



## **Summary of September 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 September 27-28, 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. Diagnosis 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](http://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](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp).

**None of the proposals discussed at the October meeting will go into effect April 1, 2008. If approved by CMS and NCHS, these revisions will go into effect with discharges on or after October 1, 2008.**

Suggestions for procedure code proposals to be considered at a future Coordination and Maintenance Committee, as well as comments on procedure proposals presented at the September meeting, may be emailed to Pat Brooks at [Patricia.brooks2@cms.hhs.gov](mailto:Patricia.brooks2@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.

Suggestions for diagnosis code proposals for consideration at a future Coordination and Maintenance Committee, as well as comments on diagnosis proposals presented at the September meeting, may be emailed to Donna Pickett at [dfp4@cdc.gov](mailto:dfp4@cdc.gov) or mailed to: Donna Pickett, National Center for Health Statistics, 3311 Toledo Road, room 2402, Hyattsville, Maryland 20782.

The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled for March 19-20, 2008 and will be held at the CMS building in Baltimore, MD. New proposals for inclusion on this agenda must be received by **January 18, 2008**.

## **Diagnoses**

### **Retrolental Fibroplasia (Retinopathy of Prematurity)**

Retinopathy of prematurity (ROP) is a leading cause of blindness in children. It is a serious vasoproliferative disorder involving the developing retina in premature infants. When ROP becomes severe, it usually requires intervention, such as retinal photocoagulation. Advanced stages can progress and result in blindness.

“Retrolental fibroplasia” is an older term which mainly applies to only cicatricial disease (i.e., when the retina is actually scarred). “Retinopathy of prematurity” is the disease name used to describe the acute retinal changes seen in premature infants.

New codes have been proposed in subcategory, Other proliferative retinopathy, to identify the stages of retinopathy of prematurity. It was suggested that the title of existing code 362.21 be changed from retrolental fibroplasia to cicatricial retinopathy of prematurity since the former term is outdated.

### **Necrotizing Enterocolitis**

Necrotizing enterocolitis is a serious gastrointestinal illness seen mainly in very low birth infants and is associated with bowel injury and intestinal mucosal disruption with enteric feedings, immature immune responses, and possibly infection by a pathogenic organism. The current code doesn’t distinguish levels of severity, so new codes identifying necrotizing enterocolitis with pneumatosis and perforation have been proposed. It was suggested that codes for the stages of the disease would be a preferable approach, however, others felt that the medical record documentation may not identify the stage, whereas the presence of pneumatosis or perforation would be documented.

### **Disruption of Operation Wound**

Currently, codes 998.31 and 998.32 are differentiated by whether the disruption of the operation wound is internal or external. However, physicians tend to document the tissues and/or layers involved, rather than using the terms “internal” and “external.” It has been proposed that a new code be created for disruption of operation wound, unspecified and that inclusion terms be added under codes 998.31 and 998.32 to clarify the layers or tissues that would be classified to each code. Based on the proposed inclusion terms, disruption or dehiscence of fascia, muscle or muscle flap, ribs or rib cage, skull or craniotomy, sternum or sternotomy, and full-thickness or deep disruption or dehiscence are classified to code 998.31. Disruption or dehiscence of cornea, mucosa, and skin are classified to code 998.32. It was suggested that other inclusion terms be added, and that anastomotic leak (e.g., intestine) be clearly excluded.

## **Neuroendocrine Tumors**

Neuroendocrine tumors represent a spectrum of benign and malignant tumors that arise from endocrine or neuroendocrine cells scattered throughout the body. Neuroendocrine tumors are generally classified into two groups, carcinoid tumors and pancreatic endocrine tumors. For carcinoid tumors, the most common sites are the bronchi, stomach, small intestine, appendix, and rectum. They are commonly classified according to the presumed embryonic site of origin: the foregut (bronchi and stomach), the midgut (small intestine and appendix), and the hindgut (colon and rectum). Pancreatic endocrine tumors most often occur in the pancreas, but may also originate in extra-pancreatic tissue such as the stomach or autonomic nervous system.

These tumors are characterized by their ability to produce a variety of amine and peptides that can cause characteristic hormonal syndromes. The most common systemic syndrome caused by carcinoid tumors is the carcinoid syndrome (code 259.2).

A new section for neuroendocrine disorders in the Neoplasm chapter has been proposed. Based on the number of changes to the proposal that commenters suggested during the meeting, NCHS agreed that a revised proposal would be developed.

## **Eosinophilic Gastrointestinal Disorders**

Eosinophilic gastrointestinal disorders involve eosinophil accumulation in the tissues lining the gastrointestinal tract, in the absence of known causes for eosinophilia (such as drug reactions, parasitic infection, connective tissue disease, or malignancy). These disorders include eosinophilic esophagitis, eosinophilic gastritis, eosinophilic gastroenteritis, eosinophilic enteritis, and eosinophilic colitis. Treatment includes diet limitations (to avoid antigens that trigger disease symptoms), use of a feeding tube, treatment with steroids, and other specific therapy (such as treatment with anti-interleukin-5 antibody).

Specific codes for eosinophilic esophagitis, eosinophilic gastritis, eosinophilic gastroenteritis, and eosinophilic colitis have been proposed. It was suggested that the proposed new code for eosinophilic gastritis be 535.7 instead of 535.41, since the fifth digits in category 535 are already used to indicate hemorrhage.

## **Heparin-Induced Thrombocytopenia**

Heparin-induced thrombocytopenia (HIT) is an immune reaction to heparin. HIT will occur in 3-5% of all patients receiving unfractionated heparin for at least five days (such as for treating deep vein thrombosis or unstable angina) and in about 0.5% of those receiving low molecular-weight heparin. The thrombocytopenic syndrome that develops is totally different from other drug-induced thrombocytopenias, such as those due to vancomycin, penicillin, or quinine. Differences include the degree of thrombocytopenia, the timing, the diagnostic tests, complications, and treatment. Bleeding, as seen with other iatrogenic thrombocytopenias, is not seen with HIT. Instead, half of all patients

present with an arterial or venous thrombosis (deep vein thrombosis, pulmonary embolism, stroke, myocardial infarction). Without prompt recognition and appropriate treatment, limb amputation may result in 10-20% of the cases and death may occur in as many as 20-30% of the cases.

