AAVBC
AMERICAN ACADEMY OF VALUE BASED CARE

Amyloidosis

Quick Reference Guide

2026

Table of Contents

1. CLINICAL SNAPSHOT **3**
Systemic Amyloidosis ICD-10-CM Codes that Map to HCC **4**
2. RECOGNITION AND DIAGNOSIS **5**
Screenings for Suspected Amyloidosis Covered Under Medicare Part B **5**
Subtle Early Signs in Older Adults **7**
Risk Factors **8**
Diagnostic Thresholds **8**
Common Oversights **11**
Key Differentials in Elderly **11**
Comorbidity Screening **12**
Staging/Severity Matrix– Cardiac Amyloidosis Staging System **13**
3. MEAT DOCUMENTATION ESSENTIALS **15**
Clinical Documentation Elements **16**
Reframing Common Documentation Shortcuts **16**
4. TREATMENT AND REFERRAL QUICK GUIDE **17**
Therapy Escalation Criteria **18**
NCCN/ACC/AHA Aligned Recommendations **19**
Non-Pharmacologic Treatment and Lifestyle Modification **20**
Medication Safety and Dose Adjustments – Key Interactions for Systemic Amyloidosis **21**
When to Refer **22**
Follow-Up Timing **23**
Comorbidity Management **23**
Cost-Smart Options **24**
Quality Metrics Tie-In: None Currently for Systemic Amyloidosis **25**
5. CODING REMINDERS AND CASE EXAMPLES **26**
Documentation Specificity **26**
Annual Clinical Review and Confirmation **27**
Good Documentation is Comprehensive Coding **27**
Brief Case Examples **28**
REFERENCES **29**

1 CLINICAL SNAPSHOT

Definition: Amyloidosis is a group of diseases defined by extracellular deposition of **misfolded proteins** (**amyloid fibrils**) in tissues and organs. **Four systemic subtypes** shape primary care decision-making: **AL** (immunoglobulin light chain, plasma cell–driven), **ATTRwt** (age-related wild-type transthyretin, predominantly cardiac), **ATTRv** (hereditary transthyretin variant, cardiac and/or polyneuropathic), and **AA** (secondary to chronic inflammatory disease). Clinical impact and treatment depend entirely on subtype: AL requires prompt hematology/oncology evaluation for plasma-cell–directed therapy; ATTR requires TTR-targeted disease-modifying therapy**;** AA is managed by treating the underlying inflammatory condition. No curative therapy currently exists for systemic amyloidosis; treatment aims to halt amyloid production, manage symptoms, and preserve organ function.[1–4]

ICD-10 Codes (effective October 2025):[5] **E85.81** (light chain (AL) amyloidosis), **E85.82** (wild-type transthyretin-related amyloidosis, ATTRwt), **E85.1** (neuropathic heredofamilial amyloidosis= ATTRv with neuropathy), **E85.4** (organ-limited amyloidosis), **E85.3** (secondary systemic amyloidosis (AA) = requires coding the underlying inflammatory condition separately), **E85.9** (amyloidosis, unspecified: reserve **ONLY** when subtype cannot be confirmed after full workup). In cardiac amyloidosis, **E85.4** must be sequenced **BEFORE I43** (cardiomyopathy in diseases classified elsewhere).[2]

Prevalence and Diagnostic Delay: Systemic amyloidosis is **systematically underdiagnosed**. AL amyloidosis has an estimated US incidence of **12 to 17 cases per million person-years**, with approximately 3,800 to 4,000 new cases diagnosed annually and a rising prevalence now estimated at **40 to 69 per million adults**.[6–8] Twenty-five percent of AL amyloidosis patients **die within 6 months of diagnosis**, driven largely by advanced cardiac damage at presentation; early-stage patients achieve approximately 80% five-year survival with contemporary treatment compared with less than 30% for advanced-stage disease.[9,10] The median diagnostic delay in AL amyloidosis is **2.7 years** from symptom onset, with 50% of patients seeing **five or more physician types before diagnosis**.[11] Other amyloidosis subtypes are less frequently diagnosed but may be more prevalent. Autopsy studies demonstrate ATTR amyloid deposits in 20 to 25% of adults older than 80 years, with wild-type ATTR-CM estimated at **155 to 191 cases** per million persons.[9–11] **ATTRv** (hereditary ATTR) due to the Val122Ile (V122I) variant, the most common pathogenic TTR variant in the US, is carried by approximately **3.4% of African Americans** (approximately 1.5 million individuals) and is associated with development of ATTR cardiomyopathy **after age 60**, with penetrance estimates ranging from 7% to 39% depending on diagnostic modality.[2,12]

AAVBC PERSPECTIVE

*From a value-based care perspective, early recognition and accurate clinical coding of systemic amyloidosis are essential for improving care coordination, reducing avoidable hospital utilization, and preserving patient function and quality of life. Use of specific ICD-10-CM **E85.X** subtype codes, **rather than unspecified E85.9 coding**, can support more precise diagnosis tracking, specialist referral pathways, reimbursement alignment, and closed loop care delivery across multidisciplinary teams. Earlier recognition and diagnosis also help connect patients to appropriate treatment strategies focused on **symptom management**, **organ preservation**, and optimization or adjustment of therapies used to manage coexisting comorbidities that may be **impacted by amyloid disease progression**. Treatment intensity, care planning, and*