



---

## SUMMARY REPORT

### ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

September 28-29, 2006

## 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. The procedure portion of the meeting was held on September 28, 2006 and was conducted by staff from the Centers for Medicare & Medicaid Services (CMS). The diagnosis portion of the meeting was held on September 29, 2006 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 28, 2006 meeting are being considered for implementation on October 1, 2007. 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](http://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](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 4, 2006.

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

Pat Brooks  
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.brooks2@cms.hhs.gov](mailto:Patricia.brooks2@cms.hhs.gov) **Please note that this is a new email address.**

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](mailto: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 on the following web address:

<http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes> . 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. Participants can register for the March 22-23, 2007 meeting beginning February 22, 2007. The registration process will close on March 17, 2007. Therefore, those wishing to attend the meeting must register online between February 22 and March 17, 2007.

### ***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 22-23, 2007. As stated earlier, the online registration for this meeting will begin on February 22, 2007 and close on March 17, 2007, 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. You 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 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, 2007 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, 2007 at the fall ICD-9-CM Coordination & Maintenance Committee meeting. Therefore, **there will be no new ICD-9-CM codes implemented on April 1, 2007.**

### **Topics:**

#### **1. SPY Procedure – Intra-operative Fluorescence Vascular Angiography**

Bruce Ferguson, MD, conducted a clinical presentation on how SPY Intra-operative Fluorescence Vascular Angiography (IFVA), a new imaging technology, is used in coronary artery bypass graft (CABG) procedures. Pat Brooks facilitated a discussion on the coding proposals. One commenter asked what percent of grafts require revisions that do not utilize the SPY technology compared to the reported 4.2% of grafts necessitating a revision that had utilized the SPY technology. Dr. Ferguson responded that generally, the assumption is that all the grafts are fine but it is never truly known. Another commenter questioned if this technology would be applied to any other vessels (i.e. peripheral) in addition to the coronary arteries. At this time the focus is on coronary arteries according to Dr. Ferguson. There was general support for option 3, to create new procedure code 88.59 Intra-operative fluorescence vascular angiography using SPY technique.

#### **2. Thoracoscopic procedures**

Joe Kelly, MD provided an overview of how the thoracoscopic approach could be applied to a number of current therapeutic procedures on tissues of the lung and pleura. There was overall support for option 2, to create new thoracoscopy codes for procedures including lobectomy of lung, biopsy of lung, drainage of lung, pleural biopsy and decortication of lung. One commenter stated that an excludes note should be added for existing code 33.26 (Closed (percutaneous) (needle) biopsy of lung) to exclude the proposed new code (33.20) describing the thoracoscopic approach. Another commenter suggested adding an inclusion term of “clotting” for the proposed new code (34.52) describing a thoracoscopic decortication of lung procedure. This same commenter stated there are other areas that should be considered for adding the thoracoscopic approach to that could be presented at the March 2007 meeting. Another commenter expressed support for option 2 stating these services have been difficult for coders to identify what approach to assign and the creation of the thoracoscopic approach codes would be extremely helpful.

### **3. Pelvic Prolapse Repair Procedures Involving Graft or Prosthesis**

Nicolette Horbach, MD conducted a clinical presentation on how various grafts and prosthesis are currently being used for the repair of pelvic prolapse in women. Ann Fagan led the discussion on the coding proposal. One commenter questioned if it would be beneficial to identify the type of graft material (synthetic, allogenic, xenogenic, etc.) being used in these repair procedures. Dr. Horbach indicated it would helpful to distinguish the synthetic grafts from the biologic grafts for tracking and outcomes. Another commenter asked if coders would actually see the documentation in a medical record to determine what type of graft material was used. The response was that usually the operating room (OR) nurse documents the type of graft material in the record. One commenter stated they supported having the various types of grafts to choose from as a coding option. Another commenter suggested creating adjunct codes to describe the type of material used for the graft or prosthesis. A commenter agreed with the idea of adjunct codes and suggested using subcategory 70.9 (Other operations on vagina and cul-de-sac) for the placement of them. Another commenter provided options from the ICD-10-PCS perspective and what is currently included in that section of the draft ICD-10-PCS. There was general support for option 2, to create new codes identifying the use of grafts or prosthesis in pelvic prolapse repair.

### **4. Blood Brain Barrier Disruption (BBBD) Chemotherapy**

David Peereboom, MD provided a clinical overview of how disruption of the blood brain barrier can improve the delivery of chemotherapeutic drugs to the central nervous system. Ann Fagan facilitated a discussion on the coding proposal. One commenter questioned if this procedure could be used for other conditions in the future. Dr. Peereboom stated that potentially this could be possible, but those applications were definitely in the future. One commenter suggested changing the title of the proposed new code to Blood brain barrier disruption (BBBD) instead of Selective intracerebral arterial infusion. Another commenter stated if the decision was to keep the code title as proposed then all the other arterial infusions would need direction on how to code since there are several other types of arterial infusions. Another commenter suggested adding the term “intra-arterial” to the inclusion term of mannitol infusion. One commenter asked if disruption of the blood brain barrier was part of the chemotherapy encounter or if it was a separate procedure. The response was that BBBD is clearly a separate procedure. One commenter asked how this would be coded; if it would be considered an admission for chemotherapy where the V58.11 (Encounter for antineoplastic chemotherapy) would apply as the principal diagnosis. The response was yes, it would be an admission for chemotherapy. Another commenter stated that if disruption of the blood brain barrier is only performed with chemotherapy then perhaps a code also note should be added to the proposed new code (00.19) to code also the chemotherapy. This same commenter then asked if an excludes note would be needed at code 99.29 (Injection or infusion of other therapeutic or prophylactic substance). Another commenter stated the alphabetic Index should take care of the exclusion for code 99.29. Generally, there appeared to be support of option 2, create a new code to describe disruption of the blood brain barrier, but with consideration of the suggested modifications.

