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## SUMMARY REPORT

### ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

March 23-24, 2006

#### 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 meeting marks the 21<sup>st</sup> year in which the Committee has been discussing ICD-9-CM updates. The procedure portion of the meeting was held on March 23, 2006 and was conducted by staff from the Centers for Medicare & Medicaid Services (CMS). The diagnosis portion of the meeting was held on March 24, 2006 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. All procedure code issues discussed at the March 23, 2006 meeting are being considered for implementation on October 1, 2006. 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/ICD9ProviderDiagnosticCodes/](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/). A summary report of the diagnosis part of the meeting will be placed on NCHS' web site at [www.cdc.gov/nchs/icd9.htm](http://www.cdc.gov/nchs/icd9.htm). The public is offered an opportunity to make additional written comments by mail or e-mail until April 14, 2006.

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](mailto: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](mailto: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 updated

CMS has updated their ICD-9-CM web page, and has a new 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 28-29, 2006 meeting beginning June 29, 2006. The registration site will close on September 22, 2006. Therefore, those who wish to attend the spring meeting must register online by September 22, 2006.

#### 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. Requestors are encouraged to go to the CMS ICD-9-CM home page at <http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/> for instruction on the process for requesting a new or revised ICD-9-CM procedure code. As described, the request should include comprehensive background information describing the procedure, relevant information on FDA approval, 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.

### **Next C&M Meeting**

**The next C&M meeting will be September 28-29, 2006. As stated earlier, the online registration for this meeting will begin on June 29, 2006 and close on September 22, 2006, or earlier if the number of registrants meets the 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 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.

### **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 in the Federal Register on August 12, 2005 beginning on page 47318 (70 FR 47318). 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 fall C&M meeting that the new code is needed to describe new technologies. The public attending the fall C&M meetings will be given an opportunity to comment on the requestor's statement that the new code should be implemented on the following April 1.

The participants were informed that they should make known any requests for an April 1, 2007 code implementation at the fall meeting. If there are no such requests, the proposed

codes discussed at the fall meeting would be considered for implementation on the following October 1.

If a strong and convincing case were not made at the fall C&M meeting for an April 1 implementation, then the new code would be considered for a routine October 1 implementation. If there are no requests for an April 1 implementation of a specific code at the fall C&M meeting, 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, 2006 at the fall ICD-9-CM Coordination & Maintenance Committee meeting. Therefore, **there will be no new ICD-9-CM codes implemented on April 1, 2006.**

Pat Brooks announced that there would be US Public Health Service Retirement Ceremony for CAPT Ann Fagan, RHIA who recently retired after 30 years of service. The ceremony will take place from 12 noon to 12:30 pm and all participants are invited to stay for the ceremony. Ann has now converted to civil service employment for CMS.

## **Topics:**

### **1. Automated Mechanical Anastomosis**

Keith B. Allen, MD, provided a clinical presentation on the automated mechanical anastomosis procedure using the Cardica® C-Port™ Anastomosis System for coronary artery bypass graft (CABG) procedures. Ann Fagan facilitated a discussion on the coding proposal. One commenter stated that the creation of this code would be confusing; it is a violation of every other ICD-9-CM coding guideline which states not to code services that are considered inherent in a procedure. Another commenter suggested revising the approach for the code to be stated as *percutaneous* or *minimally invasive*. Dr. Allen stated that he did not agree that the concept of minimally invasive approach was of benefit to the coding system. He simply wants to track the use of this device for efficacy. One commenter suggested that if a code were created, to give consideration of adding the term “vascular” in the code title to read *Automated mechanical vascular anastomosis*. This same commenter also stated that the code should not be limited to use solely for the heart. Another commenter stated that there is an excludes note at category 39 which reads *excludes those on coronary vessels (36.0-36.99)* so the new code could not be 39.3 as proposed. One commenter asked if the anastomosis can be performed more than one time and if so, would it be necessary to capture the number of times it was done. Dr. Allen responded that yes, the anastomosis can be performed more than one time but he did not believe it was beneficial to be tracked that way. Another commenter asked Dr. Allen if he felt that the automated mechanical anastomosis would be the future way of doing procedures and if it could be used for off-pump cardiopulmonary bypass surgeries. Dr. Allen stated that he could not predict the future, however, the automated mechanical anastomosis can be used for on or off-pump cardiopulmonary bypass procedures. Dr.

