
SUMMARY REPORT

ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

September 29-30, 2005

PROCEDURE DISCUSSIONS

Introductions and Overview

Pat Brooks welcomed the participants to the ICD-9-CM Coordination and Maintenance (C&M) Committee meeting. Approximately 250 participants registered to attend the meeting. This meeting marks the 20th year in which the Committee has been discussing ICD-9-CM updates. The procedure portion of the meeting was held on September 29, 2005 and was conducted by staff from the Centers for Medicare & Medicaid Services (CMS). The diagnosis portion of the meeting was held on September 30, 2005 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 September 29, 2005 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: <http://www.cms.hhs.gov/paymentsystems/icd9>. A summary report of the diagnosis part of the meeting will be placed on NCHS' web site at <http://www.cdc.gov/nchs/icd9.htm>. The public is offered an opportunity to make additional written comments by mail or e-mail until December 2, 2005.

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

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Centers for Medicare & Medicaid Services (CMS)
CMM, HAPG, Division of Acute Care
Mail Stop C4-08-06
7500 Security Blvd.

Baltimore, MD 21244-1850
Patricia.brooks1@cms.hhs.gov

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

Donna Pickett
NCHS
3311 Toledo Road
Room 2402
Hyattsville, MD 20782
Dfp4@cdc.gov

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

CMS ICD-9-CM homepage updated

CMS has updated their ICD-9-CM web page, <http://www.cms.hhs.gov/paymentsystems/icd9>. 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. Alternatively, participants can go to <http://www.cms.hhs.gov> and click on "Events". You can see a variety of meetings for which you can register. Participants can register for the March 23-24, 2006 meeting beginning January 3, 2005. The registration site will close on March 17, 2006. Therefore, those who wish to attend the spring meeting must register online by March 17, 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. The request should include detailed background information describing the procedure, patients on whom the procedure is performed, any complications, and other relevant information. If this procedure is a significantly different means of performing a procedure than is already described in ICD-9-CM, this difference should be clearly described. The manner in which the procedure is currently coded should be described along with information from the requestor on why they believe the current code is not appropriate. Possible new or revised code titles should then be recommended.

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

A presentation is made at the C&M meeting, which describes the clinical issues and the procedure. CMS staff will coordinate a discussion of possible code revisions. The participants at the meeting are encouraged to ask questions concerning the clinical and

coding issues. Comments concerning proposed code revisions are taken for consideration. Final decisions on code revisions are made through a clearance process within the Department of Health and Human Services. No final decisions are made at the meeting.

Next C&M Meeting

The next C&M meeting will be March 23-24, 2006. As stated earlier, the online registration for this meeting will begin on January 3, 2006 and close on March 17, 2006, or earlier if registrations meet room limitations. The registration process will change for the next meeting. Participants will be able to sign up for each individual day of the meeting. 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. Allow time to get through security when entering the complex.

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 August 12, 2005 (70 FR 47318) beginning on page 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, 2006 code implementation at the fall meeting. If there are no such request, 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 this ICD-9-CM Coordination & Maintenance Committee meeting. Therefore, **there will be no new ICD-9-CM codes implemented on April 1, 2006.**

Topics:

1. Insertion of Spinal Stabilization Device

Hansen Yuan, MD, conducted a clinical presentation on the M-Brace™ Spinal Stabilization System, which is currently under development by Applied Spine Technologies. Amy Gruber led a discussion on the coding proposal. Several commenters expressed support to continue coding this procedure to the current code, 84.59, Insertion of other spinal devices, due to limited code availability in the ICD-9-CM classification system and the status of applying for FDA approval for this technology. Some commenters suggested establishing stringent criteria to determine what procedures should receive new codes due to the lack of available codes. Another commenter stated that there would be confusion among coders of when to code this procedure since both fusion and non-fusion procedures involve the use of pedicle screw instrumentation. A commenter proposed to add an excludes note if a new code were created, directing coders to only assign the new code with non-fusion procedures. Conversely, another commenter stated that it may be appropriate to code pedicle screw fixation for fusion and non-fusion procedures. One commenter stated that there is a clear segmentation for this technology and merit to begin tracking it, and questioned whether category 84.8 is available for expansion. One commenter stated in looking at outcomes from a patient perspective, fusion vs. motion-preserving technology, that the use of codes should capture other motion-preserving approaches.

