Marc Hartstein, Director, Hospital and Ambulatory Policy Group

March 5, 2013
ICD-9-CM Coordination and Maintenance Committee Meeting

Pat Brooks
CMS Co-Chairman

March 5, 2013
Introductions & Overview

- ICD-9-CM Coordination & Maintenance (C&M) Committee is public forum on ICD-9-CM & ICD-10 code updates
- CMS & CDC Co-chair the meetings
  - CMS has lead on procedure issues
  - CDC has head on diagnosis issues
- Coding proposals presented and public given opportunity to comment
• No final decisions made at the meeting
• Public can submit written comments after the meeting
• ICD-9-CM procedure code topics discussed today are for implementation on October 1, 2013
  – Any comparable ICD-10-PCS updates would also be implemented October 1, 2013
• Currently under a partial code freeze
  – ICD-10 will be implemented for services provided on or after October 1, 2014
  – Only codes for new technologies and new diagnoses are being considered
  – All other code updates would be made after the code freeze ends on October 1, 2015
• New name - ICD-10 Coordination & Maintenance Committee as of the March 2014 meeting
  – At that meeting only ICD-10 issues will be addressed
• Detailed timeline within the C&M handouts
  – April 6, 2013 - Comments due on topics presented today
    • Procedure comments to Pat Brooks, CMS
      patricia.brooks2@cms.hhs.gov
    • Diagnosis comments to Donna Pickett, CDC
      nchsicd9@cdc.gov
  – April 2013 - Notice of Proposed Rulemaking, IPPS, includes ICD-9-CM diagnosis and procedure updates (but not those from today’s meeting)
Introductions & Overview

• Detailed timeline within the C&M handouts (Continued)

  June 2013 – Final addendum posted

  • Diagnosis addendum -
    http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

  • Procedure addendum -
    http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/addendum.html
• Detailed timeline within the C&M handouts (Continued)
  – July 12, 2013 – Deadline for submitting topics for September 18-19, 2013 C&M meeting
  – August 1, 2013 – IPPS final rule published. Includes all final ICD-9-CM codes to be implemented October 1, 2013.
• Detailed timeline within the C&M handouts (Continued)
  – August 2013 – Tentative agenda for September 18-19, 2013 C&M meeting on CMS and CDC websites
  – August 16, 2013 – On-line registration opens for September C&M meeting
  – September 18-19, 2013 – C&M meeting
• For this meeting the public may participate in three ways
  – Attend public C&M meeting
  – Listen to proceedings through free conference lines
  – Participate through a free webcast
• CMS & CDC hope this provides greater opportunity for public participation
No matter how you participate – please send in your written comments after the meeting
ICD-10 Implementation Announcements

Geanelle Herring, CMS
Health Insurance Specialist

ICD-9-CM Coordination and Maintenance Committee Meeting

March 5, 2013
ICD-10/5010 Implementation

1. CMS set the October 1, 2014 deadline for the ICD-10 transition based on industry feedback.
2. ICD-10 is a linchpin of our work to transform the nation’s health care system with the power of eHealth technologies and programs.
3. While CMS has HIPAA enforcement authority, our goal is to work with industry toward a successful ICD-10 transition, not to impose penalties.
4. CMS encourages everyone covered by HIPAA to ensure that their electronic health care administrative transactions are Version 5010 compliant.
5. Everyone should allow at least a year for testing with your business trading partners.
6. Now is the time to get ICD-10 compliant systems in place.
7. Vendors and their customers need to discuss ICD-10 with one another right away if they have not done so already.
ICD-10 Resources

- ICD-10 checklists, timelines and other resources are available on the CMS ICD-10 website at [cms.gov/ICD10](http://cms.gov/ICD10)
- Subscribe to the CMS ICD-10 Email Update for weekly news and updates on resources and events, including step-by-step guidance for making the transition to ICD-10

[http://cms.gov/Medicare/Coding/ICD10/CMS_ICD-10_Industry_Email_Updates.html](http://cms.gov/Medicare/Coding/ICD10/CMS_ICD-10_Industry_Email_Updates.html)
ICD-10 Implementation Announcements

Pat Brooks, CMS
Senior Technical Advisor

ICD-9-CM Coordination and Maintenance Committee Meeting

March 5, 2013
ICD-10 Updates

• CMS will provide a variety of ICD-10 updates during this meeting
  – Updates on ICD-10 implementation issues
  – Availability of ICD-10 MS-DRG v30 mainframe and PC software
  – Updates on ICD-10 conversions of National Coverage Determinations
  – Updated impact analysis of ICD-10 MS-DRGs
ICD-10 Updates

