



Summary of March 2007 ICD-9-CM Coordination and Maintenance Committee Meeting

The ICD-9-CM Coordination and Maintenance Committee, cosponsored by the National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS), met on March 22-23, 2007 in Baltimore, MD. Donna Pickett, RHIA, from NCHS, and Patricia Brooks, RHIA, from CMS, cochaired the meeting.

Proposed modifications to ICD-9-CM were presented and are summarized below. This summary does not include all of the details of the code proposals or all of the recommendations made at the meeting. For complete details, review the minutes and code proposals posted on the CMS and NCHS websites. Diagnostic code proposals and the minutes from the diagnosis portion of the meeting are posted on the NCHS website and can be accessed at the following link:

www.cdc.gov/nchs/about/otheract/icd9/maint/maint.htm. Procedure code proposals and the minutes from the procedure portion of the meeting can be found at the CMS website and can be accessed at the following link:

http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.

Once they are approved by CMS and NCHS, some changes may go into effect with discharges on or after October 1, 2007, whereas others may not go into effect until October 1, 2008. Those proposals that are being considered for October 1, 2007 implementation are indicated in the meeting summary below.

Suggestions for diagnosis code proposals for consideration at a future Coordination and Maintenance Committee may be emailed to Donna Pickett at dfp4@cdc.gov or mailed to: National Center for Health Statistics, ICD-9-CM Coordination and Maintenance Committee, 3311 Toledo Road, room 2402, Hyattsville, Maryland 20782.

Suggestions for procedure code proposals to be considered at a future Coordination and Maintenance Committee, may be emailed to Pat Brooks at PBrooks@cms.hhs.gov or mailed to: Centers for Medicare & Medicaid Services, CMM, HAPG, Division of Acute Care, Mail Stop C4-08-06, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled for September 27-28, 2007 and will be held at the CMS building in Baltimore, MD. New proposals for inclusion on this agenda must be received by **July 27, 2007**. Anyone wishing to have a new code considered for implementation on April 1, 2008

must make this request at the September meeting and justify the need for expedited implementation to capture new technology.

Diagnoses

Migraines and Other Headache Syndromes

In order to properly classify types of headaches and to reflect the current edition of the International Classification of Headache Disorders, a number of new codes and modifications to existing codes have been proposed. These proposed changes include a new category for “other headache syndromes,” with subcategories for:

- Cluster headaches and other trigeminal autonomic cephalgias (TACS)
- Tension type headache
- Post-traumatic headache
- Complicated headache syndromes
- Other headache syndromes

A new code would also be created for drug induced headache, not elsewhere classified.

Modifications to category 346, Migraine, have been proposed. The title of code 346.0 would be changed to “migraine with aura” and the title of code 346.1 would be changed to “migraine without aura.”

New fifth digits would be created to indicate “without mention of intractable migraine with status migrainosus” and “with intractable migraine, so stated, with status migrainosus.”

New codes would be created in category 346 to describe:

- Hemiplegic migraine
- Menstrual migraine
- Persistent migraine aura without cerebral infarction
- Persistent migraine aura with cerebral infarction
- Chronic migraine

It was suggested that tension headache and tension type headache need to be better differentiated in order to avoid confusion and misuse of the codes. The appropriate code assignment for premenstrual headache needs to be considered. Concerns were raised that medical record documentation will not match the terminology used in the proposal.

Exposure to Toxic Metals and Chemicals

A new V code category has been proposed for exposure to potentially hazardous substances which would include codes for exposure to arsenic and exposure to dyes. Exposure to either of these substances is considered a risk factor for bladder cancer. The proposal presented in March represents a revised version of a proposal presented at the September 2006 Coordination and Maintenance Committee meeting.

An expansion of code 599.7, Hematuria, has been proposed in order to differentiate gross hematuria from microscopic hematuria. A “use additional code” note under subcategory 599.7 has also been proposed to identify specific risk factors for bladder cancer, including exposure to various hazardous chemicals, family history of malignant neoplasm of bladder, and history of tobacco use.

