– Jascayd Prior Authorization Policy. July 15, 2026. https://static.cigna.com/assets/chcp/pdf/coveragePolicies/cnf/cnf_956_coveragepositioncriteria_idiopathic_pulmonary_fibrosis_and_related_lung_disease_jascayd_pa.pdf, accessed 8/21/2026.
4 Sheffield B, Jackson PD. B41-31 Progressive Fibrosing Interstitial Lung Disease (PF-ILD) Is Under-Diagnosed: A Detailed Analysis of Coded vs Proxy Patient Populations, American Journal of Respiratory and Critical Care Medicine, Volume 212, Issue Supplement_1, May 2026, aamag162.2499, https://doi.org/10.1093/ajrccm/aamag162.2499

TABULAR MODIFICATIONS

J84 Other interstitial pulmonary diseases

J84.1 Other interstitial pulmonary diseases with fibrosis

J84.11 Idiopathic interstitial pneumonia

J84.112 Idiopathic pulmonary fibrosis

Add — Excludes1: progressive pulmonary fibrosis (J84.12)

New code — J84.12 Progressive pulmonary fibrosis
Add — Progressive fibrotic interstitial lung disease NOS
Add — Excludes1: idiopathic pulmonary fibrosis (J84.112)
Add — other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere (J84.17-)

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

J84.170 Interstitial lung disease with progressive fibrotic phenotype in diseases classified elsewhere
Delete — ~~Progressive fibrotic interstitial lung disease~~
Add — Excludes1: idiopathic pulmonary fibrosis (J84.112)
Add — progressive pulmonary fibrosis (J84.12)

Reactive Infectious Mucocutaneous Eruption

Reactive Infectious Mucocutaneous Eruption (RIME) is a distinct clinical disease characterized by acute mucositis involving two or more mucosal sites (oral, ocular, genital), that may include limited skin blistering, following an infectious prodrome and in the absence of a medication trigger. Mycoplasma pneumoniae is the most common trigger, and less common pathogen triggers include SARS-CoV-2, Chlamydia pneumoniae, influenza, and adenovirus.

The clinical course of RIME commonly begins with respiratory symptoms approximately one week prior to the onset of mucocutaneous eruption. RIME is a dermatologic condition marked by prominent mucositis with minimal skin involvement. Mucositis can affect the mouth, eyes, and genitals. When Mycoplasma pneumoniae is identified, the condition may be referred to as Mycoplasma-Induced Rash and Mucositis (MIRM).

RIME/MIRM is distinct from Stevens-Johnson Syndrome (SJS) and Toxic Epidermal Necrolysis (TEN) because it is triggered by pathogens, more commonly affects children and adolescents, and principally affects mucous membranes more severely than the skin.

There is currently no dedicated ICD-10-CM code for RIME or MIRM. Current coding is often performed using Mycoplasma infection codes (A49.3, B96.0) and mucositis codes (K12.3X), which are non-specific. In a review of 136 cases of Stevens-Johnson Syndrome, 83 cases (39.9%) were reclassified as RIME following expert review, demonstrating the potential impact of misclassification.

The Pediatric Dermatology Research Alliance is requesting a new code to improve diagnostic accuracy, case identification, epidemiologic surveillance, and clinical research.

References:

1. Canavan TN, Mathes EF, Frieden I, Shinkai K. Mycoplasma pneumoniae-induced rash and mucositis as a syndrome distinct from Stevens-Johnson syndrome and erythema multiforme: a systematic review. J Am Acad Dermatol. 2015 Feb;72(2):239-45. doi: 10.1016/j.jaad.2014.06.026. PMID: 25592340.
2. Martinez-Cabriales S, Coulombe J, Aaron M, Hussain SH, Linggonegoro D, Lara-Corrales I, Barootes H, Brandling-Bennett H, Covelli I, Kirkorian AY, Shah N, Castelo-Soccio L, McKenzie P, Arkin LM, Heinze A, Liy-Wong C, Travis N, Rieder M, Del Pozzo-Magana BR, Schoch JJ, Monir R, Glick SA, Uwakwe L, Skillman S, Hekman DP, Lethebe BC, Ramien ML. Preliminary summary and reclassification of cases from the Pediatric Research of Management in Stevens-Johnson syndrome and Epidermonecrolysis (PROMISE) study: A North American, multisite retrospective cohort. J Am Acad Dermatol. 2024 Mar;90(3):635-637. doi: 10.1016/j.jaad.2023.08.112. Epub 2023 Nov 4. PMID: 37926378.
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TABULAR MODIFICATIONS

L51 Erythema multiforme
L51.8 Other erythema multiforme

New code L51.81 Reactive Infectious Mucocutaneous Eruption

Add Use additional code, to identify associated infections such as:
Add Mycoplasma pneumoniae (B96.0)

New code L51.89 Other erythema multiforme

Recurrent respiratory papillomatosis

Recurrent Respiratory Papillomatosis (RRP) is a rare, chronic, incurable viral disease typically caused by persistent infection with human papillomavirus (HPV) types 6 and 11. HPV oncoproteins E6 and E7 upregulate vascular endothelial growth factor (VEGF) through interaction with hypoxia-inducible factor 1-alpha, promoting recurrent exophytic squamous papilloma growth at mucosal squamo-columnar transition zones throughout the aerodigestive tract leading to growth of papillomas on the epithelial surface.

RRP presents in two clinically distinct forms. Juvenile-onset RRP (JORRP) is acquired perinatally through vertical transmission and typically manifests before age 5. It is associated with higher surgical frequency, greater disease extent, and longer lifetime disease burden. HPV-11 in JORRP carries elevated risk of tracheal and pulmonary spread. Adult-onset RRP (AORRP) is acquired through sexual transmission and presents most commonly in the third or fourth decade of life.

The three sites for which dedicated codes are requested represent clinically and prognostically distinct disease tiers:

- **Laryngeal RRP:** The most common presentation. Papillomas arise at the true and false vocal folds, ventricles, subglottis, and epiglottis, causing progressive dysphonia, hoarseness, stridor, and airway obstruction. Standard treatment is repeated microlaryngoscopy with laser ablation or mechanical surgical debridement, sometimes combined with adjuvant medical therapies (On-Label, Off-Label).
- **Tracheal RRP:** Occurs predominantly in HPV-11 infection, following tracheostomy, or with aggressive JORRP. Tracheal papillomas cause progressive airway narrowing, dyspnea, and recurrent respiratory infections. Management requires rigid bronchoscopy with laser ablation, often with systemic adjuvant therapy. Tracheal involvement represents a distinct severity tier with higher surgical risk and greater likelihood of pulmonary progression than laryngeal-only disease.
- **Pulmonary RRP (bronchus and lung):** The most severe form, occurring in up to 9% of all RRP patients. Papillomas in the bronchi and lung parenchyma cause recurrent pneumonia, bronchiectasis, progressive respiratory failure, and in rare cases malignant transformation to squamous cell carcinoma. Pulmonary RRP is almost exclusively HPV-11 associated and carries significant mortality risk.

RRP is a distinct, internationally recognized clinical entity with a specific viral etiology (HPV-6/11), an obligate recurrent disease course, and a treatment trajectory that differs fundamentally from other benign neoplasms of the respiratory tract. Estimated U.S. prevalence is approximately 27,000 active adult cases (Precigen Papzimeos FDA BLA, 2025). Published incidence figures range from approximately 4.3 per 100,000 children per year for JORRP to approximately 1.8 per 100,000 adults per year for AORRP. All published figures are acknowledged to be unreliable because they are derived from multi-code proxy algorithms rather than a unique identifier.

The Recurrent Respiratory Papillomatosis Foundation (RRPF) is requesting new codes to differentiate this condition from other benign neoplasms of the respiratory tract.

References:

1. N. Kohli, S. I. Pai, J. Buckingham, et al., " *A Clinical Consensus Statement on Pulmonary Recurrent Respiratory Papillomatosis*," *The Laryngoscope* 135, no. 12 (2025): 4642–4650, https://doi.org/10.1002/lary.32463.
2. Orphanet ORPHA:60032. Recurrent respiratory papillomatosis. Estimated prevalence 1 per 70,400 (UK); notes ICD-10 coding variability as a methodological limitation in prevalence studies.
3. Precigen, Inc. FDA Full Approval Announcement: Papzimeos (zopapogene imadenovec-drba) for the treatment of adults with RRP. August 15, 2025.

TABULAR MODIFICATIONS

	D14	Benign neoplasm of middle ear and respiratory system
New subcategory	D14.A	Recurrent respiratory papillomatosis
Add		Recurrent squamous papillomatosis
Add		Use additional code for associated human papillomavirus (B97.7)
Add		Excludes1: Benign neoplasm of bronchus and lung (D14.3-) Benign neoplasm of larynx (D14.1) Benign neoplasm of trachea (D14.2)
New code	D14.A0	Recurrent respiratory papillomatosis, unspecified
Add		Recurrent respiratory papillomatosis NOS
New code	D14.A1	Recurrent respiratory papillomatosis, laryngeal
New code	D14.A2	Recurrent respiratory papillomatosis, tracheal
New code	D14.A3	Recurrent respiratory papillomatosis, bronchus and lung
New code	D14.A9	Recurrent respiratory papillomatosis, multiple sites

Refractory herpes simplex virus (HSV)

Refractory herpes simplex virus (HSV) infection is a clinically distinct form of HSV disease defined by failure of lesions or other manifestations to improve appropriately despite antiviral therapy. Recent consensus literature distinguishes refractory HSV from antiviral-resistant HSV: refractory HSV is a clinical treatment-failure state, whereas resistant HSV requires phenotypic or genotypic confirmation of reduced antiviral susceptibility. This distinction is clinically important because patients frequently present first with refractory disease, while laboratory resistance testing may be delayed (3-4 weeks), unavailable, or inconclusive. The condition is therefore medically and scientifically definable, and it represents a meaningful subtype of HSV illness that is not adequately captured by existing generic HSV diagnosis codes.[1,2]

Refractory HSV occurs predominantly in immunocompromised patients, including hematopoietic stem cell transplant recipients, patients with hematologic malignancies, people with advanced HIV, and some solid organ transplant recipients.[1,3,4] The cause of refractory HSV is increasingly well understood, although not every case is explained by a single mechanism. In many patients, refractoriness reflects antiviral selection pressure after prolonged or repeated nucleoside analogue exposure in the setting of impaired cell-mediated immunity, leading to mutations affecting viral thymidine kinase, DNA polymerase, or other antiviral targets.[1,5] At the same time, not all clinically refractory cases have laboratory-confirmed resistance.

The clinical presentation of refractory HSV is sufficiently characteristic to justify separate classification. Compared with typical recurrent HSV, refractory HSV is marked by persistent, progressive, atypical, or delayed-healing lesions, often with substantial pain, tissue destruction, or recurrence despite appropriate therapy. Lesions may involve oral, labial, genital, perianal, or other mucocutaneous sites and may become hypertrophic, ulcerative, necrotic, or otherwise clinically atypical.[1,6,7] In hematologic patients with acyclovir-resistant HSV, oral lesions were present in all cases in one recent series, most commonly involving the tongue and lips, and mortality remained high despite treatment, although presumably the mortality was not due to the HSV itself.[6] These features demonstrate that refractory HSV is not a minor variation of ordinary HSV recurrence; it is a severe treatment-failure state associated with major changes in evaluation, management, and prognosis.[6,7]

HSV infection overall is highly prevalent worldwide, with an estimated 25.6 million new HSV-2 infections and 519.5 million prevalent HSV-2 infections among persons aged 15-49 years in 2020, plus 16.8 million new genital HSV-1 infections and 376.2 million prevalent genital HSV-1 infections in the same age group.[8] Against this large baseline burden, refractory HSV represents a clinically important high-risk subset concentrated in immunocompromised populations. A major review reported that acyclovir-resistant HSV is generally below 1% in immunocompetent populations, whereas markedly higher frequencies are seen in immunocompromised patients, especially hematopoietic stem cell transplant recipients.[5] A systematic review in allogeneic HSCT recipients reported a median incidence

of acyclovir-resistant HSV of 16.1%, with an increasing trend in recent years.[3] Solid organ transplant recipients also develop HSV complications, although acyclovir-resistant disease appears less common than in HSCT populations.[3]

A unique ICD-10-CM code for refractory HSV would have strong clinical utility because it would identify a treatment-failure state that reliably triggers a different care pathway than uncomplicated HSV infection. In practice, refractory HSV prompts reassessment of diagnosis, review of adherence and absorption, evaluation for antiviral resistance, consideration of immune deficits, infectious diseases consultation, and escalation to second -line or salvage therapy such as foscarnet, cidofovir, topical compounded therapies, or investigational agents. [1,2,3,7]

The clinical impact of this distinction is substantial. In the largest recent multicenter study of foscarnet -treated acyclovir-resistant or refractory mucocutaneous HSV in immunocompromised patients, only 48% of episodes healed by the end of or after treatment, while 84% of treatment episodes were complicated by at least one adverse event, including electrolyte disturbances in 65% and kidney dysfunction in 42%.[2] In a recent series of hematologic patients with acyclovir-resistant HSV, 11 of 18 patients died after a median of 3 months following diagnosis.[6] These outcomes underscore that refractory HSV is associated with considerable morbidity, toxicity, and poor prognosis, and that improved case identification would benefit clinical documentation, care standardization, outcome tracking, and research focused on a medically vulnerable population.[2,3,6]

The proposed code would be especially relevant in encounters where refractory HSV materially changes the course of care. Once documented, this diagnosis often prompts review of antiviral adherence and absorption, reassessment of immunosuppressive status, resistance testing, specialty consultation, and escalation to therapies associated with greater complexity and toxicity. In the largest recent multicenter study of immunocompromised patients treated with foscarnet for acyclovir-resistant or refractory mucocutaneous HSV, only 48% of episodes healed by the end of or after treatment, while adverse events occurred in 84% of treatment episodes, including frequent electrolyte abnormalities and kidney dysfunction.[2] This illustrates why documentation of refractory HSV is not incidental wording but rather a marker of a clinically distinct treatment-failure state that alters evaluation, monitoring, and management.[2]

Importantly, the proposed code should be assignable only when the provider clearly documents refractory HSV as a diagnosis. It should not be assigned solely on the basis of antiviral medication exposure, lesion chronicity, microbiology orders, or coder interpretation that the patient “must have” refractory disease. If the record documents only HSV infection, oral ulcers, genital lesions, “possible resistance,” or “persistent HSV” without a clear provider diagnosis of refractory HSV, clarification would be appropriate before code assignment. This approach is fully consistent with ICD-10-CM documentation principles and would promote both diagnostic specificity and coding accuracy.[9]

Accordingly, this proposal recommends that refractory HSV be classified within the existing herpes simplex disease framework, rather than in the Z series. This placement best reflects the clinical reality that refractory HSV is a current, medically meaningful infectious disease state requiring distinct evaluation and management.

The proposed changes would fill an identifiable gap in the current classification, align ICD-10-CM with contemporary medical literature distinguishing refractory HSV from antiviral-resistant HSV, and improve the ability of clinicians, health systems, and researchers to identify, document, and study a medically important condition that is currently only partially represented in coded data.[1-8,10]

Veloxis Pharmaceuticals, Inc. is requesting the following tabular modifications for monitoring and tracking refractory herpes simplex.