2. Implantable Hemodynamic Monitor

Jamie Beth Conti, MD, provided a clinical presentation via telephone on the implantable hemodynamic monitor. Amy Gruber led a discussion on the coding proposal. One commenter questioned the use of the term “lead” that was used throughout the presentation, stating this term was not reflected in the new code proposal. A suggestion was made to add “pressure sensing lead” or similar terminology, to accurately describe the device. A commenter also stated that this type of lead is not an electrical lead and should be appropriately defined to avoid any confusion, making it clear that the lead is not therapeutic. Another commenter had a question regarding complications of the

device, such as, if a lead were dislodged. This commenter questioned if this was a common occurrence and if removal of the leads would be coded, what code(s) would be assigned. Several commenters supported the creation of two new codes to identify the insertion or replacement of the implantable sensor and monitoring device. Another commenter questioned if two codes were really necessary to describe this procedure or if one code would be sufficient. In response to that statement, another commenter expressed that if two components are inserted and one is replaced without the other, two codes would indeed be necessary. Dr. Conti stated that she has replaced leads and maintained the monitoring device. Another commenter questioned if this device was intended in the use of “congestive” heart failure, in addition to both systolic and diastolic heart failure. Dr. Conti stated the device is intended for both systolic and diastolic heart failure.

3. **Laparoscopic Hysterectomy**

Mady Hue led the discussion on the coding proposal for laparoscopic hysterectomy. One commenter stated that although a precedent had already been set by previous codes, it would be preferable to change the wording to “other and unspecified” versus the “other [procedure], not otherwise specified” terminology. This commenter supported creation of the six new codes discussed. There were no other comments for or against this proposal.

4. **Bifurcated Vessel Procedure**

David Rizik, MD, conducted the clinical presentation on bifurcated vessels and the stents utilized for those procedures. Ann Fagan led the discussion on the coding proposal. The requestor submitted coding examples to be discussed as part of the coding proposal. Several comments in response to the coding examples were expressed. Many attendees stated there was too much confusion when trying to apply the rationale for the answer with regards to the number of stents utilized during the procedure. The confusion stems from the question of whether to count “bifurcation” automatically as two stents, and then use an additional code from the 00.45-00.48 series for any other stents inserted, or to use the term “bifurcation” as an adjunct-to-an-adjunct code to indicate that there was a bifurcated vessel (making no assumptions as to the number of stents inserted), and then to capture the total number of stents using the 00.45-00.48 codes. The same confusion exists when trying to describe the number of vessels upon which a procedure was performed. Additionally, how would a coder capture the presence of more than one bifurcated lesion?

One commenter questioned if there was a typographical error with the number of stents or if the answer provided was just incorrect. Another commenter stated it was too premature to create a new code specifically for bifurcated vessels and that it was extremely confusing trying to apply this new code with the coding examples provided. Another commenter expressed concern for the discussion that was taking place. This commenter stated that if codes were created to count the number of vessels and number of stents the previous year and it is worthwhile to address this bifurcation issue, then we

should do it. It was suggested by this commenter that coders take this opportunity to stretch and grow as they had done in the past with similar difficult areas. This commenter then proceeded to ask how this issue would be coded using ICD-10.

Another commenter supported the creation of new code 00.44, Procedure on bifurcated vessels, stating it would account for the data that demonstrates increased time spent in the catheterization laboratory, and the increase in resource utilization for these difficult cases. Another commenter stated it is consistent with 3M Nosology and expressed this is a legitimate argument for capturing the data with a new code.

One commenter suggested addressing this entire issue with a diagnosis code instead of a procedure code. Two additional commenters supported that suggestion. In rebuttal, another commenter noted that the presence of a diagnostic code for a bifurcated lesion doesn't necessarily imply treatment of that lesion, thus leading to further confusion and supposition concerning the data.

5. **Computerized External Fracture Fixation**

Dror Paley, MD, conducted a clinical presentation on the Taylor Spatial Frame. Ann Fagan led a discussion on the coding proposal. One commenter stated they were not comfortable having a separate code for the software portion of the procedure and device. Another commenter agreed with that decision, stating the technology for the fixator device itself warranted the creation of a unique code. This commenter stated the software component having a separate code would be precedent setting, as there are several procedures that use software technology to assist in the operative setting; however these procedures do not code the software separately.

Other attendees expressed concern regarding the title of the proposed code. Commenters asked if there were other generic terms used for the device, since after all of the discussion it was determined the device itself is not computerized. Instead, an outpatient adjustment to the frame requires computer assistance. Suggestions to rename the code, 84.74, Application of computer *dependent* external fixator device, were made. There appeared to be support for that approach, as most were in favor of creating a new code.

