

participation in the NCD decision-making process through the posting of announcements of issues under review on the Internet on the CMS coverage home page and requests for comment. At the conclusion of the NCD decision-making process, decision memoranda are published on the CMS website that announce the policy we intend to issue and discuss the evidence we evaluated and our rationale for the final national coverage determination. Coverage issues are announced at <http://cms.hhs.gov/coverage>.

Under the November 23, 2001 final rule (66 FR 58793), code lists can only be modified through the NCD process. However, subsequent experience with the code lists has indicated that processes for routine changes are necessary. For example, experience with the code lists has revealed that clerical errors occasionally occur despite rigorous review. In addition, the committees that maintain the laboratory and related code lists (ICD-9-CM and CPT-4) routinely issue changes that modify laboratory coding procedures. As a result, the code list for a laboratory NCD may not reflect the most current coding practices. For these reasons, HHS is pursuing new processes in this proposed notice to update code lists for clerical or routine changes.

D. Updates of Coding Systems

1. ICD-9-CM Codes

International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) codes were developed in 1977 as a means of classifying morbidity data for indexing medical records, medical case reviews, and ambulatory and other medical care programs, as well as for basic health statistics. It delineates the clinical picture of each patient, providing information beyond that needed for statistical groupings and analyses of healthcare trends. Early in its history, ICD-9-CM coding was used almost exclusively in institutional settings, such as hospitals. However, since 1989, § 424.32(a)(2) has required the reporting of ICD-9-CM coding on all bills for physicians' services. Thus, ICD-9-CM has come into nearly universal use as a means of reporting diagnoses for patients receiving healthcare services.

In September 1985, the ICD-9-CM Coordination and Maintenance Committee (the Committee) was formed. This is a Federal interdepartmental committee, co-chaired by CMS and the National Center for Health Statistics (NCHS), and charged with maintaining and updating the ICD-9-CM system. The Committee is jointly responsible for

approving coding changes, and developing errata, addenda, and other modifications to the ICD-9-CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The Committee encourages participation in the above process by health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding field, such as the American Health Information Management Association (AHIMA), the American Hospital Association (AHA), and various physician specialty groups, as well as physicians, medical records administrators, health information management professionals, and other members of the public, to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations that must be approved by the agencies.

ICD-9-CM coding updates are issued annually. Changes become effective October 1 of each year. Minutes from the ICD-9-CM Committee meetings are available on the Internet at <http://cms.hhs.gov/paymentsystems/icd9>. We announce the annual ICD-9-CM procedure coding changes in the **Federal Register** as part of the annual update of the hospital inpatient prospective payment system. In addition, information on the diagnosis coding changes is available on the Internet at <http://www.cdc.gov/nchs/icd9.htm>.

2. CPT-4 Coding

The Current Procedural Terminology (CPT), Fourth Edition, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide consistent codes for medical, surgical, and diagnostic services.

CPT descriptive terms and identifying codes currently serve a wide variety of important functions in the field of medical nomenclature.

The American Medical Association (AMA) owns CPT. AMA convenes the CPT Editorial Panel (the Panel) quarterly to consider requests and suggestions for changes to CPT. The

Panel uses the services of an Advisory Committee with expertise in a wide variety of specialties. Portions of CPT panel meetings are open to the public for the opportunity to make presentations and participate in open discussions. Decision-making sessions, however, are closed. More information regarding the CPT Editorial Panel is available on the following Internet Web site: <http://www.ama-assn.org/ama/pub/category/3884.html>. CPT coding changes are announced annually. Category I changes become effective on January 1 of each year.

E. Implementation of NCDs

One of the goals of section 4554 of the BBA was to promote uniformity in Medicare processing of claims for clinical diagnostic laboratory services. In order to ensure consistent and uniform implementation of the laboratory NCDs throughout the country, we developed an electronic edit table module that will be installed in each of the Medicare claims processing contractors' systems. The edit module will ensure that (1) each contractor matches diagnosis to procedures in the same manner; (2) competing laboratories in an area will have their claims processed identically regardless of whether they are processed by the carrier or fiscal intermediary; and (3) all local contractors have implemented the laboratory NCDs at the same time.

Professional coders on the negotiated rulemaking committee assisted in the development of the laboratory NCDs. Also, we presented the proposed code list to the staff in the Department of Health and Human Services and the general public for review. Nevertheless, we have discovered clerical errors in the code lists. For example, several of the codes did not include the full range of digits. That is, a code that requires 5 digits may have had only 4 digits. We identify this problem by the term "truncated codes." The issue of truncated codes is particularly problematic because our claims processing systems already include edit programs that will return claims to the biller when codes are incomplete. That is, if an entity bills the 4-digit code from the list instead of the 5-digit code, the claim will be returned to the laboratory. However, if the laboratory bills the appropriate 5-digit code, the claim will not be paid, as the 5-digit code is not on the covered code list. Other errors include instances in which the code and the descriptor did not match.