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Dear Dr. Stanfill:

The American Health Information Management Association (AHIMA) respectfully submits the following comments on the ICD-10-CM code proposals presented at the September ICD-10 Coordination and Maintenance (C&M) Committee meeting and being considered for October 1, 2027 implementation.

AHIMA is a global nonprofit association of health information (HI) professionals, with over 67,000 credential holders in the field. The AHIMA mission of empowering people to impact health® drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and clinicians. Leaders within AHIMA work at the intersection of healthcare, technology, and business, occupying data integrity and information privacy job functions worldwide.

Organizing Principles for Classification of Ultra-rare and Genetic Conditions

We fully support the proposed organizing principles for classification of ultra-rare and genetic conditions. We applaud CDC/NCHS for initiating this effort and appreciate the work that has gone into developing the proposal. AHIMA has long advocated for principles to guide decisions about whether an ultra-rare or genetic condition should be considered for unique representation in ICD-10-CM.

We recommend testing these principles against previous code proposals to assess their practical application. We anticipate further refinement as the principles are applied to actual proposals.

A C&M meeting attendee asked whether ICD-11 is taken into consideration. We do not believe that how a concept is represented in another classification or terminology should

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determine whether it merits unique representation in ICD-10-CM. However, we recommend developing a complementary set of principles to guide CDC/NCHS's internal deliberations on code approval and placement within the classification. One such principle is CDC/NCHS's practice of placing genetic disorders affecting a single body system in the appropriate body system chapter, while generally assigning a single, unifying disease-level code outside a specific body system chapter when multiple or different body systems may be affected. We support continuing this practice and believe additional principles would promote consistency in code approval decisions and code structure.

These additional principles should include consideration of how a concept is represented in ICD-11, including whether it has unique representation, its chapter and section placement, and the level of detail provided. This consideration would not require ICD-10-CM to follow the same approach when there are sound reasons for a different classification decision. Rather, the ICD-11 approach should inform CDC/NCHS's internal deliberations.

We recommend comprehensive indexing, an appendix, or both to clarify how conditions associated with different genes are classified in ICD-10-CM.

The first Action Item identifies the need to clarify the use of category QA0 codes with codes for developmental disorders in categories F80–F82. We recommend expanding this review to include the range of categories F80–F88, particularly category F88, Other disorders of psychological development, which includes "other specified neurodevelopmental disorder."

We also recommend that the other Cooperating Parties work collaboratively with CDC/NCHS to address all Action Items identified in the proposal and any additional Action Items identified as this work progresses.

Ideally, the feasibility of adopting an approach similar to ICD-11's cluster coding for ICD-10-CM reporting purposes could be explored, with the goal of explicitly linking genetic disorders with their associated clinical manifestations on reimbursement claims and in other reporting mechanisms.

Acute Posterior Vitreous Detachment

AHIMA supports the creation of new ICD-10-CM codes to differentiate acute and chronic posterior vitreous detachment, but recommends that indexing and an inclusion term clarify the default if acute vs. chronic is not documented.

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Adverse Childhood Experiences

We support the proposal to create codes to address adverse childhood experiences.

We recommend that an additional code be created in proposed new sub-subcategory Z62.84, Personal history of household stressor in childhood, for "Personal history of other household stressor in childhood."

Amyloid-Related Imaging Abnormalities

We support the updated proposal for new ICD-10-CM codes for amyloid-related imaging abnormalities.

We recommend adding an instructional note stating "code also any associated signs, symptoms, and conditions," without listing specific examples. As noted in our previous comments, the "code also" note in earlier versions of this proposal was confusing. A general note without examples would provide useful guidance while avoiding that confusion.

Biomarkers for the Detection of Barrett's Esophagus and Esophageal Adenocarcinoma

We support the proposed addition of a new code for esophageal biomarker positive for metaplasia, dysplasia, or neoplasia.

Cardiogenic Shock Staging

We support creating new codes for cardiogenic shock stages but recommend placing the code for SCAI Stage A in the same subcategory as the other stages. Specifically, we recommend retitling subcategory R57.0 "Cardiogenic shock and at risk for cardiogenic shock" and adding a new code within this subcategory for "At risk for cardiogenic shock [SCAI Stage A]."

