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

SUMMARY REPORT

ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

September 24-25, 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 September 24, 2008 and was conducted by staff from the Centers for Medicare & Medicaid Services (CMS). The diagnosis portion of the meeting was held on September 25, 2008 and was conducted by staff from the Centers for Disease Control and Prevention (CDC). 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 24, 2008 meeting are being considered for implementation on October 1, 2009. An exception is the request for codes for Laser Interstitial Thermal Therapy (LITT), which is requesting an expedited code creation effective April 1, 2009. 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 December 5, 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 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 11-12, 2009 meeting beginning February 15, 2009. The registration process will close on March 5, 2009. Therefore, those wishing to attend the meeting must register online between February 15 and March 5, 2009, or until room capacity is reached.

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 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 11-12, 2009. As stated earlier, the online registration for this meeting will begin on February 15, 2009 and close on March 5, 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 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

We received one request for an April 1, 2009 implementation date for codes to describe a new technology known as Laser Interstitial Thermal Therapy (LITT).

Participants at the meeting strongly opposed the implementation of new codes on April 1, 2009 for Laser Interstitial Thermal Therapy (LITT) for brain tumors. One commenter expressed concern over the huge expense that would be involved with systems implementation for military facilities for a procedure that would be performed in extremely small numbers under a clinical trial in 2009. The commenter spoke of creating codes on October 1, 2009 instead of April 1, 2009. Another commenter stated that it was a terrible idea to implement new codes for this technology on April 1, 2009. This commenter however, supported creation of new codes for October 1, 2009. The commenter went on to suggest that the concept of when a code is truly needed be addressed by the Committee.

In response to this comment, Amy Gruber, the CMS analyst leading discussion of the proposal, cited the statutory language in section 1886(d)(5)(K) (vii) of the Social Security Act that was amended and requires the recognition of new technologies under the Inpatient Prospective Payment System (IPPS) system. Ms. Gruber explained that the agency, through the ICD-9-CM Coordination and Maintenance Committee, has a statutory requirement to consider new code proposals with requests for an April 1 implementation date to capture new technology. The requestor is required to make a strong and convincing case for an April 1 implementation of codes to capture new technology.

Another commenter asked for clarification on the number of patients that were expected to be included in the LITT clinical trial. Mr. Duncan, CEO of Monteris Medical Incorporated, responded that there would be approximately twenty (20) to thirty (30) patients over the course of 3 trials for a total of 60-90 patients at 8 institutions beginning in 2009. Another commenter noted that with the small number of patients expected to be participating in the trials, the company could use an alternative means to capture data on the procedure. The commenter mentioned that a data registry for tracking outcomes would be much more cost-effective than implementing new codes in April 2009. The commenter also pointed out that the specific data is already captured as part of the clinical trial. There was generally strong opposition from the audience for an April 1, 2009 implementation date for new codes to identify the use of LITT for brain tumors. No one spoke in support of an April 1, 2009 code implementation.

Information on any new codes that would be implemented on April 1, 2009 will be posted on the CMS ICD-9-CM website by early November 2008. Detailed information on this issue is provided in the ICD-9-CM timeline which is included along with the agenda for the meeting.

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 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 the CMS and CDC websites by early June 2008.

Topics:

1. Cardiac Contractility Modulation

Daniel Burkhoff, MD, PhD, facilitated a clinical presentation on the concept of cardiac contractility modulation (CCM) that utilizes electrical signals which are intended to enhance the strength of the heart and overall cardiac performance. Ann Fagan conducted the coding proposal discussion. One commenter asked if the CCM device is only implanted with conventional defibrillators or if it would also be used in combination with the implantation of biventricular devices. The commenter expressed concern regarding the exclusion term under the proposed new code 17.51, Implantation of rechargeable cardiac contractility modulation, total system [CCM] which excludes implantation of cardiac resynchronization device, total system (codes 00.50-00.51). Dr. Burkhoff stated that in the United States, the CCM device is only implanted with conventional defibrillators at the present time; however it may be possible to implant the CCM device with biventricular devices in the future. Dr. Burkhoff indicated that there are studies currently going on in Europe to evaluate the implantation of a CCM device with a biventricular device. There appeared to be general support for the creation of new codes

to identify the concept of CCM. The participants were encouraged to send in any additional comments for further consideration.

