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 9-10, 2010

PROCEDURE DISCUSSIONS

Introductions and Overview

Pat Brooks welcomed the participants to the ICD-9-CM Coordination and Maintenance (C&M) Committee meeting. She shared the tragic news that CMS has lost one of its valued employees. Joe Kelly, MD, a regular participant at the C&M meetings and the Editorial Advisory Board for Coding Clinic meetings was killed on February 27, 2010 in a plane crash. Joe Kelly was a valuable member of the coding and DRG team and assisted in the preparation of all the coding proposals presented at the meeting. The coding team and the rest of CMS greatly miss Joe.

Approximately 200 participants registered to attend the meeting. CMS was able to provide phones lines for additional participants to listen to the discussions. A total of 225 phone lines were provided on a first come, first serve basis for callers to listen to the presentations. The agenda and handouts were posted on CMS' and CDC's websites in advance of the meeting to allow listeners to follow the discussions. The PowerPoint slides used by the clinical presenters could not be posted on the website since they did not meet posting restrictions. Callers were able to make comments or ask questions during the meeting. Everyone was encouraged to send their written comments after the meeting.

Pat also announced that CMS and CDC have "gone green" for this meeting. We will no longer be making paper handouts of the proposal package. This information was included on the meeting announcement and on the website. Those who wish to have a copy of the handouts will need to print their own copies prior to the meeting. To facilitate discussions, PowerPoint slides of the coding options and CMS recommendations were developed.

The procedure portion of the meeting was held on March 9, 2010 and was conducted by staff from the Centers for Medicare & Medicaid Services (CMS). The diagnosis portion of the meeting was held on March 10, 2010 and was conducted by staff from the Centers for Disease Control and Prevention (CDC). Discussion of ICD-10 topics was scheduled for the morning of March 9, 2010 and was jointly led by CMS and CDC.

An overview of the C&M Committee was provided. Procedure code issues discussed at the March 9, 2010 meeting are being considered for implementation on October 1, 2011. 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. Important dates include the following:

April 2, 2010	Deadline for receipt of public comments on proposed code revisions discussed at the March 9, 2010 ICD-9-CM Coordination and Maintenance Committee meetings for implementation of October 1, 2010.
April 2010	Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This notice will include the final ICD-9-CM diagnosis and procedure codes for the upcoming fiscal year. It will also include proposed revisions to the DRG system on which the public may comment. The proposed rule can be accessed at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp
April 2010	Summary report of the Procedure part of the March 9, 2010 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Summary report of the Diagnosis part of the March 10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
June 2010	Final addendum posted on web pages as follows: Diagnosis addendum at - http://www.cdc.gov/nchs/icd9.htm Procedure addendum at – http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes
July 16, 2010	Deadline for requestors: Those members of the public requesting that topics be discussed at the September 15-16, 2010 ICD-9-CM Coordination and Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses by this date.
August 13, 2010	On-line registration opens for the September 15-16, 2010 ICD-9-CM Coordination and Maintenance Committee meeting at: http://www.cms.hhs.gov/events
September 15 – 16, 2010	ICD-9-CM Coordination and Maintenance Committee meeting.

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.**

The public is offered an opportunity to submit additional written comments by mail or e-mail until April 2, 2010. E-mail comments are preferred since this avoids delays in mailroom screenings and deliveries.

Comments on the **procedure** part of the meeting should be sent to:
Pat Brooks
Patricia.brooks2@cms.hhs.gov

Comments on the **diagnosis** part of the meeting should be sent to:
Donna Pickett
Dfp4@cdc.gov

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 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 above as well as on the ICD-9-CM homepage.

Process for requesting code revisions

The process for requesting a coding change was explained, and is explained on the ICD-9-CM CMS website. 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 identified 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 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 at the meeting as well as in writing after the meeting. 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.

April 1 code updates

It was announced that there will be no new procedure codes implemented on April 1, 2010.

