CMS Proposes to Switch To ICD-10 Codes by 2011

BY MARY ELLEN SCHNEIDER
New York Bureau

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 is proposing to require entities covered under The Health Insurance Portability and Accountability Act of 1996 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.

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.

Beyond size, the ICD-10 code sets also provide greater specificity, such as being able to reflect the side of the body related to the diagnosis or procedure. The more detailed information available with the ICD-10 codes 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.

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 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 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. ■

POLICY & PRACTICE

Media Influences Tobacco Use

Media communications—including movies, advertising, and news—play a key role in shaping tobacco use, according to a lengthy report from the National Cancer Institute. It noted that cigarettes are among the most heavily marketed products in the United States, and that most of the cigarette industry's marketing budget is allocated to promotional activities, especially for price discounts, which accounted for 75% of the industry's $10 billion in total marketing expenditures in 2005. Depictions of cigarette smoking are pervasive in movies, occurring in three-quarters or more of contemporary box office hits, the NCI report said, adding that the weight of evidence indicates a causal relationship between exposure to depictions of smoking in movies and youth smoking initiation. The report provides the government's strongest conclusion to date on the media's powerful and causal effect on tobacco use, Dr. Cheryl Healton, president and CEO of the American Legacy Foundation, said in a statement. "This report provides the ammunition to tobacco control advocates around the world who are fighting to keep movies smoke free," she said.

Tobacco Control Support Drops

Budgets for tobacco control programs in most states are either staying level or declining, despite increases in payments from the 1997 Tobacco Master Settlement Agreement, designed to compensate states for some of the cost of smoking-related illnesses, the American Lung Association reported. The ALA report blamed the stable or reduced budgets on the poor economy in a number of states on reduced tobacco control budgets. The passage of smoke-free air laws also has slowed down in most states, the ALA found. Only two states this year—Iowa and Nebraska—have approved legislation to strengthen existing laws. And, activity on cigarette tax increases in 2008 has been slower than in previous years, with only two states and the District of Columbia approving increases, the report said. New York's increase in the cigarette tax is the highest, at $1.25 a pack, the ALA said.

'Free' Rx Samples Expensive

Free drug samples provided to physicians by pharmaceutical companies actually could cost uninsured patients more in the long run, because those patients are prescribed brand-name drugs rather than generics, according to a study done by researchers at Wake Forest University Baptist Medical Center, Winston-Salem, North Carolina. Physicians were three times more likely to prescribe generic medications to uninsured patients after drug samples were removed from their offices, according to the study, which looked at a large, university-affiliated internal medicine practice. After the clinic closed its drug sample closet, the percentage of prescribed generic medications rose from 12% to 40%, the researchers found. "It's true that samples can save patients money in the short run, but our study shows that they may end up paying more in the long run when they are given prescriptions for brand-name-only drugs," Dr. David Miller, an internist and the study's lead researcher, said in a statement.

Grants to Doctors in Hurricanes

The AMA Foundation's Health Care Recovery Fund will provide grants of up to $2,500 to physicians in places that have been declared disaster areas by the Federal Emergency Management Agency, and the foundation currently is accepting donations to help physicians who have been directly affected by Hurricane Gustav, which affected Louisiana, Mississippi, and Texas. The foundation provides the grants to physicians in FEMA-declared disaster areas to help them rebuild or restore their damaged medical practices in those locations, according to the AMA.

Tools' Usefulness Limited

Although health plans are developing tools to help consumers compare price and quality information across hospitals and physicians, the tools' pervasiveness and usefulness are limited, according to a study by the Center for Studying Health System Change. The information provided as part of the tools often lacks specificity about individual providers, and its availability often is limited to enrollees in specific geographic areas, the study showed. When providing quality information, health plans generally rely on third-party sources to package publicly available information instead of using information from their own claims, the study found. "None of the health plans we interviewed believed that price and quality information is being used extensively by their enrollees today, in part, because few have incentives in their benefit structures to encourage cost comparisons," Ann Tynan, HSC researcher and study coauthor, said in a statement.

Many Reach 'Doughnut Hole'

One in four Medicare Part D enrollees who filled prescriptions in 2007 reached the gap in coverage known as the "doughnut hole," and most remained in the doughnut hole for the rest of the year, according to an analysis from the Kaiser Family Foundation. The analysis suggested that about 3.4 million beneficiaries—14% of all Part D enrollees—reached the coverage gap last year and paid the full cost of their prescriptions for part of 2007. Beneficiaries taking drugs for serious chronic conditions had a substantially higher risk of a gap in coverage under their Medicare drug plan, the study found. For example, 64% of enrollees taking medications for Alzheimer's disease reached the coverage gap in 2007, as did 51% of those taking oral diabetes medications and 45% of patients on antidepressants, the study found. The analysis excluded beneficiaries who receive low-income subsidies because they do not face a gap in coverage under their Medicare drug plan.

—Jane Anderson