ICD-10 Coordination and Maintenance Committee Meeting
March 17-18, 2020
Diagnosis Agenda

WebEx Instructions for Remote Meeting Participation

Remote participants (attendees wishing to both view slides and ask questions during the Q&A portions of the meeting) must join the meeting by WebEx*.

• Day 1: March 17, 2020: The meeting will begin promptly at 9:00 AM ET and will end at 5:00 PM ET. Lunch will be held from 12:30 PM to 1:15 PM.

1. Event address for attendees:

https://letsmeet.webex.com/letsmeet/onstage/g.php?MTID=e20f2a065e507d5e156f34aa9076e32e8

2. Event password: This event does not require a password for attendees.

If you have any questions regarding the presentations, please use the raise hand feature during the Q&A session after each presentation and your line will be unmuted. Once your question has been addressed, please lower the raised hand.

• Day 2: March 18, 2020: The meeting will begin promptly at 9:00 AM ET and will end at 5:00 PM ET. Lunch will be held from 12:30 PM to 1:15 PM.

1. Event address for attendees:

https://letsmeet.webex.com/letsmeet/onstage/g.php?MTID=e0e9e3e18a86ed9277fac903a52d8880a

Event password: This event does not require a password for attendees.

If you have any questions regarding the presentations, please use the raise hand feature during the Q&A session after each presentation and your line will be unmuted. Once your question has been addressed, please lower the raised hand.

*Detailed instructions for joining the WebEx meeting are posted in the "Downloads" section located here: https://www.cms.gov/Medicare/Coding/ICD10/C-and-M-Meeting-Materials
If you experience technical difficulties during the meeting, please contact Michele Hudson for assistance at michele.hudson@cms.hhs.gov or 443-821-4266.

Note: Proposals for diagnosis code topics are scheduled for March 18, 2020 and will be led by the Centers for Disease Control (CDC). Please visit CDCs website for the Diagnosis agenda located at the following address: http://www.cdc.gov/nchs/icd/icd10cm_maintenance.htm.

If time does not permit you to comment or ask a question during the Q&A session, you may submit comments and questions at any time using the "Chat" feature. All comments and questions submitted using the "Chat " feature, along with and CMS' responses to them, will be posted on the CMS website as soon as possible after the meeting. Remaining questions may be submitted via the CMS ICD-10 Procedure Code Request mailbox at ICDProcedureCodeRequest@cms.hhs.gov.

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

Diagnosis Topics:

Contents

ICD-10 TIMELINE

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

March 17-18, 2020	ICD-10 Coordination and Maintenance Committee Meeting. Those who wish to attend the ICD-10 Coordination and Maintenance Committee meeting **must have registered for the meeting online by March 6, 2020.** You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building. In compliance to The Real ID Act, enacted in 2005, (http://www.dhs.gov/real-id-enforcement-brief) the following states/territories: Maine, Minnesota, Missouri, Montana and Washington State **will not** gain access into any Federal Agencies using the **above states** driver's license or ID. This means CMS visitors from these states/territories will need to provide alternative proof of identification (**such as a passport**) to gain entrance into Baltimore-based and Bethesda, Maryland CMS buildings, as well as the Humphrey Building in Washington.
March 2020	Webcast of the March 17-18, 2020 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD10/C-and-M-Meeting-Materials.html
April 1, 2020	There were no requests for ICD-10 codes to capture new diagnoses or new technology for implementation on April 1, 2020. Therefore, there will be no new ICD-10 procedure codes implemented on April 1, 2020. As announced on January 15, 2020, a new ICD-10-CM diagnosis code, U07.0 - Vaping-related disorder, is being implemented on April 1, 2020. Additional information is posted on the following website: https://www.cdc.gov/nchs/icd/icd10cm.htm
April 17, 2020	**Deadline for receipt of public comments on proposed PCS new codes and revisions discussed at the March 17-18, 2020 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2020**.
April 2020	Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This notice will include references to the finalized FY 2021 ICD-10-CM diagnosis and ICD-10-PCS procedure

	codes to date. It will also include proposed revisions to the MS-DRG system based on ICD-10-CM/PCS codes on which the public may comment. The proposed rule can be accessed at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/IPPS/list.asp
May 18, 2020	**Deadline for receipt of public comments on proposed new diagnoses codes and revisions discussed at the March 17-18, 2020 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2021.**
June 2020	Final addendum posted on web pages as follows: Diagnosis addendum - https://www.cdc.gov/nchs/icd/icd10cm.htm Procedure addendum - https://www.cms.gov/Medicare/Coding/ICD10/index.html
June 12, 2020	**Deadline for requestors: Those members of the public requesting that topics be discussed at the September 2020 ICD-10 Coordination and Maintenance Committee meeting, tentatively scheduled for September 8-9, 2020, must have their requests submitted to CMS for procedures and NCHS for diagnoses.**
August 1, 2020	Hospital Inpatient Prospective Payment System final rule to be published in the Federal Register as mandated by Public Law 99-509. This rule will also include links to all the final codes to be implemented on October 1, 2020. This rule can be accessed at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
August 2020	Tentative agenda for the Procedure part of the September 2020 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage at – https://www.cms.gov/Medicare/Coding/ICD10/C-and-M-Meeting-Materials.html Tentative agenda for the Diagnosis part of the September 8-9, 2020 ICD-10 Coordination and Maintenance Committee meeting will be posted on

	the NCHS webpage at - https://www.cdc.gov/nchs/icd/icd10cm_maintenance.htm Federal Register notice for the September 2020 ICD-10 Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.
August 3, 2020	**On-line registration opens for the September 2020 ICD-10 Coordination and Maintenance Committee meeting at:** https://www.cms.gov/apps/events/default.asp
September 4, 2020	Because of increased security requirements, those wishing to attend the September 2020 ICD-10 Coordination and Maintenance Committee meeting must register for the meeting online at: https://www.cms.gov/apps/events/default.asp **Attendees must register online by September 4, 2020; failure to do so may result in lack of access to the meeting.**
September 8-9, 2020	ICD-10 Coordination and Maintenance Committee Meeting. Those who wish to attend the ICD-10 Coordination and Maintenance Committee meeting **must have registered for the meeting online by September 4, 2020.** You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building.
September 2020	Webcast of the September 8-9, 2020 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD10/C-and-M-Meeting-Materials.html
October 1, 2020	New and revised ICD-10-CM and ICD-10-PCS codes go into effect along with DRG changes. Final addendum available on web pages as follows: **Diagnosis addendum –** https://www.cdc.gov/nchs/icd/icd10cm.htm **Procedure addendum –** https://www.cms.gov/Medicare/Coding/ICD10/
October 9, 2020	**Deadline for receipt of public comments on proposed new codes discussed at the September 8-9, 2020 ICD-10 Coordination and**

	Maintenance Committee meetings for implementation on April 1, 2021.
November 2020	Any new ICD-10 codes required to capture new technology that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2021 will be posted on the following websites: https://www.cdc.gov/nchs/icd/icd10cm.htm https://www.cms.gov/Medicare/Coding/ICD10/
November 9, 2020	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the September 8-9, 2020 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2021.**

Contact Information
Mailing address:

National Center for Health Statistics
ICD-9-CM Coordination and Maintenance Committee
3311 Toledo Road
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Comments on the diagnosis proposals presented at the ICD Coordination and Maintenance Committee meeting should be sent to the following email address: nchsicd10CM@cdc.gov

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Continuing Education Credits

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

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

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

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

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

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

Abnormal Neonatal Screening

The American Academy of Pediatrics presented a proposal on abnormal neonatal screening at the September 2019 Coordination and Maintenance Meeting. However, in response to public comments, a revised proposal is being submitted for consideration

Currently throughout the United States there are thirty-four (34) core conditions as part of the Recommended Uniform Screening Panel (RUSP) and an additional twenty-six secondary target conditions[1].

The Recommended Uniform Screening Panel is a list of disorders that are recommended by the Secretary of the Department of Health and Human Services (HHS) for states to screen as part of their state universal newborn screening (NBS) programs[2]. Disorders on the RUSP are chosen based on evidence that supports the potential net benefit of screening, the ability of states to screen for the disorder, and the availability of effective treatments. Most states screen for the majority of disorders on the RUSP. Newer conditions are still in process of being adopted and some states screen for additional disorders.

While every state may vary regarding the specific tests they mandate, there are four (4) main categories of conditions that is screened by every state. Those categories are:

1) Metabolic conditions (e.g., PKU, Maple syrup urine disease) Fatty Acid disorders, Organic acid disorders, Amino acid disorders, Other metabolic disorders
2) Endocrine conditions (e.g., congenital hypothyroidism)
3) Hemoglobin conditions (e.g., sickle cell anemia)
4) Other conditions (e.g., critical congenital heart disease)

Under the other conditions category, screening for critical congenital heart disease (CCHD) is performed on all newborns as part of the American Academy of Pediatrics Periodicity Schedule and is currently mandated by law in more than half of the states.[3] The proposed new codes are to be reported for abnormal results from a state-mandated screen. They are not to be reported when the baby is tested due to a maternal condition, even if the baby is asymptomatic.

Neonatal CCHD screening failure (abnormal findings) is a distinct clinical event that clinicians now face. As this screening is performed on asymptomatic newborns, those babies who fail the CCHD screening should have no other signs or symptoms that would justify additional testing, which includes a cardiac echo.

The current ICD-10-CM code set has a single code P09 (Abnormal findings on neonatal screening**)** as a coding option, which may include any or all newborn screens that may be abnormal or have a positive indicator.

An ICD-10-CM code for failed CCHD screen would allow the cardiology department and cardiologists to accurately report and support their additional clinical evaluations and testing even if no critical illness

is identified and when the patient is asymptomatic. Additionally, an ICD-10-CM code for a failed screening (abnormal findings) of CCHD screening would help to identify those babies who had a neonatal CCHD screen failure so that clinicians, health care delivery systems and state departments of health can more accurately assess appropriate follow-up.

The American Academy of Pediatrics is asking for expansion of P09 Abnormal findings on neonatal screening, to specifically show which screening categories were abnormal. In addition, a unique code would reflect an increase in healthcare utilization (e.g., echo test from positive CCHD screen) until a more definitive diagnosis can be made.

The American Academy of Pediatrics request the following tabular modifications:

TABULAR MODIFICATION

	P09	Abnormal findings on neonatal screening
Add		Abnormal findings on state mandated newborn screens
Delete		~~Use additional code to identify signs, symptom and conditions associated with the screening~~
New code	P09.1	Abnormal findings on neonatal screening for inborn errors of metabolism
New code	P09.2	Abnormal findings on neonatal screening for congenital endocrine disease
Add		Abnormal findings on congenital adrenal hyperplasia
Add		Abnormal findings on hypothyroidism screen
New code	P09.3	Abnormal findings on neonatal screening for congenital hematologic disorders
Add		Abnormal findings for hemoglobinothies screen
Add		Abnormal findings on red cell membrane defects screen
Add		Abnormal findings on sickle cell screen
New code	P09.4	Abnormal findings on neonatal screening for cystic fibrosis
New code	P09.5	Abnormal findings on neonatal screening for critical congenital heart disease

Add		Neonatal critical congenital heart disease screening failure
New code	P09.6	Abnormal findings on neonatal screening for neonatal hearing loss
Add		Excludes2: Z01.110 Encounter for hearing examination following failed hearing screening
New code	P09.8	Other abnormal findings on neonatal screening
New code	P09.9	Abnormal findings on neonatal screening, unspecified

1) https://www.babysfirsttest.org/newborn-screening/the-recommended-uniform-screening-panel
2) https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html
3) Glidewell J, Grosse S, Riehle-Colarusso T, et al. Actions in Support of Newborn Screening for Critical Congenital Heart Disease—United States, 2011–2018. MMWR Morb Mortal Wkly Rep 2019;68: 107-111.

Anaplasmosis Infections

Formerly known as human granulocytic ehrlichiosis, human Anaplasmosis or human granulocytic Anaplasmosis is a tick-borne disease caused by *A. phagocytophilum*, a gram-negative bacterium that infects granulocytes.

