

## SUMMARY REPORT

### ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

May 13, 1999

#### Introductions and Overview

Pat Brooks welcomed the participants to the ICD-9-CM Coordination and Maintenance Committee meeting. All participants introduced themselves. An overview of the Committee was provided. It was mentioned that items discussed at this meeting were for consideration for revisions to take place October 1, 2000. It was explained that no final decisions would take place at this meeting. Written comments after the meeting were encouraged. The time line for the ICD-9-CM process was reviewed.

#### No changes to ICD-9-CM on October 1, 1999

Special emphasis was given to one item included in the handout prepared by Pat Brooks. There will be no changes to the ICD-9-CM on October 1, 1999. Because of major efforts to ensure that all Medicare computer systems are ready to function on January 1, 2000, no ICD-9-CM code changes were allowed. Coders will continue using their current ICD-9-CM code books until October 1, 2000. As explained in the handout, all code changes proposed at the June 4, 1998 and November 2, 1998 will be considered for the next updates which will go into effect October 1, 2000. Reports of this meeting can be found on CMS's home page ([cms.hhs.gov](http://cms.hhs.gov)) under Events and Meetings.

#### Approval of future coding systems - Administrative Simplification

The participants were encouraged to review information on Administrative Simplification as it applies to standards for national coding systems. The Transaction notice of proposed rulemaking published May 7, 1998 provides detailed information on these new requirements. It was mentioned that **no decisions have been made on when or if ICD-10-CM or ICD-10-PCS will be implemented. Therefore,** there are no implementation dates. Proposals to consider these new coding systems as national standards must take place within the new process covered by Administrative Simplification.

#### ICD-10-PCS Update

Pat Brooks announced that CMS had awarded a new contract under open competition to 3M/HIS for combined DRG Grouper and ICD-10-PCS update and maintenance activities. The material in the handout on ICD-10-PCS testing was then reviewed.

The participants were pleased with the findings of the latest round of testing. One participant mentioned that it was not surprising that the testers found coding nuclear medicine and laboratory testing to be somewhat difficult. It was felt that if ICD-10-PCS were implemented, those hospitals that used the system to code these types of tests would probably generate the codes from a charge master. Therefore, the tests would only have to be assigned a code once, and then the coding would be automatically generated. There was still support for making the training manual as specific and helpful as possible. This would lead to greater standardization in coding.

There was concern expressed about the lack of obstetrical cases among those tested. The American Hospital Association volunteered to attempt to obtain samples of records to supplement those already tested. It was hoped that these would include patients who were not Medicare patients. If this additional testing can be completed by the November meeting, a report will be provided at that time.

The participants were asked to think about how CMS should proceed at this point. It was mentioned, once again, that the new contract with 3M/HIS would allow for future updates and revisions as needed. Considerations for implementing ICD-10-PCS will be discussed in greater detail at the November meeting.

### **Transurethral Microwave Thermotherapy (TUMT) of Prostate**

Charles Hawtrey, MD provided a clinical explanation of the procedure and Amy Gruber lead a discussion of the proposed code revisions. There was support from a number of participants for a new code to capture TUMT. Dr. Hawtrey mentioned that while a transurethral prostatectomy (TURP) was the gold standard, this procedure was an alternative used for patients who are poor surgical risks because they cannot tolerate anesthesia. It has also been used for patients who prefer a minimally invasive treatment. The TUMT does not remove tissue. It destroys it. The durability of this procedure is not known. A specific code would allow this data to be captured for further study.

One participant suggested that instead of creating separate codes for TUMT and for other transurethral destruction of prostate tissue by radio frequency thermotherapy, only one new code should be created. This could be called Other transurethral destruction of prostate by energy source. Others felt a problem with this approach was that one could not track the technology and determine how many TUMTs versus Transurethral needle ablations (TUNA) were performed. There was some discussion about whether the limited space in this area should be used for more precise codes.

Since this procedure is not a prostatectomy, it was felt that code 60.99, Other operations on prostate, should be used to capture this information currently. However, different advice was provided in **Coding Clinic for ICD-9-CM**, Third Quarter, 1997, page 3, where coders were advised to use 60.29, Other transurethral prostatectomy. This advice will be reviewed by the Editorial Advisory Board for possible updates/corrections in a future issue of **Coding Clinic**.