Final decisions on new ICD-9-CM codes

As indicated in the timeline, the public is informed of approved ICD-9-CM code title updates through the inpatient prospective payment system (IPPS) proposed rule. This proposed rule is anticipated to be published in April 2010. Any codes approved after the March 9-10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting will be included in the IPPS final rule published by August 1, 2010. A complete copy of the addendum will be published on CMS and CDC's websites by early June 2010.

Topics:

1. ICD-10 Updates

General Equivalence Mapping (GEMs) Discussions

The 2010 ICD-10-CM and ICD-10-PCS GEMs are posted on CMS' website at http://www.cms.hhs.gov/ICD10. The ICD-10-CM GEMs are also posted on CDC's website at http://www.cdc.gov/nchs/icd/icd10cm.htm Providers and payers are beginning to use the GEMs to convert their payment systems, edits, quality measures, and other systems from ICD-9-CM to ICD-10. By doing so, issues and questions about the GEMs have been raised. Based on these questions and feedback, CMS has updated the 2009 GEMs in response to these issues. We greatly appreciate the feedback received, and welcome any additional feedback as others apply the GEMs to their conversion activities.

Pat Brooks asked if anyone in the audience wanted to share their experiences in undertaking any ICD-10 conversion projects. Information such as lessons learned or other suggestions was requested. No one shared additional conversion experiences.

The participants were also asked to identify any additional updates that might be needed to the GEMs. Subsequent to the meeting, participants were urged to continue sharing questions and feedback with CMS and CDC on the GEMs. This information will be used in preparing the 2011 GEMs.

Freezing of Codes Prior to Implementation of ICD-10

At the September 2009 C&M meeting, extensive discussions took place on the issue of whether or not there should be a partial freeze of ICD-9-CM and ICD-10-CM/PCS codes prior to the implementation of ICD-10 on October 1, 2013. Considerable interest was expressed in dramatically reducing the number of annual updates to both coding systems. It was suggested that such a reduction in code updates would allow vendors, providers, system maintainers, payers, and educators a better opportunity to prepare for the implementation of ICD-10. A summary of these discussions at the September 16-17, 2009 ICD-9-CM Coordination and Maintenance Committee can be found in the Summary Report for that meeting at: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp

Subsequent to this meeting, additional public comments on this issue were received. Most of the comments are supporting an announcement of a limited freeze of both ICD-9-CM and ICD-10 coding systems. Based on these oral and written comments, CMS made the following recommendation in order to obtain additional comments.

Recommendation: Based on these comments we recommend that the last regular, annual updates to both ICD-9-CM and ICD-10 would be made on October 1, 2011. On October 1, 2012 there would be only limited code updates to both ICD-9-CM and ICD-10 coding systems to capture new technologies and diseases. On October 1, 2013 there would be only limited code updates to ICD-10 to capture new technologies and diseases. Any other coding issues raised would be considered for implementation in ICD-10 on October 1, 2014, a year after ICD-10 is implemented. Regular updates to ICD-10 would continue beginning with October 1, 2014. We propose that a final decision on the issue of a partial code freeze be announced at the September 15-16, 2010 ICD-9-CM Coordination and Maintenance Committee meeting after providing time for additional input on this issue.

Request for additional comments on this recommendation

CMS and CDC are interested in receiving additional comments on this issue discussed at the March 9-10, 2010 ICD-9-CM Coordination and Maintenance Committee meeting. We encourage the submission of additional written comment to Pat Brooks (patricia.brooks2@cms.hhs.gov) and Donna Pickett (dfp4@cdc.gov). We also request comments on when a final decision should be made.

The participants were very supportive of the recommendation to make the last major update to both coding systems on October 1, 2011. Several commenters stated that this was quite reasonable and that two years was an appropriate time for reduced code updates. Commenters stated that it was important to have a stable system for two years prior to ICD-10 implementation. One commenter stated that having a shorter freeze, such as October 1, 2012 would not be beneficial. Commenters supported this recommendation since they believed it would allow them to have time to plan for ICD-10 implementation. Several commenters were pleased that there would be a means to implement a limited number of diagnosis and procedures codes to capture new technologies and diagnoses.

