



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
September 28 – September 29, 2006

Patricia E. Brooks
Co-Chairperson
September 28, 2006

9:00 AM ICD-9-CM Volume 3, Procedure presentations and public comments

Topics:

- | | |
|--|---|
| 1. SPY Intraoperative Fluorescence
Vascular Angiography
Pages 9-12 | Patricia E. Brooks
Bruce Ferguson, MD
East Carolina Heart Institute |
| 2. Thoracoscopic Procedures
Pages 13-14 | Joe Kelly, MD |
| 3. Pelvic Prolapse Repair
Pages 15-16 | Ann B. Fagan
Nicolette Horbach, MD
George Washington Univ. & Hosp.
Washington, DC |
| 4. Blood Brain Barrier Disruption
(BBBD) Chemotherapy
Pages 17-18 | Ann B. Fagan
David Peereboom, MD
Department of Solid Tumor
& the Brain Tumor Institute
Cleveland Clinic
Ohio |

5. Intracranial Monitoring
Pages 19-20

Amy L. Gruber
Karen March, RN, MN,
CNRN, CCRN
Integra NeuroSciences

Pradeep Narotam, MBChB, MMED,
FCS(SA), FRCSC
Creighton Univ. School of Medicine
Division of Neurosurgery

6. Implantation of Carotid Sinus Baroreflex
Activation Device
Pages 21-23

Amy L. Gruber
Luis A. Sanchez, MD
Washington Univ. School of Med.
St. Louis, MO

7. Motion Preserving Technologies
(Spine Devices)
Pages 24-30

Mady Hue
Bart Sachs, MD, MBA, CPE
Albany Medical College
Albany, New York

8. Addenda
Pages 31-32

Mady Hue

9. ICD-10 Procedure Coding System
(PCS) Update

Rhonda Butler
3M

Registering for the meeting:

Information on registering online to attend the meeting 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, Procedure Coding Issues:

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ICD-9-CM TIMELINE

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

March 23 – March 24 2006	ICD-9-CM Coordination and Maintenance Committee meeting.
June 2006	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 28, 2006	Deadline for requestors: Those members of the public requesting that topics be discussed at the September 28-29, 2006 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses by this date.
August 18, 2006	Hospital Inpatient Prospective Payment System final rule 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, 2006. This rule can be accessed at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp
August 2006	Tentative agenda for the Procedure part of the September 28 – 29, 2006 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 28 – 29, 2006 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 28 – 29, 2006 ICD-9-CM Coordination and Maintenance Committee

meeting will be published. This will include the tentative agenda.

September 17, 2006

Because of increased security requirements, those wishing to attend the September 28 - 29, 2006 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 17, 2006; failure to do so may result in lack of access to the meeting.

September 28 – 29, 2006

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 17, 2006**. You must bring an official form of picture identification (such as a drivers license) in order to be admitted to the building.

October 2006

Summary report of the Procedure part of the September 28-29, 2006 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 28-29, 2006 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, 2006

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 13, 2006

Deadline for receipt of public comments on proposed revisions discussed at September 28-29-, 2006 ICD-9-CM Coordination and Maintenance Committee meeting for implementation on April 1, 2007

- Early November 2006 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, 2007 will be posted on the following websites:
<http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes>
<http://www.cdc.gov/nchs/icd9.htm>
- December 4, 2006** **Deadline for receipt of public comments on proposed code revisions discussed at the September 28-29, 2006 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2007.**
- January 22, 2007 Deadline for requestors: Those members of the public requesting that topics be discussed at the March 22–March 23, 2007 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses by this date.
- February 2007 Draft agenda for the Procedure part of the March 22, 2007 ICD-9-CM Coordination and Maintenance Committee meeting posted on CMS homepage as follows:
<http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes>
- Draft agenda for the Diagnosis part of the March 23, 2007 ICD-9-CM Coordination and Maintenance Committee meeting posted on NCHS homepage as follows:
<http://www.cdc.gov/nchs/icd9.htm>
- Federal Register notice of March 22 – March 23, 2007 ICD-9-CM Coordination and Maintenance Committee Meeting will be published.
- February 22, 2007 On-line registration opens for the March 22 – 23, 2007 ICD-9-CM Coordination and Maintenance Committee meeting at: <http://www.cms.hhs.gov/events>
- March 16, 2007 Because of increased security requirements, **those wishing to attend the March 22 – March 23, 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 March 16, 2007; failure to do so may result in lack of access to the meeting.

March 22 – March 23
2007

ICD-9-CM Coordination and Maintenance Committee meeting.