2. Endovascular Bioactive Coils

Beverly Aagaard Kienitz, MD, conducted a clinical presentation on the use of bioactive coils in the treatment of aneurysms with a procedure known as endovascular coil embolization. Ann Fagan led the coding proposal. Ms. Fagan explained that in addition to the new code proposal being presented, there is a companion proposal to revise the terminology "repair" in the title of category 39.7, Endovascular repair of vessel(s). One commenter asked if a unique code should be created for coated coils since the code proposal only differentiated between the use of bare metal (platinum) coils and a newer, bioactive coil. Dr. Kienitz responded that there is a higher recanalization with coated coils and they have proved to have poor patient outcomes due to the breakdown of the bioactive agent on the outer surface of the coil. Dr. Kienitz also noted they have experienced better patient outcomes with the bioactive coil, (which contains bioactive materials within the inner lumen of the microcoils) therefore, the proposal was only intended to identify the use of this new coil. Another commenter expressed support for creating a code to identify the use of these new, bioactive coils. This commenter also recommended splitting the use of coils out of code 39.72, Endovascular repair or occlusion of head and neck vessels, stating that if the use of a stent is combined with the use of a coil then two codes would be needed. The commenter expressed concern with the various terms already included with code 39.72. Lastly, in response to the proposal to revise the terminology "repair", this commenter stated that the term "repair" has been an issue but they were not sure if the proposed revised term "treatment" was appropriate either. Another commenter asked about a default code if the documentation only stated "coil embolization". Ms. Fagan replied that if only coil embolization of the head and neck vessels is documented it would still default to code 39.72. There appeared to be general support for the creation of a new code to identify bioactive coils, however, the audience was encouraged to submit written comments as well.

3. Endoscopic Bronchial Valve Insertion In Single and Multiple Lobes

Daniel Sterman, MD, facilitated a clinical discussion on the endoscopic insertion or replacement of bronchial valves in single and multiple lobes of the lung. Pat Brooks conducted the coding proposal discussion. One commenter asked what was most important - the number of valves inserted or the number of lobes involved? Dr. Sterman replied that both are important, however, from a data standpoint, the ability to identify if valves were inserted into a single lobe versus multiple lobes was much clearer from a documentation and coding perspective. Another commenter asked how the removal of these valves would be coded. Ms. Brooks responded that code 33.78, Endoscopic removal of bronchial device(s) or substances, would be the appropriate code assignment to report the removal of a bronchial valve. There was general support for establishing a

new code (33.73) to identify the endoscopic insertion or replacement of bronchial valve(s) into multiple lobes of the lung and to revise current code 33.71, Endoscopic insertion or replacement of bronchial valve(s), to identify the procedure for a single lobe of the lung.

4. Vascular Imaging

David Pennington, Manager of Clinical Operations at Luminetx and Gregory Shears, MD, conducted a clinical presentation on a vascular imaging system known as the VeinViewer®, a device that utilizes near-infrared technologies to enhance the healthcare provider's ability to access venous structures. Mady Hue led the coding proposal discussion. Ms. Hue emphasized that this was not a new technology application and informed the participants that consideration for a CPT/HCPCS code was also being evaluated separately by another agency workgroup. One commenter stated that even with an ICD-9-CM procedure code it would be difficult to track where the technology is specifically utilized in a hospital setting since almost all areas in a hospital are involved in the process of inserting an IV. Another commenter stated that while there would be clinical value in creating a CPT code to describe the use of the VeinViewer® technology, a venipuncture procedure is never actually coded in the inpatient setting using an ICD-9-CM code. Many commenters also questioned the type of documentation a coder would see in the record to identify the technology. Dr. Shears stated that he could not speak to the type of documentation a coder might see, but the ability to improve peripheral vascular access provides numerous benefits for patients and healthcare providers. Several commenters agreed that the VeinViewer® technology has a significant clinical benefit for patients by avoiding the practice of multiple IV stick attempts; however, they were generally not supportive of a new code to identify the use of the technology in an inpatient setting. Participants were also encouraged to send in written comments.

