



Final Agenda

ICD-9-CM Coordination and Maintenance Committee

Department of Health and Human Services

Centers for Medicare & Medicaid Services

CMS Auditorium

7500 Security Boulevard

Baltimore, MD 21244-1850

ICD-9-CM Volume 3, Procedures

March 22 – March 23, 2007

Patricia E. Brooks
Co-Chairperson
March 22, 2007

9:00 AM

ICD-9-CM Volume 3, Procedure presentations and public comments

Topics:

1. Intraoperative Electron Radiation
Therapy (IOERT)
Pages 6-14

Patricia E. Brooks
Joel Tepper, MD
Radiation Oncologist
Univ. North Carolina

Benjamin Calvo, MD
Associate Professor
Chief-Surg. Oncology
Univ. North Carolina

2. Intraoperative Neurophysiologic
Monitoring (IOM)
Pages 15-16

Patricia E. Brooks
Mark Stecker, MD
Geisinger Med. Ctr.
Danville, PA

3. Thoracoscopic Procedures
Page 17-19

Joe Kelly, MD

4. STARR Procedure for Males
Pages 20-22

Ann B. Fagan
Anthony Senagore, MD
Michigan State University
Grand Rapids, MI

- | | |
|-----------------------------------------------------------|---------------------------------------------------------------------------------|
| 5. Transjugular Biopsy of Liver
Page 23 | Amy L. Gruber |
| 6. Recalled Devices
Pages 24-25 | Ann B. Fagan |
| 7. Motion Preserving Technologies
Pages 26-31 | Mady Hue
Hansen Yuan, MD
SUNY Health Science Center
Syracuse, New York |
| 8. Addenda
Pages 32-33 | Mady Hue |
| 9. ICD-10 Procedure Classification System
(PCS) Update | Rhonda Butler |

Registering for the meeting:

Information on registering online to attend future meetings can be found at:

<http://www.cms.hhs.gov/apps/events/>

For questions about the registration process, please contact Mady Hue at 410-786-4510 or marilu.hue@cms.hhs.gov.

ICD-9-CM Volume 3, Procedures Coding Issues:

Mailing Address:

Centers for Medicare & Medicaid Services
CMM, HAPG, Division of Acute Care
Mail Stop C4-08-06
7500 Security Boulevard
Baltimore, MD 21244-1850
FAX: (410) 786-0681

Pat Brooks	E-mail: patricia.brooks2@cms.hhs.gov 410-786-5318
Ann Fagan	E-mail: ann.fagan@cms.hhs.gov 410-786-5662
Amy Gruber	E-mail: amy.gruber@cms.hhs.gov 410-786-1542
Mady Hue	E-mail: marilu.hue@cms.hhs.gov 410-786-4510

Summary of Meeting:

A complete report of the procedure part of the meeting, including handouts, will be available on CMS's homepage within one month of the meeting. The summary can be accessed at: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp

A summary of the diagnosis part of the meeting held on March 23 can be found at:

<http://www.cdc.gov/nchs/icd9.htm>

ICD-9-CM TIMELINE

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

March 22 – March 23 2007	ICD-9-CM Coordination and Maintenance Committee meeting.
April 1, 2007	There will not be any new ICD-9-CM codes implemented on April 1, 2007 to capture new technology.
April 13, 2007	Deadline for receipt of public comments on proposed code revisions discussed at the March 22-23, 2007 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2007.
April 2007	Notice of Proposed Rulemaking to be published in the <u>Federal Register</u> as mandated by Public Law 99-509. This notice will include the final ICD-9-CM diagnosis and procedure codes for the upcoming fiscal year. It will also include proposed revisions to the DRG system on which the public may comment. The proposed rule can be accessed at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp
April 2007	Summary report of the Procedure part of the March 22, 2007 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Summary report of the Diagnosis part of the March 23, 2007 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
June 2007	Final addendum posted on web pages as follows: Diagnosis addendum at - http://www.cdc.gov/nchs/icd9.htm Procedure addendum at – http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes
July 27, 2007	Those members of the public requesting that topics be discussed at the September 27 – 28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting must

have their requests to CMS for procedures and NCHS for diagnoses.

August 1, 2007

Hospital Inpatient Prospective Payment System final rule to be published in the Federal Register as mandated by Public Law 99-509. This rule will also include all the final codes to be implemented on October 1, 2007.

This rule can be accessed at:

<http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp>

August 16, 2007

On-line registration opens for the September 27-28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting at: <http://www.cms.hhs.gov/events>

August 2007

Tentative agenda for the Procedure part of the September 27 – 28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage at - <http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes>

Tentative agenda for the Diagnosis part of the September 27 – 28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on NCHS homepage at - <http://www.cdc.gov/nchs/icd9.htm>

Federal Register notice for the September 27 – 28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.

September 21, 2007

Because of increased security requirements, those wishing to attend the September 27 - 28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting must register for the meeting online at:

<http://www.cms.hhs.gov/apps/events>

Attendees must register online by September 21, 2007; failure to do so may result in lack of access to the meeting.

September 27 – 28, 2007

ICD-9-CM Coordination and Maintenance Committee meeting.

Those who wish to attend the ICD-9-CM Coordination and Maintenance Committee meeting **must have registered for the meeting online by September 21, 2007.** You must

October 2007

bring an official form of picture identification (such as a drivers license) in order to be admitted to the building. Summary report of the Procedure part of the September 27 – 28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows:

<http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes>

Summary report of the Diagnosis part of the September 27 – 28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows:

<http://www.cdc.gov/nchs/icd9.htm>

October 1, 2007

New and revised ICD-9-CM codes go into effect along with DRG changes. Final addendum posted on web pages as follows:

Diagnosis addendum - <http://www.cdc.gov/nchs/icd9.htm>

Procedure addendum at -

<http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes>

October 12, 2007

Deadline for receipt of public comments on proposed revisions discussed at September 27-28, 2007 ICD-9-CM Coordination and Maintenance Committee meeting for implementation on April 1, 2008.

Early November, 2007

Any new ICD-9-CM codes required to capture new technology that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2008 will be posted on the following websites:

<http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes>

<http://www.cdc.gov/nchs/icd9.htm>

December 3, 2007

Deadline for receipt of public comments on proposed code revisions discussed at the September 27-28, 2007 ICD-9-CM Coordination and Maintenance Committee meetings for implementation of October 1, 2008.