Concerns were expressed about adding a “use additional code” note for risk factors for bladder cancer. There are many other instances throughout the classification where a similar note could be added, since many conditions have associated risk factors. This type of instructional note is not necessary because it is standard coding practice to assign codes for relevant history and exposure codes when this information is documented. Also, since the use of the phrase “such as” in the proposed “use additional code” note implies that the list of given risk factors is not all-inclusive and could be construed as placing the burden of linking an exposure or history to an increased risk of bladder cancer.

Central Venous Catheter Infections

Creation of a unique code for infection due to central venous catheter has been proposed. If approved, this proposal would be implemented October 1, 2007.

Although intravascular catheters provide necessary vascular access, they place patients at risk for local and systemic infectious complications, including local site infections, catheter-related bloodstream infections, septic thrombophlebitis, endocarditis, and other infections. The majority of serious catheter-related infections are associated with central venous catheters. Types of central venous catheters include non-tunneled central venous catheters, peripherally inserted central catheters (PICC), and tunneled central venous catheters. The non-tunneled type accounts for the majority of catheter-related bloodstream infections. The Centers for Disease Control and Prevention have identified catheter-associated adverse events as one of their top health-care safety challenges, with a goal to reduce such complications by fifty percent in five years.

It was recommended that the inclusion term for vascular catheter (arterial) (dialysis) (venous) under code 996.62, Infection and inflammatory reaction due to other vascular device, implant, and graft, be modified to better distinguish this code from the proposed new code.

Myotonic Disorders

An expansion of code 359.2, Myotonic disorders, has been proposed to capture distinct types of myotonic disorders, including myotonic muscular dystrophy, myotonia congenital, myotonic chondrodystrophy, and drug induced myotonia. The proposal presented at the March meeting represents a revised version of a proposal presented at the September 2006 Coordination and Maintenance Committee meeting. If approved, this proposal would be implemented October 1, 2007.

Acquired Absence of Uterus

The creation of two codes for acquired absence of uterus with and without cervix in subcategory 629.8, Other specified disorders of female genital organs, has been proposed. There is no space to create these codes in subcategory V45.7, Acquired absence of organ. The proposal presented at the March meeting represents a revised version of a proposal presented at the September 2006 Coordination and Maintenance Committee meeting. If approved, this proposal would be implemented October 1, 2007.

Prophylactic Use of Agents Affecting Estrogen Receptors

Creation of a new subcategory for prophylactic use of agents affecting estrogen receptors has been proposed in category V07, Need for isolation and other prophylactic measures. Unique codes would be established for prophylactic use of selective estrogen receptor modulators and prophylactic use of aromatase inhibitors. A third code would capture all other drugs affecting estrogen receptors.

Many breast cancers are estrogen-sensitive, meaning that estrogen helps them to grow. Currently, there are three classes of drugs used to prevent recurrence of estrogen receptor positive breast cancer. Each of these drug classes acts in different ways. These agents are all given following traditional cancer treatment, but they may also be given prophylactically to people known to be at high risk for breast cancer.

Selective estrogen receptor modulators (SERMs) inhibit the proliferative effects of estrogen that are mediated through the estrogen receptor. Tamoxifen (also known as Nolvadex®) and raloxifene (also known as Evista®) are examples of this class of drugs.

Aromatase inhibitors (AIs) can help block the growth of these tumors by lowering the amount of estrogen in the body. Examples include anastrozole (Arimidex®), exemestane (Aromasin®), and letrozole (Femara®).

Estrogen receptor downregulators (ERDs) are an option for post-menopausal women with advanced (metastatic) breast cancer that is hormone receptor positive and has stopped responding to other anti-estrogen therapy. An example is fulvestrant (Faslodex®).

It had been requested that these code modifications be effective October 1, 2006, but it is not clear whether the affected physician specialty organizations could reach final agreement in time for implementation this year.

Since the Editorial Advisory Board (EAB) of *Coding Clinic for ICD-9-CM* is considering issues associated with Tamoxifen and the use of a personal history of breast cancer code versus a current breast cancer code, it was recommended that a decision pertaining to the proposed new codes be delayed until the EAB has a chance to provide their input.

Autoimmune Hepatitis

A new code for autoimmune hepatitis has been proposed. Currently, autoimmune hepatitis is indexed to code 571.49, Other chronic hepatitis. Chronic active hepatitis is a synonym used in the past for autoimmune hepatitis. Recent literature shows that with use of new viral serologic tests, hepatologists are able to differentiate chronic viral hepatitis from other types of liver disease, including autoimmune hepatitis.

