April 12, 2006

VIA ELECTRONIC MAIL

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Centers for Medicare & Medicaid Services
CMM, HAPG, Division of Acute Care
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Dear Pat:

The American Health Information Management Association (AHIMA) welcomes the opportunity to provide comments on the proposed procedure code modifications presented at the March 23rd ICD-9-CM Coordination and Maintenance Committee (C&M) meeting.

Oppose Code Proposal

Automated Mechanical Anastomosis
AHIMA opposes the creation of a new code for automated mechanical anastomosis. ICD-9-CM coding conventions preclude the coding of the closure of operative sites, including vascular puncture. Therefore, we believe automated mechanical anastomosis is an inherent component of the coronary artery bypass graft and should not be coded separately. To make an exception for this type of closure would be confusing, would represent a significant departure from standard coding practice, and could open the door to requests for separate identification of other types of closures of operative sites.

Also, as an attendee pointed out at the meeting, category 39 excludes operations on coronary vessels, so a code for automated mechanical anastomosis could not be created in subcategory 39.3, Suture of vessel.

Therapeutic Temperature Management
We oppose the creation of a unique code for therapeutic temperature management. This description is

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vague and is not limited to the service described in the proposal. For example, adjusting the thermostat in the patient's room, placing a blanket on the patient, or bathing the patient in cool water could conceivably be considered a form of temperature management. We further believe that therapeutic temperature management would rarely be coded in the hospital inpatient setting, and therefore, assignment of one of the few remaining unused ICD-9-CM procedure codes for this service does not make sense.

Also, it is not clear why existing codes 99.81, Hypothermia (central) (local) and 39.62, Hypothermia (systemic) incidental to open heart surgery, can't be used to describe this service. These codes do not explicitly exclude the service described in the code proposal. A meeting attendee noted that code 99.81 has always been used for cooling an arm or a leg. However, the code description is not limited to this use, and, in fact, "central" is listed as a non-essential modifier.

Surgical Decompression with Insertion of Interspinous Stabilization Device
AHIMA opposes the creation of new codes for non-fusion spinal stabilization devices. We believe that code 84.59, Insertion of other spinal devices, should be used for these devices for the time being. The terminology used to describe these devices is inconsistent and confusing. We believe that there would be confusion between the proposed new code and code 84.58, Implantation of interspinous process decompression device, since the terminology sounds very similar. Also, it is not clear whether these devices should really be considered "stabilization" devices, since some evidence suggests that only fusion can stabilize the spine. Given the conflicting terminology and clinical information about the use of these devices, we believe it is premature to create unique codes for these devices.

Stereotactic Placement of Intracerebral Catheters via Burr Hole for Delivery of Therapeutic Agents
In the interest of conserving the limited space in ICD-9-CM, we do not believe it is necessary to create a unique code for stereotactic placement of intracerebral catheter(s) via burr hole(s) for delivery of therapeutic agent(s). We recommend the title of code 01.26 be modified to describe insertion of catheter(s) into cranial cavity and/or tissue (option 1 in the code proposal).

Infusion of Cintredekin Besudotox
We also do not believe it is necessary or appropriate to create a unique code for infusion of cintredekin besudotox. ICD-9-CM is not intended or designed to identify individual drugs. The ICD-9-CM structure, and limited availability of unused codes, cannot support the creation of codes for individual drugs. Cintredekin besudotox is a biological response modifier and is appropriately captured by code 99.28, Injection or infusion of biological response modifier (BRM) as an anti-neoplastic agent.

Support Code Proposal

Thermal Ablation of Liver, Lung, and Renal Lesions or Tissues
AHIMA supports the creation of new codes to capture the various approaches used to perform thermal ablation of liver, lung, and renal lesions or tissues. However, we also agree with the comment made during the meeting that consideration should be given as to whether unique codes are also needed for other types of energy sources, such as laser, cryotherapy, and microwave therapy – or whether it would make more sense to group these energy sources together and only differentiate them by approach.

Totally Endoscopic and Robot-Assisted Transmyocardial Revascularization
We support the proposal to differentiate percutaneous and endoscopic transmyocardial revascularization. These approaches are sufficiently different to warrant distinct codes.

Endoscopic Insertion of Bronchial Valve
AHIMA supports the creation of new codes for endoscopic insertion of bronchial valve. However, we question whether three codes for insertion/replacement are necessary. It is not clear what the basis is for the breakdown of number of valves included in proposed codes 33.71, 33.72, and 33.73. According to the code proposal, between 6 and 7 valves are placed on average. However, in the option presented, 6 and 7 valves would be assigned to two different codes. If 6-7 valves are the average, it would seem both 6 and 7 valves should be assigned to the same code. Also, it is not clear how often 1 to 3 or more than 7 valves are placed and whether unique codes are warranted for these situations.

Hip Resurfacing Arthroplasty
We support the creation of unique codes for hip resurfacing. However, to be consistent with the hip replacement codes, and in the interest of conserving space, we recommend that only two codes (for total and partial) be created rather than three codes. The existing code for partial hip replacement does not differentiate whether the femoral head or acetabulum is being replaced, and we feel it would be appropriate to follow the same structure for the resurfacing codes.

Hip Replacement Bearing Surfaces
We support option 3, which would create one new code for hip replacement bearing surface, ceramic-on-polyethylene. We agree with CMS' recommendation not to create a code for metal-on-ceramic bearing surface until it is closer to FDA approval.

Repair of Ventricular Septal Defect with Prosthesis, Closed Technique
AHIMA supports the proposal to create a code to distinguish the open and closed technique for repairing a ventricular septal defect with prosthesis.

Implantation of Visual Prosthetic Device
We support the creation of a new code for implantation of visual prosthetic device. There does not appear to be an existing code that adequately describes this procedure. We also recommend that a code for "other operation on lens" be created as well.

Addenda

We recommend that if brand names are going to be included in the Index, they should be listed under the main term for the procedure rather than listing the brand name as the main term. For example, Dynesys® is listed as a main term and is not listed under "insertion." The correct way to use the Index is to look up the main term for the procedure. Thus, if coding professionals use the Index correctly, they will never see the Index entry for Dynesys because they will be looking under the main term "insertion." Also, in some cases, the brand name is listed under both the main term for the procedure and the brand name itself. For example, Alteplase is listed under both "Administration" and "Alteplase." We believe brand names should only be listed under the main term for the procedure

(administration, insertion, implantation, etc.). This will not only save space, but it will ensure consistency in the Index structure and discourage incorrect use of the Index.

We agree with all of the other proposed addenda revisions.

Conclusion

Thank you for the opportunity to comment on the proposed procedure code revisions. If you have any questions, please feel free to contact me at (312) 233-1115 or sue.bowman@ahima.org.

Sincerely,

Sue Bowman, RHIA, CCS
Director, Coding Policy and Compliance