In the United States, it is primarily transmitted to humans by the bite of an infected tick: either *Ixodes scapularis* in the Northeast and Midwestern United States or *Ixodes pacificus* along the West Coast. Anaplasmosis may also be transfusion-transmitted. (1-7) Human Anaplasmosis infection results in fever, chills, headaches, myalgia, nausea, vomiting, diarrhea, loss of appetite as well as potentially in complications such as: thrombocytopenia, respiratory failure, anemia, organ failure, and death. As signs and symptoms of anaplasmosis usually occur within 1–2 weeks after the bite of an infected tick, infection can be transfusion-transmitted during that period if infected persons donate blood. (5, 7, 8) Anaplasmosis infections occur mostly in the Northeastern (Maine, Vermont, New Hampshire, Rhode Island, Massachusetts, Connecticut, and New York) and upper Midwestern (Minnesota and Wisconsin) states, however the geographic range of anaplasmosis is expanding. (3, 5, 9) The number of Anaplasmosis cases as reported to CDC rose substantially over the last decades: from 348 in 2000 to 5,762 in 2017. (3) Due to a substantial increase in the number of reported anaplasmosis cases, detection of transfusion-transmitted cases, and the expansion of the geographic range of anaplasmosis infections (1, 3, 5, 8-12), the introduction of a new specific code to identify anaplasmosis infections will help public health organizations to ascertain spread of the anaplasmosis in the United States using real-world evidence, develop prevention strategies, and assure safety of blood supply.

The objective of the request is to improve coding specificity for human Anaplasmosis in order to allow physicians to code accurately for human infections due to A. *phagocytophilum*. The disease-specific coding will enable public health organizations to monitor the spread of anaplasmosis infections in the U.S. by states and counties of residence using real-world evidence (e.g., large databases), which will allow the development of suitable prevention strategies to assure public safety. Since anaplasmosis is also transfusion-transmissible, the new code will also allow for the development of appropriate donor testing recommendations depending on geographic distribution and spread of anaplasmosis in various regions of the country to assure blood safety. The improved coding granularity will also increase physician and population awareness of the disease and help facilitate availability and further development of diagnostic and donor testing. In summary, the introduction of a disease-specific code for anaplasmosis infections will improve coding accuracy, increase provider awareness of human anaplasmosis, help in development of testing, allow to monitor nationwide occurrence of the disease using real-world evidence, and therefore will help in the development of appropriate prevention strategies to reduce spread of the disease and assure public safety.

NCHS received two separate requests for a unique code for human Anaplasmosis infection caused by *Anaplasma phagocytophilum, A. phagocytophilum*, from FDA (Center for Biologics Evaluation and Research) and CDC (Rickettsial Zoonoses Branch).

References

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2. Dumler J, Choi K, Garcia-Garcia J, et al. Human Granulocytic Anaplasmosis and Anaplasma phagocytophilum. Emerging Infectious Diseases. 2005;11(12):1828-1834. doi:10.3201/eid1112.050898. Available at: https://wwwnc.cdc.gov/eid/article/11/12/05-0898_article
3. Centers for Disease Control and Prevention. Anaplasmosis Epidemiology and Statistics. Available at: https://www.cdc.gov/anaplasmosis/stats/index.html
4. Centers for Disease Control and Prevention. Anaplasmosis Transmission. Available at: https://www.cdc.gov/anaplasmosis/transmission/index.html
5. Centers for Disease Control and Prevention. Diagnosis and management of tickborne rickettsial diseases: Rocky Mountain spotted fever and other spotted fever group rickettsioses, ehrlichioses, and anaplasmosis—United States: a practical guide for health care and public health professionals. *MMWR* 2016;65(2):1-48. Available at: https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6502.pdf
6. Engel J, Bradley K, et al. Revision of the national surveillance case definition for ehrlichiosis (ehrlichiosis/anaplasmosis). Council of State and Territorial Epidemiologists, Infectious Diseases Committee, 2007 Position Statement Cdc-pdf[PDF – 7 pages]External. Available at: https://c.ymcdn.com/sites/www.cste.org/resource/resmgr/PS/07-ID-03.pdf
7. Centers for Disease Control and Prevention. Anaplasmosis. Available at: https://www.cdc.gov/ticks/tickbornediseases/anaplasmosis.html
8. Centers for Disease Control and Prevention. Anaplasmosis: Transmission and Epidemiology. Available at: https://www.cdc.gov/anaplasmosis/healthcare-providers/transmission-epidemiology.html
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11. Townsend RL, Moritz ED, Fialkow LB, Berardi V, Stramer SL. Probable transfusion-transmission of Anaplasma phagocytophilum by leukoreduced platelets. Transfusion 2014;54:2828-2832
Alhumaidan H, Westley B, Esteva C, et al. Transfusion transmitted anaplasmosis from leukoreduced red blood cells. Transfusion 2013;53:181-6.

TABULAR MODIFICATIONS

A79 Other rickettsioses

A79.0 Trench fever
Quintan fever
Wolhynian fever

A79.1 Rickettsialpox due to Rickettsia akari
Kew Garden fever
Vesicular rickettsiosis

A79.8 Other specified rickettsioses

A79.81 Rickettsiosis due to Ehrlichia sennetsu

New code A79.82 Anaplasmosis [A. phagocytophilum]

A79.89 Other specified rickettsioses

Cough

The American Thoracic Society (ATS) and the American College of Chest Physicians (CHEST) Clinical Practice Committee jointly submitted an updated proposal following comments received at the March 2019 Coordination and Maintenance meeting (C&M). The changes are in bold.

Physiologically, cough arises following activation of a complex sensorimotor reflex arc. Coughing is part of the body's defense mechanism against inhaled irritants and respiratory infections, serving to clear the airways of foreign material and excess secretions (Chung and Pavord, 2008). In most cases, cough resolves after the inciting factor is eliminated. For some people, however, cough becomes persistent, impacting quality of life and prompting the patient to seek medical attention.

During clinical work-up, cough is initially classified by duration; different categories of cough duration have different diagnostic possibilities and thus different algorithms for evaluation and treatment. The classification of cough by duration was outlined by the world's first cough guideline developed by the CHEST Expert Cough Panel in 1998 and has persisted through the most recent 2018 update (Irwin et al, 1998, 2018).

Cough of less than 3 weeks duration in adults is defined as acute cough (Chung and Pavord, 2008). Though acute cough can be a sign of a life-threatening condition or an exacerbation of a pre-existing respiratory condition, most acute cough cases are associated with respiratory tract infections. The most common cause of acute cough is acute bronchitis, which is most often viral (Terasaki and Paauw, 2014). Cough associated with respiratory tract infections commonly resolves shortly after the infection itself and does not require targeted therapy. In fact, limited data exist that show any benefit of symptomatic relief for acute cough with traditional cough suppressants like dextromethorphan and codeine (Bolser, 2006). The efficacy of antitussive drugs has been challenged particularly in the case of cough associated with upper respiratory tract infection (URTI); specifically, CHEST advises against the use of antitussives in the case of URTI (Irwin et al, 2018).

Subacute cough is quite like acute cough as both may be related to URTI and typically resolve after the infection clears. Subacute cough also may be caused by post-infectious cough, pertussis, infection with Mycoplasma or Chlamydia, and – similarly to acute cough – exacerbations of other diseases such as asthma or COPD (Chung and Pavord, 2008). The defining difference between subacute and acute in adults is the duration of the cough, subacute being longer, lasting from three to eight weeks. In children, a cough is defined as chronic beginning at 8 weeks duration (Chang et al, 2017).

A significant minority of patients experience chronic cough that persists despite guideline-based treatment of underlying etiologies. This subset of chronic cough is defined as cough that persists after extensive medical investigation and is thus considered a diagnosis of exclusion (Gibson and Wang, 2016). While various terms have been used to describe this population, recent CHEST guidelines define Unexplained Chronic Cough (UCC) as cough that occurs under the following circumstances: 1) chronic

cough with no diagnosable cause, 2) explained but refractory chronic cough, and 3) unexplained and refractory chronic cough (Irwin et al, 2018).

Chronic cough can have wide-ranging effects on overall health and well-being. Some of the more severe symptoms include syncope, incontinence, vomiting, and sleep deprivation (Irwin, 2006). Literature indicates that the psychosocial impact of refractory chronic cough can also be profound – studies have demonstrated that 53% of patients with chronic cough exhibit depressive symptoms and are at risk for developing clinical depression (Dicpinigaitis et al, 2006; McGarvey et al, 2006). The prevalence of depressive symptoms among patients with refractory chronic cough is comparable to that seen in other chronic disorders, such as chronic obstructive pulmonary disease, chronic heart failure, and diabetes (Brignall et al, 2008

Since research indicates paroxysmal cough is normally seen during the second stage of pertussis (whooping cough), the submitters no longer recommend listing paroxysmal cough as an inclusion term under chronic cough, R05.3. Instead, they recommend consideration of paroxysmal cough as a potential inclusion term under both Whooping cough due to Bordetella pertussis, without pneumonia, A37.00, and Whooping cough due to Bordetella pertussis, with pneumonia, A37.01.

The following proposed tabular modifications will ensure that ICD-10-CM is better aligned with the current clinical guidelines for cough.

TABULAR MODIFICATIONS

A37 Whooping cough
A37.0 Whooping cough due to Bordetella pertussis
A37.00 Whooping cough due to Bordetella pertussis without pneumonia
Add **Paroxysmal cough due to Bordetella pertussis without pneumonia**
A37.01 Whooping cough due to Bordetella pertussis with pneumonia
Add **Paroxysmal cough due to Bordetella pertussis with pneumonia**

R05 Cough

Excludes1: cough with hemorrhage (R04.2)

smoker's cough (J41.0)

New code R05.1 Acute cough

New code R05.2 Subacute cough

New code R05.3 Chronic cough

Add Cough syncope
Add Persistent cough
Add Refractory cough
Add Unexplained cough

New code R05.9 Cough, unspecified

References

Bolser DC. Cough suppressant and pharmacologic protussive therapy: ACCP evidence-based clinical practice guidelines. CHEST. 2006; 120:238S-49S.

Brignall K, Jayaraman B, Birring SS. Quality of life and psychosocial aspects of cough. Lung. 2008; 186(Suppl1):S55-58.

Centers for Disease Control. ICD-10-CM Official Coding Guidelines – Supplement; Coding encounters related to E-cigarette, or vaping, product use. Available at https://www.cdc.gov/nchs/data/icd/Vapingcodingguidance2019_10_17_2019.pdf, last accessed 11/15/19.

Chang AB, Oppenheimer JJ, Weinberger MM et al. Use of management pathways or algorithms in children with chronic cough: CHEST Guideline and Expert Panel Report. Chest 2017; 151(4):884-890.

Chung KF, Pavord ID. Chronic Cough 1: Prevalence, pathogenesis, and causes of chronic cough. Lancet. 2008; 371:1364-74.

Dicpinigaitis PV, Tso R, Banauch G. Prevalence of depressive symptoms among patients with chronic cough. Chest 2006; 130:1839–1483.

Gibson P, Wang G, et al. Treatment of unexplained chronic cough, CHEST Guideline and Expert Panel Report. Chest 2016 Jan; 149(1): 27-44.

Irwin RS. Assessing cough severity and efficacy of therapy in clinical research: ACCP evidence-based clinical practice guidelines. Chest 2006; 129(1 Suppl):232S–237S

Irwin RS et al. Managing cough as a defense mechanism and as a symptom. A consensus panel report of the American College of Chest Physicians. Chest. 1998;114(2 suppl):133S-181S.

Irwin RS, French CL, et al. Classification of cough as a symptom in adults and management algorithms; CHEST Guideline and Expert Panel Report. Chest. 2018; 153(1):196-209.

McGarvey LPA, Carton C, Gamble LA, Heaney LG, Shepherd R, Ennis M, Macmahon J. Prevalence of psychomorbidity among patients with chronic cough. Cough; 2006; 2:4.

Terasaki G, Paauw DS. Evaluation and treatment of chronic cough. Med Clin N Am. 2014; 98:391-403.

