ICD-10 Transition Deadline Is Oct. 1, 2013

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In less than 5 years, physicians and other health care providers will be required to begin using a new system of code sets to report health care diagnoses and procedures.

Under a final rule published in the Federal Register last month, the Health and Human Services department is replacing the International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) code sets now used with a significantly expanded ICD-10 code sets. Providers and health plans will have until Oct. 1, 2013, to implement the new code sets.

HHS also issued a final rule adopting new standards for certain electronic health care transactions. The rule requires health care providers to come into compliance with the updated X12 standard, Version 5010, which includes updated standards for claims, remittance advice, eligibility inquiries, referral authorization, and other administrative transactions. Use of the updated standard is necessary to use the ICD-10 code sets, according to HHS. Providers and health plans must be in compliance with the updated transaction standard by Jan. 1, 2012.

At press time, the Obama administration was in the process of reviewing and approving all new and pending regulations written under the previous administration, including the ICD-10 rules. However, a spokesman for the Centers for Medicare and Medicaid Services said that until the review is complete, it is not possible to determine which regulations are affected.

According to HHS, the ICD-9 code sets are outdated.

The ICD-9-CM contains about 17,000 codes, compared with 155,000 codes in the ICD-10 code sets. "These regulations will move the nation toward a more efficient, quality-focused health care system by helping accelerate the widespread adoption of health information technology," Mike Leavitt, HHS Secretary, said in a statement. The new codes will support quality reporting, pay for performance, and biosurveillance, he added.

The final rule gives health care providers and plans almost 2 extra years to implement the Version 5010 transaction standard and a full 2 years to switch to ICD-10, compared with the timeline originally proposed last year.

HHS officials said they decided to allow extra time for implementation in response to concerns that a short implementation phase would result in high implementation costs and inadequate time for training and testing.

The Medical Group Management Association is calling on the federal government to develop an implementation assistance program for small practices.

Physician groups praised HHS for providing additional time for implementation but said other issues persist.

Officials at the American College of Physicians said that they believe that the benefits of switching to the ICD-10 code sets in the ambulatory setting do not outweigh the collective costs, said Brett Baker, director of regulatory affairs. The costs and administrative burdens related to adopting ICD-10 could slow adoption of health information technology and make it more difficult for physicians to engage in quality improvement efforts, according to the ACP.

The ACP is urging HHS to explore alternatives to the implementation plan outlined in the final rule.

For example, the department could delay implementation of ICD-10 in the outpatient setting until a certain percentage of physicians adopted interoperable electronic health record systems. Since EHRs would ease the adoption burden for physicians, it makes sense to wait until adoption of health information technology reaches a certain threshold point, Mr. Baker said.

The Medical Group Management Association expressed concern that physician practices will struggle to implement the new code sets. The association is calling on the federal government to develop some type of implementation assistance program to help physicians, especially those in small practices and rural communities. If the value to the health system is as significant as HHS estimates, government officials should be prepared to invest that savings early on to ensure implementation runs smoothly, said Robert Tennant, of MGMA.

Mr. Tennant advised physician practices to learn the requirements and the compliance dates. Next, medical practices should find out when vendors of practice management software plan to update the software and the cost.

With that information in hand, practices can formulate a budget for implementation that includes training and testing, he said. ■

2009 Physician Quality Reporting Measures Now Available Online

Detailed descriptions of the quality measures and measures groups that can be used as part of the 2009 Medicare Physician Quality Reporting Initiative are now available online at www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp.

Officials at the Centers for Medicare and Medicaid Services also have posted an implementation guide for claims-based reporting in 2009 and instructions for reporting using measures groups.

Among the 153 measures eligible for reporting in 2009 are 52 new measures including glucocorticoid management in rheumatoid arthritis and elder maltreatment screening and follow-up planning.

Late last year, CMS officials began listing the names of physicians and other health care professionals who reported on at least 1 of the 74 PQRI measures in 2007 at www.medicare.gov/physician.

Along with the listing of physicians, CMS officials included general information about the PQRI program. They noted that physicians may have had good reasons not to report measures and that a failure to report through PQRI doesn't reflect a lack of commitment to high quality care. For example, reporting quality data may have been too costly for some physicians or that physicians may have been engaged in other quality improvement reporting activities.

—Mary Ellen Schneider

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