DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

SUMMARY REPORT

ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

September 27-28, 2007

PROCEDURE DISCUSSIONS

Introductions and Overview

Pat Brooks welcomed the participants to the ICD-9-CM Coordination and Maintenance (C&M) Committee meeting. Approximately 200 participants registered to attend the meeting. The procedure portion of the meeting was held on September 27, 2007 and was conducted by staff from the Centers for Medicare & Medicaid Services (CMS). The diagnosis portion of the meeting was held on September 28, 2007 and was conducted by staff from the National Center for Health Statistics (NCHS), 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 27, 2007 meeting are being considered for implementation on October 1, 2008. A detailed timeline was included in the handouts. It was explained that the Committee meetings serve as a public forum to discuss proposed revisions to the ICD-9-CM. The public is given a chance to offer comments and ask questions about the proposed revisions. **No final decisions on code revisions take place at the meeting.** A summary report of the procedure part of the meeting will be posted on CMS' website at: www.cms.hhs.gov/ICD9ProviderDiagnosticCodes. A summary report of the diagnosis part of the meeting will be placed on NCHS' web site at www.cdc.gov/nchs/icd9.htm. The public is offered an opportunity to make additional written comments by mail or e-mail until December 3, 2007.

Comments on the **procedure** part of the meeting should be sent to:
Pat Brooks
Centers for Medicare & Medicaid Services (CMS)
CMM, Hospital and Ambulatory Policy Group
Mail Stop C4-08-06
7500 Security Blvd.
Baltimore, MD 21244-1850
Patricia.brooks2@cms.hhs.gov

Comments on the **diagnosis** part of the meeting should be sent to:
Donna Pickett
NCHS
3311 Toledo Road
Room 2402
Hyattsville, MD 20782
Dfp4@cdc.gov

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

CMS has information on ICD-9-CM at the following web address: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes. Detailed information is provided on the homepage about 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", for a list of CMS meetings for which to register. Participants can register for the March 19-20, 2008 meeting beginning February 15, 2008. The registration site will close on March 12, 2008. Therefore, those who wish to attend the spring meeting must register online between February 15 and March 12, 2008.

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.

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 19-20, 2008. As stated earlier, the online registration for this meeting will begin on February 15, 2008 and close on March 12, 2008, or earlier if registrations meet room limitations. Due to fire code requirements, should the number of attendants meet the capacity of the room; the meeting will be closed to additional attendees. Participants must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building.

Those interested in attending the meeting should check the CMS' ICD-9-CM website 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. For March 2008, the cutoff date will be Thursday, January 18th.

April 1 code updates

The participants were informed of a point in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that has the potential to 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, 2008 code implementation at the fall meeting. If there are no such requests, the proposed codes discussed at the fall meeting would be considered for implementation on the following October 1.

If a strong and convincing case were not made at the fall C&M meeting for an April 1 implementation, then the new code would be considered for a routine October 1 implementation. If there are no requests for an April 1 implementation of a specific code at the fall C&M meeting, then there would be no April 1 ICD-9-CM updates. All code revisions would be considered for October 1.

There was one request for proposed code revisions and a new ICD-9-CM code to be implemented on April 1, 2008 at this ICD-9-CM Coordination & Maintenance Committee meeting. The request was for the topic *Biventricular Replacement – Artificial Heart.* The proposal recommended modifying existing codes and creating a new code for the removal of the device. The audience was not in favor of an April 1, 2008 implementation date for this proposal since all of the modifications involve revisions to existing codes and do not represent new technology. While they supported the proposed code modifications, they did not believe it was necessary to implement them on April 1, 2008. Therefore, **there will be no new ICD-9-CM codes implemented on April 1, 2008.**

Topics:

1. Present on admission indicator (POA).

Pat Brooks provided an overview of the new requirements to report a Present on Admission indicator (POA) to indicate whether or not a diagnosis was present on admission. The following information from Transmittal: 1240, Change Request: 5499, dated May 11, 2007 was discussed. Pat stressed that this requirement is for acute inpatient PPS hospitals (those reimbursed under MS-DRGs). **It does not apply to excluded hospitals such as children's, psychiatric and rehabilitation hospitals.**