5. Laser Interstitial Thermal Therapy for Brain Tumors

Jim Duncan, CEO of Monteris Medical, conducted a clinical presentation on a new technology known as Laser Interstitial Thermal Therapy (LITT) that is used with MRI guidance for ablating tumors in the brain. Amy Gruber facilitated the coding proposal discussion. To review a summary of the discussion regarding an April 1, 2009 code implementation for this technology, please see above under the *April 1Updates* heading.

One commenter inquired if the focused LITT (f-LITT) therapies are exclusively MRI guided. Mr. Duncan stated that the issue is with temperature monitoring, therefore, all the LITT therapy codes proposed for lesions or tissues of various sites require real time or fixed MRI. Another commenter questioned if the proposed codes identifying LITT therapy are all currently indicated or anticipated in the near future. Mr. Duncan stated that the thyroid is currently being treated with f-LITT. Ms. Gruber added that the proposed codes are for current and future use. CMS decided after review of the

requestor's proposal that a new category and codes for the various sites including the brain be proposed for this technology.

Another commenter recommended that CMS add the inclusion term, Focused Laser Interstitial Thermal Therapy (f-LITT) under MRI guidance, to each proposed code, stating that the proposed location listed under the new category could easily be missed by coders. One commenter expressed concern with listing the term "MRI" first in the code title, suggesting that there may be other modalities used with LITT in the future. There appeared to be some support in implementing new codes for this technology.

6. Intraoperative Anesthetic Effect Monitoring and Titration (IAEMT)

Marc Bloom, MD, Ph.D. conducted a clinical presentation on Intraoperative Anesthetic Effect Monitoring and Titration (IAEMT) that involves the use of brain monitoring technology by anesthesia professionals to guide anesthesia care. Amy Gruber facilitated the coding proposal discussion. One commenter questioned if IAEMT was the best title to describe this technique and noted that IAEMT is an umbrella term for several types of intraoperative neurophysiologic monitoring. Dr. Bloom responded that the term can be used for other types of monitoring and stated that the code proposed should include all types of intraoperative neurophysiologic monitoring used by anesthesia professionals. The commenter inquired if all types of monitoring are equivalent and Dr. Bloom stated that it is not yet known, and that studies are either underway or proposed to compare different types of monitoring. The same commenter expressed concern about coding a specific monitoring technique separately from the operative procedure itself, stating that IAEMT is but one of many types of patient monitoring that occur during an operative episode. Dr. Bloom responded that the BIS (Bispectral Index) monitoring system is the only FDA approved IAEMT device but that other IAEMT techniques may be coded to the same proposed new code 00.96, Intraoperative anesthetic effect monitoring and titration (IAEMT) if they are used.

Another commenter stated it was not clear how this technology would be documented in the medical record and questioned if there is a score or some other type of indication that would distinguish this technology from code 00.94, Intra-operative neurophysiologic monitoring. Dr. Bloom stated that it was easy to differentiate since the monitoring is performed by separate services. Dr. Bloom noted that IAEMT would be documented on the anesthesia record with BIS (brand name) or PSA Index notation and that coders would know by the charting, similar to blood pressure and heart rate parameters. Dr. Bloom suggested that an inclusion term, done by anesthesia provider, may be helpful in distinguishing this technology. Another commenter stated that they have seen intra-operative neurophysiologic monitoring documented clearly and do not have a problem finding it in medical records. This commenter supported creating a new code for reporting IAEMT as an adjunct procedure. Participants were encouraged to send in written comments regarding this topic.

7. Endoscopic Insertion of Colonic Stent

Mady Hue facilitated a brief overview on the use of self-expandable metal stents (SEMS) as an alternative to emergency surgery for the relief of acute malignant colonic obstruction. Ms. Hue also led the coding proposal discussion. There was no opposition regarding the proposal. Participants were encouraged to submit written comments for consideration regarding suggested modifications to the proposal.

