ICD-9-CM Coordination and Maintenance Committee Meeting
March 9-10, 2011
Diagnosis Agenda

Welcome and announcements
Donna Pickett, MPH, RHIA
Co-Chair, ICD-9-CM Coordination and Maintenance Committee

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ICD-9-CM TIMELINE

A timeline of important dates in the ICD-9-CM process is described below:

March 9 – March 10 2011  ICD-9-CM Coordination and Maintenance Committee meeting.

April 1, 2011  There will not be any new ICD-9-CM codes implemented on April 1, 2011 to capture new technology.

April 1, 2011  Deadline for receipt of public comments on proposed code revisions discussed at the March 9-10, 2011 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2011.

April 2011  Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This notice will include the final ICD-9-CM diagnosis and procedure codes for the upcoming fiscal year. It will also include proposed revisions to the DRG system on which the public may comment. The proposed rule can be accessed at:
http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp

April 2011  Summary report of the Procedure part of the March 9, 2011 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows:
http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes

Summary report of the Diagnosis part of the March 10, 2011 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows:
http://www.cdc.gov/nchs/icd.htm

June 2011  Final addendum posted on web pages as follows:
Diagnosis addendum at –
http://www.cdc.gov/nchs/icd.htm

Procedure addendum at –
http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes

July 15, 2011  Those members of the public requesting that topics be discussed at the September 14 – 15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses.

August 1, 2011  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 all the final codes to be implemented on October 1, 2011.
This rule can be accessed at:
http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp

August 2011
Tentative agenda for the Procedure part of the September 14 – 15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage at -
http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes

Tentative agenda for the Diagnosis part of the September 14 – 15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on NCHS homepage at -
http://www.cdc.gov/nchs/icd.htm

Federal Register notice for the September 14 –15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.

August 12, 2011
On-line registration opens for the September 14-15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting at:
http://www.cms.hhs.gov/apps/events

September 9, 2011
Because of increased security requirements, those wishing to attend the September 14 - 15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting must register for the meeting online at:
http://www.cms.hhs.gov/apps/events

Attendees must register online by September 9, 2011; failure to do so may result in lack of access to the meeting.

September 14 –15, 2011
ICD-9-CM Coordination and Maintenance Committee meeting.
Those who wish to attend the ICD-9-CM Coordination and Maintenance Committee meeting must have registered for the meeting online by September 9, 2011. You must bring an official form of picture identification (such as a drivers license) in order to be admitted to the building.

October 2011
Summary report of the Procedure part of the September 14 – 15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows:
http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes

Summary report of the Diagnosis part of the September 14– 15, 2011 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows:
http://www.cdc.gov/nchs/icd.htm

October 1, 2011
New and revised ICD-9-CM codes go into effect along
with DRG changes. Final addendum posted on web pages as follows:
Diagnosis addendum - http://www.cdc.gov/nchs/icd.htm
Procedure addendum at -
http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes

October 7, 2011
Deadline for receipt of public comments on proposed code revisions discussed at the September 14-15, 2011 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on April 1, 2012.

November 2011
Any new ICD-9-CM codes required to capture new technology and new diseases that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2012 will be posted on the following websites:
http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes
http://www.cdc.gov/nchs/icd.htm

November 18, 2011
Deadline for receipt of public comments on proposed code revisions discussed at the September 14-15, 2011 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2012.

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

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-9-CM 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-9-CM 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 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.
Seclusion status

Seclusion is used for behavioral health purposes to protect the patient against injury to self or others because of an emotional or behavioral disorder. The use of seclusion poses a risk to the patient’s physical safety and well-being. Seclusion has the potential to produce serious consequences, such as physical and psychological harm, violation of rights, and even death. Therefore, medical care must maximize safety by allocating sufficient resources that have specialized training. Additionally, the healthcare organization must provide assessment of each encounter.

Patients must be evaluated and monitored more closely when seclusion is used. A health care facility must be able to easily identify patients who had seclusion used during their encounter. During the use of seclusion, the services change as a higher level of monitoring and care is required while a patient is in seclusion. This is a high risk situation which requires special training and patient care. A unique code will assist in giving a better description of the episode of care.

A request was received from Lockheed Martin Health Solutions and Service to create a unique ICD-9-CM diagnosis code for seclusion status.

The following tabular modifications are proposed:

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>V07</th>
<th>Need for isolation and other prophylactic or treatment measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>V07.0</td>
<td>Isolation</td>
</tr>
<tr>
<td></td>
<td>Excludes: seclusion status (V49.88)</td>
</tr>
<tr>
<td>V49</td>
<td>Other conditions influencing health status</td>
</tr>
<tr>
<td>V49.8</td>
<td>Other specified conditions influencing health status</td>
</tr>
</tbody>
</table>

New code: V49.88 Seclusion status

- Excludes: need for isolation (V07.0)
  - seclusion imposed by correction and law enforcement authorities for security purposes – omit code
Vitreomacular adhesion

Vitreomacular adhesion (VMA) is a condition affecting the macula, a small portion of the retina which is important for central vision. VMA may lead to visual impairment or blindness and a variety of complications (macular edema, macular pucker, and macular hole) with similar symptoms. It occurs as a result of the natural process of aging, in which the vitreous gel pulls forward and away from the retina over time. VMA is not a new condition. However, there is a need from a broad health care perspective to be able to track this discrete and potentially sight-threatening condition, understand its true prevalence, and identify it separately from other traction disorders as well as associated or downstream conditions.

In a normal healthy eye, the vitreous gel fills the entire vitreous cavity. However, age-related changes in the vitreous can cause the vitreous gel to collapse. This is called posterior vitreous detachment (PVD), and it occurs when the collagen fibers which make up the vitreous cavity condense, causing the gel to "pull forward".

Within the eye, the macula is the center of the retina, and the center of the macula (much like a “bulls-eye”) is an avascular area called the fovea. The fovea has a high concentration of cone cells responsible for central vision and is therefore the main determinant for visual acuity. Any damage to the macula, and consequently the fovea, is immediately noticed since it affects the central vision.

VMA may occur after PVD, if there is only part, whereby part of the posterior hyaloid (membrane separating the vitreous from the retina) remains attached to the macular area. When adhesion persists at this site, the vitreomacular traction (VMT) generated by the adhesion may become symptomatic (sVMA).

Both researchers and clinicians have recognized VMA as a separately identifiable condition that contributes to serious vision threatening conditions, and warrants its own distinct and unique treatment upon anatomical or visual signs and symptoms of vitreomacular traction. As advanced diagnostic techniques have become universally available in the last decade and new treatments enter the health care marketplace, clinicians and researchers alike would benefit greatly from separately identifiable VMA coding.


TABULAR MODIFICATIONS

379 Other disorders of eye
379.2 Disorders of vitreous body

New code 379.27 Vitreomacular adhesion
Add Vitreomacular traction
Add Excludes: traction detachment with vitreoretinal organization (361.81)
Partial Tear of Rotator Cuff

The rotator cuff is the network of four muscles and several tendons that form a covering around the top of the upper arm bone (humerus). These muscles form a cover around the head of the humerus. The rotator cuff holds the humerus in place in the shoulder joint and enables the arm to rotate.

Rotator cuff tear is a common cause of pain and disability among adults. Most tears occur in the supraspinatus muscle, but other parts of the cuff may be involved.

The rotator cuff can be torn from a single traumatic injury. Patients often report recurrent shoulder pain for several months and a specific injury that triggered the onset of the pain. A rotator cuff tear may also happen at the same time as another injury to the shoulder, such as a fracture or dislocation.

Most tears, however, are the result of overuse of these muscles and tendons over a period of years. People who are especially at risk for overuse are those who engage in repetitive overhead motions. These include participants in sports such as baseball, tennis, weight lifting, and rowing.

Rotator cuff tears are most common in people who are over the age of 40. Younger people tend to have rotator cuff tears following acute trauma or repetitive overhead work or sports activity. A partial tear of the rotator cuff is an area of damage to the rotator cuff tendons, where the tear does not go all the way through the tendons.

Currently ICD-9-CM has a unique code for the complete tear of the rotator cuff, code 727.61, Complete rupture of rotator cuff, but does not have a unique code for a partial tear of the rotator cuff.

TABULAR MODIFICATION

<table>
<thead>
<tr>
<th>726</th>
<th>Peripheral enthesopathies and allied syndromes</th>
</tr>
</thead>
<tbody>
<tr>
<td>726.1</td>
<td>Rotator cuff syndrome of shoulder and allied disorders</td>
</tr>
</tbody>
</table>

New code 726.13 Partial tear of rotator cuff
Malnutrition

At the September 2010 ICD-9-CM Coordination and Maintenance Committee meeting the American Dietetic Association (ADA) and the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) requested several new codes and instructional notes be added to the ICD-9-CM to update the current classification of malnutrition. The existing ICD-9-CM codes for malnutrition are outdated and do not reflect the current standard of care or understanding of malnutrition-disease interaction. Thus, the existing ICD-9-CM malnutrition codes are inconsistently applied by clinicians and facilities across health care settings. Inconsistency in the recognition and documentation of malnutrition in adults is of concern and can significantly impact patient health, safety, quality of life, and health care costs.

While public comments received on this proposal agreed in principle with the need for the new codes, commenters noted that certain modifications would be necessary to avoid confusion and conflicts with existing codes and guidelines. The modifications have been incorporated into this revised proposal.

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>260</td>
<td>Kwashiorkor</td>
</tr>
<tr>
<td>Delete</td>
<td>Nutritional edema with dyspigmentation of skin and hair</td>
</tr>
<tr>
<td>Add</td>
<td>Excludes: severe malnutrition related to acute injury, illness and other disorders (262.11-262.14, 262.19)</td>
</tr>
<tr>
<td>261</td>
<td>Nutritional marasmus</td>
</tr>
<tr>
<td>Delete</td>
<td>Nutritional atrophy</td>
</tr>
<tr>
<td>Delete</td>
<td>Severe calorie deficiency</td>
</tr>
<tr>
<td>Delete</td>
<td>Severe malnutrition NOS</td>
</tr>
<tr>
<td>Add</td>
<td>Excludes: severe malnutrition related to acute injury, illness and other disorders (262.11-262.14, 262.19)</td>
</tr>
<tr>
<td>Revise</td>
<td>Other specified severe protein-calorie malnutrition</td>
</tr>
<tr>
<td>Delete</td>
<td>Nutritional edema without mention of dyspigmentation of skin and hair</td>
</tr>
<tr>
<td>New subcategory 262.1</td>
<td>Severe malnutrition in injury, illness or other disorders</td>
</tr>
<tr>
<td>New code</td>
<td>262.10</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>New code</td>
<td>262.11</td>
</tr>
<tr>
<td>New code</td>
<td>262.12</td>
</tr>
<tr>
<td>New code</td>
<td>262.13</td>
</tr>
<tr>
<td>New code</td>
<td>262.14</td>
</tr>
<tr>
<td>New code</td>
<td>262.19</td>
</tr>
<tr>
<td>263</td>
<td>Other and unspecified protein-calorie malnutrition</td>
</tr>
</tbody>
</table>
Add Excludes: severe malnutrition related to acute injury, illness and other disorders
(262.11-262.14, 262.19)

782 Symptoms involving skin and other integumentary tissue

782.3 Edema

Delete Excludes: nutritional edema (260, 262)

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Revise nutritional 261 – see Malnutrition
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Revise edema 262 – see Malnutrition
Revise multiple, syndrome 260 – see Malnutrition
Revise protein 260 – see Malnutrition
Revise syndrome, multiple 260 – see Malnutrition
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Revise due to secondary diabetes 249.8 [261] [263.8]
Revise secondary
Revise Lancereaux's (diabetes mellitus with marked emaciation) 249.8 [261] [263.8]
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Revise nutritional 263.9 – see Malnutrition
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Revise inanition 262 – see Malnutrition
Revise nutritional (newborn) 262 – see Malnutrition
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Revise second 263.0 263.9
Revise third 262 263.9
Revise mild (protein) NEC 263.1
Add due to specified underlying condition – see Malnutrition, related to, by cause
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Add due to specified underlying condition – see Malnutrition, related to, by cause
Revise severe 264 262.10
Revise protein-calorie NEC 262
Add due to specified underlying condition – see Malnutrition, related to, by cause
Add due to – see Malnutrition, related to
Revise malignant 260 263.9
mild (protein) 263.1
Add due to specified underlying condition – see Malnutrition, related to, by cause
moderate (protein) 263.0
Add due to specified underlying condition – see Malnutrition, related to, by cause
Revise protein 260 263.9
mild 263.1
Add due to specified underlying condition – see Malnutrition, related to, by cause
moderate 263.0
Add due to specified underlying condition – see Malnutrition, related to, by cause
protein-calorie 263.9
Revise severe NEC 262
specified type NEC 263.8
Add due to specified underlying condition – see Malnutrition, related to, by cause
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Add acute illness NEC 262.12
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Revise Plurideficiency syndrome of infancy 260 – see Malnutrition
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Revise extreme (due to malnutrition) 264 – see Malnutrition
Solitary Pulmonary Nodules

A single pulmonary nodule (SPN) is a round or oval spot (lesion) in the lungs typically deep within and surrounded with the lung parenchyma in a sub-segmental branch of the bronchial tree. On imaging examination more than one single pulmonary nodule may be present on the lung field. The two single pulmonary nodules tend to be distinct and not in close anatomical proximity.

The single pulmonary nodule is detected with chest X-ray, however with enhancements in Computed Tomography (CT) and Positron Emission Tomography (PET) these lesions are found with a higher frequency than with chest X-ray. A SPN, once biopsied, may be benign or malignant, carcinoma in situ, or represent different lung disease.

Twenty five (25%) to thirty five (35%) of SPNs positioned in the sub-segmental branch of the bronchial tree and deep within the lung tissue, upon biopsy using wedge resection or lobectomy are benign. Wedge resection and lobectomy result in increased morbidity and surgical complications, yet provide a viable option for a patient wanting a biopsy confirmation. Five-year survival rates approach 70% when lung cancer is detected and treated at stage 1A of the disease. The peer reviewed medical literature is abundant with articles reporting on techniques to address these peripheral, deep within the lung, lesions using less invasive techniques in support of earlier detection and treatment to save lives.

Currently in ICD-9-CM it is not possible to uniquely identify a patient that has been identified as having a SPN or that following biopsy that the lesion now identified as benign, malignant, or carcinoma in situ was originally identified was linked to a single pulmonary nodule (SPN). The intent of the proposed modifications is to (1) add specificity to the classification to identify a growing number of patients with small peripheral lung lesion(s), also referred to as a single pulmonary nodule and (2) facilitate tracking to support longitudinal research. With the improvement in technologies to detect the SPN improved accuracy of ICD-9-CM diagnosis codes can contribute to clinical decision-making regarding early detection, treatment and management of patients with lung cancer. Current trends in screening patients for lung cancer and SPN identified incident to another medical service represent an opportunity to treat patients with lung cancer earlier and thereby reduce the incidence of death due to lung cancer.

Currently the only reference in the ICD-9-CM non-specific lesions in the lung is “coin lesion” which is indexed to code 793.1, Nonspecific (abnormal) findings on radiological and other examination of lung field. The term “single pulmonary nodule” is not indexed. Proposal 1 recommends an expansion of code 793.1, Nonspecific (abnormal findings on radiological and other examination of body structure, Lung field, to specially identify the unique peripherally located smaller pulmonary lesions, or solitary pulmonary nodule(s).

Proposal 2 recommends the addition of detail for further characterization of the single pulmonary nodule as malignant, benign or carcinoma in situ. Vantage View believes that unique codes should be developed for these prevalent lung lesions to better understand their role in developing into malignant lung cancer, and how the SPN are best staged and treated.
TABULAR MODIFICATIONS

**Option 1**

793 Nonspecific abnormal findings on radiological and other examination of body structure

793.1 Lung field

Delete Coin lesion lung

Delete Shadow, lung

New Code 793.11 Solitary pulmonary nodule, sub-segmental branch of the bronchial tree

Delete Coin lesion lung

New Code 793.12 Solitary pulmonary nodule, sub-segmental branch of the bronchial tree, more than one finding on radiological and other examination of lung field

New Code 793.19 Other nonspecific abnormal finding of lung field

Shadow, lung

**Option 2**

162 Malignant neoplasm of trachea, bronchus, and lung

New code 162.7 Malignant neoplasm of sub-segmental branch of bronchial tree, solitary pulmonary nodule(s)

New subcategory 212.3 Bronchus and lung

Delete Carina

Delete Hilus of lung

New code 212.31 Benign neoplasm of sub-segmental branch of bronchial tree, solitary pulmonary nodule(s)

New code 212.39 Benign neoplasm of other site in bronchus and lung

Carina

Hilus of lung

231 Carcinoma in situ of respiratory system

New subcategory 231.2 Carcinoma in situ of bronchus and lung

New code 231.21 Carcinoma in situ sub-segmental branch of bronchial tree, solitary pulmonary nodule(s)

New code 231.29 Carcinoma in situ of other site of bronchus and lung

235 Neoplasm of uncertain behavior of digestive and respiratory systems

New subcategory 235.7 Trachea, bronchus, and lung

New code 235.71 Neoplasm of uncertain behavior of sub-segmental branch of bronchial tree, solitary pulmonary nodule(s)
| New code | 235.79 Neoplasm of uncertain behavior of other site in bronchus, and lung |
Wandering

Autism spectrum disorders (ASDs) affect 1 in 110 children and 1 in 83 children have an intellectual disability in the United States. \(^1\), \(^2\) Children and adults with ASDs and other developmental disabilities (DD) are at higher risk of wandering off than children and adults without these disorders. According to Autism Wandering Awareness Alerts Responder Education AWAARE, in a 2007 National Autism Association Survey, 92% of parents reported that their children with ASD had wandered from a safe environment one or multiple times. \(^3\) A survey of service providers found that 75% of children with intellectual disabilities were reported to have challenging behaviors associated with wandering. \(^4\)

Although not every person with ASD/DD or other disorders may have impairments in safety monitoring, for those individuals that are susceptible to wandering into dangerous situations, the consequences can be devastating.

Wandering places children and adults with ASD/DD or other disorders in harmful and potentially life-threatening situations—making this an important safety issue for individuals affected, their families and caregivers. There are reports of tragic deaths of children and adults diagnosed with an ASD associated with wandering off \(^5\), \(^6\). Although available data are very limited, the majority of wandering fatalities associated with autism are attributed to drowning. Wandering occurs among persons with developmental disabilities and may expose a person to dangerous situations (e.g. open bodies of water, traffic). \(^4\), \(^7\)

Despite reports of concern from caregivers and some studies, there are limited data on population-based estimates and predictors of risk for wandering associated with ASD/DD. \(^4\)

Diagnostic codes for wandering associated with ASDs and wandering associated with other developmental disabilities would promote (1) better data collection for and understanding of this behavior (2) prompt important safety discussions between healthcare providers, caregivers, and the person with the disability to the full extent possible. Better data should help to increase awareness and action among first responders, school administrators and residential facility administrators to recognize and understand the wandering and develop proper emergency protocols and response while supporting self-determination principles.

Currently there are no unique codes to capture wandering associated with ASDs, DDs, or other conditions such as Alzheimer’s disease. The concept of wandering was added to ICD-9-CM effective with the October 1, 2000 update as an inclusion term under code 294.11, Dementia in conditions classified elsewhere with behavioral disturbance. CDC (National Center on Birth Defects and Developmental Disabilities) has requested that new codes be created to better identify children and adults that wander associated with ASDs, DDs, and other conditions. The additional code would not be a component of the ASD or other DD diagnoses, but could be used in conjunction with other applicable codes.

References:

TABULAR MODIFICATIONS

Option 1:

799.8 Other ill-defined conditions

799.83 Wandering in diseases classified elsewhere

Code first underlying disorder such as:
  autism or pervasive developmental disorder (299.0-299.9)
  intellectual disabilities (317-319)

Option 2:

V40 Mental and behavioral problems

New subcategory V40.3 Other behavioral problems

New code V40.31 Wandering

Code first underlying disorder such as:
  autism or pervasive developmental disorder (299.0-299.9)
  intellectual disabilities (317-319)

New code V40.39 Other specified behavioral problem
Acute Kidney Diseases and Related Disorders

Assignment of certain of the existing ICD-9-CM codes for acute renal (kidney) failure requires that providers document a specific pathologic diagnosis in order to assign a diagnosis code. This is contrast to clinical practice, where impairment in kidney function is first recognized, and then a diagnosis is made. Acute kidney disease (AKD) and related disorders are a global problem. It is common and occurs in the community, in the hospital where it is common on medical, surgical, pediatric, and oncology wards, and in ICUs. It imposes a heavy burden of illness, it is a predictor of immediate and long-term adverse outcomes, and has an associated high cost with its requirements for intensive evaluation and management. Individuals with chronic kidney disease (CKD) are especially susceptible to AKD which, in turn, may act as a promoter of progression of the underlying CKD. AKD is amenable to early detection and potential prevention, and therefore important to be recognized by clinicians and health care systems. There is a relationship between CKD, AKD and acute kidney injury (AKI). AKI is a subset of AKD, and both AKI and AKD can occur in patients with CKD. AKI, as well as AKD without AKI, can be superimposed upon CKD. Individuals without AKI, AKD, or CKD have no known kidney disease. AKI is diagnosed based on a specific measured increase in serum creatinine over time, or a specific decrease in urine volume over time.

