Summary of March 2010 ICD-9-CM Coordination and Maintenance Committee Meeting

The ICD-9-CM Coordination and Maintenance (C&M) Committee, cosponsored by the National Center for Health Statistics (NCHS) in the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS), met on March 9-10, 2010 in Baltimore, MD. Donna Pickett, RHIA, from NCHS, and Patricia Brooks, RHIA, from CMS, cochaired the meeting.

Proposed modifications to ICD-9-CM were presented and are summarized below. This summary does not include all of the details of the code proposals or all of the recommendations made at the meeting. For complete details, review the minutes and code proposals posted on the CMS and NCHS websites. Diagnosis code proposals and the minutes from the diagnosis portion of the meeting are posted on the NCHS website and can be accessed at the following link: http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm. Procedure code proposals and the minutes from the procedure portion of the meeting can be found at the CMS website and can be accessed at the following link: http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.

Suggestions for procedure code proposals to be considered at a future Coordination and Maintenance Committee, as well as comments on procedure proposals presented at the March C&M Committee meeting, may be emailed to Pat Brooks at Patricia.brooks2@cms.hhs.gov or mailed to: Centers for Medicare & Medicaid Services, CMM, HAPG, Division of Acute Care, Mail Stop C4-08-06, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Suggestions for diagnosis code proposals for consideration at a future Coordination and Maintenance Committee, as well as comments on diagnosis proposals presented at the March C&M Committee meeting, may be emailed to Donna Pickett at dfp4@cdc.gov or mailed to: Donna Pickett, National Center for Health Statistics, 3311 Toledo Road, room 2402, Hyattsville, Maryland 20782.

Proposed changes intended for October 1, 2010 implementation are so noted in the summary below. All other proposed changes are intended to be implemented October 1, 2011. **The deadline for receipt of public comments on the code proposals slated for implementation on October 1, 2010 was April 2, 2010. The deadline for receipt of public comments on code proposals slated for implementation on October 1, 2011 is June 11, 2010.**

The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled for September 15-16, 2010 and will be held at the CMS building in Baltimore, MD. New proposals for inclusion on this agenda must be received by **July 16, 2010**.

DIAGNOSES

Influenza with Pneumonia

An expansion of codes 488.0, Influenza due to identified avian influenza virus, and 488.1, Influenza due to identified novel H1N1 influenza virus, is being proposed in order to uniquely capture pneumonia, other respiratory manifestations, and other manifestations occurring with these types of influenza. Category 488, Influenza due to certain identified influenza viruses, would mirror the structure of category 487, Influenza.

This proposal is being considered for implementation on October 1, 2010.

Fluency Disorder

Creation of unique codes for childhood onset fluency disorder and fluency disorder in conditions classified elsewhere has been proposed. The title of code 307.0 would be changed to "Adult onset fluency disorder." The default code for stuttering, not otherwise specified, would be the new code for childhood onset fluency disorder. Code 438.14 would continue to be assigned for stuttering due to late effect of cerebrovascular accident.

This proposal was a revised version of proposals presented in 2008 and 2009. It is being considered for implementation on October 1, 2010.

E. coli Infection – Expansion for O157:H7 Strain

Infections with certain strains of *E. coli*, known as Shiga toxin-producing *E. coli* (STEC), that cause gastrointestinal infections may lead to hemolytic uremic syndrome, a potentially fatal condition. STEC produces a toxin called Shiga toxin which is sometimes referred to as verotoxin or verocytotoxin, so they are sometimes referred to as VTEC. STEC and VTEC that cause human illness are also referred to as enterohemorrhagic *E. coli* (EHEC). STEC transmission occurs through consumption of contaminated meats that are undercooked as well as consumption of other types of contaminated products, such as unpasteurized juice, raw milk, raw produce, and water. The most commonly identified STEC in North America is *E. coli* O157:H7.

An expansion of code 041.4, Bacterial infection in conditions classified elsewhere and of unspecified site, Escherichia coli [E. coli], has been proposed to create unique codes for: Shiga toxin producing E. coli (STEC) O157; other specified Shiga toxin-producing E. coli; unspecified Shiga toxin-producing E. coli; and other E. coli.

