# Summary of September 2009 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) and the Centers for Medicare and Medicaid Services (CMS), met on September 16-17, 2009 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.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.

**The proposed code modifications, if approved by CMS and NCHS, would go into effect with discharges on or after October 1, 2010. None of the code proposals presented at this meeting is being considered for implementation on April 1, 2010.**

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 September 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 September 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.

**The deadline for receipt of public comments on the code proposals presented at the September meeting is November 20, 2009.**

The next meeting of the ICD-9-CM Coordination and Maintenance Committee is scheduled for March 9-10, 2010 and will be held at the CMS building in Baltimore, MD. New proposals for inclusion on this agenda must be received by **January 8, 2010**.

## Diagnoses

### Multiple Gestation Placenta Status

New status codes for multiple gestations that indicate the number of placentas and amniotic sacs have been requested. Depending on the number, the risk of complications is higher and the treatment plan differs.

Codes under category 651, Multiple gestation, cannot be expanded because all codes in the Obstetric chapter have fifth digits for episode of care. A new V code category has been proposed to capture the additional information on number of placentas and amniotic sacs. A code from category 651 would be sequenced first. Instructional notes would be needed regarding the appropriate code to assign when or more of the fetuses has died or there has been a selective reduction.

### Hemolytic Transfusion Reaction (HTR)

Unique codes for hemolytic transfusion reactions (HTR) have been proposed. Currently, ICD-9-CM does not distinguish between ABO and non-HBO HTRs and between acute HTRs and delayed HTRs.

A hemolytic transfusion reaction is a reaction of increased destruction of red blood cells due to incompatibility between blood donor and recipient. The reaction includes clinical and laboratory signs of increased destruction of red blood cells (e.g., fever, chills, rigors, hemoglobinuria, presence of antibodies to RBC antigens, and ABO or non-ABO incompatibility). Hemolytic reactions can be either acute or delayed, depending on the timing of their occurrence and can be due to either ABO or non-ABO incompatibility.

An acute hemolytic transfusion reaction (AHTR) involves accelerated destruction of red blood cells immediately within 24 hours of a transfusion. Clinical and laboratory signs of hemolysis are present.

A delayed hemolytic transfusion reaction (DHTR) has accelerated destruction of red blood cells which usually manifests between 24 hours and 28 days after a transfusion and includes clinical or biological signs of hemolysis.

A commenter suggested deleting the current instructional notes under 999.89, Other transfusion reaction, and moving them to the proposed new code for unspecified transfusion reaction. Another commenter suggested that an Excludes note for the proposed codes be added under subcategory 780.6, Fever and other physiologic disturbances of temperature regulation, so that post-procedural fever would not be coded in addition to the proposed new codes. It was also suggested that code 999.5, Other serum

reaction, should be reviewed to see if any changes to this code are needed in light of the proposed new codes.

**Transfusion Transmitted Infections**

A new code for transfusion transmitted infection was proposed. Tranfusion-transmitted infections include any infectious organism transmitted through transfusion of blood or blood products.

Concerns were expressed that the proposed "use additional code" note requiring the proposed new code to be sequenced before the specific infection would violate current coding guidelines regarding the sequencing of HIV. Questions were raised about the use of this code when the infection develops some time after the patient received the transfusion. A commenter noted that since there are medicolegal implications of the proposed code, consideration should be given regarding the use of the code for probable/possible/suspected cases. It was suggested that instead of creating a new code, transfusion transmitted infections could be captured by assigning the specific infection code and an external cause code for blood products.

**Febrile Nonhemolytic Transfusion Reaction (FNHTR)**

Creation of a unique code for febrile nonhemolytic transfusion reaction (FNHTR) has been proposed. Febrile nonhemolytic transfusion reaction includes fever, chills, and rigors without hemolysis, occurring within four hours after transfusion. The two most commonly described mechanisms of the reaction are passively transfused cytokines and a reaction between recipient antibodies and transfused leukocytes.

It was suggested that this proposed code be located in subcategory 780.6, Fever and other physiologic disturbances of temperature regulation, rather than in subcategory 999.8, Other infusion and transfusion reaction.