April 1, 2007

Any new ICD-9-CM codes required to capture new technology will be implemented. Information on any new codes implemented on April 1, 2007 previously posted in early November 2006 will be on the following websites:
<http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes>
<http://www.cdc.gov/nchs/icd9.htm>
<http://www.cms.hhs.gov/MLNGenInfo>

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 Federal Register 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 bring an official form of picture identification (such as a drivers license) in order to be admitted to the building.

October 2007

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.

SPY Procedure - Intra-operative Fluorescence Vascular Angiography

Issue: SPY Intra-operative Fluorescence Vascular Angiography (or SPY angiography) is a new imaging technology used to test cardiac graft patency and technical adequacy at the time of coronary artery bypass grafting (CABG). While this system does not involve fluoroscopy or cardiac catheterization, it yields results that are similar to those achieved with selective coronary arteriography and cardiac catheterization. There is not a unique code for this new procedure.

New Technology?

No

FDA Approval: Novadaq received 510(k) clearance for the SPY Intra-operative Imaging System from the U.S. Food and Drug Administration on January 19, 2005 and is currently in process of additional submissions.

Background:

The SPY Intra-operative fluorescence vascular angiography procedure allows for the real time evaluation of the coronary vasculature and the cardiac chambers during coronary artery bypass graft procedures, and it is particularly useful in assessing the quality of vascular anastomoses and bypass graft patency. Unlike conventional angiography, the SPY procedure can be performed quickly, usually in less than eight minutes, thus not adding appreciably to the length of the procedure, and it does not require the introduction of potentially harmful contrast dye.

The SPY images are generated from the fluorescence excitation of indocyanine green (IC-Green™) dye that is injected into the bloodstream via an existing central venous catheter, or into the cardiopulmonary bypass circuit. The IC-Green™ rapidly binds to plasma proteins in blood when injected into the bloodstream and is confined to the intravascular compartment. Intra-operative fluorescence imaging uses the fluorescent properties of indocyanine green (IC-G) dye and an 806 nm laser diode as a monochromatic light source. The IC-Green™ fluoresces when illuminated at 806 nm with the laser light source and emits light of a longer wavelength at 830 nm.

This fluorescence is captured on a charge coupled device (CCD) video camera at 30 frames per second. One vessel is imaged at a time as the camera is positioned over the coronary vessel of interest and displayed for review on an LCD monitor. Prior to performing the coronary bypass grafting procedure to that vessel, SPY arteriography is performed to locate and assess target vessel quality, size and function. After completion of the coronary bypass graft, SPY arteriography is performed to assess graft patency, the quality of the anastomosis and the quality of distal perfusion. SPY arteriography is suitable for both on and off pump coronary artery bypass grafting.

Since most patients referred for CABG today undergo multi-vessel bypass grafting, the use of the SPY Intra-operative Imaging system (SPY) would be as follows for a typical 3-vessel bypass procedure. The mobile device is brought to the operating room by the circulating nurse. The device is turned on and the software user interface is activated. The laser key is placed in the ready position and the circulating nurse enters patient data. One (1 x 25 mg) vial of IC-Green™ is reconstituted with one (1 x 10 ml) ampule of sterile aqueous solvent by the Anesthesiologist and drawn to several 1.0 ml syringes (one for each anticipated image sequence, typically 6 syringes). In addition, an equal number of 10.0 ml syringes of normal saline are prepared. For administration of IC-Green™ via the central venous line a two way stopcock is prepared to be used to deliver the IC-Green™ and saline bolus flush. The circulator and scrub nurse place a sterile drape over the imaging camera head and arm and position the mobile imaging device within 3 feet of the surgical field ensuring that the IR Led control switch is on and that a real time image is displayed on the monitor. To begin the image sequence, the surgeon positions the heart to optimize visualization of the bypass graft and vascular bed of interest. He/she then positions the SPY imaging camera 12” from the heart, angled within $\pm 10^\circ$ of parallel to the selected vessel, and focuses the camera. By reviewing the digital image display and status indicators on the LCD monitor, the surgeon ensures that the captured image will include the anastomotic site, the bypass graft, perfusion distal to the anastomosis, and the target microvascular coronary bed. Once the appropriate view of the heart and selected vessel has been obtained, and after ensuring that the laser safety button is in the *OUT* position, the IR light is turned off and the surgical lights are turned away to create a dark field. The surgeon coordinates: 1) with the anesthesiologist for the appropriately-timed tight bolus injection of 1.0 ml IC-Green™ followed by a rapid flush of 10.0 ml saline into the central venous system; and 2) with the circulating nurse to activate image capture on the device. Upon initiation of image capture, the laser is activated and the fluorescence is captured in 34s of cine and available for instant review.