Acquired Absence of Joint

A new subcategory for acquired absence of joint, with specific codes for acquired absence of hip, knee, and other joint, has been proposed. This subcategory would include joint prosthesis explantation status.

A new code for aftercare following explantation of joint prosthesis has also been proposed. This code would include an encounter for joint prosthesis insertion following prior explantation of joint prosthesis.

Brain Death
The National Association of Children's Hospitals and Related Institutions (NACHRI) has requested a unique code for brain death. This term is currently indexed to code 348.89, Other conditions of brain. NACHRI's review of hospital data revealed that a subset of children with brain injury classified to this code had a high mortality rate and relatively short length of stay due to the declaration of brain death early in the course of the hospital stay. Since code 348.89 includes conditions with a variety of expected patient outcomes, it would be useful to be able to identify those patients who have been declared brain dead.

Lambert-Eaton Myasthenic Syndrome (LEMS)
Lambert-Eaton myasthenic syndrome (LEMS) is a disorder of the neuromuscular junction. It is an autoimmune condition and is caused by a disruption of electrical impulses between these nerves and muscle cells. Symptoms include muscle weakness, a tingling sensation in the affected areas, fatigue, and dry mouth. LEMS is closely associated with cancer, in particular small cell lung cancer. LEMS may appear up to three years before cancer is diagnosed.

There is no cure for LEMS. Treatment is directed at decreasing the autoimmune response (through the use of steroids, plasmapheresis, or high-dose intravenous immunoglobulin) or improving the transmission of the disrupted electrical impulses by giving drugs such as di-amino pyridine or pyridostigmine bromide (Mestinon).

A new subcategory for Lambert-Eaton syndrome has been proposed in category 358, Myoneural disorders. This subcategory would include codes for unspecified Lambert-Eaton syndrome, Lambert-Eaton syndrome in neoplastic disease, and Lambert-Eaton syndrome in other diseases classified elsewhere. If Lambert-Eaton syndrome is due to neoplastic disease or another condition, the underlying condition would be sequenced first.

Pelvic Fracture without Disruption of Pelvic Circle
New codes for multiple pelvic fractures without disruption of pelvic circle have been proposed. The addition of the term "pelvic ring" as a synonymous term for pelvic circle in ICD-9-CM has also been proposed.

Exposure to Uranium
The Environmental Protection Agency, in conjunction with the Agency for Toxic Substances and Disease Registry (ATSDR) and the New Mexico Department of Health (NMDH), is investigating uranium exposure, both occupational and non-occupational. The NMDH now lists uranium exposure as a reportable disease if found in the urine at certain levels. Natural uranium mineral deposits are concentrated in certain areas in New

Mexico, and these mineral deposits can leach uranium into ground water. Other sources of exposure include contamination of sites from historical uranium mining and milling.

A new code for exposure to uranium has been proposed to assist with tracking this exposure.

Saddle Embolism of Pulmonary Artery
Saddle emboli are one of the most severe forms of embolism and are associated with high mortality rates. The most common site for a saddle embolus is the aorta, but they can occur at other sites, such as the pulmonary artery. Saddle embolus is currently indexed to code 444.0, Arterial embolism and thrombosis, of abdominal aorta.

Unique codes for saddle embolus of pulmonary artery and abdominal aorta have been proposed.

Cystostomy Complications
An expansion of code 596.8, Other specified disorders of bladder, has been proposed in order to uniquely identify cystostomy complications. Unique codes would be created for infection of cystostomy, mechanical complication of cystostomy, and other complication of cystostomy.