8. Addenda

Mady Hue reviewed the proposed addenda updates. There was general support for the addenda and no opposition.

9. ICD-10 update and Effect on MS-DRGs

Pat Brooks provided an overview of the tasks assigned to CMS' contractor, 3M this year concerning ICD-10. These major activities are as follows:
1. 3M continues to develop the annual updates to ICD-10-PCS to include new codes which were incorporated into ICD-9-CM. They also continue to refine ICD-10-PCS based on additional analysis and public recommendations. An updated 2009 version of ICD-10-PCS will be posted on CMS' ICD-10 website by the end of the calendar year. Rhonda Butler, 3M, would provide an overview of the major types of changes including work on the Body Part Key, new root operation, and streamlining of the Medical/Surgical codes.

2. As discussed at the March 2008 C&M meeting, 3M was tasked with developing a more streamlined approach to mapping between ICD-9-CM and ICD-10. This streamlined version will be used as an additional tool for those who wish to convert payment, quality, and other data systems to ICD-10. We will refer to this new mapping tool as a Reimbursement mapping since it provides the one best illustration of a one-to-one mapping when one is updating a payment system. CMS will provide this new mapping tool as part of the 2009 updates.

3. CMS has received requests from other insurers for assistance in determining how to convert payment and other systems from ICD-9-CM to ICD-10. We decided to use the currently available GEM mapping tools, (General Equivalence Mappings) to begin the process of converting MS-DRGs from ICD-9-CM to ICD-10. We began with the digestive system part of the MS-DRGs. We have learned a great deal from this process, which Rhonda Butler shared with the meeting participants. CMS has asked its contractor to continue this work and to have an ICD-10 version of the MS-DRGs available by October 2009. Any final decisions on an ICD-10 version of the MS-DRGs would be subject to rulemaking. This exercise is meant to show how the currently available mappings can be used to begin converting a variety of payment and quality systems. We

plan to post the results of this effort in converting the digestive part of the MS-DRGs as part of our 2009 updates to ICD-10-PCS.

Detailed information on Rhonda Butler's presentation covering these three issues can be found in the PDF version of her slides, posted on the CMS website.

11. Cooperating Parties and Physicians Update

Pat Brooks introduced the four Cooperating Parties for ICD-9-CM including:
Donna Pickett, CDC
Nelly Leon-Chisen, American Hospital Association (AHA)
Sue Bowman, American Health Information Management Association (AHIMA)
Pat Brooks, CMS.

The four cooperating parties have worked together to provide national leadership on ICD-9-CM by producing official coding guidelines, responding to ICD-9-CM coding questions, and updating ICD-9-CM. It is anticipated that these same four organizations would continue in their current roles should a decision be made to implement ICD-10.

On August 22, 2008, the Department of Health and Human Services released Notice of Proposed Rulemaking (NPRM) CMS-0013-P – HIPAA Administrative Simplification: Modification to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS. This NPRM proposes to implement the ICD-10-CM/PCS Coding System on October 1, 2011. To view the proposed rule for ICD-10 (CMS-0013-P), go to http://www.cms.hhs.gov/ICD10/04_Statute_Regulations_Program_Instructions.asp#TopOfPage click on the Related Links Inside CMS link below and next click on the "Transactions and Code Sets Regulations" link.

The Cooperating Parties provided an overview of ICD-10 including the following items listed below. Detailed information on their presentations is included in the PDF version of their slides, which are posted on the CMS website.

- Problems with ICD-9-CM
- ICD-10-CM and how it differs from ICD-9-CM diagnoses
- ICD-10-PCS and how it differs from ICD-9-CM procedures
- The role of AHA in ICD-9-CM activities and recommendations and plans for ICD-10
- The role of AHIMA in ICD-9-CM activities recommendations and plans for ICD-10

Jeffrey Linzer, MD and Lee Hilborne, MD provided comments on the need for better data through a new coding system. They also discussed how this improved data would benefit physicians.