



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 29 – September 30, 2005

Patricia E. Brooks
Co-Chairperson
September 29, 2005

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

- | | |
|--|--|
| 1. Insertion of Spinal
Stabilization Device
Pages 8-10 | Amy L. Gruber
Hansen Yaun, MD
Upstate Medical Center
Syracuse, NY |
| 2. Implantable Hemodynamic Monitor
Pages 11-12 | Amy L. Gruber
Jamie Beth Conti, MD
University of Florida |
| 3. Laparoscopic Hysterectomy
Pages 13-16 | Mady Hue |
| 4. Computerized External Fracture
Fixation
Pages 17-19 | Ann B. Fagan
Dror Paley, MD
Sinai Hospital
Baltimore, MD |

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|---|--|
| 5. Bifurcated Vessel Procedure
Pages 20-21 | Ann B. Fagan
David Rizik, MD
Scottsdale Healthcare- Shea |
| 6. Endovascular Mechanical
Thrombectomy of Pre-Cerebral
and Cerebral Vessels
Pages 22-23 | Ann B. Fagan
Gary R. Duckwiler, MD
UCLA |
| 7. Cardiac Electrophysiology Studies
Pages 24-27 | Joe Kelly, M.D. |
| 8. Addenda
Pages 28-32 | Mady Hue |
| 9. Availability of ICD-9-CM
Pages 33-34 | Patricia E. Brooks |
| 10. ICD-10 Procedure Classification 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/paymentsystems/icd9/>

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

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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/paymentsystems/icd9/>

A summary of the diagnosis part of the meeting held on September 30 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:

October 15, 2004	CMS implemented a new online registration process for future ICD-9-CM Coordination and Maintenance Committee (C&M) meetings. Information on future C&M meetings will be posted on the CMS events webpage at: http://www.cms.hhs.gov/events/ A link will be established from the ICD-9-CM web page at: http://www.cms.hhs.gov/paymentsystems/icd9
July 29, 2005	Deadline for requestors: Those members of the public requesting that topics be discussed at the September 29-30, 2005 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses by this date.
August 12, 2005	Hospital Inpatient Prospective Payment System final rule published in the Federal Register as mandated by Public Law 99-509. The rule can be accessed at: http://www.cms.hhs.gov/providers/hipps/frnotices.asp
August 2005	Draft agenda for the Procedure part of the September 29, 2005 ICD-9-CM Coordination and Maintenance Committee meeting posted on CMS homepage as follows: http://www.cms.hhs.gov/paymentsystems/icd9 Draft agenda for the Diagnosis part of the September 30, 2005 ICD-9-CM Coordination and Maintenance Committee meeting posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
September 2005	Because of increased security requirements, those wishing to attend the September 29 – 30, 2005 ICD-9-CM Coordination and Maintenance Committee meeting must register for the meeting online at: http://www.cms.hhs.gov/events/ Attendees must register online by September 23, 2005; failure to do so may result in lack of access to the meeting.

September 29-30, 2005	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 23, 2005. You must bring an official form of picture identification (such as a drivers license) in order to be admitted to the building.
October 1, 2005	New ICD-9-CM codes are implemented.
October 15, 2005	Deadline for receipt of public comments on proposed code revisions discussed at the September 29-30, 2005 ICD-9-CM Coordination and Maintenance Committee meeting for implementation on April 1, 2006 to capture new technology.
October 2005	Summary report of the Procedure part of the September 29, 2005 ICD-9-CM Coordination and Maintenance Committee meeting posted on CMS homepage at - http://www.cms.hhs.gov/paymentsystems/icd9 Summary report of the Diagnosis part of the September 30, 2005 ICD-9-CM Coordination and Maintenance Committee meeting report posted on NCHS homepage at - http://www.cdc.gov/nchs/icd9.htm
Early Nov. 2005	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 on April 1, 2006 will be posted on the following websites: http://www.cms.hhs.gov/paymentsystems/icd9 http://www.cdc.gov/nchs/icd9.htm http://www.cms.hhs.gov/medlearn/icd9code.asp
December 2, 2005	Deadline for receipt of public comments on proposed code revisions discussed at the September 29-30, 2005 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2006.
January 3, 2006	On-line registration opens for the March 23 – 24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting at: http://www.cms.hhs.gov/events/
January 23, 2006	Deadline for requestors: Those members of the public requesting that topics be discussed at the March 23 –March 24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting must have

their requests to CMS for procedures and NCHS for diagnoses by this date.

February 2006

Draft agenda for the Procedure part of the March 23, 2006 ICD-9-CM Coordination and Maintenance Committee meeting posted on CMS homepage as follows:

<http://www.cms.hhs.gov/paymentsystems/icd9>

Draft agenda for the Diagnosis part of the March 24, 2006 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 23 – March 24, 2006 ICD-9-CM Coordination and Maintenance Committee Meeting will be published.

March 17, 2006

Because of increased security requirements, **those wishing to attend the March 23 – March 24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting must register for the meeting online at:**

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

Attendees must register online by March 17, 2006; failure to do so may result in lack of access to the meeting.

March 23 – March 24
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 March 17, 2006.** You must bring an official form of picture identification (such as a drivers license) in order to be admitted to the building.

April 1, 2006

Any new ICD-9-CM codes required to capture new technology will be implemented. Information on any new codes implemented on April 1, 2006 previously posted in early November 2005 on the following websites:

<http://www.cms.hhs.gov/paymentsystems/icd9>

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

<http://www.cms.hhs.gov/medlearn/icd9code.asp>

April 14, 2006

Deadline for receipt of public comments on proposed code revisions discussed at the March 23-24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting for implementation on October 1, 2006 to capture new technology.

April 2006	<p>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/providers/hipps/frnotices.asp</p>
April 2006	<p>Summary report of the Procedure part of the March 23, 2006 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.cms.hhs.gov/paymentsystems/icd9</p> <p>Summary report of the Diagnosis part of the March 24, 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</p>
June 2006	<p>Final addendum posted web pages as follows: Diagnosis addendum at - http://www.cdc.gov/nchs/icd9.htm Procedure addendum at - http://www.cms.hhs.gov/paymentsystems/icd9</p>
July 28, 2006	<p>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.</p>
August 1, 2006	<p>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, 2006. This rule can be accessed at: http://www.cms.hhs.gov/providers/hipps/frnotices.asp</p>
August 2006	<p>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/paymentsystems/icd9</p> <p>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</p>

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 24, 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/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 29 – 30, 2006 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows:

<http://www.cms.hhs.gov/paymentsystems/icd9>

Summary report of the Diagnosis part of the September 29 – 30, 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 web pages as follows:

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

Procedure addendum at -

<http://www.cms.hhs.gov/paymentsystems/icd9>

Insertion of Spinal Stabilization Device

Issue:

Current ICD-9-CM procedure codes do not provide a unique code to capture the insertion of lumbar posterior pedicle screw based stabilization device without fusion following decompression surgery. This procedure is currently captured under code 84.59, Insertion of other spinal devices. Should a new procedure code be created to capture this technology?

