

SUMMARY REPORT
ICD-9-CM Coordination and Maintenance Committee
Volume 3, Procedures
June 5, 1997

Patricia E. Brooks, Co-Chairperson
Centers for Medicare and Medicaid Services

Introductions and Announcements

The members of the Committee and the participants introduced themselves. It was stated that the purpose of the Committee is to provide a public forum to discuss proposed changes to the ICD-9-CM coding system. The first half of the meeting is conducted by the Centers for Medicare and Medicaid Services (CMS) which is responsible for procedures. The second half is conducted by the National Center for Health Statistics (NCHS) which is responsible for diagnoses.

TIME FRAMES FOR CODING REVISIONS

It was explained that revisions to ICD-9-CM are made once a year, effective October 1 of each year. The following time line was provided:

November

Meeting notice and agenda for the December ICD-9-CM Coordination and Maintenance Committee meeting will be posted on the CMS Home Page under Public Affairs/What's New.

December

Last ICD-9-CM C&M Committee Meeting at which proposed code revisions can be considered for the next Addendum which will be effective the following October. Those members of the public requesting that topics be discussed at the December meeting should have their requests in two months prior to the meeting.

January

Electronic versions of the December ICD-9-CM Coordination and Maintenance Committee Meeting Summary Report will be available on the CMS Home Page under Public Affairs.

January 31

Deadline for receipt of final public comments on proposed code revisions. Clinical specialists are consulted to ensure that proposed code revisions are clinically correct.

February

Formulation of final code revisions and the initiation of the final clearance process begins within CMS.

May

Final code revisions are published in the Federal Register as part of the Prospective Payment System proposed notice as mandated by Public Law 99-509.

June

Last meeting where code revisions are considered for finalization in October of that year. Those members of the public requesting that topics be discussed at the June meeting should have their requests in two months prior to the meeting.

June

Electronic versions of the June ICD-9-CM Coordination and Maintenance Committee Meeting Summary Report will be available on the CMS Home Page under Public Affairs.

Summer

ICD-9-CM Volume 3 Addendum are published on CMS's Home Page and provided to the American Hospital Association for publication in *Coding Clinic for ICD-9-CM*.

September

Complete, updated ICD-9-CM is available on CD ROM through the Government Printing Office at (202) 512-1800.

OCTOBER 1, 1998 PROPOSALS

Topics discussed at the June 5, 1997 are under consideration for implementation October 1, 1998. The participants were urged to offer their suggestions both at the meeting and later in writing. All comments must be received by January 31, 1998 to be considered.

OCTOBER 1, 1997 ADDENDUM

CMS will place the October 1, 1997 addendum on its Home Page. Addendum for Volume 3, ICD-9-CM, Procedures, which was implemented October 1, 1997 is now available on CMS's Home Page. This can be accessed at:

URL: <http://cms.hhs.gov/>

A copy of the Volume 3 addendum was been given to the American Hospital Association. AHA published it as a part of *Coding Clinic for ICD-9-CM*.

ELECTRONIC VERSIONS OF ICD-9-CM, VOLUME 3

The complete electronic version of ICD-9-CM is available on a CD ROM from the Government Printing Office. The version includes all three volumes of ICD-9-CM as well as the official coding guidelines. This can be ordered as follows:

Government Printing Office
(202) 512-1800
Order # 017-022-01352-5
\$18

Pat announced that the topic, Minimally invasive coronary artery bypass graft, which appeared on the tentative agenda that was mailed out, would not be discussed today. This topic was discussed last June. We did not implement any changes this year due to the comments we received. We are still receiving letters from various hospitals that are performing this procedure and would like to track it. We are investigating what constitutes minimally invasive. Both procedures are open, its a matter of how open. CMS believes there should be a way of tracking this data as well as keeping the trend data we already have that identifies the number of vessels bypassed and additional arteries that are involved. Pat encouraged the participants to submit their suggestions to us.

ICD-9-CM Topics (in the order they were presented -see enclosed proposals)

1. Transmyocardial Revascularization (TMR)

Ann Fagan lead the discussion on this issue. Douglass Murphy-Chutorian, MD provided an extensive clinical presentation on the procedure. Tommy Fudge, MD added his experiences with the procedure as well as clinical trials.

There was much discussion on this topic. Some participants questioned why the proposed new codes were under category 36 Operations on vessels on heart and not category 37, Other operations on heart and pericardium. Others felt that the proposed new code 36.33, Percutaneous myocardial revascularization, should be titled percutaneous transmyocardial revascularization or have it listed as an inclusion term. There was opposition to the proposal because the procedure is not FDA approved and is premature on its use. It was suggested that the procedure continued to be coded to its current code assignment 36.3, Other heart revascularization, until FDA approval and then at that time, further expansion of the codes for transmyocardial revascularization.