Smoke Inhalation
The NCHS has received questions regarding the correct coding for smoke inhalation and how it relates to the coding of acute respiratory failure. The default code for the term "smoke inhalation" is 987.9, Toxic effect of unspecified gas, fume, or vapor. However, at the Tabular section 980-989, Toxic effects of substances chiefly nonmedicinal as to source, there is an Excludes for respiratory conditions due to external agents (506.0-508.9). Based on this Excludes note, it appears that the default for smoke inhalation, not otherwise specified, should be changed to a code in categories, 506, Respiratory conditions due to chemical fumes and vapors, or 508, Respiratory conditions due to other and unspecified external agents. The axes for these classifications are not consistent. Category 506 includes codes for specific types of respiratory conditions, whereas category 508 is split out based on the external agent. **The NCHS is requesting comments on which category would be the best choice for the default, and whether a new code in that category should be created.**

The issue of sequencing the codes in categories 506 and 508 and the associated respiratory conditions also needs to be addressed. To be consistent with the sequencing rules for other poisoning and toxic effect codes, a "use additional code" note should be added under categories 506 and 508. This note would apply to all secondary respiratory codes, including acute respiratory failure.

The term "asphyxia" is indexed to the same default as the term "smoke inhalation." **Comments are being sought on whether these terms should be considered synonymous.**

Personal History of Pulmonary Embolism and Anaphylactic Shock
A unique code for personal history of pulmonary embolism has been proposed.

A new code for personal history of anaphylactic shock has also been proposed. A meeting attendee suggested that the term "anaphylaxis" be used in the code title instead of anaphylactic shock in order to be up-to-date with current clinical practice. A suggestion was also made that the location of this code be re-considered, as subcategory V12.5, Personal history of diseases of circulatory system, may not be the most appropriate location.

Complications of Weight Loss Procedures
A new category for complications of bariatric surgery and gastric band procedures has been proposed. New subcategories would capture infections and other complications of bariatric surgery and gastric band procedures.

Postoperative Aspiration Pneumonia
A unique code for postprocedural aspiration pneumonia has been proposed in subcategory 997.3, Respiratory complications. The inclusion terms under code 997.39, Other respiratory complications, and a note would be added under this code indicating that an additional code should be assigned to identify the complication.

The inclusion terms under code 997.39 have created confusion as to whether this code should be assigned alone for aspiration pneumonia (since aspiration pneumonia is an inclusion term) or whether code 507.0 should be assigned as an additional code (per the instructional note under category 997 indicating that an additional code should be assigned to identify the complication). As a result of the confusion surrounding the interpretation of inclusion terms, the NCHS will undertake a future review of inclusion terms to assess the best way to use them in ICD-9-CM and ICD-10-CM.

Pilar Cyst/Trichilemmal Cyst
Pilar cysts are epidermal cysts formed by an outer wall of keratinizing epithelium without a granular layer, similar to the normal epithelium of the hair follicle at and distal to the sebaceous duct. Since pilar cysts occur preferentially in areas with dense hair follicle concentrations, 90% occur on the scalp. Pilar cysts are quite common, occurring in 5-10% of the population. Pilar cysts are almost always benign, with malignant transformation being extremely rare. In 2% of pilar cysts, single or multiple foci of proliferating cells lead to proliferating tumors, often called proliferating trichilemmal cysts. Although biologically benign, proliferating trichilemmal cysts may be locally aggressive, becoming large and ulcerated.

New codes have been proposed for pilar and trichilemmal cysts.

Retained Gallstones following Cholecystectomy
It is not uncommon following cholecystectomy, especially following laparoscopic cholecystectomy, for gallstones to fall into the bile duct, the abdominal cavity, or abdominal wall. These stones can later cause obstruction or infection.

An expansion of code 997.4, Digestive system complications, has been proposed to create a new code for retained cholelithiasis following cholecystectomy.

Biochemical Pregnancy
In some cases, a woman's pregnancy test comes back as positive, but an ultrasound shows that no fetus is present and an ectopic pregnancy is ruled out. These cases are essentially very early miscarriages and are often referred to as a chemical or biochemical pregnancy.

An expansion of code 631, Other abnormal products of conception, has been proposed for inappropriate rise (decline) of quantitative human chorionic gonadotropin (hCG) in early pregnancy. Biochemical pregnancy and chemical pregnancy would be listed as inclusion terms.

