



American Health Information Management Association (AHIMA)
201 West Lake Street, 226
Chicago, Illinois 60606

November 12, 2025

Captain Monica Leonard
Team Lead, Classification and Informatics Standards
National Center for Health Statistics
Centers for Disease Control and Prevention
3311 Toledo Road
Hyattsville, Maryland 20782

Dear Captain Leonard:

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, 2026 implementation.

AHIMA is a global nonprofit association of health information professionals, with over 61,000 members and more than 88,500 credentials in the field. The AHIMA mission of empowering people to impact health® drives its 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.

Alkene Exposure

AHIMA supports the proposal to create new codes for toxic effect of alkenes.

Amyloid-Related Imaging Abnormalities

We recommend that this code proposal be brought back to a future C&M meeting for further discussion. It is not clear whether amyloid-related imaging abnormalities (ARIA) should always be coded as an adverse effect of monoclonal antibody treatment. It is also not clear if an asymptomatic abnormal finding should be classified as an “adverse effect” or if it would be considered an adverse effect only if symptoms are present.

The need for separate codes for the different forms of ARIA is not clear from the presentation, and we are concerned that clinical documentation may not support this level of detail. The clinical presentation states that the goal of creating new codes is to “allow for population-based monitoring of this safety risk

in the context of Alzheimer’s disease treatment with amyloid beta-directed monoclonal antibodies.” This goal can be achieved by creating one code.

The proposed instructional notes are very confusing and need revision to improve clarity and consistency. If ARIA is secondary to the monoclonal antibody treatment, it seems more appropriate for “adverse effect of immunoglobulin (T50.Z15)” to be part of an instructional note that states “Use additional code” rather than a “Code also, if applicable” note. But as noted above, it is not clear if ARIA should always be coded as an adverse effect of the monoclonal antibody treatment.

The “Code also” note regarding symptoms and signs has confusing wording that is not consistent with other “Code also” notes in the classification. The beginning of the “Code also” note already states “Code also, if applicable.” We recommend that the part of the note referencing symptoms and signs should simply say “any associated symptoms and signs.” We do not believe it is necessary to provide a list of examples, as any symptoms and signs associated with ARIA would appropriately be coded separately even in the absence of a “Code also” note. Some of the “symptoms and signs” listed in this instructional note are not actually symptoms or signs (i.e., seizure, status epilepticus, unspecified encephalopathy, visual disturbances).

Apragmatism

We support the creation of new ICD-10-CM codes for apragmatism.

Since apragmatism was described as a language disorder during the C&M presentation, it is not clear why a code for apragmatism is being proposed in category R47, which is in the Symptom chapter. We recommend that the CDC review this code placement for appropriateness.

Arrhythmogenic Cardiomyopathy

We support the creation of a unique code for arrhythmogenic cardiomyopathy.

Biomarkers for Alzheimer’s Disease

We recommend that the term “biomarkers” not be used in the code titles, and we recommend these revisions in the code titles and addition of inclusion terms:

R77.81 Abnormality in beta-amyloid and tau plasma protein

Inclusion term: Abnormality in beta-amyloid and tau biomarkers in plasma protein

R83.81 Abnormal beta-amyloid and tau findings in cerebrospinal fluid

Inclusion term: Abnormality in beta-amyloid and tau biomarkers in cerebrospinal fluid

R90.84 Abnormal beta-amyloid and tau findings on diagnostic imaging of brain

Inclusion term: Abnormal beta-amyloid and tau biomarkers of brain

We are concerned that if the separate proposal for new codes for amyloid-related imaging abnormalities is implemented, there will be confusion between the use of those codes and proposed code R90.84.

Brugada Syndrome

AHIMA supports the creation of a unique code for Brugada syndrome.

Catatonia

We recommend the following modifications to the proposed changes involving catatonia:

The proposed new inclusion term under code F06.1, Catatonic disorder due to known physiological condition, should be changed from “Catatonia disorder due to another medical condition” to “Catatonia disorder due to **a** medical condition” (since catatonia is not a medical condition).

The first inclusion term under proposed new code R46.82, Catatonia, should be changed from “Catatonia associated with another mental disorder” to “Catatonia associated with **a** mental disorder” (since this code is in the Symptom chapter and so it represents a symptom rather than a mental disorder).