The circulator will enter comments to label the image sequence and save the data to the device hard drive. The surgeon reviews the sequence playback on the monitor, making use of a number of playback features to aid in interpretation including variable frame rate, single frame advance, and reverse mode; typically the circulator will operate the review sequence playback features of the SPY device at the surgeon’s direction. The surgeon’s review will include visual assessment of: 1) the flow through the vessel, including evaluation of the presence and rate of signal filling and dissipation; 2) the run-off in the native coronary artery; 3) a determination that a blockage or lesion is or is not in the flow path; 4) a determination that a kink, twist or spasm is or is not present in the graft. Because the ICG dye is non-toxic, if these determinations are not clear the surgeon can immediately re-image to confirm the findings, and may use a different camera angle or heart position if the image does not correlate with the epicardial coronary anatomy, If the quality of the graft is still not clear, surgical revision of the graft would then be considered, after which the above process is repeated.

This imaging sequence is repeated for each graft placed during the CABG procedure. Images can readily be obtained regardless of whether the patient is operated upon with a

conventional cardiopulmonary bypass supported approach or done as an off pump coronary artery bypass (OPCAB) procedure. Prior to closing the chest, a final image of the grafts encompassing the proximal anastomoses is typically performed. This image evaluates all of the grafts with the heart in its normal anatomic position. The same visual assessment described above is conducted, to confirm that the bypass grafts are not kinked, twisted or stretched in their natural anatomic position. If there are no abnormalities noted and the image indicates a technically adequate result, the surgeon confirms that the assessment process is complete. Saved image sequences are archived in DICOM media format and a procedure report is dictated describing results of each injection and image sequence for each coronary vessel evaluated. The device is de-draped, powered off and removed to storage.

Performance of this procedure requires specific equipment and specialized training for proficiency. The average time for completion of this procedure is 2-3 minutes per graft for an average of 8-10 minutes total added to the Coronary Artery Bypass Grafting procedure.

Current Code Assignment: The SPY Intra-operative fluorescence vascular angiography is currently captured by code 88.90, Diagnostic imaging, not elsewhere classified. This advice was published in Second Quarter 2006 Coding Clinic, page 17.

Coding Options:

Option 1: Continue capturing SPY Intra-operative fluorescence vascular angiography under code 88.90. Do not create a new code for this procedure.

Option 2: Create a new ICD-9-CM code as follow:

New Code: 88.99 Intra-operative fluorescence vascular angiography using SPY technique

Intraoperative laser arteriogram (SPY)

SPY angiography

SPY arteriogram

88.55 Coronary arteriography using a single catheter
Add exclusion term Excludes: SPY angiography (88.99)

88.57 Other and unspecified coronary arteriography
Add exclusion term Excludes: SPY angiography (88.99)

Option 3: Create a new ICD-9-CM code as follow:

New Code: 88.59 Intra-operative fluorescence vascular angiography using SPY technique

Intraoperative laser arteriogram (SPY)
SPY angiography
SPY arteriogram

88.56 Coronary arteriography using a single catheter
Add exclusion term Excludes: SPY angiography (88.59)

88.57 Other and unspecified coronary arteriography
Add exclusion term Excludes: SPY angiography (88.59)

Recommendations:

CMS recommends option 3; create new code 88.59, Intra- operative fluorescence vascular angiography using SPY technique. In the meantime, continue capturing this procedure through code 88.90, Diagnostic imaging, not elsewhere classified.

Thoracoscopic Procedures

Issue:

A number of diagnostic and therapeutic procedures on tissues of the lung and pleura do not have discrete ICD-9-CM procedure codes to identify the thoracoscopic approach.

New Technology?

No.

Background:

As momentum gains and advances are made for less invasive surgical procedures it has become apparent that consideration should be given for separate codes to describe a number of procedures that can be performed through a thoracoscope. A thoracoscope is a type of endoscope, or flexible fiberoptic tube, which is inserted into the thorax through a small incision while the tissues it encounters are visualized directly. Surgical tasks such as cutting and suturing can also be accomplished through the thoracoscope, thus enabling a number of procedures to be performed without opening the chest.

Current Coding:

- 32.4 Lobectomy of lung
- 33.26 Closed (percutaneous) (needle) biopsy of lung
- 34.04 Insertion of intercostal catheter for drainage
- 34.24 Pleural biopsy
- 34.51 Decortication of lung

Coding Options:

Option 1

Continue to use the current codes listed above; do not create new codes to describe the thoracoscopic approach.

