

SUMMARY REPORT

ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

May 11, 2000

Introductions and Overview

Pat Brooks welcomed the participants to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Coordination and Maintenance Committee meeting. All participants introduced themselves. An overview of the Committee was provided. 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. After the meeting, a summary of the meeting is posted on the home pages of the Health Care Financing Administration (CMS) and the National Center for Health Statistics (NCHS). The public is encouraged to send in written comments after the meeting, but prior to January 8, 2001. All written and oral comments will be considered prior to making a decision on final code revisions. It was announced that the November 17, 2000 meeting will be the last meeting at which proposed changes to ICD-9-CM for October 1, 2001 will be discussed. Those requesting that topics be discussed at the November 17, 2000 meeting, should submit them prior to September 17, 2000, as is indicated in the time line included in this report. An agenda for this meeting will be posted on CMS's homepage one month before the meeting.

There were no changes to ICD-9-CM on October 1, 1999 because of Y2K concerns. Therefore, all proposed changes discussed at the meetings on the following dates were considered for the October 1, 2000 addendum: June 4, 1998, November 2, 1998, May 13, 1999, and November 12, 1999. The Notice of Proposed Rulemaking (NPRM) for Inpatient Prospective Payment was published May 5, 2000 in the Federal Register. The NPRM contains the final code revisions for October 1, 2000 as well the proposed DRG changes. Addendum for the procedure part of ICD-9-CM was posted on CMS's homepage on May 10, 2000. Information on CMS's ICD-9-CM site is provided in the time line.

It was mentioned that the final notice on the Transaction Regulation naming national coding standards has not yet been published. Those wishing to follow these activities should access the Administrative Simplification homepage. This can be accessed through links on both CMS's and NCHS' home pages. It was stressed that no decision has been made on when or if ICD-10 will be implemented in the United States. These discussions will begin after the Transaction Regulation is published. Therefore there is no tentative date for implementing ICD-10, since the topic has not yet been addressed through public hearings.

Update on the ICD-10-PCS Coding System

Pat Brooks discussed the handout describing the latest round of ICD-10-PCS testing by the CDACs. This report discusses the findings of the CDACs on reviewing the latest sample of records. It was mentioned that the CDACs used the same version of ICD-10-PCS that has been used in previous testing. Many updates and edits have been identified during the previous testings. Since the CDACs used some new employees who were not familiar with ICD-10-PCS, this testing once again provided an opportunity to test the training manual. No formal training sessions were provided. The employees without ICD-10-PCS experience were able to train themselves on the new system. Interestingly, they identified the same problems and errors with the training manual which were found in previous testing. During the actual testing, they identified some of the same issues and omissions that were previously discovered.

For the most part, both contractor's findings agreed with findings and recommendations from the first two phases of testing. They continue to be impressed with the completeness and applicability of ICD-10-PCS. After an initial period of becoming familiar with ICD-10-PCS, the new system was found to be easy to use and to accurately describe the procedures being coded. As previously mentioned, the training manual was found to be an effective tool.

The samples tested consisted of three broad categories:

1. OB-GYN cases
2. Outpatient surgery cases - a broad spectrum of cases written for CPT training
3. Challenging ICD-9-CM cases - 57 cases provided by the American Hospital Association that proved quite challenging for assigning ICD-9-CM codes.

In analyzing the three different groups of sample cases, one contractor stated that their coders did not notice any significant differences in difficulty among the three categories. In fact, some of their questions related to the supposedly more simple cases. The other contractor stated that assigning codes to the challenging cases submitted by AHA was accomplished more expeditiously using ICD-10-PCS than with ICD-9-CM.

This latest round of testing indicated that ICD-10-PCS is, for the most part, complete. Once the issues previously identified are corrected in an updated version of ICD-10-PCS, the system should be ready for discussions about implementation. A revised version of ICD-10-PCS and the training manual will be prepared and placed on CMS's homepage in the fall of 2000.

CODING TOPICS

Percutaneous Endoscopic Gastrojejunostomy

Amy Gruber described the procedure and lead a discussion of the two options discussed in the handout. The audience overwhelming agreed with option 1 which would create a new code, 44.32 Percutaneous [endoscopic] gastrojejunostomy. There were no comments in support of continuing to use the existing code 44.39, Other gastroenterostomy.