AKI, AKD and CKD can be identified irrespective of etiology. CKD, AKI and AKD can all encompass various etiologies. For example, a patient may have AKI or AKD that is secondary to acute tubular necrosis, acute interstitial nephritis, acute glomerular diseases, prerenal azotemia, or acute postrenal obstructive nephropathy. The patient may also have an underlying chronic disease, which may have a known etiology, such as diabetes or IgA nephropathy. AKI and AKD can also be secondary to events, such as trauma or obstetric emergencies. The manifestations and clinical consequences of AKI are generally similar regardless of etiology. Even mild, reversible, AKI has important clinical consequences, including increased risk of death. As such, diagnostic codes for AKD and AKI, similar to CKD, should be separated from those for specific etiologies or circumstances. AKI is classified into stages based on rate of change of kidney function or magnitude of urine output. Each stage has a different clinical action plan associated with it.

The current codes for acute renal failure (584) are primarily based on etiology and pathology. However, as described above, that is in contrast to clinical practice and recent clinical practice guidelines, and is a source of confusion. The National Kidney Foundation has proposed revisions to the ICD-9-CM classification system that reflect the current understanding and definitions of acute kidney disease (AKD) and acute kidney injury (AKI), as extensively reviewed and summarized in the Kidney Disease International Global Outcomes (KDIGO) evidence based guidelines on acute kidney injury (AKI).
TABULAR MODIFICATIONS

Revise 584 Acute renal failure kidney disease and disorders and acute tubular-interstitial diseases

New code 584.1 Acute kidney injury

New code 584.10 Acute kidney injury, unspecified stage
Acute kidney injury (nontraumatic), NOS
Acute renal disease
Acute renal insufficiency

New code 584.11 Acute kidney injury, Stage 1 (mild)
New code 584.12 Acute kidney injury, Stage 2 (moderate)
New code 584.13 Acute kidney injury, Stage 3 (severe)

New code 584.2 Acute kidney disease without AKI

Use additional code for renal dialysis status (V45.11), if applicable

Add 584.5 Acute kidney failure with lesion of tubular necrosis

Excludes:
- following labor and delivery (669.3)
- posttraumatic (958.5)
- that complicating:
  - abortion (634-638 with .3, 639.3)
  - ectopic or molar pregnancy (639.3)

Add 584.6 Acute kidney failure with lesion of renal cortical necrosis

Excludes:
- following labor and delivery (669.3)
- posttraumatic (958.5)
- that complicating:
  - abortion (634-638 with .3, 639.3)
  - ectopic or molar pregnancy (639.3)

Add 584.7 Acute kidney failure with lesion of renal medullary [papillary] necrosis

Excludes:
- following labor and delivery (669.3)
- posttraumatic (958.5)
- that complicating:
  - abortion (634-638 with .3, 639.3)
  - ectopic or molar pregnancy (639.3)

Revise 584.9 Acute renal failure kidney injury or disease, unspecified
Delete Acute kidney injury (nontraumatic)
593 Other disorders of kidney and ureter
   593.9 Unspecified disorder of kidney and ureter

Delete  Acute renal disease
Delete  Acute renal insufficiency
**Smoke inhalation**

A proposal originally presented at the ICD-9-CM Coordination and Maintenance (C&M) meeting in March 2010 recommended changing the default for smoke inhalation from code 987.9, Toxic effect of unspecified gas, fume, or vapor to a code within either category 506, Respiratory conditions due to chemical fumes and vapors, or 508, Respiratory conditions due to other and unspecified external agents. The axes of classification for these categories are not consistent. Category 506 includes codes for specific types of respiratory conditions, and category 508 is broken down based on the external agent. Both categories require an external cause of injury code (E code) to identify the cause (the source of the fumes and vapors).

Comments received from the March C&M meeting recommended creating a new code in category 508, for smoke inhalation NOS as this category does not identify the type of agent causing the smoke. It was also recommended to have an excludes note for smoke inhalation from a chemical agent (to category 506).

In addition, to be consistent with the sequencing rules for other poisoning and toxic effect codes, we are proposing to add a use additional code note under categories 506 and 508 to help guide coders in use of these codes in conjunction with the associated specific respiratory conditions. This note would apply to all secondary respiratory codes, including acute respiratory failure.

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>506 Respiratory conditions due to chemical fumes and vapors</td>
<td>Add Use additional code to identify associated respiratory conditions, such as: acute respiratory failure (518.81)</td>
</tr>
<tr>
<td>508 Respiratory conditions due to other and unspecified external agents</td>
<td>Add Use additional code to identify associated respiratory conditions, such as: acute respiratory failure (518.81)</td>
</tr>
<tr>
<td>508.2 Respiratory conditions due to smoke inhalation</td>
<td>Add Smoke inhalation NOS</td>
</tr>
<tr>
<td></td>
<td>Add Excludes: smoke inhalation due to chemical fumes and vapors (506.9)</td>
</tr>
</tbody>
</table>

**TOXIC EFFECTS OF SUBSTANCES CHIEFLY NONMEDICINAL AS TO SOURCE (980-989)**

Add Excludes: respiratory conditions due to smoke inhalation NOS (508.2)

The above proposal will also require the following index entry to be revised

Inhalation

Revise smoke 987.9 508.2
Positive finding for Interferon Gamma Release Assays (IGRA)

Tuberculosis (TB) is caused by the bacteria *Mycobacterium tuberculosis* and is an airborne disease that is spread from person to person via respiratory droplets. Thus identification of TB infected individuals is a major health concern in hospital and community infection control efforts. Many infected individuals remain asymptomatic with latent TB but can develop the disease months or years after exposure to the bacteria. These patients then become a source of TB transmission. The CDC estimates that 9-14 million US residents are infected with TB in its latent (non-symptomatic) phase.

Before 2001, the tuberculin skin test (TST) was the only available immunologic test for *Mycobacterium tuberculosis* infection approved in the United States. These have been used worldwide for more than a century in diagnosing both latent and active tuberculosis. A valid TST requires proper administration method, patients return to a health-care provider for test reading. Inaccuracies and bias exist in reading the test and false-positive TSTs can result from contact with nontuberculous mycobacteria or vaccination with Bacille Calmette-Guerin (BCG).

Recognition that interferon gamma (IFN-\(\gamma\)) played a critical role in regulating cell-mediated immune responses to *M. tuberculosis* infection led to the development of a blood test for the detection of *M. tuberculosis* infection by interferon gamma release assays (IGRAs). IGRAs detect sensitization to *M. tuberculosis* by measuring IFN-\(\gamma\) release in response to antigens representing *M. tuberculosis*. In 2001, the QuantiFERON-TB test (QFT) became the first IGRA approved by the Food and Drug Administration (FDA) as an aid for diagnosing *M. tuberculosis* infection. FDA approval was granted October 10, 2007 (P010033/S011) as a supplement to the original PMA application that was approved in December 2001. Another IGRA, the TSpot TB test, was granted approval by FDA on August 1, 2008.

In June 2010, CDC published “Updated Guidelines for Using Interferon Gamma Release Assays to Detect Mycobacterium tuberculosis Infection — United States, 2010. Centers for Disease Control and Prevention, MMWR 2010;59/RR-5”. These guidelines stated that “TSTs and IGRAs (QFT-G, QFT-GIT, and T-Spot) may be used as aids in diagnosing *M. tuberculosis* infection. They may be used for surveillance purposes and to identify persons likely to benefit from treatment”.

Currently there is no ICD-9-CM diagnosis code for positive finding for interferon gamma release assays (IGRA) for tuberculosis infection. Creating a unique ICD-9-CM diagnosis code for this test would improve diagnosis, increase recognition and ultimately advance the management of tuberculosis. The only ICD-9-CM code available for diagnosis of tuberculosis infection is for the tuberculin skin test, 795.5, Nonspecific reaction to tuberculin skin test without active tuberculosis.

**TABULAR MODIFICATIONS**

<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>795</td>
<td>Other and nonspecific abnormal cytological, histological, immunological and DNA test findings</td>
</tr>
<tr>
<td>795.5</td>
<td>Nonspecific reaction to tuberculin skin test without active tuberculosis</td>
</tr>
<tr>
<td></td>
<td>Excludes: nonspecific reaction to cell mediated immunity measurement of gamma interferon antigen response without active tuberculosis (795.72)</td>
</tr>
<tr>
<td>795.7</td>
<td>Other nonspecific immunological findings</td>
</tr>
<tr>
<td>New code</td>
<td>795.72</td>
</tr>
<tr>
<td>Add</td>
<td>Excludes: nonspecific reaction to tuberculin skin test without active tuberculosis (795.5)</td>
</tr>
<tr>
<td>Add</td>
<td>positive tuberculin skin test (795.5)</td>
</tr>
</tbody>
</table>

23
Atypical femoral fracture

The American Society for Bone and Mineral Research (ASBMR) is requesting changes to allow better coding of atypical femoral fractures. In recent years, there have been an increasing number of reports of atypical fractures of the subtrochanteric region of the hip and the femoral shaft in patients receiving long-term bisphosphonate therapy. A multi-disciplinary, international task force convened by the ASBMR to address key questions related to case definition, epidemiology and diagnostic imaging recommended that a specific ICD code be developed to assist in case finding, and advancing optimal surgical and medical management of these fractures.

According to the case definition developed by the ASBMR Task Force, in addition to their location in the subtrochanteric region of the hip or the femoral shaft, atypical femur fractures may be complete and extend across both cortices or incomplete, involving only the lateral cortex. They have several additional distinctive features:

1) transverse or short oblique orientation
2) association with minimal or no trauma
3) lack of comminution
4) cortical thickening that is either generalized or localized at the lateral cortex of the fracture site
5) periosteal reaction of the lateral cortex
6) medial spike when the fracture is complete
7) association with bisphosphonates and other medications, such as glucocorticoids

Currently ICD-9-CM does not have a specific diagnosis code that identifies fractures that have the atypical features, noted above. The term atypical is not used as a descriptor, in either the tabular or index, for fractures. Fractures of the femur are coded to either pathological (733.14-733.15), stress (733.96-733.97) or traumatic (categories 820 or 821). The lack of codes specific to atypical fractures creates difficulty for physicians and researchers trying to determine the true incidence of these fractures and their relationship to medications such as various bisphosphonates and glucocorticoids. The prevailing opinion is that these fractures are a form of stress fracture associated with osteoporosis and are usually non-traumatic or spontaneous or are associated with very minor injuries.

The ASBMR requested a specific ICD code for atypical femur fractures, specifically by expanding or adding to category 733. Other disorders of bone and cartilage rather than in the traumatic fractures category. It was desired to locate this new code with stress fractures, however, there is no room to expand at or near code 733.96 or 733.97, Stress fracture of shaft of femur, as they requested. There is also no room to create codes that reflect the distinctive atypical fracture features.

There is room to add a new code to subcategory 733.1, Pathologic fracture. It should be noted that there is an excludes note at that subcategory for stress and traumatic fractures. Though there is room to create a new code for atypical fractures in category 827, Other, multiple, and ill-defined fractures of lower limb, this option was rejected since these fractures are usually stress or pathologic.

There is also room to create a code for long term (current) use of bisphosphonates at V58.68. This may be useful data for epidemiological analysis. Additionally, external cause of injury codes for adverse effect of bisphosphonates are available (E933-E933.7) if there is any documentation in the record linking the fracture to the therapeutic use of these drugs. These were created a few years ago to allow coding osteonecrosis of the jaw due to use of bisphosphonates.

The proposal was also reviewed by the American Academy of Orthopaedic Surgeons (AAOS) who favored creating a new code at subcategory 733.1, Pathologic fracture. They stated that though these fractures are pathological (e.g.similar to fracture associated with osteomalacia) and/or stress related based on altered mineral-metabolism, the term atypical might be applied to many other, non-simple fracture patterns. This can be reviewed further.
### TABULAR MODIFICATIONS

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>733</td>
<td>Other disorders of bone and cartilage</td>
</tr>
<tr>
<td>733.1</td>
<td>Pathologic fracture</td>
</tr>
<tr>
<td>733.17</td>
<td>Atypical fracture of the subtrochanteric region and femoral shaft</td>
</tr>
<tr>
<td>Add</td>
<td>Excludes: pathologic fracture of neck of femur (733.14)</td>
</tr>
<tr>
<td>Add</td>
<td>Pathologic fracture of other specified part of femur (733.15)</td>
</tr>
<tr>
<td>V58</td>
<td>Encounter for other and unspecified procedures and aftercare</td>
</tr>
<tr>
<td>V58.6</td>
<td>Long-term (current) drug use</td>
</tr>
<tr>
<td>New code</td>
<td>V58.68</td>
</tr>
</tbody>
</table>
Severely calcified coronary lesions

Jeff Chambers, M.D. has submitted a proposal requesting a unique diagnosis code, in both ICD-9-CM and ICD-10-CM, to describe severely calcified coronary lesions. This will allow the ability to distinguish this coronary lesion from other ischemic coronary lesions and better track statistics relevant to the surgical and medical management of the disease.

Calcium is sometimes deposited in the coronary arteries and can be detected both by x-ray during coronary angiography and with intravascular ultrasound. Calcified lesions are more difficult to treat with angioplasty and stenting because the calcium deposits may block stents from reaching the desired location and may prevent the stent from fully expanding to the optimal size. Research has also shown that an increased amount of calcium deposits leads to a higher incidence of major adverse cardiac events, in particular the rate of non-Q wave myocardial infarction, when compared to non-calcified (e.g., lipid rich plaque) lesions.

There are no diagnosis codes currently available to describe severely calcified coronary lesions. There are diagnosis codes for chronic total occlusions (414.2, Chronic total occlusion of coronary artery and 440.4, Chronic total occlusion of artery of the extremities) however; chronic total occlusions are different than severely calcified lesions. There is a diagnosis code for coronary atherosclerosis due to lipid rich plaque (414.3, ), however lipid rich plaque composition is very different from calcified plaque. Finally, there are two general diagnosis codes for chronic ischemic heart disease, 414.8 (Other specified forms of chronic ischemic heart disease) and 414.9, chronic ischemic heart disease, unspecified, however, these codes are too general to capture disease incidence associated with severely calcified coronary lesions (Type B Lesion classified by ACC/AHA, 1998) comprised of calcium deposits within the artery.

With the advent of interventional coronary techniques, tracking incidence of and other data associated with severely calcified coronary lesions is more important than ever. Additional time (physician, anesthesia, Cath Lab /procedure room) as well as physician skill is required when dealing with severely calcified lesions. Many interventional procedures, such as angioplasty and stent placement are not possible if the severely calcified coronary lesion cannot be crossed. In these cases, the transluminal procedure is discontinued. The patient may then have to be medically managed or a more invasive procedure, such as CABG may be required. Furthermore, most FDA approved drug eluting stent trials specifically exclude patients with severely calcified coronary lesions, further narrowing treatment options for these patients. Without a specific diagnosis code for this condition, hospital and physician coders are not able to identify such a condition that complicates immediate and ongoing patient care.

The requestor indicated that the finding of severely calcified coronary lesion(s) is typically documented by Interventional Cardiologists in their procedure notes and is tracked by the American College of Cardiology national data base, the PCI registry. It is being proposed to introduce a unique code for this condition as follows:

<table>
<thead>
<tr>
<th>TABULAR MODIFICATIONS</th>
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</thead>
<tbody>
<tr>
<td>414 Other forms of chronic ischemic heart disease</td>
</tr>
<tr>
<td>New code 414.4 Coronary atherosclerosis due to severely calcified coronary lesion</td>
</tr>
<tr>
<td>Add Code first coronary atherosclerosis (414.00-414.07)</td>
</tr>
</tbody>
</table>
Hepatopulmonary Syndrome

Hepatopulmonary Syndrome (HPS) is a complication of liver disease. It involves pulmonary microvascular dilation, with intrapulmonary shunting resulting in hypoxemia. The diagnosis may be made with contrast echocardiography, injecting agitated saline with microbubbles, that opacify the right ventricle, and if intrapulmonary shunting is present, opacify the left ventricle at least three heartbeats after the right. However, presence of other cardiovascular disease can make diagnosis difficult.

HPS is usually found in patients with chronic liver disease, particularly cirrhosis. Prevalence estimates range from 5 to 32% of chronic liver disease patients. However, it may also occur with acute ischemic hepatitis and with non-cirrhotic portal hypertension. HPS occurs in both pediatric and adult patients.

Patients with HPS and hypoxemia will often require oxygen supplementation. The only treatment effective long term for HPS related to chronic liver disease is liver transplant.

A specific code for HPS would ensure accurate reporting of the condition, provide data for research, and help reflect severity of illness and risk of mortality for this patient population. A request for this has been received from Northwestern Memorial Hospital, in Chicago, IL.

References:

TABULAR MODIFICATIONS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>572</td>
<td>Liver abscess and sequelae of chronic liver disease</td>
</tr>
<tr>
<td>572.8</td>
<td>Other sequelae of chronic liver disease</td>
</tr>
<tr>
<td>Add</td>
<td>Excludes: hepatopulmonary syndrome (573.5)</td>
</tr>
<tr>
<td>573</td>
<td>Other disorders of liver</td>
</tr>
<tr>
<td>New code</td>
<td>573.5</td>
</tr>
</tbody>
</table>

Code first underlying liver disease, such as:
- Alcoholic cirrhosis of liver (571.2)
- Cirrhosis of liver without mention of alcohol (571.5)
Infection Following Transfusion

Previously, proposals to address infections associated with transfusions at subcategory 999.3 have been presented in Sept. 2009 and Sept. 2010. However, concerns have been raised previously, initially related to the existing use additional code note at 999.3, that it could imply that this code should precede the code for HIV disease. Later concerns were raised about how this code should be used, whether just for acute cases, or for both acute and chronic cases. It was noted that these complication codes are primarily used for acute cases, rather than chronic or longer term.

As previously described, there are a number of infectious organisms (including bacteria, viruses, and parasites, among others) that may be transmitted through transfusion of blood or blood products (which include whole blood, RBCs, plasma, and platelets, among others).

A guideline could be created to specify that this code should be used for acute cases, not for chronic cases. Other notes could also be created to clarify that. One option would be to create a specific code for “Acute infection following transfusion, infusion, or injection of blood and blood products.”

Currently there are no specific ICD-9-CM diagnosis codes for infections following transfusion. A request was received from the Food and Drug Administration (FDA) Center for Biologics Evaluation and Research (CBER) to create a unique code for infection following transfusion, as proposed here.

References
Canadian transfusion safety surveillance system (http://www.phac-aspc.gc.ca/hcai-iamss/tti-it/index-eng.php)
TABULAR MODIFICATIONS

Option 1

042 Human immunodeficiency virus [HIV] disease

Add Use additional code, if applicable, to identify infection following transfusion, infusion, or injection of blood and blood products (999.33)

999 Complications of medical care, not elsewhere classified

999.3 Other infection

Add Code first, if applicable, human immunodeficiency virus (HIV) disease (042)

New code 999.33 Infection following transfusion, infusion, or injection of blood and blood products

Revise 999.39 Infection following other infusion, injection, transfusion, or vaccination

Option 2

999 Complications of medical care, not elsewhere classified

999.3 Other infection

New code 999.33 Acute infection following transfusion, infusion, or injection of blood and blood products
Postoperative Respiratory Failure

Respiratory failure—frequently defined by the need for intubation or prolonged mechanical ventilation—is a relatively common postoperative complication, affecting an estimated 0.8 to 1.2% of all patients undergoing elective non-thoracic surgical procedures, or approximately 32,000 cases annually in the US. Postoperative respiratory failure (PRF) also is associated with increased use of resources (e.g., hospitalization costs and length of stay) and a seven-fold increase in mortality. The risk of PRF can be reduced, but not eliminated, through evidence-based interventions such as preoperative smoking cessation and perioperative lung expansion exercises. As a result, PRF has become a focus of several organizations that measure quality of care, including the Agency for Healthcare Research and Quality, the Surgical Quality Improvement Program and proposed by the Center for Medicare & Medicaid Services for its programs.

AHRQ identifies PRF based on existing diagnosis code 518.81 (“acute respiratory failure”) or 518.84 (“acute and chronic respiratory failure”), or procedure codes for endotracheal intubation (96.04, dated one or more days after a major operating room [OR] procedure) or continuous mechanical ventilation (96.70 [unspecified duration] dated two or more days after a major OR procedure, or 96.72 [duration 96 consecutive hours or more] dated one or more days after a major OR procedure). Respiratory failure that is specifically described as “due to trauma, surgery or shock” is indexed to 518.5 (“pulmonary insufficiency following trauma and surgery”). However, this code is much less specific than the codes for “acute respiratory failure” (518.81) and “acute and chronic respiratory failure” (518.84). For example, other conditions indexed to 518.5 include “shock lung,” “drowned lung,” “acute pulmonary (respiratory) insufficiency following shock (surgery)(trauma),” “wet lung syndrome (adult),” “adult respiratory distress syndrome following trauma or surgery,” and “acute idiopathic pulmonary congestion.” Therefore, this code identified many patients who do not have acute respiratory failure, but instead have less severe respiratory complications that may only require supplemental oxygen or intensified observation.

AHRQ proposes that unique codes be added at 518.5 to distinguish postoperative acute respiratory failure from less severe respiratory complications of surgery or trauma, within the existing axis of ICD-9-CM codes. Additionally, current indexing of “shock lung” to 518.5, when the shock in question is unrelated to trauma or surgery, is confusing and contradicts the title of code 518.5 (“...following trauma and surgery”). In common usage, the term “shock lung” is used interchangeably with “adult respiratory distress syndrome” or “ARDS” in patients with nontraumatic shock, such as hemorrhagic shock due to gastrointestinal bleeding.