Although NCHS provided a reasonable rationale for classifying SCAI Stage A in the R code chapter rather than the Z code chapter, we do not support creating category R5A, Other cardiac signs, symptoms, and findings, not elsewhere classified. The proposed category overlaps with signs and symptoms involving the circulatory system already classified in categories R00–R09. Such signs and symptoms should be classified within those existing categories. For SCAI Stage A, however, placement within subcategory R57.0 would keep all cardiogenic shock stages together while distinguishing being at risk for cardiogenic shock from having the condition.

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Carotid Web

We support creating unique codes for carotid web.

We recommend adding an instructional note under the new sub-subcategory directing coding professionals to sequence any associated stroke first, when applicable. This would clarify sequencing when a carotid web has caused a stroke.

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

The titles of the two proposed ICD-10-CM codes for chemotherapy-induced alopecia are not mutually exclusive, because chemotherapy-induced alopecia encompasses the persistent form. **We recommend creating only one new code, for persistent chemotherapy-induced alopecia.**

If two codes are created, the title of proposed code L65.81, Chemotherapy-Induced Alopecia (CIA), should be revised to distinguish it from persistent chemotherapy-induced alopecia. Reversing the proposed code titles and their corresponding inclusion terms may address this overlap.

Degloving Injury

AHIMA supports creating unique ICD-10-CM codes for degloving injuries.

We recommend considering placement of the new codes for open degloving injuries in the open wound categories rather than in categories for "other and unspecified" injuries.

We also recommend creating codes for degloving injuries of other specified sites to capture injuries at less common anatomic sites not represented by site-specific codes.

Rather than repeating the instruction "An open degloving injury not identified as partial or complete should be coded to partial" under each new sub-subcategory, we recommend incorporating this guidance into the *Official ICD-10-CM Guidelines for Coding and Reporting*.

The rationale for distinguishing some anatomic sites while grouping others together is unclear. For example, the proposal groups shoulder and upper arm injuries together and wrist, hand, and finger injuries together, but provides separate codes for elbow and forearm and ankle and foot injuries. Similar inconsistencies appear elsewhere in the

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proposal. We recommend a more consistent approach to anatomic site specificity throughout the proposed degloving injury codes.

Diabetic Foot Ulcer

AHIMA does **not** support the proposed expansion of foot ulcer codes. The need to distinguish between "chronic" and "recurrent" foot ulcers is unclear, and this distinction is unlikely to be consistently documented in the medical record. Similarly, documentation is unlikely to clearly identify when a chronic foot ulcer is "in remission."

Doxycycline Post-exposure Prophylaxis

We support creating a new code for encounter for post-exposure prophylaxis for bacterial sexually transmitted infections prevention. This revised proposal addresses our previous concerns.

Dysphotopsia

We support creating new codes for dysphotopsia.

Electric Shock Drowning

We support representing electric shock drowning in ICD-10-CM, but recommend that consideration be given to creating an external cause code rather than expanding code T75.4, Electrocution.

Encounter for Safety Counseling in the Home

We support creating a unique code for encounter for home safety counseling.

Extreme Immaturity of Newborn

While we support the creation of new codes for extreme immaturity of newborn, we recommend expanding code P07.21, Extreme immaturity of newborn, gestational age less than 23 completed weeks, rather than creating proposed new codes P07.2A, P07.2B, and P07.2C.

Floppy Eyelid Syndrome

We support creating a new sub-subcategory for floppy eyelid syndrome.

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

We support creating unique codes for two genetic neurodevelopmental disorders as proposed.

Genitourinary Syndrome of Menopause (GSM)

AHIMA supports creating a unique code for GSM. However, we recommend that CDC/NCHS consider expanding N95.1, Menopausal and female climacteric states, rather than N95.8, Other specified menopausal and perimenopausal disorders, because menopausal symptoms are currently indexed to N95.1.

We also recommend reviewing the Index entries for menopausal symptoms (N95.1) and disorders (N95.8). The distinction between these codes and the conditions intended to be classified to each is unclear.

