



2025 CPT® Update

Presented for Kids Health First

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Notices



When a third-party payer is involved, the determination of reimbursement for services is the decision of the individual insurance company based on the patient's policy and the third-party payer guidelines. No guidance can adequately address reimbursement issues for the hundreds of insurance payers that exist. Efforts have been made to ensure the information was valid at the date of presentation. Reimbursement policies vary from insurer to insurer and the policies of the same payer may vary within different U.S. regions. All policies should be verified to ensure compliance. Therefore, it is essential that each payer be contacted for their individual requirements.



The websites listed in this presentation are current and valid as of the date of this presentation. However, webpage addresses and the information on them may change or disappear at any time and for any number of reasons. The attendee is encouraged to confirm or locate any URLs listed here that are no longer valid.

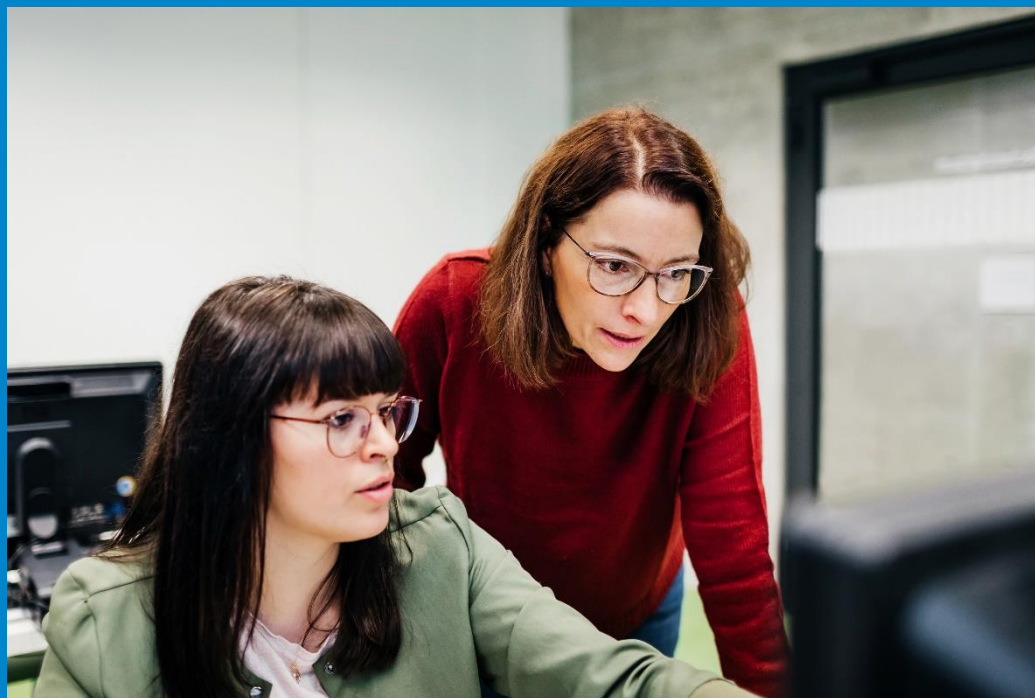


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Agenda

- CPT Updates
 - Telemedicine Spotlight
- ICD-10 Updates
- New Patient vs Established Patient
 - How to use CPT G2211
- Incident-to Billing
- Questions?

General Updates





Other Qualified Health Care Professional (QHP)

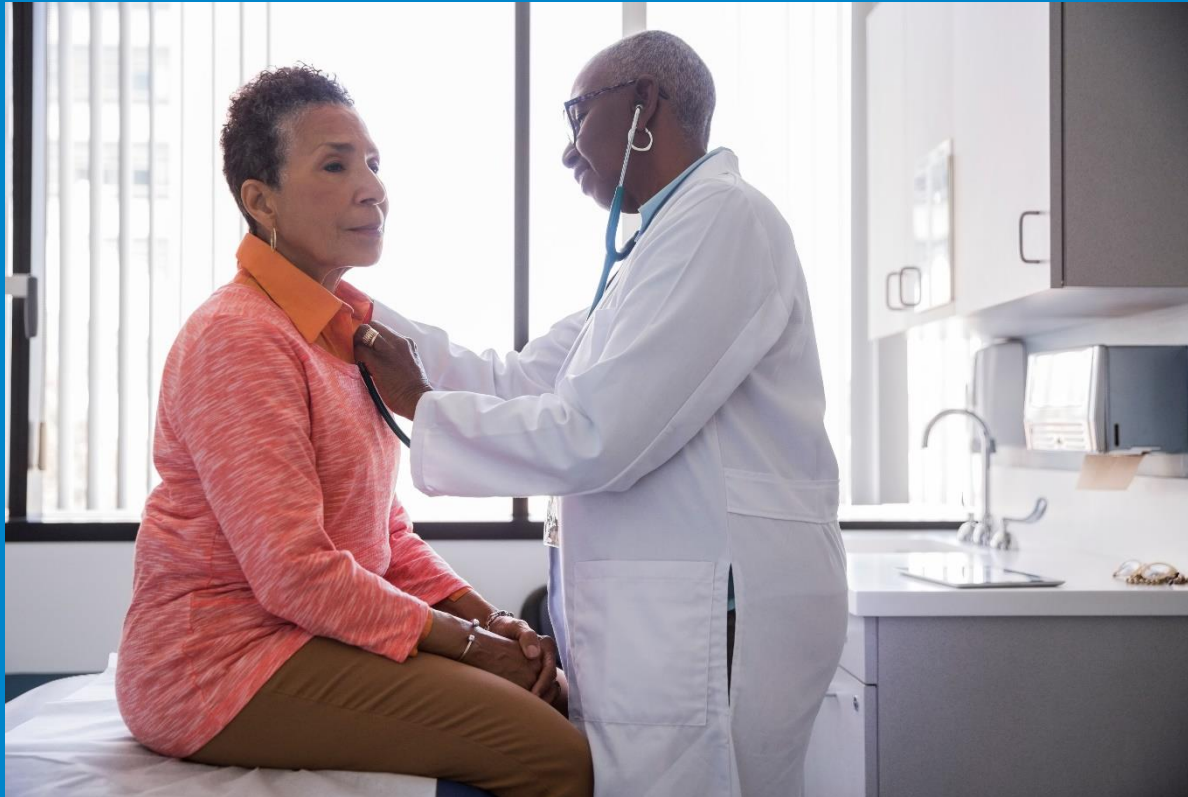
To incorporate the terminology “nonphysician qualified health care professional” throughout the CPT® Manual consistently, numerous revisions and deletions were made to address areas that were misaligned and used different terminology.

- Updates are to provide consistency in the manual
- No changes** to the definition of other QHP (below)

“...A “physician or other qualified health care professional” is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from “clinical staff.” A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services.

Throughout the CPT code set the use of terms such as “physician,” “qualified health care professional,” or “individual” is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may define a service as limited to professionals or limited to other entities (eg, hospital or home health agency).”

Evaluation and Management Updates





CPT® 2025 Code Changes - Telemedicine



Telemedicine Office Visits

Delete

- 99441 – 99443 Telephone E/M service
- Telemedicine symbol (★) removed from 99202 – 99205, 99211 – 99215. Codes are no longer used to report telemedicine office visits.

New E/M Subsection

- Telemedicine services subsection
- Added within E/M office visits or Other Outpatient Services
- Guidelines for reporting new codes

New codes

- 17 new Telemedicine codes

Telemedicine Office Visits - Guidelines

Telemedicine
Services

- Synchronous, real-time, interactive
- Physician (or other QHP) and patient
- Utilize combined audio-video or audio only

Level based on

- MDM or Time
- Unless specifically stated in code descriptor

In lieu of in-
person when

- Medically appropriate to address patient care
- Patient and/or family/caregiver agree

Telemedicine Office Visits - Guidelines

Not used
to report

- Routine telecommunications related to previous encounter
 - Example: To communicate lab results
- Asynchronous (not live in real-time)
 - Report asynchronous services with Online Digital E/M 99421 – 99423
- Oversight of clinical staff (eg. CCM)
 - Do not count telemedicine time towards chronic care management (99437, 99491) or principal care management (99424 – 99425)
- Time establishing connection or arranging appointment
- Services less than 5 minutes
- Online digital communication
- -Except via telecommunication device technology for deaf patient

Telemedicine Office Visits - Guidelines

May be used
to report

- Follow-up of previous encounter when follow-up E/M service is required
 - Use in same manner as in-person E/M service
 - Example: Patient requires re-assessment of previous visit treatment plan due to response or complications
- Audio-video connections lost and only audio restored
 - report service that accounted for majority of interactive time

Telemedicine **Follow-up** Guidelines

Do not require specific time interval from last in-person (or telemedicine) visit

- Except for 98016 (no related E/M in previous 7 days)

May be initiated by physician, other QHP, patient, or family/caregiver

- Must be performed on separate DOS from another E/M

If performed on same DOS as another E/M

- Elements of MDM and time are combined
- Overlapping time is only counted once

If minimum time for reporting telemedicine service not achieved

- Time spent with patient may still be counted towards total time on DOS of in-person E/M service

Telemedicine Office Visits

New Codes

- Reported for work involved with telemedicine (audio-visual and audio-only) office visits
- Structured like current office and other outpatient E/M codes
- Four levels depending on MDM or time
- Separate codes for new and established patients
- New virtual check-in code for evaluation of whether patient needs to be seen in person

Telemedicine Office Visits – New Patient Audio-video

CPT® Code	Description
98000	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98001	 and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98002	 and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98003	 and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)

Telemedicine Office Visits – Established Patient Audio-Video

CPT® Code	Description
98004	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
98005	 and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98006	 and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98007	 and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

Telemedicine Office Visits – New Patient Audio-Only

CPT® Code	Description
98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination , straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98009	 low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98010	 moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98011	 high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)

Telemedicine Office Visits – Established Patient Audio-Only

CPT® Code	Description
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination , straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.
98013	 low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98014	 moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98015	 high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. (For services 55 minutes or longer, use prolonged services code 99417)

Audio only, Established patients 5-10 minutes

- Patient-initiated
- Intended to evaluate whether a more extensive visit type is required (eg. in-person office of other outpatient E/M)
- Video technology not required
- Report **98016** brief communication technology services (eg, virtual check-in)
- If audio check-in leads to an in-person E/M service on same DOS:
 - ✓ Check-in time + more extensive E/M = Total Time

Telemedicine Office Visits – Virtual Check-in

New virtual check-in code
for established patients only

Evaluation of whether the
patient needs to be seen in
person

Similar to HCPCS code
G2012 Brief communication
technology-based virtual
check-in

CPT® Code	Description
98016	Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient , not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion

Telemedicine Office Visit Documentation Requirements

What's Included

- Patient/family consent for telemedicine
- Platform that you are using for the service
- Where the patient and provider are located (determines numeric POS 02 or POS 10)
- Who else is in the room with the patient/provider (for privacy reasons)
- Start and stop times for the telemedicine encounter (does not define time basis for E/M selection)

Other things to consider

- Medicare not accepting new telehealth CPT codes except for 98016
- Medicare set to revert to pre-pandemic telehealth guidelines
 - e.g. Patient cannot be at home except for behavioral or ESRD services
- Keep Monitoring Government bulletins until end of December

Other E/M Update: Female Exams

- Starting in 2024, there is a new CPT code to cover cost of performing female pelvic exams in clinic: 99459
 - Defined as pelvic examination (list in addition to code for primary procedure)
 - No wRVUs
 - Never reported alone, add on code to other E/M service
 - Payer specific coverage
 - Pelvic exam without a pap smear
 - Use with well checks OR problem visits (e.g. pelvic pain)
 - For actual Pap smears, use HCPCS Q0091 for the pap smear sample collection and conveyance