## **5. Intracranial Monitoring**

Karen March, RN and Pradeep Narotam, MBChB conducted a clinical presentation on intracranial pressure, intracranial oxygen and brain temperature monitoring and their use in the management of traumatic brain injuries, cerebrovascular injuries and other brain disorders. Amy Gruber led a discussion on the coding proposal. One commenter questioned if there are separate probes utilized for each type of monitoring. Ms. March replied that the probes are currently separate however, some may be combined. Another commenter questioned if the proposed new codes listed under option 3 were created, is there a potential to use three codes? The response given was yes, to capture the three monitoring parameters. Another commenter asked why the other parameters listed in option 2 (cerebral blood flow and brain metabolism) were not addressed in coding option 3. It was noted that according to the President of the Brain Trauma Foundation, the cerebral blood flow is new technology that is not commercially available at this time. The Brain Trauma Foundation raised no objection to proposed option 3. However, Dr. Narotam responded that he agreed they should all be addressed and coded separately. One commenter stated that the details in option 2 were not necessary at this time and endorsed option 3, the creation of three codes to describe intracranial pressure monitoring, intracranial oxygen monitoring and brain temperature monitoring.

## **6. Implantation of Carotid Sinus Baroreflex Activation Device**

Luis A. Sanchez, MD provided a clinical overview on the Rheos™ carotid sinus baroreflex activation device as a treatment for resistant hypertension. Amy Gruber facilitated a discussion on the coding proposal. One commenter stated they were surprised at the small number of patients participating in the clinical trial and the absence of cost benefit analysis. Dr. Sanchez stated that the analysis is part of the next phase of the clinical trial. Another commenter stated they felt option 3; the creation of new subcategory 39.8, Operations on carotid body, carotid sinus and other vascular bodies, and 5 new procedure codes was too premature. Therefore, this commenter supported option 2, which involved a minor modification to the code title and the addition of inclusion terms. Another commenter echoed the previous commenter's remarks and questioned how long phase II of the clinical trials was expected to last. Dr. Sanchez stated that phase II should be completed close to the end of the year, at which point they would then follow the patients for a period of time. It is anticipated that more information about this procedure will be available in 1-2 years.

## **7. Motion Preserving Technologies (Spine Devices)**

Mr. Joe Gatewood provided background information regarding the Spine Task Force, a group of 14 companies from the orthopedic industry who worked to identify non-fusion spinal stabilization procedures currently being performed (or that are in development) and to draft coding options to describe these procedures. Bart Sachs, MD conducted a clinical presentation on the indications for each of the three categories of non-fusion stabilization procedures or devices, (interspinous process devices, pedicle screw based dynamic stabilization systems and facet replacement devices) which are now referred to

as motion preserving technologies. Mady Hue led a discussion on the coding proposals. Numerous commenters appeared to agree with the creation of a new subcategory to describe these procedures; however, they strongly recommended that the language in the code titles and inclusion terms be consistent with physician documentation found in the medical records. Several commenters indicated they do not currently see the terminology presented in the code proposal in actual records. These same commenters suggested making the coding options simpler and to work with physician specialty groups on standardizing the terminology. Other commenters expressed concern and confusion over the difference between the code titles for code 84.58, Implantation of interspinous process decompression device and proposed code 84.80, Insertion or replacement of interspinous process device(s). One commenter stated that code 84.58 is the only code that currently exists to describe the FDA approved X Stop™ decompression device implantation procedure. This same commenter stated for that reason, it should not be moved into another code as it is the only procedure that is FDA approved. Another commenter questioned the difference in options 2 and 3 with the removal of all the devices being represented with one code, 80.09 (Arthrotomy for removal of prosthesis, spine) and asked if it is important to track the various devices. Dr. Sach's responded that there could be a need to track the removals separately with the example of removing one device, being able to track what was removed and why, as well as, the insertion of another type of motion preserving device. There was general support to bring this topic back for discussion at the March 2007 meeting.

## **8. Addenda**

Mady Hue facilitated a discussion on the addendum proposal. One commenter noted that the term "peripheral" has been used throughout the code book for years and preferred keeping that terminology over the proposed "non-coronary" verbiage as it could potentially cause confusion among coders about proper code assignment. Another commenter questioned if a code also note would be added to the hip resurfacing codes since the proposal to revise the current code title of hip bearing surface codes would allow their use with hip replacements, hip revisions, and hip resurfacing procedures. The response was yes, there would be a code also note added at the hip resurfacing codes instructing coders to code the type of bearing surface if known. Overall, there was general support for the addendum as proposed.

## **9. ICD-10-PCS**

Rhonda Butler led a discussion on the revisions made to ICD-10-PCS for 2007. She explained the current format of ICD-10-PCS is the same as the 2006 version with a number of separate pdf files. One commenter suggested creating a computer program or an electronic tool for colleges to teach ICD-10-PCS to their students. There is concern that potential implementation of ICD-10-PCS is not too far away and they would like to be prepared. A PowerPoint presentation of her discussion is posted on the CMS web page.