New Technology Application:

No.

FDA Approval:

The M-Brace™ Spinal Stabilization System is currently under development. Applied Spine Technologies is planning to submit for an Investigational Device Exemption by the end of 2005. The IDE study will consist of 400 patients randomized 2:1, M-Brace versus posterior pedicle screw based fusion. Eligible patients must present with clinically symptomatic lumbar spinal stenosis and be candidates for surgical decompression and posteriolateral fusion. The company plans to begin enrollment in the first quarter of 2006.

Background:

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

Initially patients are treated with non-operative care including physical therapy and pain management, which may include epidural injections. Often these measures are sufficient, however in those patients where nonoperative 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 tissue that is causing the pressure on the spinal column or nerve root. Examples of common decompression procedures include laminotomy, laminectomy, foraminotomy, and medial facetectomy. Once the spinal segment is decompressed in certain patients the segment may be deemed unstable requiring stabilization. Decompression patients who are also candidates for concurrent stabilization include those who present with significant instability and those whose decompression surgery may cause or cause the likelihood of instability. Until very recently stabilization meant spinal fusion. Fusion of the spine is accomplished by means of a bone graft and typically instrumentation to immobilize the spine until fusion is complete.

The M-Brace™ Spine Stabilization System is currently being developed by Applied Spine Technologies, Inc. It is a posterior dynamic flexible stabilization system, fixed by means of traditional pedicle screws. The device provides stabilization without fusion following decompression surgery. The technology behind the M-Brace™ system is based upon research conducted on spine biomechanics by Manojar Panjabi PhD.

The M-Brace™ system is implanted posteriorly in the lumbar spine to provide dynamic stabilization, without fusion, of the segment being treated for spinal stenosis. The system controls and supports motion in flexion, extension, and lateral bending. As mentioned above its unique ball and socket pedicle screw design offloads the pedicle screws from the stresses that can be exerted by the spine.

The M-Brace™ is being designed to provide a solution for patients with an unstable spinal segment. The M-Brace™, unlike fusion procedures, is restorative, permits motion in the hope of minimizing adjacent level disease, and is reversible so that the patient can always elect to undergo a fusion procedure.

Product Description:

The M-Brace™ consists of a variety of pedicle screws with integral locking screws and connectors. The connector which bridges contiguous vertebral pedicles houses a dynamic spring assembly. The springs within the assembly work in concert or alone depending upon the position of the spine. The springs serve to stabilize the spine dynamically in flexion, extension, and lateral bending while providing maximum support within neutral posture.

The device is comprised of titanium (pedicle screws), cobalt chrome alloys (connectors), and ePTFE (sheath which covers spring assembly). The device is intended to be implanted bilaterally at one or two contiguous levels of the lumbar spine. The device is intended to be used without bone graft.

Procedure for insertion:

The procedure for insertion and fixation of the M-Brace™ Spine Stabilization System is similar to the insertion of posterior pedicle screw based fusion systems on the market, but the technology is completely different in terms of the configuration and effect of the spring connector as well as the ball and socket articulation of the pedicle screws.

The size and location of the incision, the placement of the pedicle screws, the insertion and attachment of the device by means of locking or set screws, and the closure are all consistent with those of pedicle screw based fusion systems. The M-Brace™ technique differs in that no bone graft is inserted.

Potential Benefits:

The dynamic properties of the M-Brace™ device are intended to stabilize the spine while preserving motion. The intended effect represents a stark contrast to fusion systems which are intended to immobilize the spine to permit permanent fusion to develop. The contrast does not end with fusion systems but is also evident when comparing M-Brace™ to some of the newly emerging motion preserving devices whose effect is based upon

limiting or restricting motion versus dynamically controlling motion. The potential benefits of the M-Brace™ include pain relief via stabilization, minimization of adjacent level disease by significantly reducing motion constraint, and reduction in pedicle screw loosening and failure by minimizing load on the pedicle screws. In addition patients receiving the M-Brace™ are not precluded from any future treatment including fusion or alternative motion implant techniques.

Patient Population:

Degeneration of the spine is a common component of the normal ageing population. Approximately 80% of the U.S. population report low back problems at some point in their lives. The number of lumbar fusions performed each year is estimated at 190,000¹. Patients with lumbar spinal stenosis constitute a significant component of the total number of spinal fusions performed each year.

There will be a variety of spinal devices coming to the FDA, similar to M-Brace™, and some are in IDE now. Treatment of spinal problems can best be described as a burgeoning field.

Options:

Option 1. Due to limited code availability; the current status of applying for FDA approval for this technology; and the vast array of potential technologies in this area, continue to code this procedure to code 84.59, Insertion of other spinal devices. Once FDA approval is made for some of these devices, consider creating a unique ICD-9-CM code.

Option 2. Create a new code to capture this technology.

New code	81.67	Insertion of non-fusion spinal stabilization device Posterior pedicle screw based flexible stabilization
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Excludes: implantation of interspinous process decompression device (84.58)
spinal fusion (81.00 – 81.08, 81.30-81.39)

CMS's Recommendation:

Option 1. Due to limited code availability; the current status of applying for FDA approval for this technology; and the vast array of potential technologies in this area, continue to code this procedure to code 84.59, Insertion of other spinal devices. Once FDA approval is made for some of these devices, consider creating a unique ICD-9-CM code.

In the interim, continue to code this procedure to code 84.59, Insertion of other spinal devices.

¹ Opportunities in U.S. Spinal Fusion Markets, Health Research International, 104-1-US-0203, April 2003.

Implantable Hemodynamic Monitor

Issue:

Although ICD-9-CM codes exist for various types of short-term circulatory monitoring, there are currently no ICD-9-CM codes for procedures involving intracardiac hemodynamic monitoring systems with implanted components, used to continually sense and record physiologic heart measurements in patients with severe heart failure. Should new codes be created to capture these implantable devices?

New Technology Application:

Yes.

FDA Approval:

PMA has been submitted to FDA. It is anticipated that this device will receive FDA approval by March 2006.

Background:

Patients with more severe degrees of heart failure (NYHA Class III and IV) experience higher morbidity and higher rates of emergency and inpatient hospital treatment. The need for hospital care, in spite of the maximal medical management these patients may receive, is frequently due to volume overload brought on by high cardiac filling pressures. Volume overload is also called congestion and fluid retention.

Controlling episodes of volume overload requires close monitoring of the cardiac filling pressures. Conventionally, this has required frequent physician visits where filling pressures are assessed by physical exam as well as repeated cardiac catheterizations. In addition to involving multiple visits and procedures, a major limitation to this type of monitoring is that it can only assess filling pressures at a given point in time and cannot establish trends. To overcome these limits, an implantable hemodynamic monitor (IHM) has been developed which provides continuous monitoring. FDA approval for the first IHM system is expected in first quarter 2006.