One commenter representing a physician specialty group also supported this recommendation. The commenter stated that this would allow time for her specialty group to educate their members about ICD-10.

One commenter expressed concern about the effect this would have on DSM-V. The American Psychiatric Association (APA) is working to finalize their next major revision of DSM. It is hoped that this next revision would be ready to implement on October 1, 2012. This would be a significant revision and would hopefully match ICD-10. The APA felt it would be beneficial to implement this major change to the ICD-9-CM codes in the year prior to ICD-10 so that providers could gain experience with these codes.

ICD-10 Vendor Products

It was announced that the following organizations offer providers and others ICD-10 resources:

WEDI (Workgroup for Electronic Data Interchange) http://www.wedi.org

HIMSS (Health Information and Management Systems Society)
http://www.himss.org/icd10

ICD-10-PCS 2010 Updates

Pat informed the participants that a 2010 Version – What's New document is posted on the CMS website which gives an overview of changes included in the 2010 version. This can be found at http://www.cms.hhs.gov/ICD10/01k_2010_ICD10PCS.asp#TopOfPage

Rhonda Butler, 3M, provided an overview of updates being proposed for the 2011 version of ICD- 10-PCS. A detailed description of these proposals is included in the handouts for the meeting.

2. Central Venous Catheter Placement Using Intra-Atrial Electrocardiographic Guidance

Peter Rothenberg, MD, facilitated a clinical presentation on the Sherlock 3CG TPS System, a new device that combines electrocardiography with catheter insertion in order to accurately place the catheter tip in the proper position in the superior vena cava. Information provided by ECG-guided catheter tip placement technology gives the clinician rapid feedback so that catheter tip misplacements can be readily detected and corrected, if necessary. Pat Brooks led the coding proposal discussion. One commenter asked if Dr. Rothenberg could explain the kind of complications he was referring to when he indicated a reduced complication rate results when appropriate catheter placement is utilized. Dr. Rothenberg stated that it has been shown to decrease the incidence of venous thrombosis. Another commenter asked how this procedure would be reported with regards to other documented catheter placements, such as a PICC line. Dr. Rothenberg responded that ECG-guidance using the Bard technology has been used with several procedures, including ports and peripherally inserted central catheters (PICC). He also added that ECG-guidance alone is not available in the US and that the technology does not work on patients who are experiencing atrial fibrillation or for patients who are pacemaker dependent. There were no comments received from participants on the phone lines. Overall, participants did

not express overwhelming support either for or against creation of a new code. They were encouraged to send in any additional comments by the April 2, 2010 due date.

3. Closed Chest Intra-Cardiac Mitral Valve Repair

D. Scott Lim, MD, conducted a clinical presentation on a minimally invasive, closed chest catheter based approach for intracardiac repair of mitral regurgitation using the MitraClip® device. The procedure is performed while the heart is beating, and is an alternative to the open chest, open heart surgical approach. Ann Fagan led the coding proposal discussion. One commenter questioned why there was a need for a new code when existing code 35.96, Percutaneous valvuloplasty, appears to appropriately describe the procedure since it is also percutaneous. Dr. Lim explained that code 35.96 is percutaneous, however, it is performed for a completely different purpose and the MitraClip® is novel. The same commenter then asked what makes the procedure using the MitraClip® novel – is it lack of a balloon and a different disease process? Dr. Lim stated that the MitraClip® is a permanent implant versus the balloon (that is used in the procedure described by code 35.96) which is not an implant. Another commenter applauded CMS for addressing this issue by proposing a new code. This commenter stated that the current codes do not reflect current technology. In addition, the commenter noted that today, patients are sicker, older, more expensive, and more challenging. This commenter stated their belief that the new technology will reflect advances in treatment. One commenter expressed support for a new code; however, this commenter stated their dislike of the terminology "endovascular" in the proposed new code title. The commenter stated there is not enough distinction with the terminology since both "percutaneous" and "endovascular" describe the procedure. This commenter suggested revising the proposed code title to reflect how the vessel is accessed. The commenter questioned if the size of the catheter had any impact on whether it was more appropriate to refer to the procedure as being performed percutaneously versus endovascularly. Dr. Lim indicated no, the catheter size was not a determining factor when describing the procedure. . This same commenter suggested adding the terms "permanent device" and/or "insertion" into the code title. Another commenter recommended using the term "transcatheter" in the code description stating that the size of the catheter does not matter. This commenter stated a new code is needed to follow and track outcomes that accurately tells what was done. There were no comments received from participants on the phone lines. There appeared to be general support to create a new code, with consideration for a revised code title.