References

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TABULAR MODIFICATIONS

	A60	Anogenital herpesviral [herpes simplex] infections
New code		A60.A Refractory anogenital herpesviral infection
Add		Refractory genital herpes simplex virus infection
Add		Refractory perianal herpes simplex virus infection
Add		Refractory urogenital herpes simplex virus infection
Add		Code also, if applicable:
Add		complications of transplanted organs and tissue (T86.-)
Add		herpesviral [herpes simplex] infections (B00.0-B00.9)
Add		herpesviral infection of genitalia and urogenital tract (A60.0-A60.9)
Add		human immunodeficiency virus [HIV] disease (B20)

	B00	Herpesviral [herpes simplex] infections
New code		B00.A Refractory herpes simplex virus infection
Add		Refractory mucocutaneous herpes simplex virus infection
Add		Refractory oral herpes simplex virus infection
Add		Refractory labial herpes simplex virus infection
Add		Code also, if applicable:
Add		complications of transplanted organs and tissue (T86.-)
Add		herpesviral [herpes simplex] infections (B00.0-B00.9)
Add		herpesviral infection of genitalia and urogenital tract (A60.0-A60.9)
Add		human immunodeficiency virus [HIV] disease (B20)

Segmental vitiligo

Segmental vitiligo (SV) is a distinct subtype of vitiligo characterized by unilateral or localized depigmented patches that typically follow a dermatomal or segmental distribution. It most commonly presents in childhood or adolescence and is thought to differ from nonsegmental vitiligo (NSV) in clinical course, pathogenesis, and treatment response. SV often progresses rapidly during an early phase and subsequently stabilizes.

SV is typically diagnosed and documented by dermatologists and pediatric dermatologists through clinical examination, Wood's lamp evaluation, lesion distribution, disease history, and treatment response. Documentation may include localization, progression, stability, and treatment plans. It is hypothesized SV rapidly destroys the deep melanocyte reservoirs in hair follicles. It thus requires early, aggressive intervention during its active phase. It is also the ideal candidate for surgical intervention, rarely indicated for active generalized NSV.

SV is currently captured in ICD-10-CM under L80, Vitiligo, which encompasses multiple clinically distinct subtypes. Existing coding does not distinguish segmental vitiligo from generalized or nonsegmental forms, limiting research precision and healthcare analytics. Segmental vitiligo differs significantly from nonsegmental vitiligo in onset, distribution, prognosis, and treatment response, yet these distinctions are not currently represented in ICD-10-CM coding.

Pediatric Dermatology Research alliance is proposing the following tabular modifications to improve diagnostic specificity and support clinical care and research efforts.

TABULAR MODIFICATIONS

L80 Vitiligo
Excludes2: vitiligo of eyelids (H02.73-)
vitiligo of vulva (N90.89)

New subcategory L80.A Vitiligo

New code L80.A0 Vitiligo, unspecified
Add Vitiligo NOS

New code L80.A1 Segmental vitiligo
Add Localized vitiligo

New code L80.A2 Non-segmental vitiligo
Add Generalized vitiligo

New code L80.A9 Other vitiligo

Sepsis

This is a detailed proposal for changes to ICD-10-CM regarding the definition of sepsis based on the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) from 2016.[1] There are a number of places where the term sepsis is used in ICD-10-CM, and for the most part these have been based on the earlier consensus definitions that may be referred to as Sepsis-2 (2001)[2] or Sepsis-1 (1991)[3] (note these are the years of the sepsis consensus conferences and not of publication). This is based on input from multiple sources and incorporating changes based on multiple comments from previous presentations. This was most recently presented in brief with request for input in March 2026. There was an earlier proposal for updates to ICD-10-CM presented in September 2019 related to the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) from 2016.[1] However, proposed changes were not supported at that time.

Some previous concerns were related to a need for sepsis criteria for children, and that was addressed in the Phoenix criteria.[4] From the original Sepsis 3 definition, "Sepsis should be defined as life-threatening organ dysfunction caused by a dysregulated host response to infection."[1] The organ dysfunction can be represented by an increase in the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score, with components for respiration, coagulation, liver, cardiovascular, central nervous system, and renal.[1] However, it has been noted in comments that many health care providers have continued to use earlier definitions of the term sepsis, which include a wider range of infection. The Sepsis-1 and Sepsis-2 definitions described organ dysfunction, but it was a part of severe sepsis and was not required for the broader definition of sepsis. Also, there are other terms that can be used with some overlap, which can include generalized infection, disseminated infection, and systemic infection, as well as bloodstream infection.

There are potential issues related to certain ICD-10-CM codes related to meningococcal infections (at A39) and sepsis. One is the term meningococcemia, which would imply a bloodstream infection, but that may be milder than sepsis as defined under Sepsis-3. There are also separate codes for acute meningococcemia, chronic meningococcemia, and meningococcemia, unspecified. It appears likely that acute meningococcemia would more commonly involve Sepsis-3 defined sepsis, while chronic meningococcemia would be more likely not to involve organ dysfunction. In addition, there is a code for Waterhouse-Friderichsen syndrome, which is generally caused by a severe infection (usually but not always due to meningococcus) that leads to hemorrhage into the adrenal glands and potential adrenal insufficiency as a side effect. A number of changes are proposed to address these issues. In addition to changes at A39, it is proposed to add a code E27.81, Waterhouse-Friderichsen syndrome in diseases classified elsewhere; this would be used for example with other types of sepsis or severe infection as the cause.

In a few cases, sepsis associated with an organism has been indexed in ICD-10-CM (usually based on ICD-10) to an unspecified code. An example is indexing for Sepsis, Shigella, to the code A03.9 Shigellosis, unspecified. In this (and other cases) it is proposed to allow for coding the more specific organism (when known and documented), and to add a note to Code also, if applicable, other sepsis or generalized infection (to use the appropriate code at the A41 category).

Another issue of potential concern is related to code O85, Puerperal sepsis. The term puerperal sepsis properly refers to infections of the female genital tract, usually involving the uterus, occurring

postpartum. It may or may not involve bloodstream infection and also sepsis as defined in Sepsis-3, although it has the potential for this to develop quickly. It appears best based on this to allow for coding such infections separately in addition to the O85 code to better convey this.

This proposal includes changes to address sepsis in newborns (at category P36, Bacterial sepsis of newborn) as well as sepsis related to complications of procedures, in addition to the changes in the infectious disease chapter and as otherwise noted above.

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TABULAR MODIFICATIONS

A02 Other salmonella infections

Revise A02.1 Salmonella sepsis and other generalized salmonella infection

New code A02.11 Salmonella sepsis
Add Generalized salmonella infection with organ dysfunction
Add Salmonella sepsis with organ dysfunction
Add Use additional code for organ dysfunction, such as:
Add acute kidney failure (N17.-)
Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

New code A02.12 Other generalized salmonella infection without organ dysfunction
Add Impending salmonella sepsis
Add Salmonella sepsis without organ dysfunction
Add Systemic salmonella infection (without organ dysfunction)

A03 Shigellosis
Add Code also, if applicable, other sepsis or generalized infection (A41.89-)

A20 Plague

A20.7 Septicemic plague

New code A20.71 Sepsis due to plague
Add Generalized plague with organ dysfunction
Add Sepsis due to plague with organ dysfunction
Add Septicemic plague with organ dysfunction
Add Use additional code for organ dysfunction, such as:
Add acute kidney failure (N17.-)
Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

New code A20.72 Septicemic plague without organ dysfunction
Add Generalized plague without organ dysfunction
Add Impending sepsis due to plague
Add Sepsis due to plague without organ dysfunction
Add Systemic plague infection (without organ dysfunction)

A21 Tularemia

A21.7 Generalized tularemia

New code	A21.71	Tularemia sepsis
Add		Generalized tularemia with organ dysfunction
Add		Sepsis due to tularemia with organ dysfunction
Add		Tularemia sepsis with organ dysfunction
Add		Use additional code for organ dysfunction, such as:
Add		acute kidney failure (N17.-)
Add		organ dysfunction associated with sepsis (R65.2-)
Add		septic shock (R65.21)
New code	A21.72	Generalized tularemia without organ dysfunction
Add		Impending tularemia sepsis
Add		Sepsis due to tularemia without organ dysfunction
Add		Systemic tularemia (without organ dysfunction)

A22 Anthrax

Revise A22.7 Anthrax sepsis <u>and other generalized anthrax infection</u>

New code	A22.71	Anthrax sepsis
Add		Anthrax sepsis with organ dysfunction
Add		Generalized anthrax with organ dysfunction
Add		Sepsis due to anthrax with organ dysfunction
Add		Use additional code for organ dysfunction, such as:
Add		acute kidney failure (N17.-)
Add		organ dysfunction associated with sepsis (R65.2-)
Add		septic shock (R65.21)
New code	A22.72	Generalized anthrax infection without organ dysfunction
Add		Anthrax sepsis without organ dysfunction
Add		Impending anthrax sepsis
Add		Sepsis due to anthrax without organ dysfunction
Add		Systemic anthrax infection (without organ dysfunction)

A23 Brucellosis

Add Code also, if applicable, other sepsis or generalized infection (A41.89-)

A24 Glanders and melioidosis

Add Code also, if applicable, other sepsis or generalized infection (A41.89-)

A26 Erysipeloid

A26.7 Erysipelothrix sepsis and other generalized erysipeloid

New code A26.71 Erysipelothrix sepsis
Add Erysipelothrix sepsis with organ dysfunction
Add Generalized erysipeloid with organ dysfunction
Add Sepsis due to Erysipelothrix with organ dysfunction
Add Use additional code for organ dysfunction, such as:
Add acute kidney failure (N17.-)
Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

New code A26.72 Generalized erysipeloid without organ dysfunction
Add Erysipelothrix sepsis without organ dysfunction
Add Impending Erysipelothrix sepsis
Add Sepsis due to Erysipelothrix without organ dysfunction
Add Systemic erysipeloid infection (without organ dysfunction)

A28 Other zoonotic bacterial diseases, not elsewhere classified

A28.0 Pasteurellosis
Add Code also, if applicable, other sepsis or generalized infection (A41.89-)

A28.2 Extraintestinal yersiniosis
Add Code also, if applicable, other sepsis or generalized infection (A41.89-)

A32 Listeriosis

Revise A32.7 Listerial sepsis and other generalized listeria infection

New code A32.71 Listerial sepsis
Add Generalized listeria infection with organ dysfunction
Add Listerial sepsis with organ dysfunction
Add Sepsis due to Listeria with organ dysfunction
Add Use additional code for organ dysfunction, such as:
Add acute kidney failure (N17.-)
Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

New code A32.72 Generalized Listeria infection without organ dysfunction
Add Listerial sepsis without organ dysfunction
Add Impending listerial sepsis
Add Sepsis due to Listeria without organ dysfunction

Add — Systemic listeriosis infection (without organ dysfunction)

A39 Meningococcal infection

A39.1 Waterhouse-Friderichsen syndrome

Delete — ~~Meningococcal hemorrhagic adrenalitis~~
Delete — ~~Meningococcic adrenal syndrome~~
Add — Excludes1: Waterhouse-Friderichsen syndrome not due to meningococcal infection (E27.81)

New code — A39.11 Waterhouse-Friderichsen syndrome in meningococcal sepsis
Add — Meningococcal sepsis with adrenal hemorrhage syndrome with other organ dysfunction
Add — Meningococcal hemorrhagic adrenalitis with other organ dysfunction
Add — Meningococcic adrenal syndrome with other organ dysfunction
Add — Waterhouse-Friderichsen syndrome NOS
Add — Use additional code for organ dysfunction, such as:
Add — acute kidney failure (N17.-)
Add — organ dysfunction associated with sepsis (R65.2-)
Add — septic shock (R65.21)

New code — A39.12 Waterhouse-Friderichsen syndrome in other generalized meningococcal infection without other organ dysfunction
Add — Generalized meningococcal infection with adrenal hemorrhage syndrome without other organ dysfunction
Add — Impending meningococcal sepsis with adrenal hemorrhage syndrome
Add — Meningococcal sepsis with adrenal hemorrhage syndrome without other organ dysfunction
Add — Meningococcal hemorrhagic adrenalitis without other organ dysfunction
Add — Meningococcal sepsis with adrenal hemorrhage syndrome without other organ dysfunction
Add — Meningococcic adrenal syndrome without other organ dysfunction

A39.2 Acute meningococcemia

New code — A39.21 Acute meningococcal sepsis
Add — Acute generalized meningococcal infection with organ dysfunction
Add — Acute meningococcal sepsis with organ dysfunction
Add — Acute meningococcemia NOS

Add		Acute sepsis due to meningococcus with organ dysfunction
Add		Use additional code for organ dysfunction, such as:
Add		acute kidney failure (N17.-)
Add		organ dysfunction associated with sepsis (R65.2-)
Add		septic shock (R65.21)
New code	A39.22	Acute generalized meningococcal infection without organ dysfunction
Add		Acute meningococcal sepsis without organ dysfunction
Add		Acute meningococcal systemic infection, unspecified
Add		Acute sepsis due to meningococcus without organ dysfunction
Add		Acute impending sepsis due to meningococcus

A39.3 Chronic meningococcemia

New code	A39.31	Chronic meningococcal sepsis
Add		Chronic generalized meningococcal infection with organ dysfunction
Add		Chronic meningococcal sepsis with organ dysfunction
Add		Chronic sepsis due to meningococcus with organ dysfunction
Add		Use additional code for organ dysfunction, such as:
Add		acute kidney failure (N17.-)
Add		organ dysfunction associated with sepsis (R65.2-)
Add		septic shock (R65.21)
New code	A39.32	Chronic generalized meningococcal infection without organ dysfunction
Add		Chronic meningococcal sepsis without organ dysfunction
Add		Chronic sepsis due to meningococcus without organ dysfunction
Add		Chronic impending sepsis due to meningococcus
Add		Chronic meningococcemia NOS

A39.4 Meningococcemia, unspecified

New code	A39.41	Meningococcal sepsis, unspecified
Add		Generalized meningococcal infection with organ dysfunction
Add		Meningococcal sepsis with organ dysfunction
Add		Sepsis due to meningococcus with organ dysfunction
Add		Use additional code for organ dysfunction, such as:
Add		acute kidney failure (N17.-)
Add		organ dysfunction associated with sepsis (R65.2-)
Add		septic shock (R65.21)

New code		A39.42	Generalized meningococcal infection without organ dysfunction
Add			Impending sepsis due to meningococcus
Add			Meningococcal sepsis without organ dysfunction
Add			Meningococcemia NOS
Add			Sepsis due to meningococcus without organ dysfunction

Revise	A40	Streptococcal sepsis and other generalized streptococcal infection
Revise		Code first, if applicable for:~~, postprocedural sepsis (T81.44-)~~
Add		neonatal sepsis or generalized infection due to Streptococcus (P36.0- to P36.1-)
Add		postprocedural sepsis or generalized infection (T81.44-)
Add		puerperal sepsis (O85)
Revise		sepsis or generalized infection due to central venous catheter (T80.211-)
Revise		streptococcal sepsis or generalized infection during labor (O75.3)
Revise		streptococcal sepsis or generalized infection following abortion or ectopic or molar pregnancy (O03.37-, O03.87-, O04.87-, O07.37-, O08.82-)
Revise		streptococcal sepsis or generalized infection following immunization (T88.0-)
Revise		streptococcal sepsis or generalized infection following infusion, transfusion or therapeutic injection (T80.22-, T80.29-)
Revise		Excludes1: ~~neonatal (P36.0-P36.1)~~
Delete		~~puerperal sepsis (O85)~~
Revise		sepsis due to Streptococcus, group D (A41.81-)
Revise		A40.0 Sepsis and other generalized infection due to streptococcus, group A

New code		A40.01	Sepsis due to Streptococcus, group A
Add			Generalized infection with Streptococcus, group A, with organ dysfunction
Add			Group A Streptococcus sepsis with organ dysfunction
Add			Sepsis due to Streptococcus, group A, with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A40.02	Generalized infection with Streptococcus, group A, without organ dysfunction
Add			Group A Streptococcus sepsis without organ dysfunction
Add			Impending sepsis due to Streptococcus, group A