### **Insertable Loop Recording for Infrequent syncope**

Randy Lieberman, MD provided a clinical overview of the device and its insertion. Dr. Lieberman explained that the device is implanted in a pocket in subcutaneous tissue of the chest wall. It is used for patients who have experienced repeated syncope for which a cause has not been established. The loop recorder can capture up to 45 minutes of EKG readings. If the patient suffers a syncopal episode, he can activate the remote device upon awakening and preserve the last 45 minutes of EKG recordings. This allows the physician to determine if the syncope is possibly cardiac related. If no EKG abnormalities are noted, then additional causes of the syncope must be sought.

Ann Fagan reviewed the three options presented in the handout and recommended option 2, modification of existing inclusion terms under 86.09, Other incision of skin

and subcutaneous tissue, to capture this procedure. An inclusion term already exists under 86.09 for creation of thalamic stimulator pulse generator pocket, new site, which makes this a logical choice. **Current coding advice is to capture this procedure with codes 89.50, Ambulatory cardiac monitoring and 86.09, Other incision of skin and subcutaneous tissue.** This advice will be published in **Coding Clinic for ICD-9-CM** in 4th Quarter, 1999.

One participant suggested a modification of option 3, with consideration given to creating a broader new code than discussed in the handout. The new code would capture all subcutaneous pockets for the insertion of devices such as thalamic stimulator pulse generators and loop recorders. Other participants agreed with option 2, adding an inclusion term under 86.09 to capture this procedure. A representative for the manufacturer strongly supported adding the insertion of loop recorders to the pacemaker codes by broadening the title of the pacemaker codes as was described in option 1 of the handout. Other participants felt that since these patients did not have known cardiac problems when the decision was made to implant this monitoring device, it seemed inappropriate to place them in the pacemaker codes. In many cases, a cardiac problem will be ruled out. One other participant mentioned that monitoring codes are not routinely placed in the cardiac part of ICD-9-CM procedure codes, but are more routinely assigned to the 90's section of the book. Another participant suggested that the diagnostic information (syncope) be removed from any code title or inclusion term. Others agreed with this proposal.

#### **Addendum**

Amy Gruber reviewed the handout on proposed addenda. There was support for these changes.

All participants were urged to review the proposals in detail and send any additional comments they may have to CMS staff. Any requests for code changes to be discussed at the November 12, 1999 meeting should be submitted to CMS staff by September 10, 1999. This concluded the procedure part of the meeting. Donna Pickett of the National Center for Health Statistics then took over to lead the diagnosis part of the meeting.

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#### **AGENDA**

ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE  
Department of Health and Human Services  
CMS Auditorium  
7500 Security Boulevard  
Baltimore, MD  
ICD-9-CM Volume 3, Procedures  
May 13, 1999

Patricia E. Brooks  
Co-Chairperson

9:00 a.m. ICD-9-CM Volume 3, Procedure  
presentations and public comments

#### **Topics**

1. Update on the ICD-10 Procedure Coding System

Patricia E. Brooks

2. Transurethral Microwave Thermotherapy of Prostate

Amy L. Gruber  
Charles E. Hawtrey, MD  
American Urological Association

3. Insertion of Implantable Loop Recorder

Ann B. Fagan  
Randy A. Lieberman, M.D.  
Detroit Medical Center

4. Addenda

Amy L. Gruber

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## **ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE**

**May 13, 1999**

**Patricia E. Brooks, R.R.A., Chairman**  
**Centers for Medicare and Medicaid Services (CMS)**  
**ICD-9-CM Volume 3, Procedures**

### **An overview of the Committee**

The purpose of the ICD-9-CM Coordination and Maintenance Committee is to provide a public forum to discuss potential updates and revisions to ICD-9-CM. Proposed changes are presented and then the audience is encouraged to express their opinions and offer alternative suggestions. A summary of the procedure part of the meeting is placed on CMS's home page for wider review and comment. Written and electronic comments are encouraged after the meeting and are carefully reviewed. Similarly, NCHS places a summary of the diagnosis part of the meeting on their home page and solicits comments.

