SUMMARY REPORT

ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

April 18-19, 2002

April 18, 2002 - Procedures Discussions

Introduction and Overview

Pat Brooks welcomed the participants to the ICD-9-CM Coordination and Maintenance (C&M) Committee meeting. There were about 100 participants who attended the meeting. All participants introduced themselves. An overview of the C&M Committee was provided. It was explained that the Committee meetings serve as a public forum to discuss proposed revisions to the ICD-9-CM. The public is given a chance to offer comments and ask questions about the proposed revisions. **No final decisions on code revisions take place at the meeting**.

As this is strictly a coding meeting, no discussion is held concerning DRG assignment or reimbursement issues. After the meeting, a summary of the procedure part of the meeting is posted on the home pages of CMS. The diagnosis part of the meeting is conducted by the National Center for Health Statistics (NCHS). NCHS posts a summary of the diagnosis part of the meeting on their home page. April 18, 2002 was devoted to procedure issues, while April 19, 2002 was devoted to diagnosis issues.

We encourage the public to submit written comments by mail or e-mail concerning issues raised at the meeting. The deadline for these comments is April 26, 2002 for proposed procedure code revisions. Those proposed procedure code revisions that can be finalized by April 30, 2002 will be included in the October 1, 2002 addendum. Those proposed procedure code revisions that cannot be finalized by April 30, 2002 will still be considered for the October 1, 2003 addendum along with code proposals discussed at the December 5-6, 2002 C&M meeting.

Copies of the timeline were presented to participants. This timeline discusses important events relating to the updating of ICD-9-CM. While the Hospital Inpatient Prospective Payment Systems Notice of Proposed Rulemaking for FY 2003 was to have been

published on April 1, 2002, it was not. It is anticipated that it will be published by the end of April. The next C&M meeting will be held on December 5-6, 2002. Suggestions for the agenda must be received by October 5, 2002.

1. ICD-10-PCS Update

Pat Brooks presented an update on ICD-10-PCS. Implementation of ICD-10-PCS was discussed in great detail at the May 17, 2001 C&M meeting. Organizations provided formal statements on their views as to whether or not ICD-10-PCS should be implemented. These formal statements are included in the Summary Report of the meeting and may be accessed at: www.hcfa.gov/medicare/icd9cm.htm. There was overwhelming support for moving forward with the implementation of ICD-10-PCS. However, there was also a great deal of support for implementing the diagnosis and procedure volumes at the same time. Therefore, CMS was urged to wait until ICD-10 diagnosis was completed by NCHS prior to proceeding with ICD-10-PCS.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 established a formal process for naming national code set standards. In order to replace the current system, ICD-9-CM, with a new coding system, the HIPAA process must be followed. The next step in the process involves hearings by the National Committee on Vital and Health Statistics (NCVHS). This process began on April 9-10, 2002 with hearings before the NCVHS' Subcommittee on Standards and Security. Reports of this committee can be found at: http://ncvhs.hhs.gov/. There was general support for ICD-10-PCS along with recommendations from several organizations that ICD-10-PCS be implemented in 2005. There was additional discussion as to whether efforts should be established to work toward a uniform procedure coding system. The NCVHS discussed funding a contract over the next six months to examine this issue. The next subcommittee meeting will be on May 29-30, 2002 at which time both ICD-10-PCS and ICD-10-CM will be discussed.

Once the NCVHS concludes its hearings, it will make a recommendation to the Secretary of the Department of Health and Human Services (DHHS) as to whether ICD-10-PCS and ICD-10-CM should be named as national coding standards. After receiving the Committee's recommendation, the Secretary will decide if he will propose ICD-10-PCS and ICD-10-CM as national standards. Should he decide to propose them as standards, DHHS would publish a notice of proposed rulemaking setting out this proposal and requesting comments. Should the comments be favorable, then a final notice would be published naming the new coding standards.

The public is advised to stay actively involved in this process by attending the public meetings and submitting any comments or recommendations.