Like many cardiac devices, the implanted hemodynamic monitoring system has two key components. The first is a lead tipped with a pressure sensor that is placed within the right ventricle at the right ventricular outflow tract. Because the sensor measures cardiac pressures, it is always inserted transvenously into the heart chamber and is never implanted epicardially onto the external surface of the heart, as pacemaker and ICD leads sometimes are. The second component is the monitor device which includes pressure sensing circuitry and memory to process and collect the data obtained by the sensor. This is implanted in a subcutaneous pocket, usually in the chest. Periodically, the data collected by the monitor is downloaded non-invasively via telemetry for physician analysis and decision-making.

The implantable hemodynamic monitoring system allows clinicians to identify early signs of volume overload before they become apparent by physical exam. Clinicians can then immediately adjust treatment to reduce or prevent heart failure deterioration as well as the need for hospital treatment. The study concluded that there were eight complications associated with almost 300 implants. They were categorized as sensor (lead) dislodgement, sensor (lead) fibrosis, pocket infection and seroma. The site of service during the clinical study was about 50/50 inpatient and outpatient.

Options:

Option 1. Continue to code this procedure to code 89.63, Pulmonary artery pressure monitoring and code 37.79, Revision or relocation of cardiac device pocket.

Option 2. Create two new codes under subcategory 00.5, Other cardiovascular procedures, for implantation or replacement of the IHM sensor and the monitor device.

New code 00.56 Insertion or replacement of implantable sensor for intracardiac hemodynamic monitoring

Code also any associated implantation or replacement of monitor (00.57)

Excludes: circulatory monitoring (blood gas, arterial or venous pressure, cardiac output and coronary blood flow) (89.60-89.69)

New code 00.57 Implantation or replacement of subcutaneous device for intracardiac hemodynamic monitoring

Implantation of monitoring device with formation of subcutaneous pocket and connection to intracardiac sensor

Code also any associated insertion or replacement of implanted sensor (00.56)

CMS's Recommendation:

Option 2. As stated above.

In the interim, continue to code this procedure to code 89.63, Pulmonary artery pressure monitoring and code 37.79, Revision or relocation of cardiac device pocket.

Laparoscopic Hysterectomy

Issue:

The ICD-9-CM procedure coding system does not currently include procedure codes to fully describe all of the laparoscopic gynecological procedures available today. We propose to discuss the creation of six new codes and address additional items for consideration at future meetings. Please forward any suggestions you may have concerning this topic.

New Technology Application?

No.

Background:

Hysterectomies are among the most commonly performed surgical procedures in the United States. They are generally indicated in the treatment of abnormal uterine bleeding, uterine prolapse, pelvic pain, and precancerous or cancerous conditions. The standard approach for a hysterectomy has been either abdominal or vaginal. Recent advances in endoscopic surgery have made the laparoscopic approach to hysterectomy a viable alternative. Today, there are more laparoscopic hysterectomy procedures to choose from, according to the patient's condition and needs.

There are several inconsistencies in the terminology utilized by surgeons when describing laparoscopic hysterectomy procedures. Although the title suggests the uterus is being removed through abdominal ports, it may also refer to when laparoscopy is used to perform vaginal removal of the uterus.

A total laparoscopic hysterectomy (TLH) involves excision via laparoscope of the entire uterus with cervix. The procedure involves an incision at the umbilicus where the laparoscope is introduced. Next, secondary ½ inch operative incisions are created in the lower abdominal area. The uterus is detached from its ligaments and blood vessels laparoscopically. Following this, a vaginal incision is created laparoscopically and the uterus is detached from the top of the vagina. The vaginal incision is closed after removal of the uterus. Patients who have undergone this procedure report less pain postoperatively and a faster recovery time than patients who undergo traditional open abdominal hysterectomies.

A total laparoscopic radical hysterectomy (TLRH) involves excision via laparoscope of the uterus, cervix, upper portion of the vagina, lymph nodes, lymph channels, and tissue in the pelvic cavity surrounding the cervix. This type of extensive surgery is usually only recommended to treat some cancers of the uterus or cervix. Studies have shown that compared to laparotomy, the laparoscopic approach is associated with less blood loss and shorter hospitalization stays.

A laparoscopic modified radical hysterectomy involves excision of the uterus, the medial half of the uterosacral and cardinal ligaments, as well as a portion of the upper vagina. The ureters are exposed and pulled back laterally, without dissection from the ureteral bed.

Current codes:

68.3 Subtotal abdominal hysterectomy

68.31 Laparoscopic supracervical hysterectomy [LSH]

Classic infra fascial SEMM hysterectomy [CISH]

Laparoscopically assisted supracervical hysterectomy [LASH]

68.39 Other subtotal, abdominal hysterectomy, not otherwise specified

Supracervical hysterectomy

Excludes: classic infra fascial SEMM hysterectomy [CISH] (68.31)

laparoscopic supracervical hysterectomy [LSH] (68.31)

68.4 Total abdominal hysterectomy

Code also any synchronous removal of tubes and ovaries (65.3-65.6)

68.5 Vaginal hysterectomy

Code also any synchronous:

Removal of tubes and ovaries (65.31-65.64)

Repair of cystocele or rectocele (70.50-70.52)

Repair of pelvic floor (70.79)

68.51 Laparoscopically assisted vaginal hysterectomy [LAVH]

68.59 Other vaginal hysterectomy

Excludes: laparoscopically assisted vaginal hysterectomy [LAVH] (68.51)

68.6 Radical abdominal hysterectomy

Modified radical hysterectomy

Wertheim's operation

Code also any synchronous:

Lymph gland dissection (40.3, 40.5)

Removal of tubes and ovaries (65.61-65.64)

68.7 Radical vaginal hysterectomy

Schauta operation

Code also any synchronous:

Lymph gland dissection (40.3, 40.5)

Removal of tubes and ovaries (65.61-65.64)

68.9 Other and unspecified hysterectomy

Hysterectomy, Not Otherwise Specified

Excludes: abdominal hysterectomy, any approach (68.31-68.39, 68.4, 68.6)

vaginal hysterectomy, any approach (68.51, 68.59, 68.7)

Coding Options

Option 1:

Use code 68.9, Other and unspecified hysterectomy, for the total laparoscopic hysterectomy [TLH]

Use code 68.6, Radical abdominal hysterectomy, for the total laparoscopic radical hysterectomy [TLRH] and laparoscopic modified radical hysterectomy

Use code 68.7, Radical vaginal hysterectomy, for the laparoscopic radical vaginal hysterectomy [LRVH]

Option 2:

Create two new codes in subcategory 68.4, as follows:

68.4 Total abdominal hysterectomy

Code also any synchronous removal of tubes and ovaries (65.31-65.64)

New code 68.41 Laparoscopic total abdominal hysterectomy
 Total laparoscopic hysterectomy [TLH]

New code 68.49 Other total abdominal hysterectomy, not otherwise
 specified

*Excludes: laparoscopic total abdominal hysterectomy (68.41)
 radical abdominal hysterectomy, any approach
 (68.61-68.69)*

Create two new codes in subcategory 68.6, as follows:

68.6 Radical abdominal hysterectomy

Code also any synchronous:

lymph gland dissection (40.3-40.5)

removal of tubes and ovaries (65.31-65.64)

New code 68.61 Laparoscopic radical abdominal hysterectomy
 Laparoscopic modified radical hysterectomy
 Total laparoscopic radical hysterectomy [TLRH]

New code 68.69 Other radical abdominal hysterectomy, not otherwise specified
 Modified radical hysterectomy
 Wertheim's operation

*Excludes: laparoscopic total abdominal hysterectomy (68.41)
 laparoscopic radical abdominal hysterectomy (68.61)*

Create two new codes in subcategory 68.7, as follows:

68.7 Radical vaginal hysterectomy

Code also any synchronous:

lymph gland dissection (40.3-40.5)

removal of tubes and ovaries (65.31-65.64)

New code 68.71 Laparoscopic radical vaginal hysterectomy [LRVH]

New code 68.79 Other radical vaginal hysterectomy, not otherwise
Specified

*Excludes: Abdominal hysterectomy, any approach (68.31- 68.39,
68.41-68.49, 68.61-68.69, 68.9)*

Recommendation:

CMS recommends option 2, create new codes as described above.

Interim coding:

Use codes identified in Option 1 as follows:

Use code 68.9, Other and unspecified hysterectomy, for the total laparoscopic hysterectomy [TLH]

Use code 68.6, Radical abdominal hysterectomy, for the total laparoscopic radical hysterectomy [TLRH] and laparoscopic modified radical hysterectomy

Use code 68.7, Radical vaginal hysterectomy, for the laparoscopic radical vaginal hysterectomy [LRVH]

Computerized External Fracture Fixation

Issue:

At the March 31, 2005 ICD-9-CM Coordination & Maintenance Committee Meeting, external fracture fixation devices were discussed. Subsequently, codes were created which are available for use with discharges on or after October 1, 2005 for FY 2006. However, these codes do not describe *computerized* external fixation.

New Technology Application?

No

FDA Approval:

May 9, 1997. The Taylor Spatial Frame (TSF) external fixator and its components are indicated for open and closed fracture fixation, pseudoarthrosis or nonunions of long bones, limb lengthening by epiphyseal or metaphyseal distraction, correction of bony or soft tissue deformities, and correction of segmental or nonsegmental bony or soft tissue defects. The TSF is for use on all long bones including: tibia, fibula, femur, humerus, radius, and ulna.

Background:

Computerized external fixation devices (struts) are used to stabilize/reduce fractures and correct multi-planar and angular and translational deformities simultaneously, representing an advance in fracture treatment. The computerized external fixator's indications are noted in the preceding paragraph. Traditional external fixators provide temporary stabilization. Computerized external fixators achieve anatomic reduction of acute long bone fractures and post-traumatic or congenital deformities through computer assisted surgery.

The TSF is an external fixator system that consists in part of pins that are inserted into the bone above and below a fracture, rings or plates that attach to the pins and encircle the limb, and telescoping and pivoting struts that connect the rings or plates together. The TSF is currently the only external fixation system that also includes computer software that assists physicians in calculating a prescription for strut adjustment and replacement allowing gradual correction of fractures and deformities. This software transforms measurements of a patient's fracture or deformity into a prescription for: (1) when and how much a patient should lengthen or shorten his or her struts, and (2) when a patient should come into a doctor's office to have one of the struts replaced. The prescription is generated after surgeon has placed the frame on the patient during their inpatient stay. Almost all strut change-outs occur in outpatient settings, such as a physician's office. The hardware for this device is based on the principles of the Ilizarov method, but this external fixator product is also integrated with computer software providing a prescription for strut adjustment and replacement.

Coding Options:

1. Use existing codes to describe this procedure. Adjunct codes for application of external fixator devices were created for use beginning with discharges on October 1, 2005. Codes 84.71 – 84.73 are to be used in conjunction with the primary procedure performed. One code, 84.72, Application of external fixator device, ring system, is specifically targeted towards the Ilizarov type fixator. The computerized aspect of the procedure would be inherent in the initial procedure, and adjustments to the device would be performed in an outpatient setting, necessitating a HCPCS code, not an ICD-9-CM code.

2. Create a new adjunct code that includes the computerized aspect of this device:

84.7 Adjunct codes for external fixator devices

84.71 Application of external fixator device, monoplanar system

Excludes:

Add exclusion term computerized external fixator device (84.74)

84.72 Application of external fixator device, ring system

Excludes:

Add exclusion term computerized external fixator device (84.74)

84.73 Application of hybrid external fixator device

Excludes:

Add exclusion term computerized external fixator device (84.74)

New code 84.74 Application of computerized external fixator device

Excludes:

hybrid external fixator device (84.73)

monoplanar external fixator device (84.71)

ring system external fixator device (84.72)

78.1 Application of external fixator device

Revise code also note

Code also any type of fixator device, if known (84.71-84.734)

79 Reduction of fracture and dislocation

Revise code also note:

Type of fixator device, if known (84.71-84.734)

3. Do not create a specific code to describe this procedure. Instead, use an existing code from subcategory 00.3, Computer-assisted surgery [CAS], as appropriate. Add a code also note to category 84.7, Adjunct codes for external fixator devices, instructing to code the type of CAS, if known.

- 00.3 Computer-assisted surgery [CAS]
 - 00.31 Computer assisted surgery with CT/CTA
 - 00.32 Computer assisted surgery with MR/MRA
 - 00.33 Computer assisted surgery with fluoroscopy
 - 00.34 Imageless computer assisted surgery
 - 00.35 Computer assisted surgery with multiple datasets
 - 00.39 Other computer assisted surgery

CMS Recommendation:

CMS would be interested in hearing from the audience on this topic, both today and via written comments.