An instructional note should be added under code R47.82 that states “Code first the underlying mental disorder” (this note would be comparable to the existing “Code first” note under category F06, Other mental disorders due to known physiological condition).

The Excludes2 note for “catatonic schizophrenia (F20.2)” should be deleted under code F06.1.

An Excludes1 note for “catatonic schizophrenia (F20.2)” should be added under code R46.82.

The Excludes1 note under category R46 for “mental and behavioral disorders (F01-F99)” should be changed to an Excludes2 note to allow code R46.82 to be assigned in addition to the associated mental disorder.

Catecholaminergic Polymorphic Ventricular Tachycardia

AHIMA supports the creation of a new code for catecholaminergic polymorphic ventricular tachycardia.

Chronic Hand Eczema

We do **not** support the proposal to create a new code for chronic hand eczema. The proposal is unclear and confusing. The background material described atopic dermatitis, allergic contact dermatitis, and irritant contact dermatitis as being “subtypes” of chronic hand eczema, but these are specific types of dermatitis that can affect sites other than the hand. Also, the proposed new code is under “other specified dermatitis,” which does not make sense if atopic dermatitis, allergic contact dermatitis, and irritant contact dermatitis are subtypes of chronic hand eczema. Assigning separate codes for atopic dermatitis, allergic contact dermatitis, and irritant contact dermatitis in addition to the proposed new code, as instructed by proposed “Code also” notes, also does not make sense if these are subtypes of chronic hand eczema.

We believe existing codes for atopic dermatitis, allergic contact dermatitis, and irritant contact dermatitis can be assigned when one of these types of dermatitis affects the hands.

Contusion of Pancreas

While we recognize the value of capturing the severity of contusions of the pancreas, we believe the distinctions in the severity levels in the proposed codes need to be clearer. The proposed inclusion terms suggest that the distinction between a minor and major contusion of the pancreas is whether the pancreatic duct is involved. If that is the only distinction between a minor and major contusion, it would be clearer to add “with pancreatic duct involvement” to the code titles for major contusion of pancreas and “without pancreatic duct involvement” to the code titles for minor contusion of pancreas.

Cycloparaffin Exposure

We support the creation of new codes for toxic effects of cycloparaffins.

Doxycycline Post-Exposure Prophylaxis

We do **not** support the creation of codes for encounter for doxycycline post-exposure prophylaxis. We do not believe drug-specific codes should be created, as other drugs may be effective for prophylaxis in the future, necessitating the creation of additional codes for the new drugs. Also, the proposed codes describe an indication for a prescription, which is not typically coded in ICD-10-CM.

Ectopic Pregnancies

AHIMA supports the proposed new codes for ectopic pregnancies.

ER-low (Estrogen Receptor-low [ER+/1-10% expression]), HER2-low immunohistochemistry [IHC]

We do **not** support the expansion of category Z17 Estrogen, and other hormones and factors receptor status at this time. We believe that this proposed code expansion may be premature, and we also recommend that the CDC solicit medical specialty society review and input on this proposal. Additionally, the proposed codes would cause confusion regarding when to use the existing positive status codes or these new codes.

Exposure to Blast Overpressure

We support creation of a new subcategory for contact with and (suspected) exposure to blast (overpressure).

Familial-Genetic Dilated Cardiomyopathy

We support creation of a unique code for familial-genetic dilated cardiomyopathy.

Gadolinium Induced Gout

We do not support the proposed code expansion for gadolinium induced gout. We believe that assigning the existing gout codes in conjunction with the appropriate code from subcategory T56.82, Toxic effects of gadolinium, adequately captures this condition.

Proposed new subcategories M1A.5, Gadolinium-induced chronic gout, and M10.A, Gadolinium-induced gout, overlap.

Gender Identity Disorder, in Remission (Desistance)

We recommend that the CDC solicit input on this proposal from medical societies and organizations whose members diagnose and treat patients with gender identity disorder and related issues in order to ensure that the proposed codes align with established, standard clinical terms and definitions, and the diagnostic criteria used by clinicians. For example, terms such as “in remission,” “detransition,” and “social sex reassignment” should have established meanings and interpretations that are applied consistently in clinical practice. ICD-10-CM is a standardized medical classification system, and in order to produce standardized, consistent coded data, diagnostic codes need to be aligned with the medical community’s terminology usage. If this alignment does not occur, medical record documentation will not support the codes, and the codes will either not be used or will be used improperly, resulting in inaccurate data. As stated in the *ICD-10-CM Official Guidelines for Coding and Reporting*:

“A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.”