Lysis of Adhesions

Ann Fagan described information provided in this handout which discusses a history of challenge and perhaps inconsistencies in the coding of lysis of adhesions. She discussed information provided in the fourth quarter 1990, pages 18-19 of **Coding Clinic for ICD-9-CM**. The current issues involve coding lysis of pleural adhesions as well as mechanical and digital lysis of adhesions. No attempt was made to propose a solution at the meeting. The audience was urged to review the current problems and suggest ways in which a more systematic approach could be developed. There was agreement from the participants that there is a problem with coding open lysis of adhesions in the same manner as mechanical or digit freeing of adhesions. It was felt that codes should be more clearly defined or revised so that these different procedures are not grouped together. One participant suggested that as the problem is being analyzed, thought should be given to capturing thoracoscopic versus closed. It was felt that coders may not understand the term "digital" lysis. Synonyms may include: manual, blunt, manipulation, (gloved) finger, mechanical. It was also recommended that the current index should be reviewed to determine how adhesiolysis is handled throughout ICD-9-CM. It was felt that new codes may need to be created.

Ann urged those in attendance as well as those reading the summary report to carefully analyze the issues and send any recommendation to her by September 17. The topic will be discussed in greater detail at the November 17, 2000 meeting.

Spinal Fusion for Pseudarthrosis

Amy Gruber described this coding issue. All pseudarthrosis fusions are assigned to code 81.09, Refusion of spine, any level or technique. Therefore, all information on the approach or level of the procedure is lost. The proposal discussed options for creating a new series of codes which would provide this level of detail, or removing the excludes notes under codes 81.01 - 81.07 so that these procedures could be double coded, or continuing to code them with only 81.09.

The audience agreed that there was a need for greater detail and information on the approach and level used for pseudarthrosis. The approaches and levels make a difference in the difficulty of the procedure. There was no support for the third option which involves continuing to capture all spinal fusions for pseudarthrosis with code 81.09. Some felt that the first option with a new series of codes was a good idea since it provided all the necessary detail. Others felt that it was not appropriate to add a diagnosis into the code title. It was suggested that NCHS provide greater detail in the diagnosis codes so that the level would not be necessary. NCHS agreed to look into this recommendation. Others felt it would be appropriate to double code the procedure with code 81.09 and a code from 81.01 - 81.07.

Since NCHS will be examining the diagnosis suggestion, it was recommended that the topic be brought back to the November 17 meeting. Then any revisions to the diagnosis codes could be addressed at the same time as proposed procedure revisions are discussed. The public was strongly encouraged to send in written suggestions on this topic by September 17 so that a more definitive solution could be discussed.

Penile Plethysmography with Nerve Stimulation

Dan Muscatello and Sharad Joshi of UroMed Corporation described their company's technology used in this procedure. Ann Fagan then lead a discussion of coding options. The audience was opposed to option 3 which would create a new code 89.27, Penile plethysmography with nerve stimulation. It was felt that this code would narrow the procedure down too much. It was felt to be too specific. In addition, if the technology were to be applied to additional body sites, the code could not be used. The audience also felt it was inappropriate to use option 1 which would add inclusion terms for the procedure under radical prostatectomy. This would not allow for retrieval of information on procedures performed. There was a great deal of support for indexing this procedure to existing code 89.58, Plethysmogram, as described in option 2. It was felt that by finding cases for radical prostatectomy and code 89.58, Plethysmogram, one would clearly be able to find these cases. This also allows for a more generic description of the procedure.

The participant's main concern for this new procedure was whether physicians are clearly documenting it. The manufacturers stated that the procedure has been used for a year. Equipment for the procedure is available at 125 sites. The manufacturer was not sure whether physicians were documenting this as nerve stimulation, penile plethysmography, or with a combination of terms. One participant stated that if the use of this technology was described only briefly within the operative report, coders may not retrieve the information and code. This problem further supports the use of existing codes instead of the creation of a narrowly defined new code. The participants therefore recommended the use of option 2, adding this study to code 89.58, Plethysmogram.

Addenda

Amy Gruber has received only one recommendation for addenda to Volume 3, which she discussed with the participants. They supported the index and tabular revisions to assign code 97.55, Removal of T-tube, other bile duct tube, or liver tube, for the removal of a stent from the bile duct.