- ICD-10 POA Exempt List updates
- New ICD-10-PCS addendum format
ICD-9-CM and ICD-10-PCS Topics

• Three ICD-9-CM topics considered for October 1, 2013 implementation
  – Any comparable ICD-10-PCS updates would also be considered for October 1, 2013 implementation

• At the conclusion of the procedure topics, CDC will then begin their part of the meeting on diagnosis issues
Availability of ICD-10 Definitions Manuals and Summary of Changes

- MS-DRG V30.0 ICD-10 Definitions Manual
  - Available in text and HTML versions
- MS-DRG V30.0 ICD-10 “Summary of Changes”
- ICD-10 Definitions of Medicare Code Edits
  - Posted on ICD-10 website at http://www.cms.gov/ICD10
Availability of Mainframe and PC Software via NTIS

- MS-DRG v30 ICD-10 Mainframe Software
- MCE v30 ICD-10 Mainframe Software
- MSG/MCE v30 ICD-10 PC software

- Available via NTIS at:

- Links on CMS website at under Related Links at:
• The pilot MS-DRG ICD-10 software is released for purposes of review and evaluation
• The official MS-DRG ICD-10 software to be used to determine FY 2015 inpatient payments will not be available until the IPPS final rule for FY 2015 is issued.
Update on National Coverage Determinations and ICD-10

Janet Anderson Brock, Director
Division of Operations and Information Management
Coverage and Analysis Group
Center for Clinical Standards and Quality, CMS

ICD-9-CM Coordination and Maintenance Committee Meeting

March 5, 2013
Local Coverage Determinations

- Local coverage determinations (LCDs) are those decisions made by the individual MAC.

- These determinations are usually jurisdictionally based.

- Each individual MAC is responsible for converting the ICD-9 codes to ICD-10 codes in their LCDs.
National Coverage Determinations

• National Coverage Determinations (NCDs) are those decisions made by CMS and applied by each MAC at a national level
  • CMS is responsible for converting the ICD-9 codes to ICD-10 codes in selected NCDs
  • There are approximately 330 NCDs, spanning a range of vintages
  • Not all NCDs are appropriate for translation
    • Non-coverage NCDs that employ edits based on HCPCS
    • Older NCDs on obsolete technology or are generally considered outdated
  • CMS has determined which NCDs should be translated, and we are in the process of completing the systems changes for those NCDs.
National Coverage Determinations

CMS transmittals and MLN Matters® Articles are the vehicles used to communicate information regarding NCD translations.

Inquiries related to NCD translations can be sent to the following mailbox:

CAGinquiries@cms.hhs.gov

Please put ICD-10 in the subject line
## Links related to NCD ICD-10 conversions (as of 2/22/2013)

(To open a document, right click on any Transmittal # or Download then select “Open Hyperlink”)

<table>
<thead>
<tr>
<th>Transmittal</th>
<th>Issue Date</th>
<th>Subject</th>
<th>CR#</th>
<th>Downloads</th>
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<tr>
<td>R1174OTN</td>
<td>2/1/2013</td>
<td>Changes to the Laboratory National Coverage Determination (NCD) Software for ICD-10-22 NCDs 190.12-190.34</td>
<td>8202</td>
<td>R1174OTN [PDF, 81KB]  R1174OTN [ZIP, 641KB]</td>
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<tr>
<td>R2641CP</td>
<td>1/29/2013</td>
<td>Bariatric Surgery for the Treatment of Morbid Obesity National Coverage Determination, Addition of Laparoscopic Sleeve Gastrectomy (LSG)- NCD 100.1</td>
<td>8028</td>
<td>R2641CP [PDF, 186KB]  MM8028 [PDF, 104KB]</td>
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<td>R2628CP and R147NCD</td>
<td>1/7/2013 and 9/24/2012</td>
<td>Transcatheter Aortic Valve Replacement (TAVR) Coding Update/Policy Clarification- NCD 20.32 and National Coverage Determination (NCD) for Transcatheter Aortic Valve Replacement (TAVR) -NCD 20.32</td>
<td>8168 and 7897</td>
<td>R2628CP [PDF, 99KB]  MM8168 [PDF, 98KB]  and  R147NCD [PDF, 154KB]  MM7897 [PDF, 135KB]</td>
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### Links related to NCD ICD-10 conversions (as of 2/22/2013) con’t.
(To open a document, right click on any Transmittal # or Download then select “Open Hyperlink”)