The topic packet describes GSM as a distinct, recognized syndrome encompassing a spectrum of symptoms and changes resulting from declining sex steroids. It also states that current ICD-10-CM coding fragments GSM into multiple codes and that a dedicated code would improve data quality and reduce fragmentation. Given this rationale, adding a "code also" note to separately identify the syndrome's associated signs and symptoms appears inconsistent with the proposal's stated objective. We recommend reconsidering the necessity and appropriateness of this note.

If the note is retained, we recommend changing it to a "use additional code" note to indicate that the GSM code should be sequenced before the associated symptom codes. The note should also refer to associated "symptoms" rather than "conditions" to more accurately describe the listed examples.

If code N95.1 is expanded rather than code N95.8, and CDC/NCHS agrees that the associated symptoms of GSM should not be coded separately, we recommend placing the existing "use additional code for associated symptoms" note under N95.1 so that it does not apply to the new GSM code.

Heart Failure Stage A and Stage B

We support creating new codes for pre-heart failure (stage B) and at risk for heart failure (stage A). We also support placing the stage A code in the Z code chapter, as individuals at this stage have no symptoms, structural heart disease, or elevated cardiac biomarkers. Risk may be based solely on a family history of cardiomyopathy. Placement in chapter 18,

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as suggested by a C&M meeting attendee, does not seem appropriate because being at risk for heart failure does not, in itself, represent a symptom, sign, abnormal finding, or ill-defined condition.

Heart Failure with Improved Ejection Fraction (HFimpEF)

We support creating new subcategories for heart failure with improved ejection fraction.

Hexane and N-Butyl Acetate Exposure

We support creating new codes for toxic effect of, and contact with and (suspected) exposure to, n-butyl acetate and hexane.

Keloid or Hypertrophic Scars

We support creating a unique code for keloids.

Keratoconus Suspect

We support creating new codes for keratoconus suspect. We believe it is appropriate to create the new codes in H18.6 Keratoconus, as codes for glaucoma suspect and amblyopia suspect already exist in the same chapter.

Laryngopharyngeal Reflux Disease

We support creating new codes for laryngopharyngeal reflux disease but do not believe separate codes for its acidic and non-acidic forms are necessary.

Limbal Stem Cell Deficiency

We support creating new codes for corneal limbal stem cell deficiency.

Macular Telangiectasia

We support the proposal to create new codes for macular telangiectasia. The revised proposal addresses our previous concerns.

Neonatal Supraventricular Tachycardia

AHIMA supports the proposed expansion of code P29.11, Neonatal tachycardia, to create a code for neonatal supraventricular tachycardia.

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The proposed “Code also” note under subcategory P29.11 should be moved to proposed new code P29.118, Other neonatal tachycardia, as it is only applicable to this code and not to all of the codes in this subcategory.

Presence of Continuous Glucose Monitoring Device

We support creating a code for the presence of continuous glucose monitoring device.

Progressive Myopia

We support creating new codes for degenerative myopia with progression of refractive Error.

The CDC/NCHS stated during the C&M meeting that it is being proposed to also change the Excludes1 note for degenerative myopia (H44.2-)under subcategory H52.1, Myopia, to an Excludes2 note. As stated in our comment letter following the March 2026 C&M meeting, we do not agree with this proposed change. Since the H52.1 codes only identify the presence of myopia, and the H44.2 codes describe degenerative myopia, assigning codes from both subcategories does not provide any additional information.

Progressive Pulmonary Fibrosis

We support creating a new code for progressive pulmonary fibrosis.

We recommend evaluating whether J84.170, Interstitial lung disease with progressive fibrotic phenotype in diseases classified elsewhere, remains necessary or should be deleted. It is unclear how this existing code differs from the proposed new code or when it would continue to be used. If J84.170 is retained, we recommend clarifying its intended use through inclusion terms and Index entries and revising its title to clearly distinguish it from the proposed new code.

Reactive Infectious Mucocutaneous Eruption

We support adding a new code for Reactive Infectious Mucocutaneous Eruption. We recommend adding “RIME” as an inclusion term.

Recurrent respiratory papillomatosis

We support creating new codes for recurrent respiratory papillomatosis.