A new code for heparin-induced thrombocytopenia has been proposed in subcategory 289.8, Other specified diseases of blood and blood-forming organs. Since HIT is a hypercoagulable state and not a hemorrhagic condition, it belongs in this subcategory rather than with the code for secondary thrombocytopenia (code 287.4). It was suggested that a “use additional code” note for the E code for the drug should be added under the proposed new code.

### **Extravasation of Vesicant Chemotherapy**

Extravasation of vesicant chemotherapy can cause significant tissue damage. Extravasation occurs when a substance passes out from a vessel or organ. Chemotherapy drugs can be classified as vesicants, with the potential to cause tissue necrosis if they extravasate, and non-vesicants, which do not cause tissue damage if they extravasate.

An expansion of code 999.2, Other vascular complications, or code 999.8, Other transfusion reaction, for creation of a new code for extravasation of vesicant chemotherapy has been proposed. It was recommended that the new code not be limited to chemotherapy, since other substances also cause injury with extravasation. It was also suggested that a “use additional code” note for the E code for the drug should be added under the proposed new code. Some commenters noted that code 999.2 is not the best place for the new code, as extravasation of vesicant drugs is not really a vascular complication. They preferred expansion of code 999.8 (with a change in the title so that it includes complications of transfusions and infusions) or code 999.9 (other and unspecified complications of medical care, not elsewhere classified).

### **Pressure [Decubitus] Ulcer Staging**

The most important element in quality measurement, workload, and clinical services for pressure ulcers is the depth of the lesion. New codes to identify the stage of the ulcer have been proposed. Since the ICD-9-CM structure does not allow the site and stage of the pressure ulcer to be captured in a single code, the new codes would identify only the stage and would be reported in conjunction with the existing codes for the site. Issues raised at the meeting included how an evolving (progressing) or healed pressure ulcer should be captured, how deep tissue injury (in which the stage of the ulcer is not yet apparent) should be handled, and whether nursing documentation could be used identify the stage for coding purposes, since this information is typically documented by nursing staff rather than the physician. It was agreed that these issues would need to be addressed in the *ICD-9-CM Official Guidelines for Coding and Reporting*.

### **Ventilator-Associated Pneumonia**

The second most common hospital-associated infection after catheter-associated urinary tract infections is hospital-associated pneumonia. It accounts for 15% of all hospital-associated infections and 25% of all infections acquired in intensive care units. The primary risk factor for the development of hospital-associated bacterial pneumonia is mechanical ventilation. Ventilator-associated pneumonia accounts for 60% of all deaths due to hospital-associated infections.

An expansion of code 997.3, Respiratory complications, has been proposed in order to create a unique code for ventilator-associated pneumonia. An Excludes note would be added under code 999.9, Other and unspecified complications of medical care NEC, since ventilator-associated pneumonia is currently indexed to this code.

### **Acanthamoeba Keratitis/Fusarium Keratitis**

Acanthamoeba keratitis is a rare but potentially blinding infection of the cornea, caused by a free-living amoeba (Acanthamoeba) that is found commonly in the environment. It primarily affects otherwise healthy persons who wear contact lenses. Although it can occur even when contact lens wearers follow recommended contact lens care practices, increased risk for infection exists for people who improperly store, handle, or disinfect their lenses; swim, use hot tubs, or shower while wearing contact lenses; come in contact with contaminated water; have minor damage to their corneas; or have previous corneal trauma.

Symptoms include eye pain, eye redness, blurred vision, sensitivity to light, sensation of something in the eye, and excessive tearing.

Fusarium keratitis is a fungal keratitis more prevalent in warm climates. Risk factors include trauma (generally with plant material), chronic ocular surface diseases, immunodeficiencies, and rarely, contact lens use. Signs and symptoms include unusual redness, eye pain, tearing, discharge, or sensitivity to light.

An expansion of code 136.2, Specific infections by free-living amoebae, has been proposed to create a unique code for infection due to acanthamoeba. An additional code should be assigned to identify the manifestation, such as keratitis (370.8). Tabular changes have been proposed to clarify that fusarium keratitis should be assigned code 118, Opportunistic mycoses, plus an additional code to identify the manifestation, such as keratitis (370.8).

### **Lipid Rich Plaque**

Real-time identification of plaque as being lipid-rich or non-lipid-rich represents important diagnostic information for the interventional cardiologist. Having this diagnostic information will help the cardiologist determine the most appropriate type of

stent (drug eluting vs. bare metal) to utilize, depending on the present location and amount of lipid-rich plaque.

A new code has been proposed for coronary atherosclerosis due to lipid rich plaque. One of the existing codes for coronary atherosclerosis (414.00-414.07) would be sequenced first.

### **Long-Term Current Use of Methadone**

Methadone is an opiate analgesic used to relieve moderate to severe pain that has not been relieved by non-narcotic pain relievers. It is also used to prevent withdrawal symptoms in patients who were addicted to opiate drugs and are enrolled in treatment programs in order to stop taking or continue not taking the drugs.

A new V58.6 has been proposed for long-term current use of opiate analgesic. An alternative option would be to add long-term current use of methadone and long-term current use of opiate analgesic as inclusion terms under existing code V58.69, Long-term (current) use of other medications. Clarification would need to be provided as to whether opiate dependence should also be coded when methadone is being used in the treatment of opiate dependence.

### **Wheelchair Dependence**

Since people who are wheelchair-bound are at greater risk for a variety of medical problems, a unique code has been requested for “wheelchair confinement status.” Commenters expressed concern that this code wouldn’t provide sufficient information about wheelchair-bound patients and the associated risks, as these patients have widely variable degrees of mobility.

### **Nontraumatic hematoma/Post-traumatic Seroma**

Patients who suffer from a large traumatic hematoma may subsequently develop a seroma in the soft tissue of the affected area. An expansion of code 729.9, Other and unspecified disorders of soft tissue, has been proposed to create a new code for post-traumatic seroma. A question was raised as to whether a post-traumatic seroma would more appropriately be classified as a late effect of injury.

Additionally, a unique code has been requested for nontraumatic hematoma of muscle (code 728.3, Other specific muscle disorders, would be expanded to create this code).

### **Acquired Absence of Cervix and Uterus**

New codes for acquired absence of both cervix and uterus, acquired absence of uterus with remaining cervical stump, and acquired absence of cervix with remaining uterus have been proposed. Due to lack of space in subcategory V45.7, Acquired absence of organ, a new category would be created for these new codes.