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<th>Downloads</th>
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<tr>
<td>R2605CP</td>
<td>11/30/2012</td>
<td>Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)- NCD 160.27</td>
<td>7836</td>
<td>R149NCD [PDF, 102KB]</td>
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<tr>
<td>R2551CP</td>
<td>9/24/2012</td>
<td>Extracorporeal Photopheresis (ICD-10) NCD 110.4 and Extracorporeal Photopheresis (ICD-10) NCD 110.4</td>
<td>7806</td>
<td>R2551CP [PDF, 163KB] MM7806 [PDF, 120KB] and R143NCD [PDF, 113KB] MM7806 [PDF, 120KB]</td>
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<tr>
<td>R1122OTN</td>
<td>9/14/2012</td>
<td>International Classification of Diseases (ICD)-10 Conversion from ICD-9 of the Medicare Shared Systems as They Relate to CMS National Coverage Determinations (NCDs) (CR 1 of 3) (ICD-10) 19 NCDs: 20.19, 20.5, 70.2.1, 80.11, 80.2, 80.2.1, 80.3, 80.3.1, 110.10, 110.21, 110.4, 150.3, 160.18, 160.24, 220.13, 230.9, 250.3, 250.4, 250.5</td>
<td>7818</td>
<td>R1122OTN [PDF, 72KB] R1122OTN1 [ZIP, 314KB] MM7818 [PDF, 101KB]</td>
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<tr>
<td>R2476CP</td>
<td>5/23/2012</td>
<td>Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs (ICD-10)- NCD 210.10</td>
<td>7610</td>
<td>R2476CP [PDF, 469KB]</td>
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<tr>
<td>R2465CP</td>
<td>5/11/2012</td>
<td>Assigned Codes for Home Oxygen Use for Cluster Headache (CH) in a Clinical Trial (ICD-10) - NCD 240.2.2</td>
<td>7820</td>
<td>R2465CP [PDF, 116KB] MM7820 [PDF, 115KB]</td>
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<td>R2421CP</td>
<td>3/7/2012</td>
<td>Intensive Behavioral Therapy for Obesity - NCD 210.12</td>
<td>7641</td>
<td>R2421CP [PDF, 295KB] MM7641 [PDF, 147KB]</td>
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Estimating the Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments

ICD-9-CM Coordination and Maintenance Committee

Ron Mills, 3M HIS
March 5, 2013
Objective

- To estimate the impact on aggregate IPPS MS-DRG payments to hospitals due to the transition to ICD-10
  - Update of September 2010 C&M presentation
    - Discussion of reimbursement map replaced with discussion of reasons for MS-DRG shifts
    - Discussion of hospital-type specific results replaced with discussion of sensitivity to coding and case mix
  - New results using MS-DRG v30
Disclaimer

• MS-DRG v32 (FY2015 using ICD-10) will be subject to rule-making.

• These are estimates based on MS-DRG v30, FY2013 weights, and a “replicated” ICD-10 grouper (as much like ICD-9 as possible)

• Estimates use weights only – no provision for outliers, short stays or other adjustments
Article Describing Impact

• Estimating the Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments

How estimates made

1. 10 million MedPAR records coded in ICD-9
2. Group using ICD-9 MS-DRG v30
3. Mechanically convert records to ICD-10
4. Group using ICD-10 MS-DRG v30 grouper
5. Compare results using FY2013 weights
How estimates made

10 Million MedPAR ICD-9

Translate to ICD-10

10 Million MedPAR ICD-10

MS-DRGv30 ICD-9 grouper

MS-DRGv30 ICD-10 grouper

Compare
Terminology

• “DRG shift”
  – When the MS-DRG from a record coded in ICD-9 is different from the MS-DRG from the same record coded in ICD-10

• Problem of tiny amounts
  – Weight change of 0.01% easy to misinterpret
  – 1/10000th
  – “One penny per $100 of reimbursement”
MS-DRG v30 Results

- 99% no change in MS-DRG
- DRG shifts on 1% of the records
  - 45% of the shifts to higher weight DRGs
  - 55% of the shifts to lower weight DRGs
- Net impact across all DRGs:
  - Reduction by $4/10000^{th}$ or
  - Minus 4 pennies per $100
Anatomy of net impact

• 10 million MedPAR sample:
  – Total for negative shifts: -14 cents per $100
  – Total for positive shifts: +10 cents per $100
  – Net: -4 cents per $100

• Net change for an institution?
  – Depends on case mix and coding habits
Influence of case mix

Estimated shift in pennies per $100 for top 25 DRGs
Results

These results are very sensitive to the quality of the ICD-10 coding
Area of greatest sensitivity