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Refractory Herpes Simplex Virus (HSV)

We support creating new codes for refractory herpes simplex virus.

We recommend deleting the proposed instructional note stating "Code also, if applicable, complications of transplanted organs and tissue (T86.-)." The *ICD-10-CM Official Guidelines for Coding and Reporting* specify that a transplant complication code is assigned only when the complication affects the function of the transplanted organ. Although refractory HSV infection occurs predominantly in immunocompromised patients, including transplant recipients, its occurrence in a transplant recipient does not, by itself, establish a transplant complication. The proposed note could encourage incorrect assignment of a transplant complication code.

Segmental Vitiligo

We support creating new codes to distinguish segmental from non-segmental vitiligo.

The proposed new subcategory is unnecessary because it repeats the title of category L80, Vitiligo. We recommend creating the four proposed codes at the fourth-character level directly under category L80.

Sepsis

We appreciate CDC/NCHS's substantial efforts to update the classification of sepsis in ICD-10-CM, particularly given the complexity of the topic, the range of stakeholder comments and perspectives, and the use of differing definitions of sepsis across the healthcare industry. However, we have several concerns with the proposed modifications presented at the September C&M meeting:

- The term "generalized infection" lacks a clear clinical definition and does not reflect terminology commonly used in patient care. Its distinction from "sepsis" is unclear.
- The proposed codes overlap and lack consistency. The generalized infection code titles specify "without organ dysfunction," whereas "with organ dysfunction" appears only in the inclusion terms under the proposed sepsis codes. Without a corresponding distinction in the sepsis code titles, sepsis could be classified to either group of codes.
- Impending sepsis and sepsis without organ dysfunction are assigned to the same codes, despite representing different clinical circumstances. Classifying them together would not distinguish patients who have sepsis from those at risk of developing it.

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- The meaning of “impending sepsis” is unclear, particularly in relation to sepsis without organ dysfunction.
- Code R65.20 overlaps with the proposed new sepsis codes, creating uncertainty about when each should be assigned.

Given these concerns, we do not support the proposed additions of sepsis and generalized infection codes to chapters 1, 15, and 16. However, we support the proposed revisions to R65.20 and R65.21 to remove the term “severe sepsis.”

We recommend revising R65.20 and R65.21 as proposed, without implementing the remaining proposed changes. For sepsis with associated organ dysfunction and without septic shock, the appropriate existing sepsis code should be assigned along with R65.20, Organ dysfunction associated with sepsis without septic shock, and codes identifying the specific organ dysfunctions.

Retaining the existing sepsis codes and using the revised R65.20 to identify associated organ dysfunction would provide a clearer, more consistent approach. This approach would support identification of the Sepsis-3 population while preserving the ability to report systemic infection without organ dysfunction. It would also avoid the confusion and overlap that could result from introducing the proposed generalized infection and sepsis codes.

Spasticity

We support creating a new code for spasticity.

We recommend clarifying the proposed instructional note stating “This code is used when the underlying condition does not include spasticity.” It is unclear whether the restriction applies only when the code title for the underlying condition explicitly identifies spasticity, or also when spasticity is an inherent component of the condition but is not stated in the code title.

Tenosynovial Giant Cell Tumor

We support the reclassification of tenosynovial giant cell tumor (formerly pigmented villonodular synovitis).

Rather than retaining code M12.2, Villonodular synovitis (pigmented), with the proposed note, we recommend deleting this code when the new codes take effect. The conversion table will provide the information needed to link the deleted code to the new codes for historical data purposes. This approach would be consistent with CDC/NCHS’s past

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handling of codes that have been replaced and WHO ICD-10 codes that have not been adopted for use in ICD-10-CM.

Titanium Dioxide and Iron Oxide Exposure

We support creating new codes for toxic effect of, and contact with and (suspected) exposure to, titanium dioxide and iron oxide.

Thank you for the opportunity to comment on the ICD-10-CM code proposals being considered for October 1, 2027 implementation. If you have any questions, please feel free to contact Sue Bowman, Senior Director of Coding Policy and Compliance, at (312) 233-1115 or sue.bowman@ahima.org.

Sincerely,



Lauren Riplinger, JD
Chief Public Policy and Impact Officer

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