### **Prophylactic use of Agents Affecting Estrogen Receptors and Estrogen Levels**

A new subcategory for prophylactic use of agents affecting estrogen receptors and estrogen levels has been proposed. The long-term use of anti-estrogen agents, such as Tamoxifen and Raloxifene, following breast cancer treatment, or to prevent breast cancer in an individual with a strong family history or genetic susceptibility, would be classified to these codes.

The American College of Obstetricians and Gynecologists has indicated that these agents are used to prevent recurrence and metastasis, so classifying their use as prophylactic, regardless of whether a cancer code or a V code for history of cancer is used. So, a code from the proposed new subcategory could be used with a code for current cancer, personal history of breast cancer, family history of breast cancer, or genetic susceptibility to cancer, depending on the circumstances.

### **Staged Breast Reconstruction**

Staged breast reconstruction following full or partial mastectomy for breast disease or breast trauma usually takes place over the course of months or years. In addition to tissue expanders, implants, and grafts, revisions to the reconstructed breast may be needed to correct irregularities, the native breast may need to be balanced against the reconstructed breast, and the areola and nipple may need to be restored through grafting or tattooing. Some of the required procedures may be performed together during the same operative episode, and some may take place during separate encounters.

New codes to identify the reason for an encounter involving breast reconstruction have been proposed. Options include creating one code for encounter for breast reconstruction following mastectomy or creating several new codes differentiated by the type of procedure planned for that encounter. For both of these options, the new codes would be created in category V51, Aftercare involving the use of plastic surgery. A third option would be to not create any new codes and continue to use code V45.71, with the addition of specific inclusion terms and a revised title that states “Acquired absence of breast and nipple.”

The proposal also included new codes for ptosis of breast, hypoplasia of breast, and capsular contracture of breast implant. A new category for deformity and disproportion of reconstructed breast has also been proposed.

### **Leukemia in Relapse**

Relapse of leukemia is different from the primary disease not in remission and may require a whole new set of interventions and treatments that may be similar to the initial induction therapy or may involve more aggressive therapy. A new fifth digit subclassification for “in relapse” has been proposed for categories 203, Multiple myeloma and immunoproliferative neoplasms; 204, Lymphoid leukemia; 205, Myeloid

leukemia; 206, Monocytic leukemia; 207, Other specified leukemia; and 208, Leukemia of unspecified cell type. It has also been proposed that the title of the fifth digit subclassification “0” be modified to state “without mention of having achieved remission” in order to make the intent clearer.

### **Fever Presenting with Conditions Classified Elsewhere**

While inherent in a number of conditions, fever is considered a significant complication when associated with many chronic conditions, such as leukemia and sickle cell disease. The “code first” note currently under code 780.6, Fever, is not considered sufficient to show the connection between the underlying condition and the fever.

An expansion of code 780.6, Fever, has been proposed in order to create new codes for “Fever presenting with conditions classified elsewhere” and postprocedural fever. For fever presenting with conditions classified elsewhere, an instructional note would indicate that the underlying condition, such as leukemia, neutropenia, or sickle-cell disease, should be coded first. It was suggested that postoperative fever be classified to the new code, but post-vaccination fever should be classified to category 999, Complications of medical care, not elsewhere classified.

An Excludes note would indicate that the new codes should not be used for fever associated with confirmed infection. In this case, the confirmed infection should be coded and no additional code should be assigned for the fever. It was suggested that the title of subcategory 780.6 be revised to state “Fever and other disturbances of temperature regulation,” and that chills be moved from code 780.99 to this subcategory, since an individual may have chills without fever because he is unable to mount an immune response. It was also suggested that non-environmental hypothermia be moved to subcategory 780.6.

### **Abnormal Anal Cytologies and Anal Intraepithelial Neoplasia (AIN)**

A set of codes for abnormal anal cytologic smears that corresponds to the codes for abnormal cytologic smears of the cervix has been proposed. Due to space constraints in category 795, Other and nonspecific abnormal cytological, histological, immunological and DNA test findings, a new subcategory for abnormal cytologic smear of anus and anal HPV in category 796, Other nonspecific abnormal findings, would be created. A new code for dysplasia of the anus, which would include anal intraepithelial neoplasia I and II, has also been proposed in subcategory 569.4, Other specified disorders of rectum and anus.

### **Functional Urinary Incontinence and Functional Quadriplegia**

Functional urinary incontinence is defined as leakage of urine related to an irreversible impairment in cognitive functioning which leads to an impairment in the individual’s ability to exercise volitional control over bladder function. This type of incontinence is unique in terms of its progression, approaches to treatment, and expected outcomes.



Management strategies revolve around controlling the complications, such as urinary tract infections, and skin breakdown. Functional quadriplegia refers to the inability to move due to another condition (such as severe contractures or arthritis), resulting in the patient being “quadriplegia-like.” New codes in the Symptom chapter have been proposed for functional quadriplegia and functional urinary incontinence. Commenters noted that it would be important for instructional notes to make it clear that these codes should not be used for quadriplegia due to a neurological condition or urinary incontinence due to a urinary physiologic condition.

### **Vulvar Vestibulitis and Other Vulvodynia**

Vulvodynia is a syndrome of unexplained vulvar pain that is frequently accompanied by physical and psychological disability, limitation of daily activities, and sexual dysfunction. Vulvar vestibulitis is a subtype of vulvodynia characterized by distinct tenderness, and at times, erythema in the vestibule. The cause of vulvar vestibulitis and other vulvodynia is unknown, but it has been determined not to be associated with human papillomavirus or other sexually transmitted infections and is generally not associated with vulvar malignancies. Vulvodynia is distinct from vulvar pain due to specific conditions such as yeast infections. Treatment varies, and includes topical anesthetic agents, antidepressants, and anticonvulsants.

Creation of a new subcategory for vulvodynia has been proposed in category 625, Pain and other symptoms associated with female genital organs, with specific codes for vulvar vestibulitis and other vulvodynia.

### **External Cause for Overexertion, Strenuous and Repetitive Movements**

In order to better capture the cause of common injuries of military personnel, the US Department of Defense has requested that category E927, Overexertion and strenuous movements, be expanded to allow for the identification of the type of movement (mechanism) associated with an injury. The proposed new codes include overexertion from sudden strenuous movement, overexertion from prolonged static position, excessive physical exertion, cumulative trauma from repetitive motion, and cumulative trauma from repetitive impact. It would be possible for more than one of the proposed codes to be used together if the injury is the result of multiple causes within the category. Commenters noted that some of the terms used in the proposed code titles are rather subjective and that consideration should be given to revising the code titles to make them clearer and adding more inclusion terms for further clarity. It was also suggested that “unspecified” codes are needed for those instances when overexertion or repetitive movement is not further specified.