Intra-operative Electron Radiation Therapy (IOERT)

Issue:

Intra-operative electron radiation therapy is captured by code 92.25, Teleradiotherapy using electrons. Historically this code captured traditional therapy delivery systems that involved moving the patient to a location in the medical facility where a stationary machine has been installed. There is now a device which can be brought to the patient in the operating room and does not require a shielded location. A unique code has been requested to identify the delivery of electron radiation therapy during a procedure. It has been suggested that the use of this method of delivery impacts patient safety, decreases overall operative time, and can impact the treatment outcome. The intra-operative electron radiation therapy also eliminates the additional surgical risk associated with moving the anesthetized patient to a distant location and makes intra-operative radiation available to a wider patient population.

FDA Approval:

510 (k) clearance for Mobetron (Electron Linear Accelerators) was received in July 1998.

Background Information:

What is IOERT? – Intra-operative Electron Radiation Therapy (IOERT) is a specialized intensive radiation treatment administered during surgery directly to the cancer tumor or tumor bed while normal tissues are displaced or protected, thereby increasing the effective dose to the tumor substantially. A single, two-minute IOERT treatment can often eliminate several weeks from conventional pre/post-operative external beam radiation treatment regimens while producing better treatment outcomes. This therapy is currently captured through code 92.25, Teleradiotherapy using electrons. This code represents an antiquated term that does not reflect the advances in current technology and procedures. Current terminology refers to “radiotherapy” or “radiation therapy” and refers to the use of high-energy beams to destroy cancer cells. In the case of Mobetron, the energy is provided by electron beams.

Radiation therapy is commonly used in four ways:

1. As postoperative adjuvant therapy - radiation therapy instituted beginning several weeks after the surgery in an attempt to destroy remaining tumor cells.
2. As neo-adjuvant therapy - radiation therapy administered before surgery to reduce the size of a tumor.
3. Intra-operative therapy - radiation therapy that is part of the tumor removal operative procedure to ablate tumor cells, treat the tumor margins and administer an initial dose of treatment radiation as part of the operative procedure.
4. Palliative therapy - radiation therapy with a purpose of easing pain or pressure symptoms by reducing the size of a tumor but without a goal of cure.

IOERT has shown great potential, but difficulties in its implementation, due to equipment designs of the past, have severely limited its use. Conventional radiation

accelerators weigh tons and require tons more of radiation shielding, making it expensive and thus impractical to install in most operating room (OR) locations. Without a unit that can be placed in the OR, the surgically exposed, anesthetized patient must be transported from the surgical suite to either the radiation oncology department or to a single shielded location within the OR suite. Moving the patient poses multiple problems, such as maintaining sterility, arranging for appropriate additional personnel to accompany the patient to another location, transporting instruments, subjecting the patient to prolonged anesthesia, etc. The Mobetron is light-weight, mobile and self-shielded. Therefore, placing a Mobetron in the regular OR suite can eliminate these problems.

Description of the mobile device:

The Mobetron is a mobile, self-shielded electron linear accelerator designed specifically for use in the operating room (OR). It produces beams of electrons used in the radiation therapy treatment of both malignant (cancer) and benign conditions. The Mobetron treatment module consists of a lightweight accelerator mounted on a motor driven gantry. The unit has four electron beam treatment energies and a set of electron applicators that provide a range of field sizes from 3-10 cm in diameter. For delivery of electron beam radiation during a surgical procedure (known as Intra-operative Electron Radiation Therapy/IOERT) the Mobetron system includes a sterile cap and sterile drapes, IORT applicators, a QA system, a cantilevered surgical table, a special clamping system to attach the applicator the surgical table, and bolus material.

Patient population:

It is well-known that the likelihood of developing certain types of cancer increases with age. The American Cancer Society's "Cancer Statistics, 2006" indicates that cancer is the leading cause of death in men and women aged 60 to 79 years, killing over 284,000 men and women annually and account for 32% of the deaths in this age group (compared to 103,000 deaths by cancer in the 40 to 59 year age group). Three of the five leading sites of cancer causing death for men in this age group (lung, colorectal, and pancreas) representing 51% of the deaths by cancer in this age group, and four of the five leading sites of cancer causing death for women in this age group (lung, breast, colon and rectum, and pancreas), representing 59% of the deaths by cancer in this age group are sites that are particularly amenable to IOERT treatment.

Furthermore, according to "Cancer Statistics, 2004", there is a 34% chance of a man and a 23% chance of a woman in this age group developing cancer compared to 8% for men and 9% for women, in the 40 to 59 year age group.

Depending on the stage of the disease, patients with cancer can be effectively treated with surgery, radiation or chemotherapy, or a combination of two or more of these modalities. If the patient presents with localized or regional disease, surgery will often be an integral component of the treatment. It is estimated that

60% of all cancer patients will receive radiation therapy treatment, and perhaps 70% will receive surgical treatment.

For locally advanced disease (such as locally advanced rectal cancer, and locally advanced head and neck cancer) surgery, external beam radiation therapy and chemotherapy, do not achieve high levels of survival and often are unable to control the disease locally. For many recurrent diseases (such as recurrent rectal cancer, recurrent GYN cancer, recurrent head and neck cancer) current standard approaches offer little hope for the patient. And in some diseases (such as pancreatic cancer) the best conventional approaches do not achieve positive results. It is this group of locally advanced and recurrent patients that IOERT has historically achieved significantly higher local control when compared to traditional treatment approaches, and, in many tumor sites, increased survival.

Re-hospitalization to treat recurrences is a tragedy for the patients and their family and a cost burden to society. Providing treatments that improve local control and reduce recurrences is extremely cost effective. Re-hospitalization and re-treatment for recurrences can cost upwards of \$50,000.

IOERT technology, enabled by mobile technology, is now moving into the treatment of earlier stage disease, such as breast cancer and earlier stage rectal cancer, as well as tackling challenging cancer sites such as lung cancer where preliminary results are encouraging.

Description of how the Mobetron unit is utilized in the operating suite:

1. Prior to the surgery, the radiation team (or the surgical team) moves the Mobetron to the OR in which the surgery will occur.
2. The Radiation Therapist or the Physicist warms up the Mobetron and conducts the QA procedure. The warm up and QA take approximately 20 to 30 minutes to perform. Note: Because IOERT is a special procedure (a large dose of radiation is delivered in a single exposure) the AAPM Task Group 72 on IOERT and IOERT mobile accelerators recommends that the energy and output be checked on the day of use to assure that the unit is operating properly. After performing the QA, the radiation staff leaves, and the surgery commences.
3. The surgeon performs the initial procedure and resection using the standard surgical approach that would normally be employed for surgery of that tumor type if IOERT were not to be used. After removal of the tumor, special preparation by the surgeon of the surgical site is often required to accommodate the IOERT treatment. For example, certain radiation sensitive structures (e.g. the ureter) might need to be displaced from the planned IOERT field before radiation treatment. For breast cancer, the lumpectomy cavity might have to be temporarily reapproximated to simplify the geometry of the IOERT field and thus permit a more uniform dose delivery.