Add			Sepsis due to Streptococcus, group A, without organ dysfunction
Add			Systemic Streptococcus, group A, infection (without organ dysfunction)
Revise	A40.1		Sepsis and other generalized infection due to streptococcus, group B
New code		A40.11	Sepsis due to Streptococcus, group B
Add			Generalized infection with Streptococcus, group B, with organ dysfunction
Add			Group B Streptococcus sepsis with organ dysfunction
Add			Sepsis due to Streptococcus, group B, with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A40.12	Generalized infection with Streptococcus, group B, without organ dysfunction
Add			Group B Streptococcus sepsis without organ dysfunction
Add			Impending sepsis due to Streptococcus, group B
Add			Sepsis due to Streptococcus, group B, without organ dysfunction
Add			Systemic Streptococcus, group B, infection (without organ dysfunction)
Revise	A40.3		Sepsis and other generalized infection due to Streptococcus pneumoniae
New code		A40.31	Sepsis due to Streptococcus pneumoniae
Add			Generalized infection with Streptococcus pneumoniae with organ dysfunction
Add			Sepsis due to Streptococcus pneumoniae with organ dysfunction
Add			Streptococcus pneumoniae sepsis with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A40.32	Generalized Streptococcus pneumoniae infection without organ dysfunction
Add			Generalized infection with Streptococcus pneumoniae without organ dysfunction

Add			Impending sepsis due to Streptococcus pneumoniae
Add			Sepsis due to Streptococcus pneumoniae without organ dysfunction
Add			Streptococcus pneumoniae sepsis without organ dysfunction
Add			Systemic Streptococcus pneumoniae infection (without organ dysfunction)
Revise	A40.8	Other streptococcal sepsis and other generalized streptococcal infection	
New code		A40.81	Sepsis due to other Streptococcus
Add			Generalized infection with other Streptococcus with organ dysfunction
Add			Other Streptococcus sepsis with organ dysfunction
Add			Sepsis due to other Streptococcus with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A40.82	Generalized infection with other Streptococcus without organ dysfunction
Add			Impending sepsis due to other Streptococcus
Add			Other streptococcal generalized infection without organ dysfunction
Add			Other Streptococcus sepsis without organ dysfunction
Add			Sepsis due to other Streptococcus without organ dysfunction
Add			Systemic infection due to other Streptococcus (without organ dysfunction)
Revise	A40.9	Streptococcal sepsis and other generalized streptococcal infection, unspecified	
New code		A40.91	Sepsis due to Streptococcus, unspecified
Add			Generalized infection with unspecified Streptococcus with organ dysfunction
Add			Sepsis due to unspecified Streptococcus with organ dysfunction
Add			Unspecified Streptococcus sepsis with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A40.92	Generalized infection with unspecified Streptococcus without organ dysfunction
Add			Impending sepsis due to unspecified Streptococcus

Add — Sepsis due to unspecified Streptococcus without organ dysfunction
Add — Systemic infection due to unspecified Streptococcus (without organ dysfunction)
Add — Unspecified streptococcal generalized infection without organ dysfunction
Add — Unspecified Streptococcus sepsis without organ dysfunction

Revise A41 Other sepsis and other generalized infection

Revise — Code first, if applicable for:~~, postprocedural sepsis (T81.44-)~~
Add — neonatal sepsis or generalized infection (P36.-)
Add — postprocedural sepsis or generalized infection (T81.44-)
Add — puerperal sepsis (O85)
Revise — sepsis or generalized infection due to central venous catheter (T80.211-)
Revise — streptococcal sepsis or generalized infection during labor (O75.3)
Revise — streptococcal sepsis or generalized infection following abortion or ectopic or molar pregnancy (O03.37-, O03.87-, O04.87-, O07.37-, O08.82-)
Revise — streptococcal sepsis or generalized infection following immunization (T88.0-)
Revise — streptococcal sepsis or generalized infection following infusion, transfusion or therapeutic injection (T80.22-, T80.29-)
Excludes1: bacteremia NOS (R78.81)
Delete — ~~neonatal (P36.-)~~
Delete — ~~puerperal sepsis (O85)~~
Revise — streptococcal sepsis or generalized infection (A40.-)
Revise — Excludes2: sepsis or generalized infection (due to) (in) actinomycotic (A42.7-)
Revise — sepsis or generalized infection (due to) (in) anthrax (A22.7-)
Revise — sepsis or generalized infection (due to) (in) candidal (B37.7-)
Revise — sepsis or generalized infection (due to) (in) Erysipelothrix (A26.7-)
Revise — sepsis or generalized infection (due to) (in) extraintestinal yersiniosis (A28.2)
Revise — sepsis or generalized infection (due to) (in) gonococcal (A54.86-)
Revise — sepsis or generalized infection (due to) (in) herpesviral (B00.7-)
Revise — sepsis or generalized infection (due to) (in) listerial (A32.7-)
Revise — sepsis or generalized infection (due to) (in) melioidosis (A24.1)
Revise — sepsis or generalized infection (due to) (in) meningococcal (A39.1-~~2~~ to A39.4-)
Revise — sepsis or generalized infection (due to) (in) plague (A20.7-)
Revise — sepsis or generalized infection (due to) (in) tularemia (A21.7-)

Revise A41.0 Sepsis and other generalized infection due to Staphylococcus aureus

Revise A41.01 Sepsis and other generalized infection due to Methicillin susceptible Staphylococcus aureus

New code A41.010 Sepsis due to methicillin susceptible Staphylococcus aureus
Add Generalized infection with methicillin susceptible Staphylococcus aureus (MSSA) with organ dysfunction
Add Methicillin susceptible Staphylococcus aureus sepsis with organ dysfunction
Add Sepsis due to methicillin susceptible Staphylococcus aureus with organ dysfunction
Add Use additional code for organ dysfunction, such as:
Add acute kidney failure (N17.-)
Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

New code A41.011 Generalized infection due to methicillin susceptible Staphylococcus aureus without organ dysfunction
Add Generalized infection with methicillin susceptible Staphylococcus aureus (MSSA) without organ dysfunction
Add Methicillin susceptible Staphylococcus aureus sepsis without organ dysfunction
Add Impending sepsis due to methicillin susceptible Staphylococcus aureus
Add Sepsis due to methicillin susceptible Staphylococcus aureus without organ dysfunction
Add Systemic methicillin susceptible Staphylococcus aureus infection (without organ dysfunction)

Revise A41.02 Sepsis and other generalized infection due to Methicillin resistant Staphylococcus aureus

New code A41.020 Sepsis due to methicillin resistant Staphylococcus aureus
Add Generalized infection with methicillin resistant Staphylococcus aureus (MRSA) with organ dysfunction

Add			Methicillin resistant Staphylococcus aureus sepsis with organ dysfunction
Add			Sepsis due to methicillin resistant Staphylococcus aureus with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A41.021	Generalized infection due to methicillin resistant Staphylococcus aureus without organ dysfunction
Add			Generalized infection with methicillin resistant Staphylococcus aureus (MRSA) without organ dysfunction
Add			Methicillin resistant Staphylococcus aureus sepsis without organ dysfunction
Add			Impending sepsis due to methicillin resistant Staphylococcus aureus
Add			Sepsis due to methicillin resistant Staphylococcus aureus without organ dysfunction
Add			Systemic methicillin resistant Staphylococcus aureus infection (without organ dysfunction)
Revise	A41.1	Sepsis and other generalized infection due to other specified Staphylococcus	
New code		A41.11	Sepsis due to other specified Staphylococcus
Add			Generalized infection with other specified Staphylococcus with organ dysfunction
Add			Other specified Staphylococcus sepsis with organ dysfunction
Add			Sepsis due to other specified Staphylococcus with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)

New code	A41.12	Generalized infection due to other specified Staphylococcus without organ dysfunction
Add		Generalized infection with other specified Staphylococcus without organ dysfunction
Add		Other specified Staphylococcus sepsis without organ dysfunction
Add		Impending sepsis due to other specified Staphylococcus
Add		Sepsis due to other specified Staphylococcus without organ dysfunction
Add		Systemic infection due to other specified Staphylococcus (without organ dysfunction)

Revise A41.2 Sepsis and other generalized infection due to unspecified Staphylococcus

New code	A41.21	Sepsis due to unspecified Staphylococcus
Add		Generalized infection with unspecified Staphylococcus with organ dysfunction
Add		Unspecified Staphylococcus sepsis with organ dysfunction
Add		Sepsis due to unspecified Staphylococcus with organ dysfunction
Add		Use additional code for organ dysfunction, such as:
Add		acute kidney failure (N17.-)
Add		organ dysfunction associated with sepsis (R65.2-)
Add		septic shock (R65.21)

New code	A41.22	Generalized infection due to unspecified Staphylococcus without organ dysfunction
Add		Generalized infection with unspecified Staphylococcus without organ dysfunction
Add		Unspecified Staphylococcus sepsis without organ dysfunction
Add		Impending sepsis due to unspecified Staphylococcus
Add		Sepsis due to unspecified Staphylococcus without organ dysfunction
Add		Systemic infection due to unspecified Staphylococcus (without organ dysfunction)

Revise A41.3 Sepsis and other generalized infection due to Hemophilus influenzae

New code	A41.31	Sepsis due to Hemophilus influenzae
Add		Generalized infection with Hemophilus influenzae with organ dysfunction
Add		Hemophilus influenzae sepsis with organ dysfunction
Add		Sepsis due to Hemophilus influenzae with organ dysfunction
Add		Use additional code for organ dysfunction, such as:

Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A41.32	Generalized infection due to Hemophilus influenzae without organ dysfunction
Add			Generalized infection with Hemophilus influenzae without organ dysfunction
Add			Hemophilus influenzae sepsis without organ dysfunction
Add			Impending sepsis due to Hemophilus influenzae
Add			Sepsis due to Hemophilus influenzae without organ dysfunction
Add			Systemic Hemophilus influenzae infection (without organ dysfunction)
Revise	A41.4	Sepsis <u>and other generalized infection</u> due to anaerobes	
New code		A41.41	Sepsis due to anaerobes
Add			Generalized infection with anaerobes with organ dysfunction
Add			Anaerobe sepsis with organ dysfunction
Add			Sepsis due to anaerobes with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A41.42	Generalized infection due to anaerobes without organ dysfunction
Add			Generalized infection with anaerobes without organ dysfunction
Add			Anaerobic sepsis without organ dysfunction
Add			Impending sepsis due to anaerobes
Add			Sepsis due to anaerobes without organ dysfunction
Add			Systemic anaerobe infection (without organ dysfunction)
Revise	A41.5	Sepsis <u>and other generalized infection</u> due to other Gram-negative organisms	
Revise		A41.50	<u>Sepsis and other generalized infection due to unspecified</u> Gram-negative <u>organisms</u> ~~sepsis, unspecified~~

New code		A41.500	Sepsis due to unspecified Gram-negative organism
Add			Generalized infection with unspecified Gram-negative organism with organ dysfunction
Add			Sepsis due to unspecified Gram-negative organism with organ dysfunction
Add			Unspecified Gram-negative organism sepsis with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A41.501	Generalized infection due to unspecified Gram-negative organism without organ dysfunction
Add			Generalized infection with unspecified Gram-negative organism without organ dysfunction
Add			Impending sepsis due to unspecified Gram-negative organism
Add			Sepsis due to unspecified Gram-negative organism without organ dysfunction
Add			Systemic infection due to unspecified Gram-negative organism (without organ dysfunction)
Add			Unspecified Gram-negative organism sepsis without organ dysfunction
Revise	A41.51		Sepsis and other generalized infection due to Escherichia coli [E. coli]
New code		A41.510	Sepsis due to Escherichia coli [E. coli]
Add			Generalized infection with Escherichia coli [E. coli] with organ dysfunction
Add			Sepsis due to Escherichia coli [E. coli] with organ dysfunction
Add			Escherichia coli [E. coli] sepsis with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)

New code		A41.511	Generalized infection due to Escherichia coli [E. coli] without organ dysfunction
Add			Generalized infection with Escherichia coli [E. coli] without organ dysfunction
Add			Impending sepsis due to Escherichia coli [E. coli]
Add			Sepsis due to Escherichia coli [E. coli] without organ dysfunction
Add			Systemic Escherichia coli [E. coli] infection (without organ dysfunction)
Add			Escherichia coli [E. coli] sepsis without organ dysfunction
Revise	A41.52	Sepsis and other generalized infection due to Pseudomonas	
New code		A41.520	Sepsis due to Pseudomonas
Add			Generalized infection with Pseudomonas with organ dysfunction
Add			Sepsis due to Pseudomonas with organ dysfunction
Add			Pseudomonas sepsis with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A41.521	Generalized infection due to Pseudomonas without organ dysfunction
Add			Generalized infection with Pseudomonas without organ dysfunction
Add			Impending sepsis due to Pseudomonas
Add			Sepsis due to Pseudomonas without organ dysfunction
Add			Systemic Pseudomonas infection (without organ dysfunction)
Add			Pseudomonas sepsis without organ dysfunction
Revise	A41.53	Sepsis and other generalized infection due to Serratia	
New code		A41.530	Sepsis due to Serratia
Add			Generalized infection with Serratia with organ dysfunction
Add			Sepsis due to Serratia with organ dysfunction
Add			Serratia sepsis with organ dysfunction

Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A41.531	Generalized infection due to Serratia without organ dysfunction
Add			Generalized infection with Serratia without organ dysfunction
Add			Impending sepsis due to Serratia
Add			Sepsis due to Serratia without organ dysfunction
Add			Systemic Serratia infection (without organ dysfunction)
Add			Serratia sepsis without organ dysfunction
Revise	A41.54		Sepsis and other generalized infection due to Acinetobacter baumannii
New code		A41.540	Sepsis due to Acinetobacter baumannii
Add			Generalized infection with Acinetobacter baumannii with organ dysfunction
Add			Sepsis due to Acinetobacter baumannii with organ dysfunction
Add			Acinetobacter baumannii sepsis with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A41.541	Generalized infection due to Acinetobacter baumannii without organ dysfunction
Add			Generalized infection with Acinetobacter baumannii without organ dysfunction
Add			Impending sepsis due to Acinetobacter baumannii
Add			Sepsis due to Acinetobacter baumannii without organ dysfunction
Add			Systemic Acinetobacter baumannii infection (without organ dysfunction)
Add			Acinetobacter baumannii sepsis without organ dysfunction

Revise	A41.59		Other Gram-negative sepsis and other generalized Gram-negative infection
New code		A41.590	Sepsis due to other Gram-negative organism
Add			Generalized infection with other Gram-negative organism with organ dysfunction
Add			Sepsis due to other Gram-negative organism with organ dysfunction
Add			Other Gram-negative organism sepsis with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A41.591	Generalized infection due to other Gram-negative organism without organ dysfunction
Add			Generalized infection with other Gram-negative organism without organ dysfunction
Add			Impending sepsis due to other Gram-negative organism
Add			Sepsis due to other Gram-negative organism without organ dysfunction
Add			Systemic infection due to other Gram-negative organism (without organ dysfunction)
Add			Other Gram-negative organism sepsis without organ dysfunction
Revise	A41.8		Other specified sepsis and other generalized infection
Revise	A41.81		Sepsis and other generalized infection due to Enterococcus
New code		A41.810	Sepsis due to Enterococcus
Add			Generalized infection due to Enterococcus with organ dysfunction
Add			Sepsis due to Enterococcus with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)