### **Personal History of Antineoplastic Chemotherapy and Monoclonal Drug Therapy**

Exposure to potent medicinal agents, such as antineoplastic chemotherapies, especially at a young age, increases the risk of developing other malignancies and other serious

conditions at a later age. This is particularly true for patients who have been treated for childhood leukemias.

Two new codes for personal history of antineoplastic chemotherapy and personal history of antineoplastic monoclonal drug therapy have been proposed. These codes would be created in a new category, V87, Other specified personal exposures and history presenting hazards to health. It was suggested that “antineoplastic” be omitted from the code titles, since some of the drugs that these codes are intended to cover are used for non-neoplastic conditions.

### **Contact with and Exposure to Mold**

A new code for contact with and exposure to molds has been proposed. Exposure to damp and moldy environments may cause a variety of health effects, or none at all. Some people are sensitive to molds, and for these people, exposure to molds can cause symptoms such as nasal stuffiness, eye irritation, wheezing, or skin irritation. Some people, such as those with serious allergies to molds, may have more severe reactions. Severe reactions may occur among workers exposed to large amounts of molds in occupational settings, such as farmers working around moldy hay. Severe reactions may include fever and shortness of breath. Individuals with chronic lung illnesses, such as chronic obstructive pulmonary disease, may develop mold infections in their lungs.

### **Suspected Fetal Conditions Not Found and Antenatal Screening**

Pregnant patients are referred to maternal-fetal specialists for detailed ultrasounds when an initial screening ultrasound indicates a possible abnormality. In many cases, the detailed exam shows no abnormality.

A new category, V89, has been proposed for suspected fetal conditions not found. This category would exclude known or suspected fetal anomalies affecting management of mother, not ruled out (codes 655.00-655.93). An Excludes note for the new codes would be added under category V28, Encounter for antenatal screening of mother and the title of code V28.3 would be revised to state “Encounter for routine screening for malformation using ultrasonics.” Some commenters disagreed with the creation of new codes for suspected fetal conditions not found, as they felt screening codes could be used instead, there would be confusion as to the appropriate use of these codes, there would be confusion between these codes and category 655, and these encounters should be coded in accordance with current coding guidelines.

### **Cervical Shortening**

A short cervix in the second trimester of pregnancy appears to be a warning sign of impending premature birth among women who have previously given birth prematurely. Research has found that women whose cervixes have shortened to less than 25 millimeters in length by the 16<sup>th</sup> week of pregnancy are three times more likely to deliver prematurely.

A unique code for cervical shortening complicating pregnancy has been proposed. Cervical shortening in non-pregnant patients would be indexed to code 622.5, Incompetence of cervix, for acquired cases and code 752.49, Other anomalies of cervix, vagina, and external female genitalia, for congenital cases.

### **Secondary Diabetes Mellitus**

A new category for secondary diabetes mellitus has been proposed. Other proposals to create new codes for secondary diabetes mellitus have been presented at previous C&M meetings, but none of them were implemented due to lack of consensus. The proposal presented at the September C&M meeting was supported by the Endocrine Society. The proposed new category for secondary diabetes mellitus parallels category 250, Diabetes mellitus, with the secondary diabetes differentiated by type of complication and an additional code assigned to identify the specific manifestation. The fifth digits for “controlled” and “uncontrolled” were not part of the proposal, but the Endocrine Society has recommended that a fifth digit subclassification indicating whether the diabetes is controlled or uncontrolled be added to the proposed new category for secondary diabetes mellitus. The Endocrine Society noted that physicians should continue to be allowed, as they are now, to use their professional judgment to determine a patient’s level of control, as control differs from patient to patient. They believe it would be inappropriate to use a specific measure, such as the hemoglobin A1C, to classify the level of control.

### **Newborn Post-Discharge Health Check**

The American Academy of Pediatrics (AAP) recommends that all otherwise healthy newborns that are discharged from the hospital less than 48 hours after delivery should be examined by their primary care provider within 2 days of discharge. An expansion of code V20.2, Routine infant or child health checks, to create codes distinguishing routine health check for newborn under and over 72 hours old. The AAP recommended during the C&M meeting that the time frame in the codes be changed to 96 hours. A commenter suggested that “weight check” be specifically included in these codes, as this is often documented as the reason for the encounter.

### **Androgen Insensitivity Syndromes**

The androgen insensitivity syndromes are the most common reasons for male pseudohermaphroditism. Complete androgen insensitivity syndrome has also been called testicular feminization or Goldberg-Maxwell syndrome. Affected individuals frequently develop as normal females through childhood and to adult appearance. In general, a vagina is present, but no uterus, and there is no menarche. The testes may be undescended or may be descended to the inguinal area. There is risk for testicular cancer, so the testes must be surgically removed.

In partial androgen insensitivity syndrome, there can be a wide variety in presentation, ranging from severe hypospadias and bifid scrotum, to essentially normal male phenotype

with infertility, or there can be extreme undervirilization with apparently female phenotype, but potentially with appearance of clitoromegaly and labial fusion. Reifenstein syndrome is one form of partial androgen insensitivity syndrome, with hypospadias, gynecomastia, and hypogonadism, along with post-puberty testicular atrophy and azoospermia.

There is currently a single code for androgen insensitivity syndrome. It has been proposed that distinct codes be created for unspecified androgen insensitivity, complete androgen insensitivity, and partial androgen insensitivity.

### **Hungry Bone Syndrome**

A new code has been proposed in category 275, Disorders of mineral metabolism, for hungry bone syndrome. Hungry bone syndrome occurs commonly after parathyroidectomy for either primary or secondary hyperparathyroidism. The hungry bone syndrome may also occur after treatment for thyrotoxicosis. It is characterized by hypocalcemia, and may also involve hypophosphatemia and hypomagnesemia. The hypocalcemia usually resolves within 3 weeks, but in some cases, it can last for much longer, even years.

The pathophysiology of hungry bone syndrome is thought to usually involve an extended history of previously elevated levels of parathyroid hormone, with some related bone demineralization, potentially with osteoporosis. The subsequent change in parathyroid hormone levels to low or normal results in the bone sequestering calcium (“hungry bone”), leading to increased density of bone.