4. Approximately 30 minutes before the surgical staff anticipates that they will be ready for the IOERT, they call the radiation team to ask them to come to the OR.
5. Together with the radiation oncologist, the surgeon inspects the site, verifies margins and they make a decision of whether to treat and how to treat. Approximately one-third of patients that are planned to receive IOERT do not actually receive treatment, even though the QA was conducted in anticipation of the IOERT procedure. Reasons for cancellation of the IOERT procedure are if the surgeon is unable to achieve a gross total resection, if during surgery metastatic disease is discovered, or, more rarely, if the tumor is found to be benign at the time of surgery.
6. The physician, radiation oncologist and physicist determine the depth and scope of treatment, whether bolus or localized lead blocking of normal tissue is required, and the dose is calculated. Historically, 60-70% of pre-identified cases are treated.
7. Once a decision to treat has been made, the appropriate size applicator is positioned within the operative area, and the applicator is attached to the surgical table through use of a specialized surgical clamp provided with the Mobetron. A set of electron applicators is available in various diameters from 3 cm to 10 cm in 5 mm increments.
8. The surgical table is positioned under the Mobetron unit and there is a laser alignment system that is used to align the applicator with the Mobetron unit. This alignment is done by the radiation therapist or the Physicist. The applicators are specially designed tubes and help focus the beams safely on the tumor or the tumor bed, and prevent leakage of radiation to normal structures outside the applicator.
9. Treatment is administered in typically 2 to 3 minutes.
10. The table is moved away from the Mobetron and the surgeon completes the remainder of the surgical procedure.
11. The total time that the radiation team spends in the OR room for treatment delivery is 20 to 30 minutes, depending on how complex the treatment is and whether more than one IOERT field is needed for the tumor site. IOERT adds approximately 30 to 40 minutes to a surgical procedure, including the special surgical preparation for IOERT, the discussion and decision on how best to treat that patient., the placement of the applicator and the docking of the applicator to the Mobetron, the treatment delivery, the removal of the clamps and IOERT applicator, and the repositioning of the patient to complete the surgery.
12. After the IOERT surgery is completed, the radiation or surgical team moves the Mobetron to its proper storage location.

Current tumor sites which can be treated with the Mobetron technology include the following:

- Head and Neck cancer

- Breast Cancer
- Brain cancer
- GI Disease (colorectal cancer, gastric cancer, pancreatic cancer, hepatobiliary cancer)
- Lung and esophageal cancer
- GU Disease (bladder cancer, renal cancer, ovarian cancer, pelvic recurrences from cervical cancer)
- Soft tissue sarcomas of the extremity
- Retroperitoneal sarcomas

In addition, studies are underway in Europe which combine IOERT with radical prostatectomy for men at high risk.

Advantages of being able to administer IOERT treatment within the operating suite with Mobetron:

1. Gives a boost at the time of surgery allowing delivery to a precise location that can be visually identified with the tumor area exposed. This method of delivery has been shown to diminish recurrence of tumors and replaces 2-3 weeks of external beam therapy. For some tumor sites, it is often difficult to dose escalate using external beam radiation because of the normal tissue structures surrounding the tumor site. Improvement in local control and reduction of pre- or post-operative radiation treatments reduces the costs of treatment and provides for a better quality of life for the patient.
2. Directly destroys residual tumor cells left behind after surgical resection and also is used to destroy microscopic residual tumors that are unresectable from critical normal tissue or surrounding structures. This situation is often the case with recurrent cancers.
3. Normal tissues surrounding the tumor and critical structures within the field can be displaced and protected. This prevents or minimizes damage to healthy tissue and enables a stronger dose of electron radiation to be directed to the cancerous tumor or tumor bed.
4. Reduction in potential for surgical complications and risk of infection related to moving the patient from the operating room setting. Also, some operative procedures are too complex to allow patient transportation to a different location.
5. Allows the first dose of radiation therapy to be administered immediately during tumor resection. The surgeon and radiation oncologist are thus able to coordinate their efforts to more efficiently communicate and effectively treat patients. Without availability of this intra-operative dose, there is usually a delay of several weeks after surgery before external beam radiation therapy can be started. During this delay, residual tumor cells can continue to grow and migrate to other locations.
6. Allows dose escalation with reduced toxicity.
7. Total anesthesia/operative time can be reduced since the need to transport the patient is eliminated.

8. Better local control of tumor for most sites and better long-term survival for many sites.
9. Because it is relatively small and lightweight, the Mobetron can be moved between locations within the operative suite.
10. Mobetron uses several patented technologies to allow IOERT to be used without requiring supplemental shielding.
11. This treatment allows the radiation to be directed away from normal structures and focused on a specific area so that there may be some sparing of organ functionality.

Risks:

As with any medical procedure, there are risks associated with the administration of IOERT. Studies have shown that if the IOERT can be kept to 15 Gy or less, the risks are minimal, providing normal tissue structures are displaced or protected from the IOERT field. Reported complications attributed to IOERT range from 5-20% and include:

- Peripheral neuropathy
- Fibrosis
- Urethral stenosis
- Small bowel stenosis
- GI fistulas

Most reported complications are Grade 2 or lower. Many complications are transitory. Surgical intervention is rarely required to address them

There have been no reported cases of increased infection or prolonged hospital stay due to IOERT treatment.

Results of IORT and Statistical Information

SELECTED IOERT RESULTS

ISORT POOLED ANALYSES

Tumor Site	Patients	IOERT		Best Conventional	
		5-yr Local Control	5-yr Survival	5-yr Local Control	5-yr Survival
Locally advanced Rectal Cancer	649	87%	60%	< 50%	25%
Recurrent Rectal Cancer	160	50%	37% 54% if R0 resection	~ 30%	< 10%
Breast Boost ⁽¹⁾	1097	99.6%	99.1%	95.7%	90.1%

			(DSS) 96.5% (OS) 93% (DFS)		(DFS)
Resectable Pancreatic Cancer	185	73% w CRT	23%	30-40%	10-15%
Soft Tissue Sarcomas	255	78%	77%	Comparable	Comparable
Retroperitoneal Sarcomas	123	72% 100% if R0	58% 80% if R0	~ 50%	~ 50%
Inoperable Pancreatic Cancer	22 randomized, with and w/o sensitizer	NR	23% (3-year)	NR	0% (3-year)
Single Dose Breast (APBI) ⁽²⁾	~1200	1 330 pts	0 330 pts	1 341 pts	0 341 pts

(1) Bio-Boost compared to conventionally treated match pairs from U. of Salzburg

(2) Preliminary report on randomized results, made with only 22 months median follow-up.