Option 2

Create new thoracoscopy codes as follows:

- | | |
|----------|--|
| New code | 33.20 Thoracoscopic lung biopsy
Excludes: open biopsy of lung (33.28) |
|----------|--|

New code	34.52 Thoracoscopic decortication of lung
Add exclusion term	34.51 Decortication of lung Excludes: <u>thoracoscopic decortication of lung (34.52)</u>
Create new subcategory	32.4 Lobectomy of lung
New code	32.41 Thoracoscopic lobectomy of lung
New code	32.49 Other lobectomy of lung Excludes: thoracoscopic lobectomy of lung (32.41)
New code	34.20 Thoracoscopic pleural biopsy
Revise code title Add exclusion term	34.24 <u>Other</u> pleural biopsy Excludes: <u>thoracoscopic pleural biopsy (34.20)</u>
New code	34.06 Thoracoscopic drainage of pleural cavity
Add exclusion term	34.04 Insertion of intercostal catheter for drainage Excludes: <u>thoracoscopic drainage of pleural cavity (34.06)</u>

CMS Recommendation:

CMS recommends option 2, creating new thoracoscopy codes, as listed above.

Pelvic Prolapse Repair Procedures Involving Graft or Prosthesis

Issue:

There are no ICD-9-CM procedure codes which describe pelvic prolapse repair using grafts or prosthetic agents.

New Technology Application?

No.

FDA Approval:

Not applicable in this setting. The prosthetic components of this surgery come from a variety of manufacturers, have been previously approved for use, and are recognized as safe and effective.

Background:

The ICD-9-CM procedure coding system includes specific codes for pelvic prolapse repair procedures, defined as restorative surgical procedures. The repair consists of surgical techniques that use the patient's endogenous support structures.

However, the system does not currently contain codes that describe and differentiate the unique procedures which involve a surgical approach for pelvic prolapse repair procedures that are compensatory in nature. Specifically, appropriate codes do not exist for procedures which use some type of graft or prosthesis, including synthetic, allogenic, xenogenic, or autologous materials to replace and support deficient native vaginal wall and pelvic tissues.

This coding change would mimic the specificity found in coding for hernia repair. The hernia codes describing the use of graft or prosthesis date from the origination of ICD-9 in 1979. Due to advances in medical practice, this technology and level of detail can be ascribed to pelvic prolapse repair procedures as well.

Current Coding Structure:

Pelvic prolapse repair procedures can currently be captured using the following codes:

70.50, Repair of cystocele and rectocele

70.51, Repair of cystocele

70.52, Repair of rectocele

70.61, Vaginal construction

70.62, Vaginal reconstruction

70.77, Vaginal suspension and fixation

70.92, Other operations on cul-de-sac (repair of vaginal enterocele)

Coding Options:

Option 1:

Do not create new codes for the repair of pelvic prolapse using grafts or prostheses to replace deficient native vaginal wall or pelvic tissues. Continue to use the above codes to describe these procedures.

Option 2:

Develop new codes to identify those pelvic prolapse repair procedures utilizing grafts or prostheses to replace the function of native tissues.

	70.5	Repair of cystocele and rectocele
New code	70.53	Repair of cystocele and rectocele with graft or prosthesis
New code	70.54	Repair of cystocele with graft or prosthesis Anterior colporrhaphy (with urethrocele repair)
New code	70.55	Repair of rectocele with graft or prosthesis Posterior colporrhaphy
	70.6	Vaginal construction and reconstruction
New code	70.63	Vaginal construction with graft or prosthesis
	70.64	Vaginal reconstruction with graft or prosthesis
	70.7	Other repair of vagina
	70.78	Vaginal suspension and fixation with graft or prosthesis
	70.9	Other operations on vagina and cul-de-sac
	70.93	Other operations on cul-de-sac with graft or prosthesis Repair of vaginal enterocele with graft or prosthesis

Recommendation:

These suggested coding additions fit neatly into the existing coding structure. CMS recommends that coding option 2, as described above, be adopted for use beginning October 1, 2006.

Interim Coding:

As unique codes do not exist which specifically describe repair procedures using graft or prosthesis, continue to use existing codes to describe pelvic prolapse repair.

Blood Brain Barrier Disruption (BBBD) Chemotherapy

Issue:

There is no unique ICD-9-CM procedure code describing disruption of the blood brain barrier.

New Technology Application?

No

FDA Approval:

Not applicable in this situation. The substance used to disrupt the blood brain barrier, mannitol in solution, has previously been approved for use.

Coverage:

CMS currently has a National Coverage Analysis (NCA) underway to determine if BBBD chemotherapy is reasonable and necessary for Medicare beneficiaries. The NCA tracking sheet can be accessed at:

<http://www.cms.hhs.gov/mcd/viewtrackingsheet.asp?id=188>

Background:

Brain tumors, including both primary brain tumors and metastases, are diagnosed in almost 200,000 patients in the United States each year. While surgery and radiation therapy can be quite helpful for these patients, invariably these tumors recur. Chemotherapy, therefore, has been employed in an effort to improve the survival for patients with central nervous system (CNS) malignancies. A substantial impediment to the delivery of chemotherapy to brain tumors is the blood brain barrier (BBB). The BBB is the lining of the small blood vessels in the brain which prevents many substances such as toxins or drugs from entering the brain. Because most chemotherapy drugs do not cross the BBB very well, patients in effect receive inadequate doses of chemotherapy to their brain tumors via conventional medication delivery methods – oral or intravenous.