2. Continuous Intra-arterial Blood Gas Monitoring

Amy Gruber described the coding issue and options. Irwin Weiss, MD gave a clinical presentation of the system. One participant asked if the sensor is inserted by a physician

or a nurse. Dr. Weiss responded that this varies by hospitals. Physicians insert the sensor in some hospitals. In other hospitals this is done by a nurse. One participant questioned whether this code would be used by hospitals. It was stated that many hospitals do not currently assign the monitoring codes now. Others supported a new code. Others supported a new code but questioned whether there would be sufficient documentation in the medical record to allow coders to clearly identify the procedure. One commenter suggested that this monitoring system be captured by assigning code 38.91, Arterial catheterization. However, it was pointed out that under category 38.9, Puncture of vessel, there are excludes notes that preclude that for circulatory monitoring (89.61-89.69) and that code 38.91 would not be appropriate.

3. Multi-level Spinal Fusion

Pat Brooks led a discussion on the coding topic and Stephen Ondra, MD described the procedure and other clinical issues. This topic led to a great deal of discussion. Most participants who commented believed that it was important to try to identify patients who received multi-level spinal fusion. There was no support for option 1 which proposes no changes to the existing codes. There was agreement among many that the existing codes should not be modified to report each code each time a level is fused. This was felt to be laborious, use up too much space on the bill, and not particularly useful. There was a consensus that there was a significant difference between those patients who had one or two segments fused, versus patients with scoliosis who require 10-16 segments to be fused. Both Dr. Ondra and many of the participants felt that these patients could be identified by the use of the existing fusion code, a new multi-level fusion code, plus the diagnosis code for scoliosis.

Several participants stated that the new codes should not provide detail on the approach or level since this was already captured in the existing fusion and refusion codes. Therefore, there was not a great deal of support for options 2 and 3. Participants pointed out that option 2 would be difficult to use if the segments fused included a range of discs from two levels of the spine. Option 3 would have problems when multiple levels were fused and part, but not all, of the discs had been previously fused. These and other issues made options 2 and 3 difficult to use in the opinions of many participants.

Many in the audience liked option four since it was simple and required the least number of codes. However, it was suggested the "code also" note be changed to "code first." Others found this suggestion to be problematic since it would be the first time this type of note was used in the procedure section of ICD-9-CM. It might also cause confusion in trauma cases where other types of procedures were performed. Since the sequencing of procedure codes is not important for billing purposes, it is more important to simply make sure the codes are reported, without regard to which is first. Another participant suggest the terminology: "code in addition to" or some variation on the current note "code also any synchronous...." Another participant suggested that the index be used to list two codes, one from the fusion/refusion range and the other the new multi-level fusion code.

Another suggestion was to modify the existing fusion and refusion codes to define them as including the fusion of one or two segments (involving 2 or 3 discs). Dr. Ondra stated that the most common type of fusions involved only one or two discs. These were much more simple than those who involved a significantly larger number of segments. This could be accomplished by modifying the category title for 81.0 to Spinal fusion of one or two segments, and 81.3 to Refusion of spine of one or two segments. Includes notes could explain that this would involve two or three discs. It was then suggested that the new code be something like 81.62 "Fusion or refusion of three or more segments." This concept would put multiple fusions into the current code if two levels were fused. Fusions of more than two levels would be captured by a second code, 81.62 Fusion or refusion of three or more segments.

Another participant suggested that a range of new codes be created to show more detail on the number of segments fused such as :

81.62 Fusion or refusion of two segments
81.63 Fusion or refusion of 3-5 segments
81.63 Fusion or refusion of more than 5 segments

There was concern expressed by some participants that this type of new codes might lead coders to think that only one of the new codes would be needed, and they would not report a code from the fusion and refusion codes. If this were the case, we would lose data on the level that was fused and the approach used. Caution was urged in preparing the code titles, inclusion terms, and index. If new codes were created, it was suggested that "code also" notes be placed under 81.0 and 81.3 to use the new code(s).