Conclusion of Procedure part of the meeting

This concluded the procedure part of the meeting. Participants as well as those reading the summary were once again urged to carefully review the topics discussed and send their written comments to CMS. Addresses are provided in the attachments. Those wishing to have a topic discussed at the November 17, 2000 meeting should send them in writing prior to September 17, 2000. The agenda will be posted one month prior to the meeting. The meeting was then turned over to Donna Pickett, NCHS. A summary of NCHS's portion of the meeting can be found on their homepage as follows:

<http://www.cdc.gov/nchswww/about/otheract/icd9/maint/maint.htm>

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Summary of Meeting:

A complete report of the meeting, including handouts, will be available on CMS's homepage within one month of the meeting. Written summaries will no longer be mailed. The summary can be accessed at:

<http://cms.hhs.gov/paymentsystems/icd9/default.asp>

ICD-9-CM TIMELINE

A timeline of important dates in the ICD-9-CM process is described below:

- | | |
|-----------------|---|
| October 1, 1998 | Complete, updated ICD-9-CM available on CD ROM through the Government Printing Office at (202) 512-1800. Order number 017-022-01434-3. Cost \$18. This version of ICD-9-CM will be in effect from October 1, 1998 through September 30, 2000. |
| May 13, 1999 | ICD-9-CM Coordination and Maintenance Committee meeting. Code revisions discussed are for potential implementation on October 1, 2000. |
| June 1999 | Summary report of the Procedure part of the May 13, 1999 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS's homepage as follows:
http://cms.hhs.gov/paymentsystems/icd9/default.asp |

The **Diagnosis part** of the report will be posted on NCHS' homepage

as follows:

www.cdc.gov/nchswww/about/otheract/icd9/maint/maint.htm

- July 30, 1999 Hospital Inpatient Prospective Payment System final notice published in the **Federal Register** as mandated by Public Law 99-509. **Because of Y2K issues, no ICD-9-CM code revisions were allowed for October 1, 1999. No addendum was issued which would modify ICD-9-CM in any way. ICD-9-CM codes effective October 1, 1998 will remain in effect through September 30, 2000.**
- Sept. 10, 1999 Those members of the public requesting that topics be discussed at the November 12, 1999 meeting should have their requests to CMS for procedures and NCHS for diagnoses.
- Oct. 1, 1999 Revisions to the Hospital Inpatient Prospective Payment System go into effect.
- Nov 12, 1999 ICD-9-CM Coordination and Maintenance Committee meeting. Last meeting of the year to discuss proposed code revisions for October 1, 2000.
- December 1999 Summary report of the **Procedure part** of the November 12, 1999 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS's homepage as follows:

<http://cms.hhs.gov/paymentsystems/icd9/default.asp>

The **Diagnosis part** of the report will be posted on NCHS' homepage as follows:
www.cdc.gov/nchswww/about/otheract/icd9/maint/maint.htm
- January 7, 2000 Deadline for receipt of public comments on proposed code revisions. **Revisions will include all those discussed at FY 1999 (June 4, 1998 and November 2, 1998) and FY 2000 (May 13, 1999 and November 12, 1999) ICD-9-CM Coordination and Maintenance Committee meetings.**
- March 11, 2000 Those members of the public requesting that topics be discussed at the May 11-12, 2000 ICD-9-CM Coordination and Maintenance Committee meeting should have their requests to CMS for procedures and NCHS for diagnoses.
- April 2000 Tentative agenda for the **Procedure part** of the May 11, 2000 ICD-

9-CM Coordination and Maintenance Committee meeting will be posted on CMS's homepage as follows:
<http://cms.hhs.gov/paymentsystems/icd9/default.asp>

The **Diagnosis part** of the report will be posted on NCHS' homepage as follows:
www.cdc.gov/nchswww/about/otheract/icd9/maint/maint.htm

May 5, 2000 Notice of Proposed Rulemaking published in the Federal Register as mandated by Public Law 99-509. This included the final decisions on all ICD-9-CM code titles. It included proposed revisions to the DRG system, on which the public may comment.

May 11, 2000 ICD-9-CM Coordination and Maintenance Committee meeting.

June 2000 Summary report of the **Procedure part** of the May 11, 2000 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS's homepage as follows:
<http://cms.hhs.gov/paymentsystems/icd9/default.asp>

The **Diagnosis part** of the report will be posted on NCHS' homepage as follows:
www.cdc.gov/nchswww/about/otheract/icd9/maint/maint.htm

July 1, 2000 Hospital Inpatient Prospective Payment System final rule to be published in the **Federal Register** as mandated by Public Law 99-509.