Allen also indicated the device can be used for any type of CABG operation, including traditional open heart, thoracoscopic, and minimally invasive approaches.

## **2. Therapeutic Temperature Management**

Mary Ann Peberdy, MD, conducted a clinical presentation on the Arctic Sun™ temperature management system. Ann Fagan led a discussion on the coding proposal. Dr. Peberdy stated therapeutic temperature management is indicated for conditions where patient temperature control within a range of mild hypothermia to normothermia is required. One commenter asked how coding professionals would know that this type of service was performed or rather, how would it be documented in a medical record. Dr. Peberdy responded that documentation of “fever control” may be written in physician progress notes. Another commenter suggested revising the code title if a new code is created because they failed to see the difference between existing code 99.81, Hypothermia (central) (local) and the proposed code 99.87, Controlled (systemic) temperature management. In response to that comment, another commenter stated that the existing code, 99.81, has always been used for cooling an arm or a leg and the difference would be that with the systemic temperature management the decision is made by the doctor on which service is most appropriate. One commenter asked if this type of service is currently utilized widely. Dr. Peberdy replied that a number of hospitals are already using the system and there are recommended pathways, as well as parallel programs that are started within 48 hours of care involving both neurologists and cardiologists. Another commenter asked if the degree of hypothermia would be an issue with regard to coding and asked that there be some instruction on that subject.

## **3. Thermal Ablation of Liver, Lung and Renal Lesions or Tissues**

Mr. Derek Tessier, MSN, RNP presented an overview on thermal ablation procedures involving the liver, lung, and kidney. Mady Hue led a discussion on the coding proposal. One commenter suggested reviewing other anatomic sites to determine if “thermal” ablation should be separated out from other ablation procedures. Two commenters stated they would like to support the proposal, however, it is understood that there are various types of ablation techniques, i.e. thermal, heatwave, laser energy, cryotherapy, microwave, radiofrequency, electrosurgery, focused ultrasound, image-guided, etc. The suggestion was made to review all of these and look at how the Current Procedural Terminology (CPT) system has indexed these types of ablation services. Another commenter stated that if this coding proposal would be approved, it would be beneficial to add an excludes note at code 32.28, Endoscopic excision or destruction of lesion or tissue of lung, to exclude the proposed thermal ablation approach. One commenter stated that microwave and radiofrequency ablation procedures are unique compared to laser and cryotherapy that do not use the same energy source. Another commenter stated that they see merit in differentiating among the approaches (open, percutaneous, laparoscopic), however, felt that separating codes for a specific type of tissue destruction would be confusing to coders, especially if the physician does not clearly identify what type of ablation or destruction was performed.

#### **4. Totally Endoscopic and Robot-Assisted Transmyocardial Revascularization**

Dr. Louis “Trey” Brunsting, III, MD, provided a clinical presentation on transmyocardial revascularization. Mady Hue led a discussion on the coding proposal. One commenter stated that for coding specificity’s historical purposes and to avoid confusion with trend data, they would prefer to leave code 36.32, Other transmyocardial revascularization, as is, versus the proposal to revise the code title to read 36.32, *Endoscopic* transmyocardial revascularization. This commenter suggested leaving the “Other” transmyocardial revascularization code at 36.32 and moving the proposed *Endoscopic* code to another code number. Additionally, this same commenter stated they understood this format would not be the same as other codes that usually have the “other” code description at a point eight position (.8), however, it would eliminate the risk of disturbing historical data. One commenter agreed with all the statements the previous commenter made as they worked with survey data and felt it was important to leave the existing code as it is now. Another commenter asked Dr. Brunsting to describe how a percutaneous transmyocardial revascularization is performed. Dr. Brunsting stated that a percutaneous transmyocardial revascularization is performed in a catheterization lab and is done from inside of the heart. (A catheter is inserted up through the femoral artery). Dr. Brunsting informed the audience that this method runs the risk of cardiac tamponade and has not demonstrated proven efficacy. Although internationally there is quite a bit of interest, the percutaneous approach is not commonly performed in the United States. The commenter then suggested adding the term “endovascular” to the proposed code for a percutaneous approach. Another commenter suggested adding “robot-assisted” as an inclusion term for the proposed endoscopic approach.