One method that has been developed for improved delivery of drugs to the CNS is to disrupt the BBB and infuse chemotherapy into one of the arteries leading into the brain. With this technique, it is possible to deliver five to 10 times the concentration of the drug into the brain. For certain malignancies, notably CNS lymphoma, chemotherapy with BBBD has allowed patients to forego the need for whole brain radiation therapy. Unlike other brain tumors, CNS lymphoma involves the whole brain and is, therefore, not amenable to surgery. Whole brain radiation therapy with CNS lymphomas carries a risk of treatment-related dementia that can exceed 50 percent. Intra-arterial chemotherapy with BBBD has long-term survival (five-year survival is over 40%) equal to or better than radiotherapy, but without the risk of neurotoxicity.

Technique:

The patient is taken to the operating room or the interventional radiology suite and is given general anesthesia. A catheter is placed in the femoral artery and advanced to the carotid or vertebral artery – both of which supply blood to the brain. A solution of

mannitol is then administered into the artery. This agent opens the blood brain barrier. Shortly thereafter, chemotherapy is infused into the same artery. Within a few hours, the BBB closes again. The procedure is repeated the following day with BBBD and chemotherapy. This time, however, the chemotherapy is administered into a different artery of the brain in order to deliver the chemotherapy to a different area of the brain. The patient is usually discharged from the hospital the next day.

The intent of this procedure is to increase the delivery of drug(s) to the brain. Some side effects such as damage to the arteries are specific to this procedure; they are rare and much less common than radiation-related neurotoxicity. The common side effects are typical of those seen with chemotherapy given intravenously.

Coding Options:

Option 1:

Do not create a new code for mannitol infusion. Continue to use code 99.29, Injection or infusion or other therapeutic or prophylactic substance, for the mannitol in solution.

Option 2:

Create a new code as follows:

00 Procedures and interventions, not elsewhere classified
00.1 Pharmaceuticals

New code 00.19 Selective intracerebral arterial infusion
BBBD
Disruption of blood brain barrier
Infusion of substance to disrupt blood brain barrier
Mannitol infusion

Excludes: Other perfusion (39.97)

Recommendation:

CMS recommends option 2.

Interim Coding:

Continue to use code 99.29, Injection or infusion or other therapeutic or prophylactic substance, for the infusion of mannitol in solution.

Intracranial Monitoring

Issue: ICD-9-CM captures intracranial pressure, intracranial oxygen and brain temperature monitoring using procedure code 01.18, Other diagnostic procedures on brain and cerebral meninges. Should new codes be created to differentiate the intracranial pressure, intracranial oxygen and brain temperature monitoring from other procedures assigned to code 01.18?

New Technology Application?

No.

FDA Approval:

Not applicable in this setting. Monitoring devices have been approved for use, and are recognized as safe and effective.

Background:

Intracranial pressure, intracranial oxygen, and brain temperature monitoring devices are used in University teaching centers and community hospitals in the management of traumatic brain injury, cerebrovascular injury and other brain disorders that produce increased intracranial pressure with subsequent decrease in brain tissue oxygenation levels. It is useful to be able to track the use and outcomes associated with these new technological advances to improve the quality of care of the patients we serve. A uniform method to accurately report the use of these monitoring devices would greatly improve the data collected from the medical records and report the impact on patient outcomes. The Brain Trauma Foundation (BTF) develops national guidelines for best practice based on scientific evidence and performs national surveys of U.S. trauma centers every five years to determine best practices. In the treatment of patients with traumatic brain injuries, intracranial pressure and brain tissue oxygen monitoring is recommended in the BTF guidelines because there is evidence that this data has prognostic value and improves patient outcomes.

Options:

Option 1: Continue to code intracranial pressure, intracranial oxygen and brain temperature monitoring to code 01.18, Other diagnostic procedures on brain and cerebral meninges.

Option 2. BTF has requested 4 new codes to capture the sites of catheter insertions and 5 codes to identify various monitoring parameters.

