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

March 22-23, 2007

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 March 22, 2007 and was conducted by staff from the Centers for Medicare & Medicaid Services (CMS). The diagnosis portion of the meeting was held on March 23, 2007 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 March 22, 2007 meeting are being considered for implementation on October 1, 2007. A detailed timeline was included in the handouts. Pat Brooks reviewed important dates within the timeline with the meeting participants. The participants were encouraged to refer to the timeline for future meeting information and the deadline for receipt of public comments. 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/ICD9ProviderDiagnositicCodes .

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 April 13, 2007.

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

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 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 September 27-28, 2007 meeting beginning August 16, 2007. The registration process will close on September 21, 2007. Therefore, those wishing to attend the meeting must register online between August 16 and September 21, 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 will be posted on the website for viewing after the 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 September 27-28, 2007. As stated earlier, the online registration for this meeting will begin on August 16, 2007 and close on September 21, 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 are able to 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

There were no requests for an ICD-9-CM code to be implemented on April 1, 2007 at the September 28, 2006 ICD-9-CM Coordination & Maintenance Committee meeting. Therefore, **there will be no new ICD-9-CM codes implemented on April 1, 2007.**

Topics:

1. Intra-operative Electron Radiation Therapy (IOERT)

Joel Tepper, MD and Benjamin Calvo, MD conducted a clinical presentation on how intra-operative electron radiation therapy (IOERT) is brought to patients in the operating room (OR) and may improve patient safety, decrease overall operative time and impact treatment outcomes. Pat Brooks facilitated a discussion on the coding proposal. IOERT is a specialized intensive radiation treatment administered during surgery directly to the cancer tumor or tumor bed while normal tissues are displaced or protected, thereby increasing the effective dose to the tumor substantially. There was no opposition from the audience participants. The participants expressed support for option 2; create a new code to clearly identify the use of a mobile unit, located within the operating room suite to deliver an initial dose of IOERT therapy as part of the operative procedure. This option involves creating a new chapter, 3a. Additional Procedures and Interventions, NEC (17), with new category 17 and new code 17.10, Intra-operative electron radiation therapy.

2. Intra-operative Neurophysiologic Monitoring

Mark Stecker, MD led a clinical presentation on how the use of intra-operative neurophysiologic monitoring (IOM) techniques are an important tool used to prevent injury to the brain, spinal cord, cranial and peripheral nerves during certain surgical procedures. IOM involves using either one or more neurophysiologic testing techniques in real time in the OR to assess the integrity of critical neural structures. One commenter asked how invasive the procedure is. Dr. Stecker explained that the procedure is not very invasive and is intended to assist the surgeon who is performing complex surgery. This same commenter then stated that there are a variety of neurophysiologic tests and asked what documentation could expect to be seen and if the surgeon would include it in their report. Dr. Stecker replied that the neurophysiologist creates the report and every diagnostic study becomes a part of that report. He further stated that the surgeon is supposed to report the monitoring that is performed during the procedure. Another commenter asked what types of terms would the coders see documented. This commenter had experience in coding these tests and suggested specific terminology that would be helpful if listed as inclusion terms for the proposed new code. Dr. Stecker agreed to send additional language that could be considered for inclusion terms. One commenter expressed support for this proposal and stated it is expected to become a quality measure down the road. Another commenter asked if current code 89.58, Plethysmogram, that includes penile plethysmography with nerve stimulation, would be included in this new proposed code. Dr. Stecker stated it should not be an issue as that procedure involves a different type of testing. One commenter asked if it would be necessary to have at least three codes reported; one for the principal procedure, one for the testing and one for the IOM. This commenter also expressed the need for a code also note at the proposed new code instructing coders to code the principal procedure performed. Pat Brooks responded that it should not be necessary to have a code also note at the proposed new code instructing coders to code the principal procedure, however it can be considered. Another commenter suggested adding a code also note at the proposed new code to report the specific type of testing performed. There was general support for that suggestion. Another commenter stated clarification is needed in the form of Coding Clinic education as coding for this type of testing can be confusing. Although some minor concerns with documentation were expressed, there was general support for option 2, create a new code for intra-operative neurophysiologic monitoring. This code would be located at subcategory 00.9, Other procedures and interventions, identified by new code 00.94, Intra-operative neurophysiologic monitoring.

3. Thoracoscopic Procedures

Joe Kelly, MD continued the discussion that began at the September 2006 meeting, providing an overview of how the thoracoscopic approach could be applied to a number of current therapeutic procedures. The proposal focused on tissues of the lung and thymus. One commenter suggested adding the term “open” to the existing codes. Another commenter recommended deleting the term “destruction” from the proposed exclusion term at code 32.25, Thoracoscopic ablation of lung lesion or tissue. The terms

ablation and destruction may be used synonymously for certain procedures, therefore, the commenter stated it may cause confusion. One commenter stated the inclusion term "Thymopexy" under code 07.99, Other operations on thymus, other, which was proposed to be deleted may have been a WHO (World Health Organization) term. There was overall support for option 2, to create new thoracoscopy codes for procedures including excision of thymus, excision of lung, and resection of lung.

