Policy & Practice

California to Vote on Parental Notice

Voters in California will once again consider whether to mandate parental notification prior to a minor's receiving an abortion. California ballots next month will include an initiative to amend the state constitution to require parental notification 48 hours in advance of minors receiving abortions. In the case of reported parental abuse, another adult family member can be notified. The minor can also seek a waiver of parental notice from a judge. The initiative, Proposition 4, includes an exemption of parental notification in the case of a medical emergency. Supporters say that parental notification would help stop sexual predators from covering up their sexual exploitation of minors through secret abortions. In contrast, opponents of the measure say that parental notification is ineffective and jeopardizes the health of young women. The initiative is being opposed by the American College of Obstetricians and Gynecologists, the California Medical Association, and the California District of the American Academy of Pediatrics. Similar ballot initiatives were defeated in California in 2005 and 2006.

Inconsistent Contraceptive Use

Some women may be using contraceptives inconsistently because they are ambivalent about getting pregnant or fantasize about the idea of a pregnancy, according to a study published in the September issue of Perspectives on Sexual and Reproductive Health. The researchers conducted in-depth interviews with 24 women and 12 men from the metropolitan Atlanta area to gauge their attitudes about unprotected sex and their experiences with unintended pregnancy. The qualitative analysis found that some individuals had greater sexual arousal at the idea of conception, others had a romantic fantasy about the idea of pregnancy, and others considered an accidental pregnancy as a way to escape a bad family situation or poverty. While the study had a small sample size, the researchers said it was useful in identifying some of the factors affecting inconsistent contraceptive use. The investigators also called on other researchers to include men in these types of studies to figure out how men's attitudes can affect the use of contraceptives.

HIV Rate Highest in Black Women

Among women, African Americans bear a heavier burden of HIV/AIDS than do other ethnic groups, according to a new analysis by researchers at the Centers for Disease Control and Prevention. The HIV incidence rate for African American women was 55.7 per 100,000 population in 2006, nearly 15 times as high as the incidence rate for white women and nearly 4 times as high as the incidence for Hispanic women. The disproportionate rates of HIV infection among African Americans in the United States could be linked to a number of factors, including poverty, stigma, limited access to health care, higher rates of other sexually transmitted diseases, and drug use, according to the CDC. The analysis was published last month in the CDC's Morbidity and Mortality Weekly Report. The results are based on extrapolations from a total of 33,802 HIV diagnoses in 2006 among individuals aged 13 years and older that were reported to the CDC from 22 states.

Stem Cell Guidelines Revised

An expert committee convened by the Institute of Medicine and the National Research Council recently revised guidelines for conducting research involving human embryonic stem cells. The guidelines, which offer national ethical standards, amend guidelines issued by the standing committee in 2005 and 2007. They were revised in part to provide guidance on the use of new human stem cells called "induced pluripotent cells." These cells were developed recently and are derived by reprogramming nonembryonic adult cells. While these stem cells do not use embryos, many of the ethical and policy concerns are similar to those involving human embryonic stem cells, according to the Human Embryonic Stem Cell Research Advisory Committee. The revised guidelines also recommend that institutions that are conducting stem cell research notify the public about the types of research being pursued. The report was sponsored by the Ellison Medical Foundation, the Greenwall Foundation, and the Howard Hughes Medical Institute.

CMS Alters Overpayment Policy

Officials at the Centers for Medicare and Medicaid Services are changing the procedures for recovering certain overpayments made to physicians. The CMS will no longer seek payment from a physician for an overpayment while the physician is seeking a reconsideration of the overpayment determination by a qualified independent contractor. Under the new policy, which was mandated by the 2003 Medicare Modernization Act, the CMS can only seek to recoup the payment after a decision has been made on the reconsideration. The changes, which went into effect on Sept. 29, will apply to all Part A and Part B claims for which a demand letter has been issued. However, a number of claims have been excluded, including Part A cost reports, Hospice Caps calculations, provider initiated adjustments, Home Health Agency Requests for Anticipated Payment, Accelerated/Advanced Payments, and certain other claims adjustments. The changes do not affect the appeal process or the normal debt collection and referral process, according to the CMS.

—Mary Ellen Schneider

Replacement of ICD-9 Code Planned in 3 Years

BY MARY ELLEN SCHNEIDER
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Officials at the Centers for Medicare and Medicaid Services plan to replace the ICD-9-CM diagnosis and procedure code set with a significantly expanded set of codes—the ICD-10—by Oct. 1, 2011.

But physician groups are calling the agency's plan rushed and unworkable and want the agency to reconsider its compliance date.

In addition to the requirements for using the ICD-10 code sets, CMS also is proposing to require 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 CMS.

The two proposed regulations were published in the Federal Register on Aug. 22. CMS will accept comments on the proposals until Oct. 21.

Some physician groups say CMS is asking them and other health care providers to do too much too fast, and they want the agency to reconsider its compliance date.

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 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."

CMS also is urging a switch to the ICD-10 code sets in 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. And 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.

Under the proposal, physicians, hospitals, health plans, and other covered health care 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 CMS.

But physician groups say CMS is asking physicians and other health care providers to do too much too fast.

The American Medical Association 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, 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 and are needed for a smooth transition," Dr. Joseph Heyman, AMA board chair, said in a statement.

The Medical Group Management Association also objected. While MGMA supports the switch to the ICD-10 code sets, they said that 3 years is not enough time for the industry to implement the new system.

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

The switch to ICD-10 needs to be done separately because it will require significant changes from medical groups, according to MGMA. Recent MGMA research indicates that most medical practices will have to purchase software upgrades for their practice management systems or buy all new software in order to implement the transition to ICD-10.

"Moving to these new code sets has the potential to be the most complex change for the U.S. health care system in decades," Dr. William F. Jessee, president and CEO of MGMA, said in a statement. ■