



March 31, 2010

VIA ELECTRONIC MAIL

Patricia Brooks, RHIA
Centers for Medicare & Medicaid Services
CMM, HAPG, Division of Acute Care
Mail Stop C4-08-06
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Brooks:

The American Health Information Management Association (AHIMA) welcomes the opportunity to provide comments on the proposed procedure code modifications presented at the ICD-9-CM Coordination and Maintenance (C&M) Committee meeting held on March 9th - 10th.

ICD-10-PCS 2011 Proposed Changes

AHIMA supports the proposed changes to ICD-10-PCS that were presented at the March 9th C&M Committee meeting.

Central Venous Catheter Placement Using Intra-Vascular Electrocardiographic Guidance

We do **not** support the creation of a unique code for electrocardiogram guided central venous catheter placement, as the use of electrocardiographic guidance does not change the components of the catheterization procedure itself. The catheterization procedure is still appropriately described by code 38.93, Venous catheterization NEC, regardless of the use of any type of guidance to ensure proper positioning of the catheter.

Closed Chest Intracardiac Mitral Valve Repair

Although we support the proposal to create a unique code for the MitraClip® repair, we do not believe the proposed title of the new code adequately distinguishes this procedure from the procedures classified to code 35.96, Percutaneous valvuloplasty. If the intent of code 35.96 is to be used for balloon valvuloplasty, then the code title should be revised to state “percutaneous balloon valvuloplasty.” The title of the proposed code for the MitraClip® repair should specifically describe this procedure and code 35.96 should be clearly excluded from the new

code. It is important that code 35.96 and the proposed new code should be mutually exclusive, with no possible overlap due to broad or vague code titles.

Consideration should be given as to whether this or a similar procedure is likely to be performed on a valve other than the mitral valve, and therefore, the code title should not limit the use of the code to the mitral valve. For example, a potential title for the proposed new code might be “percutaneous, catheter-based repair of valve with implantation of device.”

Thoracoscopic Cardiac Ablation (Maze) Procedure

AHIMA supports option 3, which involves creating a new code for thoracoscopic maze procedure and accompanying revisions to existing codes 37.33 and 37.34. The thoracoscopic approach seems to be distinctly different from the other approaches and warrants a unique code. The accompanying revisions proposed in option 3 will help to clarify the appropriate use of the different codes for the maze procedure.

Fat Grafting for Reconstructive Surgery

While we support the creation of new codes for fat graft and extraction of fat for graft or banking, **we recommend that a single code be created for placing the fat graft**, rather than distinguishing the fat graft by that with and without use of enriched graft. We don't believe the documentation will typically be available to make this distinction.

Regarding CMS' suggested interim code assignments, we do **not** agree that code 86.83, Size reduction plastic operation, should be assigned for harvesting of a fat graft.

Sternal Fixation with Rigid Plates

AHIMA does **not** support the creation of a unique code for sternal fixation with rigid plates. This procedure appears to be performed as part of the primary closure of the sternum following cardiothoracic surgery. Typically, operative wound closure is not separately coded in ICD-9-CM. In fact, sternal wiring, which is also performed to close the sternum after cardiothoracic surgery, is not separately coded.

If sternal fixation is performed for an indication other than sternotomy closure, such as a fracture of the sternum, it can be appropriately captured with existing codes. The diagnosis code would describe the indication.

If CMS decides to create a unique code for sternal fixation, instructional notes should make it clear that the code should not be used for closure of the sternum following cardiothoracic

surgery. This will prevent confusion and ensure consistency with current instructions and coding advice regarding the coding of operative closure.

Laparoscopic Hernia Repair Without Graft or Prosthesis

We agree with CMS' recommendation of option 1. Since the incidence of these procedures is so low, no new codes should be created.

An inclusion term should be added under the appropriate existing codes to clarify that the laparoscopic approach is included in these codes. This inclusion term should not only be added under code 53.59, Repair of other hernia of anterior abdominal wall, but under the appropriate codes for inguinal and incisional hernia repair as well.

