Old Codes Lack Detail

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quire entities covered under HIPAA to implement updated versions of electronic transmission standards—the Accredited Standards Committee X12 Version 5010 and the National Council for Prescription Drug Programs Version D.0. Both electronic standards have a compliance date of April 1, 2010. The X12 Version 5010 must be in place before the ICD-10 codes can be used, according to the CMS.

The two proposed regulations were published in the Federal Register on Aug. 22 (http://edocket.access.gpo.gov/2008/pdf/E8-19298.pdf). The CMS will accept comments until Oct. 21.

The switch to ICD-10 has been under consideration by the Department of Health and Human Services since 1997. Size and specificity are two of the biggest drawbacks of the ICD-9-CM code set, according to CMS. Because many of the ICD-9-CM chapters are full, CMS has begun to assign codes to unrelated chapters, so that, for example, cardiac procedures have been put in the eye chapter.

The ICD-9-CM also fails to provide adequate clinical details, according to the CMS. For example, the ICD-9-CM has a single procedure code that describes endovascular repair or occlusion of the head and neck vessels. But the code leaves out details such as a description of the artery or vein on which the repair was performed, the precise nature of the repair, or whether it was a percutaneous procedure or was transluminal with a catheter.

"Because of the new and changing medical advancements during the past 20-plus years, the functionality of the ICD-9-CM code set has been exhausted," CMS officials wrote in the proposed regulation. "This code set is no longer able to respond to additional classification specificity, newly identified disease entities, and other advances."

The switch to the ICD-10 codes is also an effort to keep in step with other countries. As of October 2002, 99 countries had adopted ICD-10 or a clinical modification for coding and reporting morbidity data. The CMS contends that because it continues to use ICD-9-CM it has problems identifying emerging recent global health threats such as anthrax, Severe Acute Respiratory Syndrome (SARS), and monkeypox.

Changing medical advancements in the past 20-plus years mean that 'the funtionality of the ICD-9-CM code set has been exhausted.'

Under the proposal, physicians, hospitals, health plans, and other covered entities would be required to use the ICD-10-CM for reporting diagnoses and the ICD-10-PCS for reporting procedures. The ICD-10 code sets offer significantly more codes, about 155,000 across the two sets, compared with about 17,000 for diagnosis and procedure codes within the ICD-9-CM.

In addition to size, the ICD-10 code sets also provide greater specificity, such as being able to reflect the side of the body that is related to the diagnosis or procedure. The more detailed information available through the ICD-10 codes also will aid in the implementation of electronic health records and transmission of data for biosurveillance or pay-for-performance programs, according to the CMS.

The American Medical Association has balked at the idea of implementation of both the updated X12 Version 5010 electronic transaction standard and the ICD-10 coding system in just 3 years. The X12 Version 5010 standard should first be pilot tested before physicians and others are asked to implement it, the AMA said. "This is a massive administrative undertaking for physicians and must be implemented in a time frame that allows for physician education, software vendor updates, coder training, and testing with payers—steps that cannot be rushed," Dr. Joseph Heyman, AMA board chair, said in a statement.

The Medical Group Management Association also objected. Instead of a simultaneous implementation of the X12 Version 5010 standard and the ICD-10 code sets, the MGMA is asking the CMS to wait at least 3 years after the switch to X12 Version 5010 before implementing the ICD-10.

Officials at the American College of Physicians were still analyzing the CMS proposal at press time, but said they continue to have concerns about the switch to ICD-10. In a letter to the CMS in January 2007, ACP said it opposes the change to ICD-10 for outpatient diagnosis coding and that such a switch would be expensive and time consuming for physicians, especially those in small practices. For some physician practices, the adoption of ICD-10 would require purchasing a completely new practice management system, which could cost anywhere from $5,000 to $30,000. ■

'Contractual Issues' Put CAP on Hold

BY MARY ELLEN SCHNEIDER
New York Bureau

Medicare officials have pulled the plug at least temporarily on their Competitive Acquisition Program for Part B drugs, including some infused biologics.

The program was put on hold because of "contractual issues" with the successful vendor bidders for the 2009 cycle of the program. The Competitive Acquisition Program (CAP) will remain in effect until the end of this year, but after that, physicians who had participated in the program will have to go back to purchasing drugs using the average sales price (ASP) system. The CMS has not announced a time line for resuming the program.

The CAP was mandated by Congress under the 2003 Medicare Modernization Act. It was launched in July 2006 to give physicians an alternative to obtaining Part B infusion and injectable drugs through the ASP or "buy-and-bill" system.