Vaccine Update



Let's Start with Vaccines: COVID Refresher

CPT	Long Description	Patient population
90480	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, single dose	All-COVID ONLY
91318 (Pfizer)	Severe acute respiratory coronavirus 2 (SARS-CoV-2-) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	6 months through 4 years
91319 (Pfizer)	Severe acute respiratory coronavirus 2 (SARS-CoV-2-) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	5 years through 11 years
91320 (Pfizer)	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	12 years and older
91321 (Moderna)	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 25 mcg/0.25 mL dosage, for intramuscular use	6 months through 11 years
91322 (Moderna)	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 50 mcg/0.5 mL dosage, for intramuscular use	12 years and older
91304	COVID-19 vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, PF, 5mcg/0.5 ml dosage, for intramuscular use	Age 13+

Catch up with Vaccines: Influenza

CPT	Long Description	Manufacturer and Names	Patient population
90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free , 0.25 ml dosage, for intramuscular use	Fluzone prefilled (Sanofi)	6-35 months
90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free , 0.50 ml dosage, for intramuscular use	Fluzone prefilled (Sanofi), Fluarix prefilled (GSK), Flulaval prefilled (GSK), Afluria prefilled (Seqirus)	6 months +
90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 ml dosage, for intramuscular use	Fluzone Multidose (Sanofi), Afluria Multidose (Seqirus)	6-35 months
90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.50 ml dosage, for intramuscular use	Fluzone Multidose (Sanofi), Afluria Multidose (Seqirus)	6 months +
90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use	Flumist (AstraZeneca)	2 years +
90661	Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, antibiotic free, 0.50 ml dosage, for intramuscular use	Flucelvax prefilled or multidose (Seqirus)	6 months +
90672	Influenza vaccine, quadrivalent, live (LAIV4), for intranasal use	Flumist (AstraZeneca)	2 years +
90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.50 ml dosage, for intramuscular use	Flucelvax Quadrivalent prefilled (Seqirus)	6 months +
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free , 0.25 ml dosage, for intramuscular use	Fluzone prefilled (Sanofi)	6-35 months
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free , 0.50 ml dosage, for intramuscular use	Fluzone prefilled (Sanofi), Fluarix prefilled (GSK), Flulaval prefilled (GSK), Afluria prefilled (Seqirus)	6 months +
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 ml dosage, for intramuscular use	Fluzone (Sanofi)	6-35 months
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.50 ml dosage, for intramuscular use	Afluria multidose (Seqirus), Flulaval multidose (GSK), Fluzone multidose (Sanofi)	6 months +
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.50 ml dosage, for intramuscular use	Flucelvax Quadrivalent (Seqirus)	6 months +

Catch up with Vaccines: Influenza con't

CPT	Long Description	Manufacturer and Names	Patient population
90673	Influenza vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, 0.5 ml dosage, for intramuscular use	Flublok (Sanofi)	18 years+
90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	Fluzone High Dose prefilled (Sanofi)	65 years+
90664	Influenza virus vaccine (LAIV), pandemic formulation, for intranasal use	Flumist (AstraZeneca)	2 years +
*90637	Influenza virus vaccine, quadrivalent (qIRV), mRNA, 30 mcg/0.5 ml dosage for intramuscular use	TBD	TBD
*90638	Influenza virus vaccine, quadrivalent (qIRV), mRNA, 60 mcg/0.5 ml dosage for intramuscular use	TBD	TBD
*90666	Influenza virus vaccine (IIV), pandemic formulation, split virus, preservative free , for intramuscular use	TBD	TBD
*90667	Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted , for intramuscular use	TBD	TBD
*90668	Influenza virus vaccine (IIV), pandemic formulation, split virus, for intramuscular use	TBD	TBD
*90695	Influenza virus, vaccine, H5NB, derived from cell cultures, adjuvanted, for intramuscular use	TBD	TBD

* Pending FDA Approval, RED is new CPT Code for 2025

Injection Update: RSV

CPT	Long Description	Patient population
90380	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use (Nirsevimab)	All ages
90381	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use (Nirsevimab) *use qty 2 for 200mg dose	All ages
96380	Administration of RSV, monoclonal antibody, seasonal dose by intramuscular injection with counseling by physician or other qualified healthcare professional) (Use with 90380, 90381)	All ages
96381	Administration of RSV, monoclonal antibody, seasonal dose by intramuscular injection (Use with 90380, 90381)	All ages
99401	Preventative counseling and/or risk factor reduction intervention, separate procedure 15 min (administration did NOT take place)	All ages
G0312	Counseling on vaccination when the vaccine is NOT administered 5-15 min, alternate to 99401 by payer	All ages

- No CPT changes this year
- Most common ICD-10 for this is Z29.11 (Encounter for prophylactic immunotherapy for RSV), not Z23 (Encounter for vaccine)

Other Vaccine Updates: New CPT Codes

CPT	Long Description	Patient population
90684	Pneumococcal conjugate vaccine, 21 valent (PCV21), for intramuscular use (PREVNAR 21)	All ages
*90624	Meningococcal pentavalent vaccine, Men B-4C recombinant proteins and outer membrane vesicle and conjugated Men A,C,W,Y-diphtheria toxoid carrier, for intramuscular use	All ages

Other E/M Topics from Practices



New vs. Established Patient Criteria

- A new patient is one who has not been seen in last three years by same group and same **subspecialty**.
- If physician joins new group, his/her patients are still established to the provider
- If patient seen in hospital first (e.g. provider is moonlighting), then first outpatient visit is established
- If group joins hospital or merges with another practices, patients do not become “new” again
- Two E/Ms on same day by same group only allowable with separate certification/boarding
- How to use G2211
 - Should be consistent in the practice (i.e. one provider doesn’t bill it ever and one bills all the time)

Reimbursement for Continuity of Care: CPT G2211

What is G2211?

- This CPT is to represent additional time and resources from a provider being the one continuously responsible for patient's healthcare needs.
- Should be consistent in the practice (i.e. one provider doesn't ever bill it and one bills all the time)
- NOT FOR EVERY VISIT: a self-limited problem should not need this code, more for serious or complex conditions

Well check screening tools

CPT 96127 for depression screening is per instrument, medically unlikely edit (MUE) is 3



CPT 96110 for developmental screening (e.g. autism) is per instrument, MUE is 3

Incident to criteria: General

- NPs, CNMs, CNSs, and PAs may enroll in, and get payment from us, for “incident to” services and supplies provided by auxiliary personnel that they supervise. Additionally, NPs, CNMs, CNSs, and PAs only have the option of providing services as auxiliary personnel incident to the professional services of a supervising physician or nonphysician practitioner. States cover and pay under the incident to provision, when services and supplies comply with applicable state law and meet all these requirements:
- Are an integral part of the patient’s normal treatment when the physician or other listed practitioner personally performed an initial service and remains actively involved in the course of treatment.
- Are commonly provided without charge or included in the physician’s or other listed practitioner’s bill.
- Are an expense to the physician or other listed practitioner.
- Are commonly provided in the physician’s or other listed practitioner’s office or clinic.
- Physician or other listed practitioner provides direct supervision for the “incident to” services, and only the physician or other listed practitioner who supervises the incident to services may bill them.



Incident-to: Anthem BCBS

The supervising provider must be physically present in the office suite and/or immediately available, when necessary via interactive communication to provide assistance and direction throughout the evaluation and management (E/M) visit or other rendered service • The supervising provider must stay involved and have an active part in the ongoing care of the member. • The supervising provider must document in the medical record that they reviewed the documentation for each service the NPP or auxiliary personnel was involved with.

Incident-to Billing Criteria: CMS

- NPs, CNMs, CNSs, and PAs may enroll in, and get payment from us, for “incident to” services and supplies provided by auxiliary personnel that they supervise. Additionally, NPs, CNMs, CNSs, and PAs only have the option of providing services as auxiliary personnel incident to the professional services of a supervising physician or nonphysician practitioner. States cover and pay under the incident to provision, when services and supplies comply with applicable state law and meet all these requirements:
- Are an integral part of the patient’s normal treatment when the physician or other listed practitioner personally performed an initial service and remains actively involved in the course of treatment.
- Are commonly provided without charge or included in the physician’s or other listed practitioner’s bill.
- Are an expense to the physician or other listed practitioner.
- Are commonly provided in the physician’s or other listed practitioner’s office or clinic.
- Physician or other listed practitioner provides direct supervision for the “incident to” services, and only the physician or other listed practitioner who supervises the incident to services may bill them.



Incident-to Billing Criteria: GA Medicaid

- Certified Pediatric, OB\GYN and Family Nurse Practitioners, and CRNAs are eligible for Georgia Medicaid enrollment. Licensed physical, occupational, and speech pathology therapists are eligible for enrollment to provide services to members less than twenty-one years of age. Services provided by practitioners eligible for enrollment cannot be billed by the physician. Physicians cannot be reimbursed for services provided by physician extenders except for their enrolled physician's assistants.
- The services provided are “incident to” services performed under the direct supervision of the physician as an adjunct to the physician's personal service.
- The services are of the kinds that are commonly rendered in the medical setting.
- The services are not traditionally reserved to physicians. Services traditionally reserved to physicians include but are not limited to hospital, office, home, or nursing home visits; prescribing of medication; psychotherapy; and surgery.



2025 ICD-10-CM Updates

Coding Conventions Review



Conventions – Inclusion Terms

ICD-10-CM Official Guidelines for Coding and Reporting FY 2025 Section I.A.11.

Inclusion terms

List of terms is included under some codes. These terms are the conditions for which that code is to be used. The terms may be synonyms of the code title, or, in the case of “other specified” codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Alphabetic Index may also be assigned to a code.



Layman’s Terms

If the patient has a documented condition that is listed as an “Inclusion Term”, the code the Inclusion Term is under may be assigned.

Inclusion Terms - Example

F45.8 Other somatoform disorders

Psychogenic dysmenorrhea

Psychogenic dysphagia, including 'globus hystericus'

Psychogenic pruritus

Psychogenic torticollis

Somatoform autonomic dysfunction

Teeth grinding

Inclusion
Terms



Layman's Terms

- F45.8 may be assigned for any condition listed as an inclusion term.
- The patient does not have to have all conditions for F45.8 to be reported.

Conventions – “Code Also”

ICD-10-CM Official Guidelines for Coding and Reporting FY 2025 Section I.A.17.

“Code also” note

A “code also” note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction. The sequencing depends on the circumstances of the encounter.



Layman’s Terms

- Codes under the “Code Also” note may also be assigned, if documented in the medical record
- Coder must determine sequencing

Conventions – “Code First”

ICD-10-CM Official Guidelines for Coding and Reporting FY 2025 Section I.B.7.

“Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first, if known.



Layman’s Terms

The code listed after a “Code First” note should be assigned as a first-listed diagnosis, if documented in the medical record

Conventions – Excludes1

ICD-10-CM Official Guidelines for Coding and Reporting FY 2025 Section I.A.12.a.

Excludes1

A type 1 Excludes note is a pure excludes note. It means “NOT CODED HERE!” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.



Layman's Terms

Excludes1 = Code 1

Excludes1 - Exceptions

ICD-10-CM Official Guidelines for Coding and Reporting FY 2025 Section I.A.12.a.

An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes1 note are related or not, query the provider. For example, code F45.8, Other somatoform disorders, has an Excludes1 note for "sleep related teeth grinding (G47.63)," because "teeth grinding" is an inclusion term under F45.8. Only one of these two codes should be assigned for teeth grinding. However psychogenic dysmenorrhea is also an inclusion term under F45.8, and a patient could have both this condition and sleep related teeth grinding. In this case, the two conditions are clearly unrelated to each other, and so it would be appropriate to report F45.8 and G47.63 together.