Locally Advanced Rectal Cancer: Four participating institutions. Patients received preoperative chemoradiation therapy, followed by TME surgery + IOERT.

Recurrent Rectal Cancer: Data from single institution presented in March 2005 at the ISORT Meeting. Pooled analysis data not yet analyzed, but will have over 300 patients. In The Netherlands, protocols are being written to require all recurrent rectal patients to receive IORT as part of their treatment.

Breast Boost: Six participating institutions. Patients received 10 Gy at the time of lumpectomy, followed by 5-6 weeks of EBRT 4 to 14 weeks after the surgery (25% of the patients had chemotherapy before EBRT radiation. 52% of patients had one or more adverse factors: young age, positive nodes, high tumor grade (G3), or large size (T3). There were only four in-breast recurrences; none of them were true recurrences. This is a disease specific survival of 99.1%. Median follow-up is 53 months. This boost, called the Bio-Boost, is now the standard of care at the University of Salzburg for all patients that are candidates for breast conserving therapy. Dr. Felix Sedlmayer estimates that if all eligible women in the U.S. received the bio-boost, more than 5000 mastectomies a year could be avoided.

Resectable Pancreatic Cancer: Pooled data form four institutions. Patients treated with three IOERT techniques: IOERT alone, IOERT plus post-operative EBRT with or without chemotherapy, and preoperative chemoradiation therapy followed by IOERT. Best results are preop CRT followed by IOERT. Local control in this disease generally means absence of pain for most of remainder of life.

Soft Tissue Extremity Sarcomas: Pooled data from three institutions. Surgery alone is not curative in this tumor and radiation doses in excess of 62 Gy must be given to control the tumor and preserve the limb. With IOERT, local control and survival and limb preservation equivalent or better than with other radiation boost techniques, such as brachytherapy boost (IOERT boost more uniform, easier to deliver) or EBRT boost (increases late toxicity). IOERT allows reduction of EBRT dose and that result in excellent limb function and reduced toxicity and reduced treatment time.

Retroperitoneal Sarcomas: Pooled data from three institutions. Two thirds of the patients had recurrent disease, and more than 50% of them had tumors larger than 10 cm. Despite these poor prognosticators, if the surgeon could achieve a complete macroscopic resection, local control and survival were excellent. Local failure in this tumor group is common. It is very hard to boost effectively with EBRT due to the location of the tumor site, and the large volume at risk. IOERT would appear to be the appropriate boost to combine with surgery and post-operative EBRT.

Inoperable Pancreatic Cancer: Randomized trial testing IORT +/- radiation sensitizer followed by post-operative EBRT. In inoperable pancreatic cancer, over 50% of the patients die within 12 months, and there are virtually no three year survivors. Literature has only eight long-term survivors, all of whom received IOERT as part of their treatment. This is the first study to show benefit of radiation sensitizer. Sensitizers with IOERT could improve treatment results in other advanced and recurrent disease.

Other Japanese studies show that there is a significant increase in hospital free survival days for patient with inoperable pancreatic cancer that have received a bypass and IOERT vs. those that do not receive IOERT.

Single Dose Breast IOERT (APBI): Randomized trial for women over 48 years, small tumors (<2.5 cm), and node negative. The study is testing whether IOERT in this group of women of relatively low risk women can replace 5-7 weeks of post-operative radiotherapy. Study will be completed by end of 2006, and the results announced in 24 months when the data is mature. However, because many women have been treated with single dose off-protocol, it appears that the results of this APBI for wide excision surgery are equivalent to the results for standard BCT. Hospital is also starting a bio-boost trial with IOERT followed by hypofractionated EBRT, similar to the Phase II study currently being done at Mayo Clinic and the study that will be proposed by the ISIOR for the bio-boost. Dr. Veronesi, internationally renowned breast surgeon, has stated that he believes that within a few years, IOERT will be the standard of care for breast cancer patients.

Coding Options:

Option 1 - Continue assigning procedure code 92.25, Teleradiotherapy using electrons to capture intra-operative electron radiation therapy.

Option 2 - Create a new code to clearly identify the use of a mobile unit, located within the operating room suite to deliver an initial dose of IOERT therapy as part of the operative procedure.

New chapter	3a. Additional Procedures and Interventions, NEC (17)
New category	17 Additional procedures and interventions, NEC
	17.10 Intra-operative electron radiation therapy
	IOERT
	That using a mobile linear accelerator

Recommendation:

CMS recommends option 2; create new code 17.10 Intra-operative electron radiation therapy. In the meantime, continue capturing intra-operative electron radiation therapy using code 92.25.

Intra-Operative Neurophysiologic Monitoring

ISSUE: There is not a unique ICD-9-CM code that captures Intra-Operative Neurophysiologic Monitoring (IOM). There are codes for neurophysiologic testing; however, it is not possible to identify those performed intra-operatively. Because of the absence of specific codes, it is difficult to ascertain the overall utilization of IOM services. In addition, surgical procedures that employ IOM cannot be differentiated from equivalent procedures that do not use IOM in order to assess effects on outcome.

BACKGROUND: Intra-Operative Neurophysiologic Monitoring (IOM) has been commonly used for more than 25 years. IOM is an important tool used to prevent injury to the brain, spinal cord, cranial and peripheral nerves during certain surgical procedures. IOM involves using either one or more neurophysiologic testing techniques in real time in the operating room to assess the integrity of critical neural structures. Modalities that are commonly used include: EEG, somatosensory evoked potentials (SSEP), brainstem auditory evoked potentials, EMG, nerve conduction studies, motor evoked potentials (MEP) and transcranial Doppler.

IOM is frequently used in complex spinal surgeries to protect the spinal cord and nerve roots. It is also frequently used in surgical procedures involving blood vessels that supply the brain or spinal cord such as carotid endarterectomy, surgery for intracranial aneurysms and surgery for aortic dissection or aneurysm. It is also used during surgical procedures involving tumors near critical nerves or brain structures such as acoustic neuromas, parotid tumors, etc.