### **No changes to ICD-9-CM on October 1, 1999**

There will be no changes to ICD-9-CM on October 1, 1999. This decision was discussed in the NPRM for the prospective payment system published May 7, 1999. The reason for this decision was described as follows in the **Federal Register**, section II.B.8:

"The Committee presented proposals for coding changes for FY 2000 at public meetings held on June 14 and November 2, 1998. Even though the Committee conducted public meetings and considered approval of coding changes for FY 2000 implementation, we are not implementing any changes to ICD-9-CM codes for FY 2000. We have undertaken, and continue to undertake, major efforts to ensure that all of the Medicare computer systems are ready to function on January 1, 2000. If we were to make system changes to capture additions, deletions, and modifications to ICD-9-CM codes for FY 2000, we would endanger the functioning of the Medicare computer systems, and, specifically, we might compromise our ability to process hospital bills. Therefore, the code proposals presented at the public meetings held on June 14 and November 2, 1998, that (if approved) ordinarily would have been included as new codes for October 1, 1999, will not be included in this proposed rule. These code changes to ICD-9-CM will be considered for inclusion in the next annual update for FY 2001. The initial meeting for consideration of coding changes for implementation in FY 2001 will be held on May 13, 1999."

### **Important Dates**

A time line of important dates in the ICD-9-CM process is described below:

- July 31, 1998      Prospective Payment System final notice published in the **Federal Register** as mandated by Public Law 99-509.
- September 1998      Complete, updated ICD-9-CM available on CD ROM through the Government Printing Office at (202) 512-1800. Order number 017-022-01434-3. Cost \$18.
- May 7, 1999      Notice of Proposed Rulemaking (NPRM) published in **Federal Register** on proposed revisions to the Prospective Payment System as mandated by Public Law 99-509. **Because of Y2K issues, no ICD-9-CM code revisions were allowed for October 1, 1999. No addendum was issued which would modify ICD-9-CM in any way. ICD-9-CM codes effective October 1, 1998 will remain in effect through September 30, 2000.**
- May 13, 1999      ICD-9-CM Coordination and Maintenance Committee meeting. Code revisions discussed are for potential implementation on October 1, 2000.
- June 1999      Summary report of the May 13, 1999 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS's home page. URL: <http://cms.hhs.gov>
- July 1999      Prospective Payment System final rule to be published in the **Federal Register** as mandated by Public Law 99-509.
- Sept 10, 1999      Those members of the public requesting that topics be discussed at the November 12, 1999 meeting should have their requests to CMS for procedures and NCHS for diagnoses.
- Nov 12, 1999      ICD-9-CM Coordination and Maintenance Committee meeting. Last meeting of the year to discuss proposed code revisions for October 1, 2000.
- January 7, 2000      Deadline for receipt of public comments on proposed code revisions. **Revisions will include all those discussed at FY 1999 (June 4, 1998 and November 2, 1998) and FY 2000 (May 14, 1999 and November 12, 1999) ICD-9-CM Coordination and Maintenance Committee meetings.**

#### **Approval of future coding systems - Administrative Simplification**

There has been a change in the manner in which new coding systems are approved for use in this country. The Administrative Simplification requirements of the Health Insurance Portability and Accountability Act (HIPAA) require the establishment of national standards for code sets. This act requires proposed and final rules establishing initial national code sets. The initial code sets will remain the national standards for two years after publication of the final notice.

A notice of proposed rule making (NPRM) on Transactions was published May 7, 1998 (63 FR 25272). This NPRM proposes, for the most part, that the existing coding systems become the national standards. For hospital inpatient reporting, the NPRM proposed ICD-9-CM. The comment period closed on July 6, 1998 and the comments are being reviewed. It is anticipated that the final notice will be published in 1999.

Additional information on Administrative Simplification including NPRMs published to date can be found at the following location on the Internet:

<http://aspe.os.dhhs.gov/admsimp/>

Alternatively, one could follow the links on CMS's home page to the same location.

### **ICD-10-PCS Update**

Requests were made at the November 2, 1998 for speaker slides to be used by various organizations when they gave talks on ICD-10-PCS. CMS's contractor, 3M/HIS, developed 235 PowerPoint slides for this purpose. The slides are in both the Office 1997 version of PowerPoint as well as in a PDF format. They can be found on CMS's home page along with the rest of the ICD-10-PCS files as follows:

<http://cms.hhs.gov/paymentsystems/icd9/icd10.asp>

### **ICD-10-PCS Testing on Outpatient Records**

Clinical Data Abstraction Centers (CDACs) DynKePRO and FMAS Corporation were asked by CMS to continue the testing of the ICD-10-Procedure Coding System (ICD-10-PCS) on outpatient records. Goals of this review were to determine the following:

- Whether there is sufficient documentation in outpatient records that allows for a concise application of ICD-10-PCS codes.
- To verify that the changes made to the updated manuals were correct from our previous testing.