A. Background: Section 5001(c) of the Deficit Reduction Act of 2005 requires hospitals to begin reporting the secondary diagnoses that are present on the admission (POA) of patients effective for discharges on or after October 1, 2007. By October 1, 2007, the Secretary must select at least two conditions that are: 1) high cost or high volume or both; 2) assigned to a higher paying DRG when present as a secondary diagnosis; and 3) reasonably preventable through application of evidence based guidelines. Effective for acute care inpatient PPS discharges on or after October 1, 2008, the Secretary cannot assign cases with these conditions to a higher paying DRG unless they were present on admission. This instruction will require hospitals to begin reporting the POA code on claims with discharges beginning on or after October 1, 2007. Although hospitals must report the POA code on the claim, the information will not be used by claims processing systems until January 1, 2008. Beginning with claims with discharges on or after January 1, 2008, if hospitals do not report a valid POA code for each diagnosis on the claim, the claim will continue to process. However, hospitals will be provided with a remark code on their remittance advice advising them that they did not correctly submit the POA code on the claim. Beginning April 1, 2008, if hospitals do not report a valid POA code for each diagnosis on the claim, the claim will be returned to the hospital for correct

submission of POA information. Direct data entry (DDE) screens cannot be updated to include a space for entering POA information until January 1, 2008. Therefore, hospitals that submit claims via DDE will be unable to submit the POA indicator on October 1, 2007. These hospitals must begin submitting the POA indicator on January 1, 2008.

B. Policy: In order to group diagnoses into the proper DRG, CMS needs to capture a POA indicator for all claims involving inpatient admissions to general acute care hospitals. Use the UB-04 Data Specifications Manual and the ICD-9-CM Official Guidelines for Coding and Reporting to facilitate the assignment of the POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claim forms UB-04 and 837 Institutional. The law requires that these POA indicators be reported on all claims for inpatient admissions to general acute care hospitals with discharge dates on or after October 1, 2007. Critical access hospitals, Maryland waiver hospitals, LTCH, cancer hospitals and children's inpatient facilities are exempt from this requirement. These guidelines are not intended to replace any guidelines in the main body of the ICD-9-CM Official Guidelines for Coding and Reporting. The POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-9-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the Introduction to the ICD-9-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines, the term "provider" means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis. **NOTE:** The provider, their billing office, third party billing agents and anyone else involved in the transmission of this data shall ensure that any resequencing of diagnoses codes prior to their transmission to CMS, also includes a resequencing of the POA indicators as well.

The following information is an excerpt from the UB-04 Data Specifications Manual and is provided to assist hospitals in understanding how and when to code POA indicators. See the complete instructions in the UB-04 Data Specifications Manual when more specific instructions or examples are necessary.

General Reporting Requirements

- All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.
- Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient

encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.
• POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes.
• Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.
• If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, then the POA indicator would not be reported.
• CMS does not require a POA indicator for the external cause of injury code unless it is being reported as an "other diagnosis".

CMS Reporting Options and Definitions

• Y = Yes = present at the time of inpatient admission

• N = No = not present at the time of inpatient admission

• U = Unknown = the documentation is insufficient to determine if the condition was present at the time of inpatient admission

• W = Clinically Undetermined = the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not

• 1 = Unreported/Not used – Exempt from POA reporting - This code is the equivalent code of a blank on the UB-04, however, it was determined that blanks were undesirable when submitting this data via the 4010A1.

<u>Hospital Acquired Conditions selected</u>

The audience was informed of discussions in the inpatient PPS final rule concerning Hospital Acquired Conditions. The following eight conditions were selected for implementation on October 1, 2008:

- Three serious preventable events
  - object left in surgery
  - air embolism
  - blood incompatibility
- Catheter associated urinary tract infection
- Decubitus ulcers
- Vascular catheter associated infection
- Surgical site infection – Mediastinitis after CABG
- Falls – specific trauma codes

The following additional possibilities were also discussed in the final rule. The public was encouraged to review these conditions and send comments to CMS concerning the appropriateness of implementing these conditions.

