New ICD-9-CM Committee Presents New Codes, Changes

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This is part 1 of a two-part summary of proposals from the April 2002 ICD-9-CM Coordination and Maintenance Committee meeting and includes procedure proposals. Part 2 will include diagnosis proposals and will be published in the October Journal of AHIMA.

The ICD-9-CM Coordination and Maintenance Committee, cosponsored by the National Center for Health Statistics (NCHS) and the Centers for Medicare & Medicaid Services (CMS), met in April 2002 in Baltimore, MD. Donna Pickett, RHIA, from NCHS, and Patricia Brooks, RHIA, from CMS, co-chaired the meeting.

Proposed modifications to ICD-9-CM were presented and are summarized below. Unless otherwise indicated, the audience generally supported the proposed changes.

Procedures

The deadline for comments on procedural proposals not implemented on October 1, 2002, is January 10, 2003.[1] A meeting summary for the procedure portion can be accessed at www.hcfa.gov/medicare/icd9cm.htm.

Continuous Intra-arterial Blood Gas Monitoring

There is no specific procedure code to capture continuous intra-arterial blood gas monitoring. There is an ICD-9-CM code, 89.65, that captures measurement of systemic arterial blood gases.

Blood gas status is extremely important as a direct clinical indicator of cardiopulmonary function. In critical and surgical care patients, particularly those with acute lung disorders, multi-system organ failure, or compromised cardiac or pulmonary function, pH, pCO2, and pO2 change rapidly. 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 laboratory and intermittent results are reported to the physician.

In contrast, continuous blood gas monitoring through the use of an intra-arterial sensor has the ability to deliver an uninterrupted display of data. This type of monitoring shows the current status of the patient"s arterial blood gases and trends for the previous 24 hours. In addition to results on pH, blood gases, and temperature, the system also calculates bicarbonate, base excess, and oxygen saturation values.

A continuous blood gas monitoring system is comprised of in vivo intra-arterial continuous blood gas sensors, a monitor, and a calibrator. The adult and pediatric sensor is inserted through an arterial catheter into a patient"s peripheral radial or femoral artery. The neonatal sensor is inserted through an umbilical artery catheter. The sensor remains in situ in the patient"s bloodstream. No blood is removed for testing. This continuous monitoring enables the care team to identify the onset of adverse events through continuous real-time information and trends, immediately confirm ventilator changes and resuscitation goals, and 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, severe respiratory failure, sepsis, multi-organ system failure, and for use in trauma resuscitation, trauma surgery, and high-risk and cardiac surgery. The primary clinical indications for the use of continuous blood gas monitoring in neonates include prematurity and low birth weight, acute lung disorders, multi-organ system failure, and compromised cardiac or pulmonary function.

It has been proposed that a new code be created in subcategory 89.6, Circulatory monitoring, to capture continuous intra-arterial blood gas monitoring. In the meantime, this procedure would continue to be classified to code 89.65, Measurement of systemic arterial blood gases. A concern was raised that codes in subcategory 89.6 are underutilized and even when codes from this subcategory are assigned, they may not be reported on the reimbursement claim because more significant procedures are sequenced first.

Multi-level Spinal Fusions

Multi-level spinal fusion is a spinal fusion involving three or more vertebrae at two or more levels. Each interspace between adjacent vertebral bones is considered one level. 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). It is currently not possible to identify the number of spinal levels fused.

A spinal fusion involves removing the 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 heal over time and create 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 true for refusions, or when multiple levels are fused. Hardware may also include interbody cages, 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.

Because it is held that the average length of stay and cost are significantly increased if several levels are fused, alternative approaches for capturing information about the number of levels fused have been proposed. One approach would be to create three new codes in subcategory 81.6, Other procedure on spine, that specify the anatomic level (cervical, dorsal/dorsolumbar, and lumbar/lumbosacral) when a multiple level fusion is performed. These codes would be reported once as an additional code in conjunction with the primary fusion and refusion codes (81.02-81.08 and 81.32-81.38). These codes would indicate that additional levels of the spine were fused, but would not indicate how many levels.