4. Thoracoscopic Cardiac Ablation (maze) Procedure

Andrew Wechsler, MD, provided a clinical presentation on the various approaches that have become available to perform cardiac ablation or the "maze" procedure. This procedure treats atrial fibrillation by creating lesions in the tissue of the left and right atrium of the heart and can be performed using an open, thoracoscopic, or endovascular approach. Ann Fagan led the coding proposal discussion. Two commenters expressed support for creating a new code to identify the thoracoscopic approach and make revisions to the existing codes for an open and endovascular approach. One commenter asked how many cardiac ablation procedures are performed according to each of the approaches discussed. Dr. Wechsler responded that the most common approach utilized in cardiac ablation is a catheter based or endovascular technique. The commenter then asked about the rate of complications associated with each approach for the procedure. Dr. Wechsler responded that the complication rates are comparable and that catheter based procedures are rarely successful on the first attempt. Many facilities are currently moving

towards a combined approach. He stated that the thoracoscopic procedures are quicker to perform and may often be followed up with the catheter based approach. Also, due to the number of hospitalizations a patient may undergo, it is difficult to track outcomes without having distinct codes for each approach. Another commenter questioned if it would be appropriate to report an additional code such as 17.45, Thoracoscopic robotic assisted procedure, to describe the thoracoscopic approach along with code 37.33, Excision or destruction of other lesion or tissue of heart, open approach. This commenter asked if there were robotics involved with the procedure. The response was no. There were no comments received from participants on the phone lines. There appeared to be general support for creation of a new code and making revisions to the existing codes.

5. Fat Grafting for Reconstructive Surgery

Steven Cohen, MD, facilitated a clinical presentation on the process of harvesting fat and the new techniques that have been developed to enrich the fat for grafting. The enriched fat grafts are thought to encourage neoangiogenesis and prevent cell death, likely enhancing graft survival. Amy Gruber led the coding proposal. One commenter, who worked with the requestor of the proposed codes, supported the proposal to create 5 new codes to describe fat grafts and harvesting fat for grafting stating that they have reviewed over 6,000 cases and it is frustrating that there are currently no appropriate codes to assign for reporting fat grafting. This commenter further noted that this procedure is real tissue grafting and therefore codes to identify fat grafting used in breast reconstruction, as well as, fat grafting to other parts of the body should be created. This same commenter opposed the use of code 86.83, Size reduction plastic operation, to describe harvesting of the fat graft, citing it is not appropriate. Another commenter expressed concern about the documentation that would be available to clearly identify that a fat graft *with* use of an enriched graft versus a fat graft *without* the use of enriched graft was utilized in a procedure. However, this commenter supported codes that would identify fat grafts. There were no comments received from participants on the phone lines.

6. Sternal Fixation with Rigid Plates

Arthur T. Martella, MD, conducted a clinical presentation about the Synthes Titanium Sternal Fixation System (TSFS), a type of rigid plate fixation system that is intended to assist in the prevention of sternal dehiscence and deep sternal wound infections to patients undergoing cardiothoracic surgery. Participants in the audience expressed general support for the proposal to create a new code, 84.94, Insertion of sternal fixation device with rigid plates, to describe this procedure. There were no comments received from participants on the phone lines.

7. Laparoscopic Hernia Repair Without Mesh

Mady Hue presented a coding proposal in response to a request received for the creation of new codes to identify a laparoscopic hernia repair without mesh. One commenter stated they agreed with the CMS recommendation to not create new codes since the volume in which these procedures are performed is so low. There were no comments received from participants on the phone lines. There appeared to be general support for the CMS recommendation to not create a new code.