New category 02.2 Insertion of catheter for monitoring or Drainage of CSF (bolted or tunneled)

New code 02.20 Ventriculostomy

New code 02.21 Frontal horn of lateral ventricle for monitoring

New code 02.22 Parenchyma

New code 02.23 Subdural space

New code 02.24 Epidural space

New category to identify parameter monitoring:

- xx.xx Intracranial pressure (ICP)
- xx.xx Partial pressure of brain oxygen (PbtO₂)
- xx.xx Brain temperature
- xx.xx Cerebral blood flow (CBF)
- xx.xx Brain metabolism (Microdialysis)

Option 3: Create three new codes for intracranial pressure monitoring, intracranial oxygen monitoring, and brain temperature monitoring under category 01.1, Diagnostic procedures on skull, brain, and cerebral meninges. Add exclusion terms under code 01.18, Other diagnostic procedures on brain and cerebral meninges.

- New code 01.10 Intracranial pressure monitoring
Includes: insertion of catheter or probe for monitoring
- New code 01.16 Intracranial oxygen monitoring
Includes: insertion of catheter or probe for monitoring
Partial pressure of brain oxygen (PbtO₂)
- New code 01.17 Brain temperature monitoring
Includes: insertion of catheter or probe for monitoring

CMS' Recommendation:

Option 3: Create three new codes for intracranial pressure monitoring, intracranial oxygen monitoring, and brain temperature monitoring under category 01.1, Diagnostic procedures on skull, brain, and cerebral meninges. Add exclusion terms under code 01.18, Other diagnostic procedures on brain and cerebral meninges.

- New code 01.10 Intracranial pressure monitoring
Includes: insertion of catheter or probe for monitoring
- New code 01.16 Intracranial oxygen monitoring
Includes: insertion of catheter or probe for monitoring
Partial pressure of brain oxygen (PbtO₂)
- New code 01.17 Brain temperature monitoring
Includes: insertion of catheter or probe for monitoring

Interim Coding:

Continue to code intracranial pressure monitoring, intracranial oxygen monitoring, and brain temperature monitoring to code 01.18, Other diagnostic procedures on brain and cerebral meninges.

Implantation of Carotid Sinus Baroreflex Activation Device

Issue: Should a new ICD-9-CM procedure code be created for implantation of a carotid sinus stimulator that activates the baroreflex?

New Technology Application?

No.

FDA Approval:

The Rheos™ carotid sinus baroreflex activation device, developed by CVRx, Inc., has been implanted in 27 patients in Europe since 2004 and in 13 patients in the US since the beginning of the Category B Investigational Device Exemption (IDE) clinical trial in 2005. The device was submitted for a phase III IDE clinical trial in August 2006.

Background:

The Rheos Baroreflex Activating System™ is an implantable medical device designed to electrically activate the baroreflex. The Rheos System™ is currently under clinical investigation as a treatment for resistant hypertension. Implantation of the Rheos System™ is currently the only surgical procedure that implants a medical device to treat patients with hypertension. This system contains one implantable pulse generator, bilateral carotid sinus leads and one computer programming system. It is intended to work by electrically activating the baroreflex, the system that regulates blood pressure. When activated by the Rheos System™, signals are sent to the brain and are interpreted as a rise in blood pressure. The brain works to counteract this perceived rise by dilating blood vessels to allow blood to flow more freely, reducing the heart rate and influencing fluid handling by the kidneys. In this way, the Rheos System™ provides a physiologically rational approach to reducing high blood pressure by allowing the brain to use the body's own control mechanisms. Reduction in blood pressure is associated with a reduction in the risk of stroke, heart attack, heart failure, kidney disease and other disorders.

The Rheos™ implantable pulse generator provides control and delivery of the activation energy through the carotid sinus leads. The leads conduct activation energy from the implantable pulse generator to the left and right carotid sinus, which are two main blood pressure control points. The programmer system provides the ability to non-invasively communicate with the pulse generator.

A surgical implant procedure is used to place the pulse generator in a subcutaneous pocket in the pectoral region below the collarbone. The electrodes are placed bilaterally on the carotid sinuses and the leads run under the skin and are connected to the pulse generator in the chest. The procedure is performed in the hospital inpatient department under general anesthesia and takes approximately 2 - 4 hours to complete. The Rheos™ implant is not expected to compromise the patient's anatomy. It is removable and revisable.

Potential risks of chronic device-based baroreflex hypertension therapy include:

- Hypotension – a decrease in systolic and diastolic blood pressure below normal that could potential result in dizziness, fainting, and/or falls
- Stimulation of extravascular tissues – any event that results in localized tissue/nerve stimulation (muscle twitching, hoarseness, pain, tingling, oral sensations) that would not otherwise occur
- Stimulation of cranial nerves – any event that results in cranial nerve activity that would not otherwise occur
- Vascular injury including carotid artery rupture – injury that results in the lack of integrity of the vessel wall leading to hemorrhage

Additionally, patients receiving the carotid sinus baroreflex activation device will be exposed to operative and post-operative risks similar to related surgical procedures involving the neck and medical device implantation.