### **Isolated Systolic Hypertension and Isolated Diastolic Hypertension**

Isolated systolic hypertension is the leading cause of uncontrolled hypertension in people over 50 years old. The systolic blood pressure is the most significant predictor of cardiovascular mortality. Essential hypertension commonly is the mixed systolic/diastolic form, whereby both the systolic and diastolic blood pressure is elevated.

An expansion of category 401, Essential hypertension, has been proposed to distinguish isolated systolic hypertension, isolated diastolic hypertension, and mixed systolic/diastolic hypertension. More than one code from category 401 could be assigned, in order to identify benign or malignant hypertension as well as whether the hypertension is isolated systolic, isolated diastolic, or mixed systolic/diastolic. The proposed new codes could be used in conjunction with the codes for hypertensive heart disease and hypertensive heart and chronic kidney disease. Alternatively, a new category for isolated and mixed hypertension could be created. This option would require that a code for the type of hypertension (essential, hypertensive heart disease, hypertensive heart and chronic kidney disease, secondary hypertension) be sequenced first. Commenters expressed concern that physicians don’t typically document the terms included in this code proposal. Also, “isolated” could be confused with an isolated elevated blood pressure reading. It was suggested that it might be preferable to create codes for

“controlled” and “uncontrolled” hypertension, since these are terms commonly documented by physicians, but they don’t have unique ICD-9-CM codes.

### **Diagnosis Addenda**

Proposed diagnosis addenda changes were reviewed. Highlights of the proposed revisions include (note that these are only proposed at this point – they have not been finalized):

- Addition of note under code 289.83, Myelofibrosis, indicating that an additional code should be used for associated therapy-related myelodysplastic syndrome, if applicable (238.72, 238.73);
- Addition of note under code 289.83, Myelofibrosis, indicating that an additional external cause code should be used if due to anti-neoplastic chemotherapy (E933.1);
- Deletion of note under code 315.34, Speech and language developmental delay due to hearing loss, indicating that an additional code should be used to identify type of hearing loss;
- Addition of inclusion term for “complex regional pain syndrome type II of the upper limb” under code 354.4, Causalgia of upper limb;
- Addition of inclusion term for “complex regional pain syndrome NOS” under code 355.9, Mononeuritis of unspecified site;
- Deletion of the “code first” notes under codes 365.41, Glaucoma associated with chamber angle anomalies, 365.42, Glaucoma associated with anomalies of iris, and 365.43, Glaucoma associated with other anterior segment anomalies;
- Deletion of the “use additional code” notes under codes 365.51, Phacolytic glaucoma, 365.52, Pseudoexfoliation glaucoma, 365.59, Glaucoma associated with other lens disorders, 365.61, Glaucoma associated with papillary block, 365.62, Glaucoma associated with ocular inflammations, 365.63, Glaucoma associated with vascular disorders, 365.64, Glaucoma associated with tumors or cysts, and 365.65, Glaucoma associated with ocular trauma;
- Addition of note under code 415.11, Iatrogenic pulmonary embolism and infarction, indicating that an additional code should be assigned for associated septic pulmonary embolism, if applicable (415.12);
- Addition of note under code 746.84, Obstructive anomalies of heart NEC, indicating that an additional code should be assigned for associated anomalies, such as coarctation of aorta (747.10), congenital mitral stenosis (746.5), and subaortic stenosis (746.81);
- Addition of note under code 771.81, Septicemia [sepsis] of newborn, indicating that an additional code should be assigned to identify severe sepsis (995.92) and any associated acute organ dysfunction;
- Addition of inclusion term for “frailty” under code 797, Senility without mention of psychosis;
- Addition of acute respiratory insufficiency (518.82), acute vascular insufficiency of intestine (557.0), and necrosis of intestines (557.0) to the “use additional code” note under codes 995.92, Severe sepsis, and 995.94, Systemic inflammatory response syndrome due to non-infectious process with acute organ dysfunction;

- Addition of inclusion term for “disruption of postprocedural wound closure or post-traumatic wound repair” under subcategory 998.3, Disruption of operation wound.
- Addition of inclusion term for “sex reassignment surgery status” under subcategory 302.5, Transsexualism;
- Revision of Index entry for dermatitis, stasis (454.1);
- Addition of hand sanitizer to the Table of Drugs and Chemicals;
- Addition of Index entries for:
  - Abnormal liver function test (790.6);
  - Admission, for fitting of portacath (V58.81);
  - BOOP (bronchiolitis obliterans-organized pneumonia) (516.8);
  - Breast, dense (793.89);
  - Bronchitis, acute or subacute, with bronchiectasis (494.1);
  - Deficit, cognitive (294.9);
 

NOTE: It was suggested that this proposed Index entry should be postponed because the American Academy of Neurology is currently working on a code proposal pertaining to this topic.
  - End of life, artificial heart valve (996.02), pacemaker lead or battery (V53.31), and joint prosthesis (996.47);
 

NOTE: It was suggested that consideration should be given to differentiating “premature” vs. “routine” end of life of some of these devices. It was also suggested that Index entries for end of life of defibrillators and neurostimulators should be also created.
  - Gastroenteritis, due to antineoplastic chemotherapy (558.9);
  - Osteopenia, borderline (733.90);
  - Pregnancy, complicated by, maternal drug abuse (648.4);
  - Tachycardia, sustained (427.2), supraventricular (427.0), and ventricular (427.1);
  - Worn out, artificial heart valve (996.02), pacemaker lead or battery (V53.31), and joint prosthesis (996.47).
 

NOTE: Same comments as noted above under “end of life” apply to these Index entries as well.

## Procedures

### Non-Invasive Positive Pressure Ventilation

Currently, ICD-9-CM code 93.90, Continuous positive airway pressure [CPAP] includes non-invasive positive pressure ventilation (NIPPV). In recent years, however, respiratory treatment modalities have changed and it is suggested that CPAP is a form of NIPPV and, therefore, NIPPV should have its own unique code. It has also been suggested that NIPPV delivered via face or nasal mask utilizes resources that are similar to invasive (mechanical) positive pressure ventilation in treating patients who are diagnosed with acute respiratory failure.

In CPAP, the machine delivers a constant elevated airway pressure. This pressure is the same during inspiration and expiration and thus no breathing (ventilatory) assistance is provided. CPAP is used to stabilize airway structures in obstructive sleep apnea and stabilize alveolar structures in conditions such as pulmonary edema. CPAP is most commonly delivered via face mask, but can be provided through an endotracheal tube or tracheostomy.

