
SUMMARY REPORT

ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

October 7-8, 2004

PROCEDURE DISCUSSIONS

Introductions and Overview

Pat Brooks welcomed the participants to the ICD-9-CM Coordination and Maintenance (C&M) Committee meeting. Approximately 200 participants registered to attend the meeting. This was the highest number of participants in the 19-year history of the committee. The procedure portion of the meeting was held on October 7, 2004 and was conducted by staff from the Centers for Medicare & Medicaid Services (CMS). The diagnosis portion of the meeting was held on October 8, 2004 and was conducted by staff from the National Center for Health Statistics, CDC. All participants introduced themselves. There were a wide range of participants representing hospitals, coding groups, manufacturers, physician groups, software vendors, and publishers, among others.

An overview of the C&M Committee was provided. A detailed timeline was included in the handouts. 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.** A summary report of the procedure part of the meeting will be posted on CMS' website at: www.cms.hhs.gov/paymentsystems/icd9. A summary report of the diagnosis part of the meeting will be placed on NCHS' web site at www.cdc.gov/nchs/icd9.htm. The public is offered an opportunity to make additional written comments by mail or e-mail until January 12, 2005.

Comments on the **procedure** part of the meeting should be sent to:

Pat Brooks
Centers for Medicare & Medicaid Services (CMS)
CMM, HAPG, Division of Acute Care
Mail Stop C4-08-06
7500 Security Blvd.
Baltimore, MD 21244-1850
Patricia.brooks1@cms.hhs.gov

Comments on the **diagnosis** part of the meeting should be sent to:

Donna Pickett

NCHS

3311 Toledo Road

Room 2402

Hyattsville, MD 20782

Dfp4@cdc.gov

The participants were informed that this was strictly a coding meeting. No discussion would be held concerning DRG assignments or reimbursement issues. Comments were to be confined to ICD-9-CM coding issues.

CMS' ICD-9-CM homepage to be updated

It was announced that CMS' ICD-9-CM web page,

<http://www.cms.hhs.gov/paymentsystems/icd9> will be updated in the next few weeks.

More information will be provided on the process of requesting a new or revised code.

CMS will also be implementing an online registration process for future ICD-9-CM

Coordination and Maintenance Committee meetings. A link to the registration site will

be provided. Alternatively, participants can go to <http://www.cms.hhs.gov> and click on

“Events”. You can see a variety of meetings for which you can register. Participants can register for the March 31 – April 1, 2005 meeting beginning January 3, 2005.

Process for requesting code revisions

The process for requesting a coding change was explained. The request for a procedure code change should be sent to Pat Brooks at least two months prior to the C&M meeting.

The request should include detailed background information describing the procedure, patients on whom the procedure is performed, any complications, and other relevant

information. If this procedure is a significantly different means of performing a procedure than is already described in ICD-9-CM, this difference should be clearly

described. The manner in which the procedure is currently coded should be described along with information from the requestor on why they believe the current code is not

appropriate. Possible new or revised code titles should then be recommended.

CMS staff will use this information in preparing a background paper to be presented at the C&M meeting. The CMS background paper includes a CMS recommendation on any proposed coding revisions. The background paper is distributed for discussion at the C&M meeting and included in the summary report.

A presentation is made at the C&M meeting, which describes the clinical issues and the procedure. CMS staff will coordinate a discussion of possible code revisions. The participants at the meeting are encouraged to ask questions concerning the clinical and coding issues. Comments concerning proposed code revisions are taken for consideration. Final decisions on code revisions are made through a clearance process within the Department of Health and Human Services. No final decisions are made at the meeting.

C&M meetings for 2005 have been scheduled as follows:

March 31 – April 1, 2005

September 29 – 30, 2005

Check the CMS' ICD-9-CM site for an agenda approximately one month prior to the meeting. Requests to have a topic considered at the meeting must be received two months prior to the meeting.

C&M Visitor List Notice

Because of increased security requirements, those who wish to attend a specific ICD-9-CM Coordination and Maintenance Committee meeting in the CMS auditorium must submit their name and organization for addition to the meeting visitor list prior to each meeting. As stated earlier, we will implement an online registration system beginning with the March 31 C&M meeting. The registration site will open on January 3, 2005. You must register by March 25, 2005, or earlier if registrations meet room limitations. Due to fire code requirements, should the number of attendants meet the capacity of the room, the meeting will be closed to additional attendees. You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building.

