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

Diagnosis Topics:

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ICD-10 TIMELINE

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

March 9 – 10, 2016  ICD-10 Coordination and Maintenance Committee Meeting.

March, 2016  Webcast of the March 9-10, 2016 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: [link]

Summary report of the Diagnosis part of the March 10, 2016 ICD-10 Coordination and Maintenance Committee meeting report will be posted on the NCHS webpage as follows: [link]

April 1, 2016  There were no requests for ICD-10 codes to capture new diseases or technology for implementation on April 1, 2016. Therefore, there will be no new ICD-10 codes implemented on April 1, 2016.

April 8, 2016  Deadline for receipt of public comments on proposed new codes and revisions discussed at the March 9–10, 2016 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2016.

April 2016  Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This notice will include references to the complete and finalized FY 2017 ICD-10-CM diagnosis and ICD-10-PCS procedure codes. It will also include proposed revisions to the MS-DRG system based on ICD-10-CM/PCS codes on which the public may comment. The proposed rule can be accessed at: [link]

June 2016  Final addendum posted on web pages as follows: Diagnosis addendum - [link] Procedure addendum - [link]

July 15, 2016  Deadline for requestors: Those members of the public requesting that topics be discussed at the September 13–14, 2016 ICD-10 Coordination and Maintenance Committee meeting must have their requests submitted to CMS for procedures and NCHS for diagnoses.
August 1, 2016

Hospital Inpatient Prospective Payment System final rule to be published in the Federal Register as mandated by Public Law 99-509. This rule will also include links to all the final codes to be implemented on October 1, 2016.

This rule can be accessed at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/IPPS/list.asp

August 2016

Tentative agenda for the Procedure part of the September 13–14, 2016 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage at –

Tentative agenda for the Diagnosis part of the September 13–14, 2016 ICD-10 Coordination and Maintenance Committee meeting will be posted on the NCHS webpage at -
http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm

Federal Register notice for the September 13–14, 2016 ICD-10 Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.

August 5, 2016

On-line registration opens for the September 13-14, 2016 ICD-10 Coordination and Maintenance Committee meeting at:
https://www.cms.gov/apps/events/default.asp

September 2, 2016

Because of increased security requirements, those wishing to attend the September 13-14, 2016 ICD-10 Coordination and Maintenance Committee meeting must register for the meeting online at:
https://www.cms.gov/apps/events/default.asp

Attendees must register online by September 2, 2016; failure to do so may result in lack of access to the meeting.

September 13–14, 2016

ICD-10 Coordination and Maintenance Committee meeting.

Those who wish to attend the ICD-10 Coordination and Maintenance Committee meeting must have registered for the meeting online by September 2, 2016. You must bring an official form of picture identification (such as a driver’s license) in order to be admitted to the building.

October 2016

Webcast of the September 13–14, 2016 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows:
ICD-10 Coordination and Maintenance Committee Meeting  
March 9-10, 2016

https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/meetings.html

Summary report of the Diagnosis part of the September 13–14, 2016 ICD-10 Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows:
http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1, 2016</td>
<td>New and revised ICD-10-CM and ICD-10-PCS codes go into effect along with DRG changes. Final addendum available on web pages as follows: Diagnosis addendum - <a href="http://www.cdc.gov/nchs/icd/icd10cm.htm">http://www.cdc.gov/nchs/icd/icd10cm.htm</a></td>
</tr>
<tr>
<td>October 16, 2016</td>
<td>Deadline for receipt of public comments on proposed new codes discussed at the September 13-14, 2016 ICD-10 Coordination and Maintenance Committee meetings for implementation on April 1, 2017.</td>
</tr>
<tr>
<td>November 2016</td>
<td>Any new ICD-10 codes required to capture new technology that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2017 will be posted on the following websites: <a href="http://www.cdc.gov/nchs/icd/icd10cm.htm">http://www.cdc.gov/nchs/icd/icd10cm.htm</a> <a href="http://www.cms.gov/Medicare/Coding/ICD10/">http://www.cms.gov/Medicare/Coding/ICD10/</a></td>
</tr>
<tr>
<td>November 13, 2016</td>
<td>Deadline for receipt of public comments on proposed new codes and revisions discussed at the September 13-14, 2016 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2017.</td>
</tr>
</tbody>
</table>
ICD-10 Coordination and Maintenance Committee Meeting
March 9-10, 2016

Webcast and Dial-In Information

- The meeting will begin promptly at 9am ET and will be webcast.
- Toll-free dial-in access is available for participants who cannot join the webcast:

  Phone: 1-877-267-1577; Meeting ID: 993 921 961.

This meeting is being webcast via CMS at http://www.cms.gov/live/. By your attendance, you are giving consent to the use and distribution of your name, likeness and voice during the meeting. You are also giving consent to the use and distribution of any personally identifiable information that you or others may disclose about you during the meeting. Please do not disclose personal health information.

**NOTE:** In compliance to The Real ID Act, enacted in 2005, the following states/territories: American Samoa, Louisiana, Minnesota, New Hampshire, and New York will not gain access into any Federal Agencies using the above states’ driver’s license or ID. This means CMS visitors from these states/territories will need to provide alternative proof of identification (such as a passport) to gain entrance into Baltimore-based CMS building.

Proposals for diagnosis code topics will be led by the Centers for Disease Control (CDC) and are scheduled to begin on March 9, 2016 following procedure code proposals. They will continue until approximately 2:00 pm on March 10, 2016. Please visit CDCs website for the Diagnosis agenda located at the following address:

http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm
Contact Information

Mailing address:

National Center for Health Statistics
ICD-9-CM Coordination and Maintenance Committee
3311 Toledo Road
Hyattsville, Maryland 20782
Fax: (301) 458-4022

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

Donna Pickett (301) 458-4434
David Berglund (301) 458-4095
Cheryl Bullock (301) 458-4297
Shannon McConnell-Lamptey (301) 458-4612
Traci Ramirez (301) 458-4454

NCHS Classifications of Diseases web page:
http://www.cdc.gov/nchs/icd.htm
Please consult this web page for updated information.
Partial Code Freeze for ICD-9-CM and ICD-10

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

The partial freeze will be implemented as follows:

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

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

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

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

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

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

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

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

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

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

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

The American Urological Association (AUA) is proposing the creation of new codes for specific abnormal findings in urine collection. One of the most commonly used diagnostic tests for patients who form kidney stones is a urine collection looking for abnormal levels of certain substances, so that abnormalities can be treated to reduce the risk of future stone formation.

For example, patients with high levels of urine calcium (hypercalciuria) may be treated with thiazide diuretics, those with high levels of oxalate (hyperoxaluria) may be treated with dietary changes or medications, those with low citrate levels (hypocitraturia) may be treated with citrate medications, and those with high levels of uric acid (hyperuricosuria) may be treated with dietary measures and possibly treatment of an underlying condition.

The existing code E72.53, hyperoxaluria, is for a childhood inborn error of metabolism primary hyperoxaluria, which is a diagnostic condition that can be determined by genetic testing. This is different than someone who has an idiopathic or diet-induced mild elevation of oxalate in the urine who does not have the genetic inborn error of metabolism.

To help better capture the unique characteristics of these abnormal findings and to help with research and public health, AUA is requesting the following ICD-10-CM tabular changes.

TABULAR MODIFICATIONS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R82</td>
<td>Other and unspecified abnormal findings in urine</td>
</tr>
<tr>
<td>R82.9</td>
<td>Other and unspecified abnormal findings in urine</td>
</tr>
<tr>
<td>R82.99</td>
<td>Other abnormal findings in urine</td>
</tr>
<tr>
<td>Add</td>
<td>Excludes1: Primary Hyperoxaluria (E72.53)</td>
</tr>
<tr>
<td>Delete</td>
<td>Cells and casts in urine</td>
</tr>
<tr>
<td>Delete</td>
<td>Crystalluria</td>
</tr>
<tr>
<td>Delete</td>
<td>Melanuria</td>
</tr>
<tr>
<td>New Code</td>
<td>R82.991</td>
</tr>
<tr>
<td>New Code</td>
<td>R82.992</td>
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<tr>
<td>New Code</td>
<td>R82.993</td>
</tr>
<tr>
<td>New Code</td>
<td>R82.994</td>
</tr>
<tr>
<td>New Code</td>
<td>R82.998</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Abscess of Anal and Rectal Regions

Most experts categorize abscesses of the anal and rectal regions according to their anatomic location: perianal, ischiorectal, intersphincteric, and supralelevator. Perianal abscesses are the most common, comprising over half of all anorectal abscesses. They are superficially located adjacent to the anus. Ischiorectal abscesses are the next most common location, located deep to the superficial subcutaneous fascia in the perirectal region. Superficial to the levator and anal sphincter muscles in the ischiorectal space. Intersphincteric abscesses occur between the external and internal sphincter muscles. Supralelevator abscesses are located deep to the levator muscle in the true pelvis. The anatomic details determine appropriate treatment and accurate prognostication.

This proposal was originally presented at the September 2015 C&M meeting at the request of The Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma. Modifications have been made to the proposal based on public comments and resubmitted for the proposed tabular modifications.

TABULAR MODIFICATIONS

K61 Abscess of anal and rectal regions

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

K61.0 Anal abscess

Perianal abscess

Revise

Excludes‡2:  Intrasphincteric abscess (K61.4)
Intersphincteric abscess (K61.4)

Add

K61.3 Ischiorectal abscess

Abscess of ischiorectal fossa

Ischioanal abscess

Delete

New sub-subcategory

K61.31 Horseshoe Abscess

K61.32 Ischiorectal Abscess,NOS

Abscess of ischiorectal fossa

Add

K61.4 Intrasphincteric abscess

Intersphincteric abscess

New code

K61.5 Supralelevator abscess
Blindness and Low Vision

The World Health Organization (WHO) uses blindness as a term that includes multiple categories of visual loss. Typically, when used in the U.S. the word “blindness” generally means total blindness in both eyes. Categories of visual impairment, recognized by WHO and listed in ICD-10-CM, indicate distinctly different levels of impairment and usable residual vision in patients with reduced vision. ICD-10-CM describes each category of reduced vision in the listing, but then collapses them, eliminating the precision required for rehabilitation. The loss of precision makes it impossible to demonstrate significant progression of vision loss.

a. An individual whose visual acuity drops from 20/70 to 20/320 within the same calendar year might not receive further rehabilitation intervention, although their entire function, safety and wellbeing is compromised, because the severity of the decline would not be detected by the code set.

b. An individual whose visual acuity drops from 20/500 to total blindness could not receive further rehabilitation intervention although their needs are greatly different and their function, mental health, wellbeing and safety compromised, because they demonstrate no change when using the codes.

The American Academy of Ophthalmology is proposing new codes for blindness and low vision to allow more granular differentiation of categories for visual impairment. They are proposing the following tabular modifications.