“The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved.”

We also recommend that consideration be given to locating the code for “Posttransition Distress” in the Symptom chapter rather than in category F64, Gender identity disorders, as that is a better location for this code, based on the organization and structure of ICD-10-CM.

Code Z87.890 currently exists for personal history of sex reassignment. This code in combination with current symptoms or conditions will provide a clear clinical picture. There are existing medical complication codes to capture any complications from sex reassignment surgery. We are concerned that medical record documentation will not support the proposed expansion of code Z87.890, as it may not indicate the type of sex reassignment the patient underwent, or the patient may have had a combination of types and so it will not be clear which code should be assigned. Also, the meaning and intended use of the proposed code for “personal history of gender transition, social” is not clear and may not be well-understood. The type of documentation that would be needed to support the use of this code is also not clear.

We are concerned that proposed code Z87.894, Personal history of detransition, will be used inconsistently due to the lack of clarity or a universal understanding of the meaning of “detransition.” Inclusion terms might be helpful.

The proposed “Code also any manifestations” notes are not appropriate under personal history codes. Personal history codes explain a patient’s past medical condition that no longer exists and is not receiving any treatment, and therefore, there cannot be any “manifestations” of a personal history. Current symptoms or medical or mental health conditions the patient has would be coded in addition to any personal history, so no instructional note to code existing symptoms/conditions is necessary.

Glanzmann Thrombasthenia

AHIMA supports the creation of a unique ICD-10-CM code for Glanzmann thrombasthenia.

Glutamate Receptor Ionotropic Neurodevelopmental Disorders

We do **not** support expanding code QA0.011, Neurodevelopmental disorders, related to pathogenic variants in glutamate receptor genes, to identify certain distinct neurological disorders related to the ionotropic glutamate receptor, each with a specific genetic basis.

We remain concerned that continuing to create codes for individual genetic diseases due to specific genetic variants is not sustainable in the long-term and not appropriate for a classification.

Hepatic Fibrosis

We support the proposed modifications to the codes for hepatic fibrosis.

Hexamethylene Diisocyanate Exposure

We support the creation of codes for toxic effects of hexamethylene diisocyanate.

Hypertriglyceridemia

We support the proposal to create a new subcategory for hypertriglyceridemia level.

Koolen-de Vries Syndrome

While we support the creation of a unique code for Koolen-de Vries Syndrome, we do not agree with the proposed creation of a subcategory and sub-subcategory that have the same title. Unless the title of the sub-subcategory shown in the topic packet is incorrect and is supposed to be different than the subcategory title, we recommend that only a new subcategory be created (and not a sub-subcategory) and that the code for Koolen-de Vries Syndrome be created in proposed subcategory QA0.7 rather than in a sub-subcategory.

Ledderhose Disease/Plantar Fibromatosis & Plantar Fasciitis

AHIMA supports the creation of new codes for plantar fasciitis and the expansion of code M72.2, Plantar fascial fibromatosis to identify laterality.

Lipedema and Lipolymphedema

We are concerned that the level of clinical detail in the lipedema proposal (identifying both stages and subtypes) will often not be documented in medical records.

Since the proposal only describes four stages of lipedema, and codes are proposed to identify each of these stages, it is not clear when proposed new code E88.838, Other lipedema stage, would be assigned.

We do not believe an “unspecified subtype” code is necessary. If the subtype is not specified, no subtype code should be assigned.

We recommend that code I89.0, Lymphedema, not elsewhere classified, be assigned for idiopathic lymphedema, rather than creating a unique code.

Loeys-Dietz Syndrome

We support the addition of a new code for Loeys-Dietz syndrome.

Consideration should be given to changing the proposed Excludes2 note to an Excludes1 note. The background material explains how Loeys-Dietz syndrome is different from the other conditions identified in this note and seems to suggest that a patient would only have one of these conditions (either Loeys-Dietz syndrome or one of the conditions listed in the note). If that is the case, an Excludes1 note would be more appropriate.