8. Cranial Implantation of Neurostimulator

Martha Morrell, MD, and Robert Worth, MD, conducted a clinical presentation on the RNS System, a technology designed for the treatment of medically refractory localization-related (focal) (partial) epilepsy. The leads are implanted through burr holes and/or a craniotomy in the area(s) of seizure onset in the brain followed by the neurostimulator implantation in the patient's skull in a single-stage procedure. Amy Gruber led the coding proposal discussion. One commenter expressed support for two new codes but questioned the interim coding advice for the implantation or replacement and removal of the pulse generator since the recommended codes 86.95, Insertion or replacement of dual array neurostimulator pulse generator, not specified as rechargeable, and code 86.05, Incision with removal of foreign body or device from skin and subcutaneous tissue, are listed under category 86, Operations on skin and subcutaneous tissue. The commenter suggested the assignment of code 02.99, Other operations on skull, brain, and cerebral meninges, for these procedures. Amy responded that CMS would take the comment under advisement. Another commenter recommended creating an analogous "V" code to note the status of these patients for quality measure purposes. Amy indicated that representatives from the Centers for Disease Control's, National Center for Health Statistics, were in the audience and could make a note of that request for future consideration. One commenter suggested adding a code also note for the cranial implantation or replacement of neurostimulator pulse generator at existing code 02.93, Implantation or replacement of intracranial neurostimulator lead(s). Another commenter also recommended adding "subcutaneous" to the code also note to reflect the different types of generators. This commenter also supported the creation of new codes and asked why new codes could not be created at category 02.9, Other operations on skull, brain, and cerebral meninges, which is the same category as the implantation or replacement of the intracranial neurostimulator lead. Amy responded that the proposed codes were assigned under category 01.2 since that is the craniotomy and craniectomy category. There were no comments received from participants on the phone lines. There appeared to be general support for the CMS recommendation to create new codes.

9. <u>Intralaminar Lumbar Decompression and Laminotomy with Epidurography and Image Guidance</u>
Lora Lee Brown, MD, provided a clinical presentation on the *mild*® (minimally invasive lumbar decompression) technology. This technology uses specialized devices to perform lumbar decompressive procedures for the treatment of a variety of spinal conditions. The intralaminar lumbar decompression procedure with epidurography and image guidance is for the treatment of lumbar spinal stenosis. Mady Hue led the coding proposal discussion. One commenter expressed support for the creation of a new code and questioned how many cases have been performed to date. Dr. Brown responded that approximately 600 cases have performed in the US to date. Another commenter stated that a decompression usually removes the lamina and questioned if any debulking was involved. Dr. Brown replied, yes, a laminotomy and debulking are performed. The commenter also questioned if the laminotomy was performed only to access the ligamentum flavum because there is an exclusion term at existing code 03.09, Other exploration and decompression of spinal canal, instructing coders to omit that done as an operative approach. This same commenter expressed concern with the title of the proposed new code, specifically about the terms "intralaminar" and "laminotomy" being in the title; however the commenter did support the creation of a new code. The commenter also suggested the possibility of using 2 codes, one to describe when the procedure is used to only resect the ligamentum flavum. The commenter also proposed considering adding an inclusion term to state "includes that via laminotomy". A commenter from the phone lines supported CMS'

recommendation to create a new code. There appeared to be general support for the creation of a new code along with revisions to the proposed code title for consideration.

10. Biopsy of Soft Tissue Mass

Ann Fagan presented a coding proposal in response to a request received to address coding for a closed biopsy of soft tissue. Currently, code 83.21, Biopsy of soft tissue, does not identify that a *closed* biopsy of soft tissue was performed. The proposal also included modifications to existing code 86.11, Biopsy of skin and subcutaneous tissue. Two commenters opposed making revisions to existing code 86.11. There were no comments received from participants on the phone lines. There appeared to be general support for the creation of a new code.