Cranial Implantation of Neurostimulator

AHIMA supports the creation of two new codes for cranial implantation or replacement of neurostimulator pulse generator and cranial removal of neurostimulator pulse generator. A "code also" note should be added under code 02.93, Implantation or replacement of intracranial neurostimulator(s) to refer to the new code for any implantation of neurostimulator pulse generator.

We respectfully disagree with part of the interim coding advice that was described in the code proposal. Code 86.95, Insertion or replacement of dual array neurostimulator pulse generator, not specified as rechargeable, should not currently be assigned for the cranial implantation or replacement of a neurostimulator. This code is located in a category for operations on skin and subcutaneous tissue. Therefore, code 86.95 would not be appropriate for a cranial procedure. The interim code assignment should be code 01.24, Other craniotomy.

Intralaminar Lumbar Decompression and Laminotomy with Epidurography and Image Guidance

We support option 2, creation of a new code to describe intralaminar lumbar decompression and laminotomy with epidurography and image guidance. Based on the code proposal and the presentation given at the C&M Committee, the procedure appears to be uniquely different from other lumbar decompression procedures classified to code 03.09, Other exploration and decompression of spinal canal.

We recommend that the proposed code title be revised to better reflect the specific procedure performed.

Biopsy of Soft Tissue Mass

AHIMA supports creation of a new code for closed [percutaneous] [needle] biopsy of soft tissue and the revision of the title of existing code 83.21 to indicate “open.” A default for biopsy of soft tissue, not otherwise specified, will need to be indicated in the index.

However, we disagree with revising the title of code 86.11 to specify “closed [percutaneous] [needle] biopsy of skin and subcutaneous tissue.” The title of code 86.11 should remain as “Biopsy of skin and subcutaneous tissue” so that this code may appropriately be assigned for any type of biopsy of the skin and subcutaneous tissue. The proposed revision to the code title would create confusion as to the appropriate use of this code and the proper code to assign for skin and subcutaneous tissue biopsies that are not described as closed/percutaneous/needle.

Continuous Glucose Monitoring

AHIMA opposes the creation of unique codes for continuous glucose monitoring. ICD-9-CM is not an appropriate code set for capturing the monitoring of glucose levels. This type of information would be more appropriately captured by a clinical terminology incorporated into an electronic health record system.

Circulating Tumor Cell Enumeration Test

AHIMA opposes the creation of a code for circulating tumor cell enumeration test. ICD-9-CM codes are not currently used to capture any type of laboratory test. It would not make sense to create a code that likely would not be used. ICD-9-CM is not an appropriate code set for identifying specific laboratory tests.

Intra-operative Angiography in Coronary Artery Bypass Graft Surgery

We agree with CMS’ recommendation of option 1 to not create any new angiography codes. As CMS noted, classifying both SPY and fluorescence coronary angiography to code 88.57, Other and unspecified coronary arteriography, would disrupt thirty years of trend data. Both of the options presented for new codes were confusing and unclear as to the intent. They would also result in changing the meaning of existing codes.

We believe the procedures described in the code proposal can be accurately captured with the use of existing codes.

Patricia Brooks
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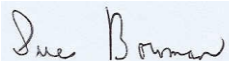
Addenda

We support the proposed addenda changes.

We especially appreciate CMS' efforts to improve the clarity of the spinal fusion codes. We support the changes to these codes that were presented at the March C&M meeting. However, some additional clarification as to how "technique" for the spinal fusion codes should be determined may be needed. At the C&M meeting, the position of the patient on the operating table and the anatomical approach were both mentioned. **We believe the technique should be based on the anatomical approach rather than the position of the patient.**

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,

A handwritten signature in cursive script that reads "Sue Bowman". The signature is written in black ink on a light blue rectangular background.

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