TABULAR MODIFICATIONS

518 Other diseases of lung

518.5 Pulmonary insufficiency following trauma and surgery

New code

518.51 Acute respiratory failure following trauma and surgery
Respiratory failure, not otherwise specified, following trauma and surgery

Excludes:

Acute respiratory failure in other conditions (518.81)

518.52 Other pulmonary insufficiency, not elsewhere classified, following trauma and surgery

Adult respiratory distress syndrome
Pulmonary insufficiency following:
surgery
trauma
Shock lung related to trauma and surgery

Excludes: adult respiratory distress syndrome associated with other conditions (518.82)
pneumonia:
  aspiration (507.0)
  hypostatic (514)
  shock lung, not related to trauma or surgery (518.82)

New code

518.53 Acute and chronic respiratory failure following trauma and surgery

Excludes:

Acute and chronic respiratory failure in other conditions (518.84)

518.8 Other diseases of lung

Revise

518.81 Acute respiratory failure
Respiratory failure NOS

Excludes: acute and chronic respiratory failure (518.84)
  acute respiratory distress (518.82)
  chronic respiratory failure (518.83)
  respiratory arrest (799.1)
  respiratory failure, newborn (770.84)
  acute respiratory failure following trauma and surgery (518.51)

Revise

518.82 Other pulmonary insufficiency, not elsewhere classified

Acute respiratory distress
Acute respiratory insufficiency
Adult respiratory distress syndrome NEC

Excludes: adult respiratory distress syndrome associated with trauma or surgery (518.52)
pulmonary insufficiency following trauma or surgery (518.52)
respiratory distress:
  NOS (786.09)
  newborn (770.89)
  syndrome, newborn (769)

  shock lung (518.5)
Revise 518.84 Acute and chronic respiratory failure
  Acute on chronic respiratory failure
  Excludes: acute and chronic respiratory failure following trauma or surgery (518.54)
**Postoperative Shock**

Postoperative shock is a complication that often arises after major surgery, and is therefore referred to as “postoperative shock” in this setting. Shock is not a disease, but a physiologic state characterized by decreased perfusion (i.e., hypoperfusion) of body tissues, resulting in decreased oxygen delivery and local imbalance between oxygen delivery and consumption. The effects of oxygen deprivation are initially reversible, but rapidly become irreversible: cell death, end-organ injury, multi-system organ failure, death. Manifestations of shock include low mean blood pressure (hypotension), tachycardia (in response to hypotension), cool and clammy (poorly perfused) skin, altered mental status, and decreased urine output (oliguria).5

In both surgical and nonsurgical patients, shock has several fundamentally different causes or mechanisms:

1. Hypovolemic shock (785.59) is attributable to loss of intravascular volume, which can result from either hemorrhage or severe dehydration. In the setting of trauma, the term “traumatic shock” (985.4) is commonly used.
2. Cardiogenic shock (785.51) is attributable to cardiac pump failure, which can result from myocardial infarction or systolic heart failure.
3. Distributive shock is attributable to dilation of systemic arterioles (vasodilation) with decreased vascular resistance. The most common subtypes are septic shock (785.52), due to severe infection with end-stage systemic inflammatory response syndrome, and anaphylactic shock (995.0), due to a severe allergic reaction.

Postoperative patients can experience any of these phenomena. For example, internal bleeding from poor surgical technique or disseminated intravascular coagulation may lead to hemorrhagic shock, which is treated with blood products. Postoperative volume shifts, also known as “third spacing,” may lead to nonhemorrhagic hypovolemic shock, which is treated with intravenous fluids. Postoperative myocardial infarction may lead to cardiogenic shock, which is treated with inotropic agents to improve cardiac output. Postoperative infections originating in the wound, lungs, or blood/vascular catheter may lead to septic shock, which is treated with antibiotics and supportive care. In addition, different types of shock can coexist in postoperative patients. For example, patients with septic shock often have a hypovolemic component (due to vomiting and diarrhea), a cardiogenic component (due to myocardial dysfunction), and a distributive component (due to inflammation-related changes in vascular resistance and permeability).

Despite this complex clinical picture, most forms of postoperative shock are included at code 998.0 which interferes with national and regional efforts to identify patients who experience postoperative sepsis with shock, which is a particularly important postoperative complication. AHRQ has requested that unique codes be created to describe specific types or mechanisms of postoperative shock. The proposed coding structure is exactly parallel to the existing coding structure for “shock without mention of trauma” (785.5x). A less preferred option would be to add a “use additional code” note at 998.0 to require a code from subcategory 785.5x to describe the type of postoperative shock.
ICD-9-CM Coordination and Maintenance Committee Meeting  
March 9-10, 2011

References:
1. Galeski D. Shock in adults: Types, presentation, and diagnostic approach. In www.uptodate.com, Section Editor

TABULAR MODIFICATIONS

Option 1:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>998</td>
<td>Other complications of procedures, not elsewhere classified</td>
</tr>
</tbody>
</table>

<table>
<thead>
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<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>998.0</td>
<td>Postoperative shock</td>
</tr>
<tr>
<td></td>
<td>Collapse, not otherwise specified, during or resulting from a surgical procedure</td>
</tr>
<tr>
<td></td>
<td>Shock (endotoxic)(hypovolemic)(septic), during or resulting from a surgical procedure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>998.00</td>
<td>Postoperative shock, unspecified</td>
</tr>
<tr>
<td></td>
<td>Collapse, not otherwise specified, during or resulting from a surgical procedure</td>
</tr>
<tr>
<td></td>
<td>Failure of peripheral circulation (postoperative)</td>
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</table>

<table>
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<th>Description</th>
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<tbody>
<tr>
<td>998.01</td>
<td>Postoperative shock, cardiogenic</td>
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<tr>
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<th>Description</th>
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</thead>
<tbody>
<tr>
<td>998.02</td>
<td>Postoperative shock, septic</td>
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</tbody>
</table>

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<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>998.09</td>
<td>Postoperative shock, other</td>
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<tr>
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<td>Postoperative hypovolemic shock</td>
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</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>998.09</td>
<td>Postoperative shock, other</td>
</tr>
<tr>
<td></td>
<td>Postoperative hypovolemic shock</td>
</tr>
</tbody>
</table>
Drug-Induced Pancytopenia

There have been a number of changes related to pancytopenia in ICD-9-CM. However, the issue has been raised that at this time, drug induced pancytopenia would be coded to 284.89, Other specified aplastic anemias. However, pancytopenia related to drugs would not necessarily be related to aplastic anemia. To better handle such cases, it is proposed to create a specific code, 284.11, Drug induced pancytopenia, although aplastic anemia due to drugs should still be excluded to code 284.89. At the same time, it is proposed to create a code 284.19, Other pancytopenia. This issue was raised related to questions to the Editorial Advisory Board for Coding Clinic.

TABULAR MODIFICATIONS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>284</td>
<td>Aplastic anemia and other bone marrow failure syndromes</td>
</tr>
<tr>
<td>284.1</td>
<td>Pancytopenia</td>
</tr>
<tr>
<td></td>
<td>Excludes:</td>
</tr>
<tr>
<td></td>
<td>pancytopenia (due to) (with):</td>
</tr>
<tr>
<td></td>
<td>drug induced (284.89)</td>
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<tr>
<td></td>
<td>Delete</td>
</tr>
<tr>
<td>New code</td>
<td>284.11</td>
</tr>
<tr>
<td></td>
<td>Excludes: aplastic anemia due to drugs (284.89)</td>
</tr>
<tr>
<td>New code</td>
<td>284.19</td>
</tr>
</tbody>
</table>
Hypertrophic Cardiomyopathy

Hypertrophic cardiomyopathy can have two levels of manifestation, obstructive or nonobstructive. Whether or not it is obstructive can impact the need for different medical or surgical treatments.

In ICD-9-CM, code 425.1 is Hypertrophic obstructive cardiomyopathy. Hypertrophic cardiomyopathy that is nonobstructive, or not described as obstructive, is currently coded to 425.4, Other primary cardiomyopathies.

Jerre F. Lutz, MD, of the Emory Clinic, has proposed restructuring 425.1 as a subcategory, and moving hypertrophic cardiomyopathy not specified as obstructive to this subcategory, giving it a new code.

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>425 Cardiomyopathy</th>
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</thead>
<tbody>
<tr>
<td>Revise 425.1 Hypertrophic obstructive cardiomyopathy</td>
</tr>
<tr>
<td>Delete Hypertrophic subaortic stenosis (idiopathic)</td>
</tr>
<tr>
<td>Add Excludes: ventricular hypertrophy (429.3)</td>
</tr>
<tr>
<td>New code 425.11 Hypertrophic obstructive cardiomyopathy</td>
</tr>
<tr>
<td>New code 425.12 Other hypertrophic cardiomyopathy</td>
</tr>
<tr>
<td>425.4 Other primary cardiomyopathies</td>
</tr>
<tr>
<td>Cardiomyopathy: hypertrophic</td>
</tr>
<tr>
<td>Delete nonobstructive</td>
</tr>
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</table>
Acute Interstitial Pneumonitis

Acute interstitial pneumonitis (AIP) is a rapidly progressive form of interstitial pneumonia, with a distinct histopathology described as an organizing diffuse alveolar damage, identical to the pattern found in acute respiratory distress syndrome (ARDS) caused by sepsis and shock. The term acute interstitial pneumonitis is reserved for cases of unknown cause. Some of the cases described by Hamman and Rich in 1944 probably represented AIP; Hamman-Rich syndrome is now considered to be synonymous with AIP.

Acute interstitial pneumonitis may also be referred to as “acute interstitial pneumonia.” This topic was presented previously in September 2010 with that title. However, concerns were raised about the potential use of the term “acute interstitial pneumonia” when referring to certain bacterial pneumonias, with atypical appearance on x-rays that might be described as an interstitial process.

The term “acute interstitial pneumonia” is indexed in ICD-9-CM to code 136.3, Pneumocystosis. The histologic pattern in AIP of diffuse alveolar damage may also occur due to Pneumocystis carinii pneumonia, as well as due to a number of other potential causes. However, at this time, based on the 2001 consensus statement of the American Thoracic Society and the European Respiratory Society, the term “acute interstitial pneumonia” should be reserved for cases of unknown cause, and thus represents a specific idiopathic interstitial pneumonia. To avoid confusion, the indexing for the term “acute interstitial pneumonia” will be updated, to reflect the various possible meanings.

The American Thoracic Society (ATS) and the American College of Chest Physicians (ACCP) have requested creation of a specific code for AIP, as well as for a number of other interstitial lung diseases. AIP has a different course, and a less favorable prognosis than other idiopathic interstitial pneumonias, and thus needs to be distinguished from them. A specific code will facilitate epidemiological, clinical, comparative effectiveness and cost effectiveness research.

References


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TABULAR MODIFICATIONS

516  Other alveolar and parietoalveolar pneumonopathy

Revise  516.3  Idiopathic fibrosing alveolitis interstitial pneumonia

New code  516.33  Acute interstitial pneumonitis

Hamman Rich syndrome

Excludes: Pneumocystis pneumonia (136.3)

518  Other diseases of lung

518.8  Other diseases of lung

518.82  Other pulmonary insufficiency, not elsewhere classified

Add  Excludes:  acute interstitial pneumonitis (516.33)

INDEX MODIFICATIONS

Pneumonia...

... interstitial 516.8

...  acute 136.3

Revise  due to Pneumocystis (carinii) (jiroveci) 136.3

Add  meaning:

acute interstitial pneumonitis (516.33)

atypical pneumonia – see Pneumonia, atypical

bacterial pneumonia – see Pneumonia, bacterial
**Pneumothorax and Air Leak**

The term "postoperative air leak" is currently indexed in ICD-9-CM to code 512.1, iatrogenic pneumothorax. However, concern has been raised about this, as one can have a postoperative air leak without significant air in the pleural space, since chest tubes are often placed following procedures where this is a risk. A specific code for postoperative air leak has been proposed by the American College of Surgeons, as well as additional specific codes as further described.

There is also the issue of a persistent air leak which is not postoperative, such as when a chest tube has been placed for a primary spontaneous pneumothorax and the lung re-expands but the air leak persists. That is a relatively frequent occurrence, but the leak usually shuts off in a few days. When it persists, that is an indication for a surgical intervention, usually thoracoscopic.

Spontaneous pneumothorax may be primary, or secondary and thus related to various other conditions. It was proposed to differentiate these. Some causes of secondary pneumothorax include cystic fibrosis, spontaneous rupture of the esophagus, Marfan's syndrome, lymphangioleiomyomatosis, metastatic cancer, primary lung cancer, catamenial, pneumocystis carinii pneumonia, and eosinophilic pneumonia.
TABULAR MODIFICATIONS

Revise 512 Pneumothorax and air leak

New code 512.2 Postoperative air leak

Revise 512.8 Other spontaneous pneumothorax and air leak
Delete Pneumothorax:
Delete NOS
Delete acute
Delete chronic

New code 512.81 Primary spontaneous pneumothorax

New code 512.82 Secondary spontaneous pneumothorax

Code first underlying condition, such as:
  cancer metastatic to lung (197.0)
  catamenial pneumothorax due to endometriosis (617.8)
  cystic fibrosis (277.02)
  eosinophilic pneumonia (518.3)
  lymphangioleiomyomatosis (516.4)
  Marfan syndrome (759.82)
  pneumocystis carinii pneumonia (136.3)
  primary lung cancer (162.3-162.9)
  spontaneous rupture of the esophagus (530.4)

New code 512.83 Other air leak
Persistent air leak

New code 512.89 Other pneumothorax
  acute pneumothorax
  chronic pneumothorax
  pneumothorax NOS
  spontaneous pneumothorax NOS
Thalassemia

Thalassemia is a family of inherited hemoglobinopathies which in severest form require life-long blood transfusions for survival. The subsequent iron overload can lead to multisystem complications. It is a complex disease with multiple genotype combinations leading to a wide spectrum of phenotypes. There have been many recent advances in the care of these patients including new iron chelators and new technology for the management of the complications (e.g., MRI assessment of iron burden). However, because transfusion-dependent anemias are rare in the US, disseminating this new information to providers across the U.S. is often very slow. For 2010, there is no accurate estimate of the number of symptomatic thalassemia patients in the U.S. Key groups involved in care of patients with severe thalassemia (CDC, NHLBI, and the patient advocacy group, the Cooley’s Anemia Foundation) recognize that there is probably a significant number of patients scattered all over the U.S. that have not been accounted for and may be receiving care by non-expert-center providers. Attempts to locate these patients have been made through the Cooley’s Anemia Foundation and informal networks but has not yielded large numbers of new patients.

Currently there is a single ICD-9-CM code (242.49) to capture all non-sickle cell related thalassemias. This one code includes the entire spectrum from asymptomatic patients (silent carrier or thalassemia trait) to patients with severe disease (thalassemia major).

Attempts to search large administrative databases (e.g., hospital systems, state or federal systems) would be fruitless using the single code, as the vast majority of patients with that code would be asymptomatic thalassemia trait patients. There is a new network of several states funded under the RuSH grant through the CDC and NIH trying to determine the true number of patients in the U.S. affected by hemoglobinopathies, including thalassemia. Having ICD-9-CM codes that more accurately describe these patients would help tremendously toward this important aim. Identifying who has trait vs disease has important public health implications for surveillance of populations and genetics for future generations. There is currently no way to disentangle the millions of asymptomatic thalassemia trait persons from the thousands of patients with disease. These patients represent both high public health and research utilization, because they require life-long monthly blood transfusions, iron overload monitoring, chelation therapy, and they are candidates for hematopoetic stem cell transplant. Tracking those who have real disease will help blood banks, hospitals, state insurance programs, and others to plan for use of health care resources.

The Thalassemia Clinical Research Group/Cooley’s Anemia Foundation and the American Academy of Pediatrics have requested expedited consideration for expansion of the codes for Thalassemia in ICD-9-CM. While this problem is addressed in ICD-10-CM, concern is raised that the delay in having these codes in place in the existing ICD-9-CM would have a deleterious effect in the tracking and study of this condition.

**TABULAR MODIFICATIONS**

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<tr>
<td>282.41</td>
<td>Sickle-cell thalassemia without crisis</td>
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<tr>
<td>Add</td>
<td>Microdrepanocytosis</td>
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41
<table>
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<th>New code</th>
<th>Code</th>
<th>Description</th>
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<td>Alpha thalasemia</td>
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<tr>
<td></td>
<td>Alpha thalasemia major</td>
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<tr>
<td></td>
<td>Hemoglobin H disease</td>
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<td></td>
<td>Hemoglobin H Constant Spring</td>
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<td>Severe alpha thalasemia</td>
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<td>Triple gene defect alpha thalasemia</td>
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<td>Alpha thalasemia trait or minor (282.46)</td>
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<td>Hydrops fetalis due to isoimmunization (773.3)</td>
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<td>Hydrops fetalis not due to immune hemolysis (778.0)</td>
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<tr>
<td>282.44</td>
<td>Beta thalasemia</td>
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<tr>
<td></td>
<td>Beta thalasemia major</td>
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<tr>
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<td>Cooley’s anemia</td>
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<tr>
<td></td>
<td>Homozygous beta thalasemia</td>
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<td>Severe beta thalasemia</td>
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<td>Thalassemia intermedia</td>
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<td>Thalassemia major</td>
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<td>Excludes</td>
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<td>Beta thalasemia trait (282.46)</td>
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<td>Delta-beta thalasemia (282.45)</td>
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<td>Hemoglobin E beta thalasemia (282.47)</td>
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<td>Sickle-cell beta thalasemia (282.41, 282.42)</td>
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<td>282.45</td>
<td>Delta-beta thalasemia</td>
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<td>Homozygous delta-beta thalasemia</td>
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<td>Delta-beta thalasemia trait (282.46)</td>
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New code 282.46 Thalassemia minor
- Alpha thalassemia minor
- Alpha thalassemia trait
- Alpha thalassemia silent carrier
- Beta thalassemia minor
- Beta thalassemia trait
- Delta-beta thalassemia trait
- Thalassemia trait NOS

Excludes:
- Alpha thalassemia (282.43)
- Beta thalassemia (282.44)
- Delta beta thalassemia (282.45)
- Hemoglobin E-beta thalassemia (282.47)
- Sickle-cell trait (282.5)

New code 282.47 Hemoglobin E-beta thalassemia

Excludes:
- Beta thalassemia (282.44)
- Beta thalassemia minor (282.46)
- Beta thalassemia trait (282.46)
- Delta-beta thalassemia (282.45)
- Delta-beta thalassemia trait (282.46)
- Hemoglobin E disease (282.7)
- Other hemoglobinopathies (282.7)
- Sickle-cell beta thalassemia (282.41, 282.42)

282.49 Other thalassemia

Delete Cooley’s anemia
Add Dominant thalassemia
Add Hemoglobin Bart’s Disease
Add Hemoglobin C thalassemia
Delete Microdrepanocytosis
Add Mixed thalassemia
Revise Thalassemia (alpha) (beta) (intermedia) (major) (minima)
(minor) (mixed) (trait) (with other hemoglobinopathy)

Delete Thalassemia NOS
Add Excludes:
- Hemoglobin C disease (282.7)
- Hemoglobin E disease (282.7)
- Other hemoglobinopathies (282.7)
- Sickle cell anemias (282.6)
- Sickle-cell beta thalassemia (282.41-282.42)

282.7 Other hemoglobinopathies

Add Excludes: hemoglobin E-beta thalassemia (282.47)
Add other hemoglobinopathies with thalassemia (282.49)
INDEX MODIFICATIONS

Anemia ...
Revise microdrepanocytosis 282.41 282.49

Disease ...
Revise microdrepanocytic 282.41 282.49

Revise Microdrepanocytosis (thalassemia-Hb-S disease) 282.41 282.49
Add with sickle cell crisis 282.42
Infection Due to Central Venous Catheter

Central line-associated bloodstream infections (CLABSI) are common, with an estimated 250,000 cases occurring in hospitals in the United States. These cause significantly longer hospitalizations and resource use. Such infections are currently indexed to 999.31, “Infection due to central venous catheter.” However, there are two major categories of infections due to central venous catheters: local and systemic. The existing code does not distinguish between central line-associated bloodstream infections, which are systemic, and local infections. These have very different clinical and epidemiologic implications.

A variety of local catheter infections can occur, including exit or insertion site infections, port or reservoir infections, and tunnel infections. Signs of infection may involve purulent discharge, and localized findings such as pain, erythema, or tenderness may also be present. In exit site infections, these are found at the catheter exit or insertion site. Port or reservoir infections are associated with implantable venous access devices, with signs involving the skin over the reservoir; there also may be a purulent exudate within the reservoir or in the subcutaneous pocket around it. A tunnel infection involves the area where the catheter runs underneath the skin. Signs of exit site inflammation or infection may or may not be present.

The Central Line Associated Bloodstream Infections have been carefully defined by the Centers for Disease Control and Prevention as part of its National Healthcare Safety Network (NHSN), as laboratory-confirmed bloodstream infections (LCBI) that are not secondary to an infection at another site (see reference for Central Line-Associated Bloodstream Infection (CLABSI) Event).

The primary target of current surveillance and prevention efforts is catheter-related bloodstream infection. However, use of the same code (999.31) for local catheter infections and bloodstream infections interferes with national and regional efforts to identify patients who experience central line-associated bloodstream infections, which are a particularly important complication of health care.

In addition, the current ICD-9-CM tabular language does not use the currently preferred term “central line-associated bloodstream infection.” This term has a broader, more surveillance-oriented meaning than previous terms. The surveillance definition includes all BSIs that occur in patients with CVCs, when other sites of infection have been excluded. This overestimates the true incidence of catheter-related BSI, because not all BSIs originate from a catheter.

This proposal from AHRQ is intended to address these issues.