Autoimmune hepatitis is characterized by continuing hepatocellular inflammation and necrosis, which tends to progress to cirrhosis. Immune serum markers frequently are present, and the disease is often associated with other autoimmune diseases. Autoimmune hepatitis cannot be explained on the basis of chronic viral infection, alcohol consumption, or exposure to hepatotoxic medications or chemicals.

Plateau Iris Syndrome and Pingueculitis

New codes for plateau iris syndrome and pingueculitis have been proposed.

Plateau iris syndrome refers to a postoperative condition in which a patent iridectomy has removed the relative papillary block that is ordinarily important in causing angle closure. The angle closure usually occurs in the early postoperative period, but may occur long after iridectomy when the pupil dilates spontaneously or in response to mydriatics (agents that dilate the pupil). It most often occurs in females, in their 30s-50s, and normally in patients with a family history of angle-closure glaucoma. It is a risk factor for glaucoma.

A pingueculum is a raised area of conjunctival tissue probably produced by sunlight damage. Pingueculae are characterized by yellowish, slightly raised, lipid-like deposits in the nasal and temporal limbal conjunctiva and are most commonly seen in middle-aged patients with chronic sun exposure. Normally, pingueculae are asymptomatic and an incidental finding. However, they can lead to the formation of pterygia. Both pingueculae and pterygia can become vascularized and inflamed, and may be associated with corneal punctuate epitheliopathy and corneal dellen (corneal thinning secondary to dryness). Pingueculitis occurs when pinguecula become acutely vascularized, red, irritated, and highly symptomatic.

Personal and Family History of Military Deployment

New codes for personal and family history of military deployment to armed conflict/war have been proposed. A personal history code is needed in order to track medical issues associated with military deployment. Tracking follow-up for non-military personnel who have worked in areas of armed conflict, such as contractors, media, and federal civilian employees, is also important. It is unknown if there is an increase in medical conditions related to deployment among the non-military who served in armed conflicts in foreign countries.

A family history code is needed to track symptoms, behaviors, and diseases associated with a family member having been deployed to an armed conflict in a foreign country. This will assist in improvement of prevention activities in both the military and civilian communities.

Participants suggested that the word “military” should be omitted from the proposed code descriptions if the intent is to use these codes for both military personnel and civilians deployed to armed conflict/war. It was also suggested that consideration be given to putting limitations on the family history code to ensure that it couldn’t be used if a distant relative or even an ancestor had been deployed to an armed conflict/war. However, the proposed codes are only intended to be used if the deployment affects the current episode of care.

Genital and Other Warts

A new code for plantar wart and modifications to the existing codes in subcategory 078.1, Viral warts, have been proposed. Genital warts NOS would be reclassified from code 078.19, Other specified genital warts, to code 078.11, Condyloma acuminatum. Condyloma NOS would be reclassified from code 078.1, Viral warts, unspecified, to code 078.11. Anogenital, cervical, vaginal, vulvar, and penile warts would be indexed to code 078.11.

Erythema Multiforme and Other Erythematous Conditions

An expansion of code 695.1, Erythema multiforme, has been proposed to create distinct codes for several conditions currently classified to this code and to separately identify the percentage of body surface involved in skin exfoliation.

Unique codes would be created for: erythema multiforme minor; erythema multiforme major; Stevens-Johnson syndrome; Stevens-Johnson syndrome-toxic epidermal necrolysis overlap syndrome; and toxic epidermal necrolysis. A new “use additional code” note would indicate that any associated manifestation should be separately coded. An additional code should also be assigned to identify the percentage of skin exfoliation. An instructional note would also indicate that an E code should be used to identify the drug, if the condition is drug-induced.

A new subcategory would be created for erythematous conditions causing exfoliation according to extent of body surface involved. This subcategory would contain several codes distinguished by percent of body surface involved in exfoliation. The erythematous condition causing the exfoliation should be sequenced first.