Current and history of Non-suicidal self-harm

Nonsuicidal self-harm also referred to as nonsuicidal self-injury (NSSI) is the deliberate, self-inflicted destruction of body tissue resulting in immediate damage without suicidal intent. It is the act of deliberately harming your own body, such as cutting, burning oneself, banging or punching objects and or oneself. It's typically not meant as a suicide attempt. Rather, this type of self-injury is a harmful way to cope with emotional pain, intense anger and frustration.

While self-harm (self-injury) may bring a momentary sense of calm and a release of tension, it's usually followed by guilt and shame and the return of painful emotions. Although life-threatening injuries are usually not intended, with self-injury comes the possibility of more serious and even fatal self-aggressive actions.

What defines self-injury has less to do with what it looks like (e.g. in what particular way someone hurts his/her body) than with the intention one has when doing it. Because NSSI can look so much like a suicidal gesture, it can be confusing, and often frightening, to those who see it but who do not know what it means. This is one of the reasons that it is important to assess the why of the injuries as well as the what.

Many individuals who practice self-harm (self-injury) report overwhelming sadness, anxiety, or emotional numbness as common emotional triggers. They often report that this action provides a way to manage intolerable feelings or a way to experience some sense of feeling. It is also used as means of coping with anxiety or other negative feelings and to relieve stress or pressure. Some report doing it simply because it feels good or provides an energy rush. Regardless of the specific reason provided, self-injury may best be understood as a maladaptive coping mechanism, but one that works – at least for a while

Suicidal behavior and nonsuicidal self-injury are both relatively common in the general population [1-5] but differ in terms of demographics, risk factors, and management [6-9].

Currently, ICD-10-CM does not offer a unique code for current or history of nonsuicidal self-harm (self-injury), nonsuicidal self-mutilation, or other similar behaviors. It is important to establish a unique code for self-harming behaviors so that these conditions can be adequately treated and tracked in medical records and clinical databases. In addition, a new code would allow the ability to differentiated between suicidal and non-suicidal self-harm.

The American Psychiatric Association (APA) is proposing the following tabular modifications.

TABULAR MODIFICATIONS

R45 Symptoms and signs involving emotional state

R45.8 Other symptoms and signs involving emotional state

R45.85 Homicidal and suicidal ideations
Excludes1: suicide attempt (T14.91)
R45.850 Homicidal ideations
R45.851 Suicidal ideations

R45.86 Emotional lability

R45.87 Impulsiveness

New code R45.88 Nonsuicidal self-harm
Add Nonsuicidal self-mutilation
Add Code also injury, if known

R45.89 Other symptoms and signs involving emotional state

Z91 Personal risk factors, not elsewhere classified
Excludes2:contact with and (suspected) exposures hazardous to health (Z77.-)
exposure to pollution and other problems related to physical environment (Z77.1-)
female genital mutilation status (N90.81-)
personal history of physical injury and trauma (Z87.81, Z87.82-)
occupational exposure to risk factors (Z57.-

New subcategory Z91.5 Personal history of self-harm
Delete ~~Personal history of parasuicide~~
Delete ~~Personal history of self-poisoning~~
Delete ~~Personal history of suicide attempt~~

New code Z91.51 Personal history of suicidal behavior
Add Personal history of parasuicide
Add Personal history of self-poisoning
Add Personal history of suicide attempt

New code Z91.52 Personal history of nonsuicidal self-harm
Add Personal history of self-mutilation

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Gastric intestinal metaplasia

This topic was previously presented at the September 2019 Coordination and Maintenance (C&M) meeting. Based on public comments received, the revised proposal is being presented for consideration.

Gastric cancer is the fourth most common cancer worldwide and the second leading cause of cancer deaths. It afflicts approximately 26,000 Americans yearly. The location of gastric intestinal metaplasia (IM) is a significant predictor for gastric cancer risk and as is one of the most important characteristics of the disease. Currently, there is no ICD-10-CM unique code for gastric IM. A similar precursor lesion for esophageal cancer, Barrett's esophagus (also known as esophageal intestinal metaplasia) has a unique code (K22.7-).

It is believed the risk for progression into gastric cancer is highest among patients with diffuse gastric IM (which involves both antrum and body). European guidelines use presence of diffuse gastric IM as a marker of higher risk. Gastric IM is categorized histopathologically into incomplete and complete types. Endoscopic gastric mapping to define extent of IM should be done for patients with incomplete IM to rule out dysplasia or adenocarcinoma. Once dysplasia is present, the location is less important as there is a higher risk regardless of location.

The American Gastroenterological Association (AGA) is requesting new codes to contribute to epidemiologic understanding and subsequent development of appropriate surveillance guidelines in the United States.

TABULAR MODIFICATIONS

K31 Other diseases of stomach and duodenum

New subcategory	K31.A	Gastric intestinal metaplasia without dysplasia
Add		Intestinal metaplasia
New code		K31.A0 Gastric intestinal metaplasia without dysplasia, unspecified site
New code		K31.A1 Gastric intestinal metaplasia without dysplasia, involving the antrum
New code		K31.A2 Gastric intestinal metaplasia without dysplasia, involving the body (corpus)
New code		K31.A3 Gastric intestinal metaplasia without dysplasia, involving the fundus
New code		K31.A4 Gastric intestinal metaplasia without dysplasia, involving the cardia
New code		K31.A5 Gastric intestinal metaplasia without dysplasia, involving multiple sites

New subcategory	K31.B	Gastric intestinal metaplasia with dysplasia
New code	K31.B0	Gastric intestinal metaplasia with dysplasia, unspecified
New code	K31.B1	Gastric intestinal metaplasia with dysplasia, low grade
New code	K31.B2	Gastric intestinal metaplasia with dysplasia, high grade

Immune Effector Cell Associated Neurotoxicity Syndrome (ICANS)

Chimeric Antigen Receptor T (CAR-T) Cell Therapy has been a welcome advancement in the treatment of relapsed or refractory leukemia and large b-cell lymphoma, however complications of the therapy have been observed. Two of the most prevalent complications are Cytokine Release Syndrome (CRS) and Immune effector Cell Associated Neurotoxicity Syndrome (ICANS). The Alliance of Dedicated Cancer Centers (ADCC) submits a request for new codes address this clinical condition.

ICANS is defined as "a disorder characterized by a pathologic process involving the central nervous system following any immune therapy that results in the activation or engagement of endogenous or infused T cells and/or other immune effector cells. "Signs and symptoms can be progressive and may include aphasia, altered level of consciousness, impairment of cognitive skills, motor weakness, seizures, and cerebral edema."[1]

Like CRS, some of the symptoms that occur as part of this syndrome are nonspecific, and it is of the opinion of the Alliance of Dedicated Centers (ADCC) and other clinical experts, that coding signs and symptoms of neurotoxicity will not be enough to understand which patients have this diagnosis and its severity. To enable research and comparisons, it is also important to have codes to describe the consensus grading scale grades of ICANS.

In January 2019, the ASTCT published a paper on the formal consensus grading in the official journal of the ASTCT, then named Biology of Blood and Marrow Transplantation.[2] Now that there is consensus on a grading scale, there is widespread agreement among clinicians and their institutions that unique ICD-10-CM diagnosis codes are essential to describe this frequent complication in patients in who receive immune effector cell therapy.

There are currently no ICD-10-CM diagnosis codes to report the ICANS complication of immune effector cell therapy, nor are there codes to report the severity of ICANS. The creation of new codes will allow coding professionals to accurately translate physician documentation and clinical terminology into the codes reported to describe the occurrence and severity of IEC therapy's most significant and common complications (i.e., the different grades of ICANS). This will allow hospitals and clinicians information needed to help explain differences in patient care delivery, resource consumption (i.e., use of the intensive care unit, overall length of stay, additional drugs, etc.), and outcomes for different types of IEC therapy cases.

1 Lee DW, Santomasso BD, Locke FL, et al., "ASTCT Consensus Grading for Cytokine Release Syndrome and Neurologic Toxicity Associated with Immune Effector Cells," Biol Blood Marrow Transplant. 2019 Apr;25(4):625-638. doi: 10.1016/j.bbmt.2018.12.758. Epub 2018 Dec 25. 2 Ibid.

TABULAR MODIFICATIONS

G92 Toxic encephalopathy

Delete		~~Toxic encephalitis~~
Delete		~~Toxic metabolic encephalopathy~~
		Code first, if applicable, drug induced (T36-T50)
Revise		Code first, <u>if applicable</u> (T51-T65) to identify toxic agent
New subcategory	G92.0	Immune effector cell-associated neurotoxicity syndrome
New code	G92.00	Immune effector cell-associated neurotoxicity syndrome, grade unspecified
Add		ICANS, grade unspecified
New code	G92.01	Immune effector cell-associated neurotoxicity syndrome, grade 1
Add		ICANS, grade 1
New code	G92.02	Immune effector cell-associated neurotoxicity syndrome, grade 2
Add		ICANS, grade 2
New code	G92.03	Immune effector cell-associated neurotoxicity syndrome, grade 3
Add		ICANS, grade 3
New code	G92.04	Immune effector cell-associated neurotoxicity syndrome, grade 4
Add		ICANS, grade 4
New code	G92.05	Immune effector cell-associated neurotoxicity syndrome, grade 5
Add		ICANS, grade 5
New code	G92.09	Other toxic encephalopathy
Add		Toxic encephalitis
Add		Toxic metabolic encephalopathy

Immunization Counseling

Patients and caregivers seek counseling services without signs or symptoms, and unrelated to medical care, e.g. preventive care, for a many reason. While there are a number of codes for a variety of counseling services, currently there are no codes for counseling services related to immunizations.

A unique code being requested to identify encounters where the parent/patient present specifically for vaccine counseling. Typically, these parents want an alternative vaccine, alternative vaccine schedule or spend time with the provider asking questions about vaccine safety. It is important to be able to show that counseling is being done particularly when a patient does not have an update immunization record.

Vaccines, which have proven to be a safe and very effective preventive measure, are under constant fire through social media outlets with little to no scientific backing. Parents will read this information and decide not to vaccinate their children or want to discuss this with their child's provider. It has proven to be a public health issue when misinformation leads to many pediatric patients going unimmunized or underimmunized. This has recently been evident by the measles outbreaks in the US.

The Academy of Pediatrics requests the addition of a specific code to identify this encounter when vaccines are discussed at length with parents/patients.

TABULAR MODIFICATIONS

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

Excludes2: contraceptive or procreation counseling (Z30-Z31)

sex counseling (Z70.-)

Z71.8 Other specified counseling

New Code Z71.85 Encounter for immunization counseling

Add Encounter for vaccine product safety counseling

Add Code also, if applicable, encounter for immunization (Z23)

Legal Intervention to include involving other specified means, unspecified person injured

The Massachusetts Injury Surveillance Program (ISP) within the Massachusetts Department of Public Health has requested new ICD-10-CM codes related to injuries resulting from legal intervention. The original proposal was presented at the September 11-12, 2018. This proposal is to include a new code for legal intervention involving other specified means, unspecified person injured, to be in consistent with the ICD-10-CM coding convention.

TABULAR MODIFICATIONS

Y35 Legal intervention

Y35.89 Legal intervention involving other specified means

Y35.891 Legal intervention involving other specified means, law enforcement official injured

Y35.892 Legal intervention involving other specified means, bystander injured

Y35.893 Legal intervention involving other specified means, suspect injured

New code Y35.899 Legal intervention involving other specified means, unspecified person injured

Long term (current) drug therapy

The number and types of medications that patients are taking daily seems to be increasing almost exponentially. Some of these medications carry longer term risks and should be identified so they can be more closely monitored and tracked.

Currently there is a subcategory of Z79.8, Other long term (current) drug therapy, which does identify certain long term (current) drug therapy medications. The American Academy of Pediatrics (AAP) is requesting expansion of this code set to capture more of these medications to better identify and monitor the risk and long term outcomes.