References:


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TABULAR MODIFICATIONS

996  Complications peculiar to certain specified procedures

  996.6  Infection and inflammatory reaction due to internal prosthetic device, implant, and graft

  996.62  Due to vascular device, implant and graft

  Excludes: infection due to:
  
  Revise  central venous catheter (999.31-999.32)
  Revise  Hickman catheter (999.31-999.32)
  Revise  peripherally inserted central catheter (PICC) (999.31-999.32)
  Revise  portacath (port-a-cath) (999.31-999.32)
  Revise  triple lumen catheter (999.31-999.32)
  Revise  umbilical venous catheter (999.31-999.32)

999  Complications of medical care, not elsewhere classified

  999.3  Other infection

  Revise  999.31  bloodstream infection due to central venous catheter
  Revise  bloodstream infection due to:
  
  Revise  Hickman catheter
  Revise  peripherally inserted central catheter (PICC)
  Delete  portacath (port-a-cath)
  Revise  triple lumen catheter
  Add  central line-associated bloodstream infection
  Add  infection due to central venous catheter, unspecified
New code 999.32 Local infection due to central venous catheter exit or insertion site infection
local infection due to:
  Hickman catheter
  peripherally inserted central catheter (PICC)
  portacath (port-a-cath)
  triple lumen catheter
  umbilical venous catheter
  port or reservoir infection
  tunnel infection
Atrial Fibrillation and Flutter

Atrial fibrillation is an abnormal irregularly irregular heart rhythm in which the atria do not have the regular, coordinated contractions they normally do. On electrocardiogram (ECG), there is an absence of P waves, with irregular oscillations instead, and ventricular response is often rapid. Blood clots can form in the atria, and then embolize, potentially causing a stroke or other vascular problem. Atrial fibrillation is the most common abnormal heart rhythm.

In 2001, the American College of Cardiology (ACC), the American Heart Association (AHA), and the European Society of Cardiology (ESC) released guidelines for treatment of patients with atrial fibrillation. This also described classification of atrial fibrillation. It recommended distinguishing first-detected episodes of atrial fibrillation from those that are recurrent. Paroxysmal atrial fibrillation involves episodes that terminate spontaneously within 7 days (most less than one day). Persistent atrial fibrillation is sustained generally for over 7 days; it may be terminated by drug therapy or electrical cardioversion. Long standing persistent atrial fibrillation is persistent atrial fibrillation that has been present for a year or more, but that is still susceptible to being terminated by cardioversion or other procedures such as ablation. Permanent atrial fibrillation is long standing (over a year), with attempts to terminate it unsuccessful or not indicated or attempted. These terms apply for atrial fibrillation that is not related to a reversible cause. If it is secondary to a treatable underlying condition, then it would be considered separately, as such treatment will usually eliminate the arrhythmia. Causes of secondary atrial fibrillation may include acute myocardial infarction, cardiac surgery, pericarditis, myocarditis, hyperthyroidism, pulmonary embolism, pneumonia, and acute pulmonary disease.

Atrial flutter is a reentrant heart rhythm, where the wave of activation through the atria makes a circuit (typically in the right atrium) that re-activates a region that has just shortly before contracted, and this continues at a fast rate. On ECG, this shows up as a saw tooth pattern with a rate of close to 300 beats per minute, instead of normal P waves. The ventricular response is usually regular, often in a ratio of 2 atrial beats to one ventricular beat, although it may range to 4 to 1. The ventricular rate may be close to 150 beats per minute, or lower if the conduction ratio is higher. In typical atrial flutter, the reentrant circuit involves conduction around the tricuspid annulus, usually in a counterclockwise direction. Atypical atrial flutter involves a reentrant circuit in some other atrial location.

Atrial fibrillation and atrial flutter may frequently coexist, and either one may spontaneously convert to the other in some cases.

A request was received from Medtronic to create specific codes for the specific types of atrial fibrillation, based on the classification used by the ACC/AHA/ESC. Also, WHO will be making changes in ICD-10, that will overlap with these changes.

References:

### TABULAR MODIFICATIONS for ICD-9-CM

#### 427 Cardiac dysrhythmias

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>427</td>
<td>Cardiac dysrhythmias</td>
</tr>
<tr>
<td>427.3</td>
<td>Atrial fibrillation and flutter</td>
</tr>
<tr>
<td>427.31</td>
<td>Atrial fibrillation, unspecified</td>
</tr>
<tr>
<td>427.32</td>
<td>Atrial flutter</td>
</tr>
<tr>
<td>New code</td>
<td>427.33</td>
</tr>
<tr>
<td>New code</td>
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*Code first, if applicable, underlying etiology*
TABULAR MODIFICATIONS for ICD-10-CM

I48  Atrial fibrillation and flutter

Revise  I48.0  Paroxysmal Atrial fibrillation

Revise  I48.1  Persistent atrial fibrillation Atrial flutter

New code  I48.11  Long standing persistent atrial fibrillation

New code  I48.19  Other persistent atrial fibrillation

New subcategory  I48.2  Chronic and permanent atrial fibrillation

New code  I48.20  Chronic atrial fibrillation
               Long standing atrial fibrillation

               Excludes: long standing persistent atrial fibrillation (I48.11)

New code  I48.21  Permanent atrial fibrillation

New code  I48.3  Typical atrial flutter

New code  I48.4  Atypical atrial flutter

New code  I48.8  Other atrial fibrillation
               acute atrial fibrillation
               first episode atrial fibrillation
               secondary atrial fibrillation

               Code first, if applicable, underlying etiology

New subcategory  I48.9  Atrial fibrillation and atrial flutter, unspecified

New code  I48.90  Atrial fibrillation, unspecified

New code  I48.91  Atrial flutter, unspecified
**Novel Influenza**

Influenza causes significant morbidity and mortality worldwide. New forms can threaten to spread widely, with little existing immunity in populations. Novel influenza A is a nationally reportable disease. It includes all human infections with influenza A viruses that are different from currently circulating human influenza viruses. These include viruses subtyped as nonhuman in origin, and those that are unsubtypable with standard laboratory methods. The 2009 pandemic influenza is now regularly referred to as 2009 H1N1 influenza, rather than novel H1N1 influenza. Changes to ICD-9-CM for novel influenza have been recommended by the CDC National Center For Immunization and Respiratory Diseases (NCIRD).

**TABULAR MODIFICATIONS for ICD-9-CM**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>488</td>
<td>Influenza due to certain identified influenza viruses</td>
</tr>
<tr>
<td>Revise</td>
<td>Excludes: influenza caused by unspecified or seasonal influenza viruses (487.0-487.8)</td>
</tr>
</tbody>
</table>

**Revised**:

- 488.1 Influenza due to identified novel 2009 H1N1 influenza virus
- 2009 H1N1 [swine] swine influenza virus
- Novel (Novel) 2009 influenza H1N1
- Swine flu

**Added**:

- Excludes: bird influenza virus infection (488.01-488.09)
- Swine influenza virus infection (488.81-488.89)
- Influenza A/H5N1 (488.01-488.09)
- Other human infection with influenza virus of animal origin (488.81-488.89)

**Revised**:

- 488.11 Influenza due to identified novel 2009 H1N1 influenza virus with pneumonia
- Novel (Novel) 2009 H1N1 influenzal: bronchopneumonia
- Pneumonia

**Revised**:

- 488.12 Influenza due to identified novel 2009 H1N1 influenza virus with other respiratory manifestations
- Novel (Novel) 2009 H1N1 influenza NOS
- Laryngitis
- Pharyngitis
- Respiratory infection (acute) (upper)

**Revised**:

- 488.19 Influenza due to identified novel 2009 H1N1 influenza virus with other manifestations
Revise       Encephalopathy due to identified (novel) 2009 H1N1 influenza
Revise       (Novel) 2009 H1N1 influenza with involvement of gastrointestinal tract

New subcategory  488.8  Influenza due to novel influenza A
    Influenza due to animal origin influenza virus
    Infection with influenza viruses occurring in pigs or other animals
    Other novel influenza A viruses not previously found in humans

    Excludes:  bird influenza virus infection (488.01-488.09)
               influenza due to identified 2009 H1N1 influenza virus (488.11-488.19)

New code  488.81  Influenza due to identified novel influenza A virus with pneumonia
    Influenza due to animal origin influenza virus with pneumonia, any form
    Novel influenza A:  bronchopneumonia
                        pneumonia
    Use additional code to identify the type of pneumonia (480.0-480.9, 481, 482.0-482.9, 483.0-483.8, 485)

New code  488.82  Influenza due to identified novel influenza A virus with other respiratory manifestations
    Influenza due to animal origin influenza A virus with other respiratory manifestations
    Novel influenza A:  laryngitis
                        pharyngitis
                        respiratory infection (acute) (upper)

New code  488.89  Influenza due to identified novel influenza A virus with other manifestations
    Encephalopathy due to novel influenza A
    Influenza due to animal origin influenza virus with encephalopathy
    Influenza due to animal origin influenza virus with involvement of gastrointestinal tract
    Novel influenza A with involvement of gastrointestinal tract

    Excludes:  "intestinal flu" [viral gastroenteritis] (008.8)
### TABULAR MODIFICATIONS for ICD-10-CM

#### J09  Influenza due to certain identified influenza viruses

<table>
<thead>
<tr>
<th>Action</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
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<tr>
<td>Add</td>
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<td>Excludes1: seasonal influenza due to other identified influenza virus (J10.-)</td>
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<tr>
<td>Add</td>
<td></td>
<td>seasonal influenza due to unidentified influenza virus (J11.-)</td>
</tr>
<tr>
<td>Delete</td>
<td>J09.0</td>
<td>Influenza due to identified avian influenza virus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Avian influenza</td>
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<tr>
<td></td>
<td></td>
<td>Bird-flu</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Influenza A/H5N1</td>
</tr>
<tr>
<td>Delete</td>
<td>J09.01</td>
<td>Influenza due to identified avian influenza virus with pneumonia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Code also associated lung abscess, if applicable (J85.1)</td>
</tr>
<tr>
<td>Delete</td>
<td>J09.010</td>
<td>Influenza due to identified avian influenza virus with identified avian influenza pneumonia</td>
</tr>
<tr>
<td>Delete</td>
<td>J09.018</td>
<td>Influenza due to identified avian influenza virus with other specified type of pneumonia</td>
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<td>Code also the specified type of pneumonia</td>
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<td>J09.019</td>
<td>Influenza due to identified avian influenza virus with unspecified type of pneumonia</td>
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<tr>
<td>Delete</td>
<td>J09.02</td>
<td>Influenza due to identified avian influenza virus with other respiratory manifestations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Influenza due to identified avian influenza virus NOS</td>
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<tr>
<td>Delete</td>
<td></td>
<td>Influenza due to identified avian influenza virus with laryngitis</td>
</tr>
<tr>
<td>Delete</td>
<td></td>
<td>Influenza due to identified avian influenza virus with pharyngitis</td>
</tr>
<tr>
<td>Delete</td>
<td></td>
<td>Influenza due to identified avian influenza virus with upper respiratory symptoms</td>
</tr>
<tr>
<td>Delete</td>
<td></td>
<td>Use additional code for associated pleural effusion, if applicable (J91.8)</td>
</tr>
<tr>
<td>Delete</td>
<td></td>
<td>Use additional code for associated sinusitis, if applicable (J01.-)</td>
</tr>
<tr>
<td>Delete</td>
<td>J09.03</td>
<td>Influenza due to identified avian influenza virus with gastrointestinal manifestations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Influenza due to identified avian influenza virus gastroenteritis</td>
</tr>
<tr>
<td>Delete</td>
<td></td>
<td>Excludes1: &quot;intestinal flu&quot; [viral gastroenteritis] (A08.-)</td>
</tr>
<tr>
<td>Delete</td>
<td>J09.09</td>
<td>Influenza due to identified avian influenza virus with other manifestations</td>
</tr>
</tbody>
</table>
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Delete

J09.090—Influenza due to identified avian influenza virus with encephalopathy

Delete

J09.091—Influenza due to identified avian influenza virus with myocarditis

Delete

J09.092—Influenza due to identified avian influenza virus with otitis media
Use additional code for any associated perforated tympanic membrane (H72.1)

Delete

J09.098—Influenza due to identified avian influenza virus with other manifestations
Use additional codes to identify the manifestations

Delete

J09.1—Influenza due to identified novel H1N1 influenza virus
2009 H1N1 [swine] influenza virus
Novel 2009 influenza H1N1
Novel H1N1-influenza
Novel influenza A/H1N1
Swine flu

Delete

J09.11—Influenza due to identified novel H1N1 influenza virus with pneumonia
Code also associated lung abscess, if applicable (J85.1)

Delete

J09.110—Influenza due to identified novel H1N1 influenza virus with identified novel H1N1 influenza pneumonia

Delete

J09.118—Influenza due to identified novel H1N1 influenza virus with other specified type of pneumonia

Delete

J09.119—Influenza due to identified novel H1N1 influenza virus with unspecified type of pneumonia

Delete

J09.12—Influenza due to identified novel H1N1 influenza virus with other respiratory manifestations
Influenza due to identified novel H1N1 influenza virus NOS
Influenza due to identified novel H1N1 influenza virus with laryngitis
Influenza due to identified novel H1N1 influenza virus with pharyngitis
Influenza due to identified novel H1N1 influenza virus with upper respiratory symptoms

Delete

Use additional code for associated pleural effusion, if applicable (J91.8)

Delete

Use additional code for associated sinusitis, if applicable (J01.1)
Delete  J09.13 Influenza due to identified novel H1N1 influenza virus with gastrointestinal manifestations
Delete  Influenza due to identified novel H1N1 influenza virus gastroenteritis
Delete  Excludes1: "intestinal flu" [viral gastroenteritis] (A08.-)
Delete  J09.19 Influenza due to identified novel H1N1 influenza virus with other manifestations
Delete  J09.190 Influenza due to identified novel H1N1 influenza virus with encephalopathy
Delete  J09.191 Influenza due to identified novel H1N1 influenza virus with myocarditis
Delete  J09.192 Influenza due to identified novel H1N1 influenza virus with otitis media
Delete  Use additional code for any associated perforated tympanic membrane (H72.-)
Delete  J09.198 Influenza due to identified novel H1N1 influenza virus with other manifestations
Delete  Use additional codes to identify the manifestations

New subcategory  J09.X Influenza due to identified novel influenza A virus
Avian influenza
Bird influenza
Influenza A/H5N1
Influenza of other animal origin, not bird or swine
Swine influenza virus (viruses that normally cause infections in pigs)

New code  J09.X1 Influenza due to identified novel influenza A virus with pneumonia
Code also, if applicable, associated:
lung abscess (J85.1)
other specified type of pneumonia

New code  J09.X2 Influenza due to identified novel influenza A virus with other respiratory manifestations
Influenza due to identified novel influenza A virus NOS
Influenza due to identified novel influenza A virus with laryngitis
Influenza due to identified novel influenza A virus with pharyngitis
Influenza due to identified novel influenza A virus with upper respiratory symptoms
Use additional code, if applicable, for associated:
pleural effusion (J91.8)
sinusitis (J01.-)
New code  J09.X3   Influenza due to identified novel influenza A virus with gastrointestinal manifestations
Influenza due to identified novel influenza A virus gastroenteritis
Excludes1: "intestinal flu" [viral gastroenteritis] (A08.-)

New code  J09.X9   Influenza due to identified novel influenza A virus with other manifestations
Influenza due to identified novel influenza A virus with encephalopathy
Influenza due to identified novel influenza A virus with myocarditis
Influenza due to identified novel influenza A virus with otitis media
Influenza due to identified novel influenza A virus with other manifestations
Use additional codes to identify the manifestations
ICD-9-CM TABULAR LIST OF DISEASES
PROPOSED ADDENDA (Effective October 1, 2011)

099  Other venereal diseases

Add 099.3  Reiter's disease
      Reactive arthritis

209  Neuroendocrine tumors

Add 209.7  Secondary neuroendocrine tumors
      Mesentery metastasis of neuroendocrine tumor

Delete 209.71  Secondary neuroendocrine tumor of distant lymph nodes

Add 209.74  Secondary neuroendocrine tumor of peritoneum
      Mesentery metastasis of neuroendocrine tumor

294  Persistent mental disorders due to conditions classified elsewhere

Delete 294.1  Dementia in conditions classified elsewhere

Revise Code first any underlying physical condition as:

Add  dementia in:
      Parkinson’s disease (332.0)

Revise
Category
Title

MENTAL RETARDATION INTELLECTUAL DISABILITIES (317-319)

Revise 317  Mild mental retardation  Mild intellectual disabilities

Revise 318  Other specified mental retardation  Intellectual disabilities

Revise 318.0  Moderate mental retardation  Intellectual disabilities

Revise 318.1  Severe mental retardation  Intellectual disabilities

Revise 318.2  Profound mental retardation  Intellectual disabilities

Revise 319  Unspecified mental retardation  Intellectual disabilities

345  Epilepsy and recurrent seizures

Delete 345.8  Other forms of epilepsy and recurrent seizures

Add  Seizure disorder NOS

Delete 345.9  Epilepsy, unspecified

Delete  Recurrent seizures NOS
514  Pulmonary congestion and hypostasis

Revise Excludes: hypostatic pneumonia due to or specified as a specific type of pneumonia -
code to the type of pneumonia (480.0-480.9, 481, 482.0-482.9, 483.0-
483.8, 485, 486, 487.0, 488.01, 488.11)
**ICD-9-CM INDEX TO DISEASES AND INJURIES**
**PROPOSED ADDENDA (Effective October 1, 2011)**

Aplasia - see also Agenesis

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<thead>
<tr>
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<th>Description</th>
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<tr>
<td>Revise</td>
<td>284.81</td>
<td>red cell (with thymoma) (adult)</td>
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<td>acquired (secondary)</td>
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<td>due to drugs</td>
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<tr>
<td>Add</td>
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<td>adult</td>
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<td></td>
<td>284.01</td>
<td>pure</td>
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<tr>
<td>Add</td>
<td></td>
<td>due to drugs</td>
</tr>
<tr>
<td>Add</td>
<td>783.3</td>
<td>Aversion</td>
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<td>779.31</td>
<td>oral</td>
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<td></td>
<td>307.59</td>
<td>nonorganic origin</td>
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<tr>
<td>Revise</td>
<td></td>
<td>Bruck-de Lange disease or syndrome (Amsterdam dwarf, intellectual disabilities, and brachycephaly)</td>
</tr>
<tr>
<td>Revise</td>
<td>560.32</td>
<td>Coprostanis</td>
</tr>
<tr>
<td>Dementia</td>
<td>294.8</td>
<td>due to or associated with condition(s) classified elsewhere</td>
</tr>
<tr>
<td>Add</td>
<td></td>
<td>Parkinson’s disease</td>
</tr>
<tr>
<td>Add</td>
<td>332.0 [294.11]</td>
<td>with behavioral disturbance</td>
</tr>
<tr>
<td>Add</td>
<td>332.0 [294.10]</td>
<td>without behavioral disturbance</td>
</tr>
<tr>
<td>Revise</td>
<td></td>
<td>Dilatation</td>
</tr>
<tr>
<td></td>
<td>751.69</td>
<td>bile duct (common) (cystic) (congenital)</td>
</tr>
<tr>
<td>Revise</td>
<td></td>
<td>Disability, disabilities</td>
</tr>
<tr>
<td>Add</td>
<td>319</td>
<td>intellectual</td>
</tr>
<tr>
<td>Add</td>
<td>V62.89</td>
<td>borderline</td>
</tr>
<tr>
<td>Add</td>
<td>317</td>
<td>mild, IQ 50-70</td>
</tr>
<tr>
<td>Add</td>
<td>318.0</td>
<td>moderate, IQ 35-49</td>
</tr>
<tr>
<td>Add</td>
<td>318.2</td>
<td>profound, IQ under 20</td>
</tr>
<tr>
<td>Add</td>
<td>318.1</td>
<td>severe, IQ 20-34</td>
</tr>
<tr>
<td>Add</td>
<td>289.81</td>
<td>Factor V Leiden mutation</td>
</tr>
<tr>
<td>Impaction, impacted bowel, colon, rectum 560.30 by</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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- Revise calculus 560.32
- Revise specified type NEC 560.32
- Intestine(s) 560.30
- By
- Revise calculus 560.32
- Revise specified type NEC 560.32

Metastasis, metastatic
- Revise mesentery, of neuroendocrine tumor 209.71 209.74

Migraine
- Add complicated 346.0

Mutation
- Revise factor V Leiden 289.81

Obstruction...
- Intestine ... 560.9
- Revise impaction 560.32

Retardation
- Mental – see Disability, intellectual
- Delete borderline V62.89
- Delete mild, IQ 50-70 317
- Delete moderate, IQ 35-49 318.0
- Delete profound, IQ under 20 318.2
- Delete severe, IQ 20-34 318.1

[NOTE: All existing entries with the term “mental retardation” will be revised to “intellectual disabilities”]

Tuberculosis...
- Add latent 795.5
- Add Virilism (adrenal) E25.9

with
- Delete 3-beta-hydroxysteroid dehydrogenase defect 255.2
- Delete 11-hydroxylase defect 255.2
- Delete 21-hydroxylase defect 255.2
- Add 3-beta-hydroxysteroid dehydrogenase defect 255.2
- Add 11-hydroxylase defect 255.2
- Add 21-hydroxylase defect 255.2

Wound, open
<table>
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<td>anus 863.89</td>
</tr>
<tr>
<td>Delete</td>
<td>complicated 879.7</td>
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</table>
Place of Occurrence

NCHS has received a request to expand Y92.00, Unspecified non-institutional (private) residence as the place of occurrence of the external cause, to include the same level of detail included at Y92.01-through Y92.8-. It was noted that documentation may often contain information about the room in which the injury occurred but that the type of dwelling may only be specified as house. Given that the term “house” is used to describe, depending on the geographic area, an apartment, a single family dwelling, or townhouse, creating a default would not be appropriate.