<table>
<thead>
<tr>
<th>New subcategory</th>
<th>H54.0 Blindness, both eyes</th>
</tr>
</thead>
<tbody>
<tr>
<td>New code</td>
<td>H54.0X33 Blindness right eye category 3, Blindness left eye category 3</td>
</tr>
<tr>
<td>New code</td>
<td>H54.0X34 Blindness right eye category 3, Blindness left eye category 4</td>
</tr>
<tr>
<td>New code</td>
<td>H54.0X35 Blindness right eye category 3, Blindness left eye category 5</td>
</tr>
<tr>
<td>New code</td>
<td>H54.0X44 Blindness right eye category 4, Blindness left eye category 4</td>
</tr>
<tr>
<td>New code</td>
<td>H54.0X43 Blindness right eye category 4, Blindness left eye category 3</td>
</tr>
<tr>
<td>New code</td>
<td>H54.0X45 Blindness right eye category 4, Blindness left eye category 5</td>
</tr>
<tr>
<td>New code</td>
<td>H54.0X55 Blindness right eye category 5, Blindness left eye category 5</td>
</tr>
<tr>
<td>New code</td>
<td>H54.0X53 Blindness right eye category 5, Blindness left eye category 3</td>
</tr>
<tr>
<td>New code</td>
<td>H54.0X54 Blindness right eye category 5, Blindness left eye category 4</td>
</tr>
</tbody>
</table>
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H54.1 Blindness, one eye, low vision other eye

H54.10 Blindness, one eye, low vision other eye, unspecified

New sub-subcategory H54.11 Blindness right eye, low vision left eye

New code H54.1131  Blindness right eye category 3, low vision left eye category 1
New code H54.1132  Blindness right eye category 3, low vision left eye category 2
New code H54.1141  Blindness right eye category 4, low vision left eye category 1
New code H54.1142  Blindness right eye category 4, low vision left eye category 2
New code H54.1151  Blindness right eye category 5, low vision left eye category 1
New code H54.1152  Blindness right eye category 5, low vision left eye category 2

New sub-subcategory H54.12 Blindness left eye, low vision right eye

New code H54.1213  Blindness right eye category 1, low vision left eye category 3
New code H54.1214  Blindness right eye category 1, low vision left eye category 4
New code H54.1215  Blindness right eye category 1, low vision left eye category 5
New code H54.1223  Blindness right eye category 2, low vision left eye category 3
New code H54.1224  Blindness right eye category 2, low vision left eye category 4
New code H54.1125  Blindness right eye category 2, low vision left eye category 5

New subcategory H54.2 Low Vision, both eyes

New code H54.2X11  Blindness right eye category 1, Blindness left eye category 1
New code H54.2X12  Blindness right eye category 1, Blindness left eye category 2
New code H54.2X22  Blindness right eye category 2, Blindness left eye category 2
New code H54.2X21  Blindness right eye category 2, Blindness left eye category 1
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H54.3 Unqualified visual loss both eyes

H54.4 Blindness, one eye

New sub-subcategory

H54.40 Blindness, one eye, unspecified other eye

New code

H54.41 Blindness right eye, normal vision left eye

New code

H54.413A Blindness right eye category 3, normal vision left eye

New code

H54.414A Blindness right eye category 4, normal vision left eye

New code

H54.415A Blindness right eye category 5, normal vision left eye

New sub-subcategory

H54.42 Blindness left eye, normal vision right eye

New code

H54.42A3 Blindness left eye category 3, normal vision right eye

New code

H54.42A4 Blindness left eye category 4, normal vision right eye

New code

H54.42A5 Blindness left eye category 5, normal vision right eye

H54.5 Low vision, one eye

New sub-subcategory

H54.50 Low vision one eye, unspecified eye

New code

H54.51 Low vision right eye, normal vision left eye

New code

H54.511A Low vision right eye category 1, normal vision left eye

New code

H54.512A Low vision right eye category 2, normal vision left eye

New sub-subcategory

H54.52 Low vision left eye, normal vision right eye

New code

H54.52A1 Low vision left eye category 1, normal vision right eye

New code

H54.52A2 Low vision left eye category 2, normal vision right eye
H54.6 Unqualified visual loss, one eye
   H54.60 Unqualified visual loss, unspecified eye
   H54.61 Unqualified visual loss, right eye, normal vision left eye
   H54.62 Unqualified visual loss, left eye, normal vision right eye

Note: The table below gives a classification of severity of visual impairment recommended by a

The term 'low vision' in category H54 comprises categories 1 and 2 of the table, the term
'blindness' categories 3, 4 and 5, and the term 'unqualified visual loss' category 9.
If the extent of the visual field is taken into account, patients with a field no greater than
10 but greater than 5 around central fixation should be placed in category 3 and patients
with a field no greater than 5 around central fixation should be placed in category 4, even
if the central acuity is not impaired.

<table>
<thead>
<tr>
<th>Category of visual impairment</th>
<th>Visual acuity with best possible correction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maximum less than:</td>
</tr>
<tr>
<td>1</td>
<td>6/18</td>
</tr>
<tr>
<td></td>
<td>3/10 (0.3)</td>
</tr>
<tr>
<td></td>
<td>20/70</td>
</tr>
<tr>
<td>2</td>
<td>6/60</td>
</tr>
<tr>
<td></td>
<td>1/10 (0.1)</td>
</tr>
<tr>
<td></td>
<td>20/200</td>
</tr>
<tr>
<td>3</td>
<td>3/60</td>
</tr>
<tr>
<td></td>
<td>1/20 (0.05)</td>
</tr>
<tr>
<td></td>
<td>20/400</td>
</tr>
<tr>
<td>4</td>
<td>1/60 (finger counting at one meter)</td>
</tr>
<tr>
<td></td>
<td>1/50 (0.02)</td>
</tr>
<tr>
<td></td>
<td>5/300</td>
</tr>
<tr>
<td>5</td>
<td>No light perception</td>
</tr>
<tr>
<td>9</td>
<td>Undetermined or unspecified</td>
</tr>
</tbody>
</table>
Classification of Myocardial Infarction

The 2012 expert consensus document of the Joint European Society of Cardiology / American College of Cardiology Foundation / American Heart Association / World Heart Federation Task Force for the Universal Definition of Myocardial Infarction is the authoritative, world-wide consensus of the professional societies representing the cardiovascular communities regarding classification of myocardial infarction (MI) (1). By way of background, in 2000, the First Global MI Task Force presented a new definition of MI, specifically that myocardial necrosis as detected by cardiac biomarkers in the setting of myocardial ischemia should be labelled as an MI (2). These principles were further refined by the Second Global MI Task Force, leading to the Universal Definition of Myocardial Infarction Consensus Document in 2007, which emphasized the different conditions which might result in an MI (3). Following the second consensus document, the development of increasingly sensitive assays for the biomarkers of myocardial necrosis mandated further revision, particularly acknowledging that the detection of these biomarkers occurs not infrequently in the setting of the critically ill, after percutaneous coronary intervention and after cardiac surgery. The Third Global MI Task Force was convened to integrate these insights with new clinical outcomes data into a universal classification, particularly the establishment of the diagnosis of MI based on cardiac biomarkers and the prognostic implications of MI in various clinical contexts (1). In 2014, the classification was formally developed by the ACC/AHA Task Force on Data Standards as a controlled terminology for the purposes of interoperability among electronic health information systems (4).

In brief, the classification is as follows (1):

1. Spontaneous myocardial infarction (MI Type 1) is a clinical event typically caused by rupture or erosion of an atherosclerotic plaque resulting in thrombus formation in one or more of the coronary arteries. This is the prototypic “heart attack” for which there are extensive guidelines regarding evaluation and management. ST Elevation MI (STEMI) and Non ST Elevation MI (NSTEMI) share the same pathophysiology, and both are considered Type 1 MIs.

2. Myocardial infarction secondary to ischemic imbalance (myocardial demand exceeding supply) is defined as MI Type 2. This is where a condition other than coronary artery disease results in the imbalance between myocardial oxygen supply and / or demand. Of note, coronary vasospasm and/or endothelial dysfunction also have the potential to cause a Type 2 MI. Of note, the treatment guidelines for Type 1 MI are generally NOT applicable to the management of a Type 2 MI.

3. Patients who present with death from a presumed cardiac etiology (i.e., symptoms or signs suggestive of myocardial ischemia, such as typical chest pain and / or ECG changes) but without confirmatory cardiac biomarkers being available, are classified as having an MI Type 3.

4. Myocardial infarction associated with revascularization procedures are classified as MI Types 4 and 5, with Type 4 MI occurring in the context of percutaneous coronary intervention (PCI) and / or stent implantation, and Type 5 MI being associated with coronary artery bypass graft surgery (CABG). There are subclassifications of Type 4 MI reflecting the different contexts in which biomarkers can turn positive in the context of PCI. Critically, the cardiac biomarker reference values for Type 4 and Type 5 MIs are substantively different than Type 1 (and Type 2) MI.
Requests to add specific ICD-10-CM codes related to certain MI types, particularly Type 2 MI, have been received from the American College of Cardiology, the American Heart Association, and others. The American College of Cardiology and the American Heart Association are requesting that these codes be considered for implementation on October 1, 2016. Comments on this topic are therefore requested by April 8, 2016.

References


TABULAR MODIFICATIONS

Revise I21 Acute ST-elevation (STEMI) and non-ST-elevation (NSTEMI) myocardial infarction

Add I21.0 ST elevation (STEMI) myocardial infarction of anterior wall

Add Type 1 ST elevation myocardial infarction of anterior wall

Add I21.1 ST elevation (STEMI) myocardial infarction of inferior wall

Add Type 1 ST elevation myocardial infarction of inferior wall

Add I21.2 ST elevation (STEMI) myocardial infarction of other sites

Add Type 1 ST elevation myocardial infarction of other sites
ICD-10 Coordination and Maintenance Committee Meeting  
March 9-10, 2016

I21.3 ST elevation (STEMI) myocardial infarction of unspecified site  
Myocardial infarction (acute) NOS  
Add  
Type 1 ST elevation myocardial infarction of unspecified site

I21.4 Non-ST elevation (NSTEMI) myocardial infarction  
Add  
Type 1 Non-ST elevation myocardial infarction

New subcategory I21.A Other type of myocardial infarction

New code  
I21.A1 Myocardial infarction type 2  
Myocardial infarction due to demand ischemia  
Myocardial infarction secondary to ischemic imbalance  

Code also the underlying cause, if known, such as:  
Anemia (D50.0-D64.9)  
Chronic obstructive pulmonary disease (J44.-)  
Heart failure (I50.-)  
Paroxysmal tachycardia (I47.0-I47.9)  
Renal failure (N17.0-N19)  
Shock (R57.0-R57.9)

New code  
I21.A9 Other myocardial infarction type  
Myocardial infarction associated with revascularization Procedure  
Myocardial infarction type 3  
Myocardial infarction type 4a  
Myocardial infarction type 4b  
Myocardial infarction type 4c  
Myocardial infarction type 5  

Code also complication, such as:  
(Acute) stent occlusion (T82.897-)  
(Acute) stent stenosis (T82.857-)  
(Acute) stent thrombosis (T82.867-)  
Cardiac arrest due to underlying cardiac condition (I46.2)  
Complication of percutaneous coronary intervention (PCI) (I97.89)  
Occlusion of coronary artery bypass graft (T82.218-)
**Clostridium difficile**

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

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

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

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

This proposal was orginally presented at the September 2015 C&M meeting at the request of Merck & Company. For reference or comparasion to this latest proposal, you may access the previous meeting materials at at [http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm](http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm). Modifications to this proposal are being submitted based on public comment and clinical input from subject matter experts including CDC Office of Infectious Disease National Center for Emerging and Zoonotic Infectious Diseases (NCEZID).

