November 29, 2005

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 Pat:

The American Health Information Management Association (AHIMA) welcomes the opportunity to provide comments on the proposed procedure code modifications presented at the September 29th ICD-9-CM Coordination and Maintenance Committee (C&M) meeting.

**Do not support code proposal**

**Insertion of Spinal Stabilization Device**
AHIMA does not support the creation of a new code for insertion of non-fusion spinal stabilization. We agree with CMS’ recommendation that code 84.59, Insertion of other spinal devices, should continue to be assigned for this procedure, given the limited availability of ICD-9-CM codes, the lack of FDA approval, and the vast array of potential technologies in this area.

**Computerized External Fracture Fixation**
We do not support creation of a code for application of computerized external fixator device. For one thing, the proposed code description is misleading because the device itself is not “computerized.” The “computerization” aspect is just computer software that assists physicians in calculating a prescription for strut adjustment and replacement. We do not believe that this use of computer software requires a distinct code. We recommend that existing codes for application of external fixator devices be used, and the use of computer software should be considered inherent.

We also do not support option #3 which suggested the use of a code from subcategory 00.3, Computer-assisted surgery [CAS], in conjunction with an existing code for application of an external fixator device.
We do not believe that application of the Taylor Spatial Frame could be considered a type of computer-assisted surgery.

Procedure on Bifurcated Vessels
AHIMA does not support the proposal for a new code for procedure on bifurcated vessel. We believe the proposal, as presented at the meeting, would result in significant confusion as to when this code should be used and how it should be used with the new codes for number of vessels and number of stents. However, we recognize the increased complexity of inserting stents to treat a lesion at a bifurcation and the value of capturing data on these procedures. We believe a new code for “insertion of stents at a vessel bifurcation” (rather than just “procedure on bifurcated vessel”), with clear instructions that additional codes should be assigned for the angioplasty, number of vessels treated, number of stents inserted, and whether the stent was drug-eluting or non-drug-eluting, would be a preferable alternative to the code proposed at the meeting. A code that clearly describes the use of stents to treat a lesion at a vessel bifurcation would be easier to understand and apply consistently than the code description presented at the meeting.

Support Code Proposal

Implantable Hemodynamic Monitor
We support the proposal to create two codes for insertion or replacement of sensor and subcutaneous device for intracardiac hemodynamic monitoring. Based on the presenter’s comments, we believe two codes are necessary for those cases when both components are not replaced. We agree with the suggestion made during the meeting that the term “pressure sensor lead” should be used in either the code description or in an inclusion term.

Laparoscopic Hysterectomy
AHIMA supports the proposal to create new codes for laparoscopic hysterectomies. We recommend that the descriptions for proposed codes 68.49, 68.69, and 68.79 should state “other and unspecified” rather than “not otherwise specified.”

Endovascular Mechanical Thrombectomy of Precerebral and Cerebral Vessels
We support the proposal for a new code for endovascular removal of obstruction from head and neck vessel(s). We agree with the suggestion made during the meeting that an additional code should be assigned for the number of vessels treated (00.40-00.43), since more than one vessel might undergo treatment at the same operative episode. We also support the recommendation that an Excludes note for the proposed new code be added under code 38.01, Incision of vessel, intracranial vessels.

Cardiac Electrophysiologic Studies
We fully support distinguishing between catheter-based invasive electrophysiologic testing from noninvasive programmed electrical stimulation and adding notes under the codes for implantation of pacemakers and defibrillators indicating that device testing is inherent in the procedure. These changes should alleviate the confusion surrounding the coding of various types of cardiac electrophysiologic studies and improve coding accuracy and consistency. However, we recommend that a new code be created for catheter-based invasive electrophysiologic testing instead of re-titling code 37.26 so as not to change the meaning of an existing code. We also agree with the comment made during the meeting that the note under the pacemaker/defibrillator implantation codes should state that device testing performed
during the operative episode is an inherent part of the implantation procedure (to clarify that device testing performed separately from the implantation procedure is not inherent).

**Addenda**

We support the proposed addenda revisions presented at the meeting.

**Availability of ICD-9-CM**

AHIMA opposes the random assignment of procedure codes to inappropriate chapters as an acceptable approach for addressing the dwindling availability of codes. This approach would significantly disrupt the system structure, increase coding errors, and have a major detrimental effect on data quality. We also oppose the deletion and re-use of infrequently-assigned codes due to the negative impact on trend data and research. **We believe the ultimate solution in order to maintain the integrity and quality of national healthcare data is to implement ICD-10-PCS as a replacement for the ICD-9-CM procedural coding system.** We commend CMS for their Herculean effort in keeping ICD-9-CM going for this long, but all reasonable approaches for stretching its capacity will soon be exhausted, necessitating nothing short of a complete replacement. Any further attempts at Band-Aid solutions will result in a complete breakdown of the coding system, leading to unacceptable consequences for the quality of our healthcare data and all of the purposes for which it is used.

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