Sept. 17, 2000 Those members of the public requesting that topics be discussed at the November 17, 2000 ICD-9-CM Coordination and Maintenance Committee meeting should have their requests to CMS for procedures and NCHS for diagnoses.

October 1, 2000 New and revised ICD-9-CM go into effect along with all other DRG changes.

October 2000 Tentative agenda for the **Procedure part** of the November 17, 2000 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS's homepage as follows:
<http://cms.hhs.gov/paymentsystems/icd9/default.asp>

The Diagnosis part of the report will be posted on NCHS' homepage as follows:

www.cdc.gov/nchswww/about/otheract/icd9/maint/maint.htm

Nov. 17, 2000 ICD-9-CM Coordination and Maintenance Committee meeting in CMS Auditorium.

December 2000 Summary report of the **Procedure part** of the November 17, 2000 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS's homepage as follows:
<http://cms.hhs.gov/paymentsystems/icd9/default.asp>

The **Diagnosis part** of the report will be posted on NCHS' homepage as follows:
www.cdc.gov/nchswww/about/otheract/icd9/maint/maint.htm

January 8, 2001 Deadline for receipt of public comments on proposed code revisions discussed at the May 11, 2000 and November 17, 2000 ICD-9-CM Coordination and Maintenance Committee meetings. These proposals are being considered for implementation on October 1, 2001.

April 1, 2001 Notice of Proposed Rulemaking to be published in the **Federal Register** as mandated by Public Law 99-509. This will include the final decisions on all ICD-9-CM code titles. It will include proposed revisions to the DRG system, on which the public may comment.

July 1, 2001 Hospital Inpatient Prospective Payment System final rule to be published in the **Federal Register** as mandated by Public Law 99-509.

October 1, 2001 New and revised ICD-9-CM go into effect along with all other DRG changes.

ICD-10-PCS UPDATE

The International Classification of Diseases, Tenth Revision, Procedure Classification System (ICD-10-PCS) is being developed as a replacement for Volume 3 of ICD-9-CM. The development of ICD-10-PCS is being funded by the Health Care Financing Administration (CMS). CMS has the lead within the Department of Health and Human Services on ICD procedure coding. ICD-10-PCS is a seven character, alphanumeric procedure coding system that provides a unique code for all substantially different procedures. It allows for new procedures to be easily incorporated within the system.

Development

CMS began work on a preliminary design for a replacement for Volume 3 of ICD-9-CM in 1992. After encouraging results, a contract was awarded to 3M Health Information Systems in 1995 for a three year contract to complete the development of ICD-10-PCS. A draft of the complete system was placed on CMS's homepage in 1998 at the following address:

<http://cms.hhs.gov/paymentsystems/icd9/icd10.asp>

At the request of the general public, CMS also placed copies of a training manual for ICD-10-PCS, a paper describing the system, and speaker slides on ICD-10-PCS on the homepage.

Objectives

Four major objectives were established for the development of ICD-10-PCS which are as follows:

- **Completeness** - There should be a unique code for all substantially different procedures.
- **Expandability** - As new procedures are developed the structure of ICD-10-PCS should allow them to be easily incorporated as unique codes.
- **Multiaxial** - ICD-10-PCS should have a multiaxial structure with each code character having the same meaning within a specific procedure section and across procedure sections to the extent possible.
- **Standardized Terminology** - ICD-10-PCS should include definitions of the terminology used. While the meaning of specific words can vary in common usage, ICD-10-PCS should not include multiple meanings for the same term and each term must be assigned a specific meaning.

Extensive testing was conducted by the Clinical Data Abstraction Centers (CDACs) DynKePRO and FMAS Corporation, who are CMS contractors. The first stage focused on 2,600 inpatient records and led to suggestions to improve the training manual, revise definitions, and expand entries in the index and tabular section. This was followed by a second testing period which focused on ambulatory records. Additional recommendations for edits were determined. The results of this testing indicated that for the most part ICD-10-PCS met the four major objectives. At the May 13, 1999 ICD-9-CM Coordination and Maintenance Committee, suggestions were made to perform additional testing in the area of obstetrics as well as non-Medicare types of cases. The American Hospital Association volunteered to assist in obtaining additional records. Others were encouraged to forward sample cases.