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>A04</td>
<td>Other bacterial intestinal infections</td>
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<tr>
<td></td>
<td>Excludes 1: bacterial foodborne intoxications, NEC (A05.-)</td>
</tr>
<tr>
<td></td>
<td>tuberculosis enteritis (A18.32)</td>
</tr>
<tr>
<td>A04.7</td>
<td>Enterocolitis due to <em>Clostridium difficile</em></td>
</tr>
<tr>
<td></td>
<td>Foodborne intoxication by <em>Clostridium difficile</em></td>
</tr>
<tr>
<td></td>
<td>Pseudomembranous colitis</td>
</tr>
<tr>
<td></td>
<td><strong>New code</strong> A04.71 Enterocolitis due to <em>clostridium difficile</em>, recurrent</td>
</tr>
<tr>
<td></td>
<td><strong>New code</strong> A04.72 Enterocolitis due to <em>clostridium difficile</em>, not specified as recurrent</td>
</tr>
</tbody>
</table>
**Congenital Sacral Dimple**

A congenital sacral dimple is an indentation, present at birth, in the skin on the lower back. It is a relatively common condition for neonates that may be benign in nature. Sacral dimples that are accompanied by a nearby tuft of hair or certain types of skin discoloration are sometimes or may indicate a serious health issue such as spina bifida or tethered cord syndrome.

Currently in ICD-10-CM the diagnosis is an inclusion term in the code category L05.01 Pilonidal cysts with abscess and L05.91 Pilonidal cyst without abscess, which does not relate to this condition.

The American Academy of Pediatrics (AAP) requests a new code for congenital sacral dimple to be established. The current code delineation does not allow for accurate tracking of the true frequency of this condition nor does it adequately support health resource utilization in the diagnosis or treatment.

**TABULAR MODIFICATIONS**

Q82 Other congenital malformations of skin

New code Q82.6 Congenital sacral dimple
- Parasacral dimple
  - Excludes2: Pilonidal cyst with abscess (L05.01)
  - Pilonidal cyst without abscess (L05.91)

L05 Pilonidal cyst and sinus

L05.0 Pilonidal cyst and sinus with abscess
  - L05.01 Pilonidal cyst with abscess

Add
  - Excludes2: Congenital sacral dimple (Q82.6)
  - Parasacral dimple

L05.9 Pilonidal cyst and sinus without abscess
  - L05.91 Pilonidal cyst without abscess

Add
  - Excludes2: Congenital sacral dimple (Q82.6)
  - Parasacral dimple
Dermatomyositis

Dermatomyositis is an idiopathic inflammatory myopathy involving proximal muscle weakness, characteristic rash, characteristic muscle biopsy findings, and elevations in muscle enzymes on laboratory evaluation. It is described in Medline Plus and has numerous studies associated with it in clinicaltrials.gov. Polymyositis is a similar condition to dermatomyositis, but the symptoms do not include a skin rash. In ICD-9-CM, there were specific codes 710.3, Dermatomyositis, and 710.4, Polymyositis.

Dermatopolymyositis is not distinctly listed on Medline Plus and has no formal diagnosis. It is used either to represent a larger group that includes patients with dermatomyositis and polymyositis, or rarely to indicate those where one cannot tell which of the two diagnosis the patient has. There are no studies in clinicaltrials.gov that use the specific term “dermatopolymyositis,” and in searching the term it changes your search result to dermatomyositis or polymyositis. In Pubmed dermatopolymyositis as a term returns papers with either polymyositis or dermatomyositis with only about 100 papers having the actual word “dermatopolymyositis,” compared to “dermatomyositis” which returns over 8700 papers.

In the WHO ICD-10, there is a category M33, Dermatopolymyositis, with specific codes M33.0, Juvenile dermathomyositis, M33.1, Other dermatomyositis, M33.2, Polymyositis, and M33.9, Dermatopolymyositis, unspecified. In ICD-10-CM, the subcategory titles for M33.0 and M33.1 use the term dermatopolymyositis, instead of dermatomyositis, as do the specific codes in these subcategories.

Based on the idea that dermatomyositis is a more specific diagnosis and different than dermatopolymyositis, that dermatomyositis is more clearly defined, and that dermatomyositis is a much more frequently used term, as well as noting that dermatomyositis has distinct separate codes in ICD-9-CM and in ICD-10, it is proposed by the International Myositis Assessment and Clinical Studies Group to have dermatomyositis identified with specific ICD-10-CM codes, as well as its juvenile equivalent juvenile dermatomyositis.

It is being proposed that the titles at M33.0 and M33.1 be changed to match the original WHO titles, and that the codes within these subcategories also be changed in the same way. It is also proposed that the subcategory M33.1, Other dermatomyositis, have inclusion terms added for “Adult dermatomyositis,” and “Dermatomyositis NOS.” Additionally, new codes are proposed, M33.03, Juvenile dermatomyositis without myopathy, M33.13, Other dermatomyositis without myopathy, and M33.93, Dermatopolymyositis, unspecified without myopathy.

References
Dermatomyositis article
Dermatopolymyositis search returns about 100 papers, about one third of which are in English.
http://www.ncbi.nlm.nih.gov/pubmed/?term=%22dermatopolymyositis%22
Dermatomyositis search returns over 8700 papers.
http://www.ncbi.nlm.nih.gov/pubmed/?term=%22dermatomyositis%22
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>M33.0</td>
<td>Juvenile dermatomyositis dermatopolymyositis</td>
</tr>
<tr>
<td>M33.00</td>
<td>Juvenile dermatomyositis dermatopolymyositis, organ involvement unspecified</td>
</tr>
<tr>
<td>M33.01</td>
<td>Juvenile dermatomyositis dermatopolymyositis with respiratory involvement</td>
</tr>
<tr>
<td>M33.02</td>
<td>Juvenile dermatomyositis dermatopolymyositis with myopathy</td>
</tr>
<tr>
<td></td>
<td>New Code</td>
</tr>
<tr>
<td>M33.03</td>
<td>Juvenile dermatomyositis without myopathy</td>
</tr>
<tr>
<td>M33.09</td>
<td>Juvenile dermatomyositis dermatopolymyositis with other organ involvement</td>
</tr>
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<td>Add</td>
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<td>M33.1</td>
<td>Other dermatomyositis dermatopolymyositis</td>
</tr>
<tr>
<td></td>
<td>Adult dermatomyositis</td>
</tr>
<tr>
<td></td>
<td>Dermatomyositis NOS</td>
</tr>
<tr>
<td>M33.10</td>
<td>Other dermatomyositis dermatopolymyositis, organ involvement unspecified</td>
</tr>
<tr>
<td>M33.11</td>
<td>Other dermatomyositis dermatopolymyositis with respiratory involvement</td>
</tr>
<tr>
<td>M33.12</td>
<td>Other dermatomyositis dermatopolymyositis with myopathy</td>
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<td>New Code</td>
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<td>M33.13</td>
<td>Other dermatomyositis without myopathy</td>
</tr>
<tr>
<td>M33.19</td>
<td>Other dermatomyositis dermatopolymyositis with other organ involvement</td>
</tr>
<tr>
<td></td>
<td>M33.9 Dermatopolymyositis, unspecified</td>
</tr>
<tr>
<td></td>
<td>New Code</td>
</tr>
<tr>
<td>M33.93</td>
<td>Dermatopolymyositis, unspecified without myopathy</td>
</tr>
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</table>
**Ectopic Pregnancy**

In September 2014, the American Congress of Obstetricians and Gynecologists (ACOG), submitted a proposal for new codes to capture multiple gestational pregnancy with co-existing ectopic and intrauterine pregnancies. This was done to recognize the increased incidence of ectopic pregnancy occurrence with the use of assisted reproductive technologies. These new codes have been approved for the October 2016 addenda.

ACOG is requesting to amend the prior proposal to include laterality. Laterality is important to track since patients who have had ectopic pregnancies in the past are more likely to have subsequent ectopic pregnancies. It is also important to know on which side an ectopic pregnancy occurred from a clinical perspective.

From a patient history perspective, capturing laterality codes in the patient record will allow for more efficient patient management during subsequent pregnancies. Data collection from the use of these codes will provide an ongoing method of tracking the frequency of these conditions as well as the efficacy of the various treatment protocols.

ACOG is requesting the following additional codes at category O00, Ectopic pregnancy.