Since there is already a note at the category level (category Q87) that states “Use additional code(s) to identify all associated manifestations,” the proposed “Use additional code” under the proposed code for Loeys-Dietz syndrome is not necessary.

Low Body Mass Index (BMI)

We support the proposed BMI codes.

Lynch Syndrome and Other Genetic Cancer Syndromes

AHIMA continues to believe that only one ICD-10-CM code should be created for Lynch syndrome rather than multiple gene-specific codes. We acknowledge that the proposal indicated lifetime cancer risks vary by gene, and we do not believe the proposed level of detail is appropriate for a classification system.

The proposed “Code also” note under category QA1, Genetic disorders associated with neoplasms, not elsewhere classified, is problematic. This note states “Code also, if applicable, any associated conditions,” but two of the three code categories listed in this note are not medical conditions (genetic susceptibility to malignant neoplasm and personal history of malignant neoplasm). Also, we disagree with assigning codes from subcategory Z15.0, Genetic susceptibility to malignant neoplasm, in conjunction with codes in category QA1, Genetic disorders associated with neoplasms, not elsewhere classified, since all of the disorders classified to this category involve genetic susceptibility to malignant neoplasms (as indicated by the category title). In fact, “if applicable” does not make sense in the “Code also” note when applied to codes in subcategory Z15.0. Genetic susceptibility to malignant neoplasms would always be applicable because this increased risk is inherent to the disorders classified to category QA1.

Medetomidine Withdrawal Syndrome

We support the proposed new sub-subcategory for toxic effect of medetomidine in subcategory T65.8, Toxic effect of other specified substances.

We do **not** support the creation of code F13.A1, Medetomidine causing related disorders. Since medetomidine is a sedative used in veterinary medicine and not in human medicine, the toxic effect code seems more appropriate than a category in F13. It is not clear when this code would be used instead of the toxic effect. Only toxic effect codes were created for another drug approved for use in veterinary medicine but not approved for human use (xylazine). Also, the title of proposed code F13.A1 is confusing and inconsistent with other ICD-10-CM code titles and it is likely not consistent with terminology documented in medical records. It is also not clear when it would be used or how it is intended to be used with proposed new code F13.238, Sedative, hypnotic, or anxiolytic dependence with withdrawal with other disturbances.

We do support the creation of code F13.238, Sedative, hypnotic, or anxiolytic dependence with withdrawal with other disturbances, as it is not specific to medetomidine and can capture disturbances other than the ones specifically identified by existing codes in sub-subcategory F13.23, Sedative, hypnotic or anxiolytic dependence with withdrawal.

Metabolic Dysfunction and Alcohol Associated Liver Disease

The two proposed new codes have the same meaning. We recommend creating one code, K70.8, Other specified alcoholic liver disease, with an inclusion term of "Metabolic dysfunction- and alcohol associated liver disease (MetALD)."

Nipple Ischemia and Nipple Necrosis

AHIMA supports the creation of new codes for intraoperative and postprocedural nipple ischemia and necrosis.

Nonsegmental and Segmental Vitiligo

We support the proposed expansion of code L80, Vitiligo, but it is not clear why the proposed code numbers are L80.A, L80.B, and L80.C (rather than L80.1, L80.2, and L80.9), since there no other L80 codes.

Obesity Due to Disruption of MC4R Pathway

We do **not** support the proposed expansion of code E88.82, Obesity due to disruption of MC4R pathway. We do not believe this level of detail is necessary in ICD-10-CM, and we are concerned it will not be supported by medical record documentation.

Odontogenic Sinusitis

We support the proposed new codes for odontogenic sinusitis.

Okur-Chung Neurodevelopmental Syndrome

We support the creation of a unique code for Okur-Chung neurodevelopmental syndrome.

Pediatric Healthcare: Impact of Parental Mental Health

AHIMA does **not** support the proposal to create a new subcategory for child at risk due to parental mental (behavioral) health condition. There are several issues with this proposal. “Child at risk” in the code titles lacks clarity. What does “at risk” mean? Could this refer to a family history of a parental mental health issue, current exposure to a parental mental health issue, or something else? What medical record documentation would be needed to support that the child is “at risk?” Is the fact that a parent has a mental health issue sufficient, or do additional factors need to be documented to indicate that the parental mental health issue places the child at risk?