Additional testing - fall 1999 to April 2000

The CDACs were used once again to assign ICD-10-PCS codes to the sample of records. Although it was thought that by using the same contractors, there would be a continuity of reviewers familiar with ICD-10-PCS, this was not completely the case. There had been a turnover of personnel since the initial testing activities in 1997. FMAS used four coders in the most recent testing. All four had worked on the second phase of testing involving outpatient records, but only one had also worked on the

first phase involving inpatient records. DyneKePRO used six coders in this phase of testing. Of the six, only one had participated in the first two testing phases. The remaining five coders were self trained in ICD-10-PCS using the training manual.

A benefit of using both experienced as well as coders inexperienced with ICD-10-PCS was that the training manual could once again be evaluated. It was apparent that the coding system could be understood in a rather rapid fashion using the training materials.

Study

In order to maintain consistency, the same version of ICD-10-PCS was used in all three phases of testing. This was the 1998 version on CMS's homepage. Although a number of improvements and corrections have been identified for the training manual as well as for the coding system, it was felt that neither should be updated prior to this final phase of testing. As a result, many of the same issues and edits were once again identified in both the training manual as well as the coding system. This reinforced the need for these suggestions. It also showed that coders were consistently approaching the use of the new system. In particular, coders inexperienced with ICD-10-PCS who were teaching themselves about ICD-10-PCS with the training manual, discovered all the same issues and errors that will be corrected in the next version of the manual.

Sample

There were 108 cases to be coded in this phase of the study. This resulted in 188 procedures using ICD-10-PCS. The procedures included were very broad based. They encompassed neurology, maternity, ophthalmology, cardiology, gastroenterology, and orthopedics. The contractors stated that the variety of records offered an excellent forum for testing the depth of ICD-10-PCS. There were three major categories that made up this sample. We asked the contractors to code these specific cases and then to analyze the three major groups overall to determine if one group was more difficult to code than the other. Obviously, the challenging ICD-9-CM cases described below which were forwarded by AHA had presented extensive coding problems to hospitals as well as the board of Coding Clinic.

1. **OBGYN** - Only a limited number of records were received in this category. They involved dilation and curettage, tubal ligation and bilateral tubal repair, as well as two obstetric cases (one vaginal delivery and one cesarean section).
2. **OUTPATIENT SURGERIES** - This sample involved an extensive variety of procedures commonly performed in an ambulatory setting. The cases were written to be used in training coders in the use of CPT. Therefore the sample was quite varied. A member of the public who submitted the cases felt that it would be an excellent sample for testing.
3. **CHALLENGING ICD-9-CM CASES** - The American Hospital Association supplied 57 cases that had been discussed at past meetings of the Editorial Advisory Board for Coding Clinic for ICD-9-CM. The Board had found these 57 cases to be quite difficult to code using ICD-9-CM. In many cases multiple

meetings were required in order to achieve consensus on how they should be coded using ICD-9-CM. In many cases, the code determined was at best a compromise since ICD-9-CM did not adequately address the issue. AHA felt that these challenging cases would provide a good indication on how well ICD-10-PCS would address new technologies as well as problematic areas.

Findings

For the most part, both contractor's findings agreed with findings and recommendations from the first two phases of testing. Following is a summary of their main findings.

1. In this third test of ICD-10-PCS, the contractors continue to be impressed by the completeness and applicability of the coding system. After an initial period of becoming familiar with ICD-10-PCS, the new system was found to be easy to use and to accurately describe the procedures being coded.
2. The training manual was an effective tool in learning to use ICD-10-PCS. The experienced coding participants re-reviewed the training manual prior to initiating their review of records. For the most part, this only required a few hours to refresh their memory of the system. One coder took several days to review the manual prior to feeling comfortable initiating the review. However, since the training manual had not been updated with recommended changes from the first two phases of testing, many of the same issues were once again identified. Specific recommendations were made for adding more examples and providing an alphabetical procedure index for the training manual. These recommendations have been extensively documented and will be incorporated into the next version of the training manual.
3. The depth of specificity with ICD-10-PCS is a great asset. For many of the procedures, such as orthopedics, ICD-10-PCS were far superior to the more general ICD-9-CM codes. This leads to a more rapid and clear choice in codes.
4. The consistency of character definitions across body systems facilitated clear assignment of codes. This consistency, along with the high degree of specificity with ICD-10-PCS, were felt to be the most appealing characteristics of the system.
5. For the less experienced coders, there were problems when the terms used in the operative or test reports did not exactly match the terms used in the coding scheme. Suggestions were made for improvements in the training manual as well as in both the tabular and index sections to reduce these problems. In other cases it was felt that the coder's lack of understanding of anatomy or terminology may have lead to particular problems in code selection. Once again, many of these issues could be reduced with improvements in the training manual as well as greater guidance in the index of ICD-10-PCS. In addition, it was recommended that additional resources be developed prior to any national training initiative.
6. In analyzing the three different groups of sample cases, one contractor stated that their coders did not notice any significant difference in difficulty among the OB, ambulatory, or challenging cases as far as assigning an ICD-10-PCS code. In fact, some of their questions and suggestions submitted to 3M were for the supposedly simpler procedures. These involved knowing where to start the coding process in the absence of specific index entries. Many of these will be corrected in the next version of ICD-10-PCS.