TABULAR MODIFICATION

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<tr>
<th>Y92</th>
<th>Place of Occurrence of External Cause</th>
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<tbody>
<tr>
<td>New subcategory</td>
<td>Y92.00 Unspecified non-institutional (private) residence as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>New code</td>
<td>Y92.000 Kitchen of unspecified non-institutional (private) residence as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>New code</td>
<td>Y92.001 Dining room of unspecified non-institutional (private) residence as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>New code</td>
<td>Y92.002 Bathroom of unspecified non-institutional (private) residence single-family (private) house as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>New code</td>
<td>Y92.003 Bedroom of Unspecified non-institutional (private) residence as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>New code</td>
<td>Y92.008 Other place in unspecified non-institutional (private) residence as the place of occurrence of the external cause</td>
</tr>
<tr>
<td>New code</td>
<td>Y92.009 Unspecified place in unspecified non-institutional (private) residence as the place of occurrence of the external cause</td>
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</tbody>
</table>
Other Chronic Pain

In 2006, several ICD-9-CM diagnosis codes were implemented in a newly created category 338, Pain, not elsewhere classified. Subcategory 338.2, Chronic pain, includes four codes: chronic pain due to trauma, chronic post-thoracotomy pain, other chronic postoperative pain, and other chronic pain. ICD-10-CM mirrors this structure with category G89, Pain, not elsewhere classified, and subcategory G89.2, Chronic pain, not elsewhere classified. However, G89.2 includes only three codes: chronic pain due to trauma, chronic post-thoracotomy pain, and other chronic postoperative pain. While ICD-9-CM assigns 338.29 for other chronic pain, ICD-10-CM does not have a specific code for other chronic pain.

The current 2011 draft of ICD-10-CM indexes chronic pain NOS to code R52, Pain unspecified. The term 'other chronic pain' is not specifically indexed. Although G89.2 is classified as nervous system code, R52 is classified as a symptom code.

While acute pain is usually self-limited and serves as a warning to the body of injury other chronic pain serves no such function. It typically results from damage to nervous tissue itself (e.g. chronic arachnoiditis, post-herpetic neuralgia, pathological vertebral fracture in osteoporosis) and can persist after the tissue is healed. For these reasons, chronic pain can be seen as a neurologic disease process in its own right and is treated as a distinct condition, for example by implantation of a spinal neurostimulator or an intrathecal infusion pump. It is necessary to acknowledge this clinical perspective on other chronic pain with its own unique code in subcategory G89.2 and not at code R52 which also classifies acute pain NOS, generalized pain NOS, and pain NOS.

Classifying 'other chronic pain' to R52 also disrupts the pain code guidelines currently in the draft ICD-10-CM Official Guidelines for Coding and Reporting. These state that codes in category G89 are assigned and sequenced as the principal diagnosis when the reason for the encounter is pain control or pain management, as in an encounter for steroid injection or admission for neurostimulator implantation. That will work for chronic pain that is post-traumatic, post-thoracotomy and post-procedural, since those conditions are classified to category G89. But since 'other chronic pain' is not specifically indexed it will be coded to R52 as a symptom. Therefore, the underlying cause will need to be sequenced as the principal diagnosis and it's questionable if pain will be coded at all. Encounters for pain management and control will likely be coded and sequenced inconsistently, depending on how the chronic pain is characterized and then coded in ICD-10-CM.

It is proposed to create a unique ICD-10-CM diagnosis code for other chronic pain, in subcategory G89.2, Chronic pain, not elsewhere classified.

**TABULAR MODIFICATIONS**

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<thead>
<tr>
<th></th>
<th>G89</th>
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<tbody>
<tr>
<td><strong>New code</strong></td>
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<td>G89.29 Other chronic pain</td>
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</tbody>
</table>
Migraines

The American Headache Society (AHS) is requesting changes to category G43, Migraine and G44, Other headache syndromes. The proposed changes were developed with and are supported by the American Academy of Neurology (AAN).

Three of the four terms included in ICD-9-CM subcategory 346.2X, Variants of migraine, not elsewhere classified were given unique codes in ICD-10-CM: G43A-, Cyclical vomiting; G43B- Ophthalmologic migraine; and G43C- Periodic headache syndromes in child or adult. The fourth term, abdominal migraine, also listed under variants of migraine in ICD-9-CM, was not included in ICD-10-CM. The AHS proposes that a unique code be established for abdominal migraine. In the 2011 version of ICD-10-CM, menstrual migraine is assigned to subcategory G43D, however, it is requested that the new codes for abdominal migraine be assigned to G43D to allow keeping the variants of migraine conditions together. The codes for menstrual migraine are being proposed to be moved to new subcategories in G43.8, Other migraine.

The AHS is also proposing to delete the codes for "with and without status migrainosus" under G43A-, G43B-, and G43C-. Status migrainosus refers to a prolonged headache lasting more than 72 hours. Status migrainosus would not apply to these codes because they describe disorders other than the pain associated with migraines; e.g. abdominal migraine is abdominal pain, not headache, and Ophthalmologic migraine is palsy of the third cranial nerve and not migraine. The default (NOS) for each of these conditions would be the codes for not intractable and the index will reflect this.

**TABULAR MODIFICATIONS**

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<tr>
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<th>Code</th>
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<td>G43.A0</td>
<td>Cyclical vomiting, not intractable</td>
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<td></td>
<td>G43.A01</td>
<td>Cyclical vomiting, not intractable, with status migrainosus</td>
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<td>Delete</td>
<td>G43.A09</td>
<td>Cyclical vomiting, not intractable, without status migrainosus</td>
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<tr>
<td>Delete</td>
<td>G43.A11</td>
<td>Cyclical vomiting, intractable, with status migrainosus</td>
</tr>
<tr>
<td>Delete</td>
<td>G43.A19</td>
<td>Cyclical vomiting, intractable, without status migrainosus</td>
</tr>
<tr>
<td>G43 B</td>
<td>G43.B0</td>
<td>Ophthalmoplegic migraine, not intractable</td>
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<td>G43.B01</td>
<td>Ophthalmoplegic migraine, not intractable, with status migrainosus</td>
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<tr>
<td>Delete</td>
<td>G43.B09</td>
<td>Ophthalmoplegic migraine, not intractable, without status migrainosus</td>
</tr>
</tbody>
</table>
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Delete

Ophthalmoplegic migraine NOS

G43.B1 Ophthalmoplegic migraine, intractable

Delete

G43.B11 Ophthalmoplegic migraine, intractable, with status migrainosus

Delete

G43.B19 Ophthalmoplegic migraine, intractable, without status migrainosus

G43.C Periodic headache syndromes in child or adult

G43.C0 Periodic headache syndromes in child or adult, not intractable

Delete

G43.C01 Periodic headache syndromes in child or adult, not intractable, with status migrainosus

Delete

G43.C09 Periodic headache syndromes in child or adult, not intractable, without status migrainosus

Delete

Periodic headache syndromes in child or adult NOS

Delete

G43.C1 Periodic headache syndromes in child or adult, intractable

Delete

G43.C11 Periodic headache syndromes in child or adult, intractable, with status migrainosus

Delete

G43.C19 Periodic headache syndromes in child or adult, intractable, without status migrainosus

Delete

Menstrual migraine

Delete

Menstrual headache

Delete

Menstrually related migraine

Delete

Pre-menstrual headache

Delete

Pre-menstrual migraine

Delete

Pure-menstrual migraine

Delete

Code also associated premenstrual tension syndrome (N94.3)

Delete

G43.d0 Menstrual migraine, not intractable

Delete

G43.d01 Menstrual migraine, not intractable, with status migrainosus

Delete

G43.d01 Menstrual migraine, not intractable, with status migrainosus

Delete

G43.d09 Menstrual migraine, not intractable, without status migrainosus

Delete

Menstrual migraine NOS

Delete

G43.d1 Menstrual migraine, intractable

Delete

G43.d11 Menstrual migraine, intractable, with status migrainosus
Delete G43.d19—Menstrual migraine, intractable, without status migrainosus

New subcategory G43.D Abdominal migraine

New code G43.D0 Abdominal migraine, not intractable
New code G43.D1 Abdominal migraine, intractable

New subcategory G43.82 Menstrual migraine, not intractable
Add Menstrual headache, not intractable
Add Menstrually related migraine, not intractable
Add Pre-menstrual headache, not intractable
Add Pre-menstrual migraine, not intractable
Add Pure menstrual migraine, not intractable
Add Code also associated premenstrual tension syndrome (N94.3)
New code G43.821 Menstrual migraine, not intractable, with status migrainosus
New code G43.829 Menstrual migraine, not intractable, without status migrainosus

Add Menstrual migraine NOS

New subcategory G43.83 Menstrual migraine, intractable
Add Menstrual headache, intractable
Add Menstrually related migraine, intractable
Add Pre-menstrual headache, intractable
Add Pre-menstrual migraine, intractable
Add Pure menstrual migraine, intractable
Add Code also associated premenstrual tension syndrome (N94.3)
New code G43.831 Menstrual migraine, intractable, with status migrainosus
New code G43.839 Menstrual migraine, intractable, without status migrainosus
Landau-Kleffner Syndrome

Currently, in ICD-10-CM, Landau-Kleffner Syndrome is coded to F80.3, Acquired aphasia with epilepsy [Landau-Kleffner]. Additionally, category G40, Epilepsy and recurrent seizures, has an Excludes1 note for Landau-Kleffner Syndrome (directing to use code F80.3). In ICD-9-CM, Landau-Kleffner Syndrome was indexed to code 345.8x, Other forms of epilepsy and recurrent seizures.

Landau-Kleffner Syndrome is a neurologic condition with evidence of abnormality on an EEG. The International League Against Epilepsy (ILAE) defines Landau-Kleffner Syndrome as an electro-clinical syndrome, that is, the diagnosis is based on the EEG and not the clinical presentation. The ILAE’s full published “Revised terminology and concepts for organization of seizures and epilepsies: Report of the ILAE Commission on Classification and Terminology, 2005 - 2009 (Epilepsia, 51(4):676–685, 2010) is available at: http://www.ilae-epilepsy.org/Visitors/Centre/ctf/ctfoverview.cfm

The American Academy of Neurology (AAN) proposes to deactivate code F80.3, and revise the index to direct Landau-Kleffner Syndrome to be coded to subcategories G40.80- or G40.81-. Other epilepsy (4th character dependant on intractability) with appropriate 5th characters applied for status epilepticus. In addition appropriate exclusion notes in Chapter 5 and at category G40 would be revised to direct using codes at subcategories G40.80- and G40.81-.

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>F80</th>
<th>Specific developmental disorders of speech and language</th>
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<tr>
<td>F80.1</td>
<td>Expressive language disorder</td>
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<td>Revise</td>
<td>Excludes2: acquired aphasia with epilepsy [Landau-Kleffner] (G40.80-, G40.81-)</td>
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<tr>
<td>F80.2</td>
<td>Mixed receptive-expressive language disorder</td>
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<tr>
<td>Revise</td>
<td>Excludes2: acquired aphasia with epilepsy [Landau-Kleffner] (G40.80-, G40.81-)</td>
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<td>F80.3 - Acquired aphasia with epilepsy [Landau-Kleffner]</td>
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<tr>
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<td>Excludes1: aphasia NOS (R47.01)</td>
</tr>
<tr>
<td>Delete</td>
<td>Excludes2: pervasive developmental disorders (F84.--)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>G40</th>
<th>Epilepsy and recurrent seizures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delete</td>
<td>Excludes1: Landau-Kleffner syndrome (F80.3)</td>
</tr>
<tr>
<td>Add</td>
<td>G40.8 Other epilepsy and seizures</td>
</tr>
<tr>
<td></td>
<td>Landau-Kleffner syndrome</td>
</tr>
</tbody>
</table>

**INDEX MODIFICATIONS**

| Aphasia... | - acquired, with epilepsy (Landau-Kleffner syndrome) G40.80- |
| Add        | - - intractable G40.81-                                     |
| Revise     | Landau-Kleffner syndrome G40.80-                            |
| Add        | - - intractable G40.81-                                     |

| Syndrome... | - Landau-Kleffner G40.80- |
| Add         | - - intractable G40.81-  |
Epilepsy and recurrent seizures

The American Academy of Neurology (AAN) is proposing several revisions to better group the disorders and syndromes at category G40, Epilepsy and Recurrent Seizures. The AAN found that many inclusion terms at subcategories G40.3, Generalized idiopathic epilepsy and epileptic syndromes, and G40.4, Other generalized epilepsy and epileptic syndromes are dissimilar. Some terms are not syndromes and, for others, it often is not clear if the epilepsy is generalized or localized. The AAN is proposing that some of these inclusion terms be moved to other existing codes in this category, while others would be better classified with unique codes. These proposals are consistent with the International League Against Epilepsy (ILAE) published “Revised terminology and concepts for organization of seizures and epilepsies: Report of the ILAE Commission on Classification and Terminology, 2005 - 2009 (Epilepsia, 51(4):676–685, 2010) whose full published report is available at: http://www.ilae-epilepsy.org/Visitors/Centre/ctf/ctfoverview.cfm

G40.3, Generalized idiopathic epilepsy and epileptic syndromes - The AAN proposes to remove all inclusion terms at this subcategory and do the following:

Benign myoclonic epilepsy in infancy, and Benign neonatal convulsions (familial): Index these terms to direct to the use of G40.8- Other epilepsy and seizures. The basis of assignment to the generalized epilepsy category is based upon the consistent onset of a seizure from both hemispheres simultaneously. This is not the case with either of these syndromes. Thus it would be more accurate to put each in a category in which ictal onset can be either focal or generalized. Furthermore, in the past the term “benign” has frequently been associated with “idiopathic”. Per the 2010 Revision of the classification of seizures and epilepsies by the ILAE, the term “benign” is being discouraged as these syndromes do not always result in seizure freedom and normal cognition. Thus, these disorders should be dissociated from the term ‘idiopathic’ wherever possible.

Absence epilepsy syndromes: These syndromes constitute distinct entities with differing inclusion criteria, and thus should be coded separately so as not be “lost” within the other generalized syndromes. The AAN recommends creating a new code, G40.A-, Absence Epileptic Syndromes. They also propose moving the following three inclusion terms to the proposed new code: Childhood absence epilepsy [pyknolepsy], Juvenile absence epilepsy, Absence epilepsy NOS.

Juvenile myoclonic epilepsy [impulsive petit mal]: Since this epilepsy syndrome is distinct and relatively common in the population a separate code is indicated so that it can be tracked independently from other different and/or less common syndromes. Thus it is proposed to remove this term from G40.3 and create a new subcategory G40.B, Juvenile myoclonic epilepsy [impulsive petit mal].

Nonspecific - atonic, clonic, myoclonic, tonic, tonic-clonic, and grand mal seizures and epilepsy with grand mal seizures upon awakening: These terms refer to seizures and only when these seizures occur consistently in an individual is the term “epilepsy” appropriate. These epilepsies are very frequently not idiopathic and should be put in a classification that is less specific. It is therefore recommended to move these seven terms to subcategory G40.4, Other generalized epilepsy and epileptic syndromes.

G40.4, Other generalized epilepsy and epileptic syndromes - In addition to moving the nonspecific terms, mentioned above from G40.3 to this subcategory, the following changes are proposed:

Lennox-Gastaut Syndrome: This is a distinct syndrome from the other disorders included under G40.4 with specific pharamaco sensitivities and prognosis. In order to assess epidemiology in the future, a separate code is needed. It is recommended to delete this inclusion term and create two new codes: G40.82 Lennox-Gastaut Syndrome, not intractable and G40.83 Lennox-Gastaut Syndrome, intractable.
Infantile spasms, Salaam attacks, and West's syndrome: These three terms are essentially equivalent. It is recommended to delete these inclusion terms at G40.4 and create two new codes: G40.84 Epileptic Spasms, not Intractable and G40.85 Epileptic Spasms, Intractable and include these terms with the new codes. This will be consistent with the ILAE classification which recognizes this seizure type and the fact that spasms can occur beyond infancy (as noted on page 678 of the referenced ILAE article).

**G40.8, Other Epilepsy and Seizures-**
In ICD-9-CM, Other forms of epilepsy and recurrent seizures is coded as 345.8. Recurrent seizures NOS is included at that code. The term "recurrent" was not included in ICD-10-CM subcategory G40.8, Other epilepsy and seizures. Recurrent seizures NOS is currently listed as an inclusion term at code G40.909, Epilepsy, unspecified, not intractable, without status epilepticus. In an effort to conform G40.8 with the ICD-9-CM AAN proposes that the term "recurrent" be added to subcategory G40.8. Other epilepsy and seizures. In addition the term recurrent seizures NOS, should be deleted from code G40.909 and added as an inclusion term to subcategory G40.8.

**TABULAR MODIFICATIONS**

<table>
<thead>
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<th>G40</th>
<th>Epilepsy and recurrent seizures</th>
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</thead>
<tbody>
<tr>
<td>G40.3</td>
<td>Generalized idiopathic epilepsy and epileptic syndromes</td>
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<td>Benign myoclonic epilepsy in infancy</td>
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<tr>
<td>Delete</td>
<td>Benign neonatal convulsions (familial)</td>
</tr>
<tr>
<td>Delete</td>
<td>Childhood absence epilepsy [pyknolepsy]</td>
</tr>
<tr>
<td>Delete</td>
<td>Epilepsy with grand mal seizures on awakening</td>
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<td>Delete</td>
<td>Grand mal seizure NOS</td>
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<tr>
<td>Delete</td>
<td>Juvenile absence epilepsy</td>
</tr>
<tr>
<td>Delete</td>
<td>Juvenile myoclonic epilepsy [impulsive petit mal]</td>
</tr>
<tr>
<td>Delete</td>
<td>Nonspecific atonic epileptic seizures</td>
</tr>
<tr>
<td>Delete</td>
<td>Nonspecific clonic epileptic seizures</td>
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<td>Delete</td>
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</tr>
<tr>
<td>Delete</td>
<td>Nonspecific tonic epileptic seizures</td>
</tr>
<tr>
<td>Delete</td>
<td>Nonspecific tonic-clonic epileptic seizures</td>
</tr>
<tr>
<td>Delete</td>
<td>Petit mal seizure NOS</td>
</tr>
</tbody>
</table>

New subcategory G40.A | Absence epileptic syndrome |
Add | Childhood absence epilepsy [pyknolepsy] |
Add | Juvenile absence epilepsy |
Add | Absence epileptic syndrome, NOS |

New subcategory G40.A0 | Absence Epileptic Syndrome, not intractable |

New code G40.A01 | Absence Epileptic Syndrome, not intractable, with status epilepticus |
New code G40.A09 | Absence Epileptic Syndrome, not intractable, without status epilepticus |

New subcategory G40.A1 | Absence Epileptic Syndrome, intractable |

New code G40.A11 | Absence Epileptic Syndrome, intractable, with status epilepticus |
New code
G40.A19 Absence Epileptic Syndrome, intractable, without status epilepticus

New subcategory
G40.B Juvenile myoclonic epilepsy [impulsive petit mal]

New subcategory
G40.B0 Juvenile myoclonic epilepsy, not intractable

New code
G40.B01 Juvenile myoclonic epilepsy, not intractable, with status epilepticus

New code
G40.B09 Juvenile myoclonic epilepsy, not intractable, without status epilepticus

New subcategory
G40.B1 Juvenile myoclonic epilepsy, intractable

New code
G40.B11 Juvenile myoclonic epilepsy, intractable, with status epilepticus

New code
G40.B19 Juvenile myoclonic epilepsy, intractable, without status epilepticus

G40.4 Other generalized epilepsy and epileptic syndromes
Add Epilepsy with grand mal seizures on awakening
Add Grand mal seizure NOS
Delete Infantile spasms
Delete Lennox-Gastaut syndrome
Add Nonspecific atonic epileptic seizures
Add Nonspecific clonic epileptic seizures
Add Nonspecific myoclonic epileptic seizures
Add Nonspecific tonic epileptic seizures
Add Nonspecific tonic-clonic epileptic seizures
Delete Salaam attacks
Delete West's syndrome

Revise G40.8 Other epilepsy and recurrent seizures
Add Recurrent seizures NOS

New subcategory
G40.82 Lennox-Gastaut Syndrome, not intractable

New code
G40.821 Lennox-Gastaut Syndrome, not intractable, with status epilepticus

New code
G40.829 Lennox-Gastaut Syndrome, not intractable, without status epilepticus
New subcategory G40.83 Lennox-Gastaut Syndrome, intractable

New code G40.831 Lennox-Gastaut Syndrome, intractable, with status epilepticus

New code G40.839 Lennox-Gastaut Syndrome, intractable, without status epilepticus

New subcategory G40.84 Epileptic spasms, not intractable

Add Infantile spasms, not intractable
Add Salaam attacks, not intractable
Add West's syndrome, not intractable

New code G40.841 Epileptic spasms, not intractable, with status epilepticus

New code G40.849 Epileptic spasms, not intractable, without status epilepticus

New subcategory G40.85 Epileptic spasms, intractable

Add Infantile spasms, intractable
Add Salaam attacks, intractable
Add West's syndrome, intractable

New code G40.851 Epileptic spasms, intractable, with status epilepticus

New code G40.859 Epileptic spasms, intractable, without status epilepticus

G40.9 Epilepsy, unspecified

G40.90 Epilepsy, unspecified, not intractable

G40.909 Epilepsy, unspecified, not intractable, without status epilepticus

Delete Recurrent seizures NOS

INDEX MODIFICATIONS

Note: The following index modifications were submitted with the AAN proposal. Complete modifications, including re-directing terms mentioned above and indexing any new codes will be listed in the complete ICD-10-CM index addenda.