IOM techniques can also be used to guide the surgeon in placing leads or electrodes in regions of the nervous system with specific physiologic properties. These techniques are especially valuable during epilepsy surgery where EEG recordings can help localize the source of seizures and electrical stimulation can identify regions of the brain associated with important functions such as speech. Similarly, IOM is also useful in determining the optimal placement for deep brain stimulating electrodes for the treatment of movement disorders and the placement of spinal cord and cortical stimulating electrodes for the treatment of severe pain syndromes.

The significant clinical value of IOM during specific high risk surgical procedures has been established primarily by a strong consensus of expert opinion as well as large numbers of small scale uncontrolled studies. However, large scale multicenter studies have not been performed.

In the outpatient diagnostic setting, responses from the patient are compared to those of a normal group and interpretations regarding the location and type of any abnormalities are provided typically within 24 hours of the study. In the case of IOM, the studies are initially performed in order to establish a baseline and then carried out continuously during the entire surgical procedure in order to detect any changes that could suggest impending reversible injury to the nervous system. This information must be conveyed immediately to the surgeon so that measures can be taken to prevent permanent injury.

This requires that a professional level neurophysiologist be available in real time to interpret the results of the monitoring and provide feedback to the surgeon. In addition, complexity of applying electrodes and obtaining high quality test results in an electrically hostile environment such as the OR makes it necessary that only technicians or neurophysiologists with significant training and experience perform such testing.

The following ICD-9-CM procedure codes describe some of these neurophysiologic tests:

- 01.18 Other diagnostic procedures on brain and cerebral meninges
- 03.39 Other diagnostic procedures on spinal cord and spinal canal
- 04.19 Other diagnostic procedures on cranial and peripheral nerves and ganglia
- 89.14 Electroencephalography
- 93.08 Electromyography
- 95.23 Visual evoked potential [VEP]

The codes listed above do not indicate that the testing is performed during surgery. Because of the marked differences between the practice and use of neurophysiologic testing in the intra-operative and extra-operative setting, such a code may be warranted.

Since the manner in which the testing is performed and the demands on the technical and professional staff performing the procedure in the operating room are quite different, a unique ICD-9-CM code would allow the use of IOM during surgery to be identified. The presence of an ICD-9-CM procedure code describing IOM would allow for statistical studies tracking the utilization of this procedure and its effect on the outcomes of surgery.

OPTIONS:

Option 1. Do not create a new code for Intra-Operative Neurophysiologic Monitoring (IOM). Continue assigning existing codes for the specific type of testing performed as listed above.

Option 2. Create a new code for Intra-Operative Neurophysiologic Monitoring (IOM) as follows:

- 00.9 Other procedures and interventions
- New Code 00.94 Intra-Operative Neurophysiologic Monitoring
 - Intra-operative Neurophysiologic Testing
 - IOM
 - Includes: Spinal Cord, Cranial Nerve and Peripheral Nerve Testing

RECOMMENDATION: CMS recommends Option 2 - Create new code 00.94 Intra-Operative Neurophysiologic Testing. CMS solicits recommendations concerning whether coders should also report the code(s) for the specific type of testing. In the meantime, continue to assign existing codes for the specific types of testing performed.

Thoracoscopic Procedures

Issue:

At the last Coordination and Maintenance Committee meeting we considered a number of diagnostic and therapeutic procedures that are done using a thoracoscope that did not have discreet ICD-9-CM Procedure Codes. Today we will continue that discussion to include a number of similar procedures on the lung and the thymus.

New Technology?

No.

Background:

A thoracoscope is a type of endoscope, or flexible fiberoptic tube that is inserted into the thorax through a small incision while the tissues it encounters are visualized directly. Surgical tasks such as cutting, suturing and resecting can also be accomplished through the thoracoscope, thus enabling a number of procedures to be performed without opening the chest.

Current coding:

07.8 Thymectomy

07.80 Thymectomy, not otherwise specified

07.81 Partial excision of thymus

07.82 Total excision of thymus

07.9 Other operations on thymus

07.92 Incision of thymus

07.99 Other

32.2 Local excision or destruction of lesion or tissue of lung

32.28 Endoscopic excision or destruction of lesion or tissue of lung

32.29 Other local excision or destruction of lesion or tissue of lung

32.3 Segmental resection of lung

32.5 Complete pneumonectomy

Coding options:

Option 1: Do not create new codes. Continue to use existing codes as described above.

Option 2: Create new codes as follows:

07.8 Thymectomy

New code 07.83 Thoracoscopic partial excision of thymus

New code 07.84 Thoracoscopic total excision of thymus

07.9 Other operations on thymus

New code 07.95 Thoracoscopic incision of thymus

New code 07.98 Other and unspecified thoracoscopic operations on thymus

Revise code title 07.99 Other and unspecified operations on thymus

Add inclusion term Transcervical thymectomy

Delete inclusion term ~~Thymopexy~~

Add exclusion term Excludes: thoracoscopic operations on thymus (07.98)

32.2 Local excision or destruction of lesion or tissue of lung

New code 32.20 Thoracoscopic excision or destruction of lesion or tissue of lung
Thoracoscopic wedge resection

Add exclusion term 32.25 Thoracoscopic ablation of lung lesion or tissue
Excludes: thoracoscopic excision or destruction of lesion or tissue of lung (32.20)

Add exclusion term 32.29 Other local excision or destruction of lesion or tissue of lung
Excludes: thoracoscopic excision or destruction of lesion or tissue of lung (32.20)

Create new subcategory

32.3 Segmental resection of lung
Partial lobectomy

New code 32.30 Thoracoscopic segmental resection of lung

New code	32.39 Other and unspecified segmental resection of lung Excludes: thoracoscopic segmental resection of lung (32.30)
Revise title/Create new subcategory	32.5 Complete P pneumonectomy
New code	32.50 Thoracoscopic pneumonectomy
New code	32.59 Other and unspecified pneumonectomy Excludes: thoracoscopic pneumonectomy (32.50)

CMS Recommendation:

CMS recommends option 2. Create new codes to identify the thoracoscopic approach for these procedures.

Interim Coding:

In the meantime, continue to code using the existing codes as listed above.

STARR Procedure (Stapled Transanal Rectal Resection)

Issue:

CMS received a request from the Health Information Management Services Department of the Israel Ministry of Health requesting a new ICD-9-CM procedure code for the STARR (stapled transanal rectal resection) procedure for male patients. The current code for the STARR procedure sends the coder to 70.52, Repair of rectocele, which is located in Chapter 12, Operations on the Female Genital Organs.