TABULAR MODIFICATONS

Z79 Long term (current) drug therapy

New subcategory	Z79.6 Long term (current) use of immunemodulators and suppressants
Add	Excludes2: long term (current) use of steroids (Z79.5-)
Add	long term (current) use of agents affecting estrogen receptors and estrogen levels (Z79.81-)
New code	Z79.61 Long term (current) use of immunemodulator
New code	Z79.62 Long term (current) use of immunosuppressant
New code	Z79.63 Long term (current) use of chemotherapeutic agent
New code	Z79.64 Long term (current) use of myelosuppressive agent

Malignant neoplasm of bilateral ovaries

Currently in ICD-10-CM Category C56 malignant neoplasm of ovary, there are existing codes for malignant neoplasm of the right, left and unspecified ovaries. A code for malignant neoplasm of bilateral ovaries was requested.

The American College of Obstetricians and Gynecologists (ACOG) and the Society for Gynecologic Oncology (SGO) has reviewed and supports this proposal.

TABULAR MODIFICATIONS

C56 Malignant neoplasm of ovary

Use additional code to identify any functional activity

C56.1 Malignant neoplasm of right ovary

C56.2 Malignant neoplasm of left ovary

New code C56.3 Malignant neoplasm of bilateral ovaries

C56.9 Malignant neoplasm of unspecified ovary

Moisture associated skin damage

Among its multiple vital functions, the skin acts as a barrier to protect the body against mechanical trauma, noxious irritants, infectious pathogens and excessive fluids. Overexposure of the skin to moisture can compromise the integrity of the skin's epithelial barrier, disrupting the intricate molecular arrangement of intercellular lipids in the stratum corneum, the intercellular connections between epidermal cells (corneocytes) and the cutaneous microbiome. Once damaged, the skin is more permeable and susceptible to irritant penetration, leading to inflammation or dermatitis. The term moisture-associated skin damage (MASD) delineates a spectrum of injury characterized by the inflammation and erosion (or denudation) of the epidermis resulting from exposure to various sources of moisture and potential irritants (e.g. urine, stool, saliva or respiratory secretions and stoma or fistula effluent. With a shift in demographics toward an aging population worldwide, MASD is a common condition and its prevalence is likely to rise.

Moisture-associated skin damage is a complex, heterogenous condition, which includes irritant contact dermatitis (persistent erythema with or without erosion of superficial skin layers). Both urinary and fecal incontinence are known to cause irritant contact dermatitis on any portion of the skin. Irritant contact dermatitis has been shown to be an independent risk factor for full thickness pressure ulceration. Similarly, skin around the stoma or fistula exposed to urinary, fecal or fistula effluent is at risk for irritant contact dermatitis impairing the efficacy of pouching systems and exposing the skin to other forms of damage. Saliva or respiratory secretions from the mouth, nose, a tracheostomy or a spit fistula may cause irritant contact dermatitis on nearby skin. Unique ICD-10-CM codes would improve data collection and facilitate research.

Wound Ostomy and Continence Nurses Society is proposing the following tabular modifications to identify these conditions.

TABULAR MODIFICATIONS

	L24	Other and unspecified dermatitis
New subcategory	L24.A	Irritant contact dermatitis due to friction or contact with body fluids
New code	L24.A1	Irritant contact dermatitis due to saliva or digestive secretions
New code	L24.A2	Irritant contact dermatitis due to respiratory secretions
New code	L24.A3	Irritant contact dermatitis due to fecal, urinary or dual incontinence
New code	L24.A4	Irritant contact dermatitis related to stoma or fistula secretions

Newborn affected by Positive Group B Streptococcus

Group B Streptococcus (GBS), also known as Group B Strep Infection, is a type of bacterial infection that can be found in a pregnant woman's vagina or rectum. About 25% of all healthy, adult women will test positive for GBS. The mother can pass GBS to her baby during delivery.

GBS affects about 1in every 2,000 babies in the United States[1]. Not every baby who is born to a mother who tests positive for GBS will become ill. Although GBS is uncommon in pregnant women, the outcome to the newborn can be severe. As such, physicians include testing as a routine part of prenatal care. Newborns are at increased risk for GBS disease if their mother tests positive for the bacteria during pregnancy.

While any person can become ill with GBS, rates of serious GBS infections are higher among newborns. Among babies, there are 2 main types of GBS disease[2] : Early-onset which occurs during the first week of life and late-onset which occurs from the second week through three months of life.

In the United States on average each year about 900 babies get early-onset GBS disease; approximately 1,200 babies get late-onset GBS disease and the mortality rate for a GBS infected newborn is 4-6% (2-3 of every 50 babies). GBS infection is a leading cause of meningitis and bloodstream infections in a newborn's first three months of life.

Because of the high risk of morbidity and mortality for babies who are born to GBS positive mothers, the Academy of Pediatrics (AAP) is requesting a new code which will provide important clinical information for the newborns who are at risk and allow for adequately tracking and monitoring.

TABULAR MODIFICATIONS

P00 Newborn affected by maternal conditions that may be unrelated to present pregnancy

Code first any current condition in newborn

Excludes2: encounter for observation of newborn for suspected diseases and conditions ruled out (Z05.-)
newborn affected by maternal complications of pregnancy (P01.-)
newborn affected by maternal endocrine and metabolic disorders (P70-P74)
newborn affected by noxious substances transmitted via placenta or breast milk (P04.-)

P00.2 Newborn affected by maternal infectious and parasitic diseases

Add — Excludes2: Newborn affected by (positive) maternal group B streptococcus (GBS) colonization (P00.82)

P00.8 Newborn affected by other maternal conditions

P00.81 Newborn affected by periodontal disease in mother

New code — P00.82 Newborn affected by (positive) maternal group B streptococcus (GBS) colonization

Add — Contact with positive maternal group B streptococcus

P00.89 Newborn affected by other maternal conditions

Add — Excludes2: Newborn affected by positive maternal group B streptococcus (GBS) colonization (P00.82)

Sources:

[1.] American Pregnancy Association. Group B Strep Infection: GBS https://americanpregnancy.org/pregnancy-complications/group-b-strep-infection/ Accessed 12/4/2019

[2]. Centers for Disease Control. Group B Strep, Fast Facts. Website https://www.cdc.gov/groupbstrep/about/fast-facts.html Accessed 12/4/2019

Non-ischemic Myocardial Injury

A request has been received from the American College of Cardiology to create a new code for non-ischemic myocardial injury. Myocardial infarction has been recognized as being able to be diagnosed based on cardiac biomarkers, in the presence of cardiac ischemia, as determined by the First Global MI Task Force in 2000 (1). Subsequent refinement and classification of MI into 5 subtypes occurred, with subsequent meetings of Second, Third, and Fourth Global MI Task Force, as detailed further below (2-5). Along with updated definitions of MI, most recently in 2018 there is a definition of non-ischemic myocardial injury (5).

Advances in clinical science, particularly the development and clinical adoption of even more sensitive assays for markers of myocardial injury (in particular, high sensitivity troponin), led to the convening of the Fourth Global MI Task Force by the European Society of Cardiology, American College of Cardiology, American Heart Association, and the World Heart Federation. The resulting Fourth Universal Definition of Myocardial Infarction was published in 2018 (5). Specifically, the introduction of high sensitivity troponin provides the ability to explicitly detect non-ischemic, non-trauma related myocardial injury secondary to any number of conditions such as renal failure and heart failure. The need for clinicians to distinguish whether patients have either a non-ischemic etiology of myocardial injury or one of the MI subtypes has thus been heightened. Where there is a lack of evidence suggesting myocardial ischemia, a diagnosis of myocardial injury is to be made.

With the current ICD-10-CM code set, there is no specific code corresponding to non-traumatic myocardial injury. Given the high severity of illness typical of patients with non-ischemic myocardial injury, appropriate classification of these patients is paramount in terms of aligning appropriate diagnostic and treatment strategies while avoiding inappropriate approaches that would otherwise be suggested by miscoding.

Of note, the generic term “myocardial injury” is not sufficiently complete to indicate the etiology of the injury (ischemic or non-ischemic, traumatic or non-traumatic). Ischemic myocardial injury, which is synonymous with myocardial infarction, is already well delineated in the ICD-10-CM coding schema in sections I21.- and I22.-; traumatic myocardial injury is delineated in section S26.-. Since myocardial infarction and traumatic myocardial injury will typically be described in clinical documentation, we recommend that documentation referring to "myocardial injury" without concomitant documentation of myocardial infarction or trauma default to non-ischemic, non-traumatic myocardial injury per the proposed new code.

Background

In 2000, the First Global MI Task Force presented a new definition of myocardial infarction (MI), specifically that myocardial necrosis as detected by cardiac biomarkers in the setting of myocardial ischemia should be termed an MI (1). These principles were further refined by the Second Global MI Task Force, leading to the Universal Definition of Myocardial Infarction Consensus Document in 2007, which emphasized the different conditions that might result in an MI (2). Following the second consensus document, the development of increasingly sensitive assays for the biomarkers of myocardial necrosis mandated further revision, particularly acknowledging that the detection of these biomarkers occurs not infrequently in the setting of the critically ill, after percutaneous coronary intervention and after cardiac surgery. The Third Global MI Task Force was convened to integrate these insights with new clinical outcomes data; it updated the definition of MI to include the establishment of the diagnosis of MI based on cardiac biomarkers and the prognostic implications of MI in various clinical contexts (3). This work codified an MI classification schema with 5 subcategories, and in 2014, this was formally developed by the American College of Cardiology/American Heart Association Task Force on Data Standards as a controlled terminology for the purposes of interoperability among electronic health information systems (4). In brief, the classification is as follows:

In brief, the classification of MI into five subcategories is as follows. Spontaneous myocardial infarction (MI Type 1) is a clinical event typically caused by rupture or erosion of an atherosclerotic plaque resulting in thrombus formation in one or more of the coronary arteries. This is the prototypic “heart attack,” and includes ST Elevation MI (STEMI) and Non-ST Elevation MI (NSTEMI). This corresponds to ICD-10-CM codes in category I21. Myocardial infarction secondary to ischemic imbalance (myocardial demand exceeding supply) is defined as MI Type 2. This is where a condition other than coronary artery disease results in the imbalance between myocardial oxygen supply and / or demand. Of note, coronary vasospasm and/or endothelial dysfunction also have the potential to cause a Type 2 MI. Patients who present with death from a presumed cardiac etiology (i.e., symptoms or signs suggestive of myocardial ischemia, such as typical chest pain and / or ECG changes) but without confirmatory cardiac biomarkers being available, are classified as having an MI Type 3. Myocardial infarction associated with revascularization procedures are classified as MI Types 4 and 5, with Type 4 MI occurring in the context of percutaneous coronary intervention (PCI) and / or stent implantation, and Type 5 MI being associated with coronary artery bypass graft surgery (CABG). Critically, the cardiac biomarker reference values for Type 4 and Type 5 MIs are substantively different than Type 1 (and Type 2) MI.

Because of the differences in diagnostic criteria, therapeutic approaches, and clinical outcomes of Type 2 MI compared with Type 1 (as well as the other types) of MI, a request to add a specific ICD-10-CM code for Type 2 MI was forwarded by the American College of Cardiology and the American Heart Association at the ICD-10 Coordination and Maintenance Committee Meeting March 9-10, 2016. This resulted in the introduction of the code I21.A1, Myocardial infarction type 2, and also code I21.A9, Other myocardial infarction type, into the ICD-10-CM code set effective October 1, 2017.

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4. Hicks KA, Tcheng JE, Bozkurt B, Chaitman BR, Cutlip DE, Farb A, Fonarow GC, Jacobs JP, Jaff MR, Lichtman JH, Limacher MC, Mahaffey KW, Mehran R, Nissen SE, Smith EE, Targum SL. 2014 ACC/AHA Key Data Elements and Definitions for Cardiovascular Endpoint Events in Clinical Trials: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Cardiovascular Endpoints Data Standards). Circulation. 2015 Jul 28;132(4):302-61 (PMID: 25547519; J Nucl Cardiol. 2015 Oct;22(5):1041-144 (PMID: 26204990); J Am Coll Cardiol. 2015 Jul 28;66(4):403-69 (PMID: 25553722).

5. Thygesen K, Alpert JS, Jaffe AS, Chaitman BR, Bax JJ, Morrow DA, White HD; Executive Group on behalf of the Joint European Society of Cardiology (ESC)/American College of Cardiology (ACC)/American Heart Association (AHA)/World Heart Federation (WHF) Task Force for the Universal Definition of Myocardial Infarction. J Am Coll Cardiol. 2018 Oct 30;72(18):2231-2264. doi: 10.1016/j.jacc.2018.08.1038.

