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

SUMMARY REPORT

ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

March 11-12, 2009

PROCEDURE DISCUSSIONS

Introductions and Overview

Pat Brooks welcomed the participants to the ICD-9-CM Coordination and Maintenance (C&M) Committee meeting. Approximately 140 participants registered to attend the meeting. The procedure portion of the meeting was held on March 11, 2009 and was conducted by staff from the Centers for Medicare & Medicaid Services (CMS). The diagnosis portion of the meeting was held on March 12, 2009 and was conducted by staff from the Centers for Disease Control and Prevention (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. All procedure code issues discussed at the March 11, 2009 meeting are being considered for implementation on October 1, 2009. Pat Brooks reviewed important dates within the timeline with the meeting participants. The participants were encouraged to refer to the timeline for future meeting information and the deadline for receipt of public comments. 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.** The participants were also informed that this was strictly a coding meeting. No discussion would be held concerning DRG assignments or reimbursement issues.

A summary report of the procedure part of the meeting will be posted on CMS' website at: www.cms.hhs.gov/ICD9ProviderDiagnositicCodes .

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 April 3, 2009.

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.brooks2@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

CMS ICD-9-CM homepage

CMS has information on ICD-9-CM on the following web address: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes . Detailed information is provided on the homepage on the process of requesting a new or revised code. CMS implemented an online registration for the ICD-9-CM Coordination and Maintenance Committee Meetings. A link to the registration site is provided on the ICD-9-CM homepage. Participants can register for the September 16-17, 2009 meeting beginning August 14, 2009. The registration process will close on September 10, 2009. Therefore, those wishing to attend the meeting must register online between August 14 and September 10, 2009, or until room capacity is reached.

Process for requesting code revisions

The process for requesting a coding change was explained, and is explained on the ICD-9-CM CMS website. 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 posted on the website for viewing after the meeting.

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 at the meeting as well as in writing after the meeting. 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.

Next C&M Meeting

The next C&M meeting will be held on September 16-17, 2009. As stated earlier, the online registration for this meeting will begin on August 14, 2009 and close on September 10, 2009, 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.

Those interested in attending the meeting should check the CMS' ICD-9-CM website 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.

CMS is attempting to provide a limited number of audio conference telephone lines so that participants can listen to the meeting proceedings offsite. Information on any audio conferencing links provided for the meeting will be publicized prior to the next meeting.

April 1 code updates

There were no requests approved for an ICD-9-CM code to be implemented on April 1, 2009. The participants were informed that one requestor had asked that a code for Laser Interstitial Thermal Therapy (LITT) for Brain Tumors, be implemented on April 1, 2009. However, CMS received numerous comments opposing the implementation of this code on April 1, 2009.

Information on any new codes that would be implemented on April 1 of any year will be posted on the CMS ICD-9-CM website by early November of the preceding year. Detailed information on this issue is provided in the ICD-9-CM timeline which is included along with the agenda for the meeting.

Final decisions on new ICD-9-CM codes

As indicated in the timeline, the public is informed of approved ICD-9-CM code title updates through the inpatient prospective payment system (IPPS) proposed rule. This proposed rule is anticipated to be published in April 2009. Any codes approved after the March 2009 ICD-9-CM Coordination and Maintenance Committee meeting will be

included in the IPPS final rule published around August 1, 2009. A complete copy of the addendum will be published on CMS and CDC's websites by early June 2009.

Topics:

1. Intravenous Infusion of Clofarabine

Yvonne Barnes, RN, MSN, CPNP, Medical Science Liaison at Genzyme, conducted a clinical presentation on the intravenous infusion of clofarabine. CLOLAR® (clofarabine) represents an alternative chemotherapy option for elderly patients with acute myeloid leukemia (AML). Amy Gruber explained to the audience that the requestor for this code proposal submitted a new technology add-on payment application for consideration in the next fiscal year, FY 2010. Amy Gruber facilitated the coding proposal discussion. One commenter asked if Ms. Barnes could describe the difference between complete versus partial remission. Ms. Barnes explained that for a complete remission a patient's quality of life is greatly enhanced as there are no further signs that the disease is present. Alternatively, for a partial remission, the disease is still present however; there is a decreased amount of the disease which is still effective in improving a patient's quality of life. Ms. Barnes stated that the long-term survival for these patients is not high. Approximately, 26 percent of patients live to one year. Another commenter expressed concern regarding the proposal to create a unique code for this specific drug given intravenously when there are several drugs that could be administered intravenously as well. This commenter suggested evaluating a general class of drugs for a new code. Ms. Barnes responded that the proposal for a unique code to identify this substance is based on differences with the dosing regimen in comparison to the standard for chemotherapeutic agents, the specific population it is intended to treat, the number of patients it is anticipated to be administered to and its ability to minimize the toxicity of other chemotherapeutic agents. In addition, another commenter responded that this proposal is also being considered for a new technology application and under that process, if approved, a unique code would be required to identify and track the substance appropriately. One commenter asked for further clarification regarding the exclusion criteria for this drug. This commenter questioned why certain patients would not be eligible to receive the therapy. Ms. Barnes explained that the information shown on the slide was the identifying eligibility criteria, not exclusion criteria. Therefore, the patients in question were eligible to receive this treatment. This same commenter also asked if this substance was identifiable with a HCPCS code. Amy Gruber responded that there is an existing HCPCS code to identify this drug. Another commenter stated that they understood the request for a new code; however, this commenter expressed concern with the proposed subcategory title noting that it appears to be too limited. It was suggested that "Other Things" as a possible subcategory title. Amy Gruber encouraged this commenter to submit alternative suggestions for consideration.

2. Virtual Histology Intravascular Ultrasound (VH™-IVUS)

Gail Daubert, RN, JD, of Reed Smith, LLP, representing Volcano Corporation, presented virtual histology intravascular ultrasound (VH™-IVUS) topic. This technology enables visualization and evaluation of coronary vasculature in real-time colorized tissue maps that illustrate plaque composition. Ann Fagan conducted the coding proposal discussion. One commenter expressed concerns with documentation of this technology and noted that it is extremely likely for a physician to simply document IVUS, when they may have actually utilized VH™-IVUS. This commenter also stated that a physician may begin a procedure using what is referred to as "grayscale" IVUS or intravascular ultrasound of coronary vessels (code 00.24, Intravascular imaging of coronary vessels) and then convert to VH™-IVUS, so if a new code were to be created, there would need to be clear instructions for the coders on how to handle these situations. The commenter wondered whether, given that the claim form only accepts six procedure codes, both the existing code for IVUS and the new code for VH™-IVUS would be required. Ms. Daubert addressed the clinical portion of that question, saying that in her research she has received feedback that physicians are clearly documenting VH™-IVUS if utilized. Another commenter questioned if [clinically] the VH™-IVUS technology had the potential to be used in other vessels. Ms. Daubert responded that it does have the potential to be used in other vessels; however, health research outcomes to date have demonstrated better results in the coronary vessels. Ms. Daubert added that the device can be utilized for all vessels; however, the catheter size may be affected. One commenter questioned why a physician would start out with "grayscale" IVUS and convert to the VH™-IVUS technology when they could have just begun the procedure using the VH™-IVUS in the first place. Ms. Daubert noted that several facilities already have the existing IVUS technology and it is less expensive than the VH™-IVUS, therefore they will continue to use "grayscale" IVUS. Another commenter supported CMS' recommendation to not create a new code for VH™-IVUS and continue using the existing codes. One commenter stated that this technology represents a quantum leap and questioned how long arteriography was going to be around with the advent of this type of [improved] technology. This commenter supported new codes for all applicable sites. Another commenter voiced their opinion that they did not feel strongly about using the existing code(s) or creating a new code(s), however, this commenter recommended moving the proposed inclusion term at option number one to the subcategory code level if this option was to be finalized. There did not appear to be strong support for or against creation of a new code(s) to identify VH™-IVUS. Ann Fagan encouraged the audience members to submit written comments.