Stevens-Johnson syndrome (SJS) had previously been considered synonymous with erythema multiforme major, but these are now considered distinct. SJS is believed to be part of the same spectrum of disease as toxic epidermal necrolysis (TEN), although it generally involves body surface area of less than 10 percent. TEN involves significant skin sloughing, generally involving over 30 percent of the body surface area. This is similar to the skin loss with a severe burn, and treatment is best done in a burn unit. The

percent body surface area involved is a very important clinical factor in the care required. There is also an overlap condition with an intermediate percent of body surface area affected (10 to 30 percent), which may be termed SJS-TEN overlap syndrome. SJS and TEN commonly may be drug reactions.

Staphylococcal scalded skin syndrome may be considered synonymous with Ritter disease. However, at this time, staphylococcal scalded skin syndrome is indexed to code 695.1, Erythema multiforme, and Ritter's disease has its own code (695.81). It is being proposed to move scalded skin syndrome (and staphylococcal scalded skin syndrome) to code 695.81.

It was suggested that additional conditions that cause erythematous conditions, such as scarlet fever, should be included. It was also suggested that because the incidence of Stevens-Johnson syndrome is very low, perhaps it doesn't warrant a unique code.

Poxviruses

It has been proposed to expand code 051.0, Cowpox, and re-title it "cowpox and vaccinia not from vaccination" in order to create a new code for vaccinia not from vaccination. A new category for "other poxvirus infections" has also been proposed. This category would contain codes for distinct types of orthopoxvirus infections, parapoxvirus infections, and yatapoxvirus infections.

Poxviruses affecting humans can be grouped into five genera: orthopoxviruses, parapoxviruses, molluscipoxviruses, and others (yet unclassified). Laboratory tests have recently been developed to diagnose human infections caused by poxviruses in each of these genera.

Orthopoxviruses include variola virus (agent of smallpox), monkeypox virus, vaccinia virus, and cowpox virus. Although naturally occurring smallpox has been eradicated, variola virus is still maintained in two laboratories, and the potential for infection with variola virus through accidental or deliberate means still exists. Humans may be intentionally (i.e., smallpox vaccination) or unintentionally (e.g., secondary spread from a vaccine or infection from a dairy-associated wild type strain) infected with vaccinia virus. Monkeypox virus and cowpox virus are not endemic within the US but have the potential for importation via infected travelers or imported animals. Orthopoxviruses cause systemic infections in humans, whereas other poxviruses cause infections compartmentalized to the skin, so orthopoxviruses have implications for specific diagnosis, treatment, and infection control precautions distinct from other poxviruses. These factors support the separation of orthopoxvirus infections as a distinct subcategory. It might be preferable to classify them to an entirely separate category, but that is not feasible within the constraints of ICD-9-CM.

Parapoxviruses include orf virus, pseudocowpox virus, bovine popular stomatitis virus, and sealpox virus, which are all endemic within the US. Orf virus causes a sore mouth and is associated with contact with sheep and goats. Pseudocowpox is also called milker's nodule and is associated with beef cattle. Bovine popular stomatitis is also

associated with contact with beef cattle. In general, these infections are self-limited, but may cause severe infections in immunocompromised hosts.

Yatapoxviruses include tanapox virus and yaba monkey tumor virus. These viruses are endemic to sub-Saharan Africa and are a concern for travelers and potentially for handlers in animal research facilities.

Molluscipoxviridae includes only one species, molluscum contagiosum virus. It is perceived to be the most common cause of poxvirus infections in the US. It would continue to be classified to code 078.0, Molluscum contagiosum.

It was suggested that because these conditions are extremely rare in the US, the level of granularity represented by this proposal may be unnecessary.

Prion Diseases

An expansion of code 046.1, Jakob-Creutzfeldt disease, has been proposed in order to differentiate variant Creutzfeldt-Jakob disease from other types of Creutzfeldt-Jakob disease. Several new codes have also been proposed for other prion diseases of the central nervous system, including Gerstmann-Straussler-Scheinker syndrome and fatal familial insomnia.

Prion diseases infecting humans were previously thought to be caused by a slow virus, but are now widely believed to be caused by proteinaceous infectious particles known as prions.

Carotid Sinus Syndrome

An expansion of code 337.0, Idiopathic peripheral autonomic neuropathy, has been proposed in order to differentiate carotid sinus syndrome from other types of idiopathic peripheral autonomic neuropathy.