Diagnosis Addenda
Proposed diagnosis addenda changes were reviewed. Proposed revisions for consideration for implementation October 1, 2010 include a few error corrections as well as:

- Addition of inclusion term for "screening colonoscopy NOS" under code V76.51, Special screening for malignant neoplasms, colon;
- Revision of Index entry for basal pneumonia – see Pneumonia, by type;
- Addition of Index entry for screening colonoscopy (V76.51).

Highlights of the proposed revisions for consideration for implementation October 1, 2011 include:

- Addition of instructional note under code 042, Human immunodeficiency virus [HIV] disease, indicating that human immunodeficiency virus [HIV] disease due to blood transfusion (999.39) should be coded first;
  [NOTE: Several meeting attendees disagreed with the proposed note and felt that code 042 should be sequenced first. One commenter suggested that if the proposed note is approved, "if applicable" should be added.]
- Addition of "human immunodeficiency virus [HIV] disease (042)" in "Code first underlying disease" instructional note under code 323.0, Encephalitis, myelitis, and encephalomyelitis in viral diseases classified elsewhere;
- Revision of title of subcategory 646.7 to state "Liver and biliary tract disorders in pregnancy;"
- Addition of Excludes note under code 968.5, Surface [topical] and infiltration anesthetics, indicating that poisoning by cocaine (crack) used as a central system stimulant is classified to code 970.81;
- Addition of "human immunodeficiency virus [HIV] disease (042)" in "use additional code to identify the specified infection" instructional note under subcategory 999.3, Complications of medical care, not elsewhere classified, other infection;
- Revision of inclusion term under code V58.69, Long-term (current) use of other medications, to state "long-term current use of methadone for pain control;"

- Addition of Excludes notes under code V58.69, Long-term (current) use of other medications, for methadone maintenance NOS (304.00) and methadone use NOS (304.00);
- Addition of instructional note under category E967, Perpetrator of child and abuse, indicating that codes from category E967 correspond only to codes under subcategory 995, Child maltreatment syndrome, and codes 995.80-995.85, Adult maltreatment and abuse, and they are not for use to identify the perpetrator of other types of assault;
- Addition of Index entries for:
  - Chronic anemia (285.9);
  - Borderline high blood pressure (796.2);
  - Borderline diabetes mellitus (790.29);
  - Aortic intramural hematoma – see Dissection, aorta;
  - Angiolymphoid hyperplasia, with eosinophilia (ALHE) (228.01);
  - Interrogation of a cardiac pacemaker (V53.31);
    [NOTE: Meeting attendees suggested also adding Index entries for interrogation of a cardiac defibrillator, neurostimulator, and loop recorder)]
  - IRIS (Immune Reconstitution Inflammatory Syndrome) (995.90);
  - Pregnancy complicated by cholestasis (646.7);
  - Pregnancy complicated by insulin resistance (648.8);
  - Saddle injury – see Contusion, by site;
    [NOTE: A meeting attendee noted that saddle injury may also be an open wound, so it was suggested that the proposed Index entry be changed to direct the user to "see Injury, by type"]
  - Post chemoembolization syndrome – code to associated conditions.
- Deletion of a number of the outdated non-essential modifiers for the main term "Pneumonia" in the Index;
- Revision of Index entry for localized sepsis – code to specific localized infection.

PROCEDURES

Central Venous Catheter Placement Using Intravascular Electrocardiographic Guidance

A new approach to inserting indwelling vascular catheters involves the use of electrocardiographic guidance to assist with proper positioning of the catheter. The 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.

Creation of a new code for electrocardiogram guided central venous catheter placement has been proposed.

Closed Chest Intracardiac Mitral Valve Repair

The MitraClip® procedure is a minimally invasive, closed chest catheter based approach for intracardiac repair of mitral regurgitation caused by mitral valve pathology and/or left ventricular dysfunction. This procedure is an alternative to the open chest, open heart

surgical approach. The MitraClip® device is designed to reduce mitral regurgitation by clipping together the leaflets of the mitral valve. While cardiopulmonary bypass is not required, this less invasive valve repair procedure remains a major intracardiac intervention requiring highly trained medical personnel, substantial facility resources, and operative time similar to open heart mitral valve surgery.