- Ventilator associated pneumonia – working to create new code

- Staphylococcus aureus septicemia – need to clarify instances when preventable
- Deep vein thrombosis and pulmonary embolism – need to identify instances when preventable, such as after certain elective surgeries

Additional information on hospital acquired conditions and present on admission indicators is available at:

- IPPS final rule - http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1533fc.pdf
  - Hospital acquired conditions – page 47200
- MLN Matters – POA information http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5499.pdf
- POA guidelines http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide06.pdf

2. ICD-10- Procedure Classification System (PCS) Update

Pat Brooks provided an update on the 2008 version of ICD-10-PCS. A handout summarizing all the code changes in the current release was provided to the participants, as well as the detailed changes to each section. Participants were informed of the updated GEM (General Equivalence Mapping) files that are available for viewing on the CMS website. Pat also announced that a new ICD-10 webpage was under development to allow the transfer of all existing ICD-10-PCS materials (currently found on the ICD-9-CM webpage) due to limited space. The ICD-10 webpage will include both ICD-10-PCS and ICD-10-CM information for downloading. **The webpage is now active and can be located at the following link: http://www.cms.hhs.gov/ICD10/.**

3. Non-invasive Positive Pressure Ventilation

Neil MacIntyre, MD, conducted a clinical presentation on mechanical ventilation delivery through a face or nasal mask (non-invasive positive pressure ventilation [NIPPV]), that has been demonstrated to show improved outcomes for patients diagnosed with acute respiratory failure. Mady Hue led the coding proposal options. The discussion noted the differences between current code 93.90, Continuous positive airway pressure [CPAP] and NIPPV, which is currently an inclusion term for CPAP, compared to traditional invasive mechanical ventilation via an endotracheal tube or tracheostomy and is identified by subcategory 96.7, Other continuous mechanical ventilation. One commenter suggested adding the term "invasive" and revising the title for subcategory 96.7, Other continuous (invasive) mechanical ventilation. Another commenter suggested adding the term "mechanical" in the title for proposed new code 96.8, Other non-invasive (mechanical) positive pressure ventilation, to help clarify that NIPPV is still mechanical ventilation; however, the delivery of the ventilation differs. One commenter asked where does positive expiratory end pressure [PEEP] fit into the proposal since it was being proposed to delete the term. Dr. MacIntyre responded that PEEP can be utilized for both invasive and non-invasive treatments. Mady stated that this term could be included in the list with

the other terms associated with positive pressure ventilation noted on page 10 in the agenda and handout packet. Another commenter inquired about the appropriateness of having a notation for the duration or numbers of hours for the NIPPV treatment since the invasive codes under subcategory 96.7 have a 96 hour designation. Dr. MacIntyre replied that it is almost always less than 96 hours. Mady responded that in preparing this coding proposal it was felt that the duration was not necessary since the diagnosis code(s) would provide the indication for the treatment. One commenter stated that if a patient was receiving NIPPV and was then converted to invasive positive pressure ventilation that both codes would be used and it would be helpful to have an instruction to coders explaining this. This commenter suggested an article in AHA's *Coding Clinic for ICD-9-CM*. Another commenter questioned the appropriate coding for a patient receiving BiPAP via a tracheostomy. Dr. MacIntyre replied that a patient with a tracheostomy who is ventilated and a patient who is receiving BiPAP with a tracheostomy adaptor are receiving the same amount of ventilatory support. He explained that the term BiPAP® is a trade name for Respironics, Incorporated. He further noted that BiPAP® delivered via a tracheostomy should be assigned to the subcategory 96.7. Mady stated the excludes notes would need to be revised based on his comment. As a result, BiPAP® delivered via a face or nasal mask would be assigned to proposed new code 96.8. There appeared to be general support for option 2, with minor revisions based on the comments. The audience was encouraged to send in written comments as well.