Also, the proposed codes for child at risk due to parental mental health condition, parental substance use, and parental alcohol use overlap with the codes in the toxic stress code proposal for “Living with a household member with a mental health issue” and “Living with household member with a substance use problem.” **We prefer the toxic stress code proposal**, as the codes are much clearer and they were developed through the Gravity Project’s robust process for developing evidence-based, consensus-based data standards.

There are also overlaps among some of the codes in the pediatric code proposal. For example, proposed codes Z62.A10, Child at risk due to biological parent mental (behavioral) health condition, Z62.A13, Child at risk due to maternal post-partum depression or another post-partum mood disorder, Z62.A18, Child at risk due to biological parental with other mental (behavioral) health condition, and code Z62.A19, Child at risk due to biological parental unspecified mental (behavioral) health condition, are overlapping or duplicative concepts. These overlaps are replicated in all of the proposed sub-subcategories. The proposed codes for “parental substance use” and “parental alcohol use” also overlap, as alcohol is a type of substance.

Proposed code titles are inconsistent. “Parent” and “parental” are used interchangeably. We recommend that “parental” be used consistently throughout the proposed code titles.

Pediatric Healthcare: Impact of Parental Social Circumstance

We support the creation of a new code to indicate a child with an adolescent parent.

Pediatric Healthcare: Screening for and Preventing Child Maltreatment

We do not support the proposal for a code for encounter for screening for child abuse, neglect and other

maltreatment. Development of consensus-based data standards for child abuse concepts is on the Gravity Project's upcoming work plan, and we believe addressing whether a code should be created for encounter for child abuse should be part of that work.

Pediatric Hypertrophic Pyloric Stenosis

We support the creation of a unique code for pediatric hypertrophic pyloric stenosis.

We agree with the suggestions made during the C&M meeting that the proposed new code should be the default when the hypertrophic pyloric stenosis is not specified as congenital, and that "pyloric stenosis in childhood not specified as congenital" should be added as an inclusion term under the new code.

Personal history of Clostridioides Difficile Infection

We support the creation of a code for personal history of Clostridioides difficile infection.

Pneumothorax that occurs after CPR

While we support creating a code for pneumothorax associated with CPR, we recommend deleting rib fracture from the code title. The rib fracture will be captured by a separate code, and as noted by a clinician at the C&M meeting, pneumothorax can occur as a result of CPR without a rib fracture.

We also recommend adding an Excludes1 note for the new code under existing code J95.811, Postprocedural pneumothorax, to avoid confusion between the two codes.

Post-Bariatric Hypoglycemia

We support the creation of new codes for postprocedural hypoglycemia.

We recommend that "following a procedure" be deleted from the title of proposed new subcategory E89.83, Postprocedural hypoglycemia following a procedure, as this phrase is redundant with the term "postprocedural."

The "Use additional code" note under the proposed new subcategory should state "if known" rather than "if applicable." Since the codes describe hypoglycemia, the codes for hypoglycemia level would always be applicable, but the level might not be known.

Postprocedural Open Deep Wound without Disruption

While we support the creation of codes for postprocedural open surgical wound, we recommend revising the titles of two of the proposed new codes as follows to improve clarity:

Z98.880 Postprocedural (temporary) open abdominal surgical wound

Z98.881 Postprocedural (temporary) open chest surgical wound

Potts' Puffy Tumor

We support the proposed expansion of the ICD-10-CM codes for osteomyelitis.

Prevesical Abscess and Other Pelvic Abscess

We support the creation of new subcategory for pelvic abscess.

We recommend that the title of proposed code K6A.09 be changed to "Other and unspecified pelvic abscess," since "pelvic abscess, unspecified" is an inclusion term.

Pulmonary Mycetoma

We support the proposal to create a unique code for pulmonary mycetoma.

We recommend that the proposed "Code also" notes referencing the pulmonary mycetoma code should state only "Code also, if applicable, pulmonary mycetoma (J4B)," since the causal organism is not part of the pulmonary mycetoma code title.

Risk Stratification of Cancer

AHIMA does **not** support the creation of new codes for risk of malignancy status. We are concerned that these codes will be misused, as they could be misinterpreted as identifying a patient's risk for developing cancer rather than the risk of disease recurrence or progression for an existing cancer. We also do not believe risk stratification of patients with cancer should be classified in ICD-10-CM.