Excludes1 - Exceptions

F45.8 Other somatoform disorders

Psychogenic dysmenorrhea

Psychogenic dysphagia, including 'globus hystericus'

Psychogenic pruritus

Psychogenic torticollis

Somatoform autonomic dysfunction

Teeth grinding

Excludes1: sleep related teeth grinding (G47.63)

Unrelated Condition
(Uterine Pain)

Related
Conditions



Layman's Terms

- Uterine pain is unrelated to teeth grinding
- Both F45.8 and G47.63 can be reported

Conventions – Excludes2

ICD-10-CM Official Guidelines for Coding and Reporting FY 2025 Section I.A.12.b.

Excludes2

A type 2 Excludes note represents “Not included here.” An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.



Layman's Terms

Excludes2 = Code 2

Excludes2 - Example

I26 Pulmonary embolism

Unrelated Conditions

Excludes2 chronic pulmonary embolism (I27.82)
personal history of pulmonary embolism (Z86.711)
pulmonary embolism complicating abortion, ectopic or molar pregnancy (O00-O07, O08.2)
pulmonary embolism complicating pregnancy, childbirth and the puerperium (O88.-)
pulmonary embolism due to trauma (T79.0, T79.1)
pulmonary embolism due to complications of surgical and medical care (T80.0, T81.7-, T82.8-)
septic (non-pulmonary) arterial embolism (I76)



Layman's Terms

All Excludes2 codes listed under 3-digit category code I26 can be reported with all codes beginning with I26, if documented in the medical record.

Conventions – Use Additional Code

ICD-10-CM Official Guidelines for Coding and Reporting FY 2025 Section I.B.7.

Multiple coding for a single condition

In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. “Use additional code” notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as the etiology/manifestation pair, “use additional code” indicates that a secondary code should be added, if known.



Layman’s Terms

If the patient has a documented condition that is listed after a “Use Additional Code” note, it should be assigned as a secondary diagnosis.



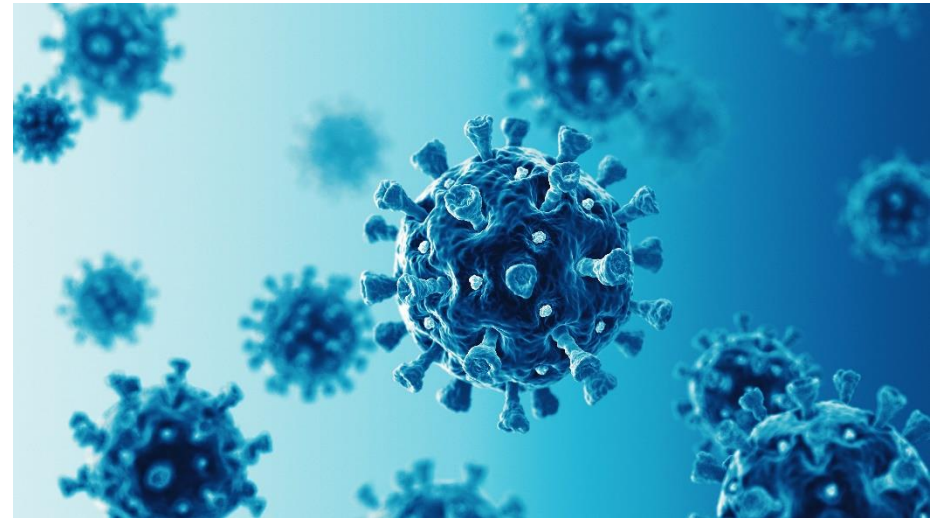
Guidelines



Chapter 1

Certain Infectious and Parasitic Diseases

A00 – B99



Chapter 1 (A00 – B99)

A04 Other bacterial intestinal infections

Add

A04.7 Enterocolitis due to Clostridium difficile
Clostridioides difficile colitis

3 minor spelling revisions

Revise

A18.4 Tuberculosis of skin and subcutaneous tissue
Lupus ex~~e~~edens

A50.45 Juvenile general paresis
Juvenile tab~~e~~toparetic neurosyphilis

A77.41 Ehrlichiosis chafeensis [E. chaf~~e~~feensis]

Chapter 2

Neoplasms

C00 – D49



Chapter 2 (C00 – D49)

C50 Malignant Neoplasm of Breast

Revise

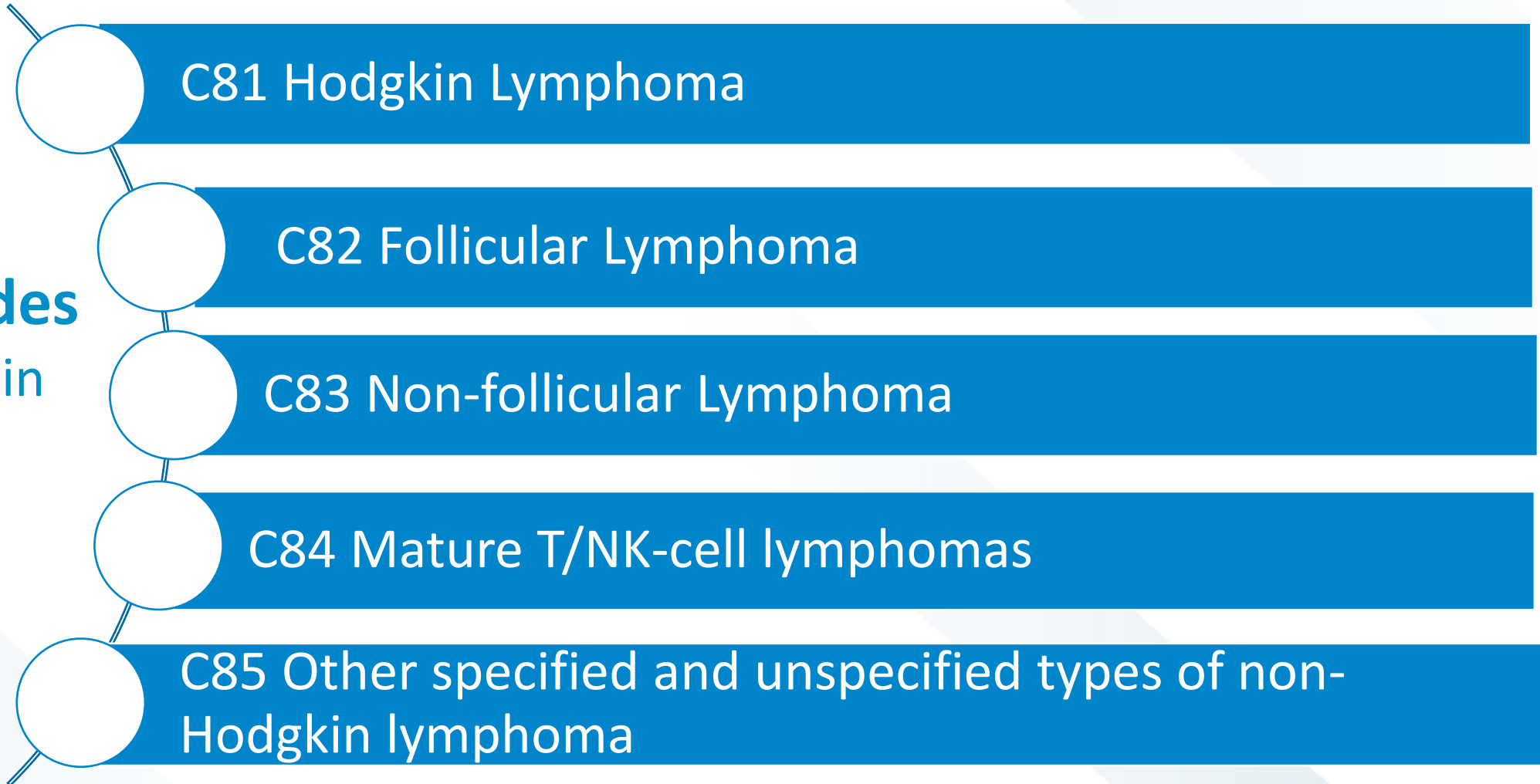
Use Additional code to identify estrogen, **and other hormones and factors**
receptor status ~~(Z17.0, Z17.1)~~ (Z17.-)

Coming up:

- 59 new codes further defining lymphomas as
 - “in remission” or
 - “not having achieved remission”
- Numerous inclusion terms under new codes are NOT included in this presentation
- Recommended that coders review inclusion terms in their 2025 ICD-10-CM codebooks

Chapter 2 (C00 – D49)

33 new codes
Lymphoma in
remission



C81 Hodgkin Lymphoma

7 new codes indicating lymphoma in remission

Add

C81.0 Nodular lymphocyte predominant Hodgkin lymphoma C81.0A Nodular lymphocyte predominant Hodgkin lymphoma, in remission
C81.1 Nodular sclerosis Hodgkin lymphoma C81.1A Nodular sclerosis Hodgkin lymphoma, in remission
C81.2 Mixed cellularity Hodgkin lymphoma C81.2A Mixed cellularity Hodgkin lymphoma, in remission
C81.3 Lymphocyte depleted Hodgkin lymphoma C81.3A Lymphocyte depleted Hodgkin lymphoma, in remission
C81.4 Lymphocyte-rich Hodgkin lymphoma C81.4A Lymphocyte-rich Hodgkin lymphoma, in remission
C81.7 Other Hodgkin lymphoma C81.7A Other Hodgkin lymphoma, in remission
C81.9 Hodgkin lymphoma, unspecified C81.9A Hodgkin lymphoma, unspecified, in remission

C82 Follicular Lymphoma

8 new codes indicating lymphoma **in remission**

Add

C82.0 Follicular lymphoma grade I
C82.0A Follicular lymphoma grade I, in remission
C82.1 Follicular lymphoma grade II
C82.1A Follicular lymphoma grade II, in remission
C82.3 Follicular lymphoma grade IIIa
C82.3A Follicular lymphoma grade IIIa, in remission
C82.4 Follicular lymphoma grade IIIb
C82.4A Follicular lymphoma grade IIIb, in remission
C82.5 Diffuse follicle center lymphoma
C82.5A Diffuse follicle center lymphoma, in remission
C82.6 Cutaneous follicle center lymphoma
C82.6A Cutaneous follicle center lymphoma, in remission
C82.8 Other types of follicular lymphoma
C82.8A Other types of follicular lymphoma, in remission
C82.9 Follicular lymphoma, unspecified
C82.9A Follicular lymphoma, unspecified, in remission

C83 Non-follicular lymphoma

7 new codes indicating lymphoma in remission

Add	C83.0 Small cell B-cell lymphoma C83.0A Small cell B-cell lymphoma, in remission
	C83.1 Mantle cell lymphoma C83.1A Mantle cell lymphoma, in remission
	C83.3 Diffuse large B-cell lymphoma C83.3A Diffuse large B-cell lymphoma, in remission
	C83.5 Lymphoblastic (diffuse) lymphoma C83.5A Lymphoblastic (diffuse) lymphoma, in remission
	C83.7 Burkitt lymphoma C83.7A Burkitt lymphoma, in remission
	C83.8 Other non-follicular lymphoma C83.8A Other non-follicular lymphoma, in remission
	C83.9 Non-follicular (diffuse) lymphoma, unspecified C83.9A Non-follicular (diffuse) lymphoma, unspecified, in remission