After almost one and a half hours of discussions, Pat Brooks urged the participants to write down specific suggestions on how the code book should be modified to capture multi-level fusions. Specific suggestions were solicited on the tabular as well as the index. Once again the participants were told to have their comments in by April 26 on the procedure topics. Since this topic involved so many comments and suggestions, it was pointed out that the proposal may not be finalized in time for the October 1, 2002 addendum. If a workable solution cannot be achieved in time to be included in the update to the official ICD-9-CM version on Folio CD-ROM, then a second proposal will be brought to the December 5, 2002 C&M meeting for further discussion. This would allow for changes to be made for the October 1, 2003 addendum.

4. Vascular Access Device

Ann Fagan led a discussion on the coding issue. John Ross, MD described the clinical issues. One participant asked whether this device could be inserted in an outpatient setting. Dr. Ross said that his best guess was that about 70% of the time these devices were inserted on an outpatient basis. In about 30% of the cases, an inpatient admission was required. Another participant asked how long these devices could safely be left in

the patient. Dr. Ross stated that this was not yet known. However, some patients have had the devices in for up to two years already.

Several participants expressed concern about the ability of coders to determine if this were an implantable access valve system or a vascular access device. The documentation in the medical record may not let coders tell the difference between devices in 86.07 Insertion of totally implantable vascular access device (VAD), and proposed new code 86.08. One participant asked if the critical difference between the two devices was the fact that one had a valve. Dr. Ross said this was one factor. However, some would have a septum and not a valve. Another issue is that this new device was used for hemodialysis. Others expressed concern with using the term "hemodialysis" in the code title. They asked if this term should be removed or used as an includes note. Others asked if the code title should be "Insertion of implantable vascular access valve system." Otherwise, one would not understand what was being accessed.

Others continued to express concern about the ability of coders to use this code even with the changes suggested.

5. Addenda

Amy Gruber led a discussion on the proposed addenda. One person suggested that the following modification to the Exploration of ventriculoperitoneal shunt. It was suggested that the term "at" be moved up to the proposed subterm, ventriculoperitoneal at.

Some participants asked if the term "diagnostic" in the proposed subterm diagnostic (endoscopic) bronchoalveolar lavage (BAL) was necessary under Lavage, bronchus. However, it was pointed out that therapeutic lavages would not be assigned to code 33.24, Closed [endoscopic]biopsy of bronchus so it was appropriate to keep the term. On this same item, it was suggested that whole lung lavage be listed under lung as well as bronchus. It was also suggested that the term total lung be added as a subterm.

Under 86.65 Hererograft to skin, it was suggested that the exclusion term be modified to read: Excludes: application of dressing only (93.57).

The participants expressed support for the rest of the proposed addenda items.

This concluded the procedure portion of the meeting. The participants were advised once again that they must have their comments in to CMS by April 26. Only those items that can be resolved and finalized by the end of April would appear in the October 1, 2002 addendum. Those with outstanding questions or unresolved issues will be evaluated for inclusion in the October 1, 2003 addendum. The meeting was adjourned. NCHS was to start their part of the meeting on April 19, 2002 to discuss diagnosis issues.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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
April 18-19, 2002

Patricia E. Brooks
Co-Chairperson
April 18, 2002

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

Topics:

1. ICD-10 Procedure Classification System (PCS) - Update
   Patricia E. Brooks

2. Continuous Intra-arterial Blood Gas Monitoring
   Amy L. Gruber
   Irwin Weiss, MD
   Mattel Children's Hospital at UCLA

3. Multi-level Spinal Fusion
   Patricia E. Brooks
   Stephen L. Ondra, MD
   Northwestern University

4. Vascular Access Device
   Ann B. Fagan
   John R. Ross, MD
   Bamberg County Hospital,SC

5. Addenda

Amy L. Gruber

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

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Summary of Meeting:

A complete report of the meeting, including handouts, will be available on CMS's homepage within one month of the meeting. Written summaries will no longer be routinely mailed. The summary can be accessed at:

http://www.hcfa.gov/medicare/icd9cm.htm

NCHS will present diagnosis topics at the conclusion of the procedure topics. For information pertaining to the diagnosis agenda and summary reports, please contact Donna Pickett or Amy Blum at (301) 458-4200 or visit the NCHS Classification of Diseases website at: www.cdc.gov/nchs/icd9.htm