TABULAR MODIFICATIONS

I24 Other acute ischemic heart diseases

Add Excludes2: non-ischemic myocardial injury (I5A)

I25 Chronic ischemic heart disease

Add Excludes2: non-ischemic myocardial injury (I5A)

Revise Other forms of heart disease (I30-~~I52~~I5A)

New code: I5A Non-ischemic myocardial injury (non-traumatic)
Acute (non-ischemic) myocardial injury
Chronic (non-ischemic) myocardial injury
Unspecified (non-ischemic) myocardial injury

Code first the underlying cause, if known and applicable, such as:
Acute kidney failure (N17.-)
Acute myocarditis (I40.-)
Cardiomyopathy (I42.-)
Chronic kidney disease (CKD) (N18.-)
Heart failure (I50.-)
Hypertensive urgency (I16.0)
Nonrheumatic aortic valve disorders (I35.-)
Paroxysmal tachycardia (I47.-)
Pulmonary hypertension (I27.0, I27.2-)

Pulmonary embolism (I26.-)
Sepsis (A41.-)
Takotsubo syndrome (I51.81)

Excludes1: Acute myocardial infarction (I21.-)
Injury of heart (S26.-)

Excludes2: Other acute ischemic heart diseases (I24.-)

INDEX MODIFICATIONS

	Injury (see also specified injury type) …
Revise	- heart (traumatic) S26.90
Add	- -non-traumatic (acute) (chronic) (non-ischemic) I5A
	…
Add	- myocardial (non-traumatic) (acute) (chronic) (non-ischemic) I5A
Add	- - traumatic – see Injury, heart
Revise	- myocardium – see also Injury, heart
Add	- - non-traumatic – see Injury, myocardial

Pediatric Feeding Disorder

Pediatric Feeding Disorder (PFD) can be described as impaired oral intake that is not age-appropriate, and is associated with medical, nutritional, feeding skill, and/or psychosocial dysfunction. Regardless of whether PFD is associated with problems in body function and structure, individuals with PFD experience limitations. These may include not being able to feed effectively which leads to participation restrictions or modifications in childcare, school and other environments that involve mealtime interactions. Pediatric feeding disorders can profoundly impact a child's physical, social, emotional, and/or cognitive function, and increase caregiver stress.

This topic was presented at the September 2019 Coordination and Maintenance Meeting. Based on public comment, a revised proposal for placement of PFD in Chapter 18 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99) with expansion and modifications to code category R63.3-, Feeding difficulties, is being presented for consideration.

PFD is most frequently seen in young children but can affect children of all ages. Age-appropriate feeding was chosen as the reference standard for oral intake. This refers to the progressive acquisition of feeding skills in the infant and child to enable progression from breast or bottle feeding to self-feeding a variety of age-appropriate table foods. Children with developmental delays may have feeding behaviors that are appropriate for their level of development but not their age; these children may have PFD if this is associated with activity limitation and/or participation restriction.

Four important domains underlie PFD: medical, nutritional, feeding skills and psychosocial.
For each domain, impairments that can lead to PFD, and potential interactions among health conditions, personal factors, and environmental factors, resulting in disability are discussed. PFD, in turn can cause dysfunction in each of the domains. The diagnosis of PFD often involves dysfunctions across multiple domains. Additionally, a feeding problem is often the presenting symptom that initiates interdisciplinary evaluation of one or more of the four underlying domains that may lead to identification of additional problems requiring intervention.

Symptoms must be present daily for at least 2 weeks; acute illness, once resolved, is associated with spontaneous improvement in feeding. Consistent with accepted norms, PFD can be classified into acute (< 3 months' duration) and chronic (≥ 3 months' duration). Acute PFD may be triggered by medical conditions, such as esophagitis or a choking episode. Chronic PFD has myriad causes (e.g., gastroesophageal reflux, dysphagia, malnutrition, and psychosocial issues)

Assigning a single diagnostic term and diagnosis code will enable practitioners and researchers to better characterize the needs of heterogeneous patient populations, facilitate inclusion of all relevant disciplines in treatment planning, and allow the health-care team to use the common, precise terminology necessary to advance clinical practice and research.

The American Academy of Pediatrics, with support from its Committee on Nutrition and Section on Gastroenterology Hepatology and Nutrition and working collaboratively with the American Speech-Language-Hearing Association (ASHA), are requesting the following tabular modifications.

TABULAR MODIFICATION

R63 Symptoms and signs concerning food and fluid intake

Excludes1: bulimia NOS (F50.2)
eating disorders of nonorganic origin (F50.-)
malnutrition (E40-E46)

New subcategory R63.3 Feeding difficulties
Delete ~~Feeding problem (elderly)(infant) NOS~~
Delete ~~Picky eater~~

Revise Excludes~~1~~2:eating disorders (F50.-)
feeding problems of newborn (P92.-)
infant feeding disorder of nonorganic origin (F98.2-)

New code R63.30 Feeding difficulties, unspecified

New code R63.31 Pediatric feeding disorder, acute
Add Pediatric feeding dysfunction, acute

Add Code also, if applicable, associated conditions such as:
Add aspiration pneumonia (J69.0)
Add dysphagia (R13.1-)
Add malnutrition (E40-E46)

New code R63.32 Pediatric feeding disorder, chronic
Add Pediatric feeding dysfunction, chronic

Add Code also, if applicable, associated conditions such as:
Add aspiration pneumonia (J69.0)
Add dysphagia (R13.1-)
Add malnutrition (E40-E46)

New code	R63.39 Other feeding difficulties
Add	Feeding problem (elderly) (infant) NOS
Add	Picky eater

Personal history of Chimeric Antigen Receptor T-Cell Therapy (CAR-T)

The Alliance of Dedicated Cancer Centers (ADCC) proposes tabular modifications to address the need to track patients who have received Chimeric Antigen Receptor T-Cell Therapy (CAR-T). This information is important to understand the long-term impact and benefits of CAR-T therapy, assess costs and other issues presented by this evolving therapy.

This topic was presented at the September 2019 Coordination and Maintenance meeting. In response to public comment, a revised proposal is being submitted for reconsideration.

In October 2017, the U.S. Food and Drug Administration (FDA) approved the first CAR-T products for use in the treatment of certain blood cancers. These patients are seeing clinicians to assess their status after CAR-T therapy, including treatment response and to address late on-set complications.

The typical complications of CAR-T therapy include Cytokine Release Syndrome (CRS) and/or neurotoxicity, which usually occur in the first few weeks after receiving the cell infusion (when the patient is typically still in the hospital.) Sometimes, however, such complications occur post-discharge and can be the reason for additional medical encounters (i.e. visit to a physician or ED).

There is currently no ICD-10-CM code to capture the status of a patient after receiving CAR-T therapy.

A new code is being requested to accurately track patient outcomes, reason for additional tests and or treatment and additional resources that may occur as a result of the patient's status as a CAR-T recipient.

TABULAR MODIFICATIONS

Z92 Personal history of medical treatment
Excludes2: postprocedural states (Z98.-)

Z92.8 Personal history of other medical treatment

New sub-subcategory Z92.85 Personal history of cellular therapy

New code Z92.850 Personal history of Chimeric Antigen Receptor T-cell therapy
Personal history of CAR-T therapy

New code	Z92.858 Personal history of other cellular therapy
New code	Z92.859 Personal history of cellular therapy, unspecified
New code	Z92.86 Personal history of gene therapy

Problems Related to Upbringing

A proposal on problems related to upbringing was presented at the September 2019 Coordination and Maintenance meeting. In response to comments received, the Academy of Pediatrics (AAP) is submitting a revised proposal for reconsideration.

Today there are a greater variety of family dynamics that are more extended then the traditional nuclear family. A child may be living with a step-parent or non-parental guardian, such as a grandparent, almost as often as living with a biological or adopted parent.

The current ICD-10-CM codes identifying problems related to upbringing and parent-child conflict do not cover some of these other family situations. These types of circumstances often present unique situations that frequently contribute to the child being brought to seek medical attention.

The American Academy of Pediatrics (AAP) requests that the code set at Z62, Problems related to upbringing, be expanded to represent "family" dynamics and conflicts that can complicate an encounter.

TABULAR MODIFICATIONS

Z62 Problems related to upbringing
Includes: current and past negative life events in childhood
current and past problems of a child related to upbringing
Excludes2: maltreatment syndrome (T74.-)
problems related to housing and economic circumstances (Z59.-)

Z62.2 Upbringing away from parents
Excludes1: problems with boarding school (Z59.3)

Z62.21 Child in welfare custody
Delete ~~Child in care of non-parental family member~~
Child in foster care
Excludes2: problem for parent due to child in welfare custody (Z63.5)
Z62.22 Institutional upbringing
Child living in orphanage or group home

New code Z62.23 Child in custody of non-parental guardian Add Child in care of non-parental family member
Add Child in custody of grandparent
Add Child in kinship care
Add Excludes 1: child in welfare custody (Z62.21)

Z62.8 Other specified problems related to upbringing
Revise Z62.82 Parent caregiver-child conflict
Add Legal guardian conflict
Add Other relative conflict
Add Code also, if applicable:
Absence of family member (Z63.3-)
Add Disappearance and death of family member (Z63.4)
Add Disruption of family by separation and divorce (Z63.5)
Add Other specified problems related to primary support group (Z63.8)
Add Other stressful life events affecting family and household (Z63.7-)

Z62.820 Parent-biological child conflict
Parent-child problem NOS
Z62.821 Parent-adopted child conflict Z62.822 Parent-foster child conflict
New code Z62.823 Parent-step child conflict

New code Z62.824 Non-parental relative guardian-child conflict
Add Grandparent-child conflict
Add Kinship-care conflict
Add Other relative-child conflict

Add Excludes1: Group home staff-child conflict (Z62.825)
New code Z62.825 Group home staff-child conflict

Z65 Problems related to other psychosocial circumstances
Z65.0 Conviction in civil and criminal proceedings without imprisonment

Z65.1 Imprisonment and other incarceration
Z65.2 Problems related to release from prison
Z65.3 Problems related to other legal circumstances
Arrest
Child custody or support proceedings
Litigation
Prosecution
Z65.5 Exposure to disaster, war and other hostilities
Excludes1: target of perceived discrimination or persecution (Z60.5)

New code
Add

Z65.A Runaway from current living environment
Child leaving living situation without permission

Z65.8 Other specified problems related to psychosocial circumstances
Religious or spiritual problem

Pseudoexfoliation

Pseudoexfoliation is a disease of the eye where microscopic, flaky, whitish material resembling dandruff is deposited primarily on the pupil, iris, on the front surface of the lens of the eye, and in the trabecular meshwork of the eye. The pseudoexfoliation flakes are deposited on the pupil and iris can damage the various muscles of the iris and prevent the pupil from dilating properly during eye exams.

The pseudoexfoliation flakes are deposited on the trabecular meshwork of the eye can block aqueous humor fluid from exiting out of the eye, causing a buildup of pressure inside the eye. This is called ocular hypertension and can advance to pseudoexfoliation glaucoma when the increased eye pressure damages the optic nerve of the eye and causes loss of vision. There are no early symptoms to identify pseudoexfoliation or pseudoexfoliation glaucoma, so annual exams are important.

The American Optometric Association is proposing the following tabular modifications to identify and track these patients.

TABULAR MODIFICATIONS

H27 Other disorders of lens

H27.8 Other specified disorders of lens

New sub-subcategory — H27.81 Pseudoexfoliation of lens

Add — Excludes1: pseudoexfoliation with glaucoma (H40.14)
pseudoexfoliation with cataract (H26.-)

New code — H27.811 Pseudoexfoliation of lens, right eye

New code — H27.812 Pseudoexfoliation of lens, left eye

New code — H27.813 Pseudoexfoliation of lens, bilateral

New code — H27.819 Pseudoexfoliation of lens, unspecified eye

New code — H27.89 Other specified disorders of lens

Secondary Malignant Neoplasm of Bilateral Ovaries

Currently in ICD-10-CM Category C79.6-, secondary malignant neoplasm of ovary, there are existing codes for secondary malignant neoplasm of the right, left and unspecified ovaries. A code for secondary malignant neoplasm of bilateral ovaries was requested.

