ICD-10 on the Horizon

Save to myBoK

by Sue Prophet, RHIA, CCS, CHC

ICD-10 has taken hold around the globe, so why is the US still using ICD-9-CM? This article reviews the history of ICD-10 in the US.

Other countries are using it. Why aren't we? Coding professionals across the country and around the world are wondering why ICD-10-CM hasn't been adopted yet in the US. In this article, we'll look at the status of ICD-10 and the steps preceding its implementation.

Room for Improvement

One of the first delays to ICD-10 implementation in the US was the need for a clinical modification (CM) to the original code set written by the World Health Organization. In 1994, the National Center for Health Statistics (NCHS) awarded a contract to the Center for Health Policy Studies (CHPS) to conduct a comprehensive evaluation of ICD-10 to determine if it was a significant improvement over ICD-9-CM and should be implemented in the US. The evaluation concluded that modification would be necessary to make the system an improvement over ICD-9-CM and that such a modification would be worth implementing. A technical advisory panel concluded that modifications were needed to:

- return to the level of specificity found in ICD-9-CM
- develop an improved Alphabetic Index
- modify code titles and narrative descriptions to enhance the consistency with accepted clinical practice in the US
- remove procedure descriptions included with diagnosis codes
- remove "multiple" descriptions (such as codes for multiple injuries and multiple burns) because coding professionals will be expected to report multiple, individual codes to describe the specific injuries
- remove codes unique to mortality coding or those designed specifically for emerging nations (codes unique to mortality coding include unattended death, traumatic amputation at neck level, and sudden infant death syndrome)

The Public Speaks

After the development of the US clinical modification, a draft of the Tabular List of ICD-10-CM and a preliminary crosswalk between ICD-9-CM and ICD-10-CM were made available on the NCHS Web site (www.cdc.gov/nvhs) in 1997 and public comments were solicited. During this comment period, more than 1,200 comments were received from 22 individuals and organizations representing a variety of groups, including one governmental agency, two research institutions, three information system developers, four professional organizations (including AHIMA), and several healthcare providers. CHPS then compiled and analyzed the public comments received, which ranged from general observations (both favorable and critical) to very specific and detailed analyses. Comments include requests for changes in both terminology and code structure. CHPS addressed the comments by categorizing them in six ways:

- implement as stated
- no further action or no need for further response (an example would be a comment that was stated as a question about how a particular condition would be coded)
- add to appendix (e.g., request for definitions of new concepts)
- recommend as stated (issues had merit, but there were several alternatives to address the issue)
- reject as stated (requests for changes to coding structure that are inconsistent with ICD-10 or represented commenters' misperceptions)
- requires further study (e.g., issues that require further review to determine exactly where specific changes need to be made)

Then, of the comments received, CHPS recommended that:

- 238 required no response or necessitated no further action
- 180 comments merited the direct incorporation into ICD-10-CM
- 77 comments had merit but would require further study for the possibility of inclusion into ICD-10-CM
- 480 comments should be rejected

The individuals and organizations that reviewed the draft of ICD-10-CM generally considered it a significant improvement over ICD-9-CM because it incorporates greater specificity and clinical detail and information relevant to ambulatory and managed care encounters was added. Further, ICD-10-CM's structure will allow greater expansion than is possible with ICD-9-CM.

After the conclusion of CHPS' analysis of the public comments, NCHS determined which comments should be incorporated into ICD-10-CM and made the necessary changes to the Tabular List. Then, NCHS revised the Alphabetic Index, revised the crosswalk to ICD-9-CM, updated the Table of Drugs and Chemicals and the Neoplasm Table, and developed a revised Alphabetic Index to the External Causes of Injury. Obviously, any changes to the Tabular List require changes to the Alphabetic Index. At press time, NCHS was in the process of finalizing completion of the Alphabetic Index. NCHS has not yet publicized the revised version of ICD-10-CM or the nature of the specific changes that have been made as a result of the comments.