Creation of a unique code for endovascular mitral valvuloplasty has been proposed. Meeting attendees suggested that the proposed code title should be revised as it is too broad and is not clearly distinguished from existing code 35.96, Percutaneous valvuloplasty. It was suggested that the title of code 35.96 may also need to be revised.

Thoracoscopic Cardiac Ablation (Maze) Procedure

The maze procedure can be performed by open, thoracoscopic, or endovascular approach. As with the open approach, the thoracoscopically-assisted and total thoracoscopic techniques require opening the pericardium. Significant dissection of the pericardial sinuses and other vital structures is necessary to gain access to the target sites of the heart. As with the open technique, incisions can be made into the atria thorocoscopically, but linear ablations are most commonly used. The same energy sources are used as with the open technique. However, creation of the lesions is visualized via the thoracoscope.

Creation of a new code for excision or destruction of other lesion or tissue of heart, thoracoscopic approach, has been proposed, with accompanying revisions to existing codes 37.33, Excision or destruction of other lesion or tissue of heart, open approach, and 37.34, Excision or destruction of other lesion or tissue of heart, other approach. An alternative option presented would be to move the thoracoscopic approach from code 37.33 to code 37.34 instead of creating a new code.

Fat Grafting for Reconstructive Surgery

Fat grafting is a technique in which prepared fat cells are injected to correct soft tissue defects. Fat grafts are commonly used in reconstructive procedures, particularly in the breast following lumpectomy and as an adjunctive procedure with post-mastectomy reconstruction. Fat grafts are also used in cosmetic procedures, such as augmenting lips and filling in facial wrinkles.

The fat used for grafting is always autologous. Fat is harvested by liposuction from elsewhere on the patient's body, typically an unobtrusive area such as the abdomen, flanks, or thighs. After injecting tumescent fluid, a standard liposuction cannula is placed subcutaneously and adipose tissue is then aspirated. The volume of fat taken varies with the amount needed for reconstruction.

Before being used as a graft, the lipoaspirate must be processed to concentrate the number of fat cells. Conventionally, the standard is to filter the fat by centrifuging it. This procedure removes the extra fluid and leaves a more concentrated graft. Unfortunately, results have been variable and unpredictable because fat cells are subject to ischemia after grafting. This can lead to cell atrophy and recurring soft tissue defects. Therefore, new techniques have been developed to enrich the fat graft with more adipose progenitor

cells, also called adipose-derived stem and regenerative cells. Because the regenerative cells are believed to encourage neoangiogenesis and prevent cell death, this enriched material is likely to enhance graft survival. The first step in the enrichment process is to divide the lipoaspirate into two aliquots. One aliquot is biochemically "digested" to produce the adipose stem cells and other regenerative precursor cells. These are then mixed with the remaining portion of lipoaspirate to create a progenitor-enriched fat graft with a far greater concentration of stem and regenerative cells.

The technique for placement in the recipient area is the same for conventional and enriched fat grafts. The graft material is loaded into a syringe. The needle or cannula is inserted into the subcutaneous tissues at the site of the defect and small droplets of fat are injected. The needle is passed through many layers and in many directions to ensure even distribution and maximal surface area of the fat grafts. This maximizes exposure of the fat grafts to the surrounding native tissue to increase availability of oxygen and nutrients until the graft establishes a new blood supply. Total operative time for conventional fat grafting in breast reconstruction is about 1 ½ to 2 ½ hours. Because of the preparation, total operative time for enriched grafts is about 3 to 4 hours.

Creation of five new codes for fat graft to breast with and without use of enriched graft, fat graft of other subcutaneous sites with and without use of enriched graft, and extraction of fat for graft or banking has been proposed. CMS recommended not creating new codes, but rather, continuing to assign code 85.99, Other operations on the breast, for fat grafting to the breast. They also recommended continuing to assign code 86.83, Size reduction plastic operation, for liposuction to harvest the fat graft.