**Post Transfusion Purpura (PTP)**

A new code for post transfusion purpura (PTP) has been proposed. This condition is characterized by sudden severe thrombocytopenia, usually arising 5-12 days following transfusion of blood components.

**Transfusion-Associated Circulatory Overload (TACO)**

A new code for transfusion-associated circulatory overload (TACO) has been proposed. TACO is a circulatory overload following transfusion of blood or blood components, which may be either due to the high rates and large volumes of infusion that cannot be effectively processed by the recipient, or underlying cardiac or pulmonary pathology. TACO is characterized by acute respiratory distress, increased blood pressure, pulmonary edema secondary to congestive heart failure, and positive fluid balance, during or within 6 hours of transfusion. Occurrence of TACO is very likely to be underreported due to a

variety of differential diagnoses that present as acute respiratory distress in the transfused individuals, including transfusion-associated lung injury (TRALI) and anaphylaxis.

A commenter noted that clarification will be needed regarding the sequencing of the proposed code with the heart failure codes.

**Transfusion-Associated Hemochromatosis (Iron Overload)**

Creation of a unique code for hemochromatosis due to repeated red blood cell transfusions has been proposed. An alternative option was presented that would involve creating codes for other causes of iron overload as well.

Transfusion-associated hemochromatosis may result in organ damage, including heart, kidney, and liver dysfunction.

It was suggested that inclusion terms for frequently-used descriptions for this condition be added under the proposed new code, since transfusion-associated hemochromatosis may not be specifically documented.

**Stuttering**

A new code for childhood onset stuttering disorder has been proposed, along with a revision of the title of existing code 307.0 to state "stuttering with onset after puberty."

There are three major recognized forms of stuttering: stuttering with onset in early childhood, stuttering with onset after puberty, and fluency disorder subsequent to brain lesion or disease, most typically as a result of cerebrovascular disease (sometimes called neurogenic stuttering).

It was suggested that the proposed revision to the title of code 307.0 be revised to state "adult onset" instead of "onset after puberty." A commenter noted that there is a fourth type of stuttering, that due to traumatic brain injury or other neurological conditions. It was suggested that this type of stuttering be classified to code 784.59, Other speech disturbance, since it would be inappropriate to assign code 307.0.

**Multiple Sclerosis**

An expansion of code 340, Multiple sclerosis, has been proposed which would create unique codes for progressive relapsing, relapsing remitting, primary progressive, and secondary progressive multiple sclerosis. Treatments are often specific for the different types of multiple sclerosis, and payers often have to request medical record documentation to obtain information on the type. The intent of the proposal was to facilitate electronic claims processing by reducing requests for additional documentation.

A commenter recommended not expanding code 340 at this time. There currently is not consensus on the types of multiple sclerosis identified by proposed code expansion. Ongoing work is being done to improve the clinical classification of multiple sclerosis. Within the next few years, medications for multiple sclerosis may be based on the patient's genetic make-up.

It was suggested that consideration be given to expanding code 340 to distinguish multiple sclerosis with and without acute exacerbation.

**Neurogenic Claudication**

A code proposal was presented that would allow lumbar stenosis with neurogenic claudication to be distinguished from that without lumbar stenosis. A new code would be created for lumbar stenosis with neurogenic claudication, and existing code 724.02, Spinal stenosis, lumbar region, would be revised to indicate "without neurogenic claudication."

Neurogenic claudication is a commonly used term for a syndrome associated with significant lumbar spinal stenosis leading to compression of the cauda equina (lumbar nerves). Symptoms experienced include buttock and lower extremity cramping, pain, and fatigue. Neurogenic claudication symptoms can be similar to vascular claudication symptoms, but are due to multiple lumbar nerve root compression rather than vascular insufficiency.

It was recommended that the American Academy of Orthopedic Surgeons be asked to review this proposal prior to final approval.

**Acquired Absence of Pancreas**

Unique codes for acquired total and partial absence of pancreas have been proposed. Since there is no more space in category V45, Other postprocedural states, or subcategory V45.7, Acquired absence of organ, creation of new codes in category V88, Acquired absence of other organs and tissue, have been proposed. Additional codes would be assigned to identify any associated insulin use or secondary diabetes mellitus.