ICD-9-CM TIMELINE

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

March 2002	Tentative agenda for the Procedure part of the April 18-19, 2002 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.hcfa.gov/medicare/icd9cm.htm Tentative agenda for the Diagnosis part of the April 18-19, 2002 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
March 26, 2002	Federal Register notice of April 18-19, 2002 ICD-9-CM Coordination and Maintenance Committee Meeting was published. This will include the tentative agenda.
April 2002	Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This will include the final decisions on ICD-9-CM diagnosis and procedure code titles which were discussed at the meetings held on May 17-18, 2001 and November 1-2, 2001. It will also include proposed revisions to the DRG system on which the public may comment. It will not include additional procedure codes that will be discussed at the April 18-19, 2002 meeting and that might also be included in the October 1, 2002 addendum. The proposed rule can be accessed at: www.hcfa.gov/medicare/ippsmain.htm
April 9-10, 2002	National Committee on Vital and Health Statistics, Subcommittee on Standards and Security - Hearing on HIPAA Code Set Issues. A discussion was held on whether or not ICD-10-PCS should be named a national standard. Information on this meeting can be found at: http://www.ncvhs.hhs.gov/
April 18-19, 2002	ICD-9-CM Coordination and Maintenance Committee Meeting in CMS's auditorium. Diagnosis code revisions discussed are for potential implementation on October 1, 2003. Procedure code revisions may be for October 1, 2002 if they can be resolved quickly and finalized by April 30, 2002. Those procedure code proposals that cannot be resolved quickly will be considered for implementation on October 1, 2003.

April 26, 2002	Written comments due on procedure code proposals discussed at the April 18, 2002 meeting.
April 2002	Summary report of the Procedure part of the April 18, 2002 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.hcfa.gov/medicare/icd9cm.htm Summary report of the Diagnosis part of the April 19, 2002 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
May 29-30, 2002	National Committee on Vital and Health Statistics, Subcommittee on Standards and Security - Hearing on HIPAA Code Set Issues. A discussion will be held on whether or not ICD-10-CM diagnosis should be named a national standard. Additional discussions will be held on whether ICD-10-PCS or CPT should be named as a uniform procedure coding system. Information on this meeting can be found at: http://www.ncvhs.hhs.gov/
August 1, 2002	Hospital Inpatient Prospective Payment System final rule to be published in the Federal Register as mandated by Public Law 99-509. This will include all code titles included in the proposed notice as well as any other procedure code titles that were discussed at the April 18, 2002 meeting and resolved in time for implementation on October 1, 2002.
October 1, 2002	New and revised ICD-9-CM codes go into effect along with DRG changes.
October 5, 2002	Those members of the public requesting that topics be discussed at the December 5-6, 2002 ICD-9-CM Coordination and Maintenance Committee meeting should have their requests to CMS for procedures and NCHS for diagnoses.
November 2002	Tentative agenda for the Procedure part of the December 5, 2002 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.hcfa.gov/medicare/icd9cm.htm

	Tentative agenda for the Diagnosis part of the November 6, 2002 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
	Federal Register notice of December 5-6, 2002 ICD-9-CM Coordination and Maintenance Committee Meeting to be published. This will include the tentative agenda.
Dec. 5-6, 2002	ICD-9-CM Coordination and Maintenance Committee Meeting. Code revisions discussed are for potential implementation on October 1, 2003. December 5 will be devoted to discussions of procedure codes. December 6 will be devoted to discussions of diagnosis codes.
December 2002	Summary report of the Procedure part of the December 5, 2002 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.hcfa.gov/medicare/icd9cm.htm
	Summary report of the Diagnosis part of the December 6, 2002 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
January 10, 2003	Deadline for receipt of public comments on proposed code revisions discussed at the April 18 - 19, 2002 and not implemented on October 1, 2002 and December 5-6, 2002 ICD-9-CM Coordination and Maintenance Committee meetings. These proposals are being considered for implementation on October 1, 2003.