10 Million MedPAR ICD-9

Translate to ICD-10

10 Million MedPAR ICD-10

MS-DRGv30 ICD-9 grouper

MS-DRGv30 ICD-10 grouper

Compare

Critical step
Translation intentions

• “What would the coder do?”
• Using the information in the ICD-9 codes, correctly code the record in ICD-10
• Ignore the MS-DRG logic
• A coder with access to the original medical record can often do a better job
# Impact of translation techniques

<table>
<thead>
<tr>
<th>Translation technique</th>
<th>DRG shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Translation as performed.</td>
<td>1.0%</td>
</tr>
<tr>
<td>Do not look for groups of ICD-9 codes that translate into single ICD-10 codes</td>
<td>3.1%</td>
</tr>
<tr>
<td>Do not add procedures where appropriate to reflect procedural information in ICD-9 diagnoses which ICD-10 does not have.</td>
<td>3.5%</td>
</tr>
<tr>
<td>When the GEMs translate one ICD-9 code into two or more ICD-10 codes (a “cluster”) to get the same meaning, put <em>only one</em> of the ICD-10 codes in the cluster on the record. Quick and easy – one ICD-10 code for each ICD-9 code.</td>
<td>4.5%</td>
</tr>
</tbody>
</table>
Grouper

Why can’t the ICD-10 grouper be made to behave exactly like the ICD-9 grouper?
Unavoidable differences

• Myth:
  – ICD-10 just adds detail to ICD-9

• Reality:
  – Distinctions no longer in common use have been removed from ICD-10.
  – Some areas (e.g. OB) use a different approach to classification.
  – ICD-10-PCS procedure codes have no diagnostic content.
  – Some coding guidelines have changed.
How shifts were minimized

• When an ICD-10 code contains conditions previously classified in different ICD-9 codes:
  – Treat the ICD-10 code like the more frequently occurring ICD-9 code
  – Cases which use the less frequent ICD-9 code now become shifts

• Example: F32.9, Major depression, unspecified
  – 311 Depressive disorder, NEC
  – 296.20 Major depression, unspecified (a CC)
Common MS-DRG shifts

- 40% of shifts to lower weight MS-DRGs come from losing a CC or MCC

- 75% of shifts to higher weight MS-DRGs come from gaining a CC or MCC
<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
<th>+/-</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>812</td>
<td>Red blood cell disorders w/o MCC</td>
<td>Pos</td>
<td>Change in coding guidelines for anemia</td>
</tr>
<tr>
<td>981</td>
<td>Extensive O.R. procedure unrelated to principal diagnosis w/MCC</td>
<td>Neg</td>
<td>Mostly MCC loss. Sometimes more detailed ICD-10 can better relate procedure to diagnoses</td>
</tr>
<tr>
<td>391</td>
<td>Esophagitis, gastroent &amp; misc disgest disorders w MCC</td>
<td>Neg</td>
<td>K22.8 Other diseases of esophagus, treated like 530.89 (not an MCC) instead of 530.82 (MCC).</td>
</tr>
<tr>
<td>885</td>
<td>Psychoses</td>
<td>Neg</td>
<td>F32.9, Major depression, unspecified, treated like 311 Depression NEC instead of 296.20 (a CC).</td>
</tr>
<tr>
<td>066</td>
<td>Intracranial hemorrhage or cerebral infarction w/o CC/MCC</td>
<td>Pos</td>
<td>I63.59, Cerebral infarction due to unspecified occlusion or stenosis of other cerebral artery, treated like 433.81 (not excluded as CC) instead of 433.31 (excluded as CC).</td>
</tr>
</tbody>
</table>
## Top 10 MS-DRG shifts (6-10)

<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
<th>+/-</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>191</td>
<td>Chronic obstructive pulmonary disease with CC</td>
<td>Neg</td>
<td>ICD-10 does not differentiate sub-types of COPD the way ICD-9 does. J44.1, COPD with exacerbation, treated like more common non-CCs. Better documentation and coding of the cause of the COPD exacerbation (e.g. pneumonia) can bring back the CC or MCC.</td>
</tr>
<tr>
<td>011</td>
<td>Tracheostomy for face, mouth and neck diagnoses with MCC</td>
<td>Pos</td>
<td>Tracheostomy was included in ICD-9 procedure 304, Radical laryngectomy, but is coded separately in ICD-10.</td>
</tr>
<tr>
<td>974</td>
<td>HIV with major related condition and MCC</td>
<td>Neg</td>
<td>In ICD-10 A41 sepsis codes treated like 995.91, excluded as MCC for 974.</td>
</tr>
<tr>
<td>292</td>
<td>Heart failure and shock with CC</td>
<td>Neg</td>
<td>Hypertension in ICD-10 no longer has malignant/benign distinction. Coding of the specific manifestation that led in ICD-9 to the “malignant” determination will often justify a CC.</td>
</tr>
<tr>
<td>037</td>
<td>Extracranial procedures with MCC</td>
<td>Pos</td>
<td>See slide 46 for MS-DRG 066</td>
</tr>
</tbody>
</table>
Lessons learned

• If you do an analysis like this with your own data, pay close attention to the mechanism you use to translate from ICD-9 to ICD-10.

