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 19-20, 2008

## 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 19, 2008 and was conducted by staff from the Centers for Medicare & Medicaid Services (CMS). The diagnosis portion of the meeting was held on the afternoon of March 19 and all day on March 20, 2008 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 19, 2008 meeting are being considered for implementation on October 1, 2008. 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 11, 2008.

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 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 on the ICD-9-CM homepage. Participants can register for the September 24-25, 2008 meeting beginning August 15, 2008. The registration process will close on September 12, 2008. Therefore, those wishing to attend the meeting must register online between August 15 and September 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 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 modifications to the procedure coding system which are under consideration. 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 24-25, 2008. As stated earlier, the online registration for this meeting will begin on August 15, 2008 and close on September 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. 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 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. Therefore, those members of the public requesting that topics be discussed at the September 24-25, 2008 meeting must have their requests to CMS for procedures and NCHS for diagnoses by July 25, 2008.**

**April 1 code updates**

There were no requests approved for an ICD-9-CM code to be implemented on April 1, 2008. Therefore, **there will be no new ICD-9-CM codes implemented on April 1, 2008.**

**Final decisions on new ICD-9-CM codes**

As indicated in the timeline, the public is informed of approved ICD-9-CM coding updates through the inpatient prospective payment system (IPPS) proposed rule. This proposed rule is anticipated to be published in the *Federal Register* in April 2008. Any codes approved after the March 2008 ICD-9-CM Coordination and Maintenance Committee meeting will be included in the IPPS final rule published around August 1, 2008. A complete copy of the addendum will be published on CMS and CDC's websites by early June 2008.

**Topics:**

**1. Laparoscopic robotic assisted surgery**

Robert Holloway, MD, conducted a clinical presentation on various gynecologic procedures that are performed with the assistance of robotics. Mady Hue led the coding proposal discussion after the second robotic assisted surgery topic was presented. Please

refer to topic number 2, Other robotic assisted surgery, for a summary of comments related to the coding proposal. One commenter stated Dr. Holloway gave a fascinating presentation and questioned what the reception has been regarding the use of robotics in gynecologic surgery specifically. Dr. Holloway responded that the use of robotics in gynecologic surgery is probably ranked number two in terms of case volume, right after prostatectomy. He stated that 2 out of 3 prostatectomy procedures are performed with the use of robotics. The adoption of robotics for use in gynecologic surgery was adopted over two years ago, added Dr. Holloway. Another commenter asked if Dr. Holloway believed that the use of robotics was taking over laparoscopy procedures. Dr. Holloway replied that there is always a role for standard laparoscopy. For example, he indicated that many normal uteruses that undergo a total laparoscopic hysterectomy do not have to be done robotically, but rather the more complex cases are typically performed with the robot. He also reported that more attention capturing abstracts are coming in at conferences and seminars regarding the use of robotics because of the data demonstrating huge improvements in patient outcomes. Dr. Holloway further stated he did not feel that robotics would replace laparoscopic cholecsytectomy or hernia procedures; however he believes it is only a matter of time for splenectomy procedures to use robotics. He sees it moving in that direction, such as rooms being set up for specific robotic instruments. One commenter stated he has experienced reports of a higher incidence of tumor at the margin in prostate surgery with the use of robotic assistance. Dr. Holloway responded that although he is not familiar with urology, in gynecology it has not been the case. He stated there is a concern with margins in cervical cancer but the concern is regarding taking too much. Another commenter stated that due to the cost and it being capital equipment, a lot of hospitals do not have the *da Vinci® System*. This same commenter asked that in addition to the surgeon, when robotics are used, who else is in the room? Dr. Holloway replied that numbers of staff are identical to the numbers used in laparoscopic procedures. He stated it is very important to develop the team to have the knowledge and get the efficiencies mastered. That concluded Dr. Holloway's presentation.

