HHS Finalizes Plans for Transition to ICD-10

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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.

In addition, 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.

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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.

The move to the new code sets was necessary, according to HHS, to replace the outdated ICD-9 code sets. 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 greatly expanded ICD-10 code sets will fully support quality reporting, pay-for-performance, biosurveillance, and other critical activities," Mr. Leavitt continued.

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.

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. In fact, 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 ACP.

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 also 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, senior policy adviser at MGMA.

HHS also should extend its outreach to the vendor community, Mr. Tennant said, since they will be the ones to provide updates to the practice management software. HHS also needs to work with private health plans to ensure there is no disruption in payments.

For their part, Mr. Tennant advised physician practices to get started by becoming familiar with the requirements and the compliance dates. Next, reach out to vendors of practice management software and find out their plans for updating the software, including the timeline and costs. With that information in hand, practices can formulate a budget for implementation that includes training and testing, he said. ■

POLICY & PRACTICE

School Embraces Medical Home

A family practice residency program at the University of Kansas, Wichita, will establish a patient-centered medical home model of care, making it one of the first residency programs in the nation to offer training in a medical home environment, the university said. The transformation of the Smoky Hill Family Medicine Residency Program in Salina, Kan., will be supported in part by a $49,500 grant from the United Methodist Health Ministry Fund. The program is to focus on electronic health records and other health information technology, increased support for patients, better chronic disease management, scheduling innovations, and alternatives to routine office visits. "The adoption of the medical home model at the residency level is particularly important because the office practices [that] physicians learn in residency—good or bad—tend to translate into their 'real life' practice upon graduation," Dr. Rick Kellerman, professor and chair of family and community medicine, said in a statement.

FDA Launches Safety Program

The Food and Drug Administration launched a pilot program aimed at ensuring the safety of drugs produced outside the United States. The agency said it plans to select 100 companies that volunteer to participate in the Secure Supply Chain pilot program. To qualify, applicants will need to maintain control over drugs and active ingredients from the time of manufacture through entry into the United States. The FDA said it's testing the practicality of a comprehensive supply chain program that could identify foreign products that fail to comply with U.S. standards. The pilot program will run for 2 years, the FDA said.

CMS IDs Protected Drug Classes

The Centers for Medicare and Medicaid Services tried to guarantee that Medicare beneficiaries with certain conditions—including HIV infection, some cancers, and mental illness—may confidently enroll in Medicare Part D prescription plans. In June 2005, the CMS directed that Part D formularies include nearly all drugs in six classes: antidepressants, antipsychotics, anticonvulsants, immunosuppressants, antiretrovirals, and antineoplastics. A new CMS rule notified Part D plans that they must continue to provide coverage of these drugs through 2010, consistent with the policy already in place. For 2011 and beyond, the CMS may propose further steps to ensure availability of drugs in the six specified classes, the agency said.

Mixed Grades on Tobacco Control

In 23 states, smoking in workplaces and public spaces has been banned, but the pace of adoption of those life-saving prohibitions has slowed, according to the American Lung Association's annual State of Tobacco Control report. Only two states passed such laws in 2008, compared with five in 2007 and six states and Washington, D.C., in 2006. Similarly, only three states and Washington, D.C., increased tobacco taxes in 2008. New York tops the list at $2.75 in taxes per pack, whereas South Carolina exacts only 7 cents per pack. In 2008, Arizona, Nebraska, and Washington state increased Medicaid beneficiaries' access to smoking cessation benefits—important because the Medicaid population smokes at a rate that's 50% higher than the national average, according to the association. The group's state-by-state report card on various tobacco-control measures is available at its Web site.

Jump in Singulair Psych Reports

Surging reports of aggressive and suicidal behavior associated with the asthma drug Singulair (montelukast) contributed to another high number of serious adverse events reported to the FDA in the second quarter of 2008, according to the nonprofit Institute for Safe Medicine Practices. The group said that a sevenfold increase in Singulair reports (to 644) was driven by the FDA's announcement in March 2008 that it was taking a closer look at the drug's side effects. For all drugs, 22,980 reports of drug-related serious injuries included 2,968 deaths. Digoxin accounted for 650 deaths, and the institute's analysis linked most of those to the recalled Digitek brand. After digoxin, the smoking-cessation drug Chantix (varenicline) accounted for the greatest number of reports: 910 cases of serious injury or death.

Group Pushes Swipable Cards

The Medical Group Management Association has launched an effort to persuade providers and health insurers to adopt standardized, machine-readable insurance cards by next January. The initiative, dubbed Project SwipeIT, would save an estimated $1 billion annually that is currently spent on "wasteful, redundant administrative tasks," said Dr. William F. Jessee, MGMA president . For example, because most people's health insurance cards have no machine-readable elements, providers usually photocopy the cards and then manually enter the information into their computers, a process that's prone to error. Many cards also feature photos, illustrations, and shading that make legible photocopying difficult. Machine-readable cards would automatically enter patient information correctly and cost-effectively, according to MGMA. The organization has developed a Web site to promote the initiative at www.SwipeIT.org.

—Jane Anderson