• Documentation improvement targeted only on new ICD-10 detail may be useful in the long run, but may not help much with first year MS-DRG reimbursement.

• What will help is general documentation improvement in areas that are not fully coded now, especially where there are differences in the classifications.
Some good news

• Anecdotal evidence from some institutions which have dual coded ICD-9 and ICD-10, or have re-coded in ICD-10 records with apparent MS-DRG shifts:
  – Coder coded records are less likely to change their MS-DRG from ICD-9 to ICD-10
  – When the day comes, net reimbursement impact may be less than that estimated here.
Questions

10 Million MedPAR ICD-9

Translate to ICD-10

10 Million MedPAR ICD-10

MS-DRGv30 ICD-9 grouper

Compare

MS-DRGv30 ICD-10 grouper
ICD-10 HAC and POA List

Celeste Beauregard, CMS

March 5, 2013
FY 2013 Hospital Acquired Condition (HAC) ICD-9-CM Code Conversion to ICD-10-CM/PCS

• Information on the V30 HAC conversion to ICD-10-CM/PCS is part of the ICD-10 MS-DRG Conversion Project which can be found at http://www.cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html in Appendix I “Hospital Acquired Conditions (HACs) List
FY 2013 Hospital Acquired Condition (HAC) ICD-9-CM Code Conversion to ICD-10-CM/PCS

• An ICD-10-CM/PCS HAC Translation Feedback Mailbox has been set up for receiving comments.

• The feedback link is titled “CMS HAC Feedback” and is located on the CMS HAC webpage [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html)
The FY 2013 ICD-10 POA Exempt List is posted to the CMS website

http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html
ICD-10-PCS Addenda Update

Rhonda Butler, 3M

ICD-9-CM Coordination and Maintenance Committee Meeting

March 5, 2013
New and Deleted Codes

Three new codes added and three codes deleted, effective October 1, 2013
Proposed at September 2012 C&M meeting
  – New codes
  – 04V00DJ Restriction of Abdominal Aorta with Temporary Intraluminal Device, Open Approach
  – 04V03DJ Restriction of Abdominal Aorta with Temporary Intraluminal Device, Percutaneous Approach
  – 04V04DJ Restriction of Abdominal Aorta with Temporary Intraluminal Device, Percutaneous Endoscopic Approach

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Abdominal Aorta</td>
<td>0 Open, 3 Percutaneous, 4 Percutaneous Endoscopic</td>
<td>D Intraluminal Device</td>
<td>J Temporary</td>
</tr>
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</table>
02VW0DJ Restriction of Thoracic Aorta with Intraluminal Device, Temporary, Open Approach

02VW3DJ Restriction of Thoracic Aorta with Intraluminal Device, Temporary, Percutaneous Approach

02VW4DJ Restriction of Thoracic Aorta with Intraluminal Device, Temporary, Percutaneous Endoscopic Approach

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<td>0 Open</td>
<td>D Intraluminal Device</td>
<td>J Temporary</td>
</tr>
<tr>
<td></td>
<td>3 Percutaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 Percutaneous</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Endoscopic</td>
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Revised ICD-10-PCS Section Title

- In response to public comment
- Change the Radiation Oncology section title
  - Current title: Radiation Oncology
  - Revised title: Radiation Therapy
- Allows codes to be used for radiation therapy procedures regardless of the diagnosis
ICD-10-PCS Addenda Format for Annual Update—Index and Definitions

• CMS received public comment requesting a more detailed set of addenda for the Index and Definitions files for future updates
• Development currently underway
• Will be posted in both PDF and text file formats
• The files will be produced using an automated process
• Must meet federal accessibility requirements (508c compliance standards)
• PDF file for individual users who want to review the changes made
• Text file format for technical users
  – machine readable file
  – uses a separate term to identify each element defined in the source content
Index Addenda