Options:

Option 1. Continue to code the implantation of carotid sinus baroreflex activation device to procedure codes: 39.8, Operations on carotid body and other vascular bodies, 04.92, Implantation or replacement of peripheral neurostimulator lead(s) and 86.96, Insertion or replacement of other neurostimulator pulse generator.

Option 2. Code this procedure to code 39.8, Operations on carotid body and other vascular bodies. Revise the code title and add inclusion terms under code 39.8.

Revise code title 39.8 Operations on carotid body, carotid sinus and other vascular bodies

Add inclusion term Implantation or replacement of carotid sinus baroreflex activation device

Add inclusion term Removal of carotid sinus baroreflex activation device

Option 3. Create new procedure codes to uniquely capture the implantation or replacement, or removal of carotid sinus baroreflex activation device.

New category 39.8 Operations on carotid body, carotid sinus and other vascular bodies

New code 39.81 Implantation or replacement of carotid sinus baroreflex activation device, total system
Implantation of carotid sinus stimulator and lead(s)
Includes: bilateral carotid explorations

Excludes: implantation or replacement of carotid sinus lead(s) only (39.82)
implantation or replacement of carotid sinus pulse generator only (39.83)

New code	39.82	Implantation or replacement of carotid sinus lead(s) only Excludes: implantation or replacement of carotid sinus baroreflex activation device, total system (39.81)
New code	39.83	Implantation or replacement of carotid sinus pulse generator only Excludes: implantation or replacement of carotid sinus baroreflex activation device, total system (39.81)
New code	39.84	Removal of carotid sinus baroreflex activation device, total system
New code	39.89	Other operations on carotid body, carotid sinus and other vascular bodies Chemodectomy Denervation of: aortic body carotid body Glomectomy, carotid Excludes: excision of glomus jugulare (20.51)

CMS' Recommendation:

CMS would like to have input from the attendees on this topic.

Interim Coding:

Continue to code the implantation of carotid sinus baroreflex activation device to procedure codes: 39.8, Operations on carotid body and other vascular bodies, 04.92, Implantation or replacement of peripheral neurostimulator lead(s) and 86.96, Insertion or replacement of other neurostimulator pulse generator. Code the removal of carotid sinus baroreflex activation device to codes 39.8, Operations on carotid body and other vascular bodies.

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:

Create new subcategory

84.8 Insertion, replacement and revision of posterior motion preservation spinal stabilization device(s)

Includes: insertion of dynamic stabilization device(s)
insertion of motion preservation 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)

Code also any synchronous surgical decompression
(03.03 – 03.04)

Excludes: implantation of interspinous process
decompression device (84.58)
insertion or replacement of pedicle screw
based dynamic stabilization device or
system (84.82)

New code

84.81 Revision or removal of interspinous process device or
interspinous process decompression device(s)

Excludes: revision or removal of pedicle screw based
dynamic stabilization device or system (84.83)

New code

84.82 Insertion or replacement of pedicle screw based dynamic
stabilization device or system

Code also any synchronous surgical decompression
(03.03 – 03.04)

Excludes: insertion of pedicle screws with spinal fusion
pedicle screw based facet replacement systems

New code	84.83 Revision or removal of pedicle screw based dynamic stabilization device or system Excludes: removal of implanted devices from bone (78.69)
New code	84.84 Insertion of facet replacement device(s) Code also any: partial facetectomy (77.89) synchronous posterior surgical decompression (03.04) total facetectomy (77.99)
New code	84.85 Revision or removal of facet replacement device(s)
Add exclusion term	84.58 Implantation of interspinous process decompression device Excludes: insertion of pedicle screw based dynamic stabilization device or system (84.82) insertion or replacement of interspinous process device (84.80)
New code	03.03 Anterior surgical decompression of spinal canal Retroperitoneal approach Transabdominal approach
New code	03.04 Posterior surgical decompression of spinal canal Decompression: Laminectomy Laminotomy Expansile laminoplasty Foraminotomy
Revise code title Delete inclusion term	03.09 Other exploration and decompression of spinal canal Decompression: Laminectomy Laminotomy Expansile laminoplasty Foraminotomy
<u>Option 3:</u> Create new subcategory	84.8 Insertion, replacement and revision of posterior motion preservation spinal stabilization device(s)

Includes: insertion of dynamic stabilization device(s)
insertion of motion preservation 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)

Code also any synchronous surgical decompression
(03.03 – 03.04)

Excludes: implantation of interspinous process
decompression device (84.58)
insertion or replacement of pedicle screw
based dynamic stabilization device or
system (84.82)