C84 Mature T/NK-cell lymphomas

8 new codes indicating lymphoma **in remission**

Add

C84.0 Mycosis fungoides

C84.0A Mycosis fungoides, in remission

C84.1 Sézary disease

C84.1A Sézary disease, in remission

C84.4 Peripheral T-cell lymphoma, not elsewhere classified

C84.4A Peripheral T-cell lymphoma, not elsewhere classified, in remission

C84.6 Anaplastic large cell lymphoma, ALK-positive

C84.6A Anaplastic large cell lymphoma, ALK-positive, in remission

C84.7 Anaplastic large cell lymphoma, ALK-negative

C84.7B Anaplastic large cell lymphoma, ALK-negative, in remission

C84.A Cutaneous T-cell lymphoma, unspecified

C84.AA Cutaneous T-cell lymphoma, unspecified, in remission

C84.Z Other mature T/NK-cell lymphomas

C84.ZA Other mature T/NK-cell lymphomas, in remission

C84.9 Mature T/NK-cell lymphomas, unspecified

C84.9A Mature T/NK-cell lymphomas, unspecified, in remission

C85 Other specified and unspecified types of non-Hodgkin lymphoma

4 new codes indicating lymphoma **in remission**

Add

C85.1 Unspecified B-cell lymphoma

C85.1A Unspecified B-cell lymphoma, in remission

C85.2 Mediastinal (thymic) large B-cell lymphoma

C85.2A Mediastinal (thymic) large B-cell lymphoma, in remission

C85.8 Other specified types of non-Hodgkin lymphoma

C85.8A Other specified types of non-Hodgkin lymphoma, in remission

C85.9 Non-Hodgkin lymphoma, unspecified

C85.9A Non-Hodgkin lymphoma, unspecified, in remission

Chapter 2 (C00 – D49)

26 new codes
Lymphoma in remission
or
Not having achieved
remission



C86 Extranodal NK/T-cell lymphoma, nasal type

C88 Malignant immunoproliferative diseases
and certain other B-cell lymphomas

C86 Other specified types of T/NK-cell lymphoma

14 new codes indicating lymphoma **in remission** or **not having achieved remission**

Add	C86.0 Extranodal NK/T-cell lymphoma, nasal type C86.00 Extranodal NK/T-cell lymphoma, nasal type not having achieved remission C86.01 Extranodal NK/T-cell lymphoma, nasal type, in remission
	C86.1 Hepatosplenic T-cell lymphoma C86.10 Hepatosplenic T-cell lymphoma not having achieved remission C86.11 Hepatosplenic T-cell lymphoma, in remission
	C86.2 Enteropathy-type (intestinal) T-cell lymphoma C86.20 Enteropathy-type (intestinal) T-cell lymphoma not having achieved remission C86.21 Enteropathy-type (intestinal) T-cell lymphoma, in remission
	C86.3 Subcutaneous panniculitis-like T-cell lymphoma C86.30 Subcutaneous panniculitis-like T-cell lymphoma not having achieved remission C86.31 Subcutaneous panniculitis-like T-cell lymphoma, in remission

C86 Other specified types of T/NK-cell lymphoma

14 new codes indicating lymphoma in remission or not having achieved remission

Add

C86.4 Blastic NK-cell lymphoma

C86.40 Blastic NK-cell lymphoma not having achieved remission

C86.41 Blastic NK-cell lymphoma, in remission

C86.5 Angioimmunoblastic T-cell lymphoma

C86.50 Angioimmunoblastic T-cell lymphoma not having achieved remission

C86.51 Angioimmunoblastic T-cell lymphoma, in remission

C86.6 Primary cutaneous CD30-positive T-cell proliferations

C86.60 Primary cutaneous CD30-positive T-cell proliferations not having achieved remission

C86.61 Primary cutaneous CD30-positive T-cell proliferations, in remission

C88 Malignant immunoproliferative diseases and certain other B-cell lymphomas

12 new codes indicating lymphoma **in remission** or **not having achieved remission**

Add

C88.0 Waldenström macroglobulinemia

C88.00 Waldenström macroglobulinemia not having achieved remission

C88.01 Waldenström macroglobulinemia, in remission

C88.2 Heavy chain disease

C88.20 Heavy chain disease not having achieved remission

C88.21 Heavy chain disease, in remission

C88.3 Immunoproliferative small intestinal disease

C88.30 Immunoproliferative small intestinal disease not having achieved remission

C88.31 Immunoproliferative small intestinal disease, in remission

C88 Malignant immunoproliferative diseases and certain other B-cell lymphomas

12 new codes indicating lymphoma **in remission** or **not having achieved remission**

Add

C88.4 Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue [MALT- lymphoma]

C88.40 not having achieved remission

C88.41 in remission

C88.8 Other malignant immunoproliferative diseases

C88.80 Other malignant immunoproliferative diseases not having achieved remission

C88.81 Other malignant immunoproliferative diseases, in remission

C88.9 Malignant immunoproliferative disease, unspecified

C88.90 Malignant immunoproliferative disease, unspecified not having achieved remission

C88.91 Malignant immunoproliferative disease, unspecified, in remission

C83.3 Diffuse large B-cell lymphoma

2 new lymphoma codes

Delete	C83.3 Diffuse large B-cell lymphoma Diffuse large B-cell lymphoma, subtype not specified
Add	C83.390 Primary central nervous system lymphoma PCNSL of brain PCNSL of meninges PCNSL of spinal cord PCNSL NOS Excludes1: Primary central nervous system lymphoma, Burkitt (C83.79) Primary central nervous system lymphoma, lymphoblastic (C83.59) Primary central nervous system lymphoma, other (C83.89) Primary central nervous system lymphoma, peripheral T-cell(C84.49)
	C83.398 Diffuse large B-cell lymphoma of other extranodal and solid organ sites

Lymphoma Coding Example

A 34-year-old male is diagnosed with hepatosplenic T-cell lymphoma.

Alphabetic Index:

- Main Term: Lymphoma
- Subterm: hepatosplenic T-cell C86.1

Tabular List:

C86.1 Hepatosplenic T-cell lymphoma

C86.10 Hepatosplenic T-cell lymphoma not having achieved remission

C86.11 Hepatosplenic T-cell lymphoma, in remission

2024
C86.1

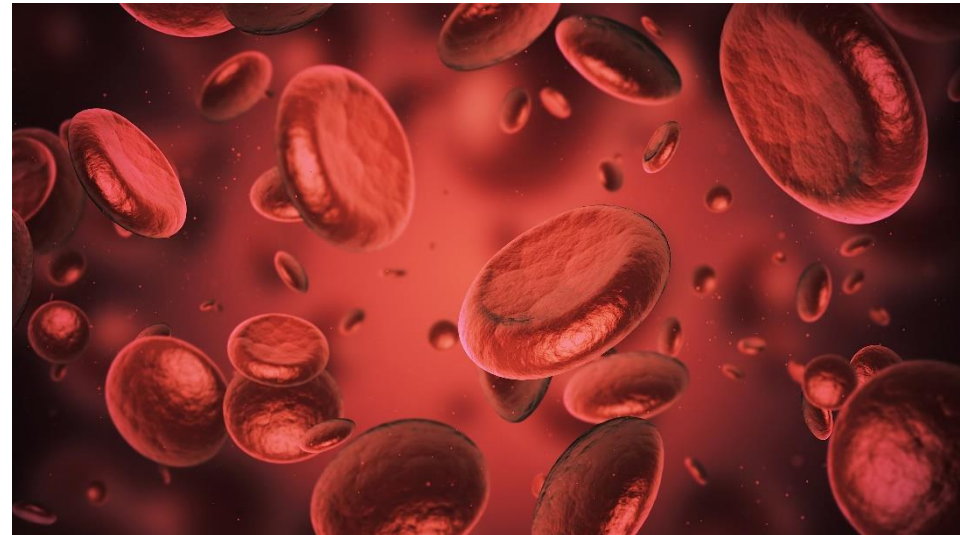
2025
C86.10

Rationale: *There is no indication of remission documented in the medical record. Coding to the highest level of specificity, C86.10 is assigned.*

Chapter 3

Diseases of the Blood and Blood-forming Organs and Certain Disorders involving the Immune Mechanism

D50 – D89



Chapter 3 (D50 – D89)

D61.0 Constitutional aplastic anemia

Delete	D61.09 Other constitutional aplastic anemia Fanconi's anemia
Add	D61.03 Fanconi anemia Fanconi pancytopenia Fanconi's anemia Excludes1: Fanconi syndrome (E72.0-)

D89.8 Other specified disorders involving the immune mechanism, not elsewhere classified

Add	D89.83 Cytokine release syndrome Use Additional code for adverse effect, if applicable, to identify immune checkpoint inhibitors and immunostimulant drugs (T45.AX5)
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Chapter 4

Endocrine, Nutritional and Metabolic Diseases

E00 – E89



Image courtesy of istockphoto.com

Chapter 4 (E00 – E89)

Use Additional code

Use Additional code for E08 – E09, E11, E13

Add

- E08 Diabetes mellitus due to underlying condition
- E09 Drug or chemical induced diabetes mellitus
- E11 Type 2 diabetes mellitus
- E13 Other specified diabetes mellitus

Use Additional injectable non-insulin antidiabetic drugs (Z79.85)

Chapter 4 (E00 – E89)

Use Additional code

Use Additional code for E08.64 – E11.54, E13.64, E15.1 – E16.2

Add

- E08.64 Diabetes mellitus due to underlying condition with hypoglycemia
- E09.64 Drug or chemical induced diabetes mellitus with hypoglycemia
- E10.64 Type 1 diabetes mellitus with hypoglycemia
- E11.64 Type 2 diabetes mellitus with hypoglycemia
- E13.64 Other specified diabetes mellitus with hypoglycemia
- E16.1 Other hypoglycemia
- E16.2 Hypoglycemia, unspecified

Use Additional code for hypoglycemia level, if applicable (E16.A-)

E10 Type 1 diabetes mellitus

4 new codes indicating **stage** of diabetes

Add	E10.A Type 1 diabetes mellitus, presymptomatic Early-stage type 1 diabetes mellitus
	E10.A0 Type 1 diabetes mellitus, presymptomatic, unspecified
	E10.A1 Type 1 diabetes mellitus, presymptomatic, Stage 1 Multiple confirmed islet autoantibodies with normoglycemia
	E10.A2 Type 1 diabetes mellitus, presymptomatic, Stage 2 Confirmed islet autoimmunity with dysglycemia



New Guideline Section I.C.4.i.1.a.