Another approach would be to create two new codes to describe the fusion or refusion of additional spinal levels without specifying the anatomic level involved. A third option would be to create one new code to describe the fusion of additional spinal levels that would be reported for both fusions and refusions.

These three options would involve reporting the new codes only once, regardless of the number of additional levels fused. There was general agreement among participants at the meeting that the codes (either the existing ones or new ones) should not be reported multiple times to identify the exact number of levels fused.

Comments from the audience indicated that fusion of two levels is more similar, both clinically and in terms of resource use, to one-level fusions than to multi-level fusions. It was also generally agreed that scoliosis patients requiring fusion of 10-16 levels were the most resource-intensive of the spinal fusion procedures. Therefore, it was suggested that perhaps codes for ranges of number of levels of fusion would be appropriate (for example, 1-2 levels, 3-5 levels, more than 5 levels).

An approach involving the use of an additional code to capture the concept that multiple levels were fused, along with one of the existing spinal codes, was favored in order to capture information about the anatomic level and approach involved. It was generally agreed that creating multiple codes to capture the number of levels involving anatomic site and approach was not an optimal solution.

Because this topic involved a great deal of discussion with numerous suggestions, CMS noted that new multi-level spinal fusion codes might not be finalized in time for the upcoming October 2002 code changes. If these new codes could not be finalized for implementation this year, then another proposal will be brought forward to the December 2002 Coordination and Maintenance Committee for further discussion.

Vascular Access Device

A new type of device is available for hemodialysis vascular access. It involves a subcutaneously implanted valve and a single lumen cannula that is placed in the selected vein, tunneled to the valve, and connected to the valve stem barbed connector.

Two access systems are implanted subcutaneously; one system serves as the draw and the other one serves as the return. To access the system and establish flow through the cannula, a 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 to flow through the cannula. When the needle is withdrawn, the pinch clamp closes the valve and prevents fluid flow. The needle is inserted at the same site for each cannulation, leading to the development of a sinus tract (or buttonhole) between the exit 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."

This type of hemodialysis access system is much more complex, costly, and requires more skill to implant than traditional venous access devices. It has been proposed to create a unique code in subcategory 86.0, Incision of skin and subcutaneous tissue, to capture this type of hemodialysis access device. Participants expressed concern that the medical record documentation might not differentiate this type of access system from those types classifiable to code 86.07, Insertion of totally implantable vascular access device. The presenter for this topic noted that some of these devices use a septum instead of a valve, which would further complicate efforts to distinguish insertion of this access system from other hemodialysis access systems.

Addenda

Proposed October 1, 2003, addenda changes were reviewed. Highlights of proposed revisions include:

- addition of Index entry for "diagnostic (endoscopic) bronchoalveolar lavage (BAL)" to direct coders to code 33.24
- addition of Index entry for "lung (whole) lavage" directing coders to code 33.99
- addition of Index entry for "neuroablation, radiofrequency" directing coders to code 04.2
- addition of Index entry for "laminoplasty, expansile" directing coders to code 03.09
- addition of Index entry for "duodenoplasty" directing coders to code 46.79
- addition of Index entry for "therapy, leech" directing coders to code 99.99
- addition of Index entry for "therapy, maggot" directing coders to code 86.28
- addition of Inclusion term under code 93.57, Application of other wound dressing, for porcine wound dressing
- addition of Inclusion term under code 37.26, Cardiac electrophysiologic stimulation and recording studies, for non-invasive programmed electrical stimulation (NIPS)

The next meeting of the ICD-9-CM Coordination and Maintenance Committee will be held on December 5-6, 2002. Diagnosis and procedure proposals for inclusion on the December agenda must be submitted by October 5, 2002.

Note

1. Comments may be e-mailed to Patricia Brooks at pbrooks@cms.hhs.gov.

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