3. Intravascular Optical Coherence Tomography

Gail Daubert, RN, JD, of Reed Smith, LLP, representing Volcano Corporation, presented intravascular optical coherence tomography (OCT) technology and described its use for visualization and evaluation of coronary and peripheral vasculature to provide images of the vessel lumen and wall structures, and to determine proper lumen sizing, facilitate full

stent apposition and optimal stent expansion. Mady Hue led the coding proposal discussion. One commenter asked Ms. Daubert if she could explain the difference between intravascular (near-infrared) spectroscopy (NIRS) and OCT. While the question could not be answered at the meeting, Mady suggested Ms. Daubert could submit additional information in response to the commenter's question for inclusion in this report. The following is a summary of the information that was received:

Although both NIRS and OCT use roughly the same spectral range (i.e., light wavelengths) and employ similar delivery methods (i.e., rotating fiber-optic catheter probes), the two technologies are very different. Image contrast for these two technologies comes from different physical phenomena (boundary reflections for OCT and chemical absorption for NIRS) All optical signals are generally composed of several types of information, such as spectral (e.g. color of objects), spatial (e.g. shapes of objects), and temporal (e.g. movement of objects). NIRS and OCT process these general types of optical information in very different ways.

Another commenter expressed concern with the FDA approval status for this technology. Ms. Daubert responded that FDA approval for the OCT technology was anticipated in February 2009, however, due to scheduling and staffing issues at FDA, the meeting was moved and they now expect approval in the next few months, prior to October 1, 2009. Mady Hue encouraged the participants to submit written comments if they are in support or not in support of creating a new code(s).

4. Addenda

Mady Hue reviewed the proposed addenda updates. There was general support for the addenda and no opposition.

ICD-10 Implementation

Pat Brooks provided an overview of the ICD-10 Final Rule (74 FR 3328) published on January 16, 2009. She referred the audience to the following site for a complete copy of the final rule: http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf. She pointed out that ICD-10-CM and ICD-10-PCS will be implemented on October 1, 2013 which will replace ICD-9-CM diagnoses and procedures as the HIPAA standard.

To further clarify, the implementation date will include those ambulatory and physician services that occur on or after October 1, 2013 and those inpatient hospital discharges that occur on or after October 1, 2013. ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013.

CMS has worked collaboratively with the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), and CDC to develop a series of Outreach calls on ICD-10. There will be additional educational efforts such as this in the future. Information on educational resources can be found at: http://www.cms.hhs.gov/ICD10/05_Educational_Resources.asp#TopOfPage

Information on the outreach calls, including presentation slides discussed during the calls and a copy of the transcript from the calls can be found at:
http://www.cms.hhs.gov/ICD10/07_Sponsored_Calls.asp#TopOfPage
Information on future calls will also be posted on this website.

Possible need for freeze on code updates

Pat announced that there was a need to discuss whether it would be necessary to freeze updates to ICD-9-CM and/or ICD-10 prior to the implementation of ICD-10. She asked that the audience consider this issue and be prepared to discuss the topic at the September 16-17, 2009 ICD-9-CM Coordination and Maintenance Committee meeting. The audience agreed that this was an extremely important topic. While several participants supported a freeze, they had not formulated clear opinions as to when the freeze should begin and if the freeze should apply to both ICD-9-CM codes as well as ICD-10-CM and ICD-10-PCS codes. Participants agreed to discuss this issue with others in their organization and be prepared to discuss this issue extensively at the September meeting.

Pat then discussed other issues included in her slides such as the structural differences of ICD-10 codes, availability of mappings, and the conversion of the MS-DRGs from ICD-9-CM codes to ICD-10 codes. Complete information on this topic can be found in the separately posted slides titled *ICD-10 Implementation*.

Participants requested information on the availability of coding products. Pat asked if any vendors in the audience cared to share information on their plans to publish updated ICD-10 books or to provide ICD-10 products. Anita Hart, Ingenix, stated that Ingenix is preparing updated, 2009 ICD-10-CM and ICD-10-PCS coding books which will be ready for release shortly. In addition, Ingenix sold out of all its 2008 ICD-10 code books once the ICD-10 final rule was published and there is now a demand for 2009 code books. Craig Puckett, Channel Publishing, stated that Channel Publishing is also working on updated ICD-10 code books. He stated these will be ready to order by early next year. No other vendors had information to share. Pat Brooks offered to raise this issue at future meetings so that vendors could share their plans to make ICD-10 products available.