4. STARR Procedure for Males

Anthony Senagore, MD conducted a clinical discussion regarding the stapled transanal rectal resection (STARR) procedure. Dr. Senagore informed the audience that the STARR procedure is a rectal repair, rather than a rectocele repair. Ann Fagan facilitated discussion of the coding proposal. Ann explained how CMS had received a request to create a code for male patients, as the existing code, 70.52, Repair of rectocele, is located in the Procedure chapter 12, Operations on the Female Genital Organs. Dr. Senagore explained that the STARR procedure is performed on patients with chronic outlet constipation and internal rectal prolapse. The participants were in agreement that this issue can best be resolved by an index change, directing coders to 48.76, Other proctopexy, to document the STARR procedure. Interim coding should follow the procedure index for female patients, and 48.76 for males.

5. Transjugular Liver Biopsy

Amy Gruber facilitated the discussion regarding transjugular liver biopsy which is an alternative to traditional methods of liver biopsy. Traditionally, the most direct approach for a liver biopsy is percutaneously via a needle directly through the skin and into the liver. A liver biopsy can also be performed using a laparoscope, or at the time of open abdominal surgical procedures. With the transjugular approach, a small catheter is inserted into the right internal jugular vein in the neck. This procedure is particularly useful when an increased risk of bleeding is present, which is very common with liver disease, because it is less traumatic than the percutaneous approach. One commenter recommended creating a separate code for the laparoscopic approach, currently assigned to code 50.19, Other diagnostic procedures on liver, since we are proposing to create a unique code for the transjugular approach. There was general support for option 2, create a new code to describe a transjugular liver biopsy. This code would be created under subcategory 50.1, Diagnostic procedures on liver, identified by proposed new code 50.13, Transjugular liver biopsy. One commenter questioned whether code 50.11, Closed (percutaneous) [needle] biopsy of liver, should be assigned as a current code assignment for the transjugular liver biopsy as opposed to code 50.19, Other diagnostic procedures on liver, which was the instruction given in the handout. It was stated at the meeting that CMS would further evaluate this issue. CMS has reviewed this issue and agrees that code 50.11 is the appropriate interim code assignment to capture transjugular liver biopsy until a new code can be created.

6. Recalled Devices

Ann Fagan presented an overview of CMS' initiative to identify cases in the Medicare population where recalls of failed implanted devices have occurred. Discussion was held concerning the best way to indicate that a device has been recalled by the Food and Drug Administration, a manufacturer, or through a voluntary field action and replaced during a hospital stay. Comments from the audience suggested that creation of a procedure code at 17.20 was inappropriate; the most appropriate code would be a diagnosis code in the V-code section of ICD-9-CM. The discussion turned to changes made to the Condition Codes by the National Uniform Billing Committee (NUBC); codes 49 and 50 were recently created to capture such recall device information. The attendees were in favor of Option 1: Do not create a new code to describe a device which has been recalled by the manufacturer and replaced during that stay.

7. Motion Preserving Technologies

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. Hansen Yuan, 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 revised coding proposals. This topic was previously presented at the September 2006 meeting; however the commenters agreed to bring the topic back for discussion after addressing concerns related to the terminology and documentation. One commenter stated that option 3a would help preserve space for billing and reporting purposes. Another commenter supported identifying the surgical decompression with the procedure performed, stating it addresses the issue of resource use. Several commenters supported option 2; deleting current code 84.58, Implantation of interspinous process decompression device, and creating new subcategory 84.8, Insertion, replacement and revision of posterior motion preservation spinal stabilization device(s) with the modification to add a code also note for code 03.09, Other exploration and decompression of spinal canal. The modification would also include a note to clarify that for these procedures the surgical decompression does not constitute an operative approach.

8. Addenda

Mady Hue facilitated a discussion on the addendum proposal. There was no opposition and overall 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. She then described the new General Equivalence Maps

(GEMs). Rhonda stated the GEMs are reference maps and should not be considered a crosswalk since there is not a one-to-one match between the systems for each code. The GEMs consist of two mappings, ICD-9-CM to ICD-10-PCS and ICD-10-PCS to ICD-9-CM. Additional information within each file is specified using flags. Participants were informed that the Documentation and User's Guide is posted at the following address: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/Downloads/GEMguide.pdf One commenter stated that the User's Guide is written in an excellent format that makes it very easy to understand. A PowerPoint presentation of Rhonda's discussion is also posted on the CMS web page.