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>O00</th>
<th>Ectopic pregnancy</th>
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<tbody>
<tr>
<td>O00.0</td>
<td>Abdominal pregnancy</td>
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<tr>
<td>New code</td>
<td>O00.00 Abdominal pregnancy without intrauterine pregnancy</td>
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<tr>
<td></td>
<td>Abdominal pregnancy NOS</td>
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<tr>
<td>New code</td>
<td>O00.01 Abdominal pregnancy with intrauterine pregnancy</td>
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<tr>
<td>O00.1</td>
<td>Tubal pregnancy</td>
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<tr>
<td>New code</td>
<td>O00.10 Tubal pregnancy without intrauterine pregnancy</td>
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<td>Tubal pregnancy NOS</td>
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<tr>
<td>New code</td>
<td>O00.101 Right tubal pregnancy without intrauterine pregnancy</td>
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<tr>
<td>New code</td>
<td>O00.102 Left tubal pregnancy without intrauterine pregnancy</td>
</tr>
<tr>
<td>New code</td>
<td>O00.109 Unspecified tubal pregnancy without intrauterine pregnancy</td>
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<tr>
<td>New code</td>
<td>O00.11 Tubal pregnancy with intrauterine pregnancy</td>
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<tr>
<td>New code</td>
<td>O00.111 Right tubal pregnancy with intrauterine pregnancy</td>
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<td>Code</td>
<td>Description</td>
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<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>O00.112</td>
<td>Left tubal pregnancy with intrauterine pregnancy</td>
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<td>O00.119</td>
<td>Unspecified tubal pregnancy with intrauterine pregnancy</td>
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<tr>
<td>O00.2</td>
<td>Ovarian pregnancy</td>
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<td>O00.20</td>
<td>Ovarian pregnancy without intrauterine pregnancy</td>
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<tr>
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<td>Ovarian pregnancy NOS</td>
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<tr>
<td>O00.201</td>
<td>Right ovarian pregnancy without intrauterine pregnancy</td>
</tr>
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<td>O00.202</td>
<td>Left ovarian pregnancy without intrauterine pregnancy</td>
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<tr>
<td>O00.209</td>
<td>Unspecified ovarian pregnancy without intrauterine pregnancy</td>
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<tr>
<td>O00.21</td>
<td>Ovarian pregnancy with intrauterine pregnancy</td>
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<tr>
<td>O00.211</td>
<td>Right ovarian pregnancy with intrauterine pregnancy</td>
</tr>
<tr>
<td>O00.212</td>
<td>Left ovarian pregnancy without intrauterine pregnancy</td>
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<tr>
<td>O00.219</td>
<td>Unspecified ovarian pregnancy with intrauterine pregnancy</td>
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<td>O00.8</td>
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<td>Other ectopic pregnancy NOS</td>
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<td>O00.81</td>
<td>Other ectopic pregnancy with intrauterine pregnancy</td>
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<td>O00.9</td>
<td>Unspecified ectopic pregnancy</td>
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<td>O00.90</td>
<td>Unspecified ectopic pregnancy without intrauterine pregnancy</td>
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<td>Ectopic pregnancy NOS</td>
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<tr>
<td>O00.91</td>
<td>Unspecified ectopic pregnancy with intrauterine pregnancy</td>
</tr>
</tbody>
</table>
**Encounter for Prophylactic Salpingectomy**

The American Congress of Obstetricians and Gynecologists (ACOG) proposes to add a new code for prophylactic removal of fallopian tubes. Although there is an existing code for prophylactic removal of the ovary, recent studies and literature suggests that ovarian cancer may actually originate in the fallopian tubes rather than in the ovaries. A new diagnosis code for tracking prophylactic removal of fallopian tubes will allow physicians to quantify outcomes when this procedure is performed.

ACOG proposes the addition of prophylactic removal of fallopian tubes in category Z40, Encounter for prophylactic surgery, as follows.

**References**


**TABULAR MODIFICATIONS**

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<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>Z40</td>
<td>Encounter for prophylactic surgery</td>
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<tr>
<td>Z40.0</td>
<td>Encounter for prophylactic surgery for risk factors related to malignant neoplasms Admission for prophylactic organ removal</td>
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<td>Use additional code to identify risk factor</td>
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<tr>
<td>New code</td>
<td>Z40.03 Encounter for prophylactic removal of fallopian tubes</td>
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</tbody>
</table>


Exercise Counseling

The Healthcare Effectiveness Data and Information Set (HEDIS) is used to calculate performance statistics and benchmarks, as well as to set standards for the National Committee for Quality Assurance (NCQA) Accreditation program. HEDIS measures address health issues such as asthma, diabetes, breast cancer screening, childhood and adult weight/Body Mass Index (BMI) assessment.

Prior to the implementation of the ICD-10-CM code set, ICD-9-CM code V65.41, Exercise counseling, was used for reporting. For the HEDIS measure of weight assessment and counseling of pediatric patients, three separate data elements from providers were reported which included BMI measurement, nutrition and physical activity counseling.

In the ICD-10-CM code set, the first two elements can be captured through the use of codes Z68.x, Body mass index (BMI) and code Z71.3 Dietary counseling and surveillance. Currently, there is no code in ICD-10-CM to capture the third data element specific to exercise counseling.

The requestor proposes the following new code in order to capture this HEDIS data element and better track these encounters.

TABULAR MODIFICATIONS

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>Z71.82</td>
<td>Exercise counseling</td>
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</table>

New code: Z71.82 Exercise counseling
**Gestational Alloimmune Liver Disease**

Gestational Alloimmune Liver Disease (GALD) is a unique disease presenting as severe hepatic injury in newborn infants. Its onset is during fetal development and manifestations of the disease begin during fetal life. It is caused by a maternal antibody to fetal hepatic cells which crosses the placenta into the fetal circulation, causing hepatic cell necrosis. Fetal liver injury often results in systemic iron overload resulting in this condition as first being referred to as neonatal hemochromatosis (NH).

There is currently no ICD-10-CM code to identify this condition. Because of its clear perinatal origin, the American Academy of Pediatrics (AAP) recommends that a new code be established in Chapter 16 Certain conditions originating in the perinatal period (P00-P96). It is noted that the pathogenesis and natural history are different from those specified by E83.1 Disorders of iron metabolism.

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>E83 Disorders of mineral metabolism</th>
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</thead>
<tbody>
<tr>
<td>E83.1 Disorders of iron metabolism</td>
</tr>
<tr>
<td>E83.11 Hemochromatosis</td>
</tr>
</tbody>
</table>

Add Excludes1: Gestational Alloimmune Liver Disease (P78.84) GALD Neonatal hemochromatosis

<table>
<thead>
<tr>
<th>Digestive disorders of newborn (P76-P78)</th>
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<tbody>
<tr>
<td>P78 Other perinatal digestive system disorders</td>
</tr>
<tr>
<td>P78.8 Other specified perinatal digestive system disorders</td>
</tr>
<tr>
<td>P78.81 Congenital cirrhosis (of liver)</td>
</tr>
<tr>
<td>P78.82 Peptic ulcer of newborn</td>
</tr>
<tr>
<td>P78.83 Newborn esophageal reflux Neonatal esophageal reflux</td>
</tr>
</tbody>
</table>

New code P78.84 Gestational Alloimmune Liver Disease Add GALD Add Neonatal hemochromatosis Add Excludes 1: Hemochromatosis (E83.11-)
Gingival recession

In September 2011, the American Academy of Periodontology submitted a proposal for the gingival recession classification to be replaced by the Miller Classification System. The previous submission was later withdrawn. Subsequently, this topic was presented at the September 2015 Coordination and Maintenance meeting and based on comments received during the public comment period it is being represented with revisions.

Gingival recession involves the gums receding back, potentially exposing the roots of the teeth. For a diagnosis related to treatment of gingival recession, there are two entities that are required. The first is whether recession is generalized (multiple teeth in an area that require treatment), or localized (limited to individual teeth in an area of the mouth). Tissue grafts in dentistry are per tooth submissions. The second entity is the degree of recession, which is indicated by minimal, moderate, or severe. Two diagnostic codes are submitted for each tooth, one describing if the recession is localized or generalized in the mouth and the second for the degree of severity on each tooth.

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

**TABULAR MODIFICATIONS**

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<td>K06.00</td>
<td>Gingival recession, unspecified</td>
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<td>K06.01</td>
<td>Gingival recession, minimal</td>
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<tr>
<td>K06.02</td>
<td>Gingival recession, moderate</td>
</tr>
<tr>
<td>K06.03</td>
<td>Gingival recession, severe</td>
</tr>
<tr>
<td>K06.04</td>
<td>Gingival recession, localized</td>
</tr>
<tr>
<td>K06.05</td>
<td>Gingival recession, generalized</td>
</tr>
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</table>
Hepatic Encephalopathy

This topic was presented at the September 2015 Coordination and Maintenance meeting and based on comments received during the public comment period it is being represented with clarification from the American Academy of Neurology. It appears ICD-10-CM has created a challenge with coding for hepatic encephalopathy by adding the manifestation of hepatic coma to various causes of hepatic failure. In ICD-9-CM, hepatic encephalopathy had a unique code with hepatic coma, portal-systemic encephalopathy and hepatocerebral intoxication as inclusion terms.

Hepatic encephalopathy (HE) involves altered consciousness and behavior related to insufficient liver function. HE is the loss of brain function that occurs when the liver is unable to remove toxins from the blood. Ammonia, which is produced by your body when proteins are digested, is one of the toxins that’s normally made harmless by your liver. When ammonia or other toxic substances build up in the body when your liver isn’t working well, it may affect your brain and cause HE.

The most commonly used staging scale of hepatic encephalopathy is the West Haven Grading System. The stages of HE span from minimal changes in memory and coordination in stage 0; sleep disruptions, and forgetfulness in stage 1; lethargy and mild disorientation in stage 2; amnesia and profound confusion in stage 3; to coma in stage 4.

The AAN proposes the following tabular changes to further categorize hepatic encephalopathy for research and clinical purposes.

TABULAR MODIFICATIONS

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<tr>
<th>Code</th>
<th>Description</th>
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<td>K70</td>
<td>Alcoholic liver disease</td>
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<td>K70.4</td>
<td>Alcoholic hepatic failure</td>
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<tr>
<td>K70.40</td>
<td>Alcoholic hepatic failure without coma</td>
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<tr>
<td>K70.401</td>
<td>Alcoholic hepatic failure without coma, without hepatic encephalopathy</td>
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<tr>
<td>K70.402</td>
<td>Alcoholic hepatic failure without coma, with hepatic encephalopathy  West Haven Criteria for Hepatic Encephalopathy Grades 0, 1, 2, and 3</td>
</tr>
<tr>
<td>K70.41</td>
<td>Alcoholic hepatic failure with coma</td>
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<td></td>
<td>West Haven Criteria for Hepatic Encephalopathy Grade 4</td>
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</table>
### K71.1 Toxic liver disease with hepatic necrosis

<table>
<thead>
<tr>
<th>New sub-subcategory</th>
<th>K71.10</th>
<th>Toxic liver disease with hepatic necrosis, without coma</th>
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</thead>
<tbody>
<tr>
<td>New code</td>
<td>K71.101</td>
<td>Toxic liver disease with hepatic necrosis, without coma, without hepatic encephalopathy</td>
</tr>
<tr>
<td>New code</td>
<td>K71.102</td>
<td>Toxic liver disease with hepatic necrosis, without coma, with hepatic encephalopathy</td>
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<tr>
<td>Add</td>
<td>K71.11</td>
<td>Toxic liver disease with hepatic necrosis, with coma</td>
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<tr>
<td></td>
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<td>West Haven Criteria for Hepatic Encephalopathy Grade 4</td>
</tr>
</tbody>
</table>

### K72.0 Acute and subacute hepatic failure

| New sub-subcategory | K72.00 | Acute and subacute hepatic failure without coma |
|---------------------|--------|-------------------------------------------------
| New code            | K72.001 | Acute and subacute hepatic failure without coma, without hepatic encephalopathy |
| New code            | K72.002 | Toxic liver disease with hepatic necrosis, without coma, with hepatic encephalopathy |
|                     |        | West Haven Criteria for Hepatic Encephalopathy Grades 0, 1, 2, and 3 |
| Add                 | K72.01 | Acute and subacute hepatic failure with coma |
|                     |        | West Haven Criteria for Hepatic Encephalopathy Grade 4 |