Continuous Intra-arterial Blood Gas Monitoring

Issue: Should a new procedure code be created to capture continuous intra-arterial blood gas monitoring? Currently there is an ICD-9-CM procedure code 89.65 that captures measurement of systemic arterial blood gases.

Background: Blood gas status is highly significant as a direct clinical indicator of cardiopulmonary function. Specifically, pH, pCO_2, and pO_2 change rapidly in critical and surgical care patients, particularly those with acute lung disorders, multi-system organ failure, or compromised cardiac or pulmonary function. There is an inherent delay in data delivery associated with traditional arterial blood gas analysis, which historically has been provided through the periodic performance of clinical laboratory tests. During this process, the sample is drawn and transported to the lab and intermittent results are reported to the physician.

However, continuous blood gas monitoring through the use of an intra-arterial sensor has the ability to deliver an uninterrupted display of data. Continuous blood gas monitoring shows the current status of the patient's arterial blood gases and trends for the prior 24 hours. The continuous blood gas sensor directly delivers results on pH, blood gases (pCO_2, pO_2) and temperature. The system also calculates bicarbonate, base excess, and oxygen saturation values. Together, these parameters represent a more comprehensive set of respiratory and metabolic data upon which to make clinical decisions.

A continuous blood gas monitoring system is comprised of in vivo intra-arterial continuous blood gas sensors, a monitor, and a calibrator. This technology is designed for high-acuity neonatal, pediatric, and adult patients in intensive care and surgical settings. This system developed by Philips Medical Systems received FDA approval in 1997.

The adult and pediatric sensor (Paratrend™) is inserted through an arterial catheter into a patient's peripheral radial or femoral artery. The neonatal sensor (Neotrend L ™) is inserted through an umbilical artery catheter (UAC). The sensor in both cases has microthin individual sensing elements within a microporous polyethylene tube. The sensor is a single-use, disposable device. Optical fibers measure pH and blood gases (pCO_2, pO_2). A thermocouple is used to measure temperature and to correct blood gas values to 37 degrees Celsius if desired. Results are displayed on a dedicated monitor (Trendcare™) or combined with the patient's hemodynamic parameters on a multiparameter patient monitor via an interface module.

The sensor remains in situ in the patient's blood stream; no blood is removed for testing. Because testing takes place in vivo, there is no time delay. This continuous monitoring enables the care team to identify the onset of adverse events through continuous real-time information and trends, to immediately confirm ventilator changes and resuscitation goals, and to reduce iatrogenic blood loss through reduced need for blood samples.

Continuous blood gas monitoring of adults and children is used in the care of patients with acute respiratory distress syndrome, sepsis, multi-organ system failure, and for use in trauma resuscitation and trauma surgery, as well as other uses.

The primary clinical indications for use in the neonatal population include prematurity/low birth weight, acute lung disorders, multi-system organ failure, and compromised cardiac or pulmonary function. It is estimated that there are at least 20 hospital NICUs in the United States that use this monitoring system to monitor critically ill neonates.

Options:

1. Continue to code this procedure to code 89.65, Measurement of systemic arterial blood gases. Inclusion term would be added to code 89.65 to include insertion and continuous monitoring of blood gases through an intra-arterial sensor.

2. Create a new code to capture continuous intra-arterial blood gas monitoring.

New code 89.60 Continuous intra-arterial blood gas monitoring
Insertion and continuous monitoring of blood gases through an intra-arterial sensor

Recommendation:

Option 2. Create a new code to capture continuous intra-arterial blood gas monitoring.

New code 89.60 Continuous intra-arterial blood gas monitoring
Insertion and continuous monitoring of blood gases through an intra-arterial sensor

In the interim, continue to code this procedure to code 89.65, Measurement of systemic arterial blood gases.

Multi-level Spinal Fusions

Issue: Current ICD-9-CM codes for spinal fusion and refusion do not capture the number of discs fused. There is no way to identify patients who have fusion of two discs versus those who have more than two discs fused.