11. Continuous Glucose Monitoring

Steven D. Wittlin, MD, facilitated a clinical presentation on two recently developed methods for continuous glucose monitoring in the inpatient setting. Both techniques involve the use of a probe and allow for blood glucose values and interstitial glucose values to be displayed on a monitor against the targeted range. Amy Gruber led the coding proposal discussion. One commenter stated there have been several monitoring codes created and questioned if any of the recently created codes are reported. This commenter stated coders do not currently code blood tests and expressed concern about creating new codes that would never be used. This same commenter further noted that the quality measures referenced in the proposal focus on glucose control as opposed to the tests used. Another commenter reported that at their organization, coders do not code inpatient, volume 3 procedure codes for lab services and that CPT (Current Procedural Terminology) has codes to identify those services. This commenter also questioned if this glucose monitoring would be considered as a nurse technician type of service. Dr. Wittlin responded that an intravenous (IV) line could be inserted by a physician or a technician. The commenter expressed support to create new codes as described in option 2 of the coding proposal. One commenter, who worked with the requestor on the proposed codes, stated that this service is not a lab test and that there are lots of monitoring codes that have been created. This commenter also stated that ICD-10-PCS has an entire section on measurement and monitoring also. This commenter stated the data may be useful and also supported creating new codes to describe continuous glucose monitoring. Another commenter stated they felt conflicted but liked the proposal to create new codes. The commenter stated that this is a huge clinical issue and would show that a hospital tried to do something about a quality of care problem. This commenter then asked if coders would use these new codes and if MedPAR would process them. Participants discussed that up to six procedure codes could be reported for MedPAR to process. A commenter questioned how this procedure would be documented, stating that coders do not code from nursing documentation. This commenter stated a doctor would have to document it clearly or it would not be reported. Dr. Wittlin noted that initially, this technology would be used in cardiothoracic units or CCUs. Another commenter noted that the data is important, however, this type of practice is not captured in ICD-9-CM codes and would be better found in the electronic health record (EHR) as a terminology issue in contrast to a coder issue. There were no comments received from participants on the phone lines.

12. Circulating Tumor Cell Enumeration Test

Ralph V. Bocchia, MD, conducted a clinical presentation on the CellSearch® Circulating Tumor Kit which is intended for the enumeration of circulating tumor cells (CTC) of epithelial origin

(CD45-, EpCAM+, and cytokeratins 8, 18+, and/or 19+) in whole blood. The presence of CTC in peripheral blood is associated with decreased progression free survival and overall survival in patients treated for metastatic breast, colorectal, or prostate cancer. Amy Gruber led the coding proposal discussion. One commenter asked from a diagnosis standpoint, if this technology would be used for staging criteria. Dr. Bocchia responded that it is not used at this time. The commenter then questioned if it would be helpful in the future to have the number of cells added to the diagnosis code to establish severity. The commenter noted that if the cells are attracted with a magnet then why couldn't they help to get the cells out of the body entirely? Dr. Bocchia answered that the magnet attracts a small fraction of the total number of cancer cells. Another commenter asked if the test is performed primarily for outpatient since coders do not assign these codes. This information is usually identified in the chargemaster and not seen in the data. The commenter stated that if the measures for this testing are mainly outpatient then CPT codes should be reviewed. Dr. Bocchia replied that it is performed in the outpatient primarily; however, it is used to evaluate progression in the inpatient setting. There were no comments received from participants on the phone lines. There did not appear to be overwhelming support for or against the creation of a new code.