Carotid sinus syndrome or carotid sinus syncope results from pressure on the carotid sinus, resulting in vagal stimulation, subsequent hypotension or bradycardia, and syncope.

Personal History of Fracture

New codes for personal history of pathologic and traumatic fracture have been proposed. It is important to be able to identify those patients who have had a pathologic fracture in the past, as it puts them at greater risk for additional fractures and it affects treatment. Although a history of a traumatic fracture may not put a patient at increased risk for future fractures, the fact that a bone was traumatically fractured in the past may be affect future treatment.

It was noted that the handling of stress fractures will need further consideration.

Noncompliance with Renal Dialysis

An expansion of code V45.1, Renal dialysis status, has been proposed in order to create a distinct code for noncompliance with renal dialysis. Dialysis patients who are noncompliant are at risk of fluid overload in addition to the other complications of chronic kidney disease. Code V15.81, Noncompliance with medical treatment, does not provide sufficient detail to indicate noncompliance with dialysis. An Excludes note would be added under code V15.81.

Other Complications of Organ Transplant and Transplant Status

New codes have been proposed for malignant neoplasm associated with transplanted organ, post-transplant lymphoproliferative disorder (PTLD), graft-versus-host disease (GVHD), and transplanted organ removal status. An additional code for the specific malignancy should be assigned in conjunction with the proposed code for malignant neoplasm associated with transplanted organ. When the proposed code for PTLD is assigned, the transplant complication code should be sequenced first. When the proposed code for GVHD is assigned, the underlying cause should be sequenced first and additional codes should be used to identify any associated manifestations.

The immunosuppressant drugs used to prevent transplant rejection leave patients more vulnerable to the development of malignancies. It is also possible that a transplanted organ may have malignant cells present prior to transplant that were undetected.

PTLD is a disease of uncontrolled proliferation of B cell lymphocytes following infection with the Epstein-Barr virus. It may regress spontaneously after reduction or cessation of immunosuppressant medication and can also be treated with anti-viral therapy. If untreated, it may form tumor masses with bowel obstruction or progress to a non-Hodgkin's lymphoma.

GVHD occurs most often as a complication of bone marrow transplant, so it is currently classified to code 996.85, Complications of transplanted organ, bone marrow. However, it can also occasionally occur following blood transfusion or any organ transplant where white blood cells are present in the organ that is transplanted. GVHD may be either acute or chronic. Acute cases may affect the skin (ranging from maculopapular rash to desquamation), gastrointestinal tract (diarrhea), or liver (elevated bilirubin), and cause increased susceptibility to infection (which may be partially a direct effect and partially due to treatment of GVHD). Chronic GVHD also may affect the skin, gastrointestinal system, and liver, and cause increased susceptibility to infection, and may additionally involve hair loss, dry eyes and mouth (sicca), and lung disorders. Treatment of GVHD involves corticosteroids and other immune suppressants.

Patients now may receive more than one transplant in a lifetime. At times, an existing transplant may need to be removed and some time may pass before the patient receives a new transplant. Therefore, it is important to capture the fact that a transplanted organ has been removed.

It was recommended that unique codes for the acute and chronic forms of GVHD should be created since there are clinical differences. Concerns were expressed as to whether the complication code or the proposed new code for GVHD should be sequenced first. For the proposed code for malignant neoplasm associated with transplanted organ, it was suggested that an instructional note be added to indicate that the code for complication of transplanted organ should be sequenced first. A question was raised as to how a post-transplant lymphoma should be coded. Regarding the use of the proposed new code for transplanted organ removal status, it was suggested that perhaps an “acquired absence” code could also be assigned in order to identify which organ had been removed.

Vulvodynia

An expansion of code 625.8, Other specified symptoms associated with female genital organs, has been proposed in order to create a specific code for vulvodynia.

Vulvodynia is vulvar pain without an identifiable cause that persists for 3 months or longer. The most commonly reported symptoms are burning, stinging, and/or rawness in the vulva.

Fetal Medicine

An updated proposal for the classification of conditions affecting a fetus and in utero procedures was presented. This topic has been discussed at several previous Coordination and Maintenance Committee meetings.