4. SuperOxygenation Therapy

Jack Martin, MD, facilitated a clinical presentation on how the administration of SuperOxygenation therapy or aqueous oxygen (AO) therapy in acute myocardial infarction (AMI) patients following percutaneous coronary intervention (PCI) is believed to reduce infarct size and results in preservation of the heart muscle. Ann Fagan led the coding proposal options. The therapy is an adjunct to current treatments available that restore coronary artery blood flow in AMI patients, directly treating the myocardial tissue susceptible to progressive microvascular damage after coronary artery blood flow has been restored. One commenter stated that this therapy reminded her of hyperbaric medicine and asked if the patient was not under any pressure, how much oxygen could be there without causing bubbles? She expressed concern about adverse events. Dr. Martin responded that the patient's vessel does not require pressure because it is a continuous infusion and the therapy is not pressuring the coronary artery. Another commenter questioned if this type of therapy would be performed on non-coronary vessels. Dr. Martin replied that it could be in the future but at the moment, the design of the clinical trial is to show superiority in reducing the size of the infarct. One commenter recommended adding excludes notes at code 93.96, Other oxygen enrichment, code 99.10, Injection or infusion of thrombolytic agent, and category 99.2, Injection or infusion of other therapeutic or prophylactic substance to exclude the proposed new code 00.60, SuperOxygenation infusion therapy.. Another commenter suggested that category 00.4, Adjunct vascular system procedures, may be a better classification for this therapy than proposed category 00.6, Procedures on blood vessels. There appeared to be general support for creating a new code.

5. Laparoscopic Repair of Hernia

Rod Brown, MD, conducted a clinical presentation on the Rebound HRD™ (Nitinol framed polymer mesh) device used in laparoscopic repair of inguinal hernias. Dr. Brown reviewed the advantages of laparoscopic surgery compared to open hernia repairs. Pat Brooks facilitated the coding proposal discussion. Currently, ICD-9-CM procedure codes do not distinguish between laparoscopic and open repairs of hernias. One commenter asked if the laparoscopic repairs are always performed with the mesh. Dr. Brown responded that virtually all hernia repairs involve the use of a mesh. Another commenter questioned if this mesh was used in any other types of hernia repair. The reply from Dr. Brown was that it is not FDA approved for other sites at this time, however it was possible that it could be used in the future for femoral hernia repairs. One commenter asked if consideration could be given to the creation of an "adjunct code" to describe that a procedure was performed laparoscopically, given the number of procedures that can now (or will soon have the ability to) be performed laparoscopically. This commenter also suggested the option of combining the proposed bilateral codes in with the proposed unilateral codes to preserve space. Another commenter suggested revising the titles to the proposed code categories as "open and other" to provide clarification about the codes contained within those categories. One commenter recommended that the codes listed under 17.1 and 17.2 in Option 2, be combined so that all of these codes are combined together under one category, such as 17.1. This would free up one category for future code use.

There appeared to be general support for the creation of new codes to describe a laparoscopic approach, however the proposed location for some of these new codes, in new chapter 17, was not as well supported. The audience acknowledged the availability of space for new codes is still a concern; however, the preference appeared to be keeping procedures in the appropriate anatomic location of the coding system if at all possible.

6. Surgical Closure of Atrial Appendage

Kathryn Barry, RN, led a clinical discussion on how cardiovascular surgeons routinely perform exclusion or closure of the left atrial appendage by oversewing, clipping, or stapling during major cardiovascular procedures (i.e. coronary artery bypass graft (CABG), mitral valve repair, maze procedure) in patients with atrial fibrillation (AF). Ann Fagan conducted a discussion of the coding proposal options. Currently, there is not a unique code to identify or describe the surgical closing [exclusion] of the left atrial appendage (LAA) by clipping, oversewing, or stapling. As patients age and develop AF, prophylactic appendage removal whenever the chest is open is suggested as a method to prevent future strokes. One commenter asked if the oversewing of the LAA should be considered inherent to the specific surgical procedure being performed, as it appears to be simply a component of the major procedure. Ms. Barry stated that there is a time factor involved with adding this procedure that needs to be recognized. Additionally, current cardiology guidelines state that this procedure should be performed; a specific code would be one method of verifying that the procedure took place. Another commenter