New code		A41.811	Other generalized infection due to Enterococcus
Add			Impending sepsis due to Enterococcus
Add			Sepsis due to Enterococcus without organ dysfunction
Add			Systemic infection due to Enterococcus (without organ dysfunction)
Revise	A41.89		Other specified sepsis and other generalized infection
Add			Code also, if applicable, other organism or associated infection
New code		A41.890	Other specified sepsis
Add			Other generalized infection with organ dysfunction
Add			Other sepsis with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		A41.891	Other generalized infection due to other organism without organ dysfunction
Add			Impending sepsis due to other organism
Add			Sepsis due to other organism without organ dysfunction
Add			Systemic infection due to other organism (without organ dysfunction)
Revise	A41.9		Sepsis and other generalized infection, unspecified organism
New code		A41.91	Sepsis, unspecified organism
Add			Generalized infection with organ dysfunction, unspecified organism
Add			Sepsis with organ dysfunction, unspecified organism
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)

New code A41.92 Other generalized infection without organ dysfunction, unspecified organism
Add Impending sepsis, unspecified organism
Add Sepsis without organ dysfunction, unspecified organism
Add Systemic infection (without organ dysfunction), unspecified organism

A42 Actinomycosis
Revise A42.7 Actinomycotic sepsis and other generalized actinomycotic infection

New code A42.71 Actinomycotic sepsis
Add Actinomycotic sepsis with organ dysfunction
Add Generalized actinomycosis with organ dysfunction
Add Sepsis due to actinomycosis with organ dysfunction
Add Use additional code for organ dysfunction, such as:
Add acute kidney failure (N17.-)
Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

New code A42.72 Generalized actinomycotic infection without organ dysfunction
Add Actinomycotic sepsis without organ dysfunction
Add Impending actinomycotic sepsis
Add Sepsis due to actinomycosis without organ dysfunction
Add Systemic actinomycotic infection (without organ dysfunction)

A48 Other bacterial diseases, not elsewhere classified

A48.3 Toxic shock syndrome
Use additional code to identify the organism (B95, B96)
Excludes1: endotoxic shock NOS (R57.8)
Revise sepsis or other generalized infection NOS (A41.9-)

A54 Gonococcal infection

A54.8 Other gonococcal infections

Revise A54.86 Gonococcal sepsis and other generalized gonococcal infection

New code	A54.860	Gonococcal sepsis	
Add		Generalized infection due to Gonococcus with organ dysfunction	
Add		Sepsis due to Gonococcus with organ dysfunction	
Add		Use additional code for organ dysfunction, such as:	
Add		acute kidney failure (N17.-)	
Add		organ dysfunction associated with sepsis (R65.2-)	
Add		septic shock (R65.21)	
New code	A54.861	Other generalized gonococcal infection	
Add		Gonococcal sepsis without organ dysfunction	
Add		Impending gonococcal sepsis	
Add		Sepsis due to Gonococcus without organ dysfunction	
Add		Systemic infection due to Gonococcus (without organ dysfunction)	

B00 Herpesviral [herpes simplex] infections

B00.7 Disseminated herpesviral disease

New code	B00.71	Herpes sepsis	
Add		Herpes sepsis with organ dysfunction	
Add		Generalized herpes with organ dysfunction	
Add		Sepsis due to herpesvirus with organ dysfunction	
Add		Use additional code for organ dysfunction, such as:	
Add		acute kidney failure (N17.-)	
Add		organ dysfunction associated with sepsis (R65.2-)	
Add		septic shock (R65.21)	
New code	B00.72	Generalized herpes without organ dysfunction	
Add		Herpes sepsis without organ dysfunction	
Add		Impending herpes sepsis	
Add		Sepsis due to herpesvirus without organ dysfunction	
Add		Systemic herpesvirus infection (without organ dysfunction)	

B37 Candidiasis

Revise B37.7 Candidal sepsis <u>and other generalized candidal infection</u>

New code	B00.71	Candidal sepsis	
Add		Candidal sepsis with organ dysfunction	
Add		Generalized candidiasis herpes with organ dysfunction	

Add — Sepsis due to Candida with organ dysfunction
Add — Use additional code for organ dysfunction, such as:
Add — acute kidney failure (N17.-)
Add — organ dysfunction associated with sepsis (R65.2-)
Add — septic shock (R65.21)

New code — B00.72 Generalized candidiasis without organ dysfunction
Add — Candidal sepsis without organ dysfunction
Add — Impending candidal sepsis
Add — Sepsis due to Candida without organ dysfunction
Add — Systemic Candida infection (without organ dysfunction)

E27 Other disorders of adrenal gland

E27.8 Other specified disorders of adrenal gland

New code — E27.81 Waterhouse-Friderichsen syndrome in diseases classified elsewhere
Add — Code first underlying disease, such as:
Add — sepsis or generalized infection due to:
Add — Pseudomonas (A41.52-)
Add — Streptococcus pneumoniae (A40.3-)
Add — Staphylococcus aureus (A41.0-)
Add — Excludes1: Waterhouse-Friderichsen syndrome in meningiococcemia (A39.1-)

New code — E27.89 Other specified disorders of adrenal gland NEC

J95 Intraoperative and postprocedural complications and disorders of respiratory system, not elsewhere classified

J95.0 Tracheostomy complications

J95.02 Infection of tracheostomy stoma
Use additional code to identify type of infection, such as:
Revise — sepsis and other generalized infection (A40, A41.-)

O03 Spontaneous abortion

O03.0 Genital tract and pelvic infection following incomplete spontaneous abortion
Revise — Excludes1: sepsis and other generalized infection following incomplete spontaneous abortion (O03.37-)

O03.3 Other and unspecified complications following incomplete spontaneous abortion

O03.31 Shock following incomplete spontaneous abortion

Revise — Excludes1: shock due to infection following incomplete spontaneous abortion (O03.370)

Revise — O03.37 Sepsis and other generalized infection following incomplete spontaneous abortion

Delete — ~~Use additional code to identify severe sepsis, if applicable (R65.2)~~

New code — O03.370 Sepsis following incomplete spontaneous abortion

Add — Generalized infection with organ dysfunction following incomplete spontaneous abortion

Add — Sepsis with organ dysfunction following incomplete spontaneous abortion

Add — Use additional code for organ dysfunction, such as:

Add — acute kidney failure (N17.-)

Add — organ dysfunction associated with sepsis (R65.2-)

Add — septic shock (R65.21)

New code — O03.371 Generalized infection without organ dysfunction following incomplete spontaneous abortion

Add — Impending sepsis following incomplete spontaneous abortion

Add — Sepsis without organ dysfunction following incomplete spontaneous abortion

Add — Systemic infection (without organ dysfunction) following incomplete spontaneous abortion

O03.5 Genital tract and pelvic infection following complete or unspecified spontaneous abortion

Revise — Excludes1: sepsis and other generalized infection following complete or unspecified spontaneous abortion (O03.87-)

O03.8 Other and unspecified complications following complete or unspecified spontaneous abortion

O03.81 Shock following complete or unspecified spontaneous abortion

Revise — Excludes1: shock due to infection following complete or unspecified spontaneous abortion (O03.870)

Revise — O03.87 Sepsis and other generalized infection following complete or unspecified spontaneous abortion

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

New code — O03.870 Sepsis following complete or unspecified spontaneous abortion

Add — Generalized infection with organ dysfunction following complete or unspecified spontaneous abortion

Add — Sepsis with organ dysfunction following complete or unspecified spontaneous abortion

Add — Use additional code for organ dysfunction, such as:

Add — acute kidney failure (N17.-)

Add — organ dysfunction associated with sepsis (R65.2-)

Add — septic shock (R65.21)

New code — O03.871 Generalized infection without organ dysfunction following complete or unspecified spontaneous abortion

Add — Impending sepsis following complete or unspecified spontaneous abortion

Add — Sepsis without organ dysfunction following complete or unspecified spontaneous abortion

Add — Systemic infection (without organ dysfunction) following complete or unspecified spontaneous abortion

O04 Complications following (induced) termination of pregnancy

O04.5 Genital tract and pelvic infection following (induced) termination of pregnancy

Revise — Excludes1: sepsis and other generalized infection following (induced) termination of pregnancy (O04.87-)

O04.8 (Induced) termination of pregnancy with other and unspecified complications

O04.81 Shock following (induced) termination of pregnancy

Revise — Excludes1: shock due to infection following (induced) termination of pregnancy (O04.87<u>0</u>)

Revise — O04.87 Sepsis <u>and other generalized infection</u> following (induced) termination of pregnancy

Delete — ~~Use additional code to identify severe sepsis, if applicable (R65.2)~~

New code — O04.870 Sepsis following (induced) termination of pregnancy

Add — Generalized infection with organ dysfunction following (induced) termination of pregnancy

Add — Sepsis with organ dysfunction following (induced) termination of pregnancy

Add — Use additional code for organ dysfunction, such as:

Add — acute kidney failure (N17.-)

Add — organ dysfunction associated with sepsis (R65.2-)

Add — septic shock (R65.21)

New code — O04.871 Generalized infection without organ dysfunction following (induced) termination of pregnancy

Add — Impending sepsis following (induced) termination of pregnancy

Add — Sepsis without organ dysfunction following (induced) termination of pregnancy

Add — Systemic infection (without organ dysfunction) following (induced) termination of pregnancy

O07 Failed attempted termination of pregnancy

O07.0 Genital tract and pelvic infection following failed attempted termination of pregnancy

Revise — Excludes1: sepsis <u>and other generalized infection</u> following failed attempted termination of pregnancy (O07.37<u>-</u>)

O07.3 Failed attempted termination of pregnancy with other and unspecified complications

O07.31 Shock following failed attempted termination of pregnancy

Revise — Excludes1: shock due to infection following failed attempted termination of pregnancy (O07.370)

Revise — O07.37 Sepsis and other generalized infection following failed attempted termination of pregnancy

Delete — ~~Use additional code to identify severe sepsis, if applicable (R65.2)~~

New code — O07.370 Sepsis following failed attempted termination of pregnancy

Add — Generalized infection with organ dysfunction following failed attempted termination of pregnancy

Add — Sepsis with organ dysfunction following failed attempted termination of pregnancy

Add — Use additional code for organ dysfunction, such as:

Add — acute kidney failure (N17.-)

Add — organ dysfunction associated with sepsis (R65.2-)

Add — septic shock (R65.21)

New code — O07.371 Generalized infection without organ dysfunction following failed attempted termination of pregnancy

Add — Impending sepsis following failed attempted termination of pregnancy

Add — Sepsis without organ dysfunction following failed attempted termination of pregnancy

Add — Systemic infection (without organ dysfunction) following failed attempted termination of pregnancy

O08 Complications following ectopic and molar pregnancy

O08.0 Genital tract and pelvic infection following ectopic and molar pregnancy

Revise — Excludes1: sepsis and other generalized infection following ectopic and molar pregnancy (O08.82-)

O08.3 Shock following ectopic and molar pregnancy
Revise Excludes1: shock due to infection following ectopic and molar pregnancy (O08.82<u>0</u>)

O08.8 Other complications following an ectopic and molar pregnancy

Revise O08.82 Sepsis <u>and other generalized infection</u> following ectopic and molar pregnancy
Delete ~~Use additional code to identify severe sepsis, if applicable (R65.2-)~~

New code O08.820 Sepsis following ectopic and molar pregnancy
Add Generalized infection with organ dysfunction following ectopic and molar pregnancy
Add Sepsis with organ dysfunction following ectopic and molar pregnancy
Add Use additional code for organ dysfunction, such as:
Add acute kidney failure (N17.-)
Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

New code O08.821 Generalized infection without organ dysfunction following ectopic and molar pregnancy
Add Impending sepsis following ectopic and molar pregnancy
Add Sepsis without organ dysfunction following ectopic and molar pregnancy
Add Systemic infection (without organ dysfunction) following ectopic and molar pregnancy

O75 Other complications of labor and delivery, not elsewhere classified

O75.3 Other infection during labor
Add Use additional code, if applicable, for sepsis or generalized infection to identify the type of infection and infectious agent, such as:
Add Other sepsis and other generalized infection (A41.-)
Add Streptococcal sepsis and other generalized streptococcal infection (A40.-)

O85 Puerperal sepsis

Add — Use additional code, if applicable, for generalized infection or sepsis with organ dysfunction to identify the type of infection and infectious agent, such as:

Add — Other sepsis and other generalized infection (A41.-)

Add — Streptococcal sepsis and other generalized streptococcal infection (A40.-)

O86 Other puerperal infections

O86.0 Infection of obstetric surgical wound

Revise — O86.04 Sepsis or generalized infection following an obstetrical procedure

Revise — Use additional code to identify the type of sepsis or generalized infection, such as:

Add — Other sepsis and other generalized infection (A41.-)

Add — Streptococcal sepsis and other generalized streptococcal infection (A40.-)

O98 Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium

O98.8 Other maternal infectious and parasitic diseases complicating pregnancy, childbirth and the puerperium

O98.81 Other maternal infectious and parasitic diseases complicating pregnancy

Add — Use additional code, if applicable, for sepsis or generalized infection to identify the type of infection and infectious agent, such as:

Add — Other sepsis and other generalized infection (A41.-)

Add — Streptococcal sepsis and other generalized streptococcal infection (A40.-)

P36 Bacterial sepsis of newborn

Delete — ~~Use additional code(s), if applicable, to identify severe sepsis (R65.2-) and associated acute organ dysfunction(s)~~

Revise — P36.0 Sepsis and other generalized infection of newborn due to streptococcus, group B

New code — P36.01 Sepsis of newborn due to Streptococcus, group B

Add — Generalized infection of newborn with Streptococcus, group B, with organ dysfunction

Add — Group B Streptococcus sepsis of newborn with organ dysfunction

Add			Sepsis of newborn due to Streptococcus, group B, with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		P36.02	Generalized infection of newborn with Streptococcus, group B, without organ dysfunction
Add			Group B Streptococcus sepsis of newborn without organ dysfunction
Add			Impending sepsis of newborn due to Streptococcus, group B
Add			Sepsis of newborn due to Streptococcus, group B, without organ dysfunction
Add			Systemic Streptococcus, group B, infection of newborn (without organ dysfunction)
Revise	P36.1		Sepsis and other generalized infection of newborn due to other and unspecified streptococci
Revise		P36.10	Sepsis and other generalized infection of newborn due to unspecified streptococci
New code			P36.100 Sepsis of newborn due to unspecified streptococci
Add			Generalized infection of newborn with unspecified streptococci, with organ dysfunction
Add			Sepsis of newborn due to unspecified streptococci, with organ dysfunction
Add			Unspecified streptococci sepsis of newborn with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code			P36.101 Generalized infection of newborn with unspecified streptococci, without organ dysfunction
Add			Impending sepsis of newborn due to unspecified streptococci
Add			Sepsis of newborn due to unspecified streptococci, without organ dysfunction

Add			Systemic infection of newborn (without organ dysfunction) due to unspecified streptococci
Add			Unspecified streptococci sepsis of newborn without organ dysfunction
Revise	P36.19		Sepsis and other generalized infection of newborn due to other streptococci
Add			Use additional code to further identify the infectious agent, if applicable, such as:
Add			Streptococcus, group A (B95.0)
Add			Streptococcus pneumoniae (B95.3)
New code		P36.190	Sepsis of newborn due to other streptococci
Add			Generalized infection of newborn with other streptococci, with organ dysfunction
Add			Other streptococci sepsis of newborn with organ dysfunction
Add			Sepsis of newborn due to other streptococci, with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		P36.191	Generalized infection of newborn with other streptococci, without organ dysfunction
Add			Impending sepsis of newborn due to other streptococci
Add			Other streptococci sepsis of newborn without organ dysfunction
Add			Sepsis of newborn due to other streptococci, without organ dysfunction
Add			Systemic infection of newborn (without organ dysfunction) due to other streptococci
Revise	P36.2		Sepsis and other generalized infection of newborn due to Staphylococcus aureus
Add			Use additional code to further identify the infectious agent, if applicable, such as:
Add			methicillin susceptible Staphylococcus aureus (MSSA) (B95.61)
Add			methicillin resistant Staphylococcus aureus (MRSA) (B95.62)
New code		P36.21	Sepsis of newborn due to Staphylococcus aureus