Interim coding:

A specific combination code does not exist that describes computerized external fixation devices. Therefore, in order to describe this type of surgery, use the appropriate principal procedure code from the following range: 78.10, 78.12-78.13, 78.15, 78.17-78.19, Application of external fixator device, or 79.00-79.89, Reduction of fracture and dislocation. Also use 84.72, Application of external fixator device, ring system, or 84.73, Application of hybrid external fixator device, as appropriate, and the appropriate code from subcategory 00.3, Computer-assisted surgery [CAS]. (This is option 3)

Procedure on Bifurcated Vessels

Issue:

At the October 7, 2004 ICD-9-CM Coordination and Maintenance Committee Meeting, we discussed coding which would identify the number of vessels treated and the number of stents inserted in either coronary or peripheral vessels. At that time, we created eight new procedure codes, with codes 00.40 – 00.43 describing the number of vessels upon which procedures were performed, and codes 00.45 – 00.48 describing the number of vascular stents inserted. Those codes will become available for use with hospital discharges occurring on or after October 1, 2005. Though we briefly discussed this topic, we did not create a specific code or codes to describe intervention on bifurcated vessels – that is, treatment on vessels that branch in two directions.

New Technology Application?

No.

Background:

Angioplasty has been widely used to treat certain types of coronary obstruction since the mid-1980s. Stent placement following angioplasty to keep the lumen of the vessel open became a common practice in the early 1990s. Initially, bare metal stents were used; these were subsequently enhanced with drug coatings. In 2003, drug-eluting stents were approved for use in the United States, making treatment of more complex coronary artery disease cases possible.

Originally, cardiac lesions were treated by open surgical repair technique using coronary artery bypass grafts (CABG). Advances in techniques and technology now make it common practice to treat cardiac lesions with less invasive (closed) approaches via percutaneous angioplasty, insertion of multiple adjoining or overlapping stents, or treatment of more than one adjoining vessel (bifurcation).

The treatment of stenosis in coronary and peripheral arteries continues its fast-paced evolution. However, despite the changes made to the coding system for use beginning October 1st, noted above, the identification of procedures on bifurcated vessels is not possible. The eight new codes do not differentiate the increased resource use including extra [OR] time or complexity.

Unfortunately, graphics do not reproduce well in CMS' summary, so the graphics provided by a stakeholder are not reproduced here. Those graphics schematically represented the look of a bifurcated lesion in branching arteries. The language associated with the graphics says that “the procedural differences between a “straight” procedure and a bifurcation procedure can be substantial, and asserts that vessel and vascular stent codes of straight intervention procedures do not translate into the same resource use as a bifurcation procedure with stent placement and/or PTCA.”

Coding Option(s):

1. Continue to use the new structure to describe the number of vessels treated. After October 1, 2005, use the following codes:

- 00.40, Procedure on single vessel
- 00.41, Procedure on two vessels
- 00.42, Procedure on three vessels
- 00.43, Procedure on four or more vessels

These codes were determined by the industry to be adequate for description of the number of vessels treated, and were created through their collaborative efforts.

2. Create a new code at 00.44, Procedure on bifurcated vessels. This code would follow all instructions set forth at subcategory 00.4.

Coding examples were provided by the requestor:

- Angioplasty of left anterior descending coronary artery and left circumflex coronary artery with insertion of two drug-eluting stents at bifurcation in left anterior descending.
00.66, Percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy
36.07, Insertion of drug-eluting coronary artery stent(s)
00.44, Procedure on bifurcated vessels
00.46, Insertion of two vascular stents
- Angioplasty of left common femoral artery and left popliteal artery with insertion of a bare metal stent in left common femoral at a bifurcation and a bare metal stent in the left popliteal.
39.50, Angioplasty or atherectomy of other non-coronary vessel(s)
39.90, Insertion of non-drug-eluting peripheral vessel stent(s)
00.44, Procedure on bifurcated vessels
00.47, Insertion of three vascular stents

CMS Recommendation:

Option 1 - Do not create a new code, using the new structure to identify the number of vessels treated. The comments received after the presentation of the general number of vessels/number of stents topic last October 2004 were almost uniformly against creating an additional code to identify bifurcated vessels. We believe that the addition of this code will cause confusion as coders attempt to count the number of vessels. (For reference on confusion, look at the number of queries on correct coding of CABG in *Coding Clinic for ICD-9-CM*.) Additionally, we believe that the focus of interest on PTCA and stents will be on the number of stents inserted, not necessarily the number of vessels treated.

Endovascular Mechanical Thrombectomy of Precerebral and Cerebral Vessels

Issue:

There are currently no ICD-9-CM codes describing endovascular mechanical thrombectomy of precerebral and cerebral vessels.

New Technology Application?

No

FDA Approval:

August 11, 2004. Indications for use: the Concentric Merci® (**M**echanical **E**mbolus **R**emoval in **C**erebral **I**schemia) Retriever is intended to restore blood flow in the neurovasculature by removing thrombus in patients experiencing ischemic stroke. Patients who are ineligible for treatment with intravenous tissue plasminogen activator (IV tPA) or who fail IV tPA therapy are candidates for treatment.

Background:

Endovascular mechanical thrombectomy is the first surgical treatment available for acute ischemic stroke.

Broadly, there are two kinds of stroke: hemorrhagic and ischemic. Hemorrhagic strokes, which account for about 10-20% of all strokes, are caused by ruptured cerebral blood vessels and aneurysms. Treatment for hemorrhagic strokes includes surgical clipping and endovascular embolization of aneurysms.

Ischemic strokes are by far the most common, accounting for 80-90% of all strokes. They are caused by obstruction and occlusion of the precerebral and cerebral blood vessels by thrombosis, embolism, and stenosis. Until recently, treatment of ischemic strokes has been exclusively medical, involving infusion of anticoagulants and thrombolytic drugs such as tPA. To be effective, however, intravenous thrombolytic drugs must be administered within 3 hours of the onset of an ischemic stroke. In August 2004, the FDA cleared a technique for mechanical thrombectomy as the first surgical treatment for acute ischemic stroke patients.

Mechanical thrombectomy physically removes thrombus from the occluded vessel. Unlike tPA, which is infused intravenously to dissolve the clots, mechanical thrombectomy is not limited to a specific timeframe and can be used to treat patients who are beyond the 3-hour window for tPA. Mechanical thrombectomy is also used for patients who received tPA but for whom tPA was not effective.

Once the location of the stroke-inducing thrombus is identified using angiography, a balloon catheter is inserted, usually via a femoral artery approach, and maneuvered to the carotid artery. A microcatheter and guidewire are then advanced into the appropriate intracranial vessel and placed just beyond the thrombus. A retrieval device, similar in appearance to a corkscrew, is deployed to ensnare the thrombus and withdraw it into the balloon catheter and ultimately out of the body. The balloon catheter is inflated to temporarily arrest blood flow during this maneuver

and is then deflated to restore blood flow after the thrombus is extracted. Several passes with the retrieval device may be necessary to ensure the thrombus is completely removed and the vessel lumen has been cleared.

Current Coding:

The existing thrombectomy code 38.01, Incision of vessel, intracranial vessel, identifies an open, not endovascular, approach. Code 39.72, Endovascular repair or occlusion of head and neck vessels, contains procedures describing coil embolization or occlusion, and further implying implant of a substance to cause an occlusion, as opposed to mechanical removal of an occlusion. Code 99.10, Injection or infusion of thrombolytic agent, describes clot-busting, but does not capture mechanical technique.