In positive pressure ventilation (PPV), the machine delivers a higher pressure during inspiration than during expiration. PPV thus provides breathing (ventilatory) assistance. It is used to provide ventilatory assistance for patients with acute respiratory failure through either a face mask (non-invasive PPV or NPPV) or an endotracheal tube or a tracheostomy (invasive). NPPV is also sometimes used during sleep to provide ventilatory assistance to patients with sleep apnea or chronic CO<sub>2</sub> retention. PPV and NPPV can be provided with a variety of different pressure and flow configurations as well as with or without backup machine breaths (e.g., assist control (ACV), volume assist control (VACV), pressure assist control (PACV), pressure support (PSV), airway pressure release ventilation (APRV), and synchronized intermittent mandatory ventilation (SIMV)). These different flow, volume, and backup rate combinations should not be used to distinguish different levels of support or intensity of support, as they all can act as respiratory life support strategies.

In positive end expiratory pressure (PEEP), the machine delivers an elevated pressure during expiration to maintain stability of alveolar structures as the lung empties. PEEP is often used in conjunction with the higher inspiratory pressures and breathing (ventilatory) assistance of PPV.

It has been proposed to create a new code for “other non-invasive positive pressure ventilation [NIPPV]” in category 96, Nonoperative intubation and irrigation. CPAP would continue to be classified to code 93.90. It was suggested that the term “invasive” be added to the title of subcategory 96.7, Other continuous mechanical ventilation, to clearly distinguish the new code from the codes in this subcategory. It was also suggested that the term “mechanical” be added to the title of the proposed new code to clarify that NIPPV is still mechanical ventilation, but the delivery of the ventilation differs from that described by the 96.7 codes. Based on a question from the audience, the presenter indicated that BiPAP<sup>®</sup> via tracheostomy should be classified to subcategory 96.7. This comment would necessitate some changes to the Excludes notes in the original proposal.

### **SuperOxygenation Therapy**

SuperOxygenation therapy is designed to ameliorate progressive myocardial necrosis by minimizing microvascular damage in acute myocardial infarction patients following percutaneous intervention with coronary artery stent placement. The net effect of this therapy is to reduce infarct size and thus preserve heart muscle. SuperOxygenation therapy is accomplished via cartridge-based automated system that withdraws arterial blood from the patient and mixes it with a small amount of saline, supersaturated with

oxygen, to create highly oxygen-enriched blood. This blood is delivered directly to the stented coronary artery via an infusion catheter.

A unique code for SuperOxygenation infusion therapy has been proposed in subcategory 00.6, Procedures on blood vessels. It was suggested that Excludes notes for the proposed new code be added under code 93.96, Other oxygenation enrichment, code 99.10, Injection or infusion of thrombolytic agent, and category 99.2, Injection or infusion of other therapeutic or prophylactic substance. It was also suggested that consideration be given to creating the new code in subcategory 00.4, Adjunct vascular system procedures, instead of subcategory 00.6.

### **Laparoscopic Repair of Hernia**

New codes for laparoscopic hernia repairs have been proposed. Rather than create separate subcategories for laparoscopic unilateral and bilateral hernia repairs, it was suggested that all of the laparoscopic hernia repair codes be created in one subcategory in order to conserve space in ICD-9-CM. An alternative suggestion was to create an adjunct code indicating a procedure was performed laparoscopically, to avoid the need to create unique codes for every procedure that will eventually be able to be performed via a laparoscopic approach and thus conserve space in ICD-9-CM.

### **Surgical Closure of Atrial Appendage**

In patients with atrial fibrillation, exclusion or closure of the left atrial appendage by oversewing, clipping, or stapling is routinely performed by cardiovascular surgeons during a major cardiovascular procedure, such as coronary artery bypass graft, mitral valve repair, or maze procedure. Closure or exclusion of the left atrial appendage is performed to prevent future strokes.

It has been proposed to create a new code for excision or destruction of left atrial appendage, open approach, in subcategory 37.3, Pericardiectomy and excision of lesion of heart. An alternative approach would be to add this procedure as an inclusion term under existing code 37.33, Excision or destruction of other lesion or tissue of heart, open approach, rather than create a new code. A commenter suggested that this procedure should be considered inherent to the major surgical procedure and not separately coded. It was also suggested that if a new code is created, subcategory 37.3 is not the best location because exclusion or closure of the left atrial appendage does not involve excising or destroying any tissue.

### **Biventricular Replacement – Artificial Heart**

Code modifications have been proposed to clarify the coding of the implantation and removal of biventricular mechanical heart assist devices (artificial heart). CMS has a longstanding noncoverage policy regarding the use of artificial hearts when used as a permanent replacement for the human heart or as a temporary replacement for patients awaiting heart transplantation. However, on August 1, 2007, CMS' Coverage and



Analysis Group issued a national covered analysis (NCA) for artificial hearts when used for bridge to heart transplantation and for destination therapy. As defined in this NCA, an artificial heart is an implanted prosthetic device that replaces the heart. As part of the artificial heart implantation, a substantial part or all of the biological heart is removed. The artificial heart differs from a ventricular assist device that is attached to the intact native heart at the ventricle. Because the heart remains intact, it is possible for the native heart to recover its function after being assisted by a ventricular assist device. Since the artificial heart requires resection of the ventricles, the native heart is no longer intact and recovery of the native heart is not possible.

The proposed code modifications include revision of the title of code 37.52 to state “Implantation of internal biventricular heart replacement system.” An instructional note would be added under this code to explain this procedure and to indicate that ventriculectomy should not be coded separately. A new code for removal of internal biventricular heart replacement system has also been proposed. This code would always be assigned in conjunction with another procedure code, such as heart transplantation or implantation of a replacement biventricular heart replacement system.

### **Oxiplex<sup>®</sup> Surgical Gel**

Oxiplex<sup>®</sup> is an absorbable, viscoelastic gel that is surgically implanted during a posterior discectomy, laminotomy, or laminectomy. Oxiplex<sup>®</sup> has been described as only being approved for use outside of the US and is designed to act as a protective coating to prevent post-surgical adhesions from forming. However, in the US pivotal trial, Oxiplex<sup>®</sup> was evaluated for pain relief, not adhesion prevention.