Add			Generalized infection of newborn with Staphylococcus aureus with organ dysfunction
Add			Sepsis of newborn due to Staphylococcus aureus with organ dysfunction
Add			Staphylococcus aureus sepsis of newborn with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		P36.22	Generalized infection of newborn with Staphylococcus aureus without organ dysfunction
Add			Impending sepsis of newborn due to Staphylococcus aureus
Add			Sepsis of newborn due to Staphylococcus aureus without organ dysfunction
Add			Staphylococcus aureus sepsis of newborn without organ dysfunction
Add			Systemic Staphylococcus aureus infection of newborn (without organ dysfunction)
Revise	P36.3		Sepsis and other generalized infection of newborn due to other and unspecified staphylococci
Revise		P36.30	Sepsis and other generalized infection of newborn due to unspecified staphylococci
New code			P36.300 Sepsis of newborn due to unspecified staphylococci
Add			Generalized infection of newborn with unspecified staphylococci, with organ dysfunction
Add			Sepsis of newborn due to unspecified staphylococci, with organ dysfunction
Add			Unspecified staphylococci sepsis of newborn with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)

New code		P36.301	Generalized infection of newborn with unspecified staphylococci, without organ dysfunction
Add			Impending sepsis of newborn due to unspecified staphylococci
Add			Sepsis of newborn due to unspecified staphylococci, without organ dysfunction
Add			Systemic infection of newborn (without organ dysfunction) due to unspecified staphylococci
Add			Unspecified staphylococci sepsis of newborn without organ dysfunction
Revise	P36.39		Sepsis and other generalized infection of newborn due to other staphylococci
New code		P36.390	Sepsis of newborn due to other staphylococci
Add			Generalized infection of newborn with other staphylococci, with organ dysfunction
Add			Other staphylococci sepsis of newborn with organ dysfunction
Add			Sepsis of newborn due to other staphylococci, with organ dysfunction
Add			Use additional code for organ dysfunction, such as:
Add			acute kidney failure (N17.-)
Add			organ dysfunction associated with sepsis (R65.2-)
Add			septic shock (R65.21)
New code		P36.391	Generalized infection of newborn with other staphylococci, without organ dysfunction
Add			Impending sepsis of newborn due to other staphylococci
Add			Other staphylococci sepsis of newborn without organ dysfunction
Add			Sepsis of newborn due to other staphylococci, without organ dysfunction
Add			Systemic infection of newborn (without organ dysfunction) due to other staphylococci
Revise	P36.4		Sepsis and other generalized infection of newborn due to Escherichia coli
Add			Use additional code to further identify the infectious agent, if applicable, such as:
Add			Shiga toxin-producing Escherichia coli [E. coli] [STEC] O157 (B96.21)

Add		other specified Shiga toxin-producing Escherichia coli [E. coli] [STEC] (B96.22)
Add		unspecified Shiga toxin-producing Escherichia coli [E. coli] [STEC] (B96.23)
New code	P36.41	Sepsis of newborn due to Escherichia coli
Add		Escherichia coli sepsis of newborn with organ dysfunction
Add		Generalized infection of newborn with Escherichia coli with organ dysfunction
Add		Sepsis of newborn due to Escherichia coli with organ dysfunction
Add		Use additional code for organ dysfunction, such as:
Add		acute kidney failure (N17.-)
Add		organ dysfunction associated with sepsis (R65.2-)
Add		septic shock (R65.21)
New code	P36.42	Generalized infection of newborn with Escherichia coli without organ dysfunction
Add		Escherichia coli sepsis of newborn without organ dysfunction
Add		Impending sepsis of newborn due to Escherichia coli
Add		Sepsis of newborn due to Escherichia coli without organ dysfunction
Add		Systemic Escherichia coli infection of newborn (without organ dysfunction)
Revise	P36.5	Sepsis and other generalized infection of newborn due to anaerobes
Add		Use additional code to further identify the infectious agent, if applicable, such as:
Add		Bacteroides fragilis [B. fragilis] (B96.6)
Add		Clostridium perfringens [C. perfringens] (B96.7)
New code	P36.51	Sepsis of newborn due to anaerobes
Add		Anaerobe sepsis of newborn with organ dysfunction
Add		Generalized infection of newborn with anaerobes with organ dysfunction
Add		Sepsis of newborn due to anaerobes with organ dysfunction
Add		Use additional code for organ dysfunction, such as:
Add		acute kidney failure (N17.-)
Add		organ dysfunction associated with sepsis (R65.2-)
Add		septic shock (R65.21)

New code	P36.52	Generalized infection of newborn with anaerobes without organ dysfunction
Add		Anaerobe sepsis of newborn without organ dysfunction
Add		Impending sepsis of newborn due to anaerobes
Add		Sepsis of newborn due to anaerobes without organ dysfunction
Add		Systemic anaerobe infection of newborn (without organ dysfunction)
Revise	P36.8	Other bacterial sepsis <u>and other generalized infection</u> of newborn
Delete		~~Use additional code from category B96 to identify organism~~
Add		Use additional code to further identify the infectious agent, if applicable, such as:
Add		Enterococcus (B95.2)
Add		other bacterial agents NEC (B96.-)
New code	P36.81	Other bacterial sepsis of newborn
Add		Generalized infection with other bacteria of newborn with organ dysfunction
Add		Other bacterial sepsis of newborn with organ dysfunction
Add		Sepsis of newborn due to other bacteria with organ dysfunction
Add		Use additional code for organ dysfunction, such as:
Add		acute kidney failure (N17.-)
Add		organ dysfunction associated with sepsis (R65.2-)
Add		septic shock (R65.21)
New code	P36.82	Generalized infection of newborn with other bacteria without organ dysfunction
Add		Impending sepsis of newborn due to other bacteria
Add		Sepsis of newborn due to other bacteria without organ dysfunction
Add		Systemic infection of newborn with other bacteria (without organ dysfunction)
Revise	P36.9	Bacterial sepsis <u>and other generalized infection</u> of newborn, unspecified
New code	P36.91	Bacterial sepsis of newborn, unspecified
Add		Generalized infection with unspecified bacteria of newborn with organ dysfunction
Add		Sepsis of newborn due to unspecified bacteria with organ dysfunction
Add		Unspecified bacterial sepsis of newborn with organ dysfunction
Add		Use additional code for organ dysfunction, such as:
Add		acute kidney failure (N17.-)

Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

New code P36.92 Generalized infection of newborn with unspecified bacteria without organ dysfunction
Add Impending sepsis of newborn due to unspecified bacteria
Add Sepsis of newborn due to unspecified bacteria without organ dysfunction
Add Systemic infection of newborn with unspecified bacteria (without organ dysfunction)
Add Unspecified bacterial sepsis of newborn without organ dysfunction

Revise R65.2 Organ dysfunction associated with sepsis ~~Severe sepsis~~

Revise R65.20 ~~Severe~~ Organ dysfunction associated with sepsis without septic shock
Add Severe sepsis

Revise R65.21 ~~Severe sepsis with septic~~ Septic shock

T80 Complications following infusion, transfusion and therapeutic injection

T80.2 Infections following infusion, transfusion and therapeutic injection
Use additional code to identify the specific infection, such as:
Add other sepsis or generalized infection (A41.89-)
Revise sepsis or generalized infection NOS (A41.9-)
Delete ~~Use additional code (R65.2-) to identify severe sepsis, if applicable~~
Add Use additional code, if applicable, for:
Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

T81 Complications of procedures, not elsewhere classified

T81.4 Infection following a procedure
Delete ~~Use additional code (R65.2-) to identify severe sepsis, if applicable~~

Revise T81.44 Sepsis and other generalized infection following a procedure

New code T81.440 Sepsis following a procedure
Add Generalized infection with organ dysfunction following a procedure

Add		Sepsis with organ dysfunction following a procedure
Add		Use additional code for organ dysfunction, such as:
Add		acute kidney failure (N17.-)
Add		organ dysfunction associated with sepsis (R65.2-)
Add		septic shock (R65.21)
New code	T81.441	Generalized infection without organ dysfunction following a procedure
Add		Impending sepsis following a procedure
Add		Sepsis without organ dysfunction following a procedure
Add		Systemic infection (without organ dysfunction) following a procedure

T82 Complications of cardiac and vascular prosthetic devices, implants and grafts

T82.6 Infection and inflammatory reaction due to cardiac valve prosthesis

Revise	Use additional code to identify infection, such as:
Add	other sepsis or generalized infection (A41.89-)
Add	sepsis or generalized infection NOS (A41.9-)
Add	Use additional code, if applicable, for:
Add	organ dysfunction associated with sepsis (R65.2-)
Add	septic shock (R65.21)

T82.7 Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts

Revise	Use additional code to identify infection, such as:
Add	other sepsis or generalized infection (A41.89-)
Add	sepsis or generalized infection NOS (A41.9-)
Add	Use additional code, if applicable, for:
Add	organ dysfunction associated with sepsis (R65.2-)
Add	septic shock (R65.21)

T83 Complications of genitourinary prosthetic devices, implants and grafts

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

Revise	Use additional code to identify infection, such as:
Add	other sepsis or generalized infection (A41.89-)
Add	sepsis or generalized infection NOS (A41.9-)
Add	Use additional code, if applicable, for:

Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

T83.6 Infection and inflammatory reaction due to prosthetic device, implant and graft in genital tract
Revise Use additional code to identify infection, such as:
Add other sepsis or generalized infection (A41.89-)
Add sepsis or generalized infection NOS (A41.9-)
Add Use additional code, if applicable, for:
Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

T84 Complications of internal orthopedic prosthetic devices, implants and grafts

T84.7 Infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts
Revise Use additional code to identify infection, such as:
Add other sepsis or generalized infection (A41.89-)
Add sepsis or generalized infection NOS (A41.9-)
Add Use additional code, if applicable, for:
Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

T85 Complications of other internal prosthetic devices, implants and grafts

T85.7 Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts
Revise Use additional code to identify infection, such as:
Add other sepsis or generalized infection (A41.89-)
Add sepsis or generalized infection NOS (A41.9-)
Add Use additional code, if applicable, for:
Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

T88 Other complications of surgical and medical care, not elsewhere classified

T88.0 Infection following immunization
Revise Use additional code to identify infection, such as:
Add other sepsis or generalized infection (A41.89-)
Add sepsis or generalized infection NOS (A41.9-)
Add Use additional code, if applicable, for:
Add organ dysfunction associated with sepsis (R65.2-)
Add septic shock (R65.21)

INDEX MODIFICATIONS

Adrenalitis, adrenitis E27.8
Revise - meningococcal, hemorrhagic (see also Syndrome, Waterhouse) A39.1-

Apoplexia, apoplexy, apoplectic
Revise - adrenal (see also Syndrome, Waterhouse) A39.1-

Revise Bruce sepsis A23.0 – see also Sepsis, Brucella

Brucellosis (infection) A23.9
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Revise - sepsis (see also Sepsis, Brucella) A23.9
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- - specified NEC A23.8

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Revise - Waterhouse-Friderichsen (see also Syndrome, Waterhouse) A39.1-

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Add - - Acinetobacter baumannii A41.541
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Meningococcus, meningococcal (see also condition) A39.9
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Add Note: for sepsis without organ dysfunction (and thus not based on Sepsis-3 criteria or definitions), see Infection, generalized.
Revise - adrenal hemorrhage syndrome (meningococcal) (see also Syndrome, Waterhouse) A39.11
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Add - - canis A23.3
Add - - melitensis A23.0
Add - - specified NEC A23.8
Add - - suis A23.2
- Shigella A03.9 - see also Dysentery, bacillary
Add - - boydii A03.2
Add - - dysenteriae A03.0
Add - - flexneri A03.1
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Revise - - hemorrhage (meningococcal) (see also Syndrome, Waterhouse) A39.1-
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Add - - due to
Add - - - generalized infection
Add - - - - meningococcal A39.12
Add - - - - Other specified organism E27.81
Add Note: The code E27.81, Waterhouse-Friderichsen syndrome in diseases classified elsewhere, requires a separate code for the infection to be coded first. See also Infection, generalized, by organism.
Add - - - - Pseudomonas A41.521 [E27.81]
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Add - - - - Other specified organism E27.81
Add Note: The code E27.81, Waterhouse-Friderichsen syndrome in diseases classified elsewhere, requires a separate code for the infection to be coded first. See also Sepsis, by organism.
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Spasticity

Spasticity is classically defined as a velocity-dependent increase in muscle tone resulting from hyperexcitability of the stretch reflex following upper motor neuron injury. It is a common and clinically significant sequela of numerous neurological disorders affecting the brain, spinal cord, and motor neurons, including stroke, traumatic brain injury, spinal cord injury, multiple sclerosis, cerebral palsy, and ALS.

Spasticity affects millions of children and adults worldwide. It has been estimated that spasticity affects between 1.8 and 5.6 million survivors of stroke in the United States alone [1,2]. It is also a sequela of other neurological disorders, including cerebral palsy, spinal cord injury, brain injury, multiple sclerosis, and amyotrophic lateral sclerosis. Affected individuals frequently require treatment to reduce pain, improve functional independence and quality of life, and prevent complications such as contractures and skin breakdown. Management strategies include rehabilitation therapies, oral medications, intrathecal baclofen, and procedural interventions such as chemical neurolysis (with alcohol or phenol), cryoneurolysis, and botulinum toxin injections [3].

Importantly, spasticity and muscle spasm are not synonymous. Spasticity is defined as a velocity-dependent increase in muscle tone due to hyperexcitability of the stretch reflex following upper motor neuron injury [4,5]. While spasticity shares certain features with other movement disorders involving involuntary muscle contraction, spasticity represents a clinically distinct condition with different underlying pathophysiology, etiologies, patterns of presentation, and treatment approaches

In contrast, muscle spasms are involuntary muscle contractions that may occur in both healthy individuals and those with neurological conditions and arise from a variety of etiologies, including exercise, electrolyte imbalance, medication effects, and muscle injury [6]. While some treatment overlap exists, certain therapies effective for spasticity are not indicated for nonspecific muscle spasms, underscoring the importance of accurate diagnostic distinction in coding.

Early identification and appropriate treatment of spasticity are essential to prevent long-term complications such as contracture, skin breakdown, pain, impaired mobility, hygiene difficulties, and caregiver burden, while also optimizing functional independence, comfort, and quality of life.

A specific diagnostic code for spasticity would help identify at risk patients, improve outcome tracking, clarify incidence and prevalence, support research and support evidence-based management.

ICD-10-CM codes exist for certain conditions that include spasticity in their descriptors—such as spastic hemiplegia (G81.1), hereditary spastic paraplegia (G11.4), tropical spastic paraplegia (G04.1), and spastic forms of cerebral palsy (G80.0–G80.2), however, there is no single, specific code that captures spasticity as a clinical entity. As a result, clinicians face ongoing challenges in accurately coding spasticity associated with other neurological conditions, including multiple sclerosis and traumatic spinal cord and brain injuries.

Spasticity is commonly recorded in health records by various professionals, including physicians (such as neurologists, physiatrists, neurosurgeons, and primary care doctors), therapists, and nursing

staff. Documentation typically notes the functional effects of spasticity and related interventions, and appears in progress notes, therapy evaluations, and follow-up records. Clinicians often specify the anatomical location and associated neurological condition, such as stroke, spinal cord injury, traumatic brain injury, or cerebral palsy.