One of the primary issues may be that of documentation. The STARR procedure may be grouped into the diagnosis of rectocele when more appropriate diagnosis should have been rectal prolapse. The STARR procedure was developed specifically to address dysfunction of the rectal musculature and internal prolapse. It was never designed as a primary treatment for rectocele but rather as a treatment for obstructed defecations syndrome (ODS). Therefore, appropriate diagnoses should be rectal prolapse and/or outlet constipation.

New Technology:

No.

Background:

The STARR procedure is performed on patients with chronic outlet constipation and internal rectal prolapse from ODS – obstructive defecation syndrome. This procedure is a minimally invasive surgical technique that is an alternative to traditional surgical techniques.

ODS is a form of chronic constipation affecting thousands of Americans – primarily women. Childbirth can injure the pelvic nerves which lead to weakening of the pelvic floor muscles. The lack of coordinated pelvic floor contraction and poor rectal emptying over time results in internal rectal prolapse and a weakening of the rectovaginal septum which is diagnosed as rectocele in women. However it is the rectal wall dysfunction that appears to be the primary pathology. Other pelvic floor dysfunction pathology can coincide with ODS, however, they are evaluated and treated separately.

Traditional surgery is done through the vagina to basically tighten the tissues between the rectum and the vagina, but excess rectal tissue itself is not removed. A disadvantage to traditional surgery for a rectocele is the possibility of making the vagina shorter and/or narrower. This surgical approach, however, has focused on the secondary event (weakening of the rectovaginal septum) and not the primary pathology in the rectal wall musculature. The STARR procedure effectively treats the primary disease without compromise to the vagina in any way.

The surgeon performs STARR through the anus, so the procedure requires no external incisions and leaves no visible scars. The patients are typically hospitalized from 1 to 3 days and may begin having normal bowel movements soon after the surgery. The

surgeon uses a surgical stapler to remove the excess tissue in the rectum (a full thickness rectal wall resection anteriorly and posteriorly) responsible for the ODS. This tissue may bulge out, creating a pocket near the anus (rectocele), and it may fold up on itself like a telescope (Intussusception).

Current Coding:

The Procedure Index reads as follows:

Repair

rectum NEC 48.79

prolapse NEC 48.76

abdominal approach 48.75

STARR (stapled transanal rectal resection) 70.52

Therefore, a coder searching for the STARR procedure would be led to code 70.52, Repair of rectocele, with the concomitant issue of its location in Chapter 12, Operations on the Female Genital Organs. However, if the physician documentation lists the procedure as repair, rectal prolapse, the coder would select 48.76, Other proctopexy.

Additionally, the *Coding Clinic for ICD-9-CM*, published by the American Hospital Association, gives advice on coding stapled transanal rectal resection in First Quarter 2006, page 12. This advice is consistent with the Procedure Indexing of STARR, sending the coder to 70.52.

Options:

Option 1:

Continue to code the STARR procedure in females to 70.52, Repair of rectocele. Create a new code for this procedure for males. There is availability at code 48.70.

Option 2:

Revise the index entry for the STARR procedure so patients of either gender would be assigned to the same code.

Index

Revise Code STARR (stapled transanal rectal resection) ~~70.52~~ 48.76

Tabular

48.7 Repair of rectum
48.76 Other proctopexy
Delorme repair of prolapsed rectum
Proctosigmoidopexy
Puborectalis sling operation
Add inclusion term Stapled transanal rectal resection
Excludes: manual reduction of rectal prolapse (96.26)

70.5 Repair of cystocele and rectocele
70.52 Repair of rectocele
Posterior colporrhaphy
Add excludes note Excludes: STARR procedure (48.76)

Recommendation:

Option 2: Revise the index entry for the STARR procedure so patients of either gender would be assigned to the same code, as described above.

Interim Coding:

In order to maintain data consistency until a new code can be implemented, follow the Index and the AHA *Coding Clinic* advice, coding the STARR procedure to 70.52, Repair of rectocele, for women. Code 48.76, Other proctopexy, to describe the STARR procedure for men. In terms of data collection, there will be no negative impact on the data base as a result of this advice.

Transjugular Liver Biopsy

Issue: ICD-9-CM Volume 3, Procedures, currently captures the closed and open approaches to biopsy of liver. Should a new code be created to capture transjugular liver biopsy?

New Technology Application:

No.

Background:

Liver biopsy is widely used as a means to help diagnose various types of liver disease, such as viral hepatitis, cirrhosis and transplant rejection. Typically in a liver biopsy, liver tissue is acquired via several different methods in order to be studied microscopically, as well as for various types of laboratory tests. Traditionally the most direct approach for a liver biopsy is percutaneously via a needle directly through the skin and into the liver. Liver biopsy can also be performed using a laparoscope, or at the time of open abdominal surgical procedures.

Transjugular liver biopsy is an alternative to these traditional methods of liver biopsy. With the transjugular approach, a small catheter is inserted into the right internal jugular vein in the neck. Under fluoroscopic guidance, the catheter is threaded through the superior vena cava, the right atrium, the inferior vena cava and into the right hepatic vein. A biopsy needle is then inserted through the catheter directly into the liver where a small sample of tissue is obtained. This procedure is particularly useful when an increased risk of bleeding is present, which is very common with liver disease, because it is less traumatic than the percutaneous approach. It is also useful when significant intra-abdominal fluid, or ascites, is present, which makes the other approaches more technically difficult and risky.

Options:

1. Continue to code transjugular liver biopsy to code 50.11, Closed (percutaneous) [needle] biopsy of liver.
2. Create a new code for transjugular liver biopsy.
Category 50.1 Diagnostic procedures on liver
New code 50.13 Transjugular liver biopsy
Transvenous liver biopsy

CMS's Recommendation:

- Option 2. Create a new code for transjugular liver biopsy.
Category 50.1 Diagnostic procedures on liver
New code 50.13 Transjugular liver biopsy
Transvenous liver biopsy

In the interim, code this procedure with procedure code **50.11, Closed (percutaneous) [needle] biopsy of liver. (Updated after meeting)**

Recalled Devices

Issue:

There are no ICD-9-CM procedure codes which can be used to identify an implanted device which has been recalled by the manufacturer.

New Technology Application?

No.

Background:

It has become a CMS initiative to identify cases in the Medicare population where recalls of failed implanted devices have occurred. In order to identify device failures, we need to be able to identify these devices by way of a specific code. While we understand that some device malfunctions may be inevitable as medical technology grows increasingly sophisticated, we believe that early recognition of problems would reduce the number of people who would be potentially adversely affected by these device problems. The medical community needs heightened and early awareness of patterns of device failures, voluntary field actions, and recalls so that it can take appropriate corrective action to care for patients.