Several participants in the audience stated that it would a good idea to begin discussing issues such as freezing future updates prior to implementation, updating guidelines, and other such topics in this public forum.

ICD-10 General Equivalence Mapping

Rhonda Butler, 3M explained how the mappings were created, their purpose, and how to use the mappings. The complete slides which cover her presentation are posted separately titled *ICD-10 GEMs*.

MS-DRG Conversion to ICD-10 Update

Rhonda Butler and Janice Bonazelli discussed the continuing work of converting the MS-DRGs from ICD-9-CM codes to ICD-10 codes. The complete slides which cover this

presentation are posted separately titled *MS-DRG Conversion*. Some of the issues raised are listed below:

Formatting ICD-10 version of the Definitions Manual for review
Janice included slides that demonstrated the two versions of the MDC 6 Definitions Manual that are currently posted on the CMS website. She also presented slides that illustrated other possible ways this information can be displayed. The participants were asked to review all the options shown and be prepared to provided feedback at the September 16-17, 2009 meeting as to which is the preferred method(s) of illustrating the ICD-10 version of the MS-DRGs. This information will be considered when preparing the final version to be posted at the end of 2009.

Length of ICD-10 Abbreviated Titles
A participant raised the issue of the current abbreviated ICD-9-CM code titles. Opinions were expressed that if these current limitations are applied to the ICD-10-CM and PCS codes that they would not provide meaningful information. With the move to new reporting systems, consideration should be given to expanding the length of the abbreviated titles according to the participant. Feedback was requested on this topic, which will be addressed at the September meeting.

Need for Updating the ICD-10-CM and PCS Guidelines
Participants were urged to review the current ICD-10 guidelines and be prepared to identify any areas where refinements or expansion may be needed. This topic will also be discussed at the September meeting.

ICD-10 PCS Updates
Pat Brooks discussed the process for requesting updates to ICD-10-PCS. She asked than any requested for code revisions be received two months prior to the ICD-9-CM Coordination and Maintenance Committee meeting. She also pointed out that a discussion will take place at the September 2009 meeting as to whether updates to ICD-10 should be frozen in advance of implementation.

Rhonda Butler provided an update on the 2009 version of ICD-10-PCS. Details from this presentation can be found in the slides posted separately titled *PCS Update*.

ICD-10 Comments and Questions
Pat Brooks and Rhonda Butler discussed specific questions received in advance of the meeting concerning the ICD-10 GEMs. A summary of these questions is included below.

GENERAL EQUIVALENCE MAPPINGS
ICD-9-CM to and from ICD-10-CM and ICD-10-PCS

TOP 10 QUESTIONS AND ANSWERS

1. **The information in the introductions to the General Equivalence Mappings (GEM) points out that, in some cases, there is a clear one-to-one match between an ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modification) code and an ICD-10-CM or ICD-10-PCS (Procedure Coding System) code. However, one ICD-9-CM code often translates to several ICD-10-CM or ICD-10-PCS codes because of the nature of going from the more general ICD-9-CM to the more specific ICD-10. Please describe the methodology that was used to create the GEMs.**

   In order to both create and maintain the GEMs, all reasonable code translation alternatives are included in its respective GEM, based on the complete meaning of the code being looked up. For example, for the ICD-9-CM to ICD-10-CM GEM, we look up an ICD-9-CM code and include all reasonable translation alternatives in that GEM based on the "complete meaning" of the ICD-9-CM code. The "complete meaning" of a code includes tabular instruction, index entries, guidelines, and applicable Coding Clinic advice.