**Do Not Resuscitate**

A unique code for do not resuscitate status has been requested. This code would only be assigned when there is an order in the medical record for the current encounter.

**Physical Restraints**

A unique code for physical restraint status has been requested. An Excludes note would indicate that no code should be assigned for physical restraints due to a procedure (i.e., use of restraints during administration of anesthesia).

**Combat Operational Stress Reaction (COSR)**

Creation of a new code for personal history of combat and operational stress reaction has been proposed. A personal history code would provide the capability of tracking patients who later have symptoms related to having had COSR. An inclusion term for combat and operational stress reaction would be added under category 308, Acute reaction to stress.

**Neurofibromatosis – Schwannomatosis**

An expansion of code 237.7, Neurofibromatosis, has been requested to create a new code for schwannomatosis.

**Mesh Erosion/Mesh Exposure**

The American College of Obstetricians and Gynecologists has requested unique codes for mesh erosion and mesh exposure in category 998, Other complications of procedures NEC.

In an abdominal sacral colpopexy, a graft is used to suspend the upper vagina to the anterior longitudinal ligament of the sacrum. Synthetic graft material used to suspend the apex of the vagina to the anterior longitudinal ligament of the sacrum has been associated with mesh erosion and subsequent pelvic infection (due to the erosion into internal organs). Treatment usually requires excision of the mesh. Exposure of the mesh into the vagina can also occur, but is a less severe condition.

Concerns were expressed that the terms "mesh erosion" and "mesh exposure" may be used interchangeably and may not be used (or used consistently) outside of gynecological surgery. It was suggested that perhaps the new codes should be located in the Genitourinary chapter so that their use could be limited to mesh used in gynecological procedures.

**Obesity Hypoventilation Syndrome (Pickwickian syndrome)**

A unique code for obesity hypoventilation syndrome has been proposed in subcategory 278.0, Overweight and obesity. In obesity hypoventilation syndrome, also known as Pickwickian syndrome, breathing problems cause chronic hypoventilation that manifests with decreased oxygen levels and elevated carbon dioxide levels. It involves sleep disordered breathing.

A commenter noted that guidance would be needed on code sequencing when other associated conditions, such as respiratory failure, are present as well.

**Heart Failure Terms Related to Systolic Function**

It has been proposed to add inclusion terms related to systolic and diastolic function under the subcategories for systolic heart failure, diastolic heart failure, and combined systolic and diastolic heart failure.

It was noted that clear instructions and guidelines would need to be provided to ensure that it is understood that these inclusion terms must be stated by the physician in order to be used for coding purposes, and that coders should not pick them up from echocardiogram reports.

**High Cardiac Output Heart Failure**

Creation of a unique code for high cardiac output heart failure has been proposed. High cardiac output heart failure develops secondary to a number of other conditions.

A question was raised as to how a diagnosis of "high output septic shock" would be coded. A commenter noted that septic shock and high output cardiac failure are separate conditions and are managed differently, so they should not be excluded from one another.

**Encounters for the Insertion, Checking or Removal of an Intrauterine Contraceptive Device**

It has been proposed that code V25.1, Insertion of intrauterine contraceptive device, be expanded to create distinct codes for insertion and removal of an intrauterine contraceptive device. Both of these codes could be used together. Code V25.42, Surveillance of previously prescribed contraceptive methods, intrauterine contraceptive device, would be limited to routine surveillance of an existing device.

It was suggested that "incidental finding" be deleted from the proposed Excludes note for presence of intrauterine contraceptive device under code V25.42, so as to not mislead people into thinking incidental findings should be coded. A commenter recommended that consideration be given to creating an additional code for "removal with immediate reinsertion of an intrauterine contraceptive device."

**External Cause Status**

A new external cause status code for volunteer activity has been proposed. The addition of an inclusion term for "activity of child or other family member assisting in compensated work of other family member" under code E000.8, Other external cause status, was also proposed. The inclusion term under code E000.0, Civilian activity done for income or pay, would be revised to clarify that only legal compensation is included in this code.