Physiatrists have reported utilizing the code for "other dystonia" to document spasticity cases as a more specific coding option is unavailable. Although there are some similarities in treatment approaches for both conditions, medication dosing—for example, botulinum toxin—differs significantly between these two indications. Additionally, dystonia may manifest without the presence of an upper motor neuron (UMN) syndrome, while spasticity is exclusively associated with UMN disorders.

A dedicated ICD-10-CM code for spasticity would be supported by clear physician documentation explicitly identifying "spasticity" as a distinct condition or clinically significant manifestation requiring evaluation and management. Examples of supporting documentation would include assessment and plan sections indicating treatment of spasticity with oral antispasmodic medications, intrathecal baclofen therapy, botulinum toxin injections, serial casting, orthotic management, or rehabilitative interventions specifically directed at tone management. Procedure documentation for chemodenervation frequently includes detailed identification of spastic muscles, severity of tone, and functional goals of treatment, further supporting the ability of clinicians and coders to reliably identify and assign a dedicated code for spasticity when present.

Objective examination findings supporting assignment of a specific spasticity code may include documentation of increased tone on examination using Modified Ashworth Scale and/or Tardieu scale scores, presence of clonus, hyperactive deep tendon reflexes, impaired passive range of motion due to tone, or gait abnormalities attributable to spasticity. In addition, documentation commonly describes the clinical impact of spasticity, including pain, impaired mobility, reduced dexterity, hygiene difficulties, caregiver burden, impaired activities of daily living, contracture risk, skin breakdown risk, or interference with orthotic use and rehabilitation participation.

This proposal is submitted by the Carolyn Millett, CPC American Academy of Physical Medicine, Senior Director, Practice, Reimbursement and Regulatory Affairs.

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TABULAR MODIFICATIONS

G24 Dystonia
Includes: dyskinesia
Excludes2: athetoid cerebral palsy (G80.3)

New code G24.A Spasticity
Add Note: This code is used when the underlying condition does not include spasticity.

Add Code first if known, underlying condition such as :
sequelae of cerebrovascular disease (I69.0-, I69.1-)

Add Excludes1: hereditary spastic paraplegia (G11.4)
Add spastic hemiplegia G81.1-
Add tropical spastic paraplegia (G04.1)

Add Excludes2: cerebral palsy (G80.-)

Tenosynovial Giant Cell Tumor (formerly Pigmented Villonodular Synovitis)

Tenosynovial giant cell tumors (TGCT) arise from the synovium, tendon sheath, and bursae of a joint. The tumors may be intra-articular, extra-articular, or both. Since tenosynovial giant cell tumors do not metastasize, they are not classified as malignant. However, tenosynovial giant cell tumors can be infiltrative, proliferative, and locally aggressive, for example causing erosion of adjacent bones, damaging ligaments, and leading to degenerative joint disease.

Within the spectrum of tenosynovial giant cell tumors, there are two subtypes: localized and diffuse. The localized form (L-TGCT) is nodular and usually involves a single tumor, commonly seen at the distal joints of the extremities. The diffuse type (D-TGCT) involves multiple tumors with extensive synovial infiltration often extending into extra-articular structures. It is usually found at the knee, hip, ankle, and shoulder joints. While the two subtypes differ in some features, they exist on a spectrum and share the same pathogenesis, molecular drivers, and treating specialists.

Outside of active surveillance, the standard treatment for tenosynovial giant cell tumor is complete surgical resection. Unfortunately, tenosynovial giant cell tumors have high recurrence rates post-resection, with the major risk factors for recurrence being incomplete resection and prior recurrence. Given that the pathogenesis of tenosynovial giant cell tumors involves aberrations in the *colony stimulating factor 1* (*CSF1*) gene, systemic CSF1 inhibitors are also used for symptomatic tumors that are either unlikely to benefit from surgery or where surgery could even worsen function.

Physician specialties caring for individuals with tenosynovial giant cell tumors include medical oncology, orthopedic oncology, orthopedic surgery, and general orthopedics. Sarcoma specialists are frequently involved.

The annual incidence of TGCT is estimated to be 43 new cases per million, or about 14,700 new cases per year in the US. However, incidence alone substantially underrepresents the number of people affected by TGCT. Because TGCT is rarely life-threatening, many individuals live with the disease for decades. As a result, while receiving a diagnosis of TGCT is relatively uncommon, living with TGCT is not. The prevalence of TGCT, representing the total number of people with TGCT in the US, is estimated at 56 per 100,000, or about 191,500 people. Further, the true burden of TGCT is likely greater a result of misdiagnosis and delayed diagnosis, and due to inaccurate reporting associated with clinical reclassification and revised nomenclature in more recent years.

Historically, the disorder was classified as a musculoskeletal inflammatory condition and referred to as pigmented villonodular synovitis (PVNS). However, advances in molecular pathology have fundamentally changed the understanding of its pathophysiology and established that TGCT is a neoplasm rather than a primary inflammatory musculoskeletal disorder. This reclassification followed the discovery of recurrent *CSF1* gene rearrangements, most commonly a fusion of the *CSF1* and *COL6A3* genes, a clonal cytogenetic abnormality characteristic of neoplastic processes, such as

sarcoma. The resulting overexpression of colony-stimulating factor 1 (CSF1) recruits non-neoplastic inflammatory cells and drives tumor growth.

The historical term "pigmented villonodular synovitis" is also misleading because the defining features implied by the name are neither universal nor central to the disease process. Hemosiderin-laden macrophages, which produce characteristic pigmentation, are not always present, and the finger-like villonodular architecture does not develop in every case. Although synovitis and other inflammatory changes commonly occur, they are secondary to the underlying neoplastic process rather than the primary disease and do not respond to anti-inflammatory medications or corticosteroids.

As clinical classification evolved to reflect the true nature of the disorder, inconsistencies in nomenclature led to variability and confusion in documentation and clinical literature. The term “pigmented villonodular synovitis” was recognized as a mischaracterization of the disorder. To resolve this, WHO standardized the nomenclature to “tenosynovial giant cell tumor” in 2013 and reaffirmed the revised nomenclature in 2020. “Tenosynovial giant cell tumor (TGCT)” and “pigmented villonodular synovitis (PVNS)” are the same clinical disorder. However, tenosynovial giant cell tumor is now the standard clinical terminology, with giant cell tumor of tendon sheath also acceptable. The term pigmented villonodular synovitis is specifically identified as “not recommended.”

ICD-10-CM continues to use the nomenclature of villonodular synovitis (pigmented).
As indicated by the WHO standard, this disorder is neoplastic rather than inflammatory. The outdated nomenclature and misclassification have led to the same condition being assigned to multiple different codes across different chapters of ICD-10-CM. As identified in an internal data analysis performed for the patient advocacy group, codes assigned for tenosynovial giant cell tumors include those for pigmented villonodular synovitis as well as those for benign neoplasms, neoplasms of uncertain behavior, synovitis and tenosynovitis, and other disorders of synovium and tendon.

Giant cell tumors are indexed to Neoplasm, uncertain behavior, by site. Notably, ICD-10-CM classifies non-malignant but locally aggressive neoplasms of synovial tissue and tendons to D48.1, Neoplasm of uncertain behavior of connective and other soft tissue. This is indicated by the instructional note in the Table of Neoplasms and exemplified by subcategory D48.11, Desmoid tumor. It is not felt necessary to create separate codes for the two subtypes of tenosynovial giant cell tumor. Beyond their common pathogenesis and management by the same treating specialists, surgical resection remains the mainstay treatment regardless of subtype. In addition, findings from a multidisciplinary survey presented in 2022 found that less than half of providers (47%) indicated a high or very high confidence level in distinguishing between L-TGCT and D-TGCT.

Rectifying the current classification while updating and standardizing the nomenclature will reflect the advances in the clinical understanding of the disorder. This will help ensure that coding will be consistent and appropriately categorized, contributing to cleaner and more accurate data for tracking and research.

This proposal has been proposed by TGCT Support, a program of the patient advocacy organization Life Raft Group. It is supported by the Musculoskeletal Tumor Society, a medical society of orthopedic oncology surgeons and the Connective Tissue Oncology Society, a multi-disciplinary international group of physicians and scientists with a primary interest in the tumors of connective tissues including medical oncologists, orthopedic oncologists, and sarcoma specialists.

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TABULAR MODIFICATIONS

D48 Neoplasm of uncertain behavior of other and unspecified sites

D48.0 Neoplasm of uncertain behavior of bone and articular cartilage

Excludes1: neoplasm of uncertain behavior of synovia (D48.1-)

D48.1	Neoplasm of uncertain behavior of connective and other soft tissue	
	D48.11	Desmoid tumor
New subcategory	D48.12	Tenosynovial giant cell tumor
Add		Giant cell tumor of tendon sheath
Add		Tenosynovial giant cell tumor, diffuse (D-TGCT)
Add		Tenosynovial giant cell tumor, localized (L-TGCT)
Add		TGCT
Add		Villonodular synovitis (pigmented)
New code	D48.120	Tenosynovial giant cell tumor, unspecified site
New sub-subcategory	D48.121	Tenosynovial giant cell tumor, shoulder
New code		D48.1211 Tenosynovial giant cell tumor, right shoulder
New code		D48.1212 Tenosynovial giant cell tumor, left shoulder
New code		D48.1219 Tenosynovial giant cell tumor, unspecified shoulder
New sub-subcategory	D48.122	Tenosynovial giant cell tumor, elbow
New code		D48.1221 Tenosynovial giant cell tumor, right elbow
New code		D48.1222 Tenosynovial giant cell tumor, left elbow
New code		D48.1229 Tenosynovial giant cell tumor, unspecified elbow
New sub-subcategory	D48.123	Tenosynovial giant cell tumor, wrist
New code		D48.1231 Tenosynovial giant cell tumor, right wrist
New code		D48.1232 Tenosynovial giant cell tumor, left wrist
New code		D48.1239 Tenosynovial giant cell tumor, unspecified wrist
New sub-subcategory	D48.124	Tenosynovial giant cell tumor, hand
New code		D48.1241 Tenosynovial giant cell tumor, right hand
New code		D48.1242 Tenosynovial giant cell tumor, left hand
New code		D48.1249 Tenosynovial giant cell tumor, unspecified hand

New sub-subcategory	D48.125	Tenosynovial giant cell tumor, hip
New code	D48.1251	Tenosynovial giant cell tumor, right hip
New code	D48.1252	Tenosynovial giant cell tumor, left hip
New code	D48.1259	Tenosynovial giant cell tumor, unspecified hip
New sub-subcategory	D48.126	Tenosynovial giant cell tumor, knee
New code	D48.1261	Tenosynovial giant cell tumor, right knee
New code	D48.1262	Tenosynovial giant cell tumor, left knee
New code	D48.1269	Tenosynovial giant cell tumor, unspecified knee
New sub-subcategory	D48.127	Tenosynovial giant cell tumor, ankle and foot
New code	D48.1271	Tenosynovial giant cell tumor, right ankle and foot
New code	D48.1272	Tenosynovial giant cell tumor, left ankle and foot
New code	D48.1279	Tenosynovial giant cell tumor, unspecified ankle and foot
New code	D48.128	Tenosynovial giant cell tumor, other specified site
Add		Tenosynovial giant cell tumor, vertebrae
New code	D48.129	Tenosynovial giant cell tumor, multiple sites

M12 Other and unspecified arthropathy

M12.2 Villonodular synovitis (pigmented)

Add **Note: Effective October 1, 2027, due to globally recognized clinical updates in classification and nomenclature, conditions previously classified to subcategory M12.2-, Villonodular synovitis (pigmented), have been reclassified to D48.12-, Tenosynovial giant cell tumor. Codes in M12.2- are maintained for historical data purposes.**

Titanium dioxide and Iron Oxide exposure

This topic was presented at the March 2026 ICD-10 Coordination and Maintenance Committee meeting. At the submitter's request, additional new Z codes in Chapter 21 have been submitted for consideration.

Iron Oxide

Iron oxide is used throughout a variety of occupations, including welding, foundry work, iron and steel manufacturing, mining, and biomedical applications for clinical use.[2] US military service members typically face exposure to iron oxide through airborne hazards, including dust storms and burn pits.

Exposure to iron oxide fumes can cause metal fume fever — a flu-like illness with symptoms of fever and chills, aches, chest tightness, and cough.[3] Prolonged or repeated contact can discolor the eyes, causing permanent iron staining. Some studies suggest that exposure to iron oxide may cause neurodegeneration[4] or stress to the body's organs.[5]

Iron oxide was the 30th most common hazard (out of 767, based on data pulled January 2023) tracked within the Individual Longitudinal Exposure Record (ILER), which tracks toxic exposures for the DOD and VA.

Titanium Dioxide

Titanium dioxide exposure typically occurs through inhalation, ingestion, injection, skin contact, or absorption in the alimentary tract.[6] Studies show that titanium dioxide can accumulate in the body, particularly in the lungs, alimentary tract, liver, heart, spleen, kidneys, and cardiac muscle.[7]

People may be exposed to titanium dioxide through various industrial applications, including building engineering, water and sewage treatment, gas combustion, use as an antibacterial material for decontamination, production of fertilizers and pesticides, biomedical and pharmaceutical applications, and in the food industry for processing and packaging.[8]

In recent years, concerns about titanium dioxide exposure have also extended to military environments. Service members deployed to Iraq and Afghanistan were frequently stationed near open-air burn pits used to dispose of waste materials, resulting in chronic exposure to airborne particulate matter and toxic metals. Titanium-containing particles have been identified in deployment-exposed veterans' lung tissue, raising concern that titanium compounds (including potentially titanium dioxide) may play a role in inhalation-related injury.[9],[10]

Documented health effects of titanium dioxide nanoparticle exposure in humans include accumulation in the lungs, liver, heart, and kidneys; oxidative stress and apoptosis in intestinal epithelial cells; DNA damage; and disruption of cellular function in internal organs.[11]

Titanium dioxide was the 36th most common hazard (out of 767, based on data pulled January 2023) tracked within the Individual Longitudinal Exposure Record (ILER).

Documentation of toxic exposures during military service is a high priority for both the Department of Defense (DOD) and the Department of Veterans Affairs (VA) because of their potential long-term health consequences and directives established in recent legislation, namely the Promise to Address Comprehensive Toxics (PACT) Act.[1] Currently, no ICD-10-CM codes exist specifically for exposure to either iron oxide or titanium dioxide. These new codes will allow documentation of exposure in the electronic health records of active-duty Service Members, Veterans, and members of the general public who may become exposed

This proposal, submitted by Laree LaPierre, MPH on behalf of the Department of Defense (DOD), Department of Veterans Affairs (VA), and the Office of Federal Electronic Health Record Modernization (FEHRM), requests new ICD-10-CM codes for toxic exposure to iron oxide and titanium dioxide.

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TABULAR MODIFICATIONS

Note: The tabular modifications below were presented and supported at March 2026 C&M Meeting.