This gel reduces the potential for inflammatory mediators that injure, tether, or antagonize the nerve root in the epidural space by creating an acquiescent, semi-permeable environment to protect against localized debris. It coats tissue such as the nerve root in the epidural space to protect the nerve root from the effects of inflammatory mediators originating from either the nucleus pulposus or from blood-derived inflammatory cells or cytokines during the healing process. This gel is used as an adjunct to posterior discectomy, laminectomy, or laminotomy for the reduction of pain, radiculopathy, and lower extremity weakness and incidence, extent and severity.

A new code has been proposed for insertion of absorbable, viscoelastic gel. Although some members of the audience were not in support of creating a unique code, there was some concern about CMS’ recommendation to use existing code 99.77, Application or administration of adhesion barrier substance, since this gel is not being used as an adhesion barrier in the US.

### **Laparoscopic Colectomy**

New codes to differentiate laparoscopic and open colectomy procedures have been proposed. It was suggested that creation of an adjunct code to indicate a procedure was performed laparoscopically should be considered, to avoid the need to create unique

codes for all of the procedures that will eventually be able to be performed laparoscopically and thus conserve space in ICD-9-CM. It was also suggested that rather than create a laparoscopic counterpart for every existing colo-rectal procedure, each procedure should be considered individually to identify those that actually are being performed laparoscopically and that are typically done in an inpatient setting.

### **Intra-Aneurysm Sac Pressure Measurement**

One potential complication during an endovascular aneurysm repair is an endoleak (leaking of blood around the graft and into the aneurysm sac). An endoleak causes continued pressurization of the aneurysm sac and may leave the patient at risk for subsequent aneurysm repair. Standard clinical practice includes the use of imaging to determine if endoleaks are present at time of graft placement. Another method used to detect endoleaks in conjunction with imaging is evaluation of sac pressure within the aneurysm. The EndoSure<sup>®</sup> Wireless Pressure Measurement System provides intra-aneurysm sac pressure during endovascular aneurysm repair. This system is comprised of a miniaturized, wireless implantable sensor and an external electronics module. The external electronics module wirelessly communicates with the sensor to deliver sac pressure. The sensor is powered by radiofrequency energy transmitted from the electronics module and provides real-time data without batteries.

A new code has been proposed for insertion of intra-aneurysm sac pressure monitoring device. “Code also” notes would be added under codes 39.71, Endovascular implantation of graft in abdominal aorta, and 39.73, Endovascular implantation of graft in thoracic aorta. An Excludes note would be added under code 89.61, Systemic arterial pressure monitoring, to refer people to the new code.

### **Percutaneous Vertebral Augmentation**

A modification of the title of code 81.66, Kyphoplasty, has been proposed in order to incorporate other comparable methods of vertebral augmentation. The proposed title of code 81.66 would be “percutaneous vertebral augmentation.” Kyphoplasty and spineoplasty would be added as inclusion terms. The title of code 81.65 would be changed to “percutaneous vertebroplasty.” An alternative option would be to collapse codes 81.65 and 81.66 into one code due to the clinical uncertainty over height restoration and the lack of consensus from the spine community on the differentiation between these various methods of vertebroplasty and vertebral augmentation.

Conventional vertebroplasty is a single step procedure in which bone cement, or polymethylmethacrylate, is percutaneously injected into the vertebrae under imaging guidance. The cement hardens and stabilizes the vertebrae, preventing further progression of the fracture or vertebral collapse, thereby reducing the associated pain.

Vertebral augmentation is a two-step procedure. Using a variety of techniques and devices, an attempt is made to mechanically augment or increase the vertebral body height, prior to injecting the cement filler. Kyphoplasty, for example, uses a technique

that involves using an inflatable balloon to create a cavity or void into which cement is then injected. Other techniques involve inserting a jack, tamp, or other shaping tool to create spaces by displacing bone and then injecting cement or other fillers. Spineoplasty involves creating a space with a shaping tool and then filling it with a mesh bag containing the filler. In another technique, thin implants are stacked on top of each other within the vertebral body prior to introducing the cement. Although a goal of augmenting the vertebrae may be to restore vertebral height, there is clinical uncertainty over whether height restoration is an established outcome.

A commenter expressed concern that adding the term “percutaneous” to the code titles for 81.65 and 81.66 would mean that these codes could not be used if these procedures are performed in conjunction with an open procedure. Another commenter preferred that the title of code 81.66 not be changed, since “kyphoplasty” is the term typically documented by physicians. It was noted that there is confusion about the distinctions between the procedures classified to codes 81.65 and 81.66 and that physicians often use the various terms interchangeably.

### **Flow Reserve and Intravascular Pressure Measurement**

Fractional Flow Reserve (FFR) is a technique developed to assess the severity of coronary artery stenoses that might otherwise not be accurately measured by conventional angiography. FFR involves using a pressure-sensitive catheter to compare the intravascular pressure distal to a coronary lesion to the mean aortic pressure proximal to the lesion at maximum hyperemia in order to develop a ratio between the two, which can then be used to assess the functional severity of the lesion in terms of limitation of blood flow. It is usually done in conjunction with other diagnostic coronary artery procedures in order to help determine the most appropriate therapeutic intervention (i.e., stenting, angioplasty). FFR also allows physicians to better diagnose more complex disease such as serial stenoses, diffuse disease, and patients with multi-vessel disease. These intravascular pressure measurements are also valuable after treatment in order to determine whether or not an intervention is successful. They have also been used in non-coronary vessels for similar clinical benefits.

Currently, code 89.69, Monitoring of coronary blood flow, is assigned for FFR of coronary arteries. Code 89.61, Systemic arterial pressure monitoring, is assigned for intravascular pressure measurement of intrathoracic and peripheral arteries. Code 89.62, Central venous pressure monitoring, is assigned for intravascular pressure measurement of venous system. New codes have been proposed for intravascular pressure measurement of coronary arteries, intrathoracic arteries, peripheral arteries, and other and unspecified vessels. It was suggested that either a new code also be created for intravascular pressure measurement of intra-abdominal arteries or else these arteries should clearly be included in one of the proposed codes. Another suggestion was to just create two codes, for coronary arteries and non-coronary arteries, in order to reduce the number of new codes and conserve space in ICD-9-CM.