PDF Example

Index Addenda, PDF example
(addenda entries beginning with D)
Blank line
No change
D
Add
Distal humerus
Add
use Humeral Shaft, Right
Add
use Humeral Shaft, Left
Add
Distal humerus, involving joint
Add
use Joint, Elbow, Right
Add
use Joint, Elbow, Left
Add
Driver stent (RX) (OTW) use Intraluminal Device
Blank line
Index Addenda, Text example (addenda entries beginning with D)

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<td>Main Add</td>
<td>use Humeral Shaft, Right</td>
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<tr>
<td>Main Add</td>
<td>use Humeral Shaft, Left</td>
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<td>Main Add</td>
<td>Distal humerus, involving joint</td>
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<td>Main Add</td>
<td>use Joint, Elbow, Right</td>
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<td>Main Add</td>
<td>use Joint, Elbow, Left</td>
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<tr>
<td>Main Add</td>
<td>Driver stent (RX) (OTW) use Intraluminal Device</td>
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<td>Revise from</td>
<td>Revise to</td>
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<td>Extraluminal Device</td>
<td>LAP-BAND® Adjustable Gastric Banding System</td>
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<td>LAP-BAND® adjustable gastric banding system</td>
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<tr>
<td>Delete</td>
<td>Hearing Device, Bone Conduction in Head and Facial Bones</td>
<td>Bone anchored hearing device</td>
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<td>Add</td>
<td>Hearing Device in Head and Facial Bones</td>
<td>Bone anchored hearing device</td>
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<tr>
<td>No change</td>
<td>Infusion Device</td>
<td>InDura, intrathecal catheter (1P) (spinal)</td>
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<td>Add</td>
<td></td>
<td>Tunneled spinal (intrathecal) catheter</td>
</tr>
</tbody>
</table>
**Definitions Addenda, Text example (Device definitions addenda in E-I)**

<table>
<thead>
<tr>
<th>Row</th>
<th>Term</th>
<th>Extraluminal Device</th>
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<tbody>
<tr>
<td></td>
<td>Includes</td>
<td>Revise from <strong>LAP-BAND® Adjustable Gastric Banding System</strong></td>
</tr>
<tr>
<td></td>
<td>Includes</td>
<td>Revise to <strong>LAP-BAND® adjustable gastric banding system</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Row</th>
<th>Term</th>
<th>Delete</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Term</td>
<td>Delete <strong>Hearing Device, Bone Conduction in Head and Facial Bones</strong></td>
</tr>
<tr>
<td></td>
<td>Includes</td>
<td>Delete <strong>Bone anchored hearing device</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Row</th>
<th>Term</th>
<th>Add</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Term</td>
<td>Add <strong>Hearing Device in Head and Facial Bones</strong></td>
</tr>
<tr>
<td></td>
<td>Includes</td>
<td>Add <strong>Bone anchored hearing device</strong></td>
</tr>
</tbody>
</table>
Infusion of 4-Factor Prothrombin Complex Concentrate (4F-PCC)

Amy Gruber, CMS

March 5, 2013
ICD-9-CM Procedure Coding Options:

• Option 1. Continue to assign code 99.06, Transfusion of coagulation factors, for the Infusion of 4-Factor Prothrombin Complex Concentrate (4F-PCC).

• Option 2. Create a new code under subcategory 00.9, Other procedures and interventions, to uniquely capture the Infusion of 4-Factor Prothrombin Complex Concentrate (4F-PCC).
Option 2 (con’t):

• New code 00.96
  Infusion of 4-Factor Prothrombin Complex Concentrate
  Infusion of 4F-PCC

Excludes:
  transfusion of coagulation factors (99.06)
  transfusion of Factor IX complex (99.06)
Option 2.  As described above.

In the interim, continue to assign code 99.06, Transfusion of coagulation factors for the infusion of 4-Factor Prothrombin Complex Concentrate (4F-PCC).
ICD-10-PCS Coding Options:

• Option 1. Continue to assign one of the following ICD-10-PCS codes under section 3 - Administration, body system 0 – Circulatory, operation 2 – Transfusion, for the Infusion of 4-Factor Prothrombin Complex Concentrate (4F-PCC).
  