One commenter questioned the incidence of infection with the pins utilized in this type of procedure, stating the documentation seen in medical records often describes that scenario. Dr. Paley stated infections due to the pins are the most common, however the bone is rarely infected this way. Another commenter asked if this type of external fixator device would be used in the treatment of scoliosis. Dr. Paley stated it has been used, however, he does not believe it is the preferred method of treatment for that diagnosis, as patients do not prefer the type of cage immobilization which would be required.

Another commenter questioned the patient population this type of device would serve. Dr. Paley indicated this device can be utilized in ages from birth to over 90 years of age. The struts come in various lengths and the rings in various sizes.

6. **Endovascular Mechanical Thrombectomy of Pre-Cerebral and Cerebral Vessels**

Gary Duckwiler, MD, conducted a clinical presentation on the Concentric Merci® Retriever. Ann Fagan led a discussion on the coding proposal. One commenter expressed support for the new code proposal and questioned if this device would be utilized in other vessels, such as the femoral or popliteal. Dr. Duckwiler stated that currently the device is cleared for neurovascular use; however, it is not unreasonable to think it could be used in the future for those other vessels. (The Merci® Retriever is not currently approved by the FDA for use in peripheral vessels.) Another commenter suggested deleting the excludes note for counting the number of vessels treated and adding it as a code also note under proposed new code, 39.74, Endovascular removal of obstruction from head and neck vessel(s), since more than one vessel may undergo treatment at the same operative episode. One commenter stated it would be beneficial to add an excludes note under code 38.01, Incision of vessel, intracranial vessel, to exclude the proposed new code, 39.74. There was general support for creating the new code.

7. **Cardiac Electrophysiology Studies**

Joe Kelly, MD, conducted the clinical presentation and coding proposal for this topic. One commenter supported changing the title to code 37.26, Cardiac electrophysiologic stimulation and recording studies to *Catheter based invasive electrophysiologic testing*. Some commenters suggested deleting code 37.26 and creating an entire new code rather than change the meaning of a pre-existing code. Category 00.5, Other cardiovascular procedures, was suggested as a placement for a new code. One commenter stated there is still confusion with code 37.26 and the decision of where to put this procedure is important. Most attendees agreed with creating new code 37.20, Noninvasive programmed electrical stimulation [NIPS]. One commenter suggested adding an excludes note “device interrogation only without arrhythmia induction (bedside check) (89.45-89.49)” to code 37.26. It was pointed out that this excludes note already exists at code 37.26. One commenter suggested that the proposed note: Device testing is inherent in the procedure be amended to state concurrent or intraoperative device testing is inherent.

8. **Proposed Addenda**

Mady Hue led a discussion on the addendum proposal. There was support for the addendum and no opposition.

9. **Availability of ICD-9-CM**

Pat Brooks led a discussion on the rapidly decreasing number of ICD-9-CM procedure codes which are available for use in assigning new codes. She reviewed the handout, Availability of ICD-9-CM and discussed CMS' current approach to selecting available

codes to capture new technology. Pat explained CMS' code creation hierarchy document with the five steps for selecting an available code (see page 33 – 34 of handouts).

There was a heated discussion on the constraints of ICD-9-CM and the need for a new coding system. Many recommended that a decision be made to move forward with ICD-10-CM and ICD-10-PCS. Several pointed out that many other countries moved to ICD-10 years ago. Several participants expressed their concern that we are now faced with making these extremely difficult choices about how to use the remaining codes in an appropriate manner. Several suggested that criteria be created as to when a new procedure proved to justify the creation of a new code. Others strongly recommended that CMS severely restrict the creation of new procedure codes so that only the truly worthy procedures are assigned new codes. Others acknowledged the difficult position in which CMS found itself. Congress has mandated that CMS identify new procedures, but the current coding system is running out of spaces.

Many supported the Code Creation Hierarchy as a sensible approach to assigning codes. Others voiced concerns that assigning codes to increasingly inappropriate places in the book would have a detrimental effect on our national data. Coders will have difficulty finding and using the most appropriate codes. Researchers will not be able to find all the appropriate codes and will make errors in examining the data.

Several participants suggested that CMS delete under used codes and then assign new technologies to these codes. Some suggested that the deleted codes remain dormant for a few years prior to reusing them. Others vigorously opposed this suggested because of problems that would arise in examining trend data. Several participants stated that their organizations would vigorously oppose the reuse of existing procedure codes because of the effect on trend data.

CMS concluded the discussions by stating it would continue to be responsive to requests for new codes to capture new technology.

10. ICD-10-PCS

Rhonda Butler provided a discussion on the updates made to ICD-10-PCS as a result of the new codes going into effect this October, as well as some minor revisions to the terminology used in the ICD-10-PCS. 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 September 30, 2005 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>