The other contractor stated that assigning codes to the challenging cases submitted by AHA was accomplished more expeditiously using ICD-10-PCS than when using ICD-9-CM. More time was spent reviewing the tabular list to ICD-9-CM to ensure that the best and most specific ICD-9-CM code was assigned. Since many of the ICD-9-CM codes in the challenging cases were quite general, assigning ICD-9-CM codes was actually more time consuming than was the case for ICD-10-PCS.

7. This latest phase of testing led the contractors to find that ICD-10-PCS was for the most part complete once the issues previously identified are corrected in an updated version of ICD-10-PCS. In many cases the testers found that any problems encountered with assigning a code with confidence was a result of lack of knowledge on the coder's part, rather than incompleteness of the coding system. Considering the rather short amount of training provided, this is truly remarkable.

FUTURE PLANS

A revised version of ICD-10-PCS and the training manual will be prepared and placed on the CMS homepage in the fall of 2000. This will better facilitate discussions on whether ICD-10-PCS should become a national standard for coding.

Percutaneous Endoscopic Gastrojejunostomy

Issue:

All gastrojejunostomies are currently assigned to code 44.39, Other gastroenterostomy. However, many of these procedures are now being performed as percutaneous endoscopic gastrojejunostomies. There is no way to differentiate between the open and percutaneous endoscopic approaches. Should a new code be created to capture percutaneous endoscopic gastrojejunostomy?

Background:

In the ICD-9-CM Volume 3, Procedures, there is a code to capture percutaneous endoscopic gastrostomy (code 43.11) and a code to capture percutaneous endoscopic jejunostomy (code 46.32).

Percutaneous endoscopic gastrojejunostomy tube is a enteral feeding tube that is performed by placing a thin tube through a gastrostomy tube and pulling it endoscopically into the proximal jejunum. This technique allows for simultaneous gastric suction and jejunal infusion. It is indicated in selective patients in need of concomitant access to the jejunum and gastric decompression.

Complications include: dislocation, obstruction, or migration of tube, infection, leakage, incisional pain, or hematoma.

Options:

1. Create a new code to capture percutaneous endoscopic gastrojejunostomy under category 44.3, Gastroenterostomy without gastrectomy.

New code 44.32 Percutaneous [endoscopic] gastrojejunostomy

2. Continue to code this procedure to code 44.39, Other gastroenterostomy.

Recommendation:

Option 1. Create a new code to capture percutaneous endoscopic gastrojejunostomy under category 44.3, Gastroenterostomy without gastrectomy.

New code 44.32 Percutaneous [endoscopic] gastrojejunostomy

In the interim, continue to code this procedure to code 44.39, Other gastroenterostomy.

Lysis of Adhesions

Issue:

There is confusion surrounding the definition and coding of lysis of adhesions, particularly in a non-open procedure.

Staging of this discussion:

This topic will be addressed in two C&M sessions; today, and again at the November 17, 2000 meeting. This topic is being introduced so that discussion will be generated, and we can decide the best approach for any changes to the procedure coding that may be deemed necessary.

Background:

At the November 1995 C&M meeting, we proposed many new codes differentiating laparoscopic/thoracoscopic procedures from their open counterparts. Where codes already existed, we took this opportunity to address lysis of adhesions. However, we did not address digital or mechanical adhesiolysis in a non-open procedure. We also did not specifically address adhesiolysis codes already in place. The American Hospital Association's publication, Coding Clinic for ICD-9-CM, fourth quarter 1990, pages 18 -19, gives the following information about adhesiolysis:

Coders should not code adhesions and lysis thereof, based solely on mention of adhesions or lysis in an operative report. Determination as to whether the adhesions and the lysis are significant enough to code and report must be made by the surgeon.