April 1 code updates

The participants were informed of an item in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that will impact the updating of ICD-9-CM. Section 503 (a) of the bill had language concerning the timeliness of data collection. The following clause was included:

“Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.”

The Centers for Medicare & Medicaid Services (CMS) discussed a proposal to accomplish this new congressional requirement in the Notice of Proposed and Final Rulemaking for the Hospital Inpatient Prospective Payment System. Information on this April 1 update process can be found in the Final Rule published August 11, 2004 (69 FR 48954) beginning on page 48954. In general, new diagnosis and procedure codes will be implemented on October 1, as has been standard practice. However, consideration will be given to implementing new codes on April 1 if a strong and convincing case is made by the requester at the C&M meeting that the new code is needed to describe new technologies. The public attending the C&M meetings would be given an opportunity to comment on the requestor's statement that the new code should be implemented on April 1.

The participants were informed that they should make known any requests for an April 1, 2005 code implementation at this meeting. If there were no such request, the proposed codes would be considered for an October 1, 2005 implementation. A number of organizations and individuals expressed concerns about the impact the April 1 ICD-9-CM coding update would have on providers. They pointed out that this would significantly impact their systems. For this reason, it is important that careful consideration be given as to whether or not a code for a new technology should be implemented on April 1. If a strong and convincing case were not made for an April 1 implementation, then the new code would be considered for a routine October 1 implementation. If there were no requests for an April 1 implementation of a specific code, then there would be no April 1 ICD-9-CM updates. All code revisions would be considered for October 1.

There were no requests for an ICD-9-CM code to be implemented on April 1, 2005 at this ICD-9-CM Coordination & Maintenance Committee meeting. Therefore, **there will be no new ICD-9-CM codes implemented on April 1, 2005.**

Topics:

1. Insertion of Multiple Stents

Ann Fagan led the discussion on this topic. Michael Cowley, MD provided a description of these procedures. There was considerable support for capturing the number of stents inserted as well as the number of vessels stented through creation of new procedure codes. One participant expressed concern about modifying code 36.01, Single vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy without mention of thrombolytic agent, as proposed because of its effect on trend data. However, this person also thought it was a good idea to put these new codes under proposed category 00.4, Other vascular system procedures, since it would be less disruptive to overall data. There was some discussion as to whether it was necessary to create new procedure codes for bifurcated stent codes since there were none on the market. Some participants opposed creating unique codes for bifurcated stents. Some discussion was held about the option of leaving space in the proposed new codes so that bifurcation could be captured at a later time

Ann solicited comments on an improved category title for 00.4. One person suggested substituting “Additional” for “Other” therapeutic vascular system procedures. Other suggestions included “Adjunct”, “Complimentary”, “Accompanying”, or “Therapeutic”. Suggestions were made to more closely examine the inclusion terms under 00.4, as the way they were organized was deemed confusing. Participants will send in specific comments on this area. One participant suggested that a note be added under category 00.4 telling coders to choose one code from 00.41 – 00.44 and one code from 00.45 – 00.48. A suggestion was also made to insert a note under code 92.27, Implantation or insertion of radioactive elements, to clarify whether or not the 00.4x codes should be reported with intravascular brachytherapy.

One participant questioned the inclusion terms under proposed code 00.49, Insertion of bifurcation stent(s), in Option 1a. This person found terms such as “T”-shaped stent(s) and “Y”-shaped stent(s) confusing.

2. Revision of Hip Replacement

Pat Brooks led the discussion on this topic. Kevin Bozic, MD provided information on these procedures. There was general support for more specific procedure codes to capture the various types of revisions of hip replacement. Many participants supported including the code under Option 3 as part of the new codes. They stated that this information would provide additional valuable data. They did not believe it would be difficult for coders to use this new code.

Several participants recommended that code 81.53, Revision of hip replacement, become the not otherwise specified (NOS) code. It was recommended that the code title for 81.53 be called Revision of hip replacement, not otherwise specified. Another participant recommended that the terms “antibiotic impregnated” be added as non-essential modifiers to the index. These terms could also be added as inclusion terms under proposed code 84.56, Insertion of (cement) spacer. A recommendation was made to add “that with exchange of femoral head” as an inclusion term under proposed code 00.71, Revision of hip replacement, acetabular component. It was also recommended that the terms “femoral stem” be added under proposed code 00.72, Revision of hip replacement, femoral component.