Meeting attendees expressed support for creating new codes for fat grafts and noted that code 86.83 is not an appropriate code for harvesting of a fat graft. It was suggested while codes for fat grafts would be useful, consideration should be given to not distinguishing those using enriched graft, as the documentation may not be available to identify this distinction.

Sternal Fixation with Rigid Plates

The conventional approach to sternal closure after cardiothoracic surgery is sternal wiring. However, in obese patients and others at increased risk for sternal dehiscence, rigid plate fixation of the sternum significantly reduces the incidence of sternal dehiscence. Sternal dehiscence is a complete or partial separation of the sternum following a medium sternotomy for cardiothoracic surgery. Patients with sternal dehiscence have an increased risk for deep sternal wound infections. Risk factors for sternal dehiscence and deep sternal wound infections after cardiothoracic surgery are obesity, diabetes mellitus, chronic obstructive pulmonary disease, renal failure, steroid use, and tobacco use.

The Synthes Titanium Sternal Fixation System (TSFS) provides rigid fixation using locking plate technology that functions like an "external fixator," but it is applied internally to the sternum. Plates link the two sternal halves and screws link the plates to the sternum and the ribs.

A new code to describe the insertion of a sternal fixation device with rigid plates has been requested. This proposed code could be used to track and measure the use and effect of sternal fixation with rigid plates in preventing sternal dehiscence and deep sternal wound infections.

Laparoscopic Hernia Repair Without Graft or Prosthesis
New codes to identify laparoscopic incisional, inguinal, or ventral hernia repair without graft of prosthesis have been requested. Since the volume of these procedures is very low, CMS recommended that no new codes be created and that code 53.59, Repair of other hernia of anterior abdominal wall continue to be assigned.

Cranial Implantation of Neurostimulator
The RNS® System is designed for the treatment of medically refractory localization-related (focal) (partial) epilepsy and includes a neurostimulator that is implanted in the skull and is connected to one or two leads that are implanted near the patient's seizure focus or foci. External products include a physician programmer and a patient remote monitor.

Existing codes for implantation of a neurostimulator pulse generator are for implantation in the subcutaneous tissue. Creation of unique codes for the cranial implantation and removal a neurostimulator pulse generator has been proposed. Existing code 02.93, Implantation or replacement of intracranial neurostimulator lead(s), would be assigned for the lead implantation.

Intralaminar Lumbar Decompression and Laminotomy with Epidurography and Image Guidance
Intralaminar lumbar decompression and laminotomy with epidurography and image guidance is a surgical treatment for lumbar spinal stenosis. This procedure removes the bone or tissue causing the pressure on the nerves through a minimally invasive approach.

A unique code for intralaminar lumbar decompression and laminotomy with epidurography image guidance has been proposed. Meeting attendees suggested revising the proposed code title to better describe the specific procedure and omit the term "laminotomy," since a laminotomy performed as an operative approach is not coded.

Biopsy of Soft Tissue Mass
Existing code 83.21, Biopsy of soft tissue, does not distinguish the approach (open vs. closed). Creation of a new coded for closed [percutaneous] [needle] biopsy of soft tissue has been proposed, along with a revision to the title of code 83.21 to limit its use to open biopsies.

Part of the code proposal involved revising the title of code 86.11, Biopsy of skin and subcutaneous tissue, to specify "closed [percutaneous] [needle]" biopsy. Meeting attendees opposed changing the title of code 86.11.

Continuous Glucose Monitoring

Hospitalized patients can be at a higher risk of infection and other complications if their blood glucose levels are elevated for prolonged periods. Conventionally, patients' glucose levels are managed by manually drawing intermittent blood samples over the course of the stay. These test results are necessarily limited to a snapshot at each point in time and may not present the entire picture of patients' glucose levels. Newer methods for continuous glucose monitoring have been developed which provide ongoing readings. Continuous glucose monitoring provides clinicians with a more comprehensive picture of trends in glucose levels and allows them to proactively manage glucose levels to within more tightly targeted ranges. There are two techniques for continuous glucose monitoring. One technique involves the direct measurement of blood glucose values, whereas the other technique measures glucose values from the interstitial fluids.