The voluntary program took the purchase of these drugs out of the hands of physicians. Those physicians who enrolled no longer took on the financial risk of buying drugs up front and being reimbursed by the CMS later. Instead, they received drugs from an approved vendor who was selected by the CMS through a competitive bidding process. Under the program, physicians were paid only for the administration of the drug.

For 2008, nearly 5,000 physicians were enrolled in the CAP. The program included more than 200 drugs.

BioScrip Inc., an Elmsford, N.Y.–based specialty pharmaceutical health care organization, has been the only approved CAP vendor throughout the history of the program. The company announced over the summer that it would not sign a new contact with CMS for CAP because the terms of the contract presented an "unacceptable short- and long-term profit risk."

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As currently designed, the CAP is "totally untenable," said Dr. Karen Kolba, a solo rheumatologist in Santa Maria, Calif., and a member of the American College of Rheumatology's Committee on Rheumatologic Care. The delay in the program will give the CMS time to consider changes that could encourage participation from rheumatologists, she said.

Dr. Kolba, who has not signed up for CAP, said the biggest problem with the program is the "all-or-nothing" requirement for ordering drugs. Once enrolled, physicians are not allowed to pick and choose what drugs they want to obtain through the CAP. If a drug they administer is available through the vendor, they must get it through the CAP. This is impractical for inexpensive, commonly used drugs such as cortisone injections, Dr. Kolba said, because CAP drugs must be ordered for specific patients and administered only to them. "It becomes something of an accounting nightmare," she said.

Dr. R. Mack Harrell, an endocrinologist in Fort Lauderdale, Fla., said postponement of the CAP is likely to result in serious access problems for patients. Many endocrinologists rely on the CAP for expensive injectable drugs like thyrotropin alfa (Thyrogen), used to test for recurrence in thyroid cancer patients.

Without the CAP as a source of these drugs, Dr. Harrell said he fears that endocrinologists won't be able to provide these drugs in the office, forcing patients to go off their thyroid hormones for weeks at a time in order to undergo necessary testing.

Between now and the end of the year, physicians who are enrolled in the CAP must obtain drugs from BioScrip if the administration date for the drug is before Dec. 31, 2008. Any drugs that will be administered on or after Jan. 1, 2009, must be obtained through the regular ASP method.

If a physician has unused Part B drugs obtained through the CAP after Dec. 31, 2008, they are considered the property of the vendor and must be purchased through the ASP system or returned to BioScrip. They cannot be given to the physician by BioScrip.

As physicians return to the ASP method of procuring drugs in 2009, they will be responsible for collecting deductibles and coinsurance from Medicare beneficiaries and should not use the CAP modifiers (J1, J2, J3, and M2) on claims. The CMS is advising physicians to contact BioScrip to minimize the amount of unused drugs.

While the program is on hold, the CMS is asking physicians to provide feedback on the program. Agency officials are looking for information on the categories of drugs provided through the program, the distribution of areas that are served by the CAP, and any procedural changes that could make the program more attractive for vendors and physicians. ■

More information on the postponement of the CAP is at www.cms.hhs.gov/CompetitiveAcquisforBios

Paying Medical Bills Poses Problem for Many

A growing number of working-age Americans are struggling to pay their medical bills or have gone into debt because of high medical expenses, according to a new report from the Commonwealth Fund.

In 2007, 41% of U.S. adults aged younger than 65 reported having medical bill problems or medical debt, versus 34% in 2005. The problem is growing across all income groups but is most common among low- and moderate-income individuals, where more than half reported being unable to pay their medical bills, being contacted by a collection agency about an unpaid medical bill, significantly changing their way of life to pay a medical bill, or paying off medical debt over time.

As health care costs have risen, employers have struggled to provide employee health insurance, leading some to drop coverage or increase employee cost sharing, said Sara R. Collins, Ph.D., lead author of the report and assistant vice president at the Commonwealth Fund.

At the same time, most Americans are facing relatively stagnant wages and rising prices for food and gas, Dr. Collins said during a press briefing.

The findings are based on the Commonwealth Fund Biennial Health Insurance Survey, a nationally representative telephone survey conducted in 2001, 2003, 2005, and 2007. The 2007 data come from an analysis of survey responses from 2,616 adults aged under 65 obtained between June and October 2007.

About 34% of adults who were uninsured at the time of the survey reported owing $4,000 or more in medical bills, compared with 20% of those who were insured.

Both insured and uninsured Americans are spending more out of pocket for their care. In 2007, 48% of Americans aged 19-64 years spent 5% or more of their income annually on out-of-pocket costs and premiums, up from 41% in 2001.

And 33% of working-age Americans spent 10% or more annually on these out-of-pocket medical expenses, compared with 21% in 2001.

—Mary Ellen Schneider