The American College of Obstetricians and Gynecologists (ACOG) and the Society for Gynecologic Oncology (SGO) has reviewed and supports this proposal.

TABULAR MODIFICATIONS

C79 Secondary malignant neoplasm of other and unspecified sites

Excludes1: secondary carcinoid tumors (C7B.-)

secondary neuroendocrine tumors (C7B.-)

C79.6 Secondary malignant neoplasm of ovary

C79.60 Secondary malignant neoplasm of unspecified ovary

C79.61 Secondary malignant neoplasm of right ovary

C79.62 Secondary malignant neoplasm of left ovary

New code C79.63 Secondary malignant neoplasm of bilateral ovaries

Slipped Upper Femoral Epiphysis, Stable, Unstable

The American Academy of Orthopedic Surgeons (AAOS) is requesting expansion of code category M93.0, Slipped upper femoral epiphysis to add codes to slipped upper femoral epiphysis. This proposal was originally presented at the September 2018, Coordination and Maintenance (C&M) meeting and is being represented following comments from the September meeting.

AAOS clarifies a question from the comment of "unspecified" in the M93.00 Unspecified slipped upper femoral epiphysis (nontraumatic) that this refers to the acuity (acute, chronic, acute on chronic) being unspecified and not to the stability being unspecified.

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

> A stable SCFE causes some stiffness or pain in the knee or groin area, and possibly a limp that causes a child to walk with a foot outward. The pain and the limp usually tend to come and go, worsening with activity and getting better with rest. With a stable SCFE, a child still can walk, even if crutches are needed. The prognosis is relatively good for functional recovery.
>
> An unstable SCFE is a more severe slip that usually happens suddenly and is usually much more painful. A child will not be able to bear weight on the affected side. An unstable SCFE is also more serious because it can restrict blood flow to the hip joint, leading to tissue death in the head of the femur. For this reason, the prognosis is much more guarded.

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

AAOS is requesting the following tabular modifications:

TABULAR MODIFICATIONS

M93 Other osteochondropathies

Excludes2: osteochondrosis of spine (M42.-)

M93.0 Slipped upper femoral epiphysis (nontraumatic)

Use additional code for associated chondrolysis (M94.3)

M93.00 Unspecified slipped upper femoral epiphysis (nontraumatic)

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

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

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

New code M93.004 Unspecified slipped upper femoral epiphysis (nontraumatic), bilateral hips

Revise M93.01 Acute slipped upper femoral epiphysis stable (nontraumatic)

Revise M93.011 Acute slipped upper femoral epiphysis stable (nontraumatic), right hip

Revise M93.012 Acute slipped upper femoral epiphysis stable (nontraumatic), left hip

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

New code M93.014 Acute slipped upper femoral epiphysis stable (nontraumatic), bilateral hips

M93.02 Chronic slipped upper femoral epiphysis (nontraumatic)

Revise M93.021 Chronic slipped upper femoral epiphysis stable (nontraumatic), right hip

Revise M93.022 Chronic slipped upper femoral epiphysis stable (nontraumatic), left hip

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

New code M93.024 Chronic slipped upper femoral epiphysis stable (nontraumatic), bilateral hips

M93.03 Acute on chronic slipped upper femoral epiphysis (nontraumatic)

Revise M93.031 Acute on chronic slipped upper femoral epiphysis stable (nontraumatic), right hip

Revise M93.032 Acute on chronic slipped upper femoral epiphysis stable

(nontraumatic), left hip

Revise — M93.033 Acute on chronic slipped upper femoral epiphysis stable (nontraumatic), bilateral hips

Revise — M93.034 Chronic slipped upper femoral epiphysis stable (nontraumatic), unspecified hip

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

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

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

New code — M93.043 Acute slipped upper femoral epiphysis, unstable (nontraumatic), unspecified hip

New code — M93.044 Acute slipped upper femoral epiphysis, unstable (nontraumatic), bilateral hips

New subcategory — M93.05 Chronic slipped upper femoral epiphysis, unstable (nontraumatic)

New code — M93.051 Chronic slipped upper femoral epiphysis, unstable (nontraumatic), right hip

New code — M93.052 Chronic slipped upper femoral epiphysis, unstable (nontraumatic), left hip

New code — M93.053 Chronic slipped upper femoral epiphysis, unstable (nontraumatic), unspecified hip

New code — M93.054 Chronic slipped upper femoral epiphysis, unstable (nontraumatic), bilateral hips

New subcategory — M93.06 Acute on chronic slipped upper femoral epiphysis, unstable (nontraumatic)

New code — M93.061 Acute on chronic slipped upper femoral epiphysis, unstable (nontraumatic), right hip

New code — M93.062 Acute on chronic slipped upper femoral epiphysis, unstable (nontraumatic), left hip

New code — M93.063 Acute on chronic slipped upper femoral epiphysis, unstable (nontraumatic), unspecified hip

New code — M93.064 Acute on chronic slipped upper femoral epiphysis, unstable (nontraumatic), bilateral hips

Stargardt's disease

Stargardt's disease is an inherited retinal disorder. Symptoms most commonly include variable loss of central vision in both eyes, typically begin in childhood or adolescence, though some patients may not notice vision loss until later in adulthood. Both the rods and cones (photoreceptors) die off in Stargardt's disease and most patients will eventually be at least legally blind, though usually not completely in darkness. Experts estimate that Stargardt's disease affects one in every eight to ten thousand people.

Currently, there is no unique code for Stargardt's disease. It is reported using ICD-10-CM code H35.53, Other dystrophies primarily involving the sensory retina. Research into the genetics and biology of Stargardt's disease is ongoing. Stargardt's disease is a sufficiently significant condition to merit a specific code that captures its unique characteristics and to facilitate analysis of research data and public health efforts. There is no cure for Stargardt's disease, though eye doctors can help the patient to maximize what vision they still have, and low vision aids can assist with daily tasks.

The American Optometric Association is proposing the following tabular modifications to capture this condition.

TABULAR MODIFICATIONS

	H35	Other retinal disorders
	H35.5	Hereditary retinal dystrophy
	H35.53	Other dystrophies primarily involving the sensory retina
Delete		~~Stargardt's disease~~
New code	H35.55	Stargardt's disease
Add		Stargardt macular dystrophy
Add		juvenile macular degeneration
Add		fundus flavimaculatus

SYNGAP1-related intellectual disability, Other genetic related intellectual disability

There are a number of specific genes which have been found to be related to intellectual disability. One of the more common such genes is *SYNGAP1*. There is a *SYNGAP1*-related intellectual disability, and this is also frequently associated with other disorders, including epilepsy and autism. Although it is considered rare, based on prevalence data, *SYNGAP1*-related intellectual disability is expected to affect over one million individuals worldwide. This proposal is based on two separate requests to create a code for *SYNGAP1*-related intellectual disability, one from the Bridge the Gap – SYNGAP1 Education and Research Foundation, and another from Hans P. Schlecht, MD, of Springfield, MA, together with the Syngap Research Fund. Also, other requests were received from Dr. Schlecht, with support from others, to create specific codes for certain other genetic related intellectual disabilities, and related genetic syndromes (those noted are not exhaustive).

The *SYNGAP1* protein is an essential contributor to function of the postsynaptic density of neurons and critical to overall neurodevelopment. *SYNGAP1* insufficiency is a rare, genetic autosomal dominant disorder resulting in reduced expression of *SYNGAP1* with disabling resulting conditions. Pathogenic variants of *SYNGAP1* are characterized by intellectual disability and developmental delay along with varying penetrance of autism, hypotonia, sleep disturbance, maladaptive behaviors, and epilepsy (Vlaskamp 2019). While a rare disease, prevalence data demonstrate that variants are common in nonsyndromic intellectual disability with >1 million individuals predicted to be affected world-wide, making pathogenic *SYNGAP1* variants more prevalent than fragile X syndrome (Hamdan 2011, Krupp 2017).

Since *SYNGAP1* encephalopathy has intellectual disability as a fundamental condition—in contrast to the variable penetrance of autism and epilepsy-- and is also categorized as a non-syndromic intellectual disability, it is proposed to classify *SYNGAP1*-related intellectual disability within F78 “Other intellectual disabilities,” but to also note that other associated issues which may be present should also be coded separately, such as autism and epilepsy.

Creation of a specific ICD-10-CM code for SYNGAP1-related intellectual disability, as well as one for other genetic related intellectual disability, would have a number of benefits, and the submitter believes this would aid: epidemiologic monitoring, assessment of disease-associated medical costs, retrospective studies comparing best practices, encouragement of pharmaceutical research, and recruitment of subjects for clinical trials and patient registries, as well as enabling improvement of assessment of resource requirements (Valdez 2016).

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TABULAR MODIFICATIONS

F78 Other intellectual disabilities

New Subcategory F78.A Other genetic related intellectual disabilities

New code F78.A1 SYNGAP1-related intellectual disability

Add Code also, if applicable, any associated:
Add Autistic disorder (F84.0)
Add Autism spectrum disorder (F84.0)
Add Epilepsy and recurrent seizures (G40.-)
Add Other pervasive developmental disorders (F84.8)
Add Pervasive developmental disorder, NOS (F84.9)

New code F78.A9 Other genetic related intellectual disability

Add Code also, if applicable, any associated disorders

INDEX MODIFICATIONS

Disability, disabilities
- intellectual F79
- - with
Add - - - pathogenic CHAMP1 (genetic) (variant) F78.A9
Add - - - pathogenic HNRNPH2 (genetic) (variant) F78.A9
Add - - - pathogenic SATB2 (genetic) (variant) F78.A9
Add - - - pathogenic SETBP1 (genetic) (variant) F78.A9
Add - - - pathogenic STXBP1 (genetic) (variant) F78.A9
Add - - - pathogenic SYNGAP1 (genetic) (variant) F78.A9
Add - - autosomal dominant F78.A9
Add - - autosomal recessive F78.A9
Add - - genetic related F78.A9
Add - - - with
Add - - - - pathogenic CHAMP1 (variant) F78.A9
Add - - - - pathogenic HNRNPH2 (variant) F78.A9
Add - - - - pathogenic SATB2 (variant) F78.A9
Add - - - - pathogenic SETBP1 (variant) F78.A9
Add - - - - pathogenic STXBP1 (variant) F78.A9
Add - - - - pathogenic SYNGAP1 (variant) F78.A9
Add - - - specified NEC F78.A9
Add - - - SYNGAP1-related F78.A1
Add - - in
Add - - - autosomal dominant mental retardation F78.A9
Add - - - autosomal recessive mental retardation F78.A9
Add - - - SATB2-associated syndrome F78.A9
Add - - - SETBP1 disorder F78.A9
Add - - - STXBP1 encephalopathy with epilepsy (see also Encephalopathy; and see also Epilepsy) F78.A9
Add - - - X-linked mental retardation (syndromic) (Bain type) F78.A9
Add - - SYNGAP1-related F78.A1
Add - - X-linked (syndromic) (Bain type) F78.A9

Synthetic cannabinoids

Synthetic cannabinoids have contributed to illness, injury and death in the United States. Synthetic cannabinoids are manmade psychoactive substances, made up of hundreds of chemical compounds. They are called cannabinoids because they act on the same brain cell receptors as tetrahydrocannabinol (THC), the main active ingredient in marijuana. While two synthetic cannabinoids (dronabinol and nabilone) have been approved by Federal Drug Administration (FDA) for clinical use, other synthetic cannabinoids are made illicitly and are illegal in the United States. The U.S. Drug Enforcement Administration (DEA) continues to add newly identified synthetic cannabinoids chemical compounds to the list of Schedule I substances under the Controlled Substance Act. However, chemists can slightly modify the chemical structure and synthesize new compounds that fall outside U.S. controlled substances laws and regulations faster than DEA can add them to the list of Schedule I substances. As a result of the growing variety in the composition of synthetic cannabinoids, there is increasing potential for unpredictable toxicology, unpredictable pharmacological and physiologic effects, and negative health outcomes.1,2

While the long-term health outcomes of synthetic cannabinoid use are not well-studied or understood, use of some synthetic cannabinoid compounds has resulted in long-term psychiatric disorders or death.3 Researchers have found that those who use synthetic cannabinoids had a relative risk of requiring emergency medical care that was 30 times greater than those who use cannabis.4 Due to the nature of the distribution channels of synthetic cannabinoids, cluster outbreaks have been documented when a tainted or particularly harmful batch enters the market. For example, from March to November 2018, 320 individuals in the Midwest and Northeast presented to healthcare facilities with symptoms of coagulopathy (e.g., severe bleeding from the nose and gums and blood in urine) following synthetic cannabinoid exposure. These synthetic cannabinoid batches appeared to be tainted with brodifacoum, a lethal vitamin K antagonist anticoagulant used as a rodenticide.5,6 In August 2018, over 70 individuals in New Haven, Connecticut overdosed on a synthetic cannabinoid labeled as K2, and most presented with loss of consciousness and decreased respiratory rate.7 Additionally, in 2018 over 1,660 individuals were transported to Washington DC area hospitals with synthetic cannabinoid overdoses.8

According to the DEA (2018), there are 105 recognized terms for synthetic cannabinoids in the United States. The most common terms include K2, Spice, and Serenity.