13. Intra-operative Angiography in CABG

Bruce T. Ferguson, MD, facilitated a clinical presentation on the two technologies currently available for intra-operative coronary angiography, 1.) X-ray coronary angiography with cardiac catheterization and fluoroscopy and 2.) Intra-operative fluorescence vascular angiography (IFVA). Michael Zenn, MD, discussed the use of IFVA (SPY technology) in non-coronary intra-operative surgical procedures. Mady Hue led the coding proposal discussion. One commenter stated they were confused with the proposal since they believed SPY was originally for coronary procedures and asked if the intent is to identify that IFVA can now have non-coronary applications as well. The commenter stated they agreed with the CMS recommendation to not disrupt the data. Mady stated it is a confusing proposal and that originally, the intent of SPY was for coronary applications, however, when code 88.59 (IFVA) was created, the decision was made not to specifically identify "coronary" within the title because of the potential use for non-coronary applications in the future. Mady then added that the requestor's goal, as she understands it, is to have one unique code to identify intra-operative completion angiography (by any means) as option 3 displayed with the proposal to also revise existing code 88.59. Dr. Ferguson responded that things are moving quickly and at the time code 88.59 was created, SPY technology use in other areas was only experimental. Dr. Ferguson continued, stating that a subset of patients are currently not being captured and that a code is needed to describe completion angiography in conjunction with a CABG. One commenter stated that prior to code 88.59 being created, code 88.90, Diagnostic imaging, not elsewhere classified, was assigned to describe the IFVA technology. This commenter stated there is a distinction between diagnostic and completion angiography. Another commenter stated the concern with option 3, combining both types of intra-operative coronary angiography, is that it loses the ability to distinguish between completion angiography with or without radiation and that this is a quality issue. One commenter recommended keeping code 88.59 as coronary so as not to disrupt trend data. Dr. Ferguson stated that the number of hybrid operating rooms is increasing and cardiac catheterizations via X-ray angiography are being performed in them. Dr. Ferguson also noted that there are 2 issues to consider. The first issue is that the SPY technology is now applicable outside of the coronary area and second, in the coronary space,

patients are not being captured that receive diagnostic cardiac catheterizations versus cardiac catheterizations in the operating room or in a hybrid operating room, intra-operatively. There were no comments received from participants on the phone lines. It was clear that the requestor's proposal was confusing for participants; therefore, Mady stated that it is not unusual to bring back a proposal when a difficult topic is discussed, as CMS has done in the past. Mady encouraged participants to submit written comments for consideration by the deadline.

14. Addenda

Mady Hue explained that the proposed revisions to the spinal fusion codes would also apply to the spinal refusion codes. She also provided a brief background from the discussion and comments that took place at the September 2009 meeting. Mady indicated that there was support to identify which column was being fused and to incorporate additional inclusion terms that were discussed from the last meeting.

During and after the comment period from September's meeting, requestors asked to see how all the updated revisions would appear, therefore, all the proposed updated terms were included for further review and comment. The updated spinal fusion proposal included a request to further revise the "Note" at subcategory 81.0, Spinal fusion, which provides clarification on what an anterior versus a posterior column fusion consists of and the various techniques that may be utilized for each procedure. It also included a request to replace the term "technique" used as an inclusion term at some of the codes with the term "fusion". One commenter suggested adding "posterior technique" to the title of code 81.04 so it would be revised to read "Dorsal and dorsolumbar fusion of the anterior column, anterior or posterior technique." This commenter stated that the proposed inclusion term "extracavitary technique" is performed by placing the patient in a prone position and elevating the paraspinous muscles from the spinous processes, therefore a posterior approach. The commenter expressed concern that coders may be confused since currently the title only refers to the anterior approach.

Another commenter had requested that CMS propose to assign the AxiaLIF procedure to code 81.06, Lumbar and lumbosacral fusion, anterior technique, versus where it is currently assigned to code 81.08, Lumbar and lumbosacral fusion, posterior technique. Mady explained that the requestor states that in the AxiaLIF procedure, access to the spinal column is a retroperitoneal approach, and therefore, they note it is clinically appropriate to have the procedure assigned there. Two commenters expressed concern with this request since the approach for the AxiaLIF is a posterior approach. These commenters stated their belief that it was more appropriate to leave AxiaLIF as an inclusion term at code 81.08.

Ann Fagan reviewed the proposed addenda revisions for the heart (maze) related procedures. One commenter recommended removing the proposed "default" code of 37.34, Excision or destruction of other lesion or tissue of heart, open approach, at the main term Excision, followed by the subterms lesion and heart. This same commenter also suggested removing the subterm for "other approach" at the same location.

There were no comments received from participants on the phone lines. The participants were encouraged to send in additional comments for consideration and review by the due date of April 2, 2010.