"If known" should be omitted from the proposed "Code first" note. If the proposed codes are implemented, they should only be used when a malignancy is documented.

Screening for Diabetes

We do **not** support the proposal to create codes for encounter for screening for diabetes mellitus. The value of these codes and their intended use are not clear. We do not believe medical record documentation will support codes identifying which type of diabetes is being screened for and may not even support identification of screening for diabetes at all. Patients are often screened for diabetes as part of an annual physical, but this screening is not explicitly documented.

Secondary Metastatic Cancers of the Oral Cavity, Larynx, and Pharynx

We support the creation of new codes for secondary malignant neoplasm of larynx, pharynx, and oral cavity.

Skin Changes Due to Skin Failure

AHIMA does **not** support the creation of codes for skin changes due to skin failure.

Based on additional clinical information we have reviewed since this proposal was presented in September 2024, we believe it is premature to create unique codes for skin failure, as the term "skin failure" is not a recognized medical diagnosis with a standardized, universally accepted definition, nor is there professional consensus around the clinical distinctions described by the unique codes outlined in the proposal.

We recommend that the *Coding Clinic for ICD-10-CM/PCS* publish updated guidance on the most appropriate diagnosis codes to use when providers document "skin failure."

Sleep Inertia

We do not support creating a new code for sleep inertia.

A literature reference from Cleveland Clinic included with this proposal stated that sleep inertia is not a health problem, but a natural phenomenon. Therefore, it is not clear that sleep inertia belongs under sleep disorders. We recommend that the American Academy of Sleep Medicine review this proposal.

Topical Steroid Withdrawal

While we support the creation of a code for chronic dermatitis following topical steroid use, we continue to believe that the adverse effect code referenced in the "Use additional code" note should be the sequela code (T49.0X5S, Adverse effect of local antifungal, anti-infective and anti-inflammatory drugs, sequela). Since the condition occurs after the use of topical steroids has stopped, we believe the sequela code is the most appropriate code.

Toxic Stress

AHIMA supports the toxic stress code proposal.

As noted above, some codes in this proposal overlap with codes in the "Impact of Parental Mental Health" code proposal. We prefer the toxic stress code proposal, as the codes are much clearer and they

were developed through the Gravity Project's robust process for developing evidence-based, consensus-based data standards.

Vanishing Twin Syndrome

We support the creation of new codes to capture vanishing twin syndrome. We acknowledge that "vanishing twin syndrome" is the accepted term even when the original number of fetuses is more than two.

Ventricular Bigeminy

While we support the creation of a code for ventricular bigeminy, we recommend that the "Code also" note be changed to a "Use additional code" note. The code for ventricular bigeminy should be sequenced first, and symptoms that are separately reportable should be assigned additional codes. Per the *ICD-10-CM Official Guidelines for Coding and Reporting*, codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis. Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes.

VEXAS Syndrome

We support the creation of a new code for VEXAS syndrome.

The proposed "Code also" note is not consistent with the standard formatting for "Code also" notes in ICD-10-CM. We recommend that this note be revised to state "Code also any associated conditions."

War Theater Exposure: Burn Pit Emissions and Agent Orange

AHIMA supports the creation of new codes for burn pit and Agent Orange exposure.

Addenda (October 1, 2026)

Under subcategory E83.5, Disorders of calcium metabolism, an Excludes1 note for "hyperparathyroidism (E21.0-E21.3)" is being proposed to change to an Excludes2 note. If this change becomes effective, it will conflict with an Excludes1 note for "familial hypocalciuric hypercalcemia (E83.52)" under code E21.2, Other hyperparathyroidism. The Excludes1 note under code E21.2 has not been proposed to change to an Excludes2 note.

Under code D68.312, Antiphospholipid antibody with hemorrhagic disorder, several Excludes1 notes are being proposed to change to Excludes2 notes. However, these notes have already been changed to Excludes2 notes, effective October 1, 2025.

Thank you for the opportunity to comment on the ICD-10-CM code proposals being considered for October 1, 2026 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,

A handwritten signature in blue ink, appearing to read "Lauren Riplinger", is positioned above the typed name. The signature is fluid and cursive.

Lauren Riplinger, JD
Chief Public Policy and Impact Officer