New code 84.81 Revision of interspinous process device or
interspinous process decompression device(s)
Excludes: revision of pedicle screw based
dynamic stabilization device or system (84.83)

New code 84.82 Insertion or replacement of pedicle screw based dynamic
stabilization device or system

Code also any synchronous surgical decompression
(03.03 – 03.04)

Excludes: insertion of pedicle screws with spinal fusion
pedicle screw based facet replacement systems

New code 84.83 Revision of pedicle screw based dynamic
stabilization device or system
Excludes: removal of implanted devices from bone
(78.69)

New code 84.84 Insertion of facet replacement device(s)

Code also any:
partial facetectomy (77.89)
synchronous posterior surgical decompression (03.04)
total facetectomy (77.99)

New code	84.85 Revision of facet replacement device(s)
	84.58 Implantation of interspinous process decompression device
Add exclusion term	Excludes: insertion of pedicle screw based dynamic stabilization device or system (84.82) insertion or replacement of interspinous process device (84.80)
New code	03.03 Anterior surgical decompression of spinal canal Retroperitoneal approach Transabdominal approach
New code	03.04 Posterior surgical decompression of spinal canal Decompression: Laminectomy Laminotomy Expansile laminoplasty Foraminotomy
Revise code title Delete inclusion term	03.09 Other exploration and decompression of spinal canal Decompression: Laminectomy Laminotomy Expansile laminoplasty Foraminotomy

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

Recommendation:

CMS recommends option 3, as stated above.

Interim coding :

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

Addenda

Tabular

Revise code title	00.55 Insertion of drug-eluting peripheral <u>non-coronary</u> vessel stent(s)
Revise code title	00.74 Hip replacement bearing surface, metal-on-polyethylene
Revise code title	00.75 Hip replacement bearing surface, metal-on-metal
Revise code title	00.76 Hip replacement bearing surface, ceramic-on-ceramic
Revise code title	00.77 Hip replacement bearing surface, ceramic-on-polyethylene
	20.99 Other operations on middle and inner ear
Add inclusion term	<u>Attachment of percutaneous abutment (screw) for prosthetic device</u>
	39.8 Operations on carotid body and other vascular bodies
Delete inclusion term	Implantation into carotid body:
Delete inclusion term	Electronic stimulator
Delete inclusion term	Pacemaker
Revise code title	39.90 Insertion of non-drug-eluting peripheral <u>non-coronary</u> vessel stent(s)
Revise code title	53.41 Repair of umbilical hernia with <u>graft or prosthesis</u>
Revise code title	53.61 Incisional hernia repair with <u>graft or prosthesis</u>
Revise code title	53.69 Repair of other hernia of anterior abdominal wall with <u>graft or prosthesis</u>
	81.0 Spinal fusion [0-8]
Add code also note	<u>Code also any synchronous excision of (locally) harvested bone for graft (77.70-77.79)</u>
	81.3 Refusion of spine [0-9]
Add code also note	<u>Code also any synchronous excision of (locally) harvested bone for graft (77.70-77.79)</u>
	81.5 Joint replacement of lower extremity Includes:

Delete inclusion term	removal of cement spacer
	81.51 Total hip replacement
Revise code also note	Code also any type of bearing surface, if known (00.74-00.767)
	81.52 Partial hip replacement
Revise code also note	Code also any type of bearing surface, if known (00.74-00.767)
	81.53 Revision of hip replacement, not otherwise specified
Revise code also note	Code also any type of bearing surface, if known (00.74-00.767)
	97.49 Removal of other device from thorax
Add exclusion term	Excludes: <u>Endoscopic removal of bronchial device(s) or substances (33.78)</u>
	98.15 Removal of intraluminal foreign body from trachea and bronchus without incision
Add exclusion term	Excludes: <u>Endoscopic removal of bronchial device(s) or substances (33.78)</u>
	99.14 Injection <u>or infusion</u> of gamma globulin

Index

Revise term	Bearing surface, hip replacement ceramic-on-ceramic 00.76
Delete subterm	Nailing, intramedullary – see Reduction, fracture with internal fixation
	Reformation cardioverter/defibrillator (automatic) pocket, new site (skin) (subcutaneous) 37.99 37.79
Revise subterm	

ICD-10-PCS 2007 Version Options

Option 1: Current Format

- Same as 2006 version—dozens of separate pdf files
 - Separate ‘master menu’ hyperlink page
 - Separate hyperlinks to Tables and Index

Option 2: Three File Basic

- Three separate files—Med/Surg and related, Ancillary Sections, Index
 - Single level of bookmarks within files

Option 3: One File Linked

- Hyperlinks generated within pdf, simplifies file download
 - Master hyperlink page
 - Nested bookmarks at front of Tables
 - Hyperlinks from each Index entry to individual table