Comprehensive surveillance on synthetic cannabinoid exposures does not exist, and public health practitioners must rely on poison control center calls or syndromic surveillance, neither of which are intended to serve as standalone surveillance systems. Currently, there is no distinction between cannabis and synthetics in ICD-10-CM. Given that cannabis and synthetic cannabinoids are substantively different in terms of chemical structure, legal status, and in other ways, this is inappropriate. As public health practitioners strive to reduce drug-related mortality and morbidity, surveillance data using synthetic cannabinoid ICD-10-CM codes is critical to monitor the public health burden.

This proposal, submitted by the Division of Overdose Prevention, National Center for Injury Prevention and Control in the Centers for Disease Control and Prevention is requesting to expand codes T40.7 to create separate and specific ICD-10-CM codes for nonfatal synthetic cannabinoid poisoning.

This proposal is supported by the U.S. Food and Drug Administration (FDA), Office of the Assistant Secretary for Planning and Evaluation (ASPE), Johns Hopkins Center for Drug Safety and Effectiveness, National Institute on Drug Abuse (NIDA), American Society of Addiction Medicine (ASAM), and Council of State and Territorial Epidemiologists (CSTE).

TABULAR MODIFICATIONS

T40 Poisoning by, adverse effect of and underdosing of narcotics and psychodysleptics [hallucinogens]

The appropriate 7th character is to be added to each code from category T40
A - initial encounter
D - subsequent encounter
S - sequela

T40.7 Poisoning by, adverse effect of and underdosing of cannabis (derivatives)

New sub-subcategory	T40.71 Poisoning by, adverse effect of and underdosing of cannabis (derivatives)
New code	T40.711 Poisoning by cannabis, accidental (unintentional)
New code	T40.712 Poisoning by cannabis, intentional self-harm
New code	T40.713 Poisoning by cannabis, assault
New code	T40.714 Poisoning by cannabis, undetermined
New code	T40.715 Adverse effect of cannabis
New code	T40.716 Underdosing of cannabis
New sub-subcategory	T40.72 Poisoning by, adverse effect of and underdosing of synthetic cannabinoids
New code	T40.721 Poisoning by synthetic cannabinoids, accidental (unintentional)
New code	T40.722 Poisoning by synthetic cannabinoids, intentional self-harm
New code	T40.723 Poisoning by synthetic cannabinoids, assault
New code	T40.724 Poisoning by synthetic cannabinoids, undetermined
New code	T40.725 Adverse effect of synthetic cannabinoids
New code	T40.726 Underdosing of synthetic cannabinoids

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Thrombocytosis and Essential Thrombocythemia

Thrombocytosis and thrombocythemia are conditions where an elevated platelet count is present in the blood. Generally, thrombocytosis (or thrombocytemia) will refer to secondary or reactive thrombocytosis, which is caused by some other condition. Primary or essential thrombocytosis, or primary or essential thrombocythemia, are a neoplastic condition, involving cancer of the blood or bone marrow (the hematopoietic system). A proposal has been received from Kim Saterbak, RHIT, CTR, the Cancer Registry Coordinator for the Minneapolis Veterans Affairs Health Care System, to create separate specific codes for thrombocytosis or thrombocytemia, when it is not specified as essential or primary, or is specified as secondary or reactive.

Based on this request, it is being proposed to create a specific code for thrombocytosis, unspecified, with secondary thrombocytosis and reactive thrombocytosis to be inclusion terms, at D75.83. This change will enable differentiation in coding between neoplastic cases of essential thrombocythemia, and cases of secondary or reactive thrombocytosis, which are not neoplastic in nature.

TABULAR MODIFICATIONS

D47 Other neoplasms of uncertain behavior of lymphoid, hematopoietic and related tissue

D47.3 Essential (hemorrhagic) thrombocythemia
Essential thrombocytosis
Idiopathic hemorrhagic thrombocythemia

Add — Excludes1: secondary thrombocytosis (D75.83)
Add — thrombocytosis NOS (D75.83)

D75 Other and unspecified diseases of blood and blood-forming organs

D75.8 Other specified diseases of blood and blood-forming organs

New code — D75.83 Thrombocytosis, unspecified
Add — Reactive thrombocytosis
Add — Secondary thrombocytosis
Add — Thrombocytemia NOS
Add — Thrombocytosis NOS

Add — Excludes1: Essential thrombocytemia (D47.3)

Traumatic Brain Compression and Herniation

This is a repeat presentation of a revised, simplified proposal, based on a previous proposal from March 2018. The previous proposal was received from the University of Utah Health, Neurology Department, and they also provided an updated proposal for 2020, requesting as a simpler alternative, a single code for traumatic brain herniation. Another recent request from an individual was for codes for traumatic brain compression, as well as related index changes. This proposal incorporates multiple inputs, including the comments received from the prior proposal, as well as subsequent input and proposals received from multiple people and organizations.

Brain compression and herniation occur when brain tissue, cerebrospinal fluid, and blood vessels are moved or pushed away from their usual position inside the skull. Pressure resulting in such movement can be due to brain swelling from a head injury, stroke, brain tumor, abscess, hydrocephaly, or other underlying cause. Brain herniation can occur between areas inside the skull, such as those separated by a rigid membrane like the tentorium or falx, or to the outside of the skull, through the foramen magnum, or through a craniotomy opening, or other defect, whether traumatic or congenital. Traumatic brain injury is one of the most common causes of brain compression and brain herniation.

Different parts of the brain may herniate, each causing a different clinical syndrome. Brain compression may also be significant, whether or not herniation is present. Brain compression and herniation can cause a number of signs and symptoms (e.g., pupillary dilation), and sometimes can be fatal in a short time if not treated. The presence or absence of brain compression or herniation is very important clinically.

Nontraumatic brain herniation is currently being captured with the use of code G93.5, Compression of brain. However, traumatic compression of brain is excluded from there, to codes at S06.2, Diffuse traumatic brain injury, and S06.3, Focal traumatic brain injury. It would also be possible to have brain herniation related to other codes within category S06. However, at this time, it is not possible to differentiate whether or not brain herniation is present using these codes.

Traumatic brain injury is also an active and important area of research. Having codes for traumatic herniation has potential to help with future research that could advance the care of these incredibly ill patients.

TABULAR MODIFICATIONS

G93 Other disorders of brain

G93.5 Compression of brain

Delete Excludes1: ~~diffuse traumatic compression of brain (S06.2-)~~

Delete ~~focal traumatic compression of brain (S06.3-)~~

Add traumatic compression of brain (S06.A-)

S06 Intracranial injury

S06.2 Diffuse traumatic brain injury

Add Use additional code, if applicable, for traumatic brain compression (S06.A-)

S06.3 Focal traumatic brain injury

Add Use additional code, if applicable, for traumatic brain compression (S06.A-)

S06.5 Traumatic subdural hemorrhage

Add Use additional code, if applicable, for traumatic brain compression (S06.A-)

S06.6 Traumatic subarachnoid hemorrhage

Add Use additional code, if applicable, for traumatic brain compression (S06.A-)

New subcategory S06.A Traumatic brain compression and herniation

Add Traumatic cerebral compression

Add Code first the underlying traumatic brain injury, such as:

Add Diffuse traumatic brain injury (S06.2)

Add Focal traumatic brain injury (S06.3-)

Add Traumatic subdural hemorrhage (S06.5-)

Add Traumatic subarachnoid hemorrhage (S06.6-)

New code	S06.A0	Traumatic brain compression without herniation
Add		Traumatic brain compression NOS
Add		Traumatic cerebral compression NOS

New code	S06.A1	Traumatic brain compression with herniation
Add		Traumatic brain herniation
Add		Traumatic cerebral compression with herniation
Add		Traumatic cerebellar compression with herniation
Add		Traumatic brainstem compression with herniation

INDEX MODIFICATIONS

	Compression
	- brain (stem) G93.5
	- - due to
Revise	- - - contusion (diffuse) –(see also Injury, intracranial, diffuse) S06.A0
Add	- - - - with herniation S06.A1
Revise	- - - - focal –(see also Injury, intracranial, focal) S06.A0
Add	- - - - - with herniation S06.A1
Revise	- - - injury NEC –(see also Injury, intracranial, diffuse) S06.A0
Add	- - nontraumatic G93.5
Revise	- - traumatic –(see also Injury, intracranial~~, diffuse~~) S06.A0
Add	- - - with herniation S06.A1
	Herniation - see also Hernia
	- brain (stem) G93.5
Add	- - nontraumatic G93.5
Add	- - traumatic S06.A1
Add	- - - cerebellar S06.A1
Add	- - - subfalcine (cingulate) S06.A1
Add	- - - tonsillar S06.A1
Add	- - - transtentorial (central) (upward cerebellar) S06.A1
Add	- - - uncal S06.A1
	- cerebral G93.5

Add - - nontraumatic G93.5
Add - - traumatic S06.A1

Injury…
Revise - intracranial (traumatic) (see also, if applicable, Compression, brain, traumatic) S06.9-

References

Kim JJ, Gean AD. Imaging for the Diagnosis and Management of Traumatic Brain Injury. Neurotherapeutics. 2011 Jan; 8(1): 39-53. Published online 2011 Jan 8.

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3026928/

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https://medlineplus.gov/ency/article/001421.htm

Vaping-related disorder

ICD-10-CM Tabular List of Diseases and Injuries
April 2020 Addenda

New chapter Chapter 22

Add Codes for special purposes (U00-U85)

New section Provisional assignment of new diseases of uncertain etiology or emergency use (U00-U49)

Add Note: Codes U00-U49 are to be used by WHO for the provisional assignment of new diseases of uncertain etiology.

New category U07 Conditions of uncertain etiology

New code U07.0 Vaping-related disorder

Add Dabbing related lung damage

Add Dabbing related lung injury

Add E-cigarette, or vaping, product use associated lung injury [EVALI]

Add Electronic cigarette related lung damage

Add Electronic cigarette related lung injury

Add Use additional code, to identify manifestations, such as:

Add abdominal pain (R10.84)

Add acute respiratory distress syndrome (J80)

Add	diarrhea (R19.7)
Add	drug-induced interstitial lung disorder (J70.4)
Add	lipoid pneumonia (J69.1)
Add	weight loss (R63.4)

ICD-10-CM Index List of Diseases and Injuries
April 2020 Addenda

Damage
Add - lung
Add - - dabbing (related) U07.0
Add - - electronic cigarette (related) U07.0
Add - - vaping (device) (product) (use) (associated) U07.0
Add - organ
Add - - dabbing (related) U07.0
Add - - electronic cigarette (related) U07.0
Add - - vaping (device) (product) (use) (associated) U07.0

Disease, diseased - see also Syndrome
- lung
Add - - dabbing (related) U07.0
Add - - electronic cigarette (related) U07.0
Add - - vaping (device) (product) (use) (associated) U07.0
Add - organ
Add - - dabbing (related) U07.0
Add - - electronic cigarette (related) U07.0
Add - - vaping (device) (product) (use) (associated) U07.0

Disorder
- lung, interstitial, drug-induced J70.4
Add - - dabbing (related) U07.0
Add - - e-cigarette (related) U07.0
Add - - electronic cigarette (related) U07.0
Add - - vaping (device) (product) (use) (associated) (related) U07.0

Injury
Add - lung
Add - - dabbing (related) U07.0
Add - - electronic cigarette (related) U07.0
Add - - EVALI - [e-cigarette, or vaping, product use associated] U07.0
Add - - vaping (device) (product) (use) (associated) U07.0

COVID-19

ICD-10-CM Tabular List of Diseases and Injuries
October 1, 2020 Addenda

Chapter 22

Codes for special purposes (U00-U85)

Provisional assignment of new diseases of uncertain etiology or emergency use (U00-U49)

Add Note: Codes U00-U49 are to be used by WHO for the provisional assignment of new diseases of uncertain etiology.