recommended the option of adding inclusion notes for oversewing, clipping, and stapling of the LAA at the major cardiovascular procedure codes. One commenter asked if this procedure had the possibility of a percutaneous approach in the future. Ms. Barry responded no, that the intent of this procedure is to be performed with open chest procedures. She also stated that it is routinely performed in the operating room (OR) by cardiothoracic surgeons. Ms. Barry explained that 90% of the thrombus occurs at the LAA, therefore as stated previously, it is an attempt to prevent future strokes, especially in patients with documented AF. One commenter questioned the assignment of code 37.33, Excision or destruction of other lesion or tissue of the heart, open approach, for this procedure because it doesn't appear that the left atrial appendage is being excised or destroyed. There appeared to be negative audience approval for creation of a new code. The audience was also encouraged to send in written comments.

7. Biventricular Replacement

Bartley Griffith, MD, conducted a clinical presentation on the implantation of a biventricular mechanical heart assist device, also known as an artificial heart. Ann Fagan facilitated the coding proposal discussion. Ann reviewed CMS' coverage policy which is summarized in the background paper. She also explained how biventricular replacement devices, depending on the type of model, replace much of the patient's native heart, including both ventricles, but may not replace the heart in its entirety (it may not replace the native atria). This type of biventricular replacement is not a ventricular assist device (VAD), because when the device is implanted, there is very little of the native heart left for the device to assist. There was general support for the proposal to modify existing code 37.52, Implantation of total replacement heart system. Another commenter asked if there are any clinical scenarios where proposed new code, 37.55, Removal of internal biventricular heart replacement system, would not be performed in conjunction with a heart transplant (code 37.51). Dr. Griffith stated no, not that he could think of or else the patient would expire without a heart.

8. Application of Surgical Gel

Alfred Rhyne, MD, facilitated a clinical discussion on Oxiplex® intraoperative surgical gel as an adjuvant to lumbar disc surgery for the reduction of leg pain, back pain and neurological symptoms. Mady Hue led the coding proposal discussion. Currently, code 99.77, Application or administration of adhesion barrier substance, describes the use of a variety of products to assist in the prevention or reduction of adhesions following surgery and Oxiplex/SP® Gel Adhesion Barrier for Spine is described as a protective coating to prevent post-surgical adhesions from forming. However in the US pivotal trial, Oxiplex® is described as an absorbable, viscoelastic gel that is surgically implanted during lumbar surgery and its indication is for pain relief. One commenter questioned if the "post surgical site blood products including fibrin, wound exudates, and inflammatory mediators which can lead to compression, inflammation, and chemical irritation" are not the same indicators for developing adhesions. Dr. Rhyne responded that the blood does

not react with neural elements. The commenter then asked if it were not indeed the same mechanism of action and the reply was that it is a component of it. Another commenter asked how this would be documented in the medical record. This commenter was not sure she would be able to determine how and when to apply the code since it is not considered an adhesion barrier, unless it was specifically indexed and documented as Oxiplex®. Dr. Rhyne indicated it would be applied to all surfaces of the nerve root and there should be documentation to develop the distinction between gel and adhesion barrier, such as the insertion of gel during a procedure. He stated there has been evolution over time from an adhesion barrier. One commenter asked how long the gel resides after it has been injected. Dr. Rhyne responded it has shown to clear in approximately 30 days in animal studies. Another commenter asked if this gel could be applied to any area where nerves are exposed. Dr. Rhyne replied he could not address other areas, but certainly the spine and perhaps peripheral. One commenter stated they did not understand the mechanism and asked if there was an additional anti-inflammatory present, was it is chemical or mechanical. Dr. Rhyne responded it is mechanical. One commenter indicated there is a problem with option 1, since that is a temporary shield and the description for this indication is different than code 99.77, therefore, he was in support of creating a new code. By polling the audience, there appeared to be support for both option 1 (do not create a new code) and option 2 (create a new code); however more participants were in support of option 1, not to create a new code.