Epilepsy, epileptic, epilepsia (attack) (cerebral) (convulsion) (fit) (seizure) G40.909

Revise - benign myoclonic in infancy - see Epilepsy, generalized, idiopathic
Add - - intractable G40.819
Add - - - with status epilepticus G40.811
Add - - - without status epilepticus G40.819
Add - - not intractable G40.809
Add - - - with status epilepticus G40.801
Add - - - without status epilepticus G40.809

Convulsions (idiopathic) (see also Seizure(s)) R56.9
Revise - - benign neonatal (familial) - see Epilepsy, generalized, idiopathic
Add - - intractable G40.819
Add - - - with status epilepticus G40.811
Add - - - without status epilepticus G40.819
Add - - not intractable G40.809
Add - - - with status epilepticus G40.801
Add - - - without status epilepticus G40.809

Seizure(s) (see also Convulsions) R56.9
Revise - recurrent G40.8-
Epileptic Seizures Related to External Causes

The descriptor for G40.5 “Special epileptic syndromes” does not accurately define the disorders included under this code. Epileptic seizures related to alcohol, drugs, hormonal changes, sleep deprivation and stress are really not syndromes, rather the seizures are symptomatic of the underlying related cause. (See pages 680 - 681 of the attached article for a discussion of epileptic syndromes) For this reason we propose revising the code descriptor for G40.5 to read Epileptic seizures related to external causes. We also propose to delete the intractable/non-intractable reference for these codes because as symptomatic seizures (those due to an external cause), they would not be intractable. However, they could still lead to status epilepticus. We also propose to add an Excludes2 note to ask that when applicable the appropriate epilepsy syndrome be coded first.

In addition, we are proposing to delete the inclusion term epilepsia partialis continua [Kozhevnikof] from G40.5. Epilepsia partialis continua [Kozhevnikof] by definition is a localization-related focal partial epilepsy with simple partial seizures and therefore should be coded to G40.1, Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures.

TABULAR MODIFICATIONS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<td>Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures</td>
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<td>Epilepsia partialis continua [Kozhevnikof]</td>
</tr>
<tr>
<td>Revise</td>
<td>G40.5 Special epileptic syndromes Epileptic seizures related to external causes</td>
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<tr>
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<td>Epilepsia partialis continua [Kozhevnikof]</td>
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<tr>
<td>Add</td>
<td>Excludes2: epilepsy and recurrent seizures (G40.0 - G40.9)</td>
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<tr>
<td>Revise</td>
<td>G40.50 Special epileptic syndromes Epileptic seizures related to external causes, not intractable</td>
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<td>Special epileptic syndromes without intractability</td>
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<td>Revise</td>
<td>G40.501 Special epileptic syndromes Epileptic seizures related to external causes, not intractable, with status epilepticus</td>
</tr>
<tr>
<td>Revise</td>
<td>G40.509 Special epileptic syndromes Epileptic seizures related to external causes, not intractable, without status epilepticus</td>
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<td>Special epileptic syndromes NOS</td>
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<tr>
<td>Add</td>
<td>Epileptic seizures related to external causes, NOS</td>
</tr>
<tr>
<td>Delete</td>
<td>G40.51 Special epileptic syndromes, intractable</td>
</tr>
<tr>
<td>Delete</td>
<td>G40.511 Special epileptic syndromes, intractable, with status epilepticus</td>
</tr>
<tr>
<td>Delete</td>
<td>G40.519 Special epileptic syndromes, intractable, without status epilepticus</td>
</tr>
</tbody>
</table>
Vascular Headaches

The American Headache Society (AHS) is requesting changes to category G44, Other headache syndromes. The proposed changes were developed with and are supported by the American Academy of Neurology (AAN).

The 2011 draft version of ICD-10-CM includes codes for vascular headache. In the International Classification of Headache Disorders, 2nd edition the term vascular headache is no longer specifically used. ICHD does include a code defined as headache attributed to cranial or cervical vascular disorder and states that "when a new headache occurs … in close temporal relation to a vascular disorder it is coded as a secondary headache attributed to the vascular disorder." The AHS is proposing that G44.1 be used in a similar fashion. For that reason it is proposed to delete codes G44.10 and G44.11 (see below) as intractability will not apply to this. Code G44.1 will, in almost all cases, be coded as a secondary diagnosis. The Excludes2 note is proposed to assure that a more specific migraine or headache code is used when that information is available.

TABULAR MODIFICATIONS

G44 Other headache syndromes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>G44.1</td>
<td>Vascular headache, not elsewhere classified</td>
</tr>
</tbody>
</table>

Add Excludes2: cluster headache (G44.0)
Add complicated headache syndromes (G44.5-)
Add drug-induced headache (G44.4-)
Add migraine (G43.-)
Add other specified headache syndromes (G44.8-)
Add post-traumatic headache (G44.3-)
Add tension-type headache (G44.2-)

Delete G44.10 Vascular headache, not elsewhere classified, not intractable
Delete Vascular headache NOS
Delete G44.11 Vascular headache, not elsewhere classified, intractable
Post-traumatic Headache

Currently, ICD-10-CM has an instruction at subcategory G44.3, Post-traumatic headache to “Code first postconcussional syndrome (F07.81)”. This instructional note is not listed at the equivalent ICD-9-CM subcategory 339.2X Post-traumatic headache. Additionally, ICD-10-CM code F07.81, Postconcussional syndrome has an instructional note to "Use additional code to identify associated post-traumatic headache (G44.3-)". In ICD-9-CM, the instructional note at code 310.2, Post-concussion syndrome states "Use additional code to identify associated post-traumatic headache, if applicable".

Chronic post-traumatic headache can occur independent of post-concussion syndrome, and therefore a "Code first" instruction is not appropriate. In addition, post-concussion syndrome requires the presence of three symptoms of which headache can be only one symptom. Also, this diagnosis requires that the symptoms be present for three months after the injury. The American Headache Society (AHS) proposes that the "Code first" instruction be removed from subcategory G44.3 and a revision be made to the instructional note for code F07.81 to include the phrase "if applicable".

**TABULAR MODIFICATION**

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<td>Personality and behavioral disorders due to known physiological condition</td>
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<td>F07.8</td>
<td>Other personality and behavioral disorders due to known physiological condition</td>
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<tr>
<td>F07.81</td>
<td>Postconcussional syndrome</td>
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<td>Use additional code to identify associated post-traumatic headache, if applicable (G44.3-)</td>
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<tr>
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<td>Other headache syndromes</td>
</tr>
<tr>
<td>G44.3</td>
<td>Post-traumatic headache</td>
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<td>Code first: postconcussional syndrome (F07.81)</td>
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</table>
**Ventral hernia**

In 2009 the World Health Organization (WHO) Update Reference Committee (URC) revised ICD-10 category K43, Ventral hernia. These changes will take effect, for ICD-10, in January 2013. Therefore they are proposed here as changes to ICD-10-CM so that they will be available when it is implemented October 1, 2013.

**TABULAR MODIFICATIONS**

<table>
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<th>Code</th>
<th>Description</th>
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<td>Ventral incisional hernia with obstruction, without gangrene</td>
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<tr>
<td>K43.1</td>
<td>Incisional hernia with gangrene</td>
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<td>K43.2</td>
<td>Incisional hernia without obstruction or gangrene</td>
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<td>K43.3</td>
<td>Parastomal hernia with obstruction, without gangrene</td>
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<td>K43.4</td>
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<td>K43.5</td>
<td>Parastomal hernia without obstruction or gangrene</td>
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<td>Other and unspecified ventral hernia with obstruction, without gangrene</td>
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<td>Ventral hernia, unspecified, with obstruction, without gangrene</td>
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<td>Incisional hernia, with gangrene</td>
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<td>Other ventral hernia, with gangrene</td>
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<td>Epigastric hernia</td>
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<td>Gangrenous ventral hernia</td>
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<tr>
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<td>Irreducible subxiphoid hernia without gangrene</td>
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Add Irreducible midline hernia without gangrene
Add Irreducible spigelian hernia without gangrene
Add Irreducible subxiphoid hernia without gangrene
Add Midline hernia causing obstruction, without gangrene
Add Spigelian hernia causing obstruction, without gangrene
Add Strangulated hypogastric hernia without gangrene
Add Strangulated midline hernia without gangrene
Add Strangulated spigelian hernia without gangrene
Add Strangulated subxiphoid hernia without gangrene
Add Subxiphoid hernia causing obstruction, without gangrene

New code K43.7 Other and unspecified ventral hernia with gangrene
Add Any condition listed under K43.6 specified as gangrenous

Revise K43.9 Other and unspecified ventral hernia without obstruction or gangrene
Add Ventral hernia NOS
Delete K43.90 Ventral hernia, unspecified, without obstruction or gangrene
Delete Ventral hernia NOS
Delete K43.91 Incisional hernia, without obstruction or gangrene
Delete K43.99 Other ventral hernia, without obstruction or gangrene
Delete Epigastric hernia
Methicillin Resistant Staphylococcus Aureus (MRSA) and Drug Resistance

In 2008 codes for Methicillin resistant Staphylococcus aureus (MRSA) were implemented, in several ICD-9-CM categories (038, 041, 482 and some V codes). This was in response to a request from the Centers for Disease Control and Prevention (CDC) to allow better tracking of these specific drug resistant infections.

In ICD-10-CM one code was created to capture drug resistance, Z16 Infection with drug resistant microorganisms. Therefore, more than one code is required to indicate a condition with drug resistance (example -- A41.0. Sepsis due to Staphylococcus aureus and Z16, Infection with drug resistant microorganisms). Additionally, if a patient has multiple drug resistant conditions, it may be difficult to match code Z16 with the appropriate code for the condition. Therefore, it has been suggested to add unique codes for MRSA, to ICD-10-CM, similar to those that were created in ICD-9-CM.

In addition, in 2009 and 2010 the World Health Organization (WHO) created and modified ICD-10 codes for drug resistance to antimicrobials and antineoplastic drugs. This further detail must also be added to ICD-10-CM before it is officially implemented on 10/1/2013. This can be accomplished by expanding category Z16.

NCHS is therefore proposing the following changes:

**TABULAR MODIFICATIONS**

**CHAPTER 1 Certain infectious and parasitic diseases (A00-B99)**

**Revise**

Use additional code for any associated drug resistance ([Z16-](#))

**A41 Other sepsis**

A41.0 Sepsis due to Staphylococcus aureus

**New code**

A41.01 Sepsis due to Methicillin susceptible Staphylococcus aureus

Add

MSSA sepsis

Add

Staphylococcus aureus sepsis NOS

**New code**

A41.02 Sepsis due to Methicillin resistant Staphylococcus aureus

**A49 Bacterial infection of unspecified site**

A49.0 Staphylococcal infection, unspecified site

**New code**

A49.01 Methicillin susceptible Staphylococcus aureus infection, unspecified site

Add

Methicillin susceptible Staphylococcus aureus (MSSA) infection

Add

Staphylococcus aureus infection NOS

**New code**

A49.02 Methicillin resistant Staphylococcus aureus infection, unspecified site

Add

Methicillin resistant Staphylococcus aureus (MRSA) infection
ICD-9-CM Coordination and Maintenance Committee Meeting
March 9-10, 2011

B95  Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified elsewhere

B95.6  Staphylococcus aureus as the cause of diseases classified elsewhere

New code  B95.61  Methicillin susceptible Staphylococcus aureus infection in diseases classified elsewhere
Add  Methicillin susceptible Staphylococcus aureus (MSSA) infection in diseases classified elsewhere
Add  Staphylococcus aureus infection NOS in diseases classified elsewhere

New code  B95.62  Methicillin resistant Staphylococcus aureus infection in diseases classified elsewhere
Add  Methicillin resistant staphylococcus aureus (MRSA) infection in diseases classified elsewhere

Malignant neoplasms (C00-C96)

Add  Use additional code (Z16.4) to identify resistance, non-responsiveness and refractive properties of the neoplasm to antineoplastic drugs

J15  Bacterial pneumonia, not elsewhere classified

    J15.2  Pneumonia due to staphylococcus

        J15.21  Pneumonia due to staphylococcus aureus

New code  J15.211  Pneumonia due to Methicillin susceptible Staphylococcus aureus
Add  MSSA pneumonia
Add  Pneumonia due to Staphylococcus aureus NOS

New code  J15.212  Pneumonia due to Methicillin resistant Staphylococcus aureus

Revise section  Resistance to antimicrobial and antineoplastic drugs (Z16)

Delete code  Z16  Infection with drug resistant microorganisms

Add category  Z16  Resistance to antimicrobial and antineoplastic drugs

Delete  This category is intended for use as an additional code for infectious conditions classified elsewhere to indicate the presence of drug resistance of the infectious organism

Add note  Note: The codes in this category are provided for use as additional codes to identify the resistance, non-responsiveness and refractive properties of a condition to antimicrobials and antineoplastic drugs.

Code first the infection

Add  Excludes1: Methicillin resistant Staphylococcus aureus pneumonia (J15.212)
Add  Methicillin resistant Staphylococcus aureus infection (A49.02)
Add Methicillin resistant Staphylococcus aureus infection in diseases classified elsewhere (B95.62)
Add Sepsis due to Methicillin resistant Staphylococcus aureus (A41.02)

New subcategory Z16.1 Resistance to beta lactam antibiotics
New code Z16.10 Resistance to unspecified beta lactam antibiotics
New code Z16.11 Resistance to penicillins
Resistance to amoxicillin
Resistance to ampicillin
New code Z16.12 Extended spectrum beta lactamase (ESBL) resistance
New code Z16.19 Resistance to other specified beta lactam antibiotics
Resistance to cephalosporins

New subcategory Z16.2 Resistance to other antibiotics
New code Z16.20 Resistance to unspecified antibiotic
Resistance to antibiotics NOS
New code Z16.21 Resistance to vancomycin
New code Z16.22 Resistance to vancomycin related antibiotics
New code Z16.23 Resistance to quinolones and fluoroquinolones
New code Z16.24 Resistance to multiple antibiotics
New code Z16.29 Resistance to other single specified antibiotic
Resistance to aminoglycosides
Add Resistance to macrolides
Add Resistance to sulfonamides
Add Resistance to tetracyclines

New subcategory Z16.3 Resistance to other antimicrobial drugs
Add Excludes1: resistance to antibiotics (Z16.1-, Z16.2-)
New code Z16.30 Resistance to unspecified antimicrobial drugs
Drug resistance NOS
New code Z16.31 Resistance to antiparasitic drug(s)
Resistance to quinine and related compounds
New code Z16.32 Resistance to antifungal drug(s)
New code Z16.33 Resistance to antiviral drug(s)
New subcategory
Z16.34   Resistance to antmycobacterial drug(s)
Add
Resistance to tuberculostatics
New code
Z16.341   Resistance to single antmycobacterial drug
Resistance to antmycobacterial drug NOS
New code
Z16.342   Resistance to multiple antmycobacterial drugs
New code
Z16.35   Resistance to multiple antimicrobial drugs
Add
Excludes1:  Resistance to multiple antibiotics only (Z16.23)
New code
Z16.39   Resistance to other specified antimicrobial drug
New code
Z16.4   Resistance to antineoplastic drugs
Add
Includes:  Non-responsiveness to antineoplastic drugs
Add
Refractory cancer

Z22   Carrier of infectious disease
Z22.3   Carrier of other specified bacterial diseases
Z22.32   Carrier of bacterial disease due to staphylococci
New code
Z22.321   Carrier or suspected carrier of Methicillin susceptible
Staphylococcus aureus
Add
MSSA colonization
New code
Z22.322   Carrier or suspected carrier of Methicillin resistant
Staphylococcus aureus
Add
MRSA colonization

Z86   Personal history of certain other diseases
Z86.1   Personal history of infectious and parasitic diseases
Z86.19   Personal history of other infectious and parasitic diseases
New code
Z86.191   Personal history of Methicillin resistant Staphylococcus
aureus infection
Add
Personal history of MRSA infection
Underdosing

Comments received following the September 2010 ICD-9-CM Coordination and Maintenance (C&M) Committee presentation of a proposal for modification to codes for opioids included concerns about the use of the term/concept of underdosing.

Discussion is needed to review the need for this concept in ICD-10-CM. This concept was added with the intent to be able to track incidents where a person did not receive adequate dose of a given medication.

There could be several reasons for underdosing, some of which include:

1. Prescription error – especially with medications where there is no established dose for a drug, such as a pediatric patient receiving a medication usually given to adults.
2. Patient/caretaker error – This could be either intentional, perhaps due to financial constraint or noncompliance issues, or unintentional such as misunderstanding dosage instructions or cognitive issues.
3. Dose adjustment needed based on blood level testing.
4. Dosage titration problems.

Underdosing can result in the disease not being properly treated or controlled which can lead to additional medical care and treatment.

The concept of underdosing does not exist in ICD-10 as released by the World Health Organization (WHO). The following changes are proposed in order to retain the concept of underdosing in ICD-10-CM:

- The definitions currently shown at the beginning of section “Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances” (T36-T50) were originally stated as inclusion statements in ICD-10 and it is recommended to return them to that format. Any definition or further instruction of these could be handled in the official coding guidelines.

- It was overwhelmingly recommended, in the comments received after the September 2010 C&M meeting, to remove any codes where the concept of underdosing is not clinically appropriate. This was especially true of codes in category T40, Poisoning by, adverse effect of and underdosing of narcotics and psychodysleptics [hallucinogens]. These are shown in the proposed modifications.

- There are also proposed changes to related codes for reason or intent for underdosing in the Chapters 20 and 21.

**TABULAR MODIFICATIONS**

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

*Delete includes: poisoning is defined as:*

*Delete overdose of substances wrong substance given or taken in error*

*Delete adverse effect is defined as:*

"hypersensitivity", "reaction", etc. of correct substance properly administered

*Delete underdosing is defined as:*

taking less of a medication than is prescribed or instructed by the manufacturer, whether inadvertently or deliberately

*Add includes: overdose of these substances*

*Add taking less substance than prescribed*

*Add wrong substance given or taken in error*
<table>
<thead>
<tr>
<th>Revise</th>
<th>T40</th>
<th>Poisoning by \textit{and} adverse effect of and \textit{underdosing of} narcotics and psychodysleptics [hallucinogens]</th>
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<tbody>
<tr>
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<td>T40.0</td>
<td>Poisoning by \textit{and} adverse effect of and \textit{underdosing of} opium</td>
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<td>T40.1x6</td>
<td>Underdosing of heroin</td>
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<tr>
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<td>Underdosing of methadone</td>
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<td>T40.5</td>
<td>Poisoning by \textit{and} adverse effect of and \textit{underdosing of} cocaine</td>
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<td>Poisoning by \textit{and} adverse effect of and \textit{underdosing of} cocaine</td>
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<td>Underdosing of cocaine</td>
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<tr>
<td>Revise</td>
<td>T40.6</td>
<td>Poisoning by \textit{and} adverse effect of and \textit{underdosing of} other and unspecified narcotics</td>
</tr>
<tr>
<td>Revise</td>
<td>T40.60</td>
<td>Poisoning by \textit{and} adverse effect of and \textit{underdosing of} unspecified narcotics</td>
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<tr>
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<td>T40.606</td>
<td>Underdosing of unspecified narcotics</td>
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<tr>
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<td>T40.69</td>
<td>Poisoning by \textit{and} adverse effect of and \textit{underdosing of} other narcotics</td>
</tr>
<tr>
<td>Delete</td>
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<td>Underdosing of other narcotics</td>
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<tr>
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<td>T40.7</td>
<td>Poisoning by \textit{and} adverse effect of and \textit{underdosing of} cannabis (derivatives)</td>
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<td>T40.7x6</td>
<td>Underdosing of cannabis (derivatives)</td>
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<td>T40.8</td>
<td>Poisoning by \textit{and} adverse effect of and \textit{underdosing of} lysergide [LSD]</td>
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<td>Poisoning by and adverse effect of lysergide [LSD]</td>
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<tr>
<td>Delete</td>
<td>T40.8x6</td>
<td>Underdosing of lysergide [LSD]</td>
</tr>
<tr>
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<td>T40.9</td>
<td>Poisoning by \textit{and} adverse effect of and \textit{underdosing of} other and unspecified psychodysleptics [hallucinogens]</td>
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<tr>
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<td>T40.90</td>
<td>Poisoning by \textit{and} adverse effect of and \textit{underdosing of} unspecified psychodysleptics [hallucinogens]</td>
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<tr>
<td>Delete</td>
<td>T40.906</td>
<td>Underdosing of unspecified psychodysleptics</td>
</tr>
</tbody>
</table>
Revise T40.99 Poisoning by, and adverse effect of and underdosing of other psychodysleptics [hallucinogens]
Delete T40.996 Underdosing of other psychodysleptics

Y63 Failure in dosage during surgical and medical care
   Y63.6 Underdosing and nonadministration of necessary drug, medicament or biological substance
Delete Y63.61 Underdosing of necessary drug, medicament or biological substance
Delete Y63.62 Nonadministration of necessary drug, medicament or biological substance

Y63.8 Failure in dosage during other surgical and medical care
Y63.9 Failure in dosage during unspecified surgical and medical care

Z91 Personal risk factors, not elsewhere classified
Delete Z91.1 Patient's noncompliance with medical treatment and regimen
Delete Z91.12 Patient's intentional underdosing of medication regimen
Delete Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship
Delete Z91.128 Patient's intentional underdosing of medication regimen for other reason
Delete Z91.13 Patient's unintentional underdosing of medication regimen
Delete Z91.130 Patient's unintentional underdosing of medication regimen due to age-related debility
Delete Z91.138 Patient's unintentional underdosing of medication regimen for other reason
Delete Z91.14 Patient's other noncompliance with medication regimen
Delete Patient's underdosing of medication NOS
Orthopedic deformities

ICD-9-CM has unique codes for several orthopedic conditions but there are no parallel codes for those conditions in ICD-10-CM. The conditions are acquired valgus and varus deformities of the hip (codes 736.31 and 736.32), vertical talus as deformity (754.61) and congenital valgus and varus deformities of the hip (codes 755.61 and 755.62).

The American Academy of Orthopedic Surgeons (AAOS) supports the addition of new codes for these conditions.