Coding Options:

Option 1:

Do not create a new code to describe a device which has been recalled by the manufacturer and replaced during that stay.

Option 2:

Develop a new code to identify instances in which an implanted device has been recalled by the manufacturer.

New chapter 3a. Additional Procedures and Interventions, NEC (17)

New category 17 Additional procedures and interventions, NEC

New subcategory 17.0 Additional procedures and interventions, NEC

New code 17.20 Replacement of recalled device or device under warranty

Note: This is an adjunct code for tracking purposes.

It is to be used when a device manufacturer has recalled any currently implanted device.

Code also any device replacement, as:

replacement of transvenous lead into left ventricle (00.52)

replacement of cardiac resynchronization pacemaker pulse generator [CRT-P] (00.53)

Recommendation:

CMS recommends that coding option 2, as described above, be adopted for use beginning October 1, 2007.

Interim Coding:

Do not code. No codes currently exist to identify recalled and replaced devices.

Motion Preservation Technologies

Interspinous Devices, Pedicle Screw Based Stabilization Systems and Facet Replacement Systems

Issue:

ICD-9-CM does not distinguish between all the types of motion preservation technologies that are presently in use or are being developed. Several of these procedures are currently captured with code 84.59, Insertion of other spinal devices. Should unique procedure codes be created to capture these new technologies?

Background:

Degenerative spine disease is a broad term encompassing a wide range of degenerative changes which can result in pain, neurological deficit, and disability.

- Lumbar spinal stenosis is a focal narrowing of the spinal canal. Nerve root compression mechanisms alone or in combination can result from impingement of the spinal cord or nerves resulting from progressive changes in the spine, including facet arthritis, the forward or backward slip of one vertebral body relative to an adjacent vertebral body (i.e. spondylolisthesis) and disc protrusion or herniation. This results in the narrowing of the spinal canal and neural foramina. This degeneration, which is linked to the natural aging process, is often caused by hypertrophy of and around the structures of the spine, and/or caused by the development of bone spurs. The resulting reduction or narrowing of the spinal canal and/or neural foramina may place pressure on the spinal column or nerve roots. When stenosis and neural compression occur in the lumbar spine, the individual may experience leg and/or back pain, neurological impairment, and neurogenic claudication.
- Degenerative disc disease (DDD) is a spine disorder resulting from the degeneration of the disc. The disc is comprised of 2 components. The outer rim is defined as the annulus and the inner area is the nucleus. Degeneration can be caused by a traumatic event or by the normal aging process. Discs are 80% water in youth and gradually dry out with age. As the nucleus dehydrates and shrinks, the load on the nucleus decreases while the load on the annulus increases. As the disc dehydrates, the annulus flattens and is susceptible to de-lamination and damage. Radial tears, cracks and fissures occur in the annulus and the nucleus may ultimately transgress through all the layers of the annulus, resulting in a disc herniation. Disc degeneration results in chronic low back pain. In DDD patients, the pain can be caused by abnormal motion of the segment from tearing of the annulus, loss of disc height, disc collapse and/or injury of the nucleus of the disc. DDD is diagnosed by radiographic diagnostic testing such as magnetic resonance imaging in conjunction with patient history and physical.

Initially patients with either spinal stenosis or DDD are treated with conservative care including physical therapy and pain management, which may include epidural injections.

Often these measures are sufficient; however, in those patients with more advanced disease where conservative care is not providing the desired relief, the patient may be a candidate for surgical decompression. Decompression is a surgical procedure which involves removal of the bone and/or tissue that is causing the pressure on the spinal cord or nerve root(s). Examples of common decompression procedures include laminotomy, laminectomy, discectomy, foraminotomy, and medial facetectomy. Depending on the extent of bone and tissue removed during the decompression procedure, the segment may be deemed unstable, and would therefore require stabilization. Patients who are candidates for concurrent stabilization include those who present with significant instability and those whose decompression surgery may cause the likelihood of instability.

Currently, stabilization is accomplished primarily with spinal fusion. Fusion of the spine is accomplished by means of a bone graft and implantable instrumentation designed to immobilize the spine until fusion is complete. The development of motion preservation technologies potentially allows for spine stabilization without the motion restriction imposed by fusion. Motion preservation technologies may be categorized into the following general areas:

- interspinous process devices
- pedicle screw dynamic stabilization systems
- facet replacement systems
- intervertebral disc replacements
- disc repair systems

Interspinous process, pedicle screw dynamic stabilization and facet replacement devices are placed in the posterior column of the lumbar spine. All are intended to provide earlier treatment options for patients without resorting to fusion. These technologies differ relative to when they are indicated in the continuum of care, as well as their design principles or mode of action.

Interspinous Process Devices:

Interspinous process devices are intended to treat leg pain secondary to lumbar stenosis or mechanical back pain due to a degenerative disc (DDD). In the continuum of care, these devices are intended to treat patients with earlier stage disease. These devices may be free-floating and act as a spacer between the spinous processes at of the vertebral bodies adjacent to the symptomatic level. The device may provide decompression, or a supplementary decompression procedure may be necessary.

The X-Stop™ device, manufactured by St. Francis Medical, received FDA approval in November 2005 and is now in commercial distribution for treatment of lumbar spinal stenosis. The ICD-9-CM procedure code that describes the procedure associated with the

technology (84.58) became effective October 2005. This interspinous process decompression device also provides decompression at the symptomatic level.

Other devices that allow for interspinous process spacing and motion are in commercial use outside of the United States and in clinical trial within the United States. Supplementary surgical decompression may be required with these technologies. Patients are currently being enrolled in FDA approved IDE clinical trials for two devices, the Wallis® device, manufactured by Abbott Spine, and the Coflex™ device, manufactured by Paradigm Spine. Other devices are in the development stage.

Pedicle Screw Dynamic Stabilization Systems:

Pedicle screw dynamic stabilization systems are intended for treatment of leg or back pain due to stenosis and/or spondylolisthesis. In the continuum of care, these devices are intended to treat mid-stage disease. These pedicle screw based systems provide posterior stabilization forces. The devices are designed to create a more normal loading pattern across the discs without loss of motion.

Various pedicle screw dynamic stabilization systems are under development. The Dynesys® System, manufactured by Zimmer Spine, completed enrollment in its FDA approved IDE study over one year ago. Follow-up on the study cohort is being completed. At least six additional Spine Task Force companies are developing pedicle screw dynamic stabilization systems, including the Stabilimax NZ™ System being developed by Applied Spine Technologies (formerly called the MBrace™).