   There may be multiple translation alternatives for a source system code (the code being looked up), all of which are equally plausible. This is true of both the ICD-10 to ICD-9-CM GEMs and the ICD-9-CM to ICD-10 GEMs. When there is only one alternative in a GEM, we can say that we have a "one-to-one" translation. This is common in the ICD-10 to ICD-9-CM GEMs and does not necessarily mean the two codes are identical. Additional information about this subject can be found at http://www.cms.hhs.gov/ICD10/01m_2009_ICD10PCS.asp on the Centers for Medicare & Medicaid Services (CMS) website. On this page, select the file labeled "2009 Mapping – ICD-10-PCS to ICD-9-CM and ICD-9-CM to ICD-10-PCS; and User Guide, Reimbursement Guide, Diagnosis, and Procedures" to access the mapping files.

2. **Are there any instances when there is no translation between an ICD-9-CM code and an ICD-10 code? How do the GEMs handle this situation**?

   Yes, there are instances where there is not a translation between an ICD-9-CM code and an ICD-10 code. When there is no plausible translation from a code in one system to *any* code in the other system, the "No Map" flag indicates this. For example, the following codes are marked with the "No Map" flag:
   - ICD-10-CM code *Y71.3 – Surgical instruments, materials and cardiovascular devices (including sutures) associated with adverse incidents*, which has no reasonable translation in ICD-9-CM; and
   - ICD-9-CM procedure code *89.8 – Autopsy*, which has no reasonable translation in ICD-10-PCS.

For more information on this subject, see page 16 of the publication titled *Procedure Code Set General Equivalence Mappings ICD-10-PCS to ICD-9-CM and ICD-9-CM to ICD-10-PCS 2009 Version Documentation and User's Guide*, which can be accessed on the CMS website at http://www.cms.hhs.gov/ICD10/01m_2009_ICD10PCS.asp. The User's Guide is posted in the Downloads Section within the file labeled "2009 Mapping – ICD-10-PCS to ICD-9-CM and ICD-9-CM to ICD-10-PCS; and User Guide, Reimbursement Guide, Diagnosis, and Procedures."

3. **Why do the GEMs go in both directions (from ICD-9-CM to ICD-10 and from ICD-10 back to ICD-9-CM)?**

   The GEMs are designed to be used like a bi-directional translation dictionary. They go in both directions so that you can look up a code to find out what it means according to the concepts and structure used by the other coding system, similar to how Spanish-English and English-Spanish dictionaries are designed. Neither the two dictionaries nor the GEMs are a mirror image of each other. Because the translation alternatives are *based on the meaning of the code you are looking up* (which includes index entries, tabular instruction, and applicable Coding Clinic advice), the ICD-10-PCS to ICD-9-CM GEM is not a mirror image of the ICD-9-CM to ICD-10-PCS GEM.

   The GEMs were designed to convert current ICD-9-CM codes to applicable ICD-10 codes. A "reverse lookup" of the backward mappings (ICD-10-CM/PCS to ICD-9-CM GEM, looked up by ICD-9-CM code) can be used to convert payment logic or coverage decisions from ICD-9-CM codes to ICD-10 codes. This mapping (ICD-10-CM/PCS to ICD-9-CM GEMs) could also be used in examining trend data over multiple years, spanning the implementation of ICD-10. For example, in 2013 it will be possible to compare how frequencies changed for a specific condition using an ICD-10 code compared to prior years using ICD-9-CM codes. The forward mapping (ICD-9-CM to ICD-10-CM/PCS GEMs) can be used to convert ICD-9-CM-based edits and can also be used for any analysis or conversion project that needs to examine ICD-10 codes and determine the ICD-9-CM code(s) that previously captured this diagnosis or procedure.

4. **What process was used to develop the GEMs? Did CMS and the Centers for Disease Control and Prevention (CDC) seek input from organizations such as the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA) regarding the development of the GEMs? Did development of the GEMs involve both clinical and coding evaluations**?

The GEMs were developed over a period of three years by CMS and CDC, with input from both AHA and AHIMA. The GEMs development and maintenance team includes clinicians and coding experts, representatives of the Cooperating Parties (CMS, CDC, AHA, and AHIMA), and the team that developed and maintains ICD-10-PCS. The General Equivalence Mappings User's Guides were collaboratively written by the Cooperating Parties.