9. Laparoscopic Colectomy

Pam Martin, MD, conducted a clinical presentation on laparoscopic colo-rectal surgery. Pat Brooks led the coding proposal options. Currently, ICD-9-CM procedure codes do not distinguish between open and laparoscopic approaches to colo-rectal surgery. One commenter again asked to consider creating an adjunct code to describe the laparoscopic approach which could be used for a variety of procedures and not take up a lot of code space. Another commenter recommended that an examination of the colo-rectal procedures that are most commonly performed should be done, since several of these procedures are performed in the outpatient setting. One commenter strongly supported the implementation of codes proposed under Option 2 since they clearly identify procedures currently being performed in inpatient hospitals. There was general support for Option 2.

10. Intra-Aneurysm Sac Pressure Measurement

Sean Roddy, MD, facilitated a clinical presentation of intra-aneurysm sac pressure measurement during endovascular aneurysm repair (EVAR) of abdominal aortic aneurysms (AAA) and thoracic aortic aneurysms (TAA). Amy Gruber led the coding proposal discussion. The presentation described how one potential complication during the EVAR procedure is an endoleak, or the leaking of blood around the graft and into the aneurysm sac. This endoleak causes continued pressurization of the aneurysm sac and may leave the patient at risk for subsequent aneurysm rupture. One method to detect

endoleaks in conjunction with imaging is to evaluate sac pressure. There were no comments from the audience and overall support for option 2, create a new procedure code to identify the intraoperative insertion of an intra-aneurysm sac pressure monitoring device, add code also notes to codes 39.71, Endovascular implantation of graft in abdominal aorta, and 39.73, Endovascular implantation of graft in thoracic aorta, and add an exclusion note to code 89.61, Systemic arterial pressure monitoring.

11. Percutaneous Vertebral Augmentation

Chetan Patel, MD, provided a clinical presentation on conventional vertebroplasty and the variety of techniques used to perform vertebral augmentation. Amy Gruber led the discussion of the three coding options. One commenter supported option 2, to revise the code titles and inclusion terms under code 81.66, Kyphoplasty, to encompass all techniques of vertebral augmentation and revise the code title for code 81.65, Vertebroplasty and requested that Dr. Patel assist CMS in identifying the various techniques utilized in vertebral augmentation. Another commenter was concerned by adding percutaneous to the code titles that would exclude using that code when it is performed with an open procedure. One commenter stated that kyphoplasty is not proprietary and that kyphoplasty is standard terminology. This commenter prefers that the code title for code 81.66 remain and that inclusion terms should be added under that code. One commenter stated that option 3, collapse codes 81.65 and 81.66 into one code, should not be an option as this action would be taking a step back in identifying these procedures. One commenter stated that there is confusion about the distinctions between these two procedures and that physicians use these terms interchangeably. This commenter stated that these options do not resolve this issue. The audience was encouraged to send in written comments.

12. Intravascular Pressure Measurement

Stuart Higano, MD, conducted a clinical presentation on fractional flow reserve (FFR), a technique developed to assess the severity of coronary artery stenoses that might otherwise not be accurately measured by conventional angiography. FFR allows physicians to better diagnose more complex disease such as serial stenoses, diffuse disease and patients with multi-vessel disease. Joe Kelly, MD facilitated the coding proposal discussion. Currently, ICD-9-CM procedure code 89.69, Monitoring of coronary blood flow, does not fully capture the use of FFR. One commenter asked about a code option for the intra-abdominal arteries. The commenter suggested adding the term "aortic" to the thoracic and peripheral intravascular pressure measurement options, or add another new code to identify intraabdominal arteries. Dr. Kelly stated that aorta and aortic arch are inclusion terms under proposed new code 00.67, Intravascular pressure measurement of intrathoracic arteries, and may be a viable option to include intraabdominal arteries, such as mesenteric and iliac. Another commenter asked where they would find documentation of this procedure and what it would look like. Dr. Higano stated it is usually done in conjunction with other diagnostic coronary artery