Coding Options:

1. Do not create a new code. Continue to use code 38.01, Incision of vessel, intracranial vessels, to describe endovascular mechanical thrombectomy of cerebral vessels. Continue to use 38.02, Incision of vessel, other vessels of head and neck, to describe endovascular mechanical thrombectomy of precerebral vessels.
2. Create a new code in subcategory 39.7, Endovascular Repair of Vessel, to describe endovascular mechanical removal of obstruction.

Revise 39.7 Endovascular repair, occlusion or removal of obstruction of vessel

New code 39.74 Endovascular removal of obstruction from head and neck vessel(s)
 Endovascular embolectomy
 Endovascular thrombectomy
 Mechanical embolectomy or thrombectomy
Code also any injection or infusion of thrombolytic agent (99.10)
Excludes:
 counting number of vessels treated (00.40-00.43)
 occlusive endovascular repair of head or neck vessels (39.72)
 open embolectomy or thrombectomy (38.01-02)

CMS Recommendation:

Create a new code as described in option 2, above.

Interim coding:

The procedure Index guides coders as follows:

Embolectomy 38.00
 head and neck NEC 38.02
 intracranial NEC 38.01

Therefore, continue to use codes 38.01 or 38.02, as appropriate, until a new code can be placed into use for endovascular mechanical thrombectomy or embolectomy.

Cardiac Electrophysiology Studies

Issue:

There is considerable coding confusion with regard to the various clinical cardiac electrophysiology studies and their relationship with certain cardiac devices. Coding refinement is necessary to accurately describe these procedures.

New Technology Application:

No.

Background:

There are four basic types of cardiac electrophysiology studies, each of which has very different clinical characteristics, and at present they are not all distinguishable by ICD-9 coding language.

Electrophysiologic Stimulation and Recording (EPS)

This is the oldest, most invasive and most labor intensive EP study. Catheters are inserted into the heart through peripheral vessels, much like a cardiac catheterization, and the electrical activity of various areas of the heart is recorded. The study involves the induction of life threatening arrhythmias in order to assess the need for the most appropriate antiarrhythmic treatment, drug and/or device. This procedure must be done in the cardiac catheterization laboratory or similarly equipped facility. It is currently described by code 37.26, Cardiac electrophysiologic stimulation and recording studies.

Noninvasive Programmed Electrical Stimulation (NIPS)

This type of EP study uses a device that is already implanted, such as an Implantable Cardiac Defibrillator, to induce arrhythmias with the pulse generator via telemetry signals in order to assess the adequacy of the device and program it optimally, or to assess the effectiveness of drug therapy. Although it is noninvasive in that no catheters are inserted into the heart, it requires the ability to emergently terminate the life threatening arrhythmias that are induced and as such must be done in the cath lab or similarly equipped facility. It is also described by code 37.26, Cardiac electrophysiologic stimulation and recording studies.

Intraoperative Testing

This form of EP testing is done at the time of implantation of a cardiac pacemaker or defibrillator in order to ascertain that it is functioning properly. It is part of the implantation procedure, rather than being a separate, stand-alone procedure like the invasive and non-invasive studies described above, and it is not coded separately from the implantation procedure.

Device Interrogation or Bedside Check

This is simply a download of the information stored in the pulse generator of a cardiac device via telemetry for evaluation of recorded data. It is described by codes 89.45, Artificial pacemaker rate check, or 89.46, Artificial pacemaker artifact wave form check,

or 89.47, Artificial pacemaker electrical electrode impedance check, or 89.48, Artificial pacemaker voltage or amperage threshold check or 89.49, Automatic implantable cardioverter/defibrillator (AICD) check, depending on the type of device being checked.

Current Coding

As mentioned above, both the Catheter Dependent EP Study (EPS) and the Noninvasive EP Study (NIPS) are coded as 37.26, despite the fact that one involves inserting catheters into the heart and the other does not.

Intraoperative testing is not coded separately from the device implantation code.

Device interrogation or bedside check is coded as 89.45 through 89.49, depending on the device being checked.

Coding Options:

Option 1.

Do nothing, and encourage continued chaos.

Option 2. There are three parts to this proposal.

1. Change the title of code 37.26 as follows:

Revise code title: 37.26 ~~Cardiac electrophysiologic stimulation and recording studies~~
Catheter based invasive electrophysiologic testing

Delete inclusion term	Non-invasive programmed electrical stimulation (NIPS)
Delete inclusion term	Programmed electrical stimulation

	Excludes:
Add exclusion term	<u>that as part of intraoperative testing – omit code</u>
Add exclusion term	<u>noninvasive programmed electrical stimulation (NIPS)</u>
	<u>(37.20)</u>

2. Create a new code as follows:

New code	37.20 Noninvasive programmed electrical stimulation [NIPS]
----------	--

Excludes:
that as part of intraoperative testing – omit code
catheter based invasive electrophysiologic testing (37.26)
device interrogation only without arrhythmia induction
(bedside check) (89.45-89.49)

3. Add note under codes 00.50, Implantation of cardiac resynchronization pacemaker without mention of defibrillation, total system [CRT-P], 00.51, Implantation of cardiac resynchronization defibrillator, total system [CRT-D], 00.53, Implantation or replacement of cardiac resynchronization pacemaker pulse generator only [CRT-P], 00.54, Implantation or replacement of cardiac resynchronization defibrillator pulse generator device only [CRT-D], category 37.8, Insertion, replacement, removal, and revision of pacemaker device, code 37.94, Implantation or replacement of automatic cardioverter/defibrillator, total system [AICD], code 37.96, Implantation of automatic cardioverter/defibrillator pulse generator only, and 37.98, Replacement of automatic cardioverter/defibrillator pulse generator only, as stated below:

00.50 Implantation of cardiac resynchronization pacemaker
without mention of defibrillation, total system [CRT-P]

Add note NOTE: Device testing is inherent in the procedure.

00.51 Implantation of cardiac resynchronization defibrillator, total system
[CRT-D]

Add note NOTE: Device testing is inherent in the procedure.

00.53 Implantation or replacement of cardiac resynchronization
pacemaker pulse generator only [CRT-P]

Add note NOTE: Device testing is inherent in the procedure.

00.54 Implantation or replacement of cardiac resynchronization
defibrillator pulse generator device only [CRT-D]

Add note NOTE: Device testing is inherent in the procedure.

37.8 Insertion, replacement, removal, and revision of pacemaker device,

Add note NOTE: Device testing is inherent in the procedure.