Facet Replacement Systems:

Facet replacement devices are intended to treat leg/back pain due to stenosis or facet degeneration. In the continuum of care, these devices are intended to treat later stage disease. These devices replace facet joints, while retaining motion and may provide for some stability.

Various devices are under development. Two companies are currently enrolling in FDA approved IDE studies. The Total Facet Arthroplasty System™ (TFAS), manufactured by Archus Orthopedics, is an articulating joint prosthesis intended to provide stabilization as an adjunct to neural decompression with facetectomy. The Artificial Facet Replacement System™ (AFRS), manufactured by Facet Solutions, is also enrolling patients for its IDE study.

Other coding issues

The current code assignment for artificial discs and disc repairs were considered along with this proposal for motion preserving technologies. The recommendation for these procedures, code range 84.60-84.69 (Replacement of spinal disc), was to leave it unchanged.

Coding Options:

Option 1:

Continue to use existing code 84.59, Insertion of other spinal devices.

Option 2:

Delete current code, 84.58 Implantation of interspinous process decompression device. This procedure would be moved to a new code in the proposed new subcategory as described below. All of the interspinous process devices would be identified under one unique code.

Delete code	84.58 Implantation of interspinous process decompression device
Create new subcategory	84.8 Insertion, replacement and revision of posterior motion preservation spinal stabilization device(s) Dynamic stabilization device(s) Excludes: fusion of spine (81.00 – 81.08, 81.30-81.39) insertion of artificial disc prosthesis (84.60- (84.69) insertion of interbody spinal fusion device (84.51)
New code	84.80 Insertion or replacement of interspinous process device(s) Includes: surgical decompression (foraminotomy, laminectomy, laminotomy) performed at the same level Interspinous process distraction device(s) Interspinous process decompression device(s) Excludes: insertion or replacement of pedicle-based dynamic stabilization device (84.82) insertion or replacement of facet replacement device (84.84)
New code	84.81 Revision of interspinous process device(s) Repair of previously inserted interspinous process device(s) Excludes: revision of pedicle-based dynamic stabilization device (84.83) revision of facet replacement device(s) (84.85)

New code	<p>84.82 Insertion or replacement of pedicle-based dynamic stabilization device(s) Includes: surgical decompression (foraminotomy, laminotomy) at the same level</p> <p>Excludes: initial insertion of pedicle screws with spinal fusion – omit code insertion or replacement of facet replacement device(s) (84.84) insertion or replacement of interspinous process device(s) (84.80) replacement of pedicle screws used in spinal fusion (78.59)</p>
New code	<p>84.83 Revision of pedicle-based dynamic stabilization device(s) Repair of previously inserted pedicle-based dynamic stabilization device(s)</p> <p>Excludes: revision of facet replacement device(s) (84.85) revision of interspinous process device(s) (84.81)</p>
New code	<p>84.84 Insertion or replacement of facet replacement device(s) Includes any synchronous: facetectomy performed at the same level surgical decompression (foraminotomy, laminectomy, laminotomy) performed at the same level</p> <p>Facet arthroplasty</p> <p>Excludes: insertion or replacement of interspinous process device(s) (84.80) insertion or replacement of pedicle-based dynamic stabilization device(s) (84.82) replacement of pedicle screws used in spinal fusion (78.59)</p>
New code	<p>84.85 Revision of facet replacement device(s) Repair of previously inserted facet replacement device(s)</p> <p>Excludes: removal of pedicle screws used in spinal fusion (78.69) replacement of pedicle screws used in spinal fusion (78.59)</p>

revision of pedicle-based dynamic stabilization device(s) (84.83)

03.09 Other exploration and decompression of spinal canal

Decompression:

laminectomy

laminotomy

Expansile laminoplasty

Foraminotomy

Add exclusion term Excludes: that with insertion, replacement or revision of posterior spinal motion preservation device(s) at the same level (84.80-84.85)

Add inclusion term 78.6x Removal of implanted devices from bone
Removal of pedicle screw(s) used in spinal fusion

Add exclusion term Excludes: removal of posterior spinal motion preservation technologies (80.09)

Option 3:

3a. Retain code 84.58, Implantation of interspinous process decompression device. Keep proposed new subcategory 84.8 as described in Option 2 and modify the code titles to state *with surgical decompression* and *without surgical decompression*.

Example:

Insertion or replacement of interspinous process device(s) with surgical decompression

Insertion or replacement of interspinous process device(s) without surgical decompression

This option may address concerns voiced at previous meetings with confusion regarding the documentation and allow improved tracking of the various resources involved, as well as the outcomes.

3b. Delete code 84.58, Implantation of interspinous process decompression device. The procedure currently assigned to this code would be reassigned to the code descriptor *without surgical decompression* since the procedure currently does not require any surgical decompression.

For the removal of all these motion preserving technologies, use procedure code 80.09, Arthrotomy for removal of prosthesis, spine.

Recommendation:

CMS invites the audience to comment on this topic.

Interim coding :

Continue to use code 84.59, Insertion of other spinal devices.

Draft Addenda for March 2007

Tabular

Revise code title	00.18	Infusion of immunosuppressive antibody therapy during induction phase of solid organ transplantation
Add inclusion term		Includes: <u>during induction phase of solid organ transplantation</u>
Add inclusion term	33.26	Closed [percutaneous] [needle] biopsy of lung <u>Fine needle aspiration (FNA) of lung</u>
Add inclusion term		<u>Transthoracic needle biopsy of lung (TTNB)</u>
Add exclusion term		Excludes: <u>thoroscopic lung biopsy (33.20)</u>
Revise inclusion term	54	Other operations on abdominal region Includes: operations on: male pelvic cavity
Delete exclusion term		Excludes: female pelvic cavity (69.01-70.92)
Add code also note	80.0	Arthrotomy for removal of prosthesis Code also any: insertion of (cement) (joint) spacer (84.56) removal of (cement) (joint) spacer (84.57) <u>replacement or revision of joint (prosthesis) to specified site, if applicable</u>
Revise inclusion term	84.56	Insertion of (cement) spacer Insertion of joint <u>(methylnmethacrylate)</u> spacer
Revise inclusion term	84.57	Removal of (cement) spacer Removal of joint <u>(methylnmethacrylate)</u> spacer
Revise exclusion term	96.7	Other continuous mechanical ventilation Excludes: bi-level <u>positive</u> airway pressure [<u>BiPAP</u>] (93.90)