**2. Other robotic assisted surgery**

Devandand Dominique, MD, facilitated a clinical presentation on the use of robotics in spinal fusion surgery. Mady Hue discussed the coding options that addressed both the *Laparoscopic robotic assisted surgery* proposal and the *Other robotic assisted surgery* proposal. One commenter stated that after listening to the second presentation it sounded as if the [spinal fusion] procedure was more computer assisted than robotic assisted and asked what the distinct differences are between the two. Dr. Dominique explained the intent of CPT codes that use computer assistance. The commenter clarified that we are discussing ICD-9-CM codes, for example, the computer assisted surgery codes from the 00.3x section in ICD-9-CM describe the use of software and CT images that assist surgeons in performing specific procedures. Dr. Dominique was not familiar with the ICD-9-CM code aspect but explained the use of the mini robot being mounted to assist in the placement of pedicle or facet screws. A number of commenters stated they support

the creation of one new code to describe the use of robotics, rather than a number of codes that describe the various approaches. The commenters stated that many procedure codes already exist that describe the various approaches so they did not see the need to include the approach in the robotic assistance code. Ms. Kathryn Barry, RN, who assisted with Dr. Holloway's presentation, responded that the reason for requesting the laparoscopic approach in particular was because many of the gynecologic procedures they described in the presentation that are being performed with robotic assistance do not currently specify the approach in the code title. She provided the example of a prostatectomy and explained that all the codes describing prostatectomy in subcategory 60.2, Transurethral prostatectomy, do not contain a specific code that identifies a laparoscopic approach was used. She further stated they have no way to identify that it was performed laparoscopically unless the robotic assistance code includes the term laparoscopic. Another commenter suggested having one code to identify the use of robotics in the 00.9, Other procedures and interventions, category since there is room. One commenter asked what was meant by the term minimally invasive and if there should be a code to describe that approach. Dr. Dominique stated that the term minimally invasive can mean different things but it is basically a smaller incision, whereas percutaneous is by a needle. Another commenter stated that as far as documentation goes, at their facility it is written as "*da Vinci*® Hysterectomy" on their reports so they are in support of only one code at this time. They feel it would be difficult for the coders to try and determine what is computer assisted versus what is robotic assisted after hearing both presentations. There appeared to be overall support for the creation of a robotic assisted procedure code, however the creation of one code versus creating a few to identify the different approaches was still in question. The audience was encouraged to send in their written comments regarding the coding options presented and other options that were discussed among the participants.

**3. Total reconstruction of the breast**

Bernard Lee, MD, provided a clinical presentation on the various surgical techniques currently being used to perform total breast reconstruction. Amy Gruber led the coding proposal discussion. One commenter suggested removing proposed code 85.72, Transverse rectus abdominis myocutaneous (TRAM) flap, not otherwise specified, from the proposed new code for total reconstruction of breast stating that the physician should be able to document whether the flap was free (proposed new code 85.74) or pedicled (proposed new code 85.73). Amy stated that we would consider that suggestion.. Dr. Lee agreed that proposed code 85.72 should be deleted. Two commenters recommended reducing the number of proposed new codes that describe the TRAM flap to one code and questioned if the expansion was necessary. Another commenter stated that we should leave room for new procedures.

Dr. Lee described the differences between the TRAM flap, free, and TRAM flap, pedicled, stating that with the TRAM free flap graft the muscle is totally separated from the body while with the TRAM pedicled flap graft, the muscle is still attached to the

body. The pedicled TRAM is a simple procedure that takes the average plastic surgeon 3 hours to perform. No special training is required. A microscope is not used. Patients stay in the hospital for 4-5 days. No special nursing care is needed while in the hospital. The free TRAM is a much more complicated procedure that takes a skilled plastic surgeon 5-6 hours to perform. Special training is required. A sterile microscope is used in the operating room. Patients stay in the hospital for 5-10 days. For the first 24 hours, intensive nursing care is required to check the viability of the breast reconstruction every 15 minutes. Therefore, the two procedures are completely unique and require different resources. One commenter asked if other vessels in the abdominal area are at risk for ischemia when a TRAM flap surgery is performed. Dr. Lee replied that vessels do not become ischemic. Another commenter questioned how often a latissimus dorsi myocutaneous flap is currently being performed and if there is really the need for proposed new code 85.71, Latissimus dorsi myocutaneous flap, since in Dr. Lee's presentation, it was stated that the procedure is not very common anymore. According to Dr. Lee, the procedure is still being performed today, however, just not as often as other autologous flap procedures. Dr. Lee explained how certain patients are not candidates to receive the TRAM flap procedure and the latissimus dorsi myocutaneous flap is the better option. Therefore, Dr. Lee stated that the need for this new code was still present. There appeared to be general support for the creation of new codes with the exception of deleting proposed new code 85.72, Transverse rectus abdominis myocutaneous (TRAM) flap, not otherwise specified. The audience was also encouraged to send in written comments.