The initial step was to review the revised training manual. Errors and/or inconsistencies were noted and discussed with 3M Health Information Systems.

### **Description of the Project:**

During the time period of October 1998 through February 19, 1999, DynKePRO reviewed 582 ambulatory records which were provided by FMAS. Of those, 369 records had procedures that could be coded. A total of 724 codes were assigned to the procedures found in the 369 records. FMAS reviewed approximately 800 outpatient records. During the review process questions were submitted to 3M for clarification during conference calls.

### **Limitations:**

- There were a limited number of outpatient records available for this testing. The CDACs used records which they had in their facilities for other Medicare

abstracting studies. Most of these were cases of atrial fibrillation which tended to have a limited number of procedures.

- Only outpatient records were reviewed, the new root-operations of Detachment and Control were not tested since these are most often seen in acute inpatient records.
- The CDACs were unable to obtain obstetrical cases to code.
- It was sometimes difficult for the coders to determine when to use more than one code to fully describe a procedure or test. For instance, lab panels were not specifically addressed in the index.
- The coders had trouble with some of the tests performed in the outpatient settings. These are not routinely coded in the inpatient stay. Therefore, the terminology was unfamiliar. This caused difficulty in identifying the code, particularly when there was no index entry.

#### **Chronology:**

- All coding participants reviewed the training manual provided by 3M for ICD-10-PCS.
- Coders submitted questions and suggestions which arose during their review of the training manual for discussion with CMS and 3M.
- CDAC coders used worksheets for coding the procedures in ICD-10-PCS for the outpatient record samples.
- The CDAC faxed questions related to the ICD-10-PCS coding system to 3M during the process of completing the records.
- 3M, CMS and both CDACs participated in conference calls addressing coding questions throughout the process of coding the outpatient records.

#### **DynKePRO findings:**

The outpatient records seemed to contain sufficient information needed for coding. The majority of the CDAC's questions were coding clarifications, such as defining terms in the Imaging and Nuclear Medicine sections. Most of what was coded included labs, echocardiograms, and chest x-rays. These are mainly procedures that are also done as an inpatient but are not coded when more invasive procedures are done. The coding process between inpatient and outpatient records was really no different. What is chosen to be coded was the most significant difference between coding in the two settings.

#### **FMAS findings:**

In comparing FMAS' experiences in using this coding system for inpatient procedures and outpatient procedures, FMAS found no significant difference in the amount of time needed to code using ICD-10-PCS or in the documentation found in the records. The major difference was in the sections used in the coding scheme. Whereas the inpatient testing concentrated on the Surgical section of ICD-10-PCS, the outpatient testing primarily was conducted using the Radiology/Nuclear Medicine and Laboratory/Pathology as well as Measurement/Monitoring and Administration sections. The documentation for these types of procedures and tests is not significantly different on inpatient and outpatient records. Thus, the process of using ICD-10-PCS translated well to the outpatient environment.

The compromise that 3M has proposed for inclusion of NOS codes was well accepted by our coding staff. The only question that arose was in the sixth character of devices. Currently, device NEC is an option which coders were instructed to use when the device was not explicitly specified in ICD-10-PCS. If this option is also used for device NOS, some information will be lost regarding whether the lack of specificity was in the coding scheme (NEC) or in the documentation in the medical record (NOS). This is classical ICD-9-CM thinking which is ingrained.

### **Final Recommendations:**

Final recommendations were similar to those from previous testing and included the following:

- The Training Manual should be expanded with more examples and definitions to assist those learning to use the system.
- More examples of procedures included in Volume II should be incorporated into the Training Manual.
- Terms used in the Imaging and Nuclear Medicine sections need to be more clearly defined and explained. Most were clarified by 3M on conference calls. However these terms should be documented in the manuals since the personal clarification may not be available when the system is implemented.
- Brand names of radiopharmaceutical need to be included and defined. Since these were not known at the time of the testing, the CDACs were not always able to code procedures that contained a brand name radiopharmaceutical, even after contacting 3M for clarification.
- Include some anatomy diagrams either in the training manual or in the coding system itself.
- Include synonyms for matching up different body parts which the coder will find documented in the record with the body parts in the coding scheme. (Femoral shaft includes intertrochanteric, for example).
- Training is the key for successful implementation of the ICD-10-PCS coding system, as it is very different from the current system.