2. Hydrostatic Reduction of Intussusception

Ann Fagan presented this topic. One participant expressed concern over placing this procedure in an operative procedure category. It was felt that this would create confusion. Instead of code 46.83 it was suggested that 96.29 be utilized. There was much discussion on the use of the term "transanal." Barometric was suggested to replace it. Some suggested that an exclude note be added to exclude diagnostic barium enema which is coded to 96.39, Other transanal enema. An exclude note was also suggested at 96.39 to exclude reduction of intussusception. It was suggested that the new code be structured like category 96.3, Nonoperative alimentary tract irrigation, cleaning and local instillation, in that the new code would be titled Nonoperative reduction of intussusception of alimentary tract. However, a comment

was made that we try not to have diagnostic information embedded in the procedure code title.

3. Addenda

Amy Gruber presented the proposed addenda which would be implemented October 1, 1998. One issue that was raised for discussion was whether the LEEP (loop electrosurgical excision procedure) of cervix and LLETZ (large loop excision of the transformation zone) of cervix should be assigned to code 67.2, Conization of cervix, instead of code 67.32, Destruction of lesion of cervix by cauterization. After further deliberation, it was agreed that code 67.32 is appropriate.

4. Update on the ICD-10 Procedure Coding System

Pat Brooks provided an overview on the testing phase of the ICD-10-PCS. (Please see enclosed handout) A participant questioned whether a cost analysis was performed on the conversion to this new system. It was explained that cost was not part of this phase of the project. We need to see if the system is a suitable replacement for Volume 3, Procedures.

NEXT MEETING

The next meeting is scheduled for December 4-5, 1997 and will be held at the CMS Auditorium, 7500 Security Boulevard, Baltimore, Maryland. Those who would like to have topics addressed should contact Amy Gruber by October 4, 1997. The meeting notice and agenda will be placed on the CMS Home Page under Public Affairs/What's New in November 1997.

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<http://cms.hhs.gov/>

Agenda
ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE
Department of Health and Human Services
CMS Auditorium
7500 Security Boulevard
Baltimore, MD
ICD-9-CM Volume 3, Procedures
June 5, 1997

Patricia E. Brooks
Co-Chairperson

9:00 a.m. ICD-9-CM Volume 3, Procedure
presentations and public comments

Topics

1. Update on the ICD-10 Procedure Coding System

Patricia E. Brooks

2. Transmyocardial Revascularization

Ann B. Fagan
Douglas Murphy-Chutorian, MD
Tommy Fudge, MD

3. Hydrostatic Reduction of Intussusception

Ann B. Fagan

4. Addenda

Amy L. Gruber

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 routinely mailed. The summary can be accessed under Public Affairs/ What's New on CMS's homepage at:

URL: <http://cms.hhs.gov/>

If you do not have access to the Internet, please submit a written request for a paper copy of the minutes.

TRANSMYOCARDIAL REVASCULARIZATION (TMR)

Issue:

There are no specific codes which describe this procedure. This topic was suggested internally at CMS.

Background:

The procedure of revascularizing the heart in this manner is currently limited by the FDA to investigational use. Randomized clinical trials are well underway. TMR is a procedure where channels are drilled through the heart wall with a laser. These channels allow improved blood flow through myocardial sinusoids, a sponge-like network of small vascular communications within the heart wall. Since 1933 physicians have been experimenting with surgical methods to bring oxygenated blood directly to ischemic myocardium. TMR is based on the insight that sinusoids provide major blood distribution to the heart and that new blood vessel growth ("vascular neo-genesis") within the heart wall can be demonstrated within weeks after performing TMR. The relative importance of channel formation compared to vascular neogenesis is under study.

In patients with either Class III or Class IV angina, such routine activities such as fetching the morning paper from the front lawn can cause overwhelming chest pain despite the use of anti-anginal drugs. For most people, the solution lies in either angioplasty or bypass surgery, where the focus is in repairing or replacing diseased blood vessels usually greater than two millimeters in diameter. However, there are a number of patients who either are not good candidates for the procedures or have had one or more of the procedures and are still debilitated by anginal pain. These people may have disease in blood vessels smaller than two millimeters in diameter as is more likely in groups such as women, diabetics, and heart transplant recipients. Certain clinical centers use TMR for patients who do not qualify for bypass or angioplasty. It is alleged, that for those people, TMR is a promising new remedy.

TMR can be performed by several different approaches. The common steps among the methods is that laser energy is applied to the heart resulting in channels or communications between the left ventricular cavity and the heart muscle. Typically 20 to 45 such holes are placed at one centimeter intervals. The procedure may take one to two hours. When the holes are placed through the outside of the heart, the exterior surface stops bleeding usually within minutes. The surgical approach to the heart can be by sternotomy, thoracotomy, or via the thoracoscope. The channels can also be placed from the inside of the heart using percutaneous methods similar to angioplasty. TMR is being studied as stand-alone therapy or as combined therapy in conjunction with coronarybypass surgery or angioplasty.