### K72.1 Chronic hepatic failure

<table>
<thead>
<tr>
<th>New sub-subcategory</th>
<th>K72.10</th>
<th>Chronic hepatic failure without coma</th>
</tr>
</thead>
<tbody>
<tr>
<td>New code</td>
<td>K72.101</td>
<td>Chronic hepatic failure without coma, without hepatic encephalopathy</td>
</tr>
<tr>
<td>New code</td>
<td>K72.102</td>
<td>Chronic hepatic failure without coma, with hepatic encephalopathy</td>
</tr>
</tbody>
</table>

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ICD-10 Coordination and Maintenance Committee Meeting
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West Haven Criteria for Hepatic Encephalopathy
Grades 0, 1, 2, and 3

K72.11 Chronic hepatic failure with coma
Add
West Haven Criteria for Hepatic Encephalopathy Grade 4

K72.9 Hepatic failure, unspecified

New sub-subcategory  K72.90 Hepatic failure, unspecified without coma

New code  K72.901 Hepatic failure, unspecified without coma, without hepatic encephalopathy

New code  K72.902 Hepatic failure, without coma, with hepatic encephalopathy
West Haven Criteria for Hepatic Encephalopathy Grades 0, 1, 2, and 3

Add  K72.91 Hepatic failure, unspecified with coma
West Haven Criteria for Hepatic Encephalopathy Grade 4

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

K91.8 Other intraoperative and postprocedural complications and disorders of digestive system

New sub-subcategory  K91.82 Postprocedural hepatic failure

New code  K72.901 Postprocedural hepatic failure, without hepatic encephalopathy

New code  K72.902 Postprocedural hepatic failure, with hepatic encephalopathy
West Haven Criteria for Hepatic Encephalopathy Grades 0, 1, 2, and 3
ICD-10 Coordination and Maintenance Committee Meeting
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B15  Acute hepatitis A
       B15.0  Hepatitis A with hepatic coma
               West Haven Criteria for Hepatic Encephalopathy Grade 4

New sub-subcategory  B15.9  Hepatitis A without coma

New code  B15.90  Hepatitis A without coma, without hepatic encephalopathy

New code  B15.91  Hepatitis A without coma, with hepatic encephalopathy
               West Haven Criteria for Hepatic Encephalopathy
               Grades 0, 1, 2, and 3

B16  Acute hepatitis B
       B16.0  Acute hepatitis B with delta-agent with hepatic coma
               West Haven Criteria for Hepatic Encephalopathy Grade 4

New sub-subcategory  B16.1  Acute hepatitis B with delta-agent without coma

New code  B16.10  Acute hepatitis B with delta-agent without coma, without hepatic encephalopathy

New code  B16.11  Acute hepatitis B with delta-agent without coma, with hepatic encephalopathy
               West Haven Criteria for Hepatic Encephalopathy
               Grades 0, 1, 2, and 3

       B16.2  Acute hepatitis B without delta-agent with hepatic coma
               West Haven Criteria for Hepatic Encephalopathy Grade 4

New sub-subcategory  B16.9  Acute hepatitis B without delta-agent without coma

New code  B16.90  Acute hepatitis B without delta-agent without coma, without hepatic encephalopathy

New code  B16.91  Acute hepatitis B without delta-agent without coma, with hepatic encephalopathy
               West Haven Criteria for Hepatic Encephalopathy
               Grades 0, 1, 2, and 3
B17  Other acute viral hepatitis

B17.1  Acute hepatitis C

New sub-subcategory  B17.10  Acute hepatitis C without hepatic coma

New code  B17.100  Acute hepatitis C without hepatic coma, without hepatic encephalopathy

New code  B17.101  Acute hepatitis C without hepatic coma, with hepatic encephalopathy
  West Haven Criteria for Hepatic Encephalopathy Grades 0, 1, 2, and 3

B17.11  Acute hepatitis C with hepatic coma

Add  West Haven Criteria for Hepatic Encephalopathy Grade 4

B19  Unspecified viral hepatitis

B19.0  Unspecified viral hepatitis with hepatic coma

Add  West Haven Criteria for Hepatic Encephalopathy Grade 4

B19.1  Unspecified viral hepatitis B

New sub-subcategory  B19.10  Unspecified viral hepatitis B without hepatic coma

New code  B19.100  Unspecified viral hepatitis B without hepatic coma, without hepatic encephalopathy

New code  B19.101  Unspecified viral hepatitis B without hepatic coma, with hepatic encephalopathy
  West Haven Criteria for Hepatic Encephalopathy Grades 0, 1, 2, and 3

B19.11  Unspecified viral hepatitis B with hepatic coma

Add  West Haven Criteria for Hepatic Encephalopathy Grade 4

B19.2  Unspecified viral hepatitis C

New sub-subcategory  B19.20  Unspecified viral hepatitis C without hepatic coma

New code  B19.200  Unspecified viral hepatitis C without hepatic coma, without hepatic encephalopathy
<table>
<thead>
<tr>
<th>New code</th>
<th>Description</th>
</tr>
</thead>
</table>
| B19.201  | Unspecified viral hepatitis C without hepatic coma, with hepatic encephalopathy  
West Haven Criteria for Hepatic Encephalopathy  
Grades 0, 1, 2, and 3 |
| B19.21   | Unspecified viral hepatitis B with hepatic coma  
Add  
West Haven Criteria for Hepatic Encephalopathy  
Grade 4 |
In utero exposure to Diethylstilbestrol (DES)

The AYR Consulting Group LLC, on behalf of scientists, medical practitioners and the DES community is requesting that a code included in ICD-9-CM (760.76) for in utero exposure to DES be created in ICD-10-CM.

Diethylstilbestrol (DES) is a synthetic form of the female hormone estrogen. It was prescribed to pregnant women between 1940 and 1971 to prevent miscarriage, premature labor, and related complications of pregnancy. The use of DES declined after studies in the 1950s showed that it was not effective in preventing these problems.

In 1971, researchers linked prenatal (before birth) DES exposure to a type of cancer of the cervix and vagina called clear cell adenocarcinoma in a small group of women. Soon after, the Food and Drug Administration (FDA) notified physicians throughout the country that DES should not be prescribed to pregnant women. DES is now known to be an endocrine-disrupting chemical, one of a number of substances that interfere with the endocrine system to cause cancer, birth defects, and other developmental abnormalities. The effects of endocrine-disrupting chemicals are most severe when exposure occurs during fetal development.

In the early 1970s, doctors in Boston identified a rare, sometimes fatal, vaginal cancer in teenage girls. The cancer had never been seen in women so young. The common denominator was the DES prescribed to the girls' mothers during pregnancy.

Since the early 1970s, over 1500 papers have been published about the effects of DES. Researchers have found increased incidence of breast cancer in mothers; increased cancer, pregnancy problems, infertility, and autoimmune disorders in daughters; and urogenital anomalies in sons.

References:
ICD-10 Coordination and Maintenance Committee Meeting  
March 9-10, 2016  

TABULAR MODIFICATIONS  

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P04</td>
<td>Newborn affected by noxious substances transmitted via placenta or breast milk</td>
</tr>
<tr>
<td>P04.1</td>
<td>Fetus and newborn affected by other maternal medication</td>
</tr>
<tr>
<td></td>
<td>New code</td>
</tr>
<tr>
<td>P04.11</td>
<td>Newborn affected by use of Diethylstilbestrol (DES)</td>
</tr>
<tr>
<td>P04.19</td>
<td>Newborn affected by other maternal medication</td>
</tr>
</tbody>
</table>
Lacunar Infarction

Lacunar infarcts are cerebral infarcts of small penetrating branch vessels in deeper portions of the brain. This condition accounts for about a quarter of all ischemic strokes. These infarcts have commonly been regarded as benign vascular lesions with a favorable long-term prognosis. Age, vascular risk factors, high nocturnal blood pressure, and severity of cerebral small-vessel disease at onset have significant prognostic implications for almost all outcomes. The “lacune” refers to the space left behind after infarct healing.

Lacunar infarctions are often manifested by syndromes based on location (over 20 have been described) which are represented in the current ICD-10-CM codes, G46.5 Pure motor lacunar syndrome; G46.6 Pure sensory lacunar syndrome and G46.7 Other lacunar syndromes.

In ICD-10-CM, lacunar infarction (the etiology of these syndromes) is not indexed as it was in ICD-9-CM. The ICD-9-CM code indexed for lacunar infarction was 434.91 Cerebral artery occlusion, unspecified.

The American Academy of Neurology (AAN) requests a distinct code and specific indexing for lacunar infarction.

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I63</td>
<td>Cerebral Infarction</td>
</tr>
<tr>
<td>I63.5</td>
<td>Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries</td>
</tr>
<tr>
<td>I63.6</td>
<td>Cerebral infarction due to cerebral venous thrombosis, nonpyogenic</td>
</tr>
<tr>
<td>New code</td>
<td>I63.7</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

References:
Lump in the Breast

The American Congress of Obstetricians and Gynecologists (ACOG), would like to add laterality and quadrant to ICD-10-CM code N63 (unspecified lump in the breast). Breast quadrants can be defined as: the upper outer (superolateral) quadrant (UOQ), upper inner (superomedial) quadrant (UIQ), lower outer (inferolateral) quadrant (LOQ), and lower inner (inferomedial) quadrant (LIQ).

ACOG would like to take this opportunity to add laterality and quadrant identifiers to the lump in the breast code. This will enable providers and coders to identify positioning of a breast mass with a single diagnosis code to capture the clinical documentation.

ACOG proposes the following tabular modifications.

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>N63 Unspecified lump in the breast</th>
</tr>
</thead>
<tbody>
<tr>
<td>New subcategory</td>
</tr>
<tr>
<td>N63.1</td>
</tr>
<tr>
<td>N63.10</td>
</tr>
<tr>
<td>N63.11</td>
</tr>
<tr>
<td>N63.12</td>
</tr>
<tr>
<td>N63.13</td>
</tr>
<tr>
<td>N63.14</td>
</tr>
<tr>
<td>N63.2</td>
</tr>
<tr>
<td>N63.20</td>
</tr>
<tr>
<td>N63.21</td>
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<td>N63.22</td>
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<td>N63.23</td>
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<td>N63.24</td>
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<td>N63.3</td>
</tr>
<tr>
<td>N63.31</td>
</tr>
<tr>
<td>N63.32</td>
</tr>
<tr>
<td>N63.4</td>
</tr>
<tr>
<td>N63.41</td>
</tr>
<tr>
<td>N63.42</td>
</tr>
</tbody>
</table>
Multiple Pregnancy - Triplets and Above - Amnion and Chorion Equal to Fetus Number

Unique diagnosis codes in subcategories O30.1 (Triplet pregnancy), O30.2 (Quadruplet pregnancy), and O30.8 (Other specified multiple gestation) are needed to report the most common type of presentation in which number of chorions is equal to number of amnions or fetuses. In multiple pregnancy, two or more fetuses may share a placenta (monochorionic) and may also share an amniotic sac (monoamniotic). Multiple pregnancies with monochorionic pairs have much greater risk of perinatal mortality; therefore, diagnosis of multiple gestation type should be determined as early as possible in the pregnancy.