E10.A- *Type 1 diabetes mellitus, presymptomatic* is assigned for early-stage type 1 diabetes that predates the onset of symptoms

E16 Other disorders of pancreatic internal secretion

3 new codes indicating hypoglycemia **level** under E16

Add

E16.A Hypoglycemia level

E16.A1 Hypoglycemia level 1

Decreased blood glucose level 1

E16.A2 Hypoglycemia level 2

Decreased blood glucose level 2

E16.A3 Hypoglycemia level 3

Decreased blood glucose level 3

E34 Other endocrine disorders

E34.0 Carcinoid syndrome

3 new codes indicating **type** of carcinoid syndrome

Add

Code also the underlying disorder, such as:
 primary neuroendocrine tumors (C7A.-)
 secondary neuroendocrine tumors (C7B.-)

E34.00 Carcinoid syndrome, unspecified
 Carcinoid disease, unspecified

E34.01 Carcinoid heart syndrome
 Carcinoid heart disease
 Hedinger syndrome

E34.09 Other carcinoid syndrome
 Carcinoid disease NEC
 Carcinoid syndrome NEC
 Other carcinoid disease

E66 Overweight and obesity

Revisions, Deletions, and Additions for E66

Revise	Use additional code to identify body mass index (BMI), if known, for adults (Z68.- Z68.45) or pediatrics (Z68.5-)
Delete	Excludes1: adiposogenital dystrophy (E23.6) lipomatosis NOS (E88.2) lipomatosis dolorosa [Dercum] (E88.2) Prader-Willi syndrome (Q87.11)
Add	Excludes2: adiposogenital dystrophy (E23.6) lipomatosis dolorosa [Dercum] (E88.2) lipomatosis NOS (E88.2) Prader-Willi syndrome (Q87.11)

Chapter 5

Mental, Behavioral and Neurodevelopmental Disorders

F01 – F99



F50.01 Anorexia nervosa, restricting type

6 new codes further identifying **severity** of anorexia nervosa

Add

F50.010 Anorexia nervosa, restricting type, mild

Anorexia nervosa, restricting type, with a body mass index greater than or equal to 17 kg/m²

F50.011 Anorexia nervosa, restricting type, moderate

Anorexia nervosa, restricting type, with a body mass index of 16.0-16.99 kg/m²

F50.012 Anorexia nervosa, restricting type, severe

Anorexia nervosa, restricting type, with a body mass index of 15.0-15.99 kg/m²

F50.013 Anorexia nervosa, restricting type, extreme

Anorexia nervosa, restricting type, with a body mass index of less than 15.0 kg/m²

F50.014 Anorexia nervosa, restricting type, in remission

Anorexia nervosa, restricting type, in full remission

Anorexia nervosa, restricting type, in partial remission

F50.019 Anorexia nervosa, restricting type, unspecified

F50.02 Anorexia nervosa, binge eating/purging type

6 new codes further identifying **severity** of anorexia nervosa, binge eating

Add

F50.020 Anorexia nervosa, binge eating/purging type, mild
Anorexia nervosa, binge eating/purging type, with a body mass index greater than or equal to 17 kg/m²

F50.021 Anorexia nervosa, binge eating/purging type, moderate
Anorexia nervosa, binge eating/purging type, with a body mass index of 16.0-16.99 kg/m²

F50.022 Anorexia nervosa, binge eating/purging type, severe
Anorexia nervosa, binge eating/purging type, with a body mass index of 15.0-15.99 kg/m²

F50.023 Anorexia nervosa, binge eating/purging type, extreme
Anorexia nervosa, binge eating/purging type, with a body mass index of less than 15.0 kg/m²

F50.024 Anorexia nervosa, binge eating/purging type, in remission
Anorexia nervosa, binge eating/purging type, in full remission
Anorexia nervosa, binge eating/purging type, in partial remission

F50.029 Anorexia nervosa, binge eating/purging type, unspecified

F50.2 Bulimia nervosa

6 new codes further identifying **severity** of bulimia nervosa

Add

F50.20 Bulimia nervosa, unspecified

F50.21 Bulimia nervosa, mild

Bulimia nervosa with 1-3 episodes of inappropriate compensatory behavior per week

F50.22 Bulimia nervosa, moderate

Bulimia nervosa with 4-7 episodes of inappropriate compensatory behavior per week

F50.23 Bulimia nervosa, severe

Bulimia nervosa with 8-13 episodes of inappropriate compensatory behavior per week

F50.24 Bulimia nervosa, extreme

Bulimia nervosa with 14 or more episodes of inappropriate compensatory behavior per week

F50.25 Bulimia nervosa, in remission

Bulimia nervosa, in full remission

Bulimia nervosa, in partial remission

F50.8 Other eating disorders

Deletions, Additions for F50.8

Delete	F50.89 Other specified eating disorder Pica in adults
Add	F50.83 Pica in adults Pica in adults, in remission Excludes1: pica in infancy and childhood (F98.3)
	F50.84 Rumination disorder in adults Rumination disorder in adults, in remission Excludes1: rumination disorder in infancy and childhood (F98.21)

F50.81 Binge eating disorder

6 new codes further identifying **severity** of binge eating disorder

Add

F50.810 Binge eating disorder, mild

Binge eating disorder with 1-3 binge eating episodes per week

F50.811 Binge eating disorder, moderate

Binge eating disorder with 4-7 binge eating episodes per week

F50.812 Binge eating disorder, severe

Binge eating disorder with 8-13 binge eating episodes per week

F50.813 Binge eating disorder, extreme

Binge eating disorder with 14 or more eating episodes per week

F50.814 Binge eating disorder, in remission

Binge eating disorder, in full remission

Binge eating disorder, in partial remission

F50.819 Binge eating disorder, unspecified

Bulimia Coding Example

A 15-year-old female is diagnosed with bulimia. The physician documents the patient states she purges 10 times per week.

Alphabetic Index:

– Main Term: Bulimia (nervosa) F50.2

Tabular List:

F50.2 Bulimia nervosa

2024
F50.2

F50.20 Bulimia nervosa, unspecified

F50.21 Bulimia nervosa, mild

Bulimia nervosa with 1-3 episodes of inappropriate compensatory behavior per week

F50.22 Bulimia nervosa, moderate

Bulimia nervosa with 4-7 episodes of inappropriate compensatory behavior per week

F50.23 Bulimia nervosa, severe

Bulimia nervosa with 8-13 episodes of inappropriate compensatory behavior per week

2025
F50.23

F50.24 Bulimia nervosa, extreme

Bulimia nervosa with 14 or more episodes of inappropriate compensatory behavior per week

F50.25 Bulimia nervosa, in remission

Bulimia nervosa, in full remission

Bulimia nervosa, in partial remission

Rationale: *There is documentation of 10 episodes per week in the medical record. An inclusion term under F50.23 states 8-13 episodes per week. Therefore, F50.23 Bulimia nervosa, severe is the most appropriate code for this encounter.*

Chapter 6

Diseases of the Nervous System

G00 – G99

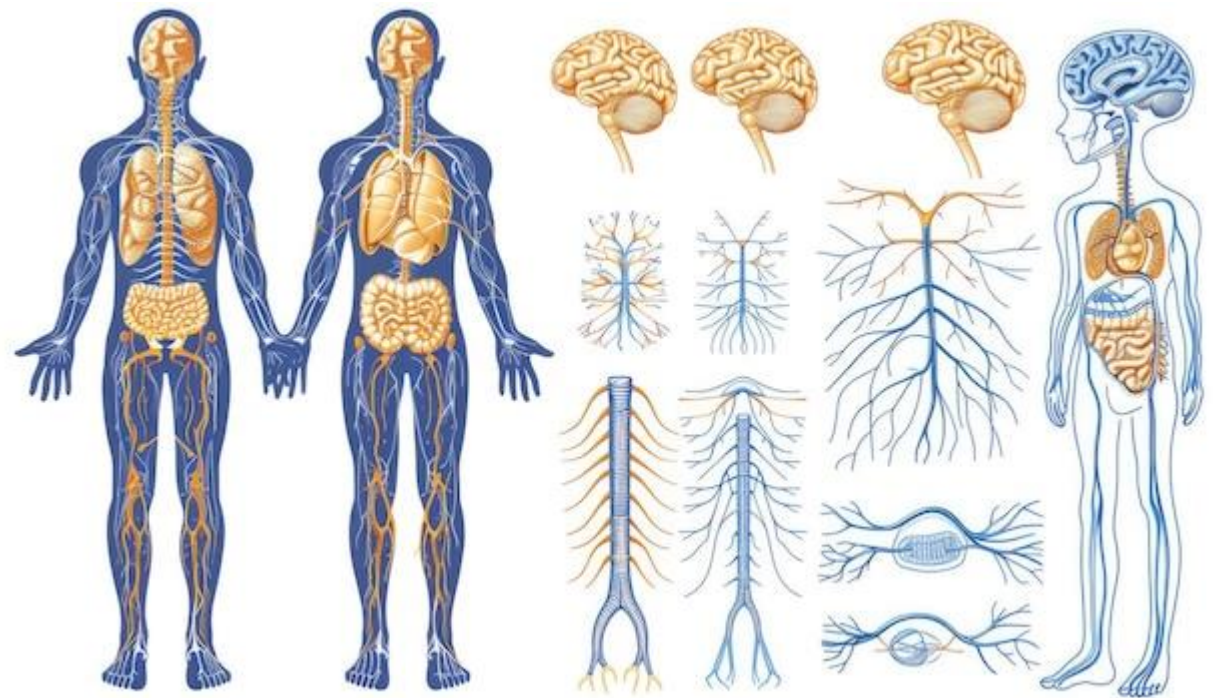


Image courtesy of istockphoto.com

G40.8 Other epilepsy and recurrent seizures

5 new codes identifying **type and status** of epilepsy

Add

G40.84 KCNQ2-related epilepsy

G40.841 KCNQ2-related epilepsy, not intractable, with status epilepticus

**G40.842 KCNQ2-related epilepsy, not intractable, without status epilepticus
KCNQ2-related epilepsy NOS**

G40.843 KCNQ2-related epilepsy, intractable, with status epilepticus

G40.844 KCNQ2-related epilepsy, intractable, without status epilepticus

G93 Other disorders of brain

G93.4 Other and unspecified encephalopathy

G93.45 Developmental and epileptic encephalopathy
Early infantile epileptic encephalopathy

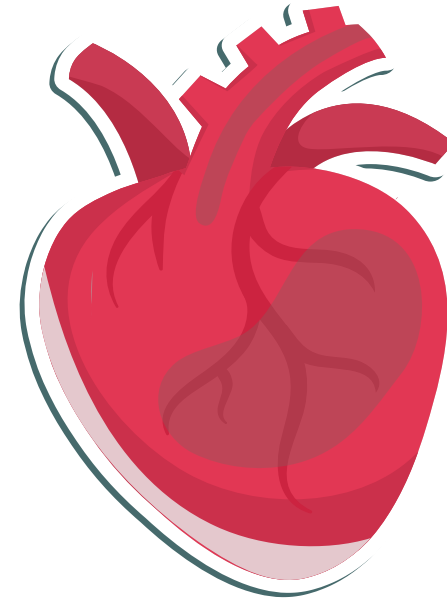
Add

Code also, if applicable, associated disorders such as:
developmental disorders of scholastic skills (F81.-)
developmental disorder of speech and language (F80.-)
epilepsy, by specific type (G40.-)
intellectual disabilities (F70-F79)
other neurodevelopmental disorder (F88)
pervasive developmental disorders (F84.-)

Chapter 9

Diseases of the Circulatory System

100 – 199



I35 Nonrheumatic aortic valve disorders

Excludes1 → Excludes2, Code also for I35

Revise	Excludes1: aortic valve disorder of unspecified cause but with diseases of mitral Excludes2: and/or tricuspid valve(s) (I08.-) aortic valve disorder specified as congenital (Q23.0, Q23.1) aortic valve disorder specified as rheumatic (I06.-) hypertrophic subaortic stenosis (I42.1)
Add	Code also, if applicable, bicuspid aortic valve (Q23.81)

Chapter 10

Diseases of the Respiratory System

J00 – J99



Image courtesy of freepik.com

J18 Pneumonia, unspecified organism

Excludes1 → Excludes2, Code also for J18

Revise	Excludes1: abscess of lung with pneumonia (J85.1) Excludes2: aspiration pneumonia due to anesthesia during labor and delivery (O74.0) aspiration pneumonia due to anesthesia during pregnancy (O29) aspiration pneumonia due to anesthesia during puerperium (O89.0) aspiration pneumonia due to solids and liquids (J69.-) aspiration pneumonia NOS (J69.0) lipid pneumonia (J69.1) pneumonitis due to external agents (J67-J70)
Add	Code also, if applicable, any associated condition such as: aspiration pneumonia (J69.-)