Recommendation:

In order to identify the transmural revascularization procedure in ICD-9-CM, the following codes are recommended:

36 Operations on vessels of heart

new category	36.3	Other heart revascularization
new code	36.31	Open chest transmural revascularization
new code	36.32	Thoracoscopic transmural revascularization
new code	36.33	Percutaneous myocardial revascularization
new code	36.39	Other heart revascularization

Abrasion of epicardium

Cardio-omentopexy

Intrapericardial poudrage
Myocardial graft:
Mediastinal fat
Omentum
Pectoral muscles

Hydrostatic Reduction of Intussusception

Issue:

There are no specific codes which describe this procedure. This topic was suggested by a hospital coder, and referred to CMS by the Editorial Advisory Board, American Hospital Association.

Background:

A literature search showed that hydrostatic reduction of intussusception has been performed for more than 40 years, all over the globe.

The definition¹ of intussusception is: Prolapse of one part of the intestine into the lumen of an immediately adjacent part, causing intestinal obstruction. This source goes on to say that intussusception is one of the most common causes of intestinal obstruction in infancy. Most cases occur in children during the first year of life, and some cases occur in the second year, but very few thereafter. The condition may be caused by a growth in the intestine or by any condition that causes the intestine to contract strongly. Usually, the cause is not known. The condition becomes apparent when a healthy, thriving infant suddenly experiences paroxysms of abdominal pain, with vomiting and restlessness. The infant usually cries out with pain and draws the knees up to the chest. The abdomen becomes tender and distended as the obstruction progresses and a sausage-shaped mass is felt in the upper right quadrant. Stools appear red and jellylike due to the presence of blood.

Diagnosis is confirmed by barium enema, which in about 75 percent of uncomplicated cases has a therapeutic effect, reducing the invagination by a hydrostatic force. Surgical intervention involves manual reduction, and if a portion of the intestine has been irreparably damaged, bowel resection.

For more than 40 years, pediatric radiologists in North America were comfortable with hydrostatic enemas for the diagnosis and treatment of intussusception. Initial clinical trials in the 1980s suggested the efficacy of the introduction of air instead of barium as a reduction medium. Subsequent clinical studies demonstrated that fluoroscopy time and radiation are less, accurate pressure measurements are possible, and reduction rates are higher with air than with hydrostatic techniques. Air intussusception reduction, subtitled "The Winds of Change", in one article, cited air as being quicker, safer, and more effective than hydrostatic enemas. Another source cited air enemas as "very effective, with the additional advantages of less radiation, less cost, and less morbidity in case of perforation".

Even more recently, a new technique has replaced the above nonoperative techniques in some institutions. This technique is the ultrasound-guided reduction. The intussusceptions were diagnosed sonographically, and reduction was done (using ultrasound guidance) by means of a normal saline enema.

The literature was unanimous in suggesting that reduction to exposure of ionizing radiation was beneficial to patients, and that moving away from barium enema and toward pneumatic (air) or ultrasonography plus normal saline enema as mediums for intussusception reduction was (or ought to be) the wave of the future.

Discussion:

The ICD-9-CM Procedure index, under Reduction, intussusception, sends coders to 46.80 - 46.85.

46 Other operations on intestine

- 46.8 Dilation and manipulation of intestine
- 46.80 Intra-abdominal manipulation of intestine, NOS
- 46.81 Intra-abdominal manipulation of small intestine
- 46.82 Intra-abdominal manipulation of large intestine
- 46.85 Dilation of intestine

The above codes, except for 46.85, describe open operative approaches. The entry "enema" in the index sends the coder 96.39, Nonoperative alimentary tract irrigation, cleaning, and local instillation, other transanal enema (rectal irrigation). While this describes a closed procedure rather than open, this code doesn't capture the therapeutic nature of the reduction of intussusception.

Capturing the radiographic component might encourage coders to look at 87.64, Lower GI series. However, use of this code this will not correctly describe the reduction procedure if an air or normal saline medium is used.

Recommendation:

The following new code is recommended to capture this procedure:
new code 46.83 Transanal manipulation of intestine
Includes that with: Fluoroscopy
Ionizing radiation enema
Ultrasonography guidance
Hydrostatic reduction
Pneumatic reduction

Additional index entries will capture more common terminology.

¹[Benjamin F. Miller, MD and Claire Brackman Keane, RN, BS, MEd, Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health , (Philadelphia, PA: W. B. Saunders Co., 1987), p. 659-660.]