With the increased use of assisted reproductive technology (ART) there has also been an increase in multiple birth pregnancies. In the majority of these cases, each fetus has its own placenta. However, there has also been an increase in monochorionic presentations. There is an incidence of monozygotic twins after natural conception of approximately 0.4%, and following ART it is around 0.9%. About two thirds of these monozygotic twins will have a monochorionic presentation.

Current ICD-10-CM codes in these categories reflect the conditions potentially associated with higher morbidity and fetal loss, where there are monochorionic or monoamniotic pairs in triplets, quadruplets, or other multiple pregnancies. However, the codes do not reflect the more common cases, where each fetus has its own amniotic sac and placenta. Therefore, new codes in the category of multiple gestation (O30) are requested. This proposal has been reviewed and supported by the American Congress of Obstetrics and Gynecology (ACOG).

References
Obstetric outcomes of monochorionic pregnancies conceived following assisted reproductive technology: A retrospective study. [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4150138/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4150138/)

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O30</td>
<td>Multiple gestation</td>
</tr>
<tr>
<td>O30.1</td>
<td>Triplet pregnancy</td>
</tr>
<tr>
<td>New sub-sub category</td>
<td>O30.13 Triplet pregnancy, trichorionic/triamniotic</td>
</tr>
<tr>
<td>New code</td>
<td>O30.131 Triplet pregnancy, trichorionic/triamniotic, first trimester</td>
</tr>
</tbody>
</table>
New code O30.132 Triplet pregnancy, trichorionic/triamniotic, second trimester

New code O30.133 Triplet pregnancy, trichorionic/triamniotic, third trimester

New code O30.139 Triplet pregnancy, trichorionic/triamniotic, unspecified trimester

O30.2 Quadruplet pregnancy

New sub-sub category O30.23 Quadruplet pregnancy, quadrachorionic/quadra-amniotic

New code O30.231 Quadruplet pregnancy, quadrachorionic/quadra-amniotic, first trimester

New code O30.232 Quadruplet pregnancy, quadrachorionic/quadra-amniotic, second trimester

New code O30.233 Quadruplet pregnancy, quadrachorionic/quadra-amniotic, third trimester

New code O30.239 Quadruplet pregnancy, quadrachorionic/quadra-amniotic, unspecified trimester

O30.8 Other specified multiple gestation

New sub-sub category O30.83 Other specified multiple gestation, same number of chorion and amnion as fetuses

Add Pentachorionic, penta-amniotic pregnancy (quintuplets)

Add Hexachorionic, hexa-amniotic pregnancy (sextuplets)

Add Heptachorionic, hepta-amniotic pregnancy (septuplets)

New code O30.831 Other specified multiple gestation, same number of chorion and amnion as fetuses, first trimester

New code O30.832 Other specified multiple gestation, same number of chorion and amnion as fetuses, second trimester

New code O30.833 Other specified multiple gestation, same number of chorion and amnion as fetuses, third trimester
New code  O30.839 Other specified multiple gestation, same number of chorion and amnion as fetuses, unspecified trimester

INDEX MODIFICATIONS

Pregnancy
- multiple
-- specified NEC
--- with
Add  ---- same number of chorion and amnion as fetuses O30.83-
Add  ---- number of chorion and amnion equals number of fetuses O30.83-
- quadruplet
--- with
Add  ---- four chorion and four amnion O30.23-
Add  -- quadrachorionic/quadra-amniotic O30.23-
- triplet
--- with
Add  ---- three chorion and three amnion O30.13-
Add  -- trichorionic/triamniotic O30.13-
Non-Healing and Slow Healing Wounds

The Association of Home Care Coding & Compliance (AHCC), a division of DecisionHealth, a consulting company, has requested new codes to capture non-healing surgical wounds and additional clarifying terms for non-healing traumatic wounds.

In ICD-9-CM, there was a specific code 998.83, Non-healing surgical wound. AHCC reports that this code was frequently used in post-acute care in situations, including home health wound care services, where there was no indication of a current medical misadventure or other complication such as infection or dehiscence. This code could be used to indicate that the wound care was not considered routine aftercare, but rather healing that is continuing slowly after an initial complication (such as infection) was resolved.

AHCC believes that a unique code to capture these wounds is imperative as they require more intense and extended wound care than routine aftercare wounds.

Currently in ICD-10-CM, one code appropriate for non-healing surgical wounds is T81.89, Other complications of procedures, not elsewhere classified. However, this has an instructional note to use an additional code to specify the complication, and there is no code to specify a non-healing or slow-healing wound.

Thus, a new code is being requested at subcategory T81.8, Other complications of procedures, not elsewhere classified: T81.84, to be titled, “Non-healing surgical wound.”

Also in ICD-10-CM, there are a number of existing codes in category T79, Certain early complications of trauma, not elsewhere classified. However, there are not currently any specific codes to capture trauma wounds described as non-healing or slow-healing; the best option for this is code T79.8, Other early complications of trauma. It is also requested that the terms “non-healing trauma wound” and “slow-healing trauma wound” be added as inclusion terms at code T79.8. This could be used to indicate ongoing active wound treatment in the home health setting or other settings.

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T79</td>
<td>Certain early complications of trauma, not elsewhere classified</td>
</tr>
<tr>
<td>T79.8</td>
<td>Other early complications of trauma</td>
</tr>
<tr>
<td></td>
<td>Non-healing trauma wound</td>
</tr>
<tr>
<td></td>
<td>Slow-healing trauma wound</td>
</tr>
<tr>
<td>Add</td>
<td></td>
</tr>
<tr>
<td>T81</td>
<td>Complications of procedures, not elsewhere classified</td>
</tr>
<tr>
<td>T81.8</td>
<td>Other complications of procedures, not elsewhere classified</td>
</tr>
<tr>
<td>New code</td>
<td>T81.84 Non-healing surgical wound</td>
</tr>
</tbody>
</table>
Non-Pressure Chronic Ulcer Severity

The Association of Home Care Coding & Compliance (AHCC), a division of DecisionHealth, a consulting company, has proposed creation of new codes for capturing additional severity levels of non-pressure chronic ulcers of the lower limb.

The ICD-10-CM category L97, Non-pressure chronic ulcer of lower limb, not elsewhere classified, is based on the original WHO category L97, Ulcer of lower limb, not elsewhere classified, with the title modified to clearly differentiate from pressure ulcers. This category was not in ICD-9-CM, but is parallel to the subcategory 707.1, Ulcer of lower limbs, except pressure ulcer. It is an important category to be able to convey the severity of a large variety of non-pressure ulcers that have not previously been able to be coded with specificity beyond the general physical location of the lower limb.

These types of chronic ulcers of the lower extremities are fairly common in the post-acute setting and often require considerable resources over a long period of time. The ability to describe the specific severity in terms of level of tissue involved enables a much better description of the situation to support the level of care needed for these ulcers as well as to improve the accuracy of coding.

The current sub-classification at L97.- offers the opportunity to describe diabetic, arterial, venous, skin and other types of chronic ulcers with the following levels of severity:

- Limited to skin breakdown
- With fat layer exposed
- With necrosis of muscle
- With bone necrosis, and
- Unspecified severity

However, AHCC believes that these are insufficient to describe all the scenarios currently encountered. For example, an ulcer that shows the presence of muscle tissue, but where the muscle tissue isn’t necrotic doesn’t fit into any of these categories. Currently, there is no code that effectively describes a non-pressure ulcer involving muscle or the tissues of bone, cartilage or tendon that does not involve necrosis. The only two options currently available for this situation are to code an unspecified severity of the ulcer, which would not be accurate, or to code to a lesser severity such as involving fat level.

Furthermore, the level under the muscle or bone involvement when there is no necrosis visible is the true depth of ulcer which would under-score the severity of the ulcer. AHCC observed that necrosis may not be discernable on visual inspection of the ulcer alone, and raised concern that it could require additional diagnostic tests such as an MRI to confirm its presence.

A non-pressure ulcer that extends into the muscle or bone structures without necrosis is a significant ulcer. AHCC believes that it will require new treatment codes to capture these situations to enable accurate description of the patient’s condition.
Therefore, AHCC recommended creation of additional codes, for ulcers with the following levels of severity:

- Muscle involvement, but without evidence of necrosis
- Bone involvement, but without evidence of necrosis
- Other specified severity level

These additional code options would carry sixth characters of 5 (muscle involvement without evidence of necrosis), 6 (bone involvement without evidence of necrosis) and 8 (other specified severity). It was proposed that these additional sixth character options be added to each of the subcategories of L97 (L97.1- through L97.9-) that currently describe the specific location and laterality of the lower extremity chronic non-pressure ulcer, for example L97.41- (Non-pressure chronic ulcer of right heel and midfoot).

AHCC believes that the availability of additional code options would enable clinicians and coders to be able to show both improvement and deterioration if the non-pressure ulcer changes over time. Also, AHCC suggests that this change would further parallel the options currently available for pressure ulcers at L89.- (Pressure ulcer) to describe the various levels of severity in a consistent manner.

NCHS staff are proposing an alternative, adding inclusion terms to codes with titles that include “with necrosis of muscle,” the alternative term replacing this as, “to a depth exposing muscle.” Likewise, titles that include “with necrosis of bone,” would be given an alternative term replacing this as, “to a depth exposing bone.”

**TABULAR MODIFICATIONS**

**Proposed Option (#1), example**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L97</td>
<td>Non-pressure chronic ulcer of lower limb, not elsewhere classified</td>
</tr>
<tr>
<td>L97.1</td>
<td>Non-pressure chronic ulcer of thigh</td>
</tr>
<tr>
<td>L97.10</td>
<td>Non-pressure chronic ulcer of unspecified thigh</td>
</tr>
<tr>
<td>New code</td>
<td>L97.105 Non-pressure chronic ulcer of unspecified thigh with muscle involvement without evidence of necrosis</td>
</tr>
<tr>
<td>New code</td>
<td>L97.106 Non-pressure chronic ulcer of unspecified thigh with bone involvement without evidence of necrosis</td>
</tr>
<tr>
<td>New code</td>
<td>L97.108 Non-pressure chronic ulcer of unspecified thigh with other specified severity</td>
</tr>
</tbody>
</table>
This is an example. It is proposed to apply this expansion for all of L97.1- to L97.9-; for consistency, NCHS also would propose to apply this at L98.4-. This would create 72 new codes. If applied only at L97, it would create 63 new codes.