#### **5. Endoscopic Insertion of Bronchial Valve**

Douglas Wood, MD, conducted a clinical presentation on the endoscopic insertion of bronchial valves. Pat Brooks led a discussion on the coding proposal. One commenter expressed concern about the volume of codes that are being created to describe or capture the number of devices inserted in a given procedure, stating there are too many codes of this type. Another commenter stated they supported the creation of new codes because there are no existing codes to describe this technology. Overall, there was general support for the coding proposal to create a new subcategory, 33.7, Endoscopic insertion, replacement and removal of therapeutic device in bronchus or lung.

#### **6. Hip Resurfacing Arthroplasty**

James Powell, MD, presented clinical information on hip resurfacing arthroplasty and how it differs from traditional hip replacement procedures. Pat Brooks led a discussion on the coding proposal. A commenter asked if there would be additional materials utilized other than metal-on-metal for these procedures in the future. Dr. Powell stated yes, he anticipates that other materials will be used. One commenter questioned if the

series of diagnoses codes that were recently created to describe complications of prosthetic joints would be applicable to hip resurfacing procedures. Dr. Powell replied that yes, he felt they would be applicable. Another commenter stated they agreed there is a need to recognize this subset of patients and supported the proposal to create new codes in the revised 00.8, Other knee *and hip* procedures section.

## **7. Hip Replacement Bearing Surfaces**

Pat Brooks led a discussion on the coding proposal for additional hip replacement bearing surface codes. There was general support for option 3, to create a new code, 00.77, Hip replacement bearing surface, ceramic-on-polyethylene.

## **8. Repair of Ventricular Septal Defect with Prosthesis, Closed Technique**

Joe Kelly, MD, provided an overview on the repair of ventricular septal defect with prosthesis, closed technique, and led the discussion for a code proposal. There was general support for the creation of a new code to describe this procedure and distinguish it from the open technique.

## **9. Surgical Decompression with Insertion of Interspinous Stabilization Device**

Dr. Gary L. Lowery, MD, PhD, conducted a clinical presentation on the coflex™ surgical decompression with insertion of interspinous stabilization device. Mady Hue led a discussion on the coding proposal. Several commenters agreed with option 1, to continue using code 84.59, Insertion of other spinal devices, to describe this procedure. One commenter expressed concern about the device not having FDA approval and suggested that CMS not accept proposals unless the device or agent being proposed is FDA approved first. Another commenter stated they were uncomfortable over the volume of code numbers being proposed and in the event the device was not approved, all the new code numbers would be unused. This would be a waste of codes in an ever-shrinking pool of available code numbers. This same commenter also mentioned that the description for code 84.58, Implantation of interspinous process decompression device, sounds similar to the coflex™ stabilization device and felt coders would be confused in distinguishing one from the other. One commenter discussed that the category of these devices should be coded and grouped according to technology and the procedure at the same time. Another commenter stated they felt the discussion of “compression” with regard to what the intent of the device may or may not do, is not within the scope of the ICD-9-CM classification system; procedure codes should only describe the service or procedure being performed.

## **10. Stereotactic Placement of Intracerebral Catheters via Burr Hole for Delivery of Therapeutic Agents**

Sandeep Kunwar, MD, conducted a clinical presentation on the stereotactic placement of intracerebral catheters via burr hole for delivery of therapeutic agents. Joe Kelly, MD,

led a discussion on the coding proposal. One commenter asked if the convention enhanced delivery (CED) method involved the actual delivery of the medication or was it used to describe the catheter placement. Dr. Kunwar's response was that the CED method involves both the stereotactic placement of the intracerebral catheters and the delivery of the medication. Another commenter suggested adding an excludes note at code 01.26, Insertion of catheter into cranial cavity, to distinguish between the two procedures. This same commenter also suggested inserting a "code also" note to code the therapeutic agent along with the proposed code 01.28, Stereotactic placement of intracerebral catheter(s) via burr hole(s) for delivery of therapeutic agent(s). Another commenter agreed with this suggestion. One commenter asked Dr. Kunwar if he would make the slides available for posting on the CMS website and his response was yes. There was general support for this code proposal.