37.94 Implantation or replacement of automatic cardioverter/defibrillator, total system [AICD]

Implantation of defibrillator with leads (epicardial patches), formation of pocket (abdominal fascia) (subcutaneous), any transvenous leads, intraoperative procedures for evaluation of lead signals and obtaining defibrillator threshold measurements

Delete inclusion term ~~(electrophysiologic studies [EPS])~~

Add note NOTE: Device testing is inherent in the procedure.

37.96 Implantation of automatic cardioverter/defibrillator pulse generator only

Add note NOTE: Device testing is inherent in the procedure.

37.98 Replacement of automatic cardioverter/defibrillator pulse generator only

Add note NOTE: Device testing is inherent in the procedure.

CMS Recommendation:

Option 2. Revise the title of code 37.26 to Catheter based invasive electrophysiologic testing, create new code 37.20, Noninvasive programmed electrical stimulation (NIPS), and add notes as outlined above.

Interim Coding

Continue to code catheter based invasive electrophysiologic testing and non-invasive programmed electrical stimulation (NIPS) to 37.26.

Proposed Addenda

Index

	Implant, implantation
	cardiac resynchronization device
Revise subterm	defibrillator (<u>BiV ICD</u>) (<u>BiV pacemaker with defibrillator</u>) (<u>BiV pacing with defibrillator</u>) (<u>biventricular</u>) (CRT-D) (device and one or more leads) (total system) 00.51
Revise subterm	pacemaker (<u>BiV</u>) (<u>biventricular</u>) (CRT-P) (device and one or more leads) (total system) 00.50
Revise subterm	CRT-D (<u>BiV ICD</u>) (<u>BiV pacemaker with defibrillator</u>) (<u>BiV pacing with defibrillator</u>) (<u>biventricular defibrillator</u>) (cardiac resynchronization defibrillator) (device and one or more leads) 00.51
Revise subterm	CRT-P (<u>BiV pacemaker</u>) (<u>biventricular pacemaker</u>) (cardiac resynchronization pacemaker) (device and one or more leads) 00.50
	electrode(s)
Add subterm	<u>gastric – see Implant, electrode(s), peripheral nerve</u>
	electronic stimulator
Add subterm	<u>gastric – see Implant, neurostimulator, peripheral nerve</u>
	pacemaker
	cardiac (device) (initial) (permanent) (replacement) 37.80
	resynchronization device
Revise subterm	(<u>BiV pacemaker</u>) (<u>biventricular pacemaker</u>) (CRT-P) total system (device and one or more leads) 00.50
Add subterm	<u>gastric – see Implant, neurostimulator, peripheral nerve</u>
	Insertion
	cardiac resynchronization device
Revise subterm	defibrillator (<u>BiV ICD</u>) (<u>BiV pacemaker with defibrillator</u>) (<u>BiV pacing with defibrillator</u>) (<u>biventricular defibrillator</u>) (CRT- D) (device and one or more leads) (total system) 00.51
Revise subterm	pacemaker (<u>BiV pacemaker</u>) (<u>biventricular pacemaker</u>) (CRT-P) (device and one or more leads) (total system) 00.50

Revise subterm	CRT-D (<u>BiV ICD</u>) (<u>BiV pacemaker with defibrillator</u>) (<u>BiV pacing with defibrillator</u>) (<u>biventricular defibrillator</u>) (cardiac resynchronization defibrillator) (device and one or more leads) 00.51
Revise subterm	CRT-P (<u>BiV pacemaker</u>) (<u>biventricular pacemaker</u>) (cardiac resynchronization pacemaker) (device and one or more leads) 00.50
Add subterm	electrode(s) <u>gastric – see Insertion, electrode(s), peripheral nerve</u>
Revise subterm	pacemaker cardiac (device) (initial) (permanent) (replacement) 37.80 resynchronization device (<u>BiV pacemaker</u>) (<u>biventricular pacemaker</u>) (CRT-P) total system (device and one or more leads) 00.50
Add subterm	<u>gastric – see Implant, neurostimulator, peripheral nerve</u>
Add subterm	stent(s) (stent graft) non-coronary vessel <u>mesenteric 39.90</u>
Add subterm	<u>renal 39.90</u>
Removal	
Revise code	cardioverter/defibrillator pulse generator without replacement (cardiac resynchronization defibrillator device (CRT-D)) 37.99 <u>37.79</u>
Revise code	pulse generator cardioverter/defibrillator 37.99 <u>37.79</u>
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Add subterm	rotator cuff (suture) 83.63 <u>by or with</u>
Add subterm	<u>graft 83.63</u>

	Replacement
	cardiac resynchronization device
Revise subterm	defibrillator (<u>BiV ICD</u>) (<u>BiV pacemaker with defibrillator</u>) (<u>BiV pacing with defibrillator</u>) (biventricular defibrillator) (CRT-D) (device and one or more leads) (total system) 00.51
Revise subterm	pacemaker (<u>BiV pacemaker</u>) (<u>biventricular pacemaker</u>) (CRT- P) (device and one or more leads) (total system) 00.50
Revise subterm	CRT-D (<u>BiV ICD</u>) (<u>BiV pacemaker with defibrillator</u>) (<u>BiV pacing with defibrillator</u>) (<u>biventricular defibrillator</u>) (cardiac resynchronization defibrillator) (device and one or more leads) 00.51
Revise subterm	CRT-P (<u>BiV pacemaker</u>) (<u>biventricular pacemaker</u>) (cardiac resynchronization pacemaker) (device and one or more leads) 00.50
	Reposition
	cardioverter/defibrillator
Revise code	lead(s) (epicardial patch) (pacing) (sensing) 37.99 <u>37.75</u>
Revise code	pocket 37.99 <u>37.79</u>
Revise code	pulse generator 37.99 <u>37.79</u>
	Revision
	cardioverter/defibrillator (automatic)
	pocket 37.99 <u>37.79</u>

Tabular

00.50 Implantation of cardiac resynchronization pacemaker without
mention of defibrillation, total system [CRT-P]

Add inclusion term	<u>BiV pacemaker</u>
Add inclusion term	<u>Biventricular pacemaker</u>

00.51 Implantation of cardiac resynchronization defibrillator, total system [CRT-D]

Add inclusion term BiV defibrillator
Add inclusion term BiV ICD
Add inclusion term BiV pacemaker with defibrillator
Add inclusion term BiV pacing with defibrillator
Add inclusion term Biventricular defibrillator

00.53 Implantation or replacement of cardiac resynchronization pacemaker pulse generator only [CRT-P]

Add inclusion term BiV pacemaker
Add inclusion term Biventricular pacemaker

00.54 Implantation or replacement of cardiac resynchronization defibrillator pulse generator device only [CRT-D]

Add inclusion term BiV defibrillator
Add inclusion term BiV ICD
Add inclusion term BiV pacemaker with defibrillator
Add inclusion term BiV pacing with defibrillator
Add inclusion term Biventricular defibrillator