3. Revision of Knee Replacement

Pat Brooks led the discussion on this topic. Kevin Bozic, MD provided information on these procedures. There was support for the detail provided by the proposed new codes. One participant recommended that the code title for 81.55, Revision of knee replacement, be retitled to Revision of knee replacement, not otherwise specified. A new code could then be created under category 00.8, Other knee procedures, for Revision of knee replacement, total (all components). It was recommended that a note be placed under this total code to explain what components constitute a total. There was also considerable support of adding Option 3 to the list of new codes. The participants felt the information provided by a code for revision of total knee replacement, tibial insert to be valuable. The participants did not feel this would be difficult for coders to identify.

4. Cardiac Support Device

Ann Fagan led the discussion on this topic. Spencer Kubo, MD provided clinical support, describing the textile mesh implanted around the ventricles of the heart for the treatment of heart failure. One participant suggested that a new code for this procedure should not be implemented until such time as the procedure was FDA approved and was being performed. One commenter suggested that the second exclusion term listed under proposed code 00.56, Implantation of prosthetic cardiac

support device around the heart, be removed and this information be listed under code 37.99, Other operations on heart and pericardium, instead.

5. Insertion of Rechargeable Neurostimulator Pulse Generator

Amy Gruber led the discussion on this topic. Eric Grigsby, MD provided information on this device. There was considerable discussion about whether the rechargeable devices would eventually replace those that are not rechargeable. Some questioned whether new codes should be created considering this fact. Others supported new codes so that the technology could be tracked. One participant stated that these new codes would be useful to capture the different types of devices being used.

6. Revision or Relocation of Defibrillator Pocket

Pat Brooks led the discussion on this topic. Joe Kelly, MD provided information on these procedures. There was support for the proposed revision to existing code 37.79, Revision or relocation of pacemaker pocket.

7. Infusion of Liquid Radioisotope

Joe Kelly, MD led the discussion on this topic. Robert Lustig, MD provided clinical background on this procedure. This topic generated considerable comments. Many participants felt that additional codes are necessary in order to capture all parts of the procedure. Participants pointed out that there are three parts to this procedure. The initial part involves tumor excision and implantation of the catheter. There is no code that describes the implantation of the catheter. At a later date the radioisotope is infused into the catheter and left for several days. Proposed code 92.20, Infusion of liquid brachytherapy radioisotope, could capture this information. The third step involves the removal of the radioisotope and the catheter. There are no codes that capture the removal of the radioisotope or the removal of the catheter. Participants were particularly concerned with the use of code 86.09, Other incision of skin and subcutaneous tissue, for this step. They felt that code 86.09 did not fully describe the procedure on the burr hole area and part of the brain. Participants felt that new codes were needed for the removal of the isotope and removal of the catheter from the brain. There was considerable support for examining this issue more closely and then discussing it again at the March 31, 2005 C&M meeting. Participants will send in specific recommendations prior to that date for consideration.

8. Addendum

Amy Gruber led the discussion on the proposed addendum. Participants expressed support for most of the proposed addendum. They raised concerns about the proposed code also note for electrophysiologic studies [EPS] that was placed under the pacemaker and defibrillator codes. It was suggested that this would be confusing.

Many felt it was best to consider EPS to be part of the insertion of the device. CMS agreed to reconsider this proposal.

9. ICD-10-PCS Procedure Classification System (PCS) Update

Thelma Grant, 3M informed the participants of the activities involved with the 2005 update to ICD-10-PCS. A copy of the PowerPoint presentation summarizing these changes is posted on CMS' web page along with this Summary Report.

This concluded the procedure part of the C&M meeting. The agenda, timeline, and background papers discussed at the meeting are posted as separate files on CMS' web page.

Participants were encouraged to send any additional comments on the coding proposals by January 12, 2005. The National Center for Health Statistics conducted the diagnosis part of the C&M meeting on October 8, 2005. A summary report along with background papers discussed at the meeting will be posted on NCHS' web page at: www.cdc.gov/nchs/icd9.htm