**4. Episiotomy and repair of spontaneous lacerations**

Laurel Durham, MPH, RN, facilitated a presentation from the quality of care aspect on current coding guidelines regarding *an episiotomy that extends spontaneously is considered to be a laceration.* According to Ms. Durham, the current guidelines do not result in quality data, nor do they accurately reflect current clinical practice. Amy Gruber presented the coding options. One commenter stated there is confusion among coders in the existing codes because although the physician may document the degree of laceration, the site of the laceration is not identified, therefore, this commenter asked if it would be possible to include the various degrees ($1^{st}$ , $2^{nd}$, $3^{rd}$, $4^{th}$) in the inclusion terms. According to Ms. Durham, there is debate among the providers and professional societies about what constitutes a $3^{rd}$ or $4^{th}$ degree laceration so she would not be in favor of including that terminology in the code descriptors. One commenter stated that the degree of laceration is captured with the diagnosis codes so, it was not necessary to include this information in the procedure code section. Two commenters were in support of the proposal to allow the coding of an episiotomy when it extends spontaneously stating this would lead to consistency among various providers. There appeared to be overall support for the proposal.

**5. Endoscopic pulmonary airway flow measurement**

Armin Ernst, MD, provided a clinical presentation on a new type of technology, the Chartis System Functional Assessment System (FAS), which assesses pulmonary airflow in patients with various types of lung disease. Pat Brooks conducted the coding proposal discussion. One commenter asked if a therapeutic procedure would be performed immediately after one of these pulmonary airway flow assessments or if the therapeutic portion would occur several weeks later. Dr. Ernst stated there could be many options for a patient, it may be clinically feasible to perform at that time, however, for now it is a stand alone assessment. Dr. Ernst indicated additional time may be needed to determine the appropriate plan of treatment after reviewing results of a patient's assessment. Another commenter stated they were not very happy with the placement of this proposed code under subcategory 33.7, Endoscopic insertion, replacement and removal of therapeutic device or substances in bronchus or lung, as it is currently titled., This commenter could not suggest a better location and suggested revising the title of subcategory 33.7 to identify that diagnostic and therapeutic procedures are included under this category. One commenter questioned the appropriateness of the term "bronchoscopic" in the proposed code. Another commenter asked if this code would be assigned in addition to a bronchoscopy code or if this code would also include any bronchoscopy performed. One suggestion was to include the bronchoscopic term in the code title to alleviate confusion between a bronchoscopic approach and a true bronchoscopy. The discussion then turned to which setting this procedure would most likely be performed in, inpatient or outpatient. Dr. Ernst indicated that if the airway flow assessment was the only procedure being performed, then it could easily be in the outpatient setting. If it were to be performed in conjunction with other more invasive procedures, then the patient would need to be admitted. The audience was encouraged to send in written comments regarding the proposal and the additional suggestions made by the audience members.

**6. Bilateral ventricular assist devices**

Mark Anderson, MD, conducted a clinical presentation on the implantation of bilateral external heart assist devices that provide temporary support to the native heart. Ann Fagan facilitated a discussion on the coding proposal. Ann explained the confusion that currently exists in coding these devices and how the proposed code revisions are an effort to clarify which code should be assigned for specific procedures utilizing the various devices. One commenter asked if it was possible to determine which patients would need a transplant after the external heart assist system was removed. Dr. Anderson stated that transesophageal echocardiography (TEE) is performed and gives a good idea of which patients may need a heart transplant. The audience appeared to be in support of the coding proposal to create a new code at 37.60 that describes the implantation or insertion of a biventricular external heart assist system. Additionally, revisions to codes 37.64, 37.65, and 37.66 were discussed. These revisions are proposed in order to assist coders

in understanding the appropriate code assignments for the many similar-yet-different circulatory and heart assist systems and devices.

## 7. Addenda

Mady Hue led the discussion for the addenda proposal. There was general support for the proposed index and tabular revisions. The audience was encouraged to review in more detail after the meeting and send in any written comments they may have.

## 8. ICD-10-Procedure Classification System (PCS) Update

Pat Brooks provided an update on ICD-10 activities.

Implementation analysis contract awarded
The Centers for Medicare & Medicaid Services (CMS) has awarded a contract to the American Health Information Management Association (AHIMA) to begin assessing the impact on CMS of replacing the ICD-9-CM code sets now used in reporting health care transactions with the ICD-10 versions.