### **11. Infusion of Cintredekin Besudotox**

Sandeep Kunwar, MD, conducted a clinical presentation on the infusion of cintredekin besudotox along with the presentation for the stereotactic placement of intracerebral catheters via burr hole for delivery of therapeutic agents. Joe Kelly, MD, led a discussion on the coding proposal. One commenter expressed concern at the code proposal to create new code, 00.19, Infusion of cintredekin besudotox, stating the agent is not FDA approved. This commenter felt that the agent, cintredekin besudotox, is a biological response modifier and is accurately captured with option 1, existing code, 99.28, Injection or infusion of biological response modifier (BRM) as an antineoplastic agent.

### **12. Implantation of Visual Prosthetic Device**

Michael Raizman, MD, provided a clinical presentation on the implantation of a visual prosthetic device, or "implantable miniature telescope", for patients diagnosed with macular degeneration. Pat Brooks led a discussion on the coding proposal. Two commenters asked clinical questions for Dr. Raizman. One commenter stated they noticed during the presentation that in the anterior chamber, the lens is almost as deep as the anterior chamber itself and protrudes posteriorly somewhat and the commenter was interested to know what happens if the bag does not stay intact. This commenter asked if it is possible to suture the haptic devices. Dr. Raizman's response was suturing of haptic devices does not work because the device is too heavy for fine sutures used in ophthalmologic surgery. Next, the commenter asked if the measurement of a patient's visual acuity is taken pre-operatively and post-operatively. Dr. Raizman replied there is approximately an improvement of 90% achieved or 3 lines of vision on an acuity chart. Another commenter asked about the term "miniature" and questioned if it was necessary as a descriptor of the device, as an implantable telescope would seem to indicate that it is miniature. This commenter also questioned if there were other devices out there that use "telescope" in their description. Dr. Raizman stated that it was given this description by the FDA product classification process. Next, the commenter asked about the endothelial cell count and if there was a noticeable decrease. Dr. Raizman informed the audience that from pre-op to 3 months, there was found to be a decrease in the count, however, at about 2 years, there was not a statistically significant drop. Another commenter asked if

this procedure would be performed more in the inpatient setting or outpatient setting. Dr. Raizman stated the procedure could be performed in both settings. One commenter suggested adding an excludes note to the existing procedure codes for Insertion of Intraocular Lens (13.70-13.72). Another commenter pointed out that the index for Operation, lens, reads NEC (not elsewhere classified) versus the handout that stated not otherwise specified.

### **13. Addenda**

Mady Hue led a discussion on the addendum proposal. One commenter suggested that the proposal to index Dynesys® as a main term should be reviewed and that they would prefer to see it indexed as a subterm to *Insertion*. Another commenter suggested adding non-essential modifiers to the main term Fistulogram, such as, *arteriovenous* and *vascular* for clarification. One commenter pointed out there was a typographical error with the code number at the term Xigris™ in the index. Another commenter suggested adding the terminology “that with” at the excludes note for code 80.51, Excision of intervertebral disc. This same commenter also suggested for code 80.99, Other excision of joint, to add the term “vertebral corpectomy with only” to the excludes note *excision of intervertebral disc (80.51)*. Another commenter stated she wanted to express her opinion that she does not agree with indexing brand names.

### **14. ICD-10-PCS Update**

Rhonda Butler facilitated a discussion on the revisions made to ICD-10-PCS as an effort to streamline the number of possible code combinations for inpatient facility reporting, to reflect a practical level of specificity and for ease of implementation. A PowerPoint presentation of her discussion is posted on the CMS web page.

This ended the procedure part of the Coordination and Maintenance Committee meeting. The meeting was adjourned. The diagnosis part of the meeting was to take place on March 24, 2006 and would be led by the National Center for Health Statistics. A Summary Report of the Diagnosis Topics can be found at:

<http://www.cdc.gov/nchs/icd9.htm>.