T56 Toxic effect of metals

T56.8 Toxic effect of other metals

New sub-subcategory	T56.83 Toxic effect of iron oxide
Add	Use additional code, if applicable for: contact with and (suspected) exposure to war theater (Z77.3-)
Add	effects of war theater (T75.83-)
New code	T56.831 Toxic effect of iron oxide, accidental (unintentional) Toxic effect of iron oxide NOS
New code	T56.832 Toxic effect of iron oxide, intentional self-harm
New code	T56.833 Toxic effect of iron oxide, assault
New code	T56.834 Toxic effect of iron oxide, undetermined

T56 Toxic effect of metals

T56.8 Toxic effect of other metals

New sub-subcategory	T56.84 Toxic effect of titanium dioxide
Add	Use additional code, if applicable for: contact with and (suspected) exposure to war theater (Z77.3-)
Add	effects of war theater (T75.83-)
New code	T56.841 Toxic effect of titanium dioxide, accidental (unintentional) Toxic effect of titanium dioxide NOS
New code	T56.842 Toxic effect of titanium dioxide, intentional self-harm

New code T56.843 Toxic effect of titanium dioxide, assault

New code T56.844 Toxic effect of titanium dioxide, undetermined

TABULAR MODIFICATIONS

Z77 Other contact with and (suspected) exposures hazardous to health

Includes: contact with and (suspected) exposures to potential hazards to health

Excludes2: contact with and (suspected) exposure to communicable diseases (Z20.-)

Add contact with and (suspected) exposure to war theater (Z77.3-)

exposure to (parental) (environmental) tobacco smoke in the perinatal period (P96.81)

newborn affected by noxious substances transmitted via placenta or breast milk (P04.-)

occupational exposure to risk factors (Z57.-)

retained foreign body (Z18.-)

retained foreign body fully removed (Z87.821)

toxic effects of substances chiefly nonmedicinal as to source (T51-T65)

Z77.0 Contact with and (suspected) exposure to hazardous, chiefly nonmedicinal, chemicals

Z77.01 Contact with and (suspected) exposure to hazardous metals

Z77.010 Contact with and (suspected) exposure to arsenic

Z77.011 Contact with and (suspected) exposure to lead

Z77.012 Contact with and (suspected) exposure to uranium

Excludes1: retained depleted uranium fragments (Z18.01)

New code Z77.013 Contact with and (suspected) exposure to titanium dioxide

New code	Z77.014 Contact with and (suspected) exposure to iron oxide
	Z77.018 Contact with and (suspected) exposure to other hazardous metals
	Contact with and (suspected) exposure to chromium compounds
	Contact with and (suspected) exposure to nickel dust

TABULAR MODIFICATIONS PROPOSED ADDENDA
All approved modifications will be effective April 1, 2027

Move from J4B Pulmonary mycetoma
Move from Pulmonary fungal ball
Move from Code also, if known, associated infection, such as:
Move from aspergillosis (B44.-)
Move from chronic pulmonary coccidioidomycosis (B38.1)
Move from pulmonary candidiasis (B37.1)

No change J45 Asthma
...

No change J47 Bronchiectasis
...

Move to J4B Pulmonary mycetoma
Move to Pulmonary fungal ball
Move to Code also, if known, associated infection, such as:
Move to aspergillosis (B44.-)
Move to chronic pulmonary coccidioidomycosis (B38.1)
Add pulmonary blastomycosis (B40.0-B40.2)
Move to pulmonary candidiasis (B37.1)

Move from K6A Diseases of the pelvis, not elsewhere classified
Move from K6A.0 Pelvic abscess
Move from Code also, if applicable:
Move from diverticular disease of intestine (K57.-)
Move from female pelvic inflammatory disease (N73.-)
Move from Use additional code (B95-B97), to identify infectious agent, if known
Move from Excludes2: peritoneal abscess (K65.1)
Move from retroperitoneal abscess (K68.1-)
Move from K6A.01 Prevesical abscess
Move from Retropubic abscess
Move from K6A.09 Other pelvic abscess
Move from Pelvic abscess, unspecified
Move from K6A.8 Other diseases of the pelvis, not elsewhere classified

No change K66 Other disorders of peritoneum
…

No change K67 Disorders of peritoneum in infectious diseases classified elsewhere
…
No change K68 Disorders of retroperitoneum
…

Move to K6A Diseases of the pelvis, not elsewhere classified
Move to K6A.0 Pelvic abscess
Move to Code also, if applicable:
Move to diverticular disease of intestine (K57.-)
Move to female pelvic inflammatory disease (N73.-)
Move to Use additional code (B95-B97), to identify infectious agent, if known
Move to Excludes2: peritoneal abscess (K65.1)
Move to retroperitoneal abscess (K68.1-)
Move to K6A.01 Prevesical abscess
Move to Retropubic abscess
Move to K6A.09 Other pelvic abscess
Move to Pelvic abscess, unspecified
Move to K6A.8 Other diseases of the pelvis, not elsewhere classified

T37 Poisoning by, adverse effect of and underdosing of other systemic anti-infectives and antiparasitics

T37.5 Poisoning by, adverse effect of and underdosing of antiviral drugs
Delete ~~Excludes1: amantadine (T42.8-)~~
Delete ~~cytarabine (T45.1-)~~

Add Excludes2: amantadine (T42.8-)
Add cytarabine (T45.1-)

Z65 Problems related to other psychosocial circumstances

Z65.8 Other specified problems related to psychosocial circumstances
At risk for feeling loneliness
Add Chronic (prolonged) exposure to politics or political figures affecting health status
Religious or spiritual problem
Add Stressful sociopolitical events affecting health status

INDEX MODIFICATIONS PROPOSED ADDENDA
All approved modifications will be effective April 1, 2027

Incompetency, incompetent, incompetence
- chronotropic I45.89

Revise - - with sinus node dysfunction ~~I49.8~~ I49.5

Problem (with) (related to)
- psychosocial Z65.9

Add - - related to politics (elections) Z65.8

Add - - related to (prominent) political figure Z65.8

Add - - related to stressful sociopolitical event Z65.8

TABULAR MODIFICATIONS PROPOSED ADDENDA
All approved modifications will be effective October 1, 2027

B40 Blastomycosis

B40.0 Acute pulmonary blastomycosis

Add Code also, if applicable:
Add pneumonia due to other specified infectious organisms (J16.8)
Add pulmonary fungal ball (J4B)
Add pulmonary mycetoma (J4B)

B40.1 Chronic pulmonary blastomycosis

Add Code also, if applicable:
Add pneumonia due to other specified infectious organisms (J16.8)
Add pulmonary fungal ball (J4B)
Add pulmonary mycetoma (J4B)

B40.2 Pulmonary blastomycosis, unspecified

Add Code also, if applicable:
Add pneumonia due to other specified infectious organisms (J16.8)
Add pulmonary fungal ball (J4B)
Add pulmonary mycetoma (J4B)

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

Note: Categories D37-D44, and D48 classify by site neoplasms of uncertain behavior, i.e., histologic confirmation whether the neoplasm is malignant or benign cannot be made.

Delete ~~Excludes1:neoplasms of unspecified behavior (D49.-)~~
Add Excludes2:neoplasms of unspecified behavior (D49.-)

D65 Disseminated intravascular coagulation [defibrination syndrome]

Add Excludes1:antepartum hemorrhage with disseminated intravascular coagulation (O46.02-)
Add premature separation of placenta with disseminated intravascular coagulation (O45.02-)

E03 Other hypothyroidism

Delete ~~Excludes1:postprocedural hypothyroidism (E89.0)~~
Add Excludes2:postprocedural hypothyroidism (E89.0)

E06 Thyroiditis

Add Code also, if applicable:
Add thyroid orbitopathy (H05.83-)

E28 Ovarian dysfunction
E28.2 Polycystic ovarian syndrome
Add Polyendocrine metabolic ovarian syndrome
E28.3 Primary ovarian failure
Add Premature ovarian insufficiency

Malnutrition (E40-E46)

Delete Excludes1: ~~intestinal malabsorption (K90.-)~~
Delete ~~sequelae of protein-calorie malnutrition (E64.0)~~

Add Excludes2: intestinal malabsorption (K90.-)
Add sequelae of protein-calorie malnutrition (E64.0)

F07 Personality and behavioral disorders due to known physiological condition
Delete ~~Code first the underlying physiological condition~~
F07.0 Personality change due to known physiological condition
Add Code first the underlying physiological condition

F07.8 Other personality and behavioral disorders due to known physiological condition
F07.89 Other personality and behavioral disorders due to known physiological condition
Add Code first the underlying physiological condition

F07.9 Unspecified personality and behavioral disorder due to known physiological condition
Add Code first the underlying physiological condition

F33 Major depressive disorder, recurrent

F33.4 Major depressive disorder, recurrent, in remission
Add Excludes2: Other recurrent depressive disorders (F33.8)
F33.40 Major depressive disorder, recurrent, in remission, unspecified
F33.41 Major depressive disorder, recurrent, in partial remission
F33.42 Major depressive disorder, recurrent, in full remission

F33.8 Other recurrent depressive disorders
Recurrent brief depressive episodes
Add SAD
Add Seasonal affective disorder

F80 Specific developmental disorders of speech and language

F80.2 Mixed receptive-expressive language disorder
Delete ~~Excludes1: central auditory processing disorder (H93.25)~~
Delete ~~dysphasia or aphasia NOS (R47.-)~~
Delete ~~expressive language disorder (F80.1)~~
Delete ~~expressive type dysphasia or aphasia (F80.1)~~
Delete ~~word deafness (H93.25)~~

Add Excludes2: central auditory processing disorder (H93.25)
Add dysphasia or aphasia NOS (R47.-)
Add word deafness (H93.25)

G12 Spinal muscular atrophy and related syndromes
G12.2 Motor neuron disease
G12.21 Amyotrophic lateral sclerosis
Add Code also, if applicable for Brait-Fahn-Schwartz disease, Parkinson's disease (G20.-)

G20 Parkinson's disease
Add Code also, if applicable for Brait-Fahn-Schwartz disease, amyotrophic lateral sclerosis (G12.21)

H40 Glaucoma
H40.8 Other glaucoma
H40.84 Neovascular secondary angle closure glaucoma
Delete ~~Code also the underlying condition such as:~~
Delete ~~diabetes mellitus (E08.39, E09.39, E10.39, E11.39, E13.39)~~

Add Code first underlying condition, such as:
Add diabetes mellitus (E08.39, E09.39, E10.39, E11.39, E13.39)

I06 Rheumatic aortic valve diseases
Revise Excludes2: aortic valve disease with mitral and/or tricuspid valve involvement (~~I08.~~ I08.0, I08.2, I08.3, and I08.8)

J38 Diseases of vocal cords and larynx, not elsewhere classified
Delete ~~Excludes1: stridor (R06.1)~~
Add Excludes2: stridor (R06.1)

J42 Unspecified chronic bronchitis
Delete Excludes1: ~~bronchiolitis obliterans and bronchiolitis obliterans syndrome (J44.81)~~
Delete ~~chronic asthmatic bronchitis (J44.-)~~
Delete ~~chronic bronchitis with airways obstruction (J44.-)~~
Delete ~~chronic emphysematous bronchitis (J44.-)~~

Delete ~~chronic obstructive pulmonary disease NOS (J44.9)~~

Add Excludes2: bronchiolitis obliterans and bronchiolitis obliterans syndrome (J44.81)
Add chronic asthmatic bronchitis (J44.-)
Add chronic bronchitis with airways obstruction (J44.-)
Add chronic emphysematous bronchitis (J44.-)
Add chronic obstructive pulmonary disease NOS (J44.9)

J96 Respiratory failure, not elsewhere classified
Delete Excludes1: ~~acute respiratory distress syndrome (J80)~~
Delete ~~cardiorespiratory failure (R09.2)~~
Delete ~~newborn respiratory distress syndrome (P22.0)~~
Delete ~~respiratory arrest (R09.2)~~
Delete ~~respiratory arrest of newborn (P28.81)~~
Delete ~~respiratory failure of newborn (P28.5)~~

Add Excludes2: acute respiratory distress syndrome (J80)
Add cardiorespiratory failure (R09.2)
Add newborn respiratory distress syndrome (P22.0)
Add respiratory arrest (R09.2)
Add respiratory arrest of newborn (P28.81)
Add respiratory failure of newborn (P28.5)

K65 Peritonitis
Delete ~~Excludes1: pelvic peritonitis, female (N73.3-N73.5)~~
Add Excludes2: pelvic inflammatory disease, female (N73.0, N73.1, N73.8)
Add pelvic peritonitis, due to pelvic inflammatory disease, female (N73.3-N73.5)

M1A Chronic gout
Revise Excludes1: gout NOS (M10.-9) (Dash is stricken out)

R40 Somnolence, stupor and coma
R40.4 Transient alteration of awareness
Add Staring episodes
Add Staring spells

R47 Speech disturbances, not elsewhere classified
Delete Excludes1: ~~autism (F84.0)~~
Delete ~~cluttering (F80.81)~~
Delete ~~specific developmental disorders of speech and language (F80.-)~~
Delete ~~stuttering (F80.81)~~

Add Excludes2: autism (F84.0)
Add cluttering (F80.81)
Add specific developmental disorders of speech and language (F80.-)
Add stuttering (F80.81)

R62 Lack of expected normal physiological development in childhood and adults

R62.5 Other and unspecified lack of expected normal physiological development in childhood

R62.51 Failure to thrive (child)
Failure to gain weight
Faltering growth
Add Faltering weight
Add Weight faltering

S31 Open wound of abdomen, lower back, pelvis and external genitals
S31.1 Open wound of abdominal wall without penetration into peritoneal cavity
Revise S31.12 Laceration ~~with foreign body~~ of abdominal wall with foreign body without penetration into peritoneal cavity
S31.120 Laceration of abdominal wall with foreign body, right upper quadrant without penetration into peritoneal cavity
S31.121 Laceration of abdominal wall with foreign body, left upper quadrant without penetration into peritoneal cavity
S31.122 Laceration of abdominal wall with foreign body, epigastric region without penetration into peritoneal cavity
S31.123 Laceration of abdominal wall with foreign body, right lower quadrant without penetration into peritoneal cavity
S31.124 Laceration of abdominal wall with foreign body, left lower quadrant without penetration into peritoneal cavity
S31.125 Laceration of abdominal wall with foreign body, periumbilic region without penetration into peritoneal cavity
Revise S31.126 Laceration ~~with foreign body~~ of abdominal wall with foreign body, right flank without penetration into peritoneal cavity
Revise S31.127 Laceration ~~with foreign body~~ of abdominal wall with foreign body, left flank without penetration into peritoneal cavity

S31.129 Laceration of abdominal wall with foreign body, unspecified quadrant without penetration into peritoneal cavity

Revise S31.12A Laceration ~~with foreign body~~ of abdominal wall with foreign body unspecified flank without penetration into peritoneal cavity

Revise Laceration ~~with foreign body~~ of abdominal wall with foreign body of flank NOS without penetration into peritoneal cavity

S31.6 Open wound of abdominal wall with penetration into peritoneal cavity

S31.63 Puncture wound without foreign body of abdominal wall with penetration into peritoneal cavity

Revise S31.636 Puncture wound ~~of abdominal wall~~ without foreign body of abdominal wall, right flank with penetration into peritoneal cavity

Revise S31.637 Puncture wound ~~of abdominal wall~~ without foreign body of abdominal wall, left flank with penetration into peritoneal cavity

Revise S31.63A Puncture wound ~~of abdominal wall~~ without foreign body of abdominal wall, unspecified flank with penetration into peritoneal cavity

Revise Puncture wound ~~of abdominal wall~~ without foreign body of abdominal wall, flank NOS, with penetration into peritoneal cavity

Z87 Personal history of other diseases and conditions

Revise Code first, if applicable, any follow-up examination after treatment (Z09)

Z91 Personal risk factors, not elsewhere classified

Z91.B Personal risk factor of exposure to diethylstilbestrol

Revise Code first ~~also~~ if applicable, associated conditions, such as:

INDEX MODIFICATIONS PROPOSED ADDENDA

All approved modifications will be effective October 1, 2027

Abnormal, abnormality, abnormalities - see also Anomaly
-chromosome, chromosomal Q99.9
Revise - - sex ~~Q99.8~~ Q99.89
Revise - - specified NEC ~~Q99.8~~ Q99.89