Background: Multi-level spinal fusion is simply a spinal fusion that involves three or more vertebrae at two or more levels. For example, fusion of L1-L2 is a single level fusion because it involves only two vertebrae at one level. Fusion of L2-L4 is multi-level because it involves three vertebrae and two levels. ICD-9-CM classifies spinal fusion on a dual axis by vertebral level (cervical, dorsal, and lumbar) and by approach (anterior, posterior, and lateral transverse). Spinal fusions are captured under codes 81.00 - 81.08. Refusions of the spine are captured under codes 81.30 - 81.39. However, at this time it is not possible to identify the number of spinal levels fused. The same code is used regardless of the number of levels fused.

A spinal fusion involves removal of the (usually damaged) flexible disc between two adjacent vertebral bones, and connecting them together using a variety of approaches, most commonly placing bone grafts around the spine that then heal over time creating the union. Supplemental hardware (typically steel or titanium rods attached to the outside of the vertebral bones with hooks and screws) is frequently used to provide additional strength and stability. This is particularly the case for refusions or when multiple levels are fused. Hardware may also include interbody cages (e.g. BAK^{TM}), threaded bone dowels, or cement implanted between the vertebrae to restore lost disc height and relieve pressure on nerves. The cage itself is packed with grafting material to create fusion. Each inter-space between adjacent vertebral bones is considered one "level". A two level procedure would involve three vertebral bones, etc.

CMS has received several letters stating that the average lengths of stay and costs increase as additional levels are fused. It is not currently possible to verify this using coded data. Attempts to capture greater detail on the number of discs fused have been problematic. One reason is that the current fusion and refusion codes are classified on a dual axis of vertebral level and approach, as was stated previously. Adding an additional axis of single versus multiple level fusion could double the number of current codes from 20 to 40 codes. This number would increase dramatically if further detail were captured in the number of levels fused. Since ICD-9-CM has limited numbers of available empty codes, careful consideration needs to be given prior to adding at a minimum, 20 new fusion/refusion codes.

We have received a variety of suggestions on this topic which we have listed below. Some that were considered, but then rejected, include revising the coding guidelines or making tabular entries instructing hospitals to report the current fusion/refusion codes multiple times to show the number of levels fused. For instance, 81.06 would be reported three times if three levels were fused. It was felt that this would be confusing and could cause problems with space limitations on bills. Current bills provide space for submitting

only six procedure codes. Hospitals would be limited to reporting six fusion codes when attempting to describe the number of levels fused. However, this number is to increase to 25 under HIPAA electronic transactions standards. It was also suggested that repeating the code to indicate the number of levels would require an educational initiative to teach coders what constitutes a "level" and how to count them. This might increase the workload and complexity in coding these cases.

In evaluating options for capturing this type of information, AHA recommended that the following series of questions be addressed prior to evaluating options. These questions provide an excellent framework for analysis and discussions of options.

- Is there a need to collect information on multiple-level spinal fusions?

- Should information be captured to specifically identify how many levels were performed, or is there a need to capture only the fact that more than one level was fused?

- Are there concerns about space limitations on the bill if coders were instructed to report each code multiple times (eg. six times if six levels fused)?

- Is there a need to identify if the additions levels fused were a fusion or a refusion? Or do the existing fusion/refusion codes adequately provide this information?

Coding Options:

1. **Make no changes. Do not make modification to capture the number of discs fused.**

Some state that the current ICD-9-CM codes for fusion and refusion are already complicated by the use of two axis: vertebral level and approach. Adding one more axis for the number of discs fused greatly increases the complexity and number of codes. Surgeons have been fusing multiple levels of discs for many years. The need to capture additional information may not justify the added complexity and increased number of codes.