New codes for each of the two techniques for continuous glucose monitoring have been proposed. CMS recommended not creating new codes, as coders generally do not assign codes for laboratory tests.

Circulating Tumor Cell Enumeration Test

Circulating tumor cells in peripheral blood have emerged as an accurate and valuable method to monitor patient response to treatment in a variety of cancer populations. The presence of circulating tumor cells in peripheral blood is associated with decreased progression-free survival and decreased overall survival in patients treated for metastatic breast, colorectal, or prostate cancer.

A new code for circulating tumor cell enumeration, immunomagnetc, has been proposed. The presenter noted that this test is primarily performed in the outpatient setting. CMS recommended not creating a new code.

Intra-operative Angiography in Coronary Artery Bypass Graft Surgery

There are two technologies currently available for intra-operative coronary angiography: x-ray coronary angiography with cardiac catheterization and fluoroscopy; and intra-operative fluorescence vascular angiography (IFVA). The clinical utility for IVFA is to assess the function of venous and arterial vessels and blood perfusion in tissues and organs without the patient safety risks associated with radiation and traditional x-ray angiography.

Currently, ICD-9-CM does not identify intra-operative coronary angiography from that not performed intra-operatively. Nor does ICD-9-CM identify intra-operative fluorescence vascular angiography performed on coronary vs. non-coronary arteries. Three options were presented. The first option would be to not create any new codes and to continue to assign code 88.59, Intra-operative fluroscence vascular angiography, for IVFA performed on either coronary or non-coronary arteries. When the procedure is performed on the coronary arteries, the appropriate coronary arteriography code would also be assigned. The second option would revise code 88.59 such that it would only be used for IVFA in non-coronary arteries and code 88.57, Other and unspecified coronary arteriography, would be assigned any type of intra-operative coronary angiography. The third option would involve creating a unique code for IVFA in coronary arteries and

revising code 88.59 to limit its use to non-coronary arteries. CMS recommended the first option, so as to avoid disrupting thirty years of data on angiography by differentiating the location of the procedure.

Procedure Addenda
Proposed procedure addenda changes were reviewed. Proposed revisions include:

- Revision of the spinal fusion codes and creation of an instructional note to provide clarification on the appropriate use of these codes; and
- Revision of Index entries for the maze procedures performed on the heart to provide clarification on the appropriate use of these codes.

ICD-10 Updates

General Equivalence Mappings (GEMs)

The 2010 version of the GEMs reflects revisions made in response to industry feedback on the 2009 version. Both CMS and CDC welcome additional feedback as organizations start using the GEMs for their conversion activities. Attendees were urged to continue providing feedback, as this feedback will be used in preparing the 2011 version of the GEMs.

Freezing Updates to ICD-9-CM and ICD-10-CM/PCS

Based on industry input, CMS and CDC announced their recommendation regarding a code set freeze. They proposed that the last regular, annual updates to both ICD-9-CM and ICD-10-CM/PCS would be made on October 1, 2011. On October 1, 2012 and October 1, 2013, there would only be limited code updates to ICD-10-CM/PCS to capture new technologies and diseases. All other code proposals during the freeze period would be considered for implementation on October 1, 2014, a year after ICD-10-CM/PCS implementation. Regular updates to ICD-10-CM/PCS would resume on October 1, 2014.

CMS and CDC are interested in receiving additional comments on this issue.

The final decision regarding a code set freeze will be announced at the September 15-16, 2010 Coordination and Maintenance Committee meeting.

ICD-10-PCS Update

Rhonda Butler from 3M provided an overview of updates being proposed for the 2011 version of ICD-10-PCS. Since ICD-10-PCS currently does not specify that an ultrasound of the heart was performed transesophageally, a new qualifier value for "transesophageal" has been proposed for the appropriate tables.

The addition of the root operation "supplement" in body system "J," Subcutaneous Tissue and Fascia, has been proposed in order to capture soft tissue supplementation procedures for specific soft tissue body parts, such as pelvic region.

It has also been proposed to add the “eye” body part to the “supplement” root operation table in the “Eye” body system in order to more accurately code scleral buckle procedures.