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>New subcategory</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M21.05 Valgus deformity, not elsewhere classified, hip</td>
<td>M21.051</td>
<td>Valgus deformity, not elsewhere classified, right hip</td>
</tr>
<tr>
<td></td>
<td>M21.052</td>
<td>Valgus deformity, not elsewhere classified, left hip</td>
</tr>
<tr>
<td></td>
<td>M21.059</td>
<td>Valgus deformity, not elsewhere classified, unspecified hip</td>
</tr>
<tr>
<td>M21.15 Varus deformity, not elsewhere classified, hip</td>
<td>M21.151</td>
<td>Varus deformity, not elsewhere classified, right hip</td>
</tr>
<tr>
<td></td>
<td>M21.152</td>
<td>Varus deformity, not elsewhere classified, left hip</td>
</tr>
<tr>
<td></td>
<td>M21.159</td>
<td>Varus deformity, not elsewhere classified, unspecified hip</td>
</tr>
</tbody>
</table>

| Q65 Congenital deformities of hip | Q65.8 Other congenital deformities of hip | Q65.81 Congenital coxa valga |
| Q65.82 Congenital coxa vara |

| Q66 Congenital deformities of feet | Q66.5 Other congenital deformities of feet |
| Q66.50 Congenital pes planus, unspecified foot |
| Q66.51 Congenital pes planus, right foot |
| Q66.52 Congenital pes planus, left foot |

| Q66.8 Other congenital deformities of feet | Q66.80 Congenital vertical talus deformity, unspecified foot |
| Q66.81 Congenital vertical talus deformity, right foot |
| Q66.82 Congenital vertical talus deformity, left foot |
| Q66.89 Other congenital deformity of feet |
Hidden or buried penis

Buried penis was described in the early 20th century as a penis of normal size that lacks an appropriate sheath of skin and is located beneath the integument of the abdomen, thigh, or scrotum. This condition is more common in children, usually presenting in neonates or obese prepubertal boys; however, it can also be seen in adults and has been observed in both circumcised and uncircumcised individuals. Marginal cases may not be diagnosed until adulthood, when increased fat deposition accentuates the problem in patient who may not be considered obese. The reason that the condition may be seen in adults is a result of balanitis xerotica obliterans (BXO) that leads to scarring and tightness of the foreskin, or phimosis (inability to pull the foreskin back behind the glans. The skin of the lower abdomen and pubis descends or sags with age, causing the penis of some men to hide under excess skin and fat deposits. Several classification systems of buried penis have been proposed, although none has been universally adopted in the literature. In most congenital pediatric cases, the buried penis is self-limited. In untreated adults, however, the condition tends to worsen as the abdominal pannus continues to grow.

The code for congenital buried penis was presented at the September 2010 ICD-9-CM Coordination and Maintenance meeting. The American Urological Association believes that it is necessary to add a code for acquired buried penis to be able to track the occurrence of buried penis that is not a congenital defect.

**TABULAR MODIFICATION**

<table>
<thead>
<tr>
<th>N48</th>
<th>Other disorders of penis</th>
</tr>
</thead>
<tbody>
<tr>
<td>New code</td>
<td>N48.7 Buried penis, acquired</td>
</tr>
</tbody>
</table>
Glasgow Coma Scale

The Glasgow Coma Scale (GCS) was introduced in 1974 by Drs. Teasdale and Jennett. This scale is composed of a score of 3 observations: status of eye opening, best verbal response and best motor response. The highest possible score is 15. The GCS is easily performed by many levels of medical personnel. Though the GCS was initially developed to measure coma and predict outcome in traumatic brain injury, it has been found a useful predictor of outcome in many other types of acute neurological impairment. It is widely used in emergency medicine, intensive care medicine, neurological, neurosurgical and trauma medicine assessments.

There are situations in which the full GCS assessment is difficult to perform. In the case of a sedated ventilator patient only the motor responses might be assessed, yet this limited score still has predictive value. Pediatric patients may require a variation of the GCS (the Pediatric Glasgow Coma Scale) that is also scored and on a 15-point basis with good predictive value.

In ICD-10-CM, coma requires three codes, each reflecting the score of one of the three areas of measurement of the GCS, and the specific time the test is administered. This is useful for trauma registries, but the more common entry into the medical record will be a total GCS score or no score at all, and the timing may not be available. The predictive value of the data is better associated with the total score than the individual variables. In the case of the sedated ventilator patient, only a best motor score might be documented. The timing of the test will have different predictive value depending on the situation.

For data coming from trauma registries, full reporting could be captured by separating coma associated with trauma from all other coma. The GCS total score stratification can be associated with other and unspecified coma as long as there is an option for instances when the GCS is not documented.

The American Academy of Neurology has proposed adding codes to ICD-10-CM to capture the GSC assessment when the detailed components are not included in the medical record documentation.

TABULAR MODIFICATION

R40.2  Coma

  R40.20  Unspecified coma
  Add    Coma NOS
  Add    Unconsciousness NOS

New subcategory   R40.24  Glasgow Coma coma scale, Total score
  Use codes R40.21- - R40.23- only when the individual score(s) are documented

New code    R40.241  Glasgow Coma Scale score 13-15
New code    R40.242  Glasgow Coma Scale score 9-12
New code    R40.243  Glasgow Coma Scale score 3-8
New code    R40.244  Glasgow Coma Scale score less than 3
New code    R40.245  Other coma, without documented Glasgow Coma Scale score, or with partial score reported.
Femoroacetabular impingement

Over the last ten years, orthopedists have identified a pathologic entity, femoroacetabular impingement (FAI) that is the cause of hip pain and dysfunction. It develops in young patients and is thought to be a condition that contributes to the ultimate development of osteoarthritis of the hip. FAI occurs when there is recurrent abutment of the anterolateral femoral head and neck upon the anterolateral rim of the acetabulum. FAI can be associated with tears of the acetabular labrum. The lesions are classified as femoral (cam) or acetabular-based (pincer) deformities. Both may occur at once.

Surgical approaches to FAI have included both open dislocations of the hip and arthroscopic approaches to this problem. The American Academy of Orthopedic Surgeons (AAOS) has requested that new codes be created for this condition.

**TABULAR MODIFICATIONS**

M24.8 Other specific joint derangements, not elsewhere classified

Note: The appropriate 7th character is to be added to each code from subcategory M24.A5:

- A cam lesion (femoral side)
- B pincer lesion (acetabular side)
- C with labral tear
- D with hip arthritis

New subcategory M24.A5 Impingement

New code M24.A51 Femoroacetabular impingement, right side

New code M24.A52 Femoroacetabular impingement, left side

New code M24.A53 Femoroacetabular impingement, bilateral

New code M24.A59 Femoroacetabular impingement, unspecified side
Dehiscence of amputation stump

Questions have been raised related to coding for a dehiscence of an amputation stump. While it is a type of disruption of an operation wound, it is also a complication of an amputation. Thus, it is coded in ICD-10-CM to T87.8, Other complications of amputation stump. It is proposed to provide a specific code for dehiscence of an amputation stump. This issue was raised related to questions to the Editorial Advisory Board for Coding Clinic.

**TABULAR MODIFICATIONS**

T81 Complications of procedures, not elsewhere classified
   T81.3 Disruption of wound, not elsewhere classified
      T81.31 Disruption of external operation (surgical) wound, not elsewhere classified
   Add: Excludes: dehiscence of amputation stump (T87.81)

T87 Complications peculiar to reattachment and amputation
   T87.8 Other complications of amputation stump
      Amputation stump contracture
      Amputation stump contracture of next proximal joint
      Amputation stump flexion
      Amputation stump edema
      Amputation stump hematoma
   New code T87.81 Dehiscence of amputation stump
   New code T87.89 Other complications of amputation stump
      Amputation stump contracture
      Amputation stump contracture of next proximal joint
      Amputation stump flexion
      Amputation stump edema
      Amputation stump hematoma
Benign Shuddering Attacks

Benign shuddering attacks are a paroxysmal nonepileptic condition found in infants and toddlers. These may resemble seizures, and require evaluation to differentiate. In ICD-9-CM this condition had its own code at 333.93. This condition is not currently indexed nor does it have a specific code in ICD-10-CM.

The American Academy of Neurology (AAN) has requested changes to ICD-10-CM to provide a code for benign shuddering attacks.

**TABULAR MODIFICATIONS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>G25.8</td>
<td>Other specified extrapyramidal and movement disorders</td>
</tr>
<tr>
<td>New code</td>
<td>G25.83 Benign shuddering attacks</td>
</tr>
</tbody>
</table>
Pulmonary conditions

Certain pulmonary conditions are represented by specific codes in ICD-9-CM, but do not have specific codes in ICD-10-CM. It has been proposed by Dr. Frank McCormack and Dr. Alan Plummer, in coordination with the American College of Chest Physicians, to add specific codes for certain of these specific conditions. These include alveolar proteinosis (516.0) and pulmonary alveolar microlithiasis (516.2), which had been included together at J84.0, Alveolar and parieto-alveolar conditions.

Idiopathic pulmonary hemosiderosis (516.1) is currently indexed in ICD-10-CM to E83.19 [J99]. It is proposed to create a new subcategory, J84.17, Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere, and a new code within that for Idiopathic pulmonary hemosiderosis, that would be used together with code E83.19, Other disorders of iron metabolism.

Postinflammatory pulmonary fibrosis (515) in ICD-9-CM includes pulmonary fibrosis NOS, and a number of additional terms. Related terms in ICD-10-CM go to code J84.1, Other interstitial pulmonary diseases with fibrosis. Consistent with prior ICD-9-CM proposals, that will be expanded. It is proposed to also add a code for pulmonary fibrosis, unspecified, and include postinflammatory pulmonary fibrosis and additional relevant terms there.

TABULAR MODIFICATIONS

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<td>Disorders of iron metabolism</td>
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<td>E83.19</td>
<td>Other disorders of iron metabolism</td>
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<td>Use additional code, if applicable, for idiopathic pulmonary hemosiderosis (J84.171)</td>
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<tr>
<td>J84</td>
<td>Other interstitial pulmonary diseases</td>
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<td>Alveolar and parieto-alveolar conditions</td>
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</table>
### J84.1 Other interstitial pulmonary diseases with fibrosis

<table>
<thead>
<tr>
<th>Delete</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cirrhosis of lung</td>
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<tr>
<td>Diffuse pulmonary fibrosis</td>
<td></td>
</tr>
<tr>
<td>Fibrosing alveolitis (cryptogenic)</td>
<td></td>
</tr>
<tr>
<td>Hamman-Rich syndrome</td>
<td></td>
</tr>
<tr>
<td>Idiopathic pulmonary fibrosis</td>
<td></td>
</tr>
<tr>
<td>Induration of lung</td>
<td></td>
</tr>
<tr>
<td>Usual interstitial pneumonia</td>
<td></td>
</tr>
</tbody>
</table>

**New code**  
J84.10 Pulmonary fibrosis, unspecified

- Postinflammatory pulmonary fibrosis
- Cirrhosis of lung (chronic or unspecified)
- Fibrosis of lung (atrophic) (confluent) (massive)
  - (perialveolar) (peribronchial) chronic or unspecified
- Induration of lung chronic or unspecified

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

**New code**  
J84.171 Idiopathic pulmonary hemosiderosis

- Essential brown induration of lung

**Code first underlying disease (E83.10-E83.19)**

**Excludes:** acute idiopathic pulmonary hemorrhage in infants [AIPHI] (R04.81)

**New code**  
J84.178 Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere

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

**Code first underlying disease, such as:**

- progressive systemic sclerosis (M34.0)
- rheumatoid arthritis (M05.00-M06.9)
- systemic lupus erythematosis (M32.0-M32.9)
Complications of genitourinary devices, implants and grafts

In reviewing the ICD-10-CM section for genitourinary prosthetic devices, grafts and implants (T83.--), the American Urological Association believes this section needs to be revised to incorporate appropriate terminology and current urological medical practice. There are certain occurrences for urological devices and prosthetics that should be included in this section and other instances where refinements are needed to remove references to specific complications that do not occur for a particular device, implant or graft.

**TABULAR MODIFICATIONS**

T83 Complications of genitourinary prosthetic devices, implants and grafts

Revise T83.0 Mechanical complication of urinary (indwelling) catheter or stent

Revise T83.01 Breakdown (mechanical) of urinary (indwelling) catheter or stent
New code T83.011 Breakdown (mechanical) of indwelling urethral catheter
New code T83.012 Breakdown (mechanical) of indwelling ureteral stent
Revise T83.018 Breakdown (mechanical) of other indwelling urethral urinary catheter

Revise T83.02 Displacement of urinary (indwelling) catheter or stent
Revise Malposition of urinary (indwelling) catheter
New code T83.021 Displacement of indwelling urethral catheter
New code T83.022 Displacement of indwelling ureteral stent
Revise T83.028 Displacement of other indwelling urethral urinary catheter

Revise T83.03 Leakage of urinary (indwelling) catheter
New code T83.031 Leakage of indwelling urethral catheter
Revise T83.038 Leakage of other indwelling urethral urinary catheter

Revise T83.09 Other mechanical complication of urinary (indwelling) catheter or stent
Revise Obstruction (mechanical) of urinary (indwelling) catheter or stent
Revise Perforation of urinary (indwelling) catheter or stent
Revise Protrusion of urinary (indwelling) catheter or stent
New code T83.091 Other mechanical complication of indwelling urethral catheter
New code T83.092 Other mechanical complication of indwelling ureteral stent
Revise T83.098 Other mechanical complication of other indwelling urethral urinary catheter
Revise T83.4 Mechanical complication of devices, prosthetics, implants and grafts of genital genitourinary tract

Revise T83.41 Breakdown (mechanical) of other prosthetic devices, implants and grafts of genital genitourinary tract

New code T83.411 Breakdown (mechanical) of urinary electronic (implanted) device
Includes: breakdown of pulse generator or receiver for sacral nerve neurostimulation

New code T83.412 Breakdown (mechanical) of urinary sphincter (implanted)

Revise T83.418 Breakdown (mechanical) of other prosthetic devices, implants and grafts of genital genitourinary tract

Revise T83.42 Displacement of other prosthetic devices, implants and grafts of genital genitourinary tract

Revise Malposition of other prosthetic devices, implants and grafts of genitourinary tract

New code T83.421 Displacement of urinary sphincter implant

New code T83.422 Displacement of urinary device (implanted)
Includes: breakdown of pulse generator or receiver for sacral nerve neurostimulation

Revise T83.428 Displacement of other prosthetics devices, implants and grafts of genital genitourinary tract

Revise T83.49 Other mechanical complication of other prosthetics devices, implants and grafts of genital genitourinary tract

Revise Leakage of other prosthetic devices, implants and grafts of genitourinary genital tract

Revise Obstruction, mechanical of other prosthetic devices, implants and grafts of genitourinary genital tract

Revise Perforation of other prosthetic devices, implants and grafts of genitourinary genital tract

Revise Protrusion of other prosthetic devices, implants and grafts of genitourinary genital tract

New code T83.491 Other mechanical complication of urinary sphincter (implanted)

New code T83.492 Other mechanical complication of urinary electronic device
Includes: breakdown of pulse generator or receiver for sacral nerve neurostimulation

T83.498 Other mechanical complication of other prosthetic devices, implants and grafts of genital tract

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

Revise T83.51 Infection and inflammatory reaction due to indwelling urinary catheter
New code  T83.510 Infection and inflammatory reaction due to cystostomy cathether
New code  T83.511 Infection and inflammatory reaction due to indwelling uretheral cathether
New code  T83.512 Infection and inflammatory reaction due to other urinary cathether
New code T83.52 Infection and inflammatory reaction due to other urinary devices and implants
New code T83.53 Infection and inflammatory reaction due to graft of urinary organ
New code T83.54 Infection and inflammatory reaction due to penile (implanted) prosthesis
New code T83.55 Infection and inflammatory reaction due to urinary sphincter (implanted)
New code T83.56 Infection and inflammatory reaction due to indwelling ureteral stent
New code T83.57 Infection and inflammatory reaction due to urinary electronic device (implanted)
Revise T83.59 Infection and inflammatory reaction due to other prosthetic device, implant and graft in urinary system

T85 Complications of other internal prosthetic devices, implants and grafts

T85.1 Mechanical complication of implanted electronic stimulator of nervous system
   T85.11 Breakdown (mechanical) of implanted electronic stimulator of nervous system
   T85.110 Breakdown (mechanical) of implanted electronic neurostimulator of brain
Add      Includes: pulse generator and/or electrode array of brain

   T85.111 Breakdown (mechanical) of implanted electronic neurostimulator of peripheral nerve
Add      Includes: pulse generator and/or electrode array of peripheral nerve

   T85.112 Breakdown (mechanical) of implanted electronic neurostimulator of spinal cord
Add      Includes: pulse generator and/or electrode array of spinal cord
   T85.113 Breakdown (mechanical) of implanted electronic neurostimulator sacral nerve
Add      Includes: pulse generator and/or electrode of sacral nerve

T85.12 Displacement of implanted electronic stimulator of nervous system
   T85.120 Displacement of implanted electronic neurostimulator of brain
Add      Includes: pulse generator and/or electrode array of brain
   T85.121 Displacement of implanted electronic neurostimulator of peripheral nerve
Add Includes: pulse generator and/or electrode array of peripheral nerve
T85.122 Displacement of implanted electronic neurostimulator of spinal cord

Add Includes: pulse generator and/or electrode array of spinal cord (electrode)
T85.123 Displacement of implanted electronic neurostimulator of sacral nerve

Add Includes: pulse generator and/or electrode array of sacral nerve

T85.19 Other mechanical complication of implanted electronic stimulator of nervous system

T85.190 Other mechanical complication of implanted electronic neurostimulator (electrode) of brain

Add Includes: pulse generator and/or electrode array of brain

T85.191 Other mechanical complication of implanted electronic neurostimulator electrode of peripheral nerve

Add Pulse generator and/or electrode array of peripheral nerve

T85.192 Other mechanical complication of implanted electronic neurostimulator (electrode) of spinal cord

Add Includes: pulse generator and/or electrode array of spinal cord

New code T85.193 Other mechanical complication of implanted electronic neurostimulator (electrode) of sacral nerve

Includes: pulse generator and/or electrode array of sacral nerve
Posterior Reversible Encephalopathy Syndrome (PRES) and Cerebral Vasoconstriction

Posterior Reversible Encephalopathy Syndrome (PRES) is a syndrome of vasogenic edema that can be associated with eclampsia (and preeclampsia), severe or acute hypertension, immunosuppressants, renal disease and autoimmune disease. The clinical presentation includes headaches, seizures, vision changes and encephalopathy. Brain MRI's of these patients will show focal (and later reversible) vasogenic edema. There is not one consistent arterial abnormality on radiography. Proposed pathophysiologies include a breakdown of cerebral regulation, endothelial dysfunction, and vasospasm.

Currently PRES is indexed in ICD-10-CM to G93.49, Other encephalopathy. Since all of the proposed mechanisms are vascular, PRES would better be represented with cerebrovascular diseases. Also, PRES is a widely recognized syndrome which warrants its own ICD-10-CM code.

Cerebral vasoconstriction syndromes are different than PRES, though both are reversible and have similar presentations. There is some overlap between the two. These patients present with the sudden onset of headache (sometimes a “Thunderclap” headache syndrome), nausea, vomiting, confusion, and visual change. They may develop focal neurologic deficits. Generalized seizures may be present. The symptoms improve over days to weeks. Cerebral vasoconstriction may be focal or diffuse, and by definition angiography will be abnormal, usually with segmental constriction and dilatation (“string of beads”). The MRI may be normal, or may show ischemic or hemorrhagic, single or multifocal strokes. Besides the earlier clinical improvement, this syndrome is differentiated from the more serious primary angiitis of the central nervous system (PACNS) by angiographic reversibility of the vasoconstriction. The Call-Fleming syndrome is one of the reversible cerebral vasoconstriction syndromes. This type of vasoconstriction is also separate from that associated with aneurysmal subarachnoid hemorrhage and other similar conditions. Reversible cerebrovascular vasoconstriction can also be associated with eclampsia and preeclampsia, as well as migraine, illicit vasoactive drugs such as Ecstasy, vasoactive medications, and some chemotherapeutic agents. There have been other reported associations.

ICD-10-CM indexes Cerebral (artery) vasospasm to G45.9, Transient cerebral ischemic attack, unspecified. This is incorrect placement, as vasospasm is not always transient and not always ischemic.

The American Academy of Neurology (AAN) has requested changes to ICD-10-CM to address these issues.
ICD-9-CM Coordination and Maintenance Committee Meeting
March 9-10, 2011

TABULAR MODIFICATIONS

I67 Other cerebrovascular diseases

I67.8 Other specified cerebrovascular diseases

Delete Acute cerebrovascular insufficiency NOS
Delete Cerebral ischemia (chronic)

New code I67.80 Cerebrovascular disease, unspecified

New code I67.81 Acute cerebrovascular insufficiency
Acute cerebrovascular insufficiency unspecified as to location or reversibility

New code I67.82 Cerebral ischemia (chronic)

New code I67.83 Posterior reversible encephalopathy syndrome (PRES)

New subcategory I67.84 Cerebral vasospasm and vasoconstriction

New code I67.841 Reversible cerebrovascular vasoconstriction syndrome
Call-Fleming syndrome

Code first underlying condition if applicable, such as: eclampsia (O15.00-O15.9)

New code I67.848 Other cerebrovascular vasospasm and vasoconstriction

New code I67.89 Other cerebrovascular disease

INDEX MODIFICATIONS

Revise PRES (Posterior Reversible Encephalopathy Syndrome) G93.49 I67.83

Revise Vasospasm (vasoconstriction) I73.9
Revise - cerebral (artery) G45.9 I67.848
Add - - reversible I67.841
Acute Necrotizing Hemorrhagic Encephalopathy

Acute necrotizing hemorrhagic encephalopathy (ANHE), also known as acute hemorrhagic leukoencephalitis or acute hemorrhagic encephalomyelitis is a relatively rare disorder with a high rate of mortality and morbidity. In contrast to acute disseminated encephalomyelitis (ADEM), ANHE has a hyperacute course and is characterized by prominent necrotizing cerebral vasculitis and hemorrhage. As with ADEM, ANHE made be due to post infectious or post immunization etiologies, however some cases have been associated with ulcerative colitis, septicemia, other underlying conditions, or the etiology may not be determined. In ICD-10, ANHE in these other cases would default to G04.30, Post infectious acute necrotizing hemorrhagic encephalopathy, which would not correctly reflect their etiology.