A new section for “other fetal management” has been proposed in the Obstetrics chapter. This section would include new codes for fetal hematologic conditions, fetal conjoined twins, and suspected fetal conditions not found. The new codes for suspected fetal conditions not found would exclude known or suspected fetal anomalies affecting management of mother, not ruled out, which are classified to category 655, Known or suspected fetal abnormality affecting management of mother.

A new section in the Obstetrics chapter for complications of in utero procedures has also been proposed. This section would contain new codes for maternal complications from in utero procedures and fetal complications from in utero procedures.

The proposal includes a new code for pregnancy resulting from assisted reproductive technology.

In the Perinatal chapter, several new codes would be created for newborn affected by amniocentesis, newborn by other in utero procedure, newborn affected by other surgical operations on mother during pregnancy, and newborn affected by previous surgical procedure on mother.

In the V codes, new codes have been proposed for personal history of undergoing in utero procedure during pregnancy, personal history of undergoing in utero procedure while a fetus, and pregnancy with history of in utero procedure during previous pregnancy.

Malignant Pleural Effusion

An expansion of code 511.8, Other specified forms of effusion, except tuberculous, has been proposed in order to create a code for malignant pleural effusion. Currently, malignant pleural effusion defaults to secondary malignant neoplasm of pleura. However, this is not a valid default, since a malignant pleural effusion may also represent a thoracic lymphoma. Malignant pleural effusion is also a sign used for staging of lung cancer.

It was suggested that an instructional note be added under the proposed new code indicating that the neoplasm should be coded first.

Abnormal Papanicolaou Smear of Vagina and Vaginal HPV

It has been proposed that codes for abnormal vaginal cytologies be created to mirror the codes recently created for abnormal cervical smears.

Secondary Diabetes

Proposals for a new set of codes to address secondary diabetes mellitus have been discussed at several previous Coordination and Maintenance Committee meetings. This topic was brought back for additional discussion in March. Various options were considered, including: creation of one code for secondary diabetes; creation of a new category of codes for secondary diabetes; and creation of two new categories for secondary diabetes.

Participants liked the idea of two separate categories for drug-induced diabetes and diabetes due an underlying condition. This approach would alleviate confusion around sequencing issues. It was suggested that the Endocrine Society be asked about whether drug-induced diabetes is considered a poisoning or late effect. A question was raised as to how post-transplant diabetes should be handled. Sometimes this is due to steroids being taken for immunosuppression, whereas at other times it may be due to treatments received prior to a kidney transplant. A question was also raised as to whether virally-induced diabetes would be considered secondary.

This topic will be discussed again at the September Coordination and Maintenance Committee meeting.

Diagnosis Addenda

Proposed diagnosis addenda changes were reviewed. Other than corrections to the official ICD-9-CM CD-ROM and changes that are needed to correspond to changes that were part of the October 1, 2006 addenda, the rest of the proposed addenda changes are being considered for implementation on October 1, 2008. Highlights of the proposed revisions include (see ICD-9-CM Coordination and Maintenance Committee proposals

on NCHS web site for all of the proposed diagnosis addenda changes addressed at the March meeting):