Specifically, CMS anticipates replacing the ICD-9-CM for diagnosis and procedure codes with the new ICD-10 codes. AHIMA, which is based in Chicago, Illinois, will analyze CMS' systems, policies and operations to determine the potential impact of the changeover from ICD-9 to ICD-10.

"The awarding of this contract reflects CMS' commitment to ensuring that the eventual transition from ICD-9-CM to ICD-10 code sets will be thoughtfully planned and implemented throughout CMS," stated CMS Acting Administrator Kerry Weems. "While no decision has been made on the implementation and timing of ICD-10, our proactive approach should send a signal to hospitals and other stakeholders who use ICD-9 coding to begin making their own transition plans."

ICD-9-CM is a code set that was designated by the Secretary of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); to be used on administrative transactions in both the government and private sectors to report diagnoses and inpatient hospital procedures. All health care providers and suppliers use ICD-9-CM diagnosis codes, while ICD-9-CM procedure codes are used only by hospitals to report inpatient procedures. ICD-9-CM codes are used for many purposes, including reimbursement, quality reporting, pay for performance, benchmarking, health care policy, public health reporting and research.

ICD-9-CM, which was developed almost three decades ago, has a total of 17,000 diagnosis and procedure codes, which limits its ability to accommodate new procedures and diagnoses. In addition, ICD-9-CM lacks the granularity needed for a number of

emerging needs. The ICD-10 code set addresses these shortcomings. By comparison, ICD-10 is a more robust, descriptive code set of approximately 150,000 diagnosis and procedure codes, allowing more room for growth to reflect new diagnoses, procedures, and technology.

The ICD-10-CM code set is maintained by the National Center for Health Statistics (NCHS) of the Centers for Disease Control and Prevention (CDC) for use in the United States, and is based on ICD-10, which was developed by the World Health Organization (WHO) and is used internationally. The ICD-10-PCS code set is maintained by CMS.

ICD-10 Webpage

Pat Brooks announced that a new ICD-10 webpage has been created for ICD-10. The ICD-10 webpage includes 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/.** The website also contains forward and backward mappings between ICD-9-CM and ICD-10.

ICD-10 Bookmark

The audience was given an ICD-10 bookmarker created by CMS. This bookmarker provides information about ICD-10 including websites at CMS and CDC.

Improvements to ICD-10 Mappings

CMS has asked 3M to update the ICD-10 to ICD-9-CM General Equivalence Mapping (GEM) files (also referred to as crosswalks) next year by adding a new field for payment mapping. We have asked that 3M develop the new payment mapping field which would indicate the best ICD-9-CM code for any ICD-10-CM or PCS code for payment purposes. This will facilitate the work of the various policy groups within CMS as well as outside insurers in their work to update current payment systems with ICD-10 codes. We perform a similar activity each year in updating the inpatient prospective payment system. When new ICD-9-CM codes are created, CMS picks the one best representation of the prior code in order to map the new code to an appropriate DRG assignment. While it will not always be possible to pick a single ICD-9-CM code to represent an ICD-10 code, this will be our goal. There will be incidences where multiple ICD-9-CM codes will be required in our new payment mapping field.

Obviously, the use of this one new payment mapping field would not provide the user with the ability of taking advantage of the significant increase in detail within ICD-10. Those who perform additional analysis to implement more appropriate use of the new ICD-10 codes will want to use the complete GEM mappings already posted on our website at: http://www.cms.hhs.gov/ICD10 However, this new payment mapping field will give numerous users a head start in analyzing the conversion of our payment, quality, and reporting systems. It is also something that other insurers and users have been pressing CMS to create. This field will serve as an excellent starting point for converting payment and coverage systems.

The new payment mapping field will be part of the 2009 updates to the ICD-10 files.

**Rhonda Butler provided an update on the ICD-10-PCS Body Part Key.**

Rhonda discussed a new initiative to provide an alternative to users in choosing the correct PCS body part value for a given anatomical term or procedure site. This new body part key is scheduled to be included in the next ICD-10-PCS update.

Rhonda reviewed the general requirements of the body part key indicating that it would be a public domain reference to accompany the PCS tables and indexed by anatomical term and PCS body part. She also stated that the PCS body part key would be considered "official" similar to ICD-9-CM inclusion notes.

The audience was provided with examples of this body part key that provides further details on a specific body part. Participants were encouraged to send in comments and if interested, were informed they could review the draft body part key by contacting Rhonda for further information. The American Health Information Management Association (AHIMA) and the American Hospital Association (AHA) volunteered to review the draft body part key document.