02.93 Implantation or replacement of intracranial neurostimulator lead(s)

Revise code Code also any insertion of neurostimulator pulse generator 86.94-~~86.96~~
86.98

03.93 Implantation or replacement of spinal neurostimulator lead(s)

Revise code Code also any insertion of neurostimulator pulse generator 86.94-~~86.96~~
86.98

04.92 Implantation or replacement of peripheral neurostimulator lead(s)

Revise code Code also any insertion of neurostimulator pulse generator 86.94-~~86.96~~
86.98

36.04 Intracoronary artery thrombolytic infusion

Excludes:

Delete exclusion term ~~percutaneous transluminal angioplasty [PTCA] or coronary atherectomy (00.66)~~

Revise title 37.7 Insertion, revision, replacement and removal of ~~pacemaker~~ leads; insertion of temporary pacemaker system; or revision of cardiac device pocket

37.75 Revision of lead [electrode]

Add inclusion term Repositioning of lead(s) (AICD) (cardiac device) (CRT-D) (CRT-P) (defibrillator) (pacemaker) (pacing) (sensing) [electrode]

37.79 Revision or relocation of cardiac device pocket

Add inclusion term Insertion of loop recorder

Add inclusion term Removal of cardiac device/pulse generator without replacement

Add inclusion term Removal without replacement of cardiac resynchronization defibrillator device

Add inclusion term Repositioning of pulse generator

Add inclusion term Revision of cardioverter/defibrillator (automatic) pocket

Add inclusion term Revision or relocation of CRT-D pocket

Excludes:

Add exclusion term removal of loop recorder (86.05)

37.97 Replacement of automatic cardioverter/defibrillator lead(s) only

Add exclusion term Excludes:

replacement of epicardial lead [electrode] into epicardium (37.74)

37.99 Other operations on heart and pericardium, Other

Delete inclusion term ~~Revision of cardioverter/defibrillator (automatic) pocket~~

Delete inclusion term ~~Revision or relocation of CRT-D pocket~~

Excludes:

Add exclusion term repositioning of pulse generator (37.79)

Add exclusion term revision of lead(s) (37.75)

Add exclusion term revision or relocation of pacemaker, defibrillator or other implanted cardiac device pocket (37.79)

AVAILABILITY OF ICD-9-CM

Plans for future code assignment

We received a request from the American Health Information Management Association (AHIMA) to discuss the issue of the limited number of unassigned ICD-9-CM codes that are available to use for new codes. AHIMA asked that the ICD-9-CM Coordination and Maintenance Committee discuss the hierarchy that CMS will use in selecting code numbers for new procedure codes. CMS has received several letters on this issue including the following statements documented in a recent letter from the American Hospital Association:

American Hospital Association
June 24, 2005
Comment letter on IP PPS rule
Pages 13 – 14

“...At the April 2005 ICD-9-CM Coordination and Maintenance (C&M) committee meeting, there were many impassioned discussions on the need to start limiting the creation of new procedure codes in order to allow the classification system to last at least two more years. ICD-9-CM procedure code categories 00 and 17 were created to capture a diverse group of procedures and interventions affecting all body systems. The establishment of these code categories was a deviation from the normal structure of ICD-9-CM and a stopgap measure to accommodate new technology when no other slots in the corresponding body system chapters (e.g. musculoskeletal system, circulatory system, etc.) were available. The plan was to use up codes in chapter 00 first and then start populating chapter 17.

We have now reached the point where category 00 is full and the C&M committee is entertaining proposals for codes in category 17. At the April C&M meeting a proposal was presented that would in effect leave only 80 codes available in this category. Many of the specific body system chapters are already filled (like cardiac and orthopedic procedures). In recent years, as many as 50 new procedure codes have been created in a single year. This means that it is possible for ICD-9-CM to completely run out of space in one-and-a-half years. We concur with the NCVHS recommendation to issue a proposed rule for adoption of ICD-10. We also would support an implementation period of at least two years following issuance of a final rule. Without the publication of even a proposed rule, the prospect of being unable to recognize new major surgical procedures and entirely new medical technology is certain grim reality.”

CMS acknowledges the fact that there are only a limited number of open series within ICD-9-CM in which to put new code categories. This is particularly problematic for cardiovascular and orthopedic procedures. However, CMS is committed to attempting to create new codes, as needed, to accurately capture new procedures and new technologies. We departed from the current organizational structure of ICD-9-CM procedures when we created a variety of procedure codes in new chapter 00 Procedures and Interventions NEC. CMS has created new codes in all

10 categories within chapter 00. There are empty codes within these categories. These will be used as necessary.

CMS proposes the following approach to utilizing unassigned code numbers to capture new procedures.

Code Creation Hierarchy

1. **Appropriate body system chapter and section.** Assign new codes in the appropriate body system chapter of ICD-9-CM. Within this body system, first attempt to assign the new code to the appropriate section of the chapter. (e.g. new code 37.41 Implantation of prosthetic cardiac support device around the heart was assigned to an appropriate section of the cardiovascular chapter which includes repair of heart).
2. **Appropriate body system, but inappropriate section.** If the new code cannot be assigned to the appropriate section of the correct body system chapter, then try to assign the code to the correct body system chapter, but to an inappropriate section within the chapter. (e.g. 84.58 Implantation of interspinous process decompression device was assigned to the appropriate body system chapter, 76-84 Operations on the musculoskeletal system. However there was not room in the spine section. Therefore the code was placed along with other recent codes under a section called other procedures on musculoskeletal system.)
3. **Chapter 00 Procedures and Interventions NEC.** If available codes cannot be identified within the appropriate body system chapter, then look for space in new chapter 00 Procedures and Interventions NEC. Within chapter 00, look for an available code within the section that includes similar procedures on the same body system. (e.g. new code 00.18 Infusion of immunosuppressive antibody therapy during induction phase of solid organ transplantation was assigned to chapter 00 and the existing section called Pharmaceuticals.
4. **Create new chapter 17 Procedures and Interventions NEC Continued.** Once the above three options are examined and empty code numbers cannot be identified, begin assigning codes to new chapter 17 which could be called Procedures and Interventions NEC continued. This chapter has 100 available codes. Structure the 10 available sections according to body systems, not to a random code assignment.
5. **Assign codes randomly to inappropriate chapters.** New cardiovascular codes could be assigned to Chapter 18-20 Operations on the ear. There is a section of 10 codes available at 18.8. Also, several of the codes in the eye chapter are only 3 digits long (e.g. 18.4 Suture of laceration of external ear, 18.5 Surgical correction of prominent ear, 18.6 Reconstruction of external auditory canal). These could be subdivided to capture other types of procedures. Another chapter that could be used for random code assignments would be Chapter 08-16 Operations on the eye. There are several three digit codes that could be subdivided into four digits to be used for new cardiovascular and orthopedic procedures.