5. **Were the GEMs designed for use by all providers and payers or was the focus on use with Medicare data?**

   The GEMs were designed as a general purpose translation tool for *all* types of providers, payers, and other users of coded data. The translations are based on the meaning of the code as contained in the tabular instruction, index entries, and applicable Coding Clinic advice. They were developed independently without reference to Medicare data. Their applicability extends equally to all types of users—providers, payers, researchers, and application development vendors.

6. **We were told that validation of the GEMs is occurring as part of the conversion of the current ICD-9-CM-based Medicare Severity Diagnosis Related Groups (MS-DRG) to ICD-10-based MS-DRGs. How does this process identify any potential updates that might be needed to the GEMs? Will the GEMs be updated to correct any inaccuracies discovered in this process?**

   Because the process of MS-DRG conversion begins with an initial translation using the ICD-10 to ICD-9-CM GEMs and then uses the ICD-9-CM to ICD-10 GEMs to identify any additional conversion issues, all four GEMs are being tested in the conversion process. Any inaccuracies discovered in the process are immediately noted so that changes can be made to the affected GEMs and included in the next annual update. Currently, the updated GEMs are posted each January to reflect the annual code updates and any corrections or enhancements to the GEMs. We will continue to update the codes and GEMs on an annual basis. As mentioned in Question 1, the updated GEMs for diagnoses can be accessed in the Downloads Section at http://www.cms.hhs.gov/ICD10/02m_2009_ICD_10_CM.asp, and the updated GEMs for procedures can be found in the Downloads Section at http://www.cms.hhs.gov/ICD10/01m_2009_ICD10PCS.asp on the CMS website.

7. **What methodology is being used in the MS-DRG ICD-10 conversion?**

   The goal of MS-DRG ICD-10 conversion is to *replicate the current MS-DRG logic*. A record coded in ICD-10-CM/PCS and processed according to the converted ICD-10-based MS-DRGs will be assigned to the same MS-DRG

as the same record coded in ICD-9-CM and processed according to the current MS-DRG logic.

We are accomplishing this goal by translating the lists of ICD-9-CM codes that comprise the MS-DRGs (approximately 500 code lists) to comparable lists of ICD-10-CM/PCS codes *without changing the underlying MS-DRG logic*. This method of replacing lists of ICD-9-CM codes with lists of ICD-10 codes is partially automated using the GEMs.

8. When do you anticipate that an ICD-10 version of the MS-DRGs will be completed and posted on the CMS website?

A draft ICD-10 version of the MS-DRGs will be completed in October 2009. We will format this ICD-10 version of the MS-DRGs and post it in January 2010 along with the 2010 updates to ICD-10 and the GEMs in the Downloads Section at http://www.cms.hhs.gov/ICD10/01m_2009_ICD10PCS.asp on the CMS website. We welcome recommendations regarding how this information should be displayed. We believe this exercise will provide useful information to other payers who will be converting their own payment systems. The final ICD-10 version of the MS-DRGs will be subject to formal rulemaking as part of the Inpatient Prospective Payment System.

9. How soon after a code has been added or deleted will the GEMs be updated to reflect these changes?

We update ICD-9-CM and ICD-10 codes each year. We post updates to the GEMs each January to reflect these annual updates and will continue to update the codes and GEMs on an annual basis. There will be future discussions at the ICD-9-CM Coordination and Maintenance Committee meetings as to whether or not we should freeze updates to ICD-9-CM and/or ICD-10 in order to facilitate planning for ICD-10 implementation. Information about the ICD-9-CM Coordination and Maintenance Committee meetings can be found at http://www.cms.hhs.gov/ICD10/08_ICD9CM_Coordination_and_Maintenance_Committee_Meetings.asp on the CMS website.

10. For what period of time following ICD-10 implementation on October 1, 2013 will the GEMs be updated?

As we discussed on pages 3337-3338 of the ICD-10 final rule, the ICD-9-CM Coordination and Maintenance Committee will discuss updating the GEMs for a minimum of three years after ICD-10 is implemented on October 1, 2013. We welcome recommendations regarding how long the GEMs should be maintained and updated. The final rule can be found at http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf on the Web.