• **30230W1** Transfusion of Nonautologous Factor IX into Peripheral Vein, Open Approach

• **30233W1** Transfusion of Nonautologous Factor IX into Peripheral Vein, Percutaneous Approach
Option 1 (con’t):

- **30240W1** Transfusion of Nonautologous Factor IX into Central Vein, Open Approach
- **30243W1** Transfusion of Nonautologous Factor IX into Central Vein, Percutaneous Approach
- **30250W1** Transfusion of Nonautologous Factor IX into Peripheral Artery, Open Approach
- **30253W1** Transfusion of Nonautologous Factor IX into Peripheral Artery, Percutaneous Approach
- **30260W1** Transfusion of Nonautologous Factor IX into Central Artery, Open Approach
- **30263W1** Transfusion of Nonautologous Factor IX into Central Artery, Percutaneous Approach
Option 2:

- Option 2. Create a new substance, B, 4-Factor Prothrombin Complex Concentrate, under section 3 - Administration, body system 0 – Circulatory, operation 2 – Transfusion, for the Infusion of 4-Factor Prothrombin Complex Concentrate (4F-PCC).
Option 2 (con’t):

3 Administration
0 Circulatory
2 Transfusion: Putting in blood or blood products

<table>
<thead>
<tr>
<th>Body System/Region</th>
<th>Approach</th>
<th>Substance</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Peripheral Vein</td>
<td>0 Open</td>
<td>B 4-Factor Prothrombin Complex</td>
<td>1 Nonautologous</td>
</tr>
<tr>
<td>4 Central Vein</td>
<td>3 Percutaneous</td>
<td>Complex Concentrate</td>
<td></td>
</tr>
<tr>
<td>5 Peripheral artery</td>
<td>0 Open</td>
<td>B 4-Factor Prothrombin Complex</td>
<td>1 Nonautologous</td>
</tr>
<tr>
<td>6 Central artery</td>
<td>3 Percutaneous</td>
<td>Complex Concentrate</td>
<td></td>
</tr>
</tbody>
</table>
CMS Recommendation and Interim Advice:

• Option 2. As described above.

• In the interim, continue to assign one of the following ICD-10-PCS codes under section 3 - Administration, body system 0 – Circulatory, operation 2 – Transfusion, for the infusion of 4-Factor Prothrombin Complex Concentrate (4F-PCC).
Interim Advice (con’t)

- **30230W1** Transfusion of Nonautologous Factor IX into Peripheral Vein, Open Approach
- **30233W1** Transfusion of Nonautologous Factor IX into Peripheral Vein, Percutaneous Approach
- **30240W1** Transfusion of Nonautologous Factor IX into Central Vein, Open Approach
- **30243W1** Transfusion of Nonautologous Factor IX into Central Vein, Percutaneous Approach
- **30250W1** Transfusion of Nonautologous Factor IX into Peripheral Artery, Open Approach
- **30253W1** Transfusion of Nonautologous Factor IX into Peripheral Artery, Percutaneous Approach
Interim Advice (con’t):

• **30260W1** Transfusion of Nonautologous Factor IX into Central Artery, Open Approach

• **30263W1** Transfusion of Nonautologous Factor IX into Central Artery, Percutaneous Approach
Implantation of Transprostatic Struts

Mady Hue

March 5, 2013
ICD-9-CM Procedure Coding options:

• Coding option 1. Do not create a new code.

Due to the restrictions of the Partial Code Freeze, CMS is unable to propose a new ICD-9-CM procedure code at this time to uniquely describe the implantation of transprostatic struts as the requester did not submit an application for New Technology. Should the requester decide to submit an application for FY 2015 we can reconsider a new code request.
ICD-9-CM Procedure Coding options:

- **Interim Coding**: CMS recommends procedure code 58.6, Dilation of urethra, to identify the implantation of transprostatic struts used to open the prostatic urethra.
ICD-10-PCS Coding Options:

- **Option 1.** Code the implantation of transprostatic struts to open the prostatic urethra to the root operation Supplement.

- 0 Medical and Surgical

- T Urinary System

- U Supplement: Putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>D Urethra</td>
<td>0 Open</td>
<td>7 Autologous Tissue</td>
<td>Z No</td>
</tr>
<tr>
<td></td>
<td>4 Percutaneous</td>
<td>Substitute</td>
<td>Substitute</td>
</tr>
<tr>
<td></td>
<td>Endoscopic</td>
<td>J Synthetic Substitute</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 Via Natural or</td>
<td>K Nonautologous Tissue</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Artificial Opening</td>
<td>Substitute</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8 Via Natural or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Artificial Opening</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Endoscopic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>X External</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ICD-10-PCS Coding Options:

- **0TUD8JZ** Supplement Urethra with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
- **0TUDXJZ** Supplement Urethra with Synthetic Substitute, External Approach