J34.8 Other specified disorders of nose and nasal sinuses

10 new codes identifying **nasal collapse**

Add

J34.82 Nasal valve collapse

J34.820 Internal nasal valve collapse

J34.8200 Internal nasal valve collapse, unspecified

J34.8201 Internal nasal valve collapse, static

J34.8202 Internal nasal valve collapse, dynamic

J34.821 External nasal valve collapse

J34.8210 External nasal valve collapse, unspecified

J34.8211 External nasal valve collapse, static

J34.8212 External nasal valve collapse, dynamic

J34.829 Nasal valve collapse, unspecified

Chapter 11

Diseases of the Digestive System

K00 – K95



Image courtesy of freepik.com

Chapter 11 (K00 – K95)

Use Additional code

K50 and K51, Use Additional code

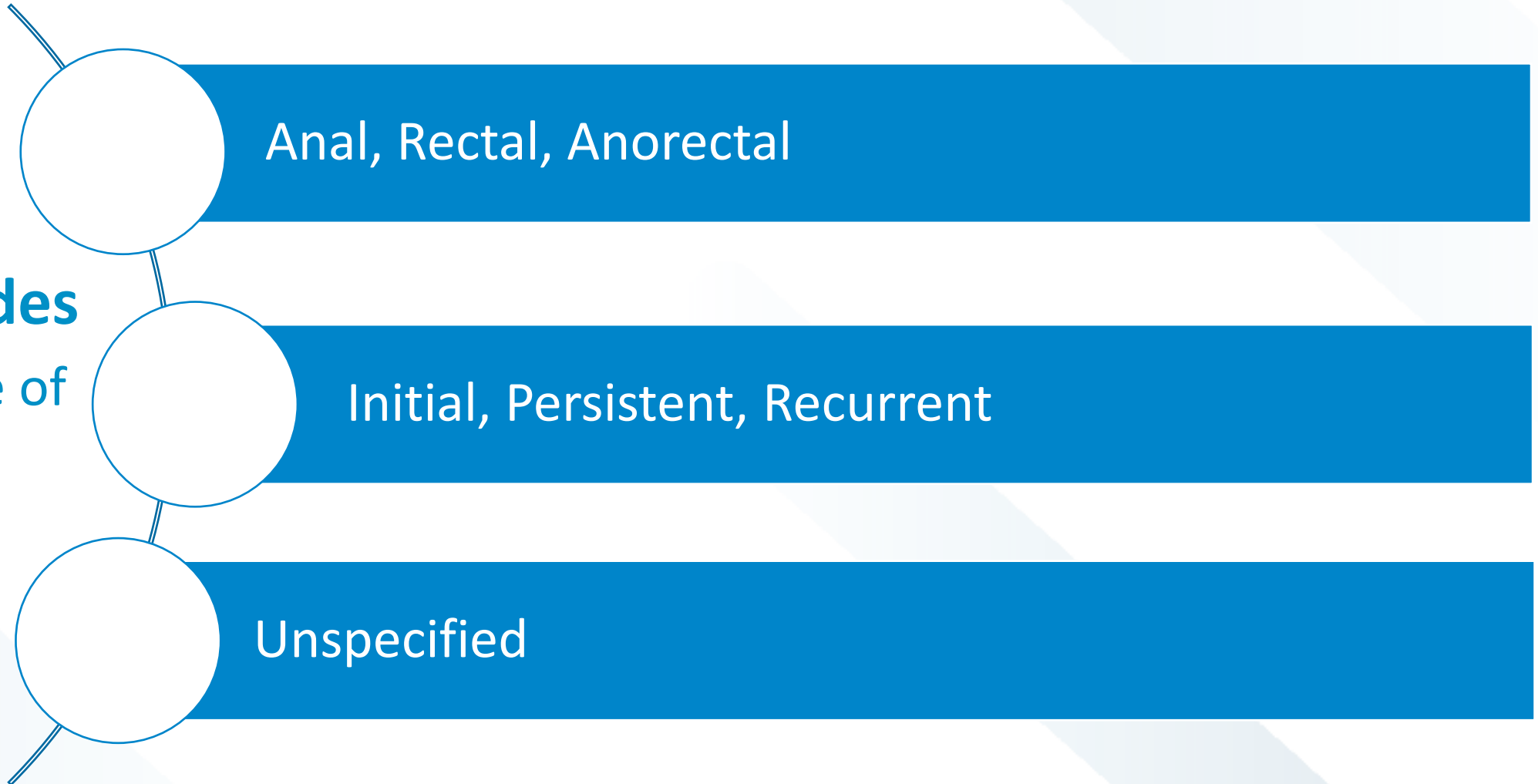
Add

- K50 Crohn's disease [regional enteritis]
- K51 Ulcerative colitis

Use Additional code to identify any associated fistulas, if applicable:
anal fistula (K60.3-)
anorectal fistula (K60.5-)
rectal fistula (K60.4-)

K60.3-, K60.4-, K60.5- Fistulas

33 new codes
identify type of
fistula



K60.3 Anal Fistula

11 new codes identify **type of fistula**

Add

K60.30 Anal fistula, unspecified

K60.31 Anal fistula, simple

K60.311 Anal fistula, simple, initial

K60.312 Anal fistula, simple, persistent

K60.313 Anal fistula, simple, recurrent

K60.319 Anal fistula, simple, unspecified

K60.32 Anal fistula, complex

K60.321 Anal fistula, complex, initial

K60.322 Anal fistula, complex, persistent

K60.323 Anal fistula, complex, recurrent

K60.329 Anal fistula, complex, unspecified

K60.4 Rectal Fistula

11 new codes identify type of fistula

Add

K60.40 Rectal fistula, unspecified

K60.41 Rectal fistula, simple

K60.411 Rectal fistula, simple, initial

K60.412 Rectal fistula, simple, persistent

K60.413 Rectal fistula, simple, recurrent

K60.419 Rectal fistula, simple, unspecified

K60.42 Rectal fistula, complex

K60.421 Rectal fistula, complex, initial

K60.422 Rectal fistula, complex, persistent

K60.423 Rectal fistula, complex, recurrent

K60.429 Rectal fistula, complex, unspecified

K60.5 Anorectal Fistula

11 new codes identify **type of fistula**

Add

K60.50 Anorectal fistula, unspecified

K60.51 Anorectal fistula, simple

K60.511 Anorectal fistula, simple, initial

K60.512 Anorectal fistula, simple, persistent

K60.513 Anorectal fistula, simple, recurrent

K60.519 Anorectal fistula, simple, unspecified

K60.52 Anorectal fistula, complex

K60.521 Anorectal fistula, complex, initial

K60.522 Anorectal fistula, complex, persistent

K60.523 Anorectal fistula, complex, recurrent

K60.529 Anorectal fistula, complex, unspecified

Rectal Fistula - Coding Example

A 45-year-old male is diagnosed with a recurrent rectal fistula involving 40% of the external anal sphincter with multiple tracts.

Alphabetic Index:

- Main Term: Fistula
- Subterm: rectum (to skin) K60.4

2024
K60.4

Tabular Index:

K60.4 Rectal Fistula

K60.42 Rectal fistula, complex

K60.421 Rectal fistula, complex, initial

K60.422 Rectal fistula, complex, persistent

K60.423 Rectal fistula, complex, recurrent

K60.429 Rectal fistula, complex, unspecified

2025
K60.423

Rationale: *Indications of a complex fistula are fistulas that involve more than 30% of the anal sphincter with multiple tracts. Coders should be aware that complex fistulas may be associated with other conditions, such as Crohn's disease, radiation treatment, or strictures.*