NCHS Preferred Option (#2), example

L97 Non-pressure chronic ulcer of lower limb, not elsewhere classified

L97.1 Non-pressure chronic ulcer of thigh

L97.10 Non-pressure chronic ulcer of unspecified thigh

L97.103 Non-pressure chronic ulcer of unspecified thigh with necrosis of muscle
Add Non-pressure chronic ulcer of unspecified thigh to a depth exposing muscle

L97.104 Non-pressure chronic ulcer of unspecified thigh with necrosis of bone
Add Non-pressure chronic ulcer of unspecified thigh to a depth exposing bone

Again, this is an example. It is proposed to add similar inclusion terms for all of L97.1- to L97.9-, and also for L98.4-. This would add inclusion terms for 120 existing codes.
Pediatric Cryptorchidism

When treating patients with an undescended testicle, it is important to determine the specific location of the testicle, as this could have important implications for follow-up and treatment. More specifically, it is important to document the various locations where an undescended or ectopic testicle is found: intra-abdominal, within the inguinal canal, high scrotal, or ectopic. In addition, a child may frequently be sent for evaluation of a non-palpable testicle, which in itself requires further evaluation to determine the location and presence/absence of that testicle.

Currently, ICD-10-CM has unique codes for abdominal testicle, ectopic, and ectopic perineal, and codes for unilateral and bilateral. However, more specific codes are needed for accurate patient description, such as inguinal undescended testicle, high scrotal undescended testicle and non-palpable testicle.

The American Urological Association (AUA) proposes the addition of new codes in order to identify these conditions.

TABULAR MODIFICATIONS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q53</td>
<td>Undescended and ectopic testicle</td>
</tr>
<tr>
<td>Q53.1</td>
<td>Undescended testicle, unilateral</td>
</tr>
<tr>
<td>Q53.11</td>
<td>Abdominal testis, unilateral</td>
</tr>
<tr>
<td>Q53.111</td>
<td>Intraabdominal</td>
</tr>
<tr>
<td>Q53.112</td>
<td>Inguinal</td>
</tr>
<tr>
<td>Q53.13</td>
<td>High scrotal testis, unilateral</td>
</tr>
<tr>
<td>Q53.2</td>
<td>Undescended testicle, bilateral</td>
</tr>
<tr>
<td>Q53.21</td>
<td>Abdominal testis, bilateral</td>
</tr>
<tr>
<td>Q53.211</td>
<td>Intraabdominal</td>
</tr>
<tr>
<td>Q53.212</td>
<td>Inguinal</td>
</tr>
<tr>
<td>Q53.23</td>
<td>High scrotal testis, bilateral</td>
</tr>
</tbody>
</table>
R39 Other and unspecified symptoms and signs involving the genitourinary System

R39.8 Other symptoms and signs involving the genitourinary system

New code R39.83 Non-palpable testicle, unilateral

New code R39.84 Non-palpable testicle, bilateral
Post-Operative Seroma

The Alliance of Dedicated Cancer Centers (ADCC) has requested that specific codes be created for post-operative seromas. A seroma is a collection of fluid that can form after surgery or trauma. A seroma contains clear serous fluid, in comparison to a hematoma, which contains blood.

For the coding of post-operative seromas in ICD-10-CM, the indexing includes a note to see also hematoma; in turn, there is a note at Hematoma, postoperative, to see Complication, postprocedural, hemorrhage. Thus, seroma is to be coded together with hematoma and hemorrhage, with a number of specific codes for different sites. The ADCC has stated a belief that “this is incorrect, since post-op seroma and post-op hematoma are not clinically the same.” There was a specific ICD-9-CM code, 998.13, Seroma complicating a procedure, as well as code 998.12, Hematoma complicating a procedure.

The ADCC raised concern that having these conditions together is resulting in inaccurate reporting and in an over-reporting of post-op hemorrhage/hematoma volumes. It will be challenging to compare complication rates using ICD-9-CM and ICD-10-CM in the absence of a specific code for post-op seroma. Doing so will require 100% chart review. Additionally, it was noted that the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) #27 is for the reporting of Perioperative Hemorrhage or Hematoma Rate.

Given the importance of quality data — and specifically the use of complication and patient safety data by so many entities — the ADCC strongly believes that a diagnosis code for post-op seroma should be created, similar to the one that existed in ICD-9-CM.

A request to implement these changes on October 1, 2016, has been made. NCHS staff are currently recommending 2017 implementation, due to the large number of codes involved (thirty), but NCHS welcomes public input on earlier implementation. Comments on this part of this topic are therefore requested by April 8, 2016.

TABULAR MODIFICATIONS

Example of changes related to postoperative seroma

Currently, postoperative seroma would be coded with postoperative hematoma. Below are shown examples of coding for seroma, with existing codes at subcategory D78.2, where a postoperative seroma involving the spleen should be coded now, along with postprocedural hematoma and hemorrhage of the spleen; also shown are previously proposed changes which are to become effective October 1, 2016, removing the words “and hematoma” from these code titles. Further below is shown how seroma will be coded subsequently.

D78 Intraoperative and postprocedural complications of spleen

Revise (2016) D78.2 Postprocedural hemorrhage and hematoma of the spleen following a procedure
ICD-10 Coordination and Maintenance Committee Meeting
March 9-10, 2016

Revise (2016)  D78.21  Postprocedural hemorrhage and hematoma of the spleen following a procedure on the spleen

Revise (2016)  D78.22  Postprocedural hemorrhage and hematoma of the spleen following other procedure

Below is shown a new subcategory previously proposed to become effective October 1, 2016, along with changes that would be made under this proposal for 2017. The hematoma codes D78.31 and D78.32 previously proposed to be created October 1, 2016, represent where seroma of the spleen would be coded from October 1, 2016, through October 1, 2017. The proposed new codes D78.33 and D78.34 represent where seroma of the spleen would be coded following implementation of these changes, October 1, 2017.

New Subcategory (2016)
Revise (2017)  D78.3  Postprocedural hematoma and seroma of the spleen following a procedure

New code (2016)  D78.31  Postprocedural hematoma of the spleen following a procedure on the spleen

New code (2016)  D78.32  Postprocedural hematoma of the spleen following other procedure

New code (2017)  D78.33  Postprocedural seroma of the spleen following a procedure on the spleen

New code (2017)  D78.34  Postprocedural seroma of the spleen following other procedure

Subsequent pages only show new proposed changes, for 2017.
Proposed changes related to seroma, to be effective October 1, 2017. Repeats the D78 changes.

**D78**  Intraoperative and postprocedural complications of spleen

*New Subcategory*

- **D78.3**  Postprocedural hematoma and seroma of the spleen following a procedure

*New code*

- **D78.33**  Postprocedural seroma of the spleen following a procedure on the spleen

- **D78.34**  Postprocedural seroma of the spleen following other procedure

**E89**  Postprocedural endocrine and metabolic complications and disorders, not elsewhere classified

*New subcategory*

- **E89.8**  Other postprocedural endocrine and metabolic complications and disorders

*Revise*

- **E89.82**  Postprocedural hematoma and seroma of an endocrine system organ or structure

*New code*

- **E89.822**  Postprocedural seroma of an endocrine system organ or structure following an endocrine system procedure

- **E89.823**  Postprocedural seroma of an endocrine system organ or structure following other procedure

**G97**  Intraoperative and postprocedural complications and disorders of nervous system, not elsewhere classified

*New subcategory*

- **G97.6**  Postprocedural hematoma and seroma of a nervous system organ or structure following a procedure

*New code*

- **G97.63**  Postprocedural seroma of a nervous system organ or structure following a nervous system procedure

- **G97.64**  Postprocedural seroma of a nervous system organ or structure following other procedure

**H59**  Intraoperative and postprocedural complications and disorders of eye and adnexa, not elsewhere classified
ICD-10 Coordination and Maintenance Committee Meeting
March 9-10, 2016

Revise

H59.3 Postprocedural hemorrhage, and hematoma and seroma of eye and adnexa following a procedure

New subcategory

H59.35 Postprocedural seroma of eye and adnexa following an ophthalmic procedure

New code

H59.351 Postprocedural seroma of right eye and adnexa following an ophthalmic procedure

New code

H59.352 Postprocedural seroma of left eye and adnexa following an ophthalmic procedure

New code

H59.353 Postprocedural seroma of eye and adnexa following an ophthalmic procedure, bilateral

New code

H59.359 Postprocedural seroma of unspecified eye and adnexa following an ophthalmic procedure

New subcategory

H59.36 Postprocedural seroma of eye and adnexa following other procedure

New code

H59.341 Postprocedural seroma of right eye and adnexa following other procedure

New code

H59.342 Postprocedural seroma of left eye and adnexa following other procedure

New code

H59.343 Postprocedural seroma of eye and adnexa following other procedure, bilateral

New code

H59.349 Postprocedural seroma of unspecified eye and adnexa following other procedure

H95 Intraoperative and postprocedural complications and disorders of ear and mastoid process, not elsewhere classified

New subcategory

Revise

H95.5 Postprocedural hematoma and seroma of ear and mastoid process following a procedure

New code

H95.53 Postprocedural seroma of ear and mastoid process following a procedure on the ear and mastoid process

New code

H95.524 Postprocedural seroma of ear and mastoid process following other procedure
ICD-10 Coordination and Maintenance Committee Meeting
March 9-10, 2016

I97 Intraoperative and postprocedural complications and disorders of circulatory system, not elsewhere classified

Revise I97.6 Postprocedural hemorrhage, and hematoma and seroma of a circulatory system organ or structure following a procedure

Revise I97.62 Postprocedural hemorrhage, and hematoma and seroma of a circulatory system organ or structure following other procedure

New code I97.622 Postprocedural seroma of a circulatory system organ or structure following other procedure

New subcategory I97.64 Postprocedural hematoma and seroma of a circulatory system organ or structure following a circulatory system procedure

New code I97.640 Postprocedural seroma of a circulatory system organ or structure following a cardiac catheterization

New code I97.641 Postprocedural seroma of a circulatory system organ or structure following cardiac bypass

New code I97.648 Postprocedural seroma of a circulatory system organ or structure following other circulatory system procedure

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

J95.8 Other intraoperative and postprocedural complications and disorders of respiratory system, not elsewhere classified

New subcategory J95.86 Postprocedural hematoma and seroma of a respiratory system organ or structure following a procedure

New code J95.862 Postprocedural seroma of a respiratory system organ or structure following a respiratory system procedure

New code J95.863 Postprocedural seroma of a respiratory system organ or structure following other procedure

K91 Intraoperative and postprocedural complications and disorders of digestive system, not elsewhere classified
K91.8 Other intraoperative and postprocedural complications and disorders of digestive system

New subcategory
Revise K91.87 Postprocedural hematoma and seroma of a digestive system organ or structure following a procedure