Commenters noted that the modification of the inclusion term under code E000.0 might actually be more confusing and make the use of this code unnecessarily complicated. Also, the meaning of the proposed inclusion term under code E000.8 is not entirely clear without the examples described in the body of the proposal. It was recommended that these examples be added to the inclusion term.

**Heat Illness (Heat Exhaustion, Heat Injury, and Heat Stroke)**

The US Army has requested the creation of a new code for heat injury. An instructional note would indicate that additional code(s) should be assigned for any associated complication of heat injury. It has also been proposed that instructional notes be added under code 992.0, Heat stroke and sunstroke, to indicate that any complications of heat stroke, such as coma or systemic inflammatory response syndrome (SIRS), should also be coded.

A commenter noted that the use of the term "heat injury" as described in the US Army's code proposal, is not consistent with terminology used in the civilian environment. The condition the US Army calls "heat injury" would usually be called "heat exhaustion." Concerns were expressed about using terms and associated definitions that are not universally recognized. It was suggested that additional input on this code proposal should be sought from appropriate medical specialty societies.

**Retained Foreign Bodies**

A new category for retained foreign body status and a new code for personal history of retained foreign body fully removed have been proposed. Although the new codes would be useful primarily for the military, they would also be applicable to any injury resulting in embedded fragments. These codes would not be applicable to internal medical devices.

Injuries from explosions often include fragments or splinters from the explosive device embedding in the injured person. In some cases, the fragments can be removed. In other cases, they are too difficult to remove because of their number or their location in the body. Any embedded object has the potential to cause infection due to the object itself or an organism present on it when it entered the body. An embedded magnetic object is a contraindication to an MRI test. Some types of embedded fragments, such as those composed of lead, pose long-term health risks. Certain metal alloys, including some containing tungsten, may also be long-term toxicological hazards.

Commenters noted that subcategory V87.3, Contact with and (suspected) exposure to other potentially hazardous substances, does not seem to be the most appropriate place to create a code for personal history of retained foreign body fully removed. It was suggested that the proposed personal history code should be created in subcategory V15, Personal history of injury. Other commenters also noted that there are differing interpretations of the meaning of "retained." The proper use of the codes containing this term, both existing codes and the proposed new codes, needs to be clarified. There needs to be a distinction in ICD-9-CM between retained versus current foreign body.

**Homicidal Ideations**

A new code for homicidal ideations has been proposed. Homicidal ideation is an important risk factor when trying to identify a person's risk for violence. Co-existing suicidal and homicidal ideations present in many patients.

It was suggested that the proposed code be allowed as either a principal or secondary diagnosis.

**Long-Term Use versus Prophylactic Use of Medications**

Changes in the Tabular and Index have been proposed to clarify the appropriate use of codes in subcategories V07.5, Prophylactic use of agents affecting estrogen receptors and estrogen levels, and V58.6, Long-term (current) drug use. Codes under subcategory V07.5 are intended to be used for any long-term use of the agents classified under this

subcategory, regardless of whether the use was prophylactic or for active treatment. However, this caused confusion because the title of code V07.5 specifies "prophylactic use."

Also, the indexing of administration for antibiotics is inconsistent. Code V58.62, Long-term (current) use of antibiotics, is the appropriate code for all long-term uses of antibiotics, including prophylactic use for the prevention of infection. Short-term use of drugs, including antibiotics, is not classified in ICD-9-CM.

As part of the proposed changes, the titles of category V07, subcategory V07.5, and the codes under this subcategory would be broadened to include treatment as well as prophylactic use. Index entries would be modified to correct inconsistencies for the long-term administration of antibiotics.

Commenters noted that "long-term" should be included in the index entries for administration of antibiotics, but it shouldn't be a non-essential modifier, as that would defeat the intent of the proposed modifications and allow use of code V58.62 for short-term antibiotic administration.

**Jaw Pain**

A new code for jaw pain has been proposed. Although this condition is currently indexed to code 526.9, Unspecified disease of the jaws, the new code would be created under subcategory 784.9, Other symptoms involving head and neck, because it may be a symptom of a condition unrelated to a jaw disorder, such as a myocardial infarction.