Chapter 12

Diseases of the Skin and Subcutaneous Tissue

L00 – L99

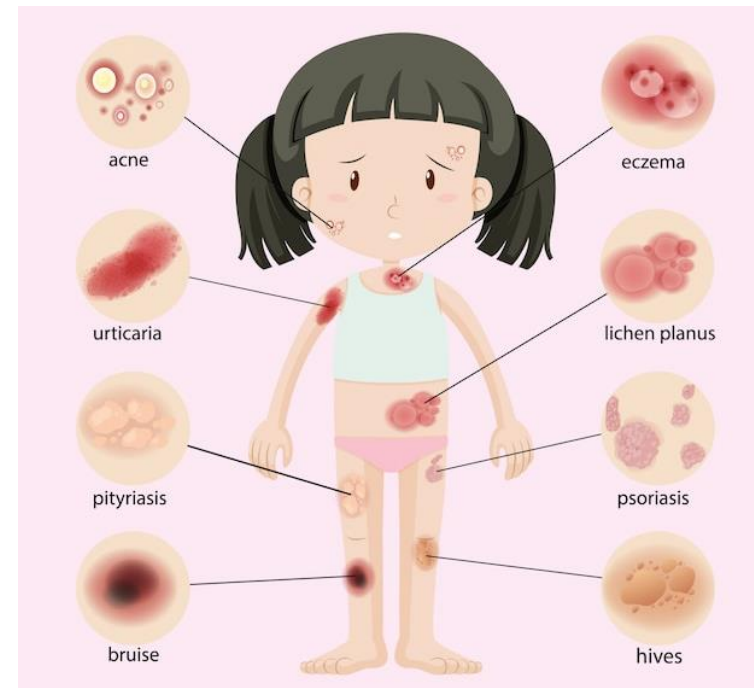


Image courtesy of freepik.com

L29 Pruritis

L29.8 Other pruritis

Add

L29.81 Cholestatic pruritus

Code also, if applicable, type of liver disease

**Use Additional code for adverse effect, if applicable, to identify drug
(T36-T50 with fifth or sixth character 5)**

L29.89 Other pruritus

Chapter 13

Diseases of the Musculoskeletal System and Connective Tissue

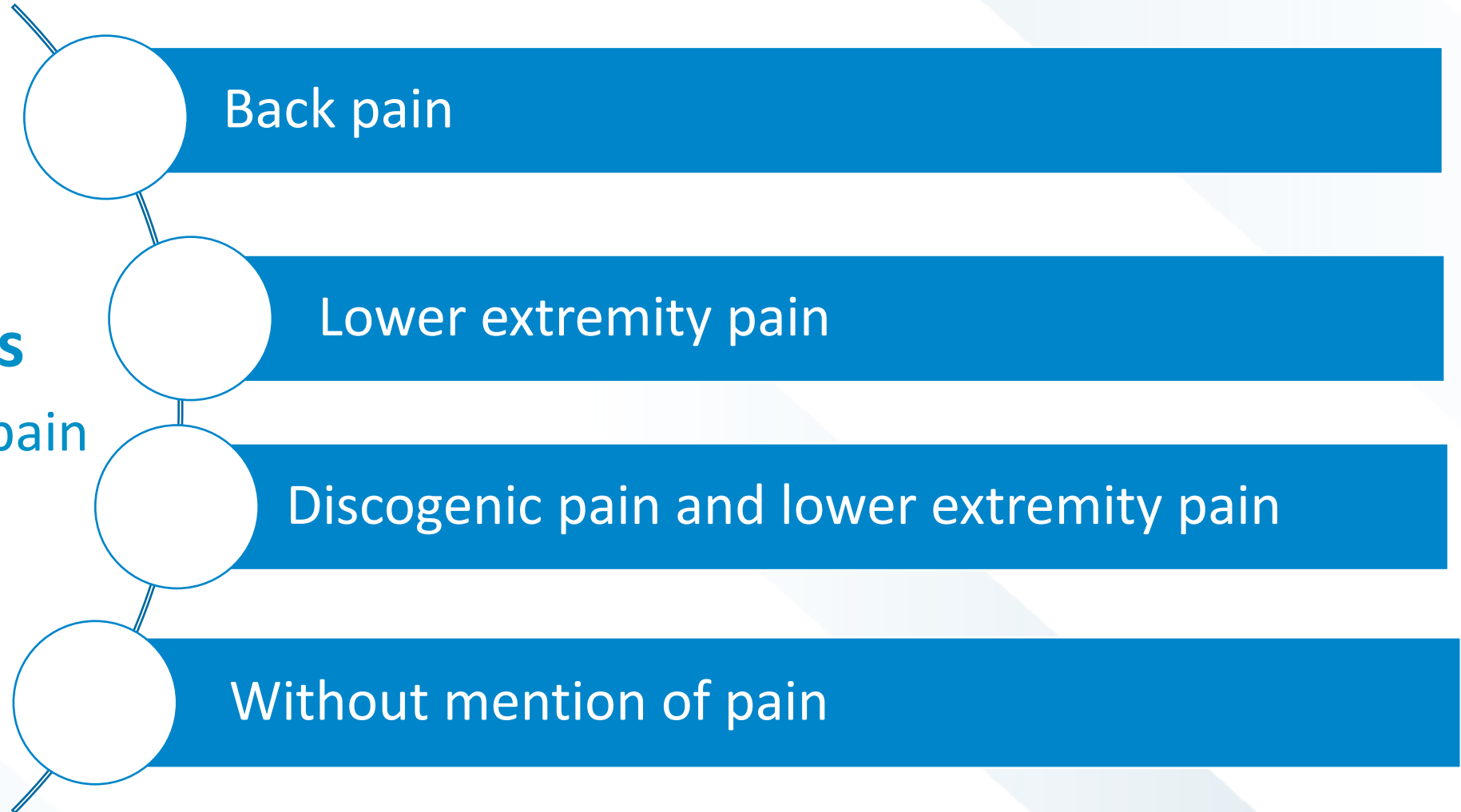
M00 – M99



Image courtesy of freepik.com

M51 Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders

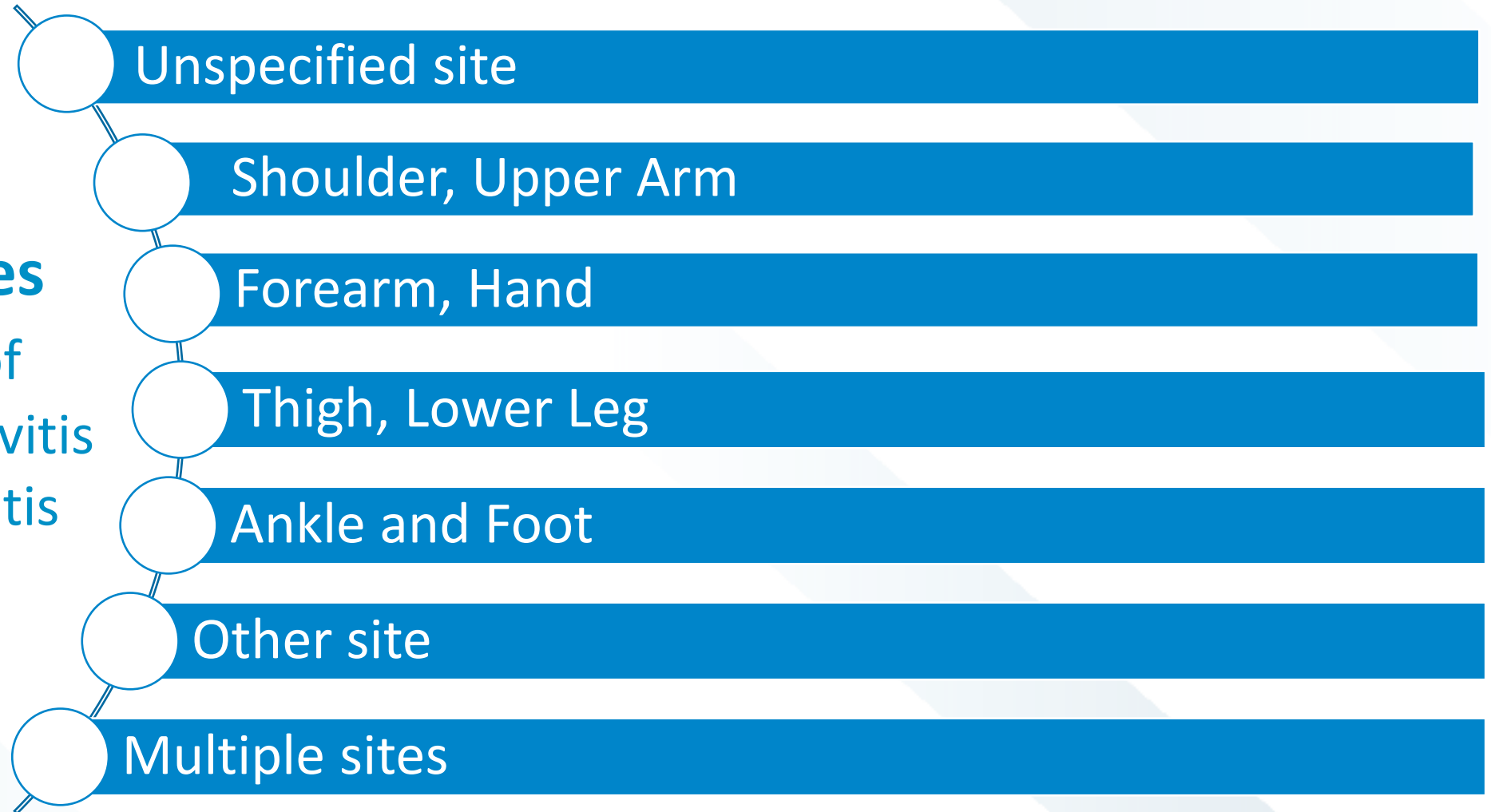
8 new codes
identify type of pain



M65 Synovitis and Tenosynovitis

31 new codes

identify site of
unspecified synovitis
and tenosynovitis



M65 Synovitis and Tenosynovitis

M65.9 Synovitis and Tenosynovitis, **unspecified**

Add

M65.90 Unspecified synovitis and tenosynovitis, unspecified site

M65.91 Unspecified synovitis and tenosynovitis, shoulder

M65.911 Unspecified synovitis and tenosynovitis, right shoulder

M65.912 Unspecified synovitis and tenosynovitis, left shoulder

M65.919 Unspecified synovitis and tenosynovitis, unspecified shoulder

M65.92 Unspecified synovitis and tenosynovitis, upper arm

M65.921 Unspecified synovitis and tenosynovitis, right upper arm

M65.922 Unspecified synovitis and tenosynovitis, left upper arm

M65.929 Unspecified synovitis and tenosynovitis, unspecified upper arm

M65 Synovitis and Tenosynovitis

M65.9 Synovitis and Tenosynovitis, **unspecified**

Add

M65.93 Unspecified synovitis and tenosynovitis, forearm

M65.931 Unspecified synovitis and tenosynovitis, right forearm

M65.932 Unspecified synovitis and tenosynovitis, left forearm

M65.939 Unspecified synovitis and tenosynovitis, unspecified forearm

M65.94 Unspecified synovitis and tenosynovitis, hand

M65.941 Unspecified synovitis and tenosynovitis, right hand

M65.942 Unspecified synovitis and tenosynovitis, left hand

M65.949 Unspecified synovitis and tenosynovitis, unspecified hand

M65 Synovitis and Tenosynovitis

M65.9 Synovitis and Tenosynovitis, **unspecified**

Add

M65.95 Unspecified synovitis and tenosynovitis, thigh

M65.951 Unspecified synovitis and tenosynovitis, right thigh

M65.952 Unspecified synovitis and tenosynovitis, left thigh

M65.959 Unspecified synovitis and tenosynovitis, unspecified thigh

M65.96 Unspecified synovitis and tenosynovitis, lower leg

M65.961 Unspecified synovitis and tenosynovitis, right lower leg

M65.962 Unspecified synovitis and tenosynovitis, left lower leg

M65.969 Unspecified synovitis and tenosynovitis, unspecified lower leg

M65.97 Unspecified synovitis and tenosynovitis, ankle and foot

M65.971 Unspecified synovitis and tenosynovitis, right ankle and foot

M65.972 Unspecified synovitis and tenosynovitis, left ankle and foot

M65.979 Unspecified synovitis and tenosynovitis, unspecified ankle and foot

M65.98 Unspecified synovitis and tenosynovitis, other site

M65.99 Unspecified synovitis and tenosynovitis, multiple sites

Unspecified Synovitis and Tenosynovitis - Coding Example

A 55-year-old female is diagnosed with tenosynovitis of the right shoulder.

Alphabetic Index:

- Main Term: Tenosynovitis (*see also* Synovitis) M65.9
- Main Term: Synovitis (*see also* Tenosynovitis) M65.9

Tabular Index:

M65.9 Synovitis and Tenosynovitis

M65.911 Unspecified synovitis and tenosynovitis, right shoulder

M65.912 Unspecified synovitis and tenosynovitis, left shoulder

M65.919 Unspecified synovitis and tenosynovitis, unspecified shoulder

**2024
M65.9**

**2025
M65.911**

Rationale: *Unspecified Synovitis and Tenosynovitis can now be identified by the site of the body area it is affecting. It should be noted that if the type of synovitis or tenosynovitis is specified, alternative codes are assigned. Example infective (M65.1-) or specified type (M65.8-).*

Chapter 14

Diseases of the Genitourinary System N00 – N99



Image courtesy of freepik.com

Chapter 14 (N00 – N99) Excludes1

N39.0 Urinary tract infection, site not specified

Add

Excludes1: pyonephrosis (N13.6)



Excludes1 = Code1

Patient cannot have a UTI (N39.0) and pyonephrosis (N13.6) at the same time. Only one condition (the reason for the exam) should be coded.

Chapter 17

Congenital Malformations, Deformations and Chromosomal Abnormalities

Q00 – Q99



Chapter 17 (Q00 – Q99)

Q23.8 Other congenital malformations of aortic and mitral valves

Add	Q23.81 Bicuspid aortic valve
	Q23.82 Congenital mitral valve cleft leaflet
	Q23.88 Other congenital malformations of aortic and mitral valves

Q87.8 Other specified congenital malformation syndromes, not elsewhere classified

Add	Q87.86 Kleeftstra syndrome
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Chapter 18

Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified R00 – R99



Image courtesy of freepik.com

R41 Other symptoms and signs involving cognitive functions and awareness

Delete	R41.89 Other symptoms and signs involving cognitive functions and awareness Anosognosia
Add	R41.85 Anosognosia



Anosognosia

This diagnosis is no longer reported with other symptoms code R41.89 and should now be reported with its more specific code R41.85.