2. **Create three new codes which specify the level for multiple level fusion within category 81.6 Other procedure on spine. These codes would be reported once as an additional code to the fusion and refusion codes (81.02 - 81.08 and 81.32 - 81.38). They would state that additional levels of the spine were fused, but would not tell how many levels.**

81.62	Fusion or refusion of additional cervical levels Code also the primary spinal fusion or refusion (81.00 - 81.08, 81.32 - 81.39)
81.63	Fusion or refusion of additional dorsal and dorsolumbar levels

Code also the primary spinal fusion or refusion (81.00 - 81.08. 81.32 - 81.39)

81.64 Fusion or refusion of additional lumbar and lumbosacral levels
Code also the primary spinal fusion or refusion (81.00 - 81.08. 81.32 - 81.39)

These codes are defined as multiple levels. Only one additional code would be assigned regardless of the number of additional levels. The codes would provide information on the level at which the multi-level fusion/refusion was performed. It has been pointed out that a problem with these codes is that they duplicate information already present in the current fusion refusion levels by stating once again the level of the fusion.

3. Create two new codes which do not specify the level for multiple level fusions and refusions.

81.62 Fusion of additional spinal levels
Code also the primary spinal fusion or refusion (81.00 - 81.08, 81.32 - 81.39)

81.63 Refusion of additional spinal levels.
Code also the primary spinal fusion or refusion (81.00 - 81.08, 81.32 - 81.39)

This option does not preserve the level at which the fusion was performed or the technique. However, if reported along with the fusion and refusion codes, this information would be available. One additional code would be assigned along with the current fusion and refusion code regardless of the number of levels fused. It may be somewhat confusing to use if some of the levels involved a fusion, while other levels involved a refusion.

4. Create one new code which does not specify the level for multiple level fusions and refusions.

81.62 Fusion or refusion of additional spinal levels
Code also the primary spinal fusion or refusion (81.00 - 81.08. 81.32 - 81.39)

This option identifies the fact that multiple levels of the spine were fused or refused, yet it only requires one new code. It would be the most simple to use since it would be assigned in addition to the current fusion and refusion codes. The primary fusion/refusion codes would provide information on the approach and level fused. Like the other options, it does not tell the number of levels fused, nor does it capture specific information about multi-level fusion with multi-level refusion performed on the same operative encounter.

Recommendation: Select option 4. Create one new code, 81.62 Fusion or refusion of additional spinal levels. In the meantime continue to use the existing fusion and refusion codes.

Vascular Access Device

Issue

There currently are no ICD-9 codes that accurately capture implantation of this type of device. Specific coding would identify this technology for outcome, utilization, and data purposes.

Background

The LifeSite® Hemodialysis Access System received 510(k) clearance from the Food and Drug Administration (FDA) on August 24, 2000. This system is used to provide access for hemodialysis in patients with end stage renal disease. It has the following components:

- Subcutaneously implanted valve. The valve includes an internal metal taper seal to accept a 14-gauge needle and an internal pinch clamp that opens and closes when the needle is inserted and removed, respectively.
- Single lumen, radiopaque cannula that is placed in the selected vein, tunneled to the valve, and connected to the valve stem barbed connector.

The LifeSite® valve offers the unique ability to use an antimicrobial solution, 70% isopropyl alcohol (IPA), to locally cleanse the buttonhole site, valve pocket, and valve. Irrigation with IPA is accomplished via a 25-gauge needle. Inserting a 25-guage-irrigation needle does not open the valve's internal metal pinch clamp, ensuring that the IPA does not enter the circulation.

Two LifeSite® Systems are implanted subcutaneously; one system serves as the draw and the other system as the return. This procedure may be more time consuming than other catheter insertions.

To access the system and establish flow through the cannula, a 14-gauge needle is inserted through the skin into the valve's internal metal taper seal. Insertion of the needle opens the valve's internal pinch clamp to allow fluid flow through the cannula. When the 14-gauge needle is withdrawn, the pinch clamp closes the valve and prevents fluid flow. Thus, the valve pinch clamp is normally closed and allows access to the patient's circulation only after insertion of a 14-gauge needle. The 14-gauge dialysis needle is inserted at the same site for each cannulation, leading to the development of a sinus tract (or buttonhole) between the exist site in the skin and the valve entrance. Between treatments, this sinus tract remains closed by tissue interstitial pressure. This is referred to as the "buttonhole technique." The port valve system is connected to two large-bore silicone catheters that provide high flow rate and low resistance.