U07 Conditions of uncertain etiology

New code U07.1 COVID-19
Add Use additional code to identify pneumonia or other manifestations.
Add Excludes1: Coronavirus infection, unspecified site (B34.2)
Add Coronavirus as the cause of diseases classified to other chapters (B97.2-)
Add Severe acute respiratory syndrome [SARS], unspecified (J12.81)

ICD-10-CM TABULAR OF DISEASES - PROPOSED ADDENDA

All proposed effective October 1, 2021

C30 Malignant neoplasm of nasal cavity and middle ear

C30.0 Malignant neoplasm of nasal cavity

Revise — Excludes1: other and unspecified malignant neoplasm of skin of nose (C44.301, C44.311, C44.321, C44.391)

C84 Mature T/NK-cell lymphomas

C84.7 Anaplastic large cell lymphoma, ALK-negative

Add — Breast implant-associated anaplastic large cell lymphoma [BIA-ALCL]

D02 Carcinoma in situ of middle ear and respiratory system

D02.3 Carcinoma in situ of other parts of respiratory system

Revise — Excludes1: carcinoma in situ of nose NOS (D09.8)

Metabolic disorders (E70-E88)

Delete — ~~Excludes1: Ehlers-Danlos syndromes (Q79.6-)~~

Add — Excludes2: Ehlers-Danlos syndromes (Q79.6-)

M35 Other systemic involvement of connective tissue

M35.7 Hypermobility syndrome

Revise — Excludes1: Ehlers-Danlos syndrome**s** (Q79.6-)

E87 Other disorders of fluid, electrolyte and acid-base balance

E87.2 Acidosis

Revise — Excludes1: diabetic acidosis - see categories E08-E10, E11, E13 with ketoacidosis

G05 Encephalitis, myelitis and encephalomyelitis in diseases classified elsewhere

Code first underlying disease, such as:

Add — congenital toxoplasmosis encephalitis, myelitis and encephalomyelitis (P37.1)

Add cytomegaloviral encephalitis, myelitis and encephalomyelitis (B25.8)
Add encephalitis, myelitis and encephalomyelitis (in) systemic lupus erythematosus (M32.19)
Add eosinophilic meningoencephalitis (B83.2)
human immunodeficiency virus [HIV] disease (B20)
poliovirus (A80.-)
suppurative otitis media (H66.01-H66.4)
trichinellosis (B75)

Excludes1: adenoviral encephalitis, myelitis and encephalomyelitis (A85.1)
Delete ~~congenital toxoplasmosis encephalitis, myelitis and encephalomyelitis (P37.1)~~
Delete ~~cytomegaloviral encephalitis, myelitis and encephalomyelitis (B25.8)~~
Delete ~~encephalitis, myelitis and encephalomyelitis (in) systemic lupus erythematosus (M32.19)~~
Delete ~~eosinophilic meningoencephalitis (B83.2)~~

G55 Nerve root and plexus compressions in diseases classified elsewhere
Revise Excludes1: nerve root compression (due to) (in) spondylosis (~~M47.0-M47.2.~~ M47.0-, M47.2-)

J80 Acute respiratory distress syndrome
Add Acute lung injury

K52 Other and unspecified noninfective gastroenteritis and colitis
K52.2 Allergic and dietetic gastroenteritis and colitis
Delete Excludes2: ~~food protein-induced proctocolitis (K52.82)~~

K52.29 Other allergic and dietetic gastroenteritis and colitis
Add Allergic proctocolitis
Add Food-induced eosinophilic proctocolitis
Add Food protein-induced proctocolitis
Add Milk protein-induced proctocolitis

K52.8 Other specified noninfective gastroenteritis and colitis

K52.82 Eosinophilic colitis

Delete ~~Allergic proctocolitis~~

Delete ~~Food-induced eosinophilic proctocolitis~~

Delete ~~Food protein-induced proctocolitis~~

Delete ~~Milk protein-induced proctocolitis~~

Add Excludes2: Allergic proctocolitis (K52.29)

Add Food-induced eosinophilic proctocolitis (K52.29)

Add Food protein-induced proctocolitis (K52.29)

Add Food protein-induced enterocolitis syndrome (FPIES) (K52.21)

Add Milk protein-induced proctocolitis (K52.29)

L89 Pressure ulcer

L89.0 Pressure ulcer of elbow

L89.01 Pressure ulcer of right elbow

L89.019 Pressure ulcer of right elbow, unspecified stage

Revise Healing pressure ulcer of right ~~of~~ elbow NOS

L89.02 Pressure ulcer of left elbow

L89.029 Pressure ulcer of left elbow, unspecified stage

Revise Healing pressure ulcer of left ~~of~~ elbow NOS

M35 Other systemic involvement of connective tissue

M35.7 Hypermobility syndrome

Delete ~~Excludes1: Ehlers-Danlos syndromes (Q79.6-)~~

Add Excludes2: Ehlers-Danlos syndromes (Q79.6-)

P04 Newborn affected by noxious substances transmitted via placenta or breast milk

Add Code first any current condition in newborn

R57 Shock, not elsewhere classified

Revise Excludes1: ~~anesthetic shock(T88.3)~~ shock due to anesthesia (T88.2)

S00 Superficial injury of head

S00.1 Contusion of eyelid and periocular area

Black eye

Revise Excludes2: contusion of eyeball and orbital tissues (S05.1-)

S01 Open wound of head

S01.0 Open wound of scalp

Revise Excludes1: avulsion of scalp (S08.0-)

T79 Certain early complications of trauma, not elsewhere classified

T79.4 Traumatic shock

Revise Excludes1: ~~anesthetic shock~~ shock due to anesthesia (T88.2)

T81 Complications of procedures, not elsewhere classified

T81.1 Postprocedural shock

Revise Excludes1: ~~anesthetic shock~~ shock due to anesthesia (T88.2)

T86 Complications of transplanted organs and tissue

T86.2 Complications of heart transplant

Excludes1: complication of:

Revise artificial heart device (T82.5-)

Revise heart-lung transplant (T86.3-)

W25 Contact with sharp glass

Revise Excludes1: fall on same level due to slipping, tripping and stumbling with subsequent striking against sharp glass (W01.110-)

Revise striking against sharp glass with subsequent fall (W18.02-)

Revise Excludes2: glass embedded in skin (W45.-)

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

Z01.0 Encounter for examination of eyes and vision

Z01.02 Encounter for examination of eyes and vision following failed vision screening

Revise Excludes1: ~~examination~~ encounter for examination of eyes and vision with abnormal findings (Z01.01)

Revise ~~examination~~ encounter for examination of eyes and vision without abnormal findings (Z01.00)

Z3A Weeks of gestation

Note: Codes from category Z3A are for use, only on the maternal record, to indicate the weeks of gestation of the pregnancy, if known.

Delete ~~Code first complications of pregnancy, childbirth and the puerperium (O09-O9A)~~

Add Code first complications of pregnancy, childbirth (O09-O60, O80-O82)

Z45 Encounter for adjustment and management of implanted device

Z45.8 Encounter for adjustment and management of other implanted devices

Z45.81 Encounter for adjustment or removal of breast implant

Encounter for elective implant exchange (different material) (different size)

Revise Encounter for removal of tissue expander with or without synchronous insertion of permanent implant

Z79 Long term (current) drug therapy

Z79.8 Other long term (current) drug therapy

Z79.84 Long term (current) use of oral hypoglycemic drugs

Long term (current) use of oral antidiabetic drugs

Revise ~~Excludes2~~ Excludes1: long term (current) use of insulin (Z79.4)

Z85 Personal history of malignant neoplasm

Z85.8 Personal history of malignant neoplasms of other organs and systems

Delete ~~Conditions classifiable to C00-C14, C40-C49, C69-C75, C7A.098, C76-C~~79

ICD-10-CM INDEX OF DISEASES - PROPOSED ADDENDA

All proposed effective October 1, 2021

Abnormal, abnormality, abnormalities - see also Anomaly
Revise - liver function test ~~R94.5~~ (see also Elevated, liver function, test) R79.89

Abscess
Add - presacral K68.19

Accident
- transport
- - occupant
Revise - - - vehicle NEC ~~V89.9~~ V89.2

Adenoma - see also Neoplasm, benign, by site
Delete ~~- duct~~

Complication(s) (from) (of)
- joint prosthesis, internal T84.9
- - mechanical
Revise - - - periprosthetic osteolysis T84.059

Revise Emaciation ~~(due to malnutrition) E41~~ R64
Add - due to malnutrition E43

Findings, abnormal, inconclusive, without diagnosis - see also Abnormal
Revise - liver function test (see also Elevated, liver function, test) R79.89

Gangrene…
Revise - with diabetes (mellitus) - see Diabetes, with, gangrene
Revise - diabetic (any site) - see Diabetes, with, gangrene

Hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic) I10
- pulmonary I27.20
- - due to
Add - - - kyphoscoliotic heart disease I27.1

Inflammation
Revise - nerve NEC - see ~~Neuralgia~~ Neuritis

Obstruction
-ureter
- - with
- - - hydronephrosis
Add - - - - congenital Q62.39

Osteoarthritis M19.90
- primary M19.91
Revise - - multiple sites ~~M89.49~~ M15.9

Polyp, polypus
- colon K63.5
- - adenomatous D12.6
Add - - - sigmoid D12.5
Add - - - transverse D12.3
Add - - ascending K63.5
Add - - cecum K63.5
Add - - descending K63.5
Revise - - sigmoid ~~D12.5~~ K63.5
Revise - - transverse ~~D12.3~~ K63.5

Pregnancy
- complicated by
- -infection(s) O98.91-
Add - - -intrauterine O41.12
Add - -inflammation
Add - - - intrauterine O41.12

Procedure (surgical)
- not done Z53.9
- - because of
- - - patient's decision Z53.20
Revise - - - - left against medical advice (AMA) ~~Z53.21~~ Z53.29
Add - - - - left without being seen Z53.21

Refusal of
- treatment (because of) Z53.20
Revise - - left against medical advice (AMA) ~~Z53.21~~ Z53.29
Add - - left without being seen Z53.21

Seizure(s) (see also Convulsions) R56.9
- petit mal G40.A-
Revise - - intractable ~~G40.419~~ G40.A1-
Revise - - - with status epilepticus ~~G40.411~~ G40.A11

Revise - - - without status epilepticus ~~G40.419~~ G40.A19
Revise - - not intractable ~~G40.409~~ G40.A0
Revise - - - with status epilepticus ~~G40.401~~ G40.A01
Revise - - - without status epilepticus ~~G40.409~~ G40.A09

Skin - see also condition
Add - dry L85.3

Stenosis…
Revise - heart valve ~~(congenital) Q24.8~~ (see also Endocarditis) I38
Revise - - aortic ~~Q23.0~~ see Stenosis, aortic
Add - - congenital Q24.8
Revise - - mitral ~~Q23.2~~ see Stenosis, mitral
Revise - - pulmonary ~~Q22.1~~ see Stenosis, pulmonary, valve
Revise - - tricuspid ~~Q22.4~~ see Stenosis, tricuspid

Test, tests, testing (for)
Revise - blood-alcohol ~~Z04.89~~ Z02.83

Vasculitis I77.6
Add - leukocytoclastic M31.0