The American Academy of Neurology (AAN) has requested addition of a new code to ICD-10-CM to enable more accurately representing this disorder.

TABULAR MODIFICATIONS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>G04.30</td>
<td>Acute necrotizing hemorrhagic encephalopathy, unspecified</td>
</tr>
<tr>
<td></td>
<td>Post infectious acute necrotizing hemorrhagic encephalopathy</td>
</tr>
<tr>
<td>Revise</td>
<td></td>
</tr>
<tr>
<td>G04.31</td>
<td>Postinfectious acute necrotizing hemorrhagic encephalopathy</td>
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<td>Postimmunization acute necrotizing hemorrhagic encephalopathy</td>
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<td>Delete</td>
<td></td>
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<tr>
<td>Acute necrotizing hemorrhagic encephalopathy NOS</td>
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<tr>
<td>Revise</td>
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<tr>
<td>G04.32</td>
<td>Postimmunization acute necrotizing hemorrhagic encephalopathy</td>
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<tr>
<td>G04.39</td>
<td>Other acute necrotizing hemorrhagic encephalopathy</td>
</tr>
<tr>
<td></td>
<td>Code also underlying etiology, if applicable</td>
</tr>
</tbody>
</table>

Use additional code to identify the vaccine (T50.A-, T50.B-, T50.Z-).
Acute disseminated encephalitis and encephalomyelitis (ADEM)

Acute disseminated encephalitis and encephalomyelitis (ADEM) is an acute neurological disorder occurring in persons of all ages, although most often in children. Widespread availability of MRI has facilitated diagnosis of ADEM, which is associated with multiple inflammatory lesions in the white matter and gray matter of the brain and spinal cord, due to autoimmune demyelination. Symptoms are variable and may include coma, seizures, loss of vision, and other cranial nerve palsies.

ADEM has occurred after immunizations or infections, but in many cases no such association can be made. In ICD-10, such cases would default to G04.00 (post infectious ADEM), or present the possibility of classification as G04.81, Other encephalitis and encephalomyelitis, Noninfectious acute disseminated encephalomyelitis (noninfectious ADEM). In reality, all cases included in G04.0x are also “noninfectious,” but rather are post infectious or postimmunization. Cases of ADEM not determined to be post infectious or post immunization belong in the ADEM code family, appropriately designated.

The American Academy of Neurology (AAN) has requested addition of a new code to ICD-10-CM to enable better representation for this disorder.

**TABULAR MODIFICATIONS**

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<tr>
<th>Code</th>
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<tr>
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<td>Acute disseminated encephalitis and encephalomyelitis (ADEM)</td>
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<td>Excludes1: Other noninfectious acute disseminated encephalomyelitis (noninfectious ADEM) (G04.81)</td>
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<td>Revise</td>
<td>G04.00 Acute disseminated encephalitis and encephalomyelitis, unspecified Post infectious acute disseminated encephalitis and encephalomyelitis (post infectious ADEM)</td>
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<tr>
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<td>Acute disseminated encephalitis and encephalomyelitis NOS</td>
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<td>Delete</td>
<td>Excludes1: noninfectious acute disseminated encephalomyelitis (noninfectious ADEM) (G04.81)</td>
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<tr>
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<td>post chickenpox encephalitis (B01.1)</td>
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<tr>
<td>Delete</td>
<td>post measles encephalitis (B05.0)</td>
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<tr>
<td>Delete</td>
<td>post measles myelitis (B05.1)</td>
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<td>Encephalitis, post immunization</td>
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<tr>
<td>Delete</td>
<td>Encephalomyelitis, post immunization</td>
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<tr>
<td>Delete</td>
<td>Use additional code to identify the vaccine (T50.A-, T50.B-, T50.Z-)</td>
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</tbody>
</table>
Add Excludes1:  post chickenpox encephalitis (B01.1)
Add  post measles encephalitis (B05.0)
Add  post measles myelitis (B05.1)

New code  G04.02 Postimmunization acute disseminated encephalitis, myelitis and encephalomyelitis
          Encephalitis, post immunization
          Encephalomyelitis, post immunization
          Use additional code to identify the vaccine (T50.A-, T50.B-, T50.Z-)
Cerebellar Ataxia in Diseases Classified Elsewhere

In ICD-9-CM there is a code 334.4, Cerebellar ataxia in diseases classified elsewhere, which is useful and specific. It includes a note to code first underlying disease. This specific concept is not currently present in ICD-10-CM, because the main ataxia heading is “hereditary”, and some of the secondary ataxias are indexed elsewhere (e.g., alcoholic ataxia to G31.2).

The American Academy of Neurology (AAN) has requested changes to ICD-10-CM to provide a code for cerebellar ataxia in diseases classified elsewhere, since such a code would be useful.

**TABULAR MODIFICATIONS**

**G13** Systemic atrophies primarily affecting central nervous system in diseases classified elsewhere

- **New code**
  - G13.2 Systemic atrophy primarily affecting the central nervous system in myxedema
    
  Code first underlying disease, such as:
  
  - hypothyroidism (E03.-)
  - myxedematous congenital iodine deficiency (E00.1)

- **Delete**
  
  G13.8 Systemic atrophy primarily affecting central nervous system in other diseases classified elsewhere
  
  Code first underlying disease, such as:
  
  - cerebellar ataxia (in):
    
    - hypothyroidism (E03.-)
    
    - myxedematous congenital iodine deficiency (E00.1)

**G32** Other degenerative disorders of nervous system in diseases classified elsewhere

- **Delete**
  
  G32.8 Other specified degenerative disorders of nervous system in diseases classified elsewhere
  
  Degenerative encephalopathy in diseases classified elsewhere

- **New code**
  
  G32.81 Cerebellar ataxia in diseases classified elsewhere
  
  Code first underlying disease, such as:
  
  - cerebellar ataxia (in):
    
    - neoplastic disease (paraneoplastic cerebellar degeneration)
    
    Excludes1: systemic atrophy primarily affecting the central nervous system in myxedema (G13.2)
    
    - alcoholic cerebellar ataxia (G31.2)

- **New code**
  
  G32.89 Other specified degenerative disorders of nervous system in diseases classified elsewhere
  
  Degenerative encephalopathy in diseases classified elsewhere
Reclassification of hemorrhoids in ICD-10

ICD-10 (and ICD-10-CM) currently classifies hemorrhoids at I84 in the vascular disease chapter. The current classification of hemorrhoids in ICD-10 as a venous disease is outdated. It is also suggested that the concept of internal and external hemorrhoids is outdated. Modern medical literature classifies hemorrhoids as an anal disease and further classifies it into four stages or degrees. The distinction of these stages is clear and affects the therapy given.

As of October 2010, the World Health Organization (WHO) has approved changes to ICD-10 (effective January 2013), that will move the hemorrhoids to a new category in Chapter 11, Diseases of the Digestive System and add new codes to the classification to reflect staging for this condition. The codes at I84 in the vascular chapter are being deleted. The scope of the new category has been expanded and will also include perianal venous thrombosis as well as the hemorrhoids.

NCHS is bringing this WHO approved proposal forward to seek input on the indexed terms that are being deleted from ICD-10 particularly internal and external hemorrhoids as well as thrombosed and prolapsed hemorrhoids. If the terms are still in active use in health care records they would be retained and re-indexed in ICD-10-CM.

### TABULAR MODIFICATIONS

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<th>Delete</th>
<th><strong>I84</strong> Hemorrhoids</th>
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<tr>
<td>Delete</td>
<td>Includes: piles</td>
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<tr>
<td>Delete</td>
<td>varicose veins of anus and rectum</td>
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<td>Excludes1: hemorrhoids complicating childbirth and the puerperium (O87.2)</td>
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<td>Delete</td>
<td>hemorrhoids complicating pregnancy (O22.4)</td>
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<td><strong>I84.00</strong> Unspecified thrombosed hemorrhoids</td>
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<td>Thrombosed hemorrhoids, unspecified whether internal or external</td>
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<td><strong>I84.01</strong> Internal thrombosed hemorrhoids</td>
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<td><strong>I84.02</strong> External thrombosed hemorrhoids</td>
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<td><strong>I84.122</strong> External prolapsed hemorrhoids</td>
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<td><strong>I84.123</strong> External strangulated hemorrhoids</td>
</tr>
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<td>Delete</td>
<td><strong>I84.124</strong> External ulcerated hemorrhoids</td>
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<td>Delete</td>
<td><strong>I84.13</strong> Internal and external hemorrhoids with other complications</td>
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<td>Delete</td>
<td><strong>I84.131</strong> Internal and external bleeding hemorrhoids</td>
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<td>Delete</td>
<td><strong>I84.132</strong> Internal and external prolapsed hemorrhoids</td>
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</table>
ICD-9-CM Coordination and Maintenance Committee Meeting
March 9-10, 2011

Delete I84.133 Internal and external strangulated hemorrhoids
Delete I84.134 Internal and external ulcerated hemorrhoids
Delete I84.2 Hemorrhoids without complication
Delete I84.20 Unspecified hemorrhoids without complication
Delete I84.21 Internal hemorrhoids without complication
Delete I84.22 External hemorrhoids without complication
Delete I84.23 Internal and external hemorrhoids without complication
Delete I84.6 Residual hemorrhoidal skin tags
Delete Hemorrhoids NOS
Delete I84.21 Internal hemorrhoids without complication
Delete Internal hemorrhoids NOS
Delete I84.22 External hemorrhoids without complication
Delete External hemorrhoids NOS
Delete I84.23 Internal and external hemorrhoids without complication
Delete Internal and external hemorrhoids NOS
Delete I84.6 Residual hemorrhoidal skin tags
Delete Skin tags of anus or rectum

New category K64 Hemorrhoids and perianal venous thrombosis
Includes: piles
Excludes: hemorrhoids complicating childbirth and the puerperium
(O87.2)
hemorrhoids complicating pregnancy (O22.4)

New code K64.0 First degree hemorrhoids
Grade/stage I hemorrhoids
Hemorrhoids (bleeding) without prolapse outside of anal canal

New code K64.1 Second degree hemorrhoids
Grade/stage II hemorrhoids
Hemorrhoids (bleeding) that prolapse with straining, but retract
spontaneously

New code K64.2 Third degree hemorrhoids
Grade/stage III hemorrhoids
Hemorrhoids (bleeding) that prolapse with straining and require
manual replacement back inside anal canal

New code K64.3 Fourth degree hemorrhoids
Grade/stage IV hemorrhoids
Hemorrhoids (bleeding) with prolapsed tissue that cannot be
manually replaced

New code K64.4 Residual hemorrhoidal skin tags
External hemorrhoids, NOS
Skin tags of anus or rectum

New code K64.5 Perianal venous thrombosis
External hemorrhoids with thrombosis
Perianal hematoma

New code K64.8 Other haemorrhoids
Internal hemorrhoids, degree not specified

New code K64.9 Unspecified hemorrhoids
Hemorrhoids (bleeding) NOS
Hemorrhoids (bleeding) without mention of degree
Concussion Codes

The codes for concussion in ICD-10-CM reflect a continuum of duration of loss of consciousness (LOC) matching that used for every brain injury code. In civilian settings concussion will most often be coded when the duration of LOC is shorter than 24 hours, as LOC longer than 24 hours is generally associated with moderate to severe traumatic brain injury. Because of the unfortunate increase in traumatic brain injury due to current military conflicts and the increased attention to sports-related concussion, the science is rapidly developing that will be better able to identify meaningful traumatic brain injury parameters in the future, and a more useful classification can be derived from that information. Therefore, at this time, the American Academy of Neurology believes it makes sense to eliminate the codes for concussion with loss of consciousness greater than 24 hours and leave the placeholder “x”. When consistent scientific evidence for the parameters (duration of LOC or otherwise) that affect outcome of brain injury is available, the classification can be restructured to meet the needs of meaningful data collection.

TABULAR MODIFICATION

S06.0 Concussion
Commotio cerebri
Excludes1: concussion with other intracranial injuries classified in category S06- code to specified intracranial injury

S06.0x Concussion

S06.0x0 Concussion without loss of consciousness

S06.0x1 Concussion with loss of consciousness of 30 minutes or less

S06.0x2 Concussion with loss of consciousness of 31 minutes to 59 minutes

S06.0x3 Concussion with loss of consciousness of 1 hour to 5 hours 59 minutes

S06.0x4 Concussion with loss of consciousness of 6 hours to 24 hours

Delete S06.0x5 Concussion with loss of consciousness greater than 24 hours with return to pre-existing conscious level

Delete S06.0x6 Concussion with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving

Delete S06.0x7 Concussion with loss of consciousness of any duration with death due to brain injury prior to regaining consciousness

S06.0x8 Concussion with loss of consciousness of any duration with death due to other cause prior to regaining consciousness

S06.0x9 Concussion with loss of consciousness of unspecified duration
Concussion NOS
ICD-10-CM Tabular List of Diseases
Proposed Addenda (Effective October 1, 2011)

A41 Other sepsis
Revise A41.9 Sepsis, unspecified organism

CHAPTER 2
Neoplasms (C00-D49)

Notes:
Delete Morphology [Histology]
Chapter 2 classifies neoplasms primarily by site (topography), with broad groupings for behavior: malignant, in situ, benign, etc. The Table of Neoplasms should be used to identify the correct topography code. In a few cases, such as for malignant melanoma and certain neuroendocrine tumors, the morphology (histologic type) is included in the category and codes. To identify the morphology for the majority of Chapter 2 codes that do not include the histologic type, comprehensive separate morphology codes are provided. These morphology codes are derived from the International Classification of Diseases for Oncology (ICD-O).

Malignant neoplasms (C00-C96)
Delete Use additional morphology codes with behavior code /3

Malignant neoplasm of bone and articular cartilage (C40-C41)
Revise Excludes1: malignant neoplasm of bone marrow NOS (C96.9)

In situ neoplasms (D00-D09)
Delete Use additional morphology codes with behavior code /2

Benign neoplasms, except benign neuroendocrine tumors (D10-D36)
Delete Use additional morphology codes with behavior code /0

Neoplasms of uncertain behavior, polycythemia vera and myelodysplastic syndromes (D37-D48)
Revise Note: Categories D37-D44, and D48 classify by site neoplasms of uncertain behavior, i.e., histologic confirmation whether the neoplasm is
malignant or benign cannot be made. Use additional morphology
codes with behavior code 4.

**G71** Primary disorders of muscles

**G71.0** Muscular dystrophy

Add Congenital muscular dystrophy NOS
Add Congenital muscular dystrophy with specific morphological
abnormalities of the muscle fiber

Delete Excludes1: congenital muscular dystrophy NOS (G71.2)
Delete Congenital muscular dystrophy with specific morphological
abnormalities of the muscle fiber (G71.2)

**G71.2** Congenital myopathies

Delete Congenital muscular dystrophy NOS
Delete Congenital muscular dystrophy with specific morphological
abnormalities of the muscle fiber

**J84** Other interstitial pulmonary diseases

**J84.2** Lymphoid interstitial pneumonia

Delete Endogenous lipid pneumonia
Delete Excludes1: exogenous lipid pneumonia (J69.1)
Delete unspecified lipid pneumonia (J69.1)

**J84.8** Other specified interstitial pulmonary diseases

Add Endogenous lipid pneumonia
Add Excludes1: exogenous lipid pneumonia (J69.1)
Add unspecified lipid pneumonia (J69.1)

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

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

J84 Other interstitial pulmonary diseases

J84.2 Lymphoid interstitial pneumonia

Delete Endogenous lipoid pneumonia

Delete Excludes1: exogenous lipoid pneumonia (J69.1)
Delete unspecified lipoid pneumonia (J69.1)

J84.8 Other specified interstitial pulmonary diseases

Add Endogenous lipoid pneumonia

Add Excludes1: exogenous lipoid pneumonia (J69.1)
Add unspecified lipoid pneumonia (J69.1)

Q28 Other congenital malformations of circulatory system

Q28.3 Other malformations of cerebral vessels

Add Developmental venous anomaly

S83 Dislocation and sprain of joints and ligaments of knee

S83.8 Sprain of other specified parts of knee

S83.8x Sprain of other specified parts of knee

Revise S83.8x2 Sprain of other specified parts of left knee

Revise S83.8x9 Sprain of other specified parts of unspecified knee

T14 Injury of unspecified body region

T14.8 Other injury of unspecified body region

Add Abrasion NOS

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

Delete Use additional code(s) for all manifestations of poisoning and adverse effects
Add Use additional code to specify the effects of the poisoning

Add Excludes: adverse effects ["hypersensitivity", "reaction", etc.] of correct substance properly administered; such cases are to be classified according to the nature of the adverse effect, such as:
- aspirin gastritis (K29.-)
- blood disorders (D50-D76)
- contact dermatitis (L23-L25)
- nephropathy (N14.0-N14.2)
- unspecified adverse effect of drug (T88.7)

Add Note: The drug giving rise to the adverse effect may be identified by use of appropriate codes in categories T36-T50

Z86 Personal history of certain other diseases

Z86.5 Personal history of mental and behavioral disorders

Delete Excludes2: substance abuse and dependence (F10-F19 with final character 1, in remission)
ICD-10-CM INDEX OF DISEASES

PROPOSED ADDENDA (Effective October 1, 2011)

<table>
<thead>
<tr>
<th>Action</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>Revise</td>
<td>Abrasion T14.8</td>
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<td>Adenocarcinoma - see also Neoplasm, malignant, by site</td>
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<td>Adhesions, adhesive…</td>
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<td>- ear</td>
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<td>Add</td>
<td>- - middle H74.1-</td>
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<td>Add</td>
<td>Aneurysm (anastomotic) (artery)… I72.9</td>
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<td>Add</td>
<td>- celiac I72.8</td>
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<td>Add</td>
<td>- gastroduodenal I72.8</td>
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<tr>
<td>Add</td>
<td>- gastroepiploic I72.8</td>
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<td>Add</td>
<td>- hepatic I72.8</td>
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<tr>
<td>Add</td>
<td>- pancreaticoduodenal I72.8</td>
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<tr>
<td>Add</td>
<td>- specified NEC I72.8</td>
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<td>Add</td>
<td>- superior mesenteric I72.8</td>
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<tr>
<td>Add</td>
<td>- visceral NEC I72.8</td>
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<td>Add</td>
<td>Angioma - see also Hemangioma, by site</td>
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<td>- venous Q28.3</td>
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<td>Revise</td>
<td>Anisocoria (pupil) H57.02</td>
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<td>Arteriosclerosis, arteriosclerotic… I70.90</td>
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<td>-carotid (see also Occlusion, artery, carotid) I65.2-</td>
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<td>Arthritis, arthritic…</td>
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<td>- in (due to)</td>
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<td>Revise</td>
<td>- - bacterial disease (see also category M01) A49.9</td>
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<tr>
<td>Revise</td>
<td>- - Hemophilus influenzae M00.8 [B96.3]</td>
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<td>Carcinoma (malignant) - see also Neoplasm, by site, malignant</td>
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<td>- infiltrating</td>
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<td>Revise</td>
<td>- - ductular</td>
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<td>Revise</td>
<td>Contusion T14.8</td>
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Revise Crush, crushed, crushing T14.8

Dementia...
- in (due to)
Revise - - Parkinson's disease (parkinsonism) G20 [F02.80]
Delete — with behavioral disturbance G31.83 [F02.81]
Add - - with behavioral disturbance G31.83 [F02.81]

Disorder (of)...
- ear
- - middle H74.9-
Add - - - adhesive H74.1-

Migraine
Add - complicated G43.109

Neoplasm
Revise - lumbosacral plexus C47.5 C79.89 - D36.16 D48.2
Revise - - subpleural C34.9- C78.0- D02.2 D14.3- D38.1

Delete Pneumonia (acute) (Alpenstich) (benign) (bilateral) (brain) (cerebral)
(ecircumscribed) (congestive) (creeping) (delayed resolution) (double)
(epidemic) (fever) (flash) (fulminant) (fungoid) (granulomatous) (hemorrhagic)
(incipient) (infantile) (infectious) (infiltration) (insular) (intermittent) (latent)
(migratory) (organized) (overwhelming) (primary (atypical) progressive)
(pseudolobar) (purulent) (resolved) (secondary) (senile) (septic) (suppurative)
(terminal) (true) (unresolved) (vesicular) J18.9
Add Pneumonia (acute) (double) (migratory) (purulent) (septic) (unresolved) J18.9

Revise Recklinghausen disease Q85.01

Sequela(e) (of) - see also condition
- disease
- - cerebrovascular I69.90
Revise - - - cognitive deficits I69.91
- - - specified type NEC I69.80
Revise - - - - cognitive deficits I69.81
- hemorrhage
- - intracerebral I69.10
Revise - - - cognitive deficits I69.11
- - intracranial, nontraumatic NEC I69.20
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<td>infarction</td>
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<td>stroke NOS</td>
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<tr>
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<td>I69.31</td>
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Telangiectasia, telangiectasis (verrucous) I78.1

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<td>Add</td>
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<td>Add</td>
<td>macular</td>
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<tr>
<td>Add</td>
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<td>H35.07</td>
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<tr>
<td>Revise</td>
<td>retinal (idiopathic) (juxtafoveal) (macular) (parafoveal)</td>
<td>H35.07</td>
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Thickening

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Von Recklinghausen

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<tr>
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