procedures and is documented as intravascular pressure measurement or FFR. Another commenter asked if this procedure had a cerebral application and Dr. Higano responded that it could possibly be used there in the future, however it is not FDA approved for cerebral use. One commenter asked if consideration should be given to having 2 codes: one for coronary arteries and one for non-coronary arteries due to code limitations. There appeared to be support for option 2 in the proposal as written, to create one new code under subcategory 00.5, Other cardiovascular procedures and 3 new codes under 00.6, Procedures on blood vessels, describing the multiple uses of intravascular pressure measurements.

13. Intravascular Spectroscopy

Jay Caplan, Chief Technology Officer for InfraReDx™, conducted a clinical presentation on the use of near infrared (NIR) spectroscopy in the detection of lipid rich coronary plaques. The catheter-based NIR spectroscopy system would assist interventional cardiologists in determining the most appropriate type of stent to utilize depending on the presence, location, and amount of lipid rich plaque. Joe Kelly, MD led the coding proposal discussion. One commenter asked for verification that this technology could be used on both coronary and peripheral vessels. Mr. Caplan responded yes, and the inclusion terms for the proposed coding options reflected this as well. Another commenter recommended adding an excludes note at subcategory 00.2, Intravascular imaging of blood vessels, if a new code were to be created. There appeared to be general support for option 2; create new code 38.23, Intravascular spectroscopy.

14. Percutaneous Dilatational Tracheostomy

Joe Kelly, MD, facilitated the clinical and coding discussion for a newer approach to tracheostomy. Currently, ICD-9-CM procedure coding does not distinguish between performing a tracheostomy using the traditional surgical approach, typically done in the operating room, from a newer approach called Percutaneous Dilatational Tracheostomy (PDT), which is typically performed at bedside. One commenter stated that if the differences between the PDT and the other types of tracheostomy are simply that the incision is smaller, a new code should not be created. In contrast, another commenter noted that new codes have been created for other types of percutaneous procedures; therefore one should be created for this procedure. There appeared to be divided support for the coding options presented. The audience members were encouraged to send in written comments.

15. Repair of the Annulus Fibrosus

Reginald Davis, MD, conducted a clinical presentation on how surgeons are beginning to repair the annulus fibrosus following a surgical diskectomy. Traditionally, the annular defect has primarily been left to heal, however not repairing this defect may contribute to recurrent disc herniation, a higher rate of reoperation, and poor patient outcomes. Mady

Hue led the coding proposal discussion. One commenter recommended looking at subcategory 80.5, Excision or destruction of intervertebral disc, to create the proposed new codes since subcategory 81.6, Other procedures on spine, includes more bone procedures. This same commenter also suggested inserting a code also note at code 80.51, Excision of intervertebral disc, since the repair of the annulus fibrosus would seldom be performed without this procedure. Another commenter questioned if the term annulus should have one "n" or two. Mady responded that it can be spelled both ways and encouraged the audience to send in comments if they had a preference for the spelling. There appeared to be support for option 2, create two new codes to describe repair of the annulus fibrosus.

16. Addenda

Mady Hue facilitated a discussion on the addendum proposal. One commenter recommended another coding option in place of proposed code 83.31, Excision of lesion of tendon sheath, to describe the debridement of a tendon. This commenter suggested code 83.42, Other tenonectomy. A question and answer published in *Coding Clinic*, Second Quarter 2005, pages 3-4, reports that when coding for debridement for areas other than skin and there is no index entry or guidance provided in the tabular entry, the coder should look for other terms such as excision or destruction of lesion of that site. There were no additional comments on the proposed agenda. There appeared to be general support for the remaining proposed updates and revisions.