Abscess (connective tissue) (embolic) (fistulous) (infective) (metastatic) (multiple) (pernicious) (pyogenic) (septic)L02.91
Revise - – flank L02.217 (removing second dash)

Acidosis (lactic) E87.20
Add - in diabetes - see Diabetes, by type, with ketoacidosis

Additional - see also Accessory
Revise - chromosome(s) (see also Trisomy) ~~Q99.8~~ Q99.89

Alcohol, alcoholic, alcohol-induced
- addiction (without remission) F10.20
- - with remission F10.21
- amnestic disorder, persisting F10.96
- - with dependence F10.26
- anxiety disorder F10.980
- bipolar and related disorder F10.94
Delete ~~- depressive disorder F10.94~~
Delete ~~- major neurocognitive disorder, amnestic-confabulatory type F10.96~~
Delete ~~- major neurocognitive disorder, nonamnestic-confabulatory type F10.97~~
Delete ~~- mild neurocognitive disorder F10.988~~
Delete ~~- psychotic disorder F10.959~~
Delete ~~- sexual dysfunction F10.981~~
Delete ~~- sleep disorder F10.982~~
- brain syndrome, chronic F10.97
- - with dependence F10.27
- cardiopathy I42.6
- counseling and surveillance Z71.41
- - family member Z71.42
- - family member Z71.42
- delirium (acute) (tremens) (withdrawal) F10.921
- - with intoxication F10.921
- - - in
- - - - abuse F10.121
- - - - dependence F10.221
- - abuse F10.131
- - - with intoxication F10.121
- - dependence (acute) (tremens) (withdrawal) F10.231

- - - with intoxication F10.221
- - use, unspecified F10.931
- - - with intoxication F10.921
- dementia F10.97
- - with dependence F10.27

Add - depressive disorder F10.94

- deterioration F10.97
- - with dependence F10.27
- hallucinosis (acute) F10.951
- - in
- - - abuse F10.151
- - - dependence F10.251
- insanity F10.959
- intoxication (acute) (without dependence) F10.129
- - with
- - - delirium F10.121
- - - dependence F10.229
- - - - with delirium F10.221
- - - - uncomplicated F10.220
- - uncomplicated F10.120
- jealousy F10.988
- Korsakoff's, Korsakov's, Korsakow's F10.26
- liver K70.9
- - acute - see Disease, liver, alcoholic, hepatitis

Add - major neurocognitive disorder, amnestic-confabulatory type F10.96

Add - major neurocognitive disorder, nonamnestic-confabulatory type F10.97

- mania (acute) (chronic) F10.959

Add - mild neurocognitive disorder F10.988

- paranoia, paranoid (type) psychosis F10.950
- pellagra E52
- poisoning, accidental (acute) NEC - see Table of Drugs and Chemicals, alcohol, poisoning
- psychosis - see Psychosis, alcoholic

Add - psychotic disorder F10.959

Add - sexual dysfunction F10.981

Add - sleep disorder F10.982

Alteration (of), Altered
- awareness
- - transient R40.4

Add - - - staring spells R40.4

Angulation

Revise - sacrum (acquired) ~~- see also subcategory M43.8~~ M43.8X8

Anomaly
- chromosomes, chromosomal Q99.9
Revise - - specified NEC ~~Q99.8~~ Q99.89

Bronchitis
- acute or subacute (with bronchospasm or obstruction) J20.9
- - with
Revise - - - chronic obstructive pulmonary disease - see also Disease, pulmonary, chronic obstructive J44.0

Revise - ~~in those~~ under l5 years age - see Bronchitis, acute

Complication(s) (from) (of)
- eye H57.9
Add - - postprocedural (see also Complications, postprocedural, by type) H59.-

Contusion (skin surface intact) T14.8
Revise - interscapular region~~S20.229~~ S20.224

Deformity Q89.9
Revise - coccyx (acquired) ~~- see subcategory M43.8~~ M43.8X8
- lumbosacral (congenital) (joint) (region) Q76.49
Revise - - acquired ~~- see subcategory M43.8~~ M43.8X7
- sacroiliac joint (congenital) Q74.2
Revise - - acquired ~~- see subcategory M43.8~~ M43.8X8
Revise - sacrum (acquired) ~~- see subcategory M43.8~~ M43.8X8

Dementia (degenerative (primary)) (persisting) (unspecified severity) (without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety) F03.90
Add - advanced – See – Dementia, severe
Add - end-stage – See – Dementia, severe

Disease
Add - Brait-Fahn-Schwartz - Note: see both, Disease, Parkinson's and also see Sclerosis, amyotrophic (lateral)

- viral, virus (see also Disease, by type of virus) B34.9
Revise - - Sin nombre (Hantavirus) (cardio)-pulmonary syndrome~~)~~ B33.4

Disorder (of) - see also Disease
- glycine metabolism E72.50
Revise - - oxalosis E72.53-
Revise - - oxaluria E72.53-
- metabolism NOS E88.9
- - amino-acid E72.9

- - - glycine E72.50
- - - - hyperoxaluria R82.992
Revise - - - - - primary E72.53-

Episode
Add - staring R40.4

Fracture, pathological (pathologic) (see also Fracture, traumatic M84.40)
- due to
Revise - - specified disease NEC ~~M84.60~~ M84.659

Hypercholesterolemia (essential) (primary) (pure) E78.00
- familial E78.019
Delete ~~- - homozygous [HoFH] E78.010~~
- - heterozygous [HeFH] E78.011
Add - - homozygous [HoFH] E78.010

Hyperoxaluria R82.992
Revise - primary E72.53-

Revise IBDU (colonic inflammatory bowel ~~dissease~~ disease unclassified) K52.3

Revise Maculae ~~ceruleae~~ cerulea B85.1

Nevus D22.9
Add - Spitz (D22.-)

Revise Oxalosis E72.53-
Revise Oxaluria E72.53-
Plagiocephaly Q67.3
Add - deformational Q67.3
Add - positional Q67.3

Pneumonia
Add - Legionella (Legionnaires) see-Disease, Legionnaires

Pneumonitis (acute) (primary) (see also Pneumonia) J98.4
- due to
Add - -immune checkpoint inhibitor (therapy) J70.-

Pregnancy
- complicated by (care of) (management affected by)
Revise - - circulatory system disorder (conditions in I00-I09, I20-I99, ~~O99.41 -)~~ O99.41-

Add Seasonal affective disorder F33.8

Add	Spitz Nevus D22.-
Add	Staring spells R40.4
	Syndrome - see also Disease - due to abnormality - - chromosomal Q99.9
Revise	- - - specified NEC ~~Q99.8~~ Q99.89
	Translocation
Revise	- chromosomes NEC ~~Q99.8~~ Q99.89

ICD-10-CM External Cause of Injuries Index
All approved modifications will be effective October 1, 2027

Accident (to) X58
- transport (involving injury to) V99
- - nonpowered, struck by
Revise - - - nonpowered vessel ~~V94.21~~ V94.22
Revise - - - powered vessel ~~V94.22~~ V94.21
- - occupant (of)
- - - watercraft NOS V94.9
Revise - - - - causing drowning - ~~see Drowning,~~ resulting from accident to ~~boat~~ watercraft -see Drowning, due to, accident to, watercraft

Asphyxia, asphyxiation
- by
Revise - - food (bone) (seed) ~~- see categories T17 and T18~~ T17.910

Aspiration
Revise - food (any type) (into respiratory tract) (with asphyxia, obstruction respiratory tract, suffocation) ~~- see categories T17 and T18~~ T17.920

Choked, choking (on) (any object except food or vomitus)
Revise - food (bone) (seed) ~~- see categories T17 and T18~~ T17.920
Revise - vomitus ~~T17.81-~~ T17.910

Compression
- trachea by
Revise - - food (lodged in esophagus) ~~- see categories T17 and T18~~ T18.120
Revise - - vomitus (lodged in esophagus) ~~T17.81-~~ T18.110

Revise Discharge ~~(accidental)~~ (undetermined)
Revise - firearm ~~(accidental)~~ (undetermined) Y24.9

Food (any type) in
Revise - air passages (with asphyxia, obstruction, or suffocation) ~~- see categories T17 and T18~~T17.920
Revise - alimentary tract causing asphyxia (due to compression of trachea) ~~- see categories T17 and T18~~ T18.120

Foreign body
- entering through
- - natural orifice W44.9
Revise - - - dart ~~W44.H1~~ W44.H9
Revise - - - sharp object ~~specified NEC W44.H9~~ W44.H0
Add - - - - specified NEC W44.H9

Revise Hanging (accidental) - see also ~~T71.16~~ T71.161

Revise Perpetrator, perpetration, of assault, maltreatment and neglect (by) Y07.9 - ~~girl friend~~ girlfriend

ICD-10-CM TABLE of DRUGS and CHEMICALS
All approved modifications will be effective April 1, 2027

Substance		Poisoning Accidental (unintentional)	Poisoning Intentional self-harm	Poisoning Assault	Poisoning Undetermined	Adverse effect	Underdosing
Revise	Acetal				~~T52.893~~ T52.894	-	-
Revise	Acetaldehyde (vapor)				~~T52.893~~ T52.894	-	-
	Acetic					-	-
	- acid	T54.2X1	T54.2X2	T54.2X3	T54.2X4		
Revise	- - ester (solvent)(vapor)				~~T52.893~~ T52.894		
Revise	- ether (vapor)				~~T52.893~~ T52.894	-	-
Revise	Acetonitrile				~~T52.893~~ T52.894		

ICD-10-CM TABLE of DRUGS and CHEMICALS
All approved modifications will be effective October 1, 2027

Substance		Poisoning Accidental (unintentional)	Poisoning Intentional self-harm	Poisoning Assault	Poisoning Undetermined	Adverse effect	Underdosing
Add	Azamethiphos	T60.0X1	T60.0X2	T60.0X3	T60.0X4	-	-
Add	Bendiocarb	T60.0X1	T60.0X2	T60.0X3	T60.0X4	-	-
Add	Chlorpyrifos	T60.0X1	T60.0X2	T60.0X3	T60.0X4	-	-
Add	Methomyl	T60.0X1	T60.0X2	T60.0X3	T60.0X4	-	-

ICD-10-CM TABLE of NEOPLASMS

All approved modifications will be effective October 1, 2027

Neoplasm	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
Neoplasm, neoplastic						
Revise abdomen, abdominal		C79.8- Remove-dash C79.89				
Revise - - cavity		C79.8- Remove-dash C79.89				
Revise - organ		C79.8- Remove-dash C79.89				
Revise - viscera		C79.8- Remove-dash C79.89				
- wall						
Revise - - connective tissue		C79.8- Remove-dash C79.89				
Revise abdominopelvic		C79.8- Remove-dash C79.89				
alveolar						
Revise - ridge or process				D16.5-Remove dash D16.5		
Revise - - lower				D16.5-Remove dash D16.5		
Revise - - carcinoma						
Revise - - - upper		C79.8- Remove-dash C79.89				
Revise - - - lower		C79.8- Remove-dash C79.89				
Revise - - - upper		C79.8- Remove-dash C79.89				
Revise - - upper				D16.4-Remove dash D16.4		
bone						

Revise	- calvarium				D16.4~~-~~Remove dash D16.4		
Revise	- coccygeal vertebra				D16.4~~-~~Remove dash D16.4		
Revise	- cranial				D16.4~~-~~Remove dash D16.4		
Revise	- hyoid				D16.4~~-~~Remove dash D16.4		
Revise	- jaw (lower)				D16.5~~-~~Remove dash ~~D16.5~~		
Revise	- mandible				D16.5~~-~~Remove dash ~~D16.5~~		
Revise	- maxilla, maxillary (superior)						
Revise	- - inferior				D16.5~~-~~Remove dash ~~D16.5~~		
Revise	- nose, nasal				D16.4~~-~~Remove dash D16.4		
Revise	- occipital				D16.4~~-~~Remove dash D16.4		
Revise	- orbit				D16.4~~-~~Remove dash D16.4		
Revise	- parietal				D16.4~~-~~Remove dash D16.4		
Revise	- sella turcica				D16.4~~-~~Remove dash D16.4		
Revise	- skull				D16.4~~-~~Remove dash D16.4		
Revise	- sphenoid				D16.4~~-~~Remove dash D16.4		
Revise	- temporal				D16.4~~-~~Remove dash D16.4		
Revise	- turbinate				D16.4~~-~~Remove dash D16.4		
Revise	- vomer				D16.4~~-~~Remove dash D16.4		
Revise	- zygomatic				D16.4~~-~~Remove dash D16.4		
Revise	broad ligament	~~C57.1~~ C57.1-					
Revise	calvarium				D16.4~~-~~Remove dash D16.4		
Revise	clivus				D16.4~~-~~Remove dash D16.4		

	ethmoid (sinus)				D16.4~~-~~Remove dash D16.4		
Revise	- bone or labyrinth				D16.4~~-~~Remove dash D16.4		
	frontal				D16.4~~-~~Remove dash D16.4		
Revise	- bone				D16.4~~-~~Remove dash D16.4		
	jaw						
Revise	- bone				D16.5~~-~~Remove dash D16.5		
Revise	- - lower				D16.5~~-~~Remove dash D16.5		
Revise	- - upper				D16.4~~-~~Remove dash D16.4		
	joint NEC (see also Neoplasm, bone)						
Revise	- temporomandibular junction				D16.5~~-~~Remove dash D16.5		
	ligament - see also Neoplasm, connective tissue						
Revise	- round	~~C57.2~~ C57.2~~-~~					
	malar				D16.4~~-~~Remove dash D16.4		
Revise	mandible				D16.5~~-~~Remove dash D16.5		
	- alveolar						
Revise	- - ridge or process				D16.5~~-~~Remove dash D16.5		
	mastoid (air cells) (antrum) (cavity)				D16.4~~-~~Remove dash D16.4		
Revise	- bone or process				D16.4~~-~~Remove dash D16.4		
Revise	maxilla, maxillary (superior)				D16.4~~-~~Remove dash D16.4		
	- alveolar						
Revise	- - ridge or process (carcinoma)				D16.4~~-~~Remove dash D16.4		
Revise	mesosalpinx	~~C57.1~~ C57.1~~-~~					

Revise	mesovarium	~~C57.1~~ C57.1-					
	nose, nasal						
Revise	- bone				D16.4-Remove dash D16.4		
	- turbinate (mucosa)						
Revise	- - bone				D16.4-Remove dash D16.4		
	occipital						
Revise	- bone				D16.4-Remove dash D16.4		
	orbit						
Revise	- bone				D16.4-Remove dash D16.4		
	parietal						
Revise	- bone				D16.4-Remove dash D16.4		
Revise	paroophoron	~~C57.1~~ C57.1-					
Revise	parovarium	~~C57.1~~ C57.1-					
Revise	round ligament	~~C57.2~~ C57.2-					
	sella turcica						
Revise	- bone				D16.4-Remove dash D16.4		
	sinus (accessory)						
Revise	- bone (any)				D16.4-Remove dash D16.4		
Revise	skull				D16.4-Remove dash D16.4		
	sphenoid						
Revise	- bone				D16.4-Remove dash D16.4		
	temporal						
Revise	- bone				D16.4-Remove dash D16.4		
Revise	turbinate (bone)				D16.4-Remove dash D16.4		
	utero-ovarian						
Revise	- ligament	~~C57.1~~ C57.1-					
	uterus, uteri, uterine						

	- ligament						
Revise	- - broad	~~C57.1~~ C57.1-					
Revise	- - round	~~C57.2~~ C57.2-					
Revise	vomer				D16.4~~-~~Remove dash D16.4		