### **Transurethral Microwave Thermotherapy (TUMT) of Prostate Issue:**

Transurethral microwave thermotherapy (TUMT) of prostate is a non-surgical alternative for the treatment of benign prostatic hyperplasia (BPH). Does this fairly new treatment warrant an unique new code or is the current code assignment of ICD-9-CM procedure code 60.99, Other operations on prostate, sufficient?

### **Background:**

Transurethral microwave thermotherapy (TUMT) is a non-surgical, catheter-based technology used in the treatment of benign prostatic hyperplasia (BPH) by necrosis of the enlarged prostatic tissue. The treatment utilizes a transurethral microwave antenna, with simultaneous urethral cooking, to heat the prostate. This heating process is regulated through temperature feedback from one sensor mounted on the urethral catheter at the level of the prostate, and three sensors mounted on the

surface of the rectal probe. A complete treatment consisted of applying microwave energy at 1296 MHz (60 watts maximum) to the prostate for 60 minutes. By combining the effects of radiative heating and conductive cooling, it targets the highest temperatures within the prostate at a depth of five to ten mm, while preserving surrounding structures, such as the bladder neck, urethral mucosa and distal sphincter.

TUMT is performed with only topical jelly. This procedure can be performed in a doctor's office or outpatient facility. TUMT does not resect tissue, it coagulates the tissue by microwave energy so therefore, there is no removal of tissue for examination by a pathologist. It is therefore not a prostatectomy.

Contraindications for this procedure include: peripheral arterial disease with intermittent claudication or Leriche's Syndrome; clinical or historical evidence of prostatic cancer or bladder cancer; severe urethral stricture preventing easy catheterization; and presence of a cardiac pacemaker, an Implantable defibrillator, or a metallic implant in the region of the hip, pelvis, or femur.

**Options:**

1. Continue to code this procedure to 60.99, Other operations of prostate.

2a. Create a new code to capture Transurethral microwave thermotherapy of prostate.

New code 60.96 Transurethral destruction of prostate tissue by  
microwave thermotherapy  
TUMT of prostate

Radio frequency thermotherapy, such as the transurethral needle ablation (TUNA) of prostate, has been utilized in the treatment of BPH.

2b. Create a new code to capture transurethral radio frequency thermotherapy of prostate.

New code 60.97 Other transurethral destruction of prostate  
tissue  
by radio frequency thermotherapy  
Transurethral needle ablation (TUNA) of  
prostate

**Recommendation:**

2a. Create a new code to capture Transurethral microwave thermotherapy of prostate.

New code 60.96 Transurethral destruction of prostate tissue by

microwave thermotherapy  
TUMT of prostate

2b. Create a new code to capture transurethral radio frequency thermotherapy of prostate.

New code      60.97      Other transurethral destruction of prostate tissue by radio frequency thermotherapy  
Transurethral needle ablation (TUNA) of prostate

**In the interim, continue to code TUMT to procedure code 60.99, Other operations on prostate.**

### **Insertable Loop Recording for Infrequent Syncope**

#### **Issue:**

Currently the ICD-9-CM coding system does not contain a specific code for implanting or removing a syncope monitor from under the skin.

#### **Background:**

In February 1998 an Implantable, patient-activated cardiac event monitor was introduced that performs long term monitoring using a pre-symptom loop memory. The device, which is placed under the patient's skin in the chest area, is used to record the heart's rhythm during infrequent, recurrent, unexplained syncope. The patient uses a hand-held activator to store cardiac rhythms associated with symptoms which may suggest a cardiac arrhythmia. The activator communicates noninvasively with the monitor through the patient's clothing and skin. The information, in the form of a two-lead subcutaneous electrocardiogram (ECG), can be used by physicians to identify or rule out heart rhythm problems as the cause of the symptoms. The device lasts up to 14 months and is capable of storing up to 42 minutes of cardiac rhythm when activated. The device is read non-invasively by radio frequency telemetry, using a pacemaker programmer.