## **Intravascular Spectroscopy**

A fiber-optic, catheter-based near-infrared spectroscopy system has been developed for the detection of lipid rich coronary plaques, which would assist interventional cardiologists in determining the most appropriate type of stent to utilize depending on the presence, location, and amount of lipid rich plaque. The detection of lipid rich plaques is believed to have a number of important clinical benefits. A number of issues have arisen with regard to the use of stents in the treatment of coronary artery disease. Drug-eluting stents have been associated with late stent thrombosis and that stenting has not been shown to prevent subsequent myocardial infarction and cardiac death. The ability to detect lipid rich plaques can assist in determining whether it is appropriate for drug-eluting stent(s) to be implanted rather than bare metal stent(s). Studies have shown that thrombosis was much more frequent when a drug-eluting stent, compared to a bare metal stent, was implanted over a lipid rich plaque. Also, since lipid rich plaques are suspected of causing secondary events after stenting, understanding whether other present, but not stented, plaques are lipid rich can influence the choice of treatment of these plaques.

A new code for intravascular spectroscopy has been proposed in subcategory 38.2, Diagnostic procedures on blood vessels. The proposed code could be used for both coronary and peripheral vessels. A commenter suggested adding an Excludes note pertaining to the new code under subcategory 00.2, Intravascular imaging of blood vessels.

## **Percutaneous Dilatational Tracheostomy**

Currently, ICD-9-CM codes do not distinguish between performing a tracheostomy using the traditional surgical approach, typically performed in the operating room, from a percutaneous dilatational tracheostomy, which is typically performed at the bedside. Percutaneous dilatational tracheostomy involves making an incision in the skin over the tracheal cartilage and inserting a needle into the trachea through which a guidewire is inserted, and then using dilator(s) to create an opening by sliding them into the trachea over the guidewire. When the opening is large enough, a standard tracheostomy tube is inserted and secured to the neck in standard fashion. Bronchoscopy is often, but not always, performed at the same time in order to visualize and confirm the placement of the needle, guidewire, and dilators. The primary difference between percutaneous tracheostomy and the traditional open tracheostomy is that in the traditional procedure, an opening is made in the trachea with a scalpel after it is surgically exposed, whereas in the percutaneous tracheostomy, an opening is made in the trachea with dilators that are passed over a guidewire.

A unique code for percutaneous dilatational tracheostomy has been proposed. Attendees' opinions were divided between creating a unique code vs. continuing to assign code 31.29, Other permanent tracheostomy, for both the traditional tracheostomy and the percutaneous dilatational tracheostomy.

## Repair of the Annulus Fibrosus

Following a discectomy, an open pathway or hole is left in the annulus fibrosus of the disc. Traditionally, this defect has primarily been left to heal. Not repairing the annular defect may contribute to recurrent disc herniation, a higher rate of reoperation, and poor patient outcomes. Today, surgeons are beginning to repair the annulus fibrosus by various techniques. Repairing and sealing the annulus fibrosus after a lumbar discectomy procedure for a herniated disc may reduce reoperations and improve patient outcomes by:

- Closing the annular defect to restrict nuclear material from re-extruding and compressing on the nerve root causing pain;
- Reducing inflammation and scar formation of the nerve root and surrounding tissues; and
- Enabling less extensive disc material removal during the discectomy procedure, allowing for better patient outcomes such as lower back pain, faster return to work, less narcotic usage, and higher patient satisfaction.

There are several possible techniques for repairing the annulus fibrosus. Microsurgical suture repair of the annulus fibrosus following lumbar discectomy is a technically difficult and time-consuming procedure for which there are different variations on the technique. One type of technique provides closure of the annular defect by using two or three 4-0 absorbable sutures on half-circle needles that are placed through the annular tissue spanning the split below the outer surface of the annulus and equidistant along the slit annulotomy incision. Additionally, an autograft can be used to augment the strength of the annuloplasty.

Another technique for repairing the annulus fibrosus is soft tissue re-approximation repair. The Xclose™ Tissue Repair System is an example of this technique. This system consists of two sterile, disposable delivery tools containing polyester tension bands constructed of tension lines and T-anchor assemblies. The needle of the delivery tool is inserted into the annular tissue to deploy the first T-anchor assembly below the outer surface of the annulus. The delivery tool is then removed from the outer surface of the annulus, repositioned across the defect, and reinserted through the annular tissue on the opposite side of the defect. A second T-anchor assembly is then deployed below the surface of the annulus. The delivery tool is removed and a knot pusher is used to secure the pre-tied knot against the outer surface of the annulus to close the defect by re-approximation of soft tissue. This technique is usually repeated with a second tension band pre-loaded on a delivery tool.

Surgical mesh repair of the annulus fibrosus following lumbar discectomy may currently be facilitated with the Inclose™ Surgical Mesh System. This system consists of a polyester mesh and two anchor band assemblies pre-loaded on sterile, disposable delivery tools. The mesh pre-loaded on its delivery tool is placed below the surface of the annulus prior to being deployed. Following mesh deployment, the first anchor band delivery tool is inserted through the annular tissue and then through the mesh below the surface of the annulus. The anchor band is then deployed, affixing the mesh to the annulus. The second anchor band is then inserted and deployed in a similar manner.

Two new codes describing repair of the annulus fibrosus with graft or prosthesis and other and unspecified repair of the annulus fibrosus have been proposed. A commenter suggested creating the new code in subcategory 80.5, Excision or destruction of intervertebral disc, instead of subcategory 81.6, Other procedures on spine. It was also suggested that a “code also” note be added under code 80.51, Excision of intervertebral disc, since the repair of the annulus fibrosus would typically be performed in conjunction with this procedure.

### **Procedure Addenda**

Proposed procedure addenda changes were reviewed. Highlights of the proposed revisions include (note that these are only proposed at this point – they have not been finalized):

- Addition of Excludes notes under codes 70.50, Repair of cystocele and rectocele, 70.51, Repair of cystocele, and 70.52, Repair of rectocele, indicating the appropriate codes for repair of cystocele and rectocele with graft or prosthesis;
- Revision of Index entry for VAD (vascular access device) – see vascular access device, totally implantable (86.07);
- Addition of Index entries for:
  - Administration (of) Proleukin (low dose) (99.28);
  - Administration (of) Proleukin, high-dose (00.15);
  - Debridement, tendon (83.31);

NOTE: A commenter suggested code 83.42, Other tenonectomy, instead of code 83.31.

  - Embolization, artery (selective), uterine (transcatheter) (99.29);
  - Infusion, interleukin-2, high-dose (00.15);
  - Infusion, interleukin-2, low-dose (99.28).