**Rationale:** Currently, in ICD-10-PCS, the female equivalent “lift” procedures for incontinence are coded in this manner. In this procedure for males, the device is being used to keep the urethra open and functioning correctly, instead of having the prostate push on it.
ICD-10-PCS Coding Options:

| Prostatic urethra | Use: Urethra |

The body part key currently instructs to use the body part “Urethra” for prostatic urethra.
ICD-10-PCS Coding Options:

- Option 2. Code the procedure with root operation Dilation.
- 0 Medical and Surgical
- T Urinary System
- 7 Dilation: Expanding an orifice or the lumen of a tubular body

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Kidney Pelvis, Right</td>
<td>0 Open</td>
<td>D Intraluminal Device</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>4 Kidney Pelvis, Left</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Ureter, Right</td>
<td>3 Percutaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Ureter, Left</td>
<td>4 Percutaneous</td>
<td>4 Percutaneous</td>
<td></td>
</tr>
<tr>
<td>8 Ureters, Bilateral</td>
<td>Endoscopic</td>
<td>7 Via Natural or Artificial Opening</td>
<td></td>
</tr>
<tr>
<td>B Bladder</td>
<td></td>
<td>8 Via Natural or Artificial Opening</td>
<td></td>
</tr>
<tr>
<td>C Bladder Neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D Urethra</td>
<td>Endoscopic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• Option 2. Code the procedure with root operation Dilation.
• Option 3. Code the procedure with root operation Insertion, body part Prostate and consider new device value?

• 0 Medical and Surgical

• V Male Reproductive System

• H Insertion: Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Prostate</td>
<td>0 Open</td>
<td>1 Radioactive Element</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td></td>
<td>3 Percutaneous</td>
<td>4 Percutaneous</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 Percutaneous Endoscopic</td>
<td>7 Via Natural or Artificial</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 Via Natural or Artificial</td>
<td>8 Via Natural or Artificial</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Opening Endoscopic</td>
<td>Opening Endoscopic</td>
<td></td>
</tr>
</tbody>
</table>
ICD-10-PCS Coding Options:

- **Option 4.** Add the body part value Prostate to root operation Supplement in the ICD-10-PCS tables, with applicable approach values (3 codes)
- 0 Medical and Surgical
- V Male Reproductive System
- U Supplement: Putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Prostate</td>
<td>0 Open 7 Via Natural or Artificial Opening 8 Via Natural or Artificial Opening Endoscopic</td>
<td>J Synthetic Substitute</td>
<td>Z No Qualifier</td>
</tr>
</tbody>
</table>
Implantation of Epiretinal Prosthesis

Celeste Beauregard

March 5, 2013
ICD-9-CM Procedure Coding Options:

Option 1. Do not create any new procedure codes for the implantation of an epiretinal visual prosthesis.

There is currently no ICD-9-CM code for the implantation of epiretinal visual prosthesis,

- Codes 14.73 (Mechanical vitrectomy by anterior approach) and 14.74 (Other mechanical vitrectomy) are reported for the vitrectomy.

- The vitrectomy codes can continue to be used as a proxy for the implant of the epiretinal visual prosthesis. Any other associated procedures could also be reported.
ICD-9-CM Procedure Coding Options:

Option 2. Create new ICD-9-CM procedure codes for Implantation of epiretinal visual prosthesis.

Create new subcategory:
14.8 Implantation of epiretinal visual prosthesis
Create three New Codes:

14.81 Implant of epiretinal visual prosthesis
   Includes lens removal if present, scleral
   buckling, vitrectomy, epiretinal membrane peeling and
   pericardial grafting

14.82 Removal of epiretinal visual prosthesis
   Includes 360-degree limbal peritomy and vitrectomy if
   performed, and device extraction

14.83 Removal of epiretinal visual prosthesis
   Includes tack replacement, device relocation, and/or
   replacement of pericardial grafting, if needed
Option 2. As described above.

In the interim, continue reporting codes 14.73 (Mechanical vitrectomy by anterior approach) and 14.74 (Other mechanical vitrectomy) for the vitrectomy as well as any other associated procedures.
Proposed ICD-10-PCS Code:

- New ICD-10-PCS device value Epiretinal Visual Prosthesis in table 08H Insertion of Eye for the retina body part values.
- Section 0 Medical and Surgical
- Body System 8 Eye
- Operation H Insertion: Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Eye, Right</td>
<td>3 Percutaneous</td>
<td>1 Radioactive Element</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>1 Eye, Left</td>
<td>x External</td>
<td>3 Infusion Device</td>
<td></td>
</tr>
<tr>
<td>E Retina, Right</td>
<td>0 Open</td>
<td>5 Epiretinal Visual Prosthesis</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>F Retina, Left</td>
<td>3 Percutaneous</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>