Chapter 19

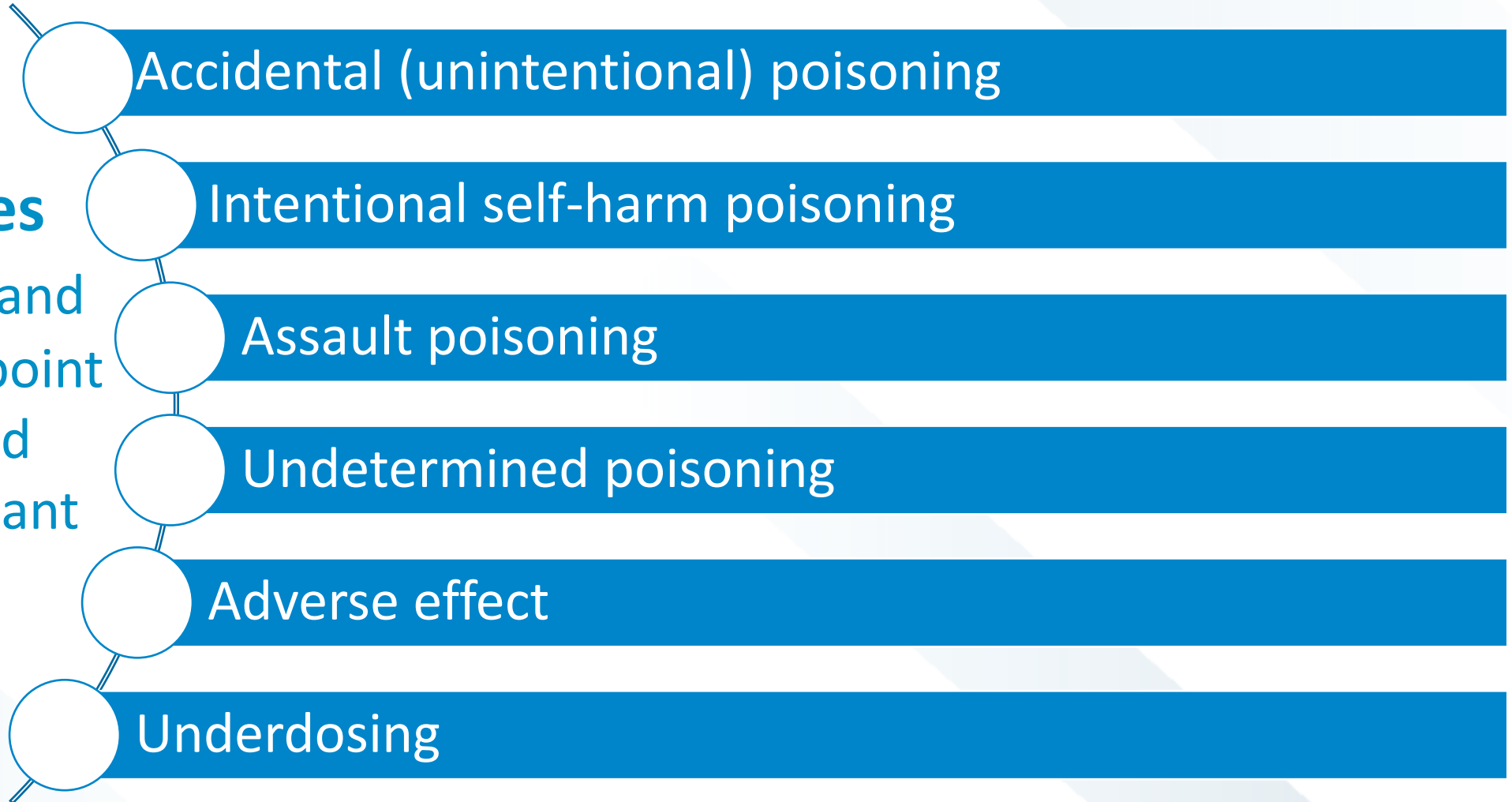
Injury, Poisoning and Certain other Consequences of External Causes S00 – T88



T45 Poisoning by, adverse effect of and underdosing of primarily systemic and hematological agents, not elsewhere classified

6 new codes

Identify cause and effect of checkpoint inhibitors and immunostimulant drugs



Chapter 19 (S00 – T88)

T45 Poisoning by, adverse effect of and underdosing of primarily systemic and hematological agents, not elsewhere classified

Add

T45.A Poisoning by, adverse effect of and underdosing of immune checkpoint inhibitors and immunostimulant drugs

T45.AX Poisoning by, adverse effect of and underdosing of immune checkpoint inhibitors and immunostimulant drugs

T45.AX1 Poisoning by immune checkpoint inhibitors and immunostimulant drugs, accidental (unintentional)

T45.AX2 Poisoning by immune checkpoint inhibitors and immunostimulant drugs, intentional self-harm

T45.AX3 Poisoning by immune checkpoint inhibitors and immunostimulant drugs, assault

T45.AX4 Poisoning by immune checkpoint inhibitors and immunostimulant drugs, undetermined

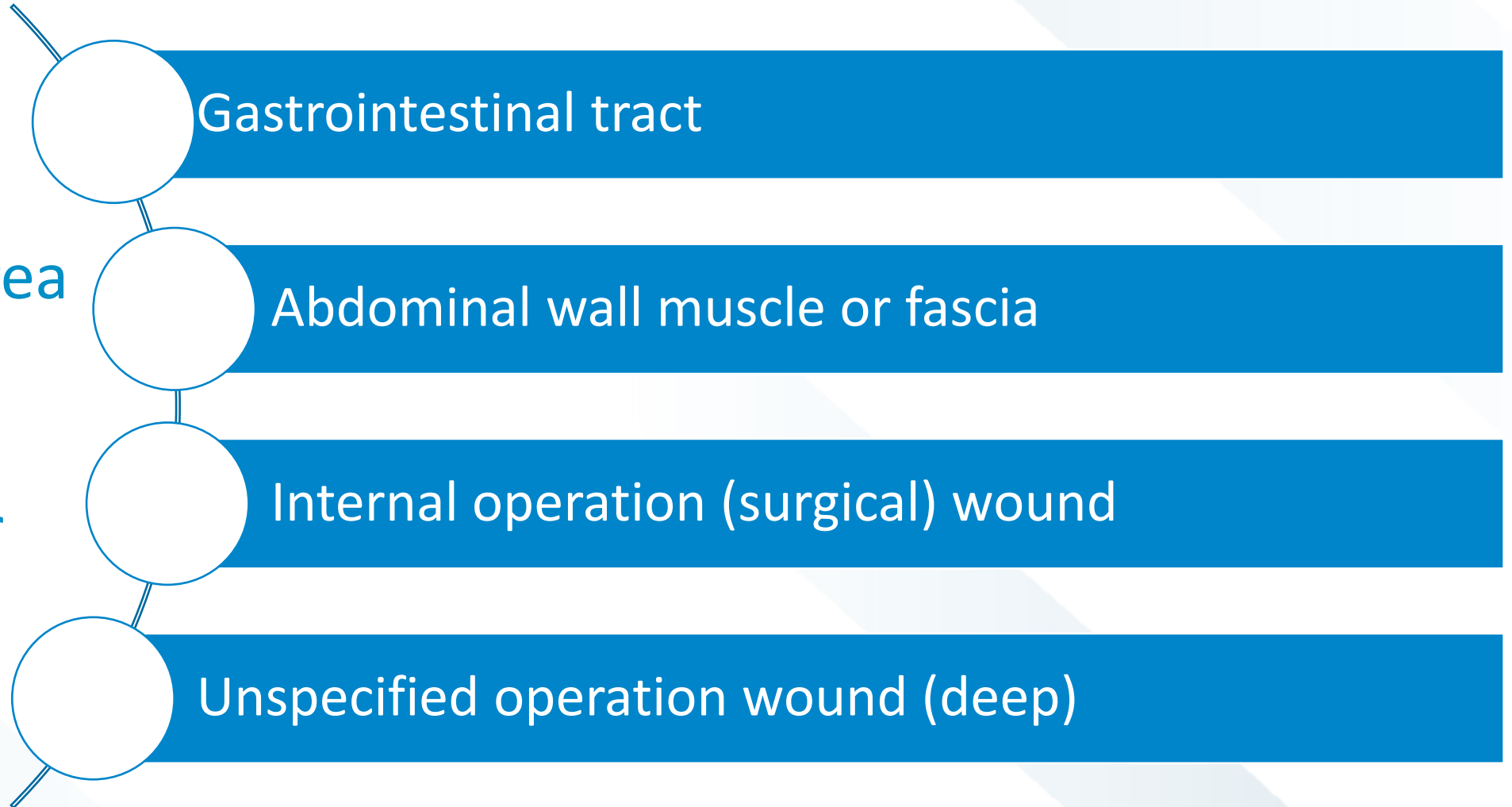
T45.AX5 Adverse effect of immune checkpoint inhibitors and immunostimulant drugs

T45.AX6 Underdosing of immune checkpoint inhibitors and immunostimulant drugs

T81.32 Disruption of internal operation (surgical) wound, not elsewhere classified

4 new codes

specify body area
of internal
wound
disruption or
dehiscence



T81.32 Disruption of internal operation (surgical) wound, not elsewhere classified

T81.3 Disruption of wound, not elsewhere classified	
Delete	T81.32 Disruption of internal operation (surgical) wound, not elsewhere classified Deep disruption or dehiscence of operation wound NOS Disruption or dehiscence of closure of internal organ or other internal tissue Disruption or dehiscence of closure of muscle or muscle flap Disruption or dehiscence of closure of ribs or rib cage Disruption or dehiscence of closure of skull or craniotomy Disruption or dehiscence of closure of sternum or sternotomy Disruption or dehiscence of closure of tendon or ligament Disruption or dehiscence of closure of superficial or muscular fascia
Add	T81.320 - T81.321, T81.328 – T81.329



Disruption of internal operation (surgical wound)

All inclusion terms have been deleted from T81.32 and more specific codes created

T81.32 Disruption of internal operation (surgical) wound, not elsewhere classified

T81.32 Disruption of internal operation (surgical) wound, not elsewhere classified

Add

T81.320 Disruption or dehiscence of gastrointestinal tract anastomosis, repair, or closure

T81.321 Disruption or dehiscence of closure of internal operation (surgical) wound of abdominal wall muscle or fascia

T81.328 Disruption or dehiscence of closure of other specified internal operation(surgical) wound

Disruption or dehiscence of closure of muscle or muscle flap (other than abdominal wall muscle)

Disruption or dehiscence of closure of ribs or rib cage

Disruption or dehiscence of closure of skull or craniotomy

Disruption or dehiscence of closure of sternum or sternotomy

Disruption or dehiscence of closure of tendon or ligament

Disruption or dehiscence of closure of superficial or muscular fascia (other than abdominal wall fascia)

T81.329 Deep disruption or dehiscence of operation wound, unspecified

Chapter 21

Factors Influencing Health Status and Contact with Health Services Z00 – Z99



Chapter 21 (Z00 – Z99)

**18 other
new codes**

- Genetic susceptibility to disease
- Sepsis aftercare
- Insufficient health insurance or welfare coverage
- Duffy blood type
- Pediatric BMI
- Types of colon polyps
- History of immune checkpoint inhibitor therapy

Chapter 21 (Z00 – Z99)

Z15 Genetic susceptibility to disease

Add

Z15.1 Genetic susceptibility to epilepsy and neurodevelopmental disorders
Z15.2 Genetic susceptibility to obesity

Z51 Encounter for other aftercare and medical care

Add

Z51.A Encounter for sepsis aftercare

Z59.7 Insufficient social insurance and welfare support

Add

Z59.71 Insufficient health insurance coverage
Z59.72 Insufficient welfare support

Chapter 21 (Z00 – Z99)

Z68.5 Body Mass Index [BMI] pediatric

Revise

Z68.54 Body mass index [BMI] pediatric, ~~greater than or equal to~~ 95th percentile for age **to less than 120% of the 95th percentile for age**

Add

Z68.55 Body mass index [BMI] pediatric, 120% of the 95th percentile for age to less than 140% of the 95th percentile for age
Z68.56 Body mass index [BMI] pediatric, greater than or equal to 140% of the 95th percentile for age



BMI percentage

Class 1 obesity >95th percentile to <120% of 95th percentile for age and sex

Class 2 obesity >120% to <140% of 95th percentile

Class 3 obesity >140% of 95th percentile



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Questions?

2025 updates can be found in full

<https://www.cms.gov/medicare/coding-billing/icd-10-codes>

2025 ICD-10-CM code book

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