ADDENDA

INDEX

Infusion (intra-arterial)(intravenous)
Add subterm *vaccine*
Add subterm *tumor 99.28*
Injection (into)(hypodermically) (intramuscularly)(intravenously)(acting locally or systemically)
Add subterm *vaccine*
Add subterm *tumor 99.28*
Add term *LEEP (loop electrosurgical excision procedure) of cervix 67.32*
Add term *Liposuction 86.83*
Add term *LLETZ (large loop excision of the transformation zone) of cervix 67.32*
Vaccination (prophylactic) (against) 99.59
Add subterm *tumor 99.28*

Tabular List

67.32 Destruction of lesion of cervix by cauterization
Add inclusion term *LEEP (loop electrosurgical excision procedure)*
Add inclusion term *LLETZ (large loop excision of the transformation zone)*
86.83 Size reduction plastic operation
Add inclusion term *Liposuction*
99.28 Injection or Infusion of biological response modifier [BRM] as an antineoplastic agent
Add inclusion term *Tumor vaccine*

ICD-10-PCS ACTIVITIES

PROJECT SUMMARY

ICD-10-PCS is a procedure coding system being developed by CMS under a contract with 3M/HSI as a replacement for Volume 3 of ICD-9-CM. CMS is in the third and final year of this project which is briefly described below.

Year 1: Complete first draft of system
Year 2: External review and limited testing
Copies of system supplied to physician specialty groups
Development of training manual
Training at AHIMA annual meeting
Informal testing
Year 3: Formal independent review and testing
Review comments from specialty groups
Independent testing
Final version produced

TESTING OF ICD-10-PCS- PROJECT OVERVIEW

INDEPENDENT REVIEWERS

CMS is using the Clinical Data Abstraction Centers (CDACs), two of its contractors, to perform the independent review. CMS awarded two CDAC contracts on August 26, 1994 to DynKePRO in York, PA and FMAS in Columbia, MD. A brief overview of the CDACs is as follows:

CDACs Primary Task: The CDACs primary task is to collect clinical data from about 1.5 million medical records over 5 years. They request medical records, track the

records, abstract clinical data, and forward the clinical data to CMS for dissemination to the PROs. The primary end product of the CDAC contracts is accurate and reliable clinical data in sufficient quantities to support the analytical efforts of the PROs as they carry out the Health Care Quality Improvement Program (HCQIP). The CDACs also perform special studies such as the testing of ICD-10-PCS.

CDAC Contracts: The CDAC contracts are 5-year contracts consisting of a 2-year base period and three 1-year options. The contracts are currently in the first option year which ends on August 31, 1997. The contracts are scheduled to continue through August 31, 1999. A determination will be made for each of the option years on whether or not to continue the contracts.

Accomplishments to Date: As of October 24, 1996, the CDACs have requested 544,640 (as of March 20, 1997) medical records from providers and abstracted 490,138 of those records. These data have been collected to support 38 different clinical improvement projects that are being performed by the Peer Review Organizations in conjunction with CMS's central office and regional offices.

TIME LINE:

May - June 1997 Training of independent reviewers (CDACs)

July - December 1997 Testing

A formal independent test of the suitability of ICD-10-PCS as a replacement for ICD-9-CM Volume 3, procedures will be conducted. A sample of 5,000 medical records will be included from records obtained by the two Clinical Data Abstraction Centers (CDACs). The sample will include only medical records containing at least one operating room procedure. The medical records will then be coded using ICD-10-PCS. The contractor will keep detailed notes of any difficulties or omissions found in either the tabular or the index section of the new system. Terms needing additional clarification would be noted. Procedures for which no code could be found would be identified. Abstraction sheets will be completed on each record coded and these sheets will be sent to 3M/HSI for review and update to the system.

In December a subset of 100 medical records will be recoded blindly by the CDACs using ICD-9-CM and ICD-10-PCS. At this point CDACs coders should be experienced in using ICD-10-PCS. The two systems will be compared with information gathered on ease of use, time to identify codes, error rates, problems, and any other issues identified.

February 1998

The CDACs will submit a draft report of their findings.

March 1998

The CDACs will submit a final report of their findings.

3M/HSI will issue a final draft of ICD-10-PCS including revisions made as a result of testing and clinical comments made from physician specialty groups.

ANALYSIS AND TESTING BY OTHERS

CMS encourages other groups to test the system and send in their analysis. Copies of the 1997 draft have been provided to those on the Technical Advisory Panel which

includes representatives from the American Health Information Management Association, American Hospital Association, and the American Medical Association as well as others.

Copies may be ordered from 3M/HSI and should be available around August 1, 1997. An order form is being developed and should be available by the middle of June.

Contact person for an order form:

Terry Dogali
3M Health Information Systems
100 Barnes Road
Wallingford, CT 06492
Phone (203) 949-0303
Fax (203) 949-6331

Diskette version \$40
Paper Version of Volume I and II \$100
Training manual \$20

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