New code
K91.872 Postprocedural seroma of a digestive system organ or structure following a digestive system procedure

New code
K91.873 Postprocedural seroma of a digestive system organ or structure following other procedure

L76 Intraoperative and postprocedural complications of skin and subcutaneous tissue

New subcategory
Revise L76.3 Postprocedural hematoma and seroma of skin and subcutaneous tissue following a procedure

New code
L76.33 Postprocedural seroma of skin and subcutaneous tissue following a dermatologic procedure

New code
L76.34 Postprocedural seroma of skin and subcutaneous tissue following other procedure

M96 Intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhere classified

M96.8 Other intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhere classified

New subcategory
Revise M96.84 Postprocedural hematoma and seroma of a musculoskeletal structure following a procedure

New code
M96.842 Postprocedural seroma of a musculoskeletal structure following a musculoskeletal system procedure

New code
M96.843 Postprocedural seroma of a musculoskeletal structure following other procedure

N99 Intraoperative and postprocedural complications and disorders of genitourinary system, not elsewhere classified
ICD-10 Coordination and Maintenance Committee Meeting
March 9-10, 2016

N99.8 Other intraoperative postprocedural complications and disorders of genitourinary system

New subcategory

Revise

N99.83 Postprocedural hematoma and seroma of a genitourinary system organ or structure following a procedure

New code

N99.832 Postprocedural seroma of a genitourinary system organ or structure following a genitourinary system procedure

New code

N99.833 Postprocedural seroma of a genitourinary system organ or structure following other procedure
Risk Level for Dental Carries

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

This proposal was originally presented at the September 2015 C&M meeting. Based on public comments, modifications have been made and resubmitted for the proposed tabular modifications.

TABULAR MODIFICATIONS

Z91 Personal Risk Factors, not elsewhere classified

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

New Subcategory Z91.84 Oral Health Risk Factors

New code Z91.841 Risk for dental caries, low
New code Z91.842 Risk for dental caries, moderate
New code Z91.843 Risk for dental caries, high
ICD-10 Coordination and Maintenance Committee Meeting
March 9-10, 2016

Type 2 diabetes mellitus with ketoacidosis

The Association of Home Care Coding & Compliance (AHCC), a division of DecisionHealth, a consulting company, has requested new ICD-10-CM codes for type 2 diabetes with ketoacidosis. Others have also made comments suggesting this separately.

AHCC reports that increasingly health care providers will state that a patient with type 2 diabetes had ketoacidosis with or without coma in an inpatient setting. There can be problems in coding this, due to there not being specific ICD-10-CM codes that convey this information.

It is recognized that it is rare to have type 2 diabetes with ketoacidosis, but it does occur. Since providers are diagnosing this condition, it has been requested that that codes be added to the type 2 diabetes category to enable this to be coded appropriately in all settings.

TABULAR MODIFICATIONS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E11</td>
<td>Type 2 diabetes mellitus</td>
</tr>
<tr>
<td>New Subcategory</td>
<td>E11.1 Type 2 diabetes mellitus with ketoacidosis</td>
</tr>
<tr>
<td>New code</td>
<td>E11.10 Type 2 diabetes mellitus with ketoacidosis without coma</td>
</tr>
<tr>
<td>New code</td>
<td>E11.11 Type 2 diabetes mellitus with ketoacidosis with coma</td>
</tr>
</tbody>
</table>
Zika Virus

ICD-10 (and ICD-10-CM) currently classify the Zika virus to code A92.8, Other specified mosquito-borne virus.

As noted by WHO in December 2015, the recent spread of Zika virus disease necessitated the need to monitor the disease with a separate code that allows tracking cases of the Zika virus disease. Codes U00-U49 are used by WHO for the provisional assignment of new diseases of uncertain etiology or in emergency situations. The provisional codes are in effect until WHO creates a new permanent code through its regular ICD-10 updating process.

WHO announced that effective December 16, 2015 new ICD-10 provisional codes were being created until such time that a permanent code(s) can be introduced into ICD-10 through the regular WHO ICD-10 updating process. Two codes were introduced for international mortality (and morbidity) use: a 3-character code (U06, Zika virus disease) for settings that use 3-character reporting and a 4-character code for those settings that are able to report at a 4-character level (U06.9, Zika, virus disease, unspecified).

As part of the regular update process, WHO has proposed a new code for the Zika virus, A92.5, Zika virus disease. The adoption of the code will be voted on during the WHO-FIC annual meeting in October 2016. NCHS/CDC is therefore proposing the new code for inclusion in ICD-10-CM, effective October 1, 2016, to be consistent with the planned WHO ICD-10 update.

TABULAR MODIFICATIONS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>A92</td>
<td>Other mosquito-borne viral fevers</td>
</tr>
<tr>
<td>New code</td>
<td>A92.5 Zika virus disease</td>
</tr>
<tr>
<td></td>
<td>Zika virus fever</td>
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<td></td>
<td>Zika virus infection</td>
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<td></td>
<td>Zika, NOS</td>
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</tbody>
</table>
**ICD-10-CM TABULAR OF DISEASES - PROPOSED ADDENDA**

*All proposed effective October 1, 2016*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Action</th>
<th>Excludes 1</th>
<th>Excludes 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>D68.62</td>
<td>Lupus anticoagulant syndrome</td>
<td>Revise</td>
<td>Lupus anticoagulant (LAC) finding without diagnosis</td>
<td>Lupus anticoagulant (LAC) finding without diagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(R79.0)</td>
<td>(R76.0)</td>
</tr>
<tr>
<td>I50</td>
<td>Heart failure</td>
<td>Revise</td>
<td>Cardiac arrest (I46.-)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add</td>
<td></td>
<td>Cardiac arrest (I46.-)</td>
</tr>
<tr>
<td>K76</td>
<td>Other diseases of liver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>K76.7 Hepatorenal syndrome</td>
<td>Revise</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Postprocedural hepatorenal syndrome (K91.82) (K91.83)</td>
<td></td>
</tr>
<tr>
<td>P00</td>
<td>Newborns affected by maternal factors and by complications of pregnancy,</td>
<td>Revise</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>labor, and delivery (P00-P04)</td>
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<tr>
<td></td>
<td>Note: These codes are for use when the listed maternal conditions are</td>
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<tr>
<td></td>
<td>specified as the cause of confirmed morbidity or potential morbidity which</td>
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<td>have their origin in the perinatal period (before birth through the first</td>
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<td>28 days after birth). Codes from these categories are also for use for</td>
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<td>newborns who are suspected of having an abnormal condition resulting from</td>
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<td>exposure from the mother or the birth process, but without signs or</td>
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<td>symptoms, and, which after examination and observation, is found not to</td>
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<td>exist. These codes may be used even if treatment is begun for a suspected</td>
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<td>condition that is ruled out.</td>
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<tr>
<td>P07</td>
<td>Disorders of newborn related to short gestation and low birth weight, not</td>
<td>Delete</td>
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<tr>
<td></td>
<td>elsewhere classified</td>
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<tr>
<td></td>
<td>Excludes1: low birth weight due to slow fetal growth and fetal malnutrition</td>
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<td></td>
<td>(P05.-)</td>
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<tr>
<td></td>
<td>P07.0 Extremely low birth weight newborn</td>
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<tr>
<td></td>
<td>Excludes1: low birth weight due to slow fetal growth and fetal malnutrition</td>
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<td></td>
<td>(P05.-)</td>
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<tr>
<td></td>
<td>P07.1 Other low birth weight newborn</td>
<td>Add</td>
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<tr>
<td></td>
<td>Excludes1: low birth weight due to slow fetal growth and fetal malnutrition</td>
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<tr>
<td></td>
<td>(P05.-)</td>
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</tbody>
</table>
Symptoms and signs involving the digestive system and abdomen (R10-R19)

Revise Excludes 1: symptoms referable to male genital organs male (N48-N50)

R13 Aphagia and dysphagia
R13.1 Dysphagia

Revise Code first if applicable, dysphagia following cerebrovascular disease
(I69. with final characters -91)

S00 Superficial injury of head
S00.8 Superficial injury of other parts of head
Add Injuries of face [any part]

T80 Complications following infusion, transfusion and therapeutic injection
T80.6 Other serum reactions
T80.69 Other serum reaction due to other serum
Add Code also Arthropathy in hypersensitivity reactions classified elsewhere (M36.4), if applicable

Z12 Encounter for screening for malignant neoplasms
Z12.4 Encounter for screening for malignant neoplasm of cervix

Revise Excludes1: encounter for screening for human papillomavirus (Z11.51)
Add Excludes2: encounter for screening for human papillomavirus (Z11.51)

Z95 Presence of cardiac and vascular implants and grafts
Z95.1 Presence of aortocoronary bypass graft
Add Presence of coronary artery bypass graft

Z79 Long term (current) drug therapy
Z79.8 Other long term (current) drug therapy
Z79.81 Long term (current) use of agents affecting estrogen receptors and estrogen levels

Revise Code first if applicable:
Bacteriuria, bacteruria N39.0
Revised  - asymptomatic N39.0-R82.7

Bursitis
Revised  - collateral ligament, tibial (M76.04)—see Bursitis, tibial collateral
Revised  - tibial collateral (M76.04)—see Bursitis, tibial collateral

Clot (blood) - see also Embolism
- heart - see also Infarct, myocardium
Revised  - - not resulting in infarction I24.0 I51.3

Delay, delayed
Revised  - development R62.50 R62.0
Revised  - - global F88 physiologic R62.59
Add  - - milestone R62.0
Add  - - physiological
Revised  - - physiological NOS R62.50

Disorder
- stress
Add  -- acute (F43.0)

Endocarditis (chronic) (marantic) (nonbacterial) (thrombotic) (valvular) I38
Add  - - viral

Lesion
Revised  - cardia K22.9 K31.9

Metaplasia
Add  - esophagus (K22.7-)

Minamata disease T26.1—T56.1

Scoliosis (acquired) (postural) M41.9
Revised  - - adolescent (idiopathic) —see Scoliosis, idiopathic, juvenile adolescent

Thrombosis, thrombotic (bland) (multiple) (progressive) (silent) (vessel) I82.90
- atrium, auricular - see also Infarct, myocardium
Revised  - - not resulting in infarction I24.0 I51.3
- cardiac - see also Infarct, myocardium
Revised  - - not resulting in infarction I24.0 I51.3
- endocardial - see also Infarct, myocardium
Revised  - - not resulting in infarction I24.0 I51.3
- heart (chamber) - see also Infarct, myocardium
- intramural - see also Infarct, myocardium

Revise - - not resulting in infarction I24.0 I51.3
Revise - - not resulting in infarction I24.0 I51.3
- mural - see also Infarct, myocardium

Revise - - not resulting in infarction I24.0 I51.3
- ventricle - see also Infarct, myocardium

Revise - - not resulting in infarction I24.0 I51.3