There are approximately 700 Implantable Loop Recorders currently in use by patients. Most patients, 95 percent, will have this implantation done during same day surgery, while 5 percent will be admitted to the hospital.

#### **Discussion:**

There is confusion in the field regarding the appropriate coding of this procedure because of the lack of a specific code or codes describing this technology. Physicians have noted the similarity between implant and removal of this device to implant and removal of a cardiac pacemaker, thereby escalating the confusion.

Some facilities have used code 37.79, Revision or relocation of pacemaker pocket, for implantation of the syncope monitor, with 37.89, Revision or removal of pacemaker device, described to remove it. Other facilities are using codes 89.50, Ambulatory cardiac monitoring, plus 86.09, Other incision of skin and subcutaneous tissue, for implant, and 86.05, Incision with removal of foreign body from skin and

subcutaneous tissue, for removal. Neither of the above options accurately describes the procedure, but a decision must be made on which code or codes to use for the sake of data consistency.

### Coding Options:

#### 1. Modify existing codes:

new title	37.7	Insertion, revision, replacement, and removal of pacemaker leads; insertion of temporary pacemaker system <b>or syncope monitor</b> ; or revision of pocket
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new title	37.79	Revision or relocation of pacemaker pocket <b>or insertion of a syncope monitor</b>
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new title	37.8	Insertion, replacement, removal and revision of pacemaker device <b>or syncope monitor</b>
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new title	37.89	Revision or removal of pacemaker device <b>or syncope monitor</b>
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#### 2. Modify existing inclusion terms

	86.0	Incision of skin and subcutaneous tissue
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add new term	86.09	Other incision of skin and subcutaneous tissue <b>Creation of syncope loop recorder pocket, new site</b> Creation of thalamic stimulator pulse generator pocket, new site
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3. Create a new code. Creation of a specific code is the most effective approach for data retrieval on the use of a specific device or technique, and also assures greater consistency in coding a procedure.

	86.0	Incision of skin and subcutaneous tissue
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new code	<b>86.08</b>	<b>Incision for creation of a syncope loop recorder pocket</b>
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### Recommendation:

While this technology is not currently well identified in the ICD-9-CM procedure

coding manual, the lack of a large patient population, in addition to the procedure's predominance in an outpatient setting suggests that the most logical choice is:

2. Modify existing inclusion terms

	86.0	Incision of skin and subcutaneous tissue
add new term	86.09	Other incision of skin and subcutaneous tissue <b>Creation of syncope loop recorder pocket, new site</b> Creation of thalamic stimulator pulse generator pocket, new site

This topic was discussed at the American Hospital Association's Editorial Advisory Board (EAB) for **Coding Clinic for ICD-9-CM** in September 1998. The recommendation from the EAB, which will be printed in 4th Quarter, 1999, was to use codes 89.50, Ambulatory cardiac monitoring, and 86.09, Other incision of skin and subcutaneous tissue.

**Therefore, in the interim, use codes 89.50, Ambulatory cardiac monitoring, and 86.09, Other incision of skin and subcutaneous tissue for implant of the insertable loop recording device, and 86.05, Incision with removal of foreign body from skin and subcutaneous tissue, for removal.**

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**Proposed Addenda - FY 2001 (October 1, 2000)  
Index**

Biopsy

Delete code	peritoneal implant	<b>54.23</b>
Add subterm	<b>closed</b>	<b>54.24</b>
Add subterm	<b>open</b>	<b>54.23</b>
Add subterm	<b>percutaneous (needle)</b>	<b>54.24</b>

Removal

	calculus	
	gallbladder	51.04
Add subterm	laparoscopic	51.88

Removal

	gallstones	
	gallbladder	51.04
Add subterm	laparoscopic	51.88

Ultrasonography

Revise subterm	heart (intravascular)	88.72
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Ultrasound  
Add subterm heart (intravascular) 88.72

**Tabular List**

78.5 Internal fixation of bone without fracture  
reduction  
Excludes note:

Change code arthroplasty and arthrodesis (81.00 -  
81.85)

88.72 Diagnostic ultrasound of heart  
Echocardiography

Add inclusion term **Intravascular ultrasound of heart**