- Reclassification of chorioadenoma (destruens), invasive hydatidiform mole, and malignant hydatidiform mole from code 236.1, Neoplasm of uncertain behavior, placenta, to code 181, Malignant neoplasm of placenta;
- Addition of Excludes note for cirrhosis due to viral hepatitis (070.0-070.9) under code 571.5, Cirrhosis of liver without mention of alcohol;
- Deletion of Excludes note for specific infections classified under “Infectious and parasitic diseases” (001.0-136.9), since it is appropriate to code both the infection and the ulcer;
- Addition of note under code 729.7, Nontraumatic compartment syndrome, indicating that post-surgical compartment syndrome, if applicable, should be coded first;
- Addition of inclusion term for anaphylactic reaction due to food under code 995.6, Anaphylactic shock due to adverse food reaction;
- Addition of Index entry for nephrogenic fibrosing dermatopathy (701.8);
- Addition of Index entry indicating that diabetes with hyperglycemia should be coded to diabetes, by type, with 5th digit for uncontrolled;
NOTE: A number of concerns were expressed regarding the indexing of diabetes mellitus with hyperglycemia. Participants were concerned that the term “hyperglycemia” is not used only when the diabetes is uncontrolled, and so an assumption should not be made that the diabetes is uncontrolled.
- Addition of Index entry for gastroesophageal reflux disease (530.81);
- Addition of Index entry for adult onset Still’s disease (714.2);
- Addition of Index entry for encephalopathy due to drugs (348.39);
- Revision of Index entry for endometritis complicating pregnancy (670);
- Addition of Index entry for abnormal findings, creatinine clearance (794.4);
- Addition of Index entry for post-surgical compartment syndrome (998.89);
- Addition of Index entries for acquired flat back syndrome (737.29) and postprocedural flat back syndrome (738.5);
- Addition of Index entry for surgical tear (incidental) (998.2).
NOTE: A number of questions were raised regarding this proposed Index entry. Advice in the past has always been that “incidental” tears should not be coded. It was recommended that this issue be brought back to the September Coordination and Maintenance Committee meeting for additional discussion.

Procedures

If approved, the procedure code proposals would be implemented October 1, 2007.

Intra-operative Electron Radiation Therapy (IOERT)

Creation of a new code for intra-operative electron radiation therapy (IOERT) has been proposed. This code would be the first one created in chapter 17.

IOERT is a specialized intensive radiation treatment administered during surgery directly to the cancer tumor or tumor bed while normal tissues are displaced or protected, thereby substantially increasing the effective dose to the tumor. Code 92.25, Teleradiotherapy using electrons, is currently assigned for IOERT. Historically, this code captured traditional therapy delivery systems that involved moving the patient to a location in the facility where a stationary machine has been installed. IOERT involves a mobile, self-shielded electron linear accelerator which can be brought to the patient in the operating room. It produces beams of electrons used in the radiation therapy treatment of both malignant and benign conditions. Use of this method of delivery impacts patient safety, decreases overall operative time, and can impact the treatment outcome. It also eliminates the additional surgical risk associated with moving the anesthetized patient to a distant location and makes intra-operative radiation available to a wider patient population.

Intra-operative Neurophysiologic Monitoring

Creation of a code for intra-operative neurophysiologic monitoring (IOM) has been proposed. It was noted that there is generally an intraoperative monitoring report that is separate from the operative report.

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

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

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

It was suggested that inclusion terms be added under the proposed new code to help clarify the types of neurophysiologic tests this code is intended to capture. It was also suggested that a “code also” note be added to allow additional code assignment to identify the specific tests performed.

Thoracoscopic Procedures

Several new codes for thoracoscopic approaches have been proposed: thoracoscopic partial excision of thymus; thoracoscopic total excision of thymus; thoracoscopic incision of thymus; other and unspecified thoracoscopic operations on thymus; thoracoscopic excision or destruction of lesion or tissue of lung; thoracoscopic segmental resection of lung; and thoracoscopic pneumonectomy.

It was suggested that modifications be made to existing code titles and appropriate Excludes notes be added to clarify that the thoracoscopic approach would no longer be included in the current codes.

STARR Procedure

It was proposed that either a new code be created for stapled transanal rectal resection (STARR) in males or that the Index be revised to allow the use of the same code regardless of whether the procedure is performed on a male or female. There was general support for the Index revision. The Index change would result in this procedure being classified to code 48.76, Other proctopexy. An inclusion term for the STARR procedure would be added under this code.

Currently, the STARR procedure is indexed to code 70.52, Repair of rectocele, which is in the chapter for operations on female genital organs. However, it is performed on patients with chronic outlet constipation and internal rectal prolapse from obstructive defecation syndrome. The STARR procedure was developed specifically to address dysfunction of the rectal musculature and internal prolapse. It was never designed as a primary treatment for rectocele, but rather as a treatment for obstructive defecation syndrome.

Transjugular Liver Biopsy

Creation of a new code for transjugular liver biopsy in category 50.1, Diagnostic procedures on liver, has been proposed. A transjugular liver biopsy involves insertion of a small catheter into the right internal jugular vein in the neck. Under fluoroscopic guidance, the catheter is threaded through the superior vena cava, the right atrium, the inferior vena cava, and into the right hepatic vein. A biopsy needle is then inserted through the catheter directly into the liver where a small sample of tissue is obtained.