It was suggested that an Excludes note be added under the proposed code to ensure that temporomandibular joint disorders are not classified as jaw pain.

**Diagnosis Addenda**

Proposed diagnosis addenda changes were reviewed. Highlights of the proposed revisions include (note that these are only proposed at this point – they have not been finalized):

- Revision of inclusion term under category 403, Hypertensive chronic kidney disease, to state "any condition classifiable to 585 and 587 with any condition classifiable to 401;
- Addition of inclusion term for "influenza NEC" under code 487.1, Influenza with other respiratory manifestations;
- Addition of note under code 572.3, Portal hypertension, indicating that an additional code should be assigned for any associated complications, such as portal hypertensive gastropathy (537.89);
- Revision of the term "habitual aborter" to "recurrent pregnancy loss;"
- Deletion of Excludes note under code 799.82, Apparent life threatening event in infant, and addition of a note indicating that the confirmed diagnosis, if known, should be coded first and a note indicating that additional code(s) should be assigned for associated signs and symptoms;

(Commenters noted that the wording of the notes needs to clarify that additional code(s) for associated signs and symptoms should not be assigned if the confirmed diagnosis is known)

- Addition of inclusion terms for "fall from motorized mobility scooter" and "fall from motorized wheelchair" under code E884.3, Fall from wheelchair;
- Revision of Index entry for allergy, allergic (reaction), anaphylactic shock (995.0);
- Addition of Index entry for complications, graft, corneal NEC, retroprosthetic membrane (996.51);
- Addition of Index entry for disease, microvillus inclusion (MVD) (751.5);
- Revision of Index entries for gastropathy, congestive portal, and gastropathy, portal hypertensive, to indicate that both codes 572.3 and 537.89 are needed to fully describe the condition;
  (Commenters noted that the concept of needing two codes to fully describe one condition applies to other conditions as well, and consideration should be given to adding the concept of showing two codes for an Index entry for these other conditions as well. Another commenter suggested that this type of new concept should not be introduced into ICD-9-CM.)
- Revision of External Cause Index entry for exhaustion, due to excessive exertion (E927.2).

## Procedures

### Insertion of Drug-Eluting Stent

A new code for insertion of drug-eluting superficial femoral artery stent(s) has been requested. The first drug-eluting peripheral stent is likely to be approved within the next year specifically for the superficial femoral artery, and the current ICD-9-CM code for insertion of drug-eluting peripheral vessel stent(s) encompasses all peripheral vessels.

CMS recommended that no new code be created, as a code already exists for insertion of drug-eluting stent in a peripheral vessel. The cases involving the superficial femoral artery would be easily identified because no other sites have been approved for insertion of peripheral stents.

### Reverse Total Shoulder Replacement

A new code has been proposed for reverse total shoulder replacement. As indicated by the name, the ball and socket implants go in opposite locations from a conventional procedure. This procedure is an alternative procedure for patients whose shoulder disorder cannot be effectively managed with a conventional total shoulder replacement, such as those with rotator cuff tear arthropathy or complex fractures, or those who had previously undergone a conventional total shoulder replacement that has failed.

According to the code proposal, code 81.97, Revision of joint replacement of upper extremity, should be assigned for conversion of a prior (or failed) total shoulder

replacement to a reverse total shoulder replacement, A commenter suggested creation of a unique code for the conversion procedure in addition to the proposed code for reverse total shoulder replacement.

**Bronchoscopic Bronchial Thermoplasty**

Creation of a unique code has been proposed for bronchoscopic bronchial thermoplasty, ablation of airway smooth muscle. Bronchial thermoplasty of airway smooth muscle is a new bronchoscopic procedure involving the application of radio-frequency based technology to the airways for treatment of severe asthma. It involves ablation of airway smooth muscle in the lung.

It was suggested that if a new code is approved, an Excludes note should be added to distinguish this procedure from existing code 32.26, Other and unspecified ablation of lung lesion or tissue. Another commenter noted that since only about 3% of these procedures are performed on an inpatient basis, perhaps code 32.26 should continue to be assigned for this procedure instead of creating a unique code.