Adhesions from previous surgery are the most common cause of intestinal obstruction in the United States. When such obstruction is present, lysis of adhesions

is usually the major procedure performed and both the diagnosis of adhesions and the procedure for lysis should be coded.

Occasionally, obstruction is not present, but a strong band of adhesions prevents the surgeon from access to the organ being removed, requiring lysis before the operation can proceed. In this case, both the diagnosis of adhesions and the lysis procedure should be coded.

Frequently, however, adhesions may exist without being organized and without causing any symptoms in the patient or increasing the difficulty of performing the operative procedure. When such minor adhesions exist and are easily lysed as part of the principal procedure, coding a diagnosis of adhesions and the procedure of lysis of adhesions is inappropriate. For example, some adhesions around the gallbladder are common and may be lysed as an integral part of the cholecystectomy. In this case, this is an incidental finding and coding of adhesions or their lysis would rarely be appropriate. Occasionally, the gallbladder is so encased in a strong band of adhesions that extensive lysis is required before the gallbladder is removed. In this case, coding of the adhesions and lysis would be appropriate.

Current Issues:

Pleural: The index directs coders to 33.39, Other surgical collapse of lung, which may have been used in the past for treatment of tuberculosis. Today's physicians, however, are reluctant to claim that they have collapsed a lung, when in fact they have not. There is room for expansion at the fourth-digit level, if creation of a new subsection code(s) is warranted, with concomitant changes to the index.

Code 34.99, Other operations on thorax, Other, is achievable through the index via Lysis, adhesions, thorax. 34.99 is vague, as well as reflecting an open approach.

Code 34.59, Other excision of pleura, was suggested by a physician-advisor as it "is more consistent with pleurectomy and a decortication of the lung - removal of thickened visceral pleurae". As it exists, this code reflects an open approach, and is not listed in the index under "Lysis".

Mechanical: Case study of an admission in which the patient was admitted because he could not receive peritoneal dialysis. The physician sedated the patient, took him to the OR, and poked a guide wire down the dialysis catheter until he freed up the adhesions which were blocking the tube. Code 54.95, Incision of peritoneum, seems like overkill, in addition to being an open procedure.

Digital: In FY-1998, we made revisions to code 34.04, Insertion of intercostal catheter for drainage, by adding an inclusion term which reads "Revision of intercostal catheter (chest tube) (with lysis of adhesions)". We believed this revision to be clear, but apparently digital lysis needs to be specifically mentioned. We had the opportunity to make that addendum change this year, but chose to review the subject as a whole, in case there are other categories of adhesiolysis which need to be addressed.

Request:

Review this topic at your facilities, and give us feedback regarding how you would like the non-operative lysis to be displayed.

Spinal Fusion for Pseudarthrosis

Issue:

Coding instructions preclude identifying the specific level or technique for pseudarthrosis fusions. All pseudarthrosis fusions are assigned to code 81.09, Refusion of spine, any level or technique. Should a new category be implemented to capture the specific technique used in pseudarthrosis fusion?

Background:

Pseudarthrosis is an abnormal union formed by fibrous tissue between parts of a bone that has fractured usually spontaneously due to congenital weakness. The frequency of pseudarthrosis after spinal fusion is measured from the time the operation is proposed until the fusion mass is solid. There is a definite relationship between the extent of fusion and the incidence of pseudarthrosis.

It has been estimated that 50 percent of patients with pseudarthrosis have no symptoms. Findings in the diagnosis of pseudarthrosis may include: sharply localized pain and tenderness over the fusion, progression of the deformity or disease, localized motion in the fusion mass as found in biplane bending roentgenograms and motion in the fusion mass found on exploration.