This system likely will provide a mid-term option for ESRD patients, an option not available in the past. It uses a port valve system made of titanium that is totally implantable subcutaneously. It provides immediate access and serves as a bridge to AV fistulas that have fewer complications compared to catheters and PTFE grafts.

Studies are ongoing, and some patients have used the system for two years. In a multi-center clinical trial, the LifeSite® Hemodialysis Access System delivered high flow rates, outstanding primary and secondary patency rates, and low infection rates.

This system is far more complex, costs more, and requires more skill to implant than traditional VADs. Its composition and use are distinctive enough that unique coding is necessary for tracking purposes.

ESRD patients who are hospitalized when immediate placement of dialysis access is required often experience an extended length of stay. This extended stay is possibly the result of the need to manage uremic complications and comorbid conditions associated with ESRD.

Coding Options

1. **Continue to use code 86.07**, Insertion of totally implantable vascular access device [VAD], to describe insertion of this device.

2. **Create a new code** describing this device. There is space in the current category, and the code would look like this:

   86.08, Insertion of implantable hemodialysis access valve system

   Alternatively, a new code could be placed in category 39, Other operations on vessels, and would look like this:

   39.81, Insertion of implantable hemodialysis access valve system

Recommendation

The Centers for Medicare and Medicaid Services (CMS) does not have a specific recommendation in this case, and would like to entertain comments from meeting attendees at this time.

Interim Coding

Continue to use code 86.07**,** Insertion of totally implantable vascular access device [VAD], to describe insertion of this device.

Proposed Addenda
FY 2004 (October 1,2003)

Index

Add term Duodenoplasty 46.79

Exploration – *see also* Incision
Add subterm shunt
Add subterm ventriculoperitoneal
Add subterm at peritoneal site 54.95
Add subterm at ventricular site 02.41

Add term Laminoplasty, expansile 03.09

Lavage
bronchus NEC 96.56
Add subterm diagnostic (endoscopic) bronchoalveolar lavage (BAL) 33.24
Add subterm whole lung lavage 33.99

Add term Neuroablation
Add subterm radiofrequency 04.2

Stimulation (electronic) – see also Implant, electronic stimulator
Add subterm defibrillator
Add subterm non-invasive programmed electrical stimulation (NIPS) 37.26

Therapy
Add subterm leech 99.99
Add subterm maggot 86.28

Tabular List

Revise code title 02.41 Irrigation and exploration of ventricular shunt
Add inclusion term Exploration of ventriculoperitoneal shunt at ventricular site

03.09 Other exploration and decompression of spinal canal
Add inclusion term Expansile laminoplasty

04.2 Destruction of cranial and peripheral nerves
Add inclusion term Radiofrequency ablation

33.24 Closed [endoscopic] biopsy of bronchus
Add inclusion term Diagnostic bronchoalveolar lavage (BAL)

Add exclusion term Excludes:
whole lung lavage (33.99)

33.99 Other operations on lung
Add inclusion term Whole lung lavage

37.26 Cardiac electrophysiologic stimulation and recording studies
Add inclusion term Non-invasive programmed electrical stimulation (NIPS)

46.79 Other repair of intestine
Add inclusion term Duodenoplasty

54.95 Incision of peritoneum
Add inclusion term Exploration of ventriculoperitoneal shunt at peritoneal site

86.28 Nonexcisional debridement of wound, infection, or burn
Add inclusion term Maggot therapy

86.65 Heterograft to skin
Add exclusion term Excludes: application of dressing (93.57)

93.57 Application of other wound dressing
Add inclusion term Porcine wound dressing

96.56 Other lavage of bronchus and trachea
Add exclusion term Excludes: diagnostic bronchoalveolar lavage (BAL)(33.24)
Add exclusion term whole lung lavage (33.99)

99.99 Other

Add inclusion term Leech therapy