**Circulatory Support Devices**

It has been proposed to create a new code for insertion of impeller pump circulatory support device. A note would indicate that this code includes both percutaneous and open approaches.

The Impella 5.0® and Impella LD® ("left direct") devices are small continuous circulatory assist devices that use an internal impeller to provide continuous high blood flow rates. An impeller is a rotating component of a centrifugal pump which transfers energy from the motor that drives the pump to the fluid (in this case, blood) being pumped by accelerating the blood outwards from the center of rotation. The 5.0® device is inserted using a catheter inserted into the femoral artery and the LD® device is inserted directly into the heart during open cardiac surgery.

CMS also proposed deletion of the inclusion terms for "acute circulatory support device" and "short-term circulatory support (up to six hours)" under code 37.62, Insertion of temporary non-implantable extracorporeal circulatory assist device. In addition, CMS asked the industry to consider whether code 37.62 should be deleted because it is unclear which devices are classified to this code versus code 37.68, Insertion of percutaneous external heart assist device.

**Carotid Sinus Baroreflex Activation Device**

Creation of a new subcategory for operations on carotid body, carotid sinus and other vascular bodies has been proposed, with specific codes created for:

- Implantation or replacement of carotid sinus baroreflex activation device, total system
- Implantation or replacement of carotid sinus lead(s) only
- Implantation or replacement of carotid sinus pulse generator only

- Removal of carotid sinus baroreflex activation device, total system
- Removal of carotid sinus lead(s) only
- Removal of carotid sinus pulse generator only
- Other and unspecified operations on carotid body, carotid sinus and other vascular bodies

The Rheos carotid sinus baroreflex activation system™ is an implantable medical device designed to electrically activate the baroreflex, the system that helps regulate cardiovascular function. It is currently in clinical trials for use in treatment of hypertension and heart failure.

A commenter suggested that the new codes for "total system" are not necessary, as the components of the procedure could be individually coded with the other proposed codes for the lead(s) and pulse generator.

### Procedure Addenda

Proposed procedure addenda changes were reviewed. Highlights of the proposed revisions include (note that these are only proposed at this point – they have not been finalized):

- Addition of inclusion term for "amygdalohippocampectomy" under code 01.59, Other excision or destruction of lesion or tissue of brain;
- Deletion of inclusion term for "modified maze procedure, trans-thoracic approach" and addition of inclusion term for "that by median sternotomy" under code 37.33, Excision or destruction of other lesion or tissue of heart, open approach;
- Deletion of "via peripherally inserted catheter" in inclusion term under code 37.34, Excision or destruction of other lesion or tissue of heart, other approach," and addition of "thoracoscopic (endoscopic) approach" to an inclusion term under this code;
- Addition of note under subcategories 81.0, Spinal fusion, and 81.3, Refusion of spine, to clarify spinal fusion techniques;
- Revisions to spinal fusion code titles and inclusion terms to clarify the appropriate use of these codes;
- Addition of Index entry for lavage, bronchus, diagnostic, bronchoalveolar lavage (BAL), mini-bronchoalveolar lavage (mini-BAL) (33.29);
- Addition of Index entry for Wang needle aspiration biopsy, lung (33.27).

## Other Discussion Topics

### ICD-10 MS-DRG Conversion Project

Pat Brooks, CMS and Rhonda Butler, 3M discussed the ICD-10 MS-DRG conversion project. Details of this project, including a comprehensive report, draft definitions manual, and the slide presentation from the September C&M Committee meeting can be

found on the CMS web site:
http://www.cms.hhs.gov/ICD10/09_ICD10_MS_DRG_Conversion_Project.asp.

**Open Discussion on Freezing ICD Code Updates**

Pat Brooks, CMS and Donna Pickett, CDC led an open discussion on whether there is a need to freeze updates to ICD-9-CM and/or ICD-10-CM/PCS prior to the implementation of ICD-10-CM/PCS. A summary of the comments provided during this discussion can be found in the summary report for the procedure portion of the September C&M Committee meeting:
http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.