Options:

1. Create a new category and codes to capture spinal fusion for pseudarthrosis.

New category	81.3 Spinal fusion for pseudarthrosis
New code	81.30 Spinal fusion for pseudarthrosis, not otherwise specified
New code	81.31 Atlas-axis spinal fusion for pseudarthrosis Cranio-cervical fusion by anterior transoral C1-C2 fusion or posterior technique Occiput C2 fusion
New code	81.32 Other cervical fusion, anterior technique for pseudarthrosis Arthrodesis of C2 level or below: anterior (interbody) technique

anterolateral technique

- New code 81.33 Other cervical fusion, posterior technique for pseudarthrosis
Arthrodesis of C2 level or below:
posterior (interbody) technique
posterolateral technique
- New code 81.34 Dorsal and dorsolumbar fusion, anterior technique for pseudarthrosis
Arthrodesis of thoracic or thoracolumbar region:
anterior (interbody) technique
anterolateral technique
- New code 81.35 Dorsal and dorsolumbar fusion, posterior technique for pseudarthrosis
Arthrodesis of thoracic or thoracolumbar region:
posterior (interbody) technique
posterolateral technique
- New code 81.36 Lumbar and lumbosacral fusion, anterior technique for pseudarthrosis
Arthrodesis of lumbar or lumbosacral region:
anterior (interbody) technique
anterolateral technique
- New code 81.37 Lumbar and lumbosacral fusion, lateral transverse process technique for pseudarthrosis
- New code 81.38 Lumbar and lumbosacral fusion, posterior technique for pseudarthrosis
Arthrodesis of lumbar or lumbosacral region:
posterior (interbody) technique
posterolateral technique
- New code 81.39 Spinal fusion for pseudarthrosis, not elsewhere classified

2. Add a code also note to code 81.09, Refusion of spine, any level or technique instructing to code in addition to code 81.09, code also any technique. Delete the excludes note: that for pseudarthrosis at codes 81.01 -81.07.

3. Continue to code all spinal fusions for pseudarthrosis to code 81.09, Refusion of spine, any level or technique.

Recommendation:

- Option 1. Create a new category and codes to capture spinal fusion for pseudarthrosis as presented above.

In the interim, continue to code this procedure to code 81.09, Refusion of spine, any level or technique.

Penile Plethysmography with Nerve Stimulation**Issue:**

There are no ICD-9-CM codes that capture the use of penile plethysmography with nerve stimulation. In order to identify this procedure and track outcomes for procedures incorporating nerve stimulation, more specific coding instruction is needed.

Background:

Radical prostatectomy is a common method of treating patients with prostate cancer. The goal of radical prostatectomy is to rid the patient of prostate cancer and save his life. Unfortunately, a high percentage of patients lose erectile function or normal urinary control as a result of the procedure. To help limit this unwanted side effect, many physicians perform a modification of the existing procedure, called a nerve sparing radical prostatectomy. However, use of and success with this technique have been very limited to date.

A new technology is now available which tries to make the hypothetical benefits of the "nerve-sparing radical prostatectomy" a reality. The product is called CaverMap, manufactured and distributed by the Uromed Corporation. CaverMap is used to stimulate nerves in the neurovascular bundle and monitor the response. To use CaverMap, urologists place a probe within the prostatic nerves and are able to detect minor changes in penile tumescence or detumescence (swelling or contraction) with the help of the penile plethysmography device, which is incorporated into CaverMap. This helps the urologist perform a nerve sparing radical prostatectomy with precision. Another advantage cited by urologists is that these bundles can be restimulated at the conclusion of the procedure, providing immediate feedback as to whether erectile function will be restored after surgery.

Coding Options:*Option 1 – Include in existing radical prostatectomy codes*

This would include modification of the inclusion terms in the existing radical prostatectomy codes to incorporate penile plethysmography. This would have the effect of clarifying classification of the procedure, but would not provide specific tracking ability.

Example:

60.5 Radical prostatectomy

Add Penile plethysmography with nerve stimulation
Prostatovesiculectomy
Radical prostatectomy by any approach

Option Two – Add this study to a code which includes plethysmography

The Index leads coders to existing code 89.58, Plethysmogram. This code reflects blood present or passing through a site, and includes carotid, air-filled, capacitance, cerebral, differential, oculoplethysmogram, photoelectric, regional, segmental, strain-gauge, venous occlusion, and water occlusion. Blood flow is the bottom line re: penile tumescence, but inclusion of this procedure in this code may remove the concept of nerve stimulation.

Option Three - Creation of a new code

There is some space in the 89.2x section, Anatomic and physiologic measurements and manual examinations – genitourinary system, so a new code could be added as follows:

New Code 89.27 Penile plethysmography with nerve stimulation

Recommendation:

CMS recommends adoption of option two, modification of the Index.

**Proposed Addenda
FY 2002**

Index

	Removal
Add	stent
subterm	bile duct 97.55

Tabular

Add inclusion	97.55 Removal of T-tube, other bile duct tube, or liver tube
term	Removal of bile duct stent