It was suggested that a unique code for laparoscopic liver biopsy also be created.

Recalled Devices

Creation of a new code in chapter 17 has been proposed to identify instances in which an implanted device has been recalled and replaced during that hospitalization. Concerns were raised that the proposed code description does not specify whether this code is intended to cover recalls by the manufacturer, the Food and Drug Administration, and/or

through a voluntary field action. Also the code descriptor includes replacement of devices under warranty, but HIM staff may not have information as to whether or not the device being replaced is under warranty. A question was also raised as to whether the proposed code should be assigned when the device is being upgraded rather than replaced with the same type of device. It was also suggested that creation of a V code might make more sense than a procedure code to capture information concerning device recalls.

It was noted that the National Uniform Billing Committee recently created Condition Codes to be used on hospital claims to identify device recalls, and this might be better approach for collecting this information than creating an ICD-9-CM code.

Motion Preservation Technologies

Creation of a new subcategory for insertion, replacement and revision of posterior motion preservation spinal stabilization device(s) has been proposed. Code 84.58, Implantation of interspinous process decompression device would be deleted, and this procedure would be moved to the new subcategory. Discussion ensued as to whether the proposed new codes should include surgical decompression performed at the same level, separate codes should be created to differentiate each procedure as to whether surgical decompression was performed or not, or assignment of code 03.09, Other exploration and decompression of spinal canal, should be allowed as an additional code to indicate the performance of surgical decompression. There was general support for reporting code 03.09 as an additional procedure code. A “code also” note would be added under the new subcategory for motion preservation technologies, and there would also be a note clarifying that for these procedures, the surgical decompression does not constitute an operative approach.

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 devices, pedicle screw dynamic stabilization systems, 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 spinal 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 are intended to treat leg pain secondary to lumbar stenosis or mechanical back pain due to a degenerative disc. 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 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, Wallis® device, and Coflex™ device, is an example of an interspinous process device.

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, they are intended to treat mid-stage disease. These systems provide posterior stabilization forces and are designed to create a more normal loading pattern across the discs without loss of motion. Examples include the Dynesys® system and the Stabilimax NZ™ system (formerly called the MBrace™).

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. Examples include the Total Facet Arthroplasty System™ (TFAS) and the Artificial Facet Replacement System™ (AFRS).

Procedure Addenda

Proposed procedure addenda changes were reviewed. The proposed revisions include (see ICD-9-CM Coordination and Maintenance Committee proposals on the CMS web site for all of the proposed procedure addenda changes addressed at the March meeting):

- Revision of Index entry for colpoperineoplasty with repair of urethrocele (70.51);
- Addition of Index entry for removal, prosthesis, joint structures, with replacement (see Revision, joint replacement by site);
- Addition of Index entry for robotic assisted surgery (see Operation (Procedure)(Surgery), by site);
- Addition of Index entry for suture, obstetrical laceration, periurethral (75.69);
- Addition of inclusion terms for fine needle aspiration of lung and transthoracic needle biopsy of lung under code 33.26, Closed[percutaneous][needle] biopsy of lung;
- Deletion of Excludes note for female pelvic cavity under category 54, Other operations on abdominal region.

ICD-10-PCS Update

An update on ICD-10-PCS was provided by staff from 3M Health Information Systems. The General Equivalence Maps (GEMs) between ICD-10-PCS and ICD-9-CM and the associated Documentation and User's Guide were described. It was noted that the GEMs are reference maps and should not be considered a crosswalk, since there is not a one-to-one match between the systems for each code.

In 2007-2008, the Imaging, Nuclear Medicine, and Radiation Oncology sections will be updated to reflect the latest technology and application. The current tables in ICD-10-PCS will be examined and enhancements consistent with current technology and clinical practice will be identified. The system will continue to be updated as needed to reflect industry developments. A draft version of the DRGs using ICD-10-CM and ICD-10-PCS codes will be created.

The most recent version of ICD-10-PCS, the general equivalence maps, and the Documentation and User's Guide for the mapping files, are available on the CMS website at the following link:

http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/08_ICD10.asp.