Once the public comment period ended, the draft of ICD-10-CM was removed from the NCHS Web site because it was no longer accurate due to the revisions resulting from the comments. After completion of the system revisions and Alphabetic Index updates, the revised version will be placed on the NCHS Web site. However, completion of the system does not mean the work is finished. The official coding guidelines will need to be revised, including the creation of some new guidelines, and training materials developed.

A System of Checks and Balances

Whether ICD-10-CM is implemented in the US depends on the process for adoption of standards under HIPAA. When HIPAA regulations were promulgated in 2000, ICD-9-CM was selected as the initial standard for diagnostic coding because ICD-10-CM was still under development and it would have been premature to name it as a national standard. Once ICD-10-CM is completed, ICD-9-CM may still remain the standard because updating it is easier than adopting ICD-10-CM, due to the definitions of "maintenance" and "modification" in HIPAA. Maintenance encompasses the activities necessary to support the use of a standard, including enhancements, additions, or deletions. Public comment and notification are required as part of the maintenance process, but regulatory action would not be required. Conversely, changes that are substantial enough to justify publication of a new version of an implementation specification are considered "modifications" and would require regulatory action. Therefore, adoption of ICD-10-CM would require regulatory action, but annual ICD-9-CM revisions would not.

For ICD-10-CM to be implemented, it must be adopted by the secretary of Health and Human Services (HHS) as a replacement of the ICD-9-CM diagnostic code set national standard after undergoing an established process involving evaluation and public input. Then, hearings are held to discuss implementation of ICD-10-CM and review all sides of the issue. The first hearing on ICD-10-CM was held by the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards and Security in May. AHIMA testified in favor of ICD-10 and stressed the need for the secretary of HHS to establish a timetable for conversion that takes into consideration the delays necessary for final approval of regulations under HIPAA. (See sidebar below.)

Thus, the process for adopting ICD-10-CM as a replacement for the ICD-9-CM diagnosis codes, or for adopting any new code set standard, requires the following steps:

- public hearings with testimony from various stakeholders and solicitation of public comments on adoption of ICD-10-CM
- recommendation to the secretary of HHS by NCVHS after consideration of comments and concerns expressed by the public
- publication of proposed rule in the *Federal Register*, with another opportunity for public input
- publication of final rule in the *Federal Register*, after consideration of all of the comments from the public, naming ICD-10-CM as the new code set standard to replace the ICD-9-CM diagnosis codes

The secretary is required to consult with the designated standard maintenance organizations (DSMOs) before adopting any standard for electronic healthcare transactions. The DSMOs are:

- Accredited Standards Committee X12
- Dental Content Committee of the American Dental Association
- Health Level 7
- National Council for Prescription Drug Programs
- National Uniform Billing Committee
- National Uniform Claim Committee

Named by the secretary under the HIPAA regulation pertaining to electronic transactions and code sets, these organizations are responsible for maintaining standards for healthcare transactions adopted by the secretary and receive and process requests for adopting a new standard or modifying an adopted standard. The DSMO process was set up to coordinate the various standards to handle changes under HIPAA. Once the secretary decides that a new code set should be adopted, the DSMO would oversee the various standards modifications needed to accommodate the new code (for example, move from five-character numeric to seven-character alpha-numeric code). The organization might also be called on during the hearing process to explain to NCVHS or the secretary how the proposed change would affect the different transaction standards. It would also coordinate updating the transaction guides for inclusion of the new standard.

There would likely be at least a two-year implementation window after the effective date of the final rule announcing adoption of ICD-10-CM. The effective date is 60 days after publication in the *Federal Register*.

Not Quite a Done Deal

Due to the HIPAA requirements regarding adoption of new standards for electronic transactions, adopting ICD-10-CM isn't just a matter of when, but also a matter of if. There is no guarantee that ICD-10-CM will ever be implemented in the US, because the process requirement for public input ensures that all those affected by a change in a code set standard have an opportunity to provide input into the decision regarding whether a new code set standard should be adopted. If the public comments are overwhelmingly opposed to its adoption or sufficient concerns are raised about the price tag of implementation, and significant doubts are expressed about the benefits outweighing the drawbacks (such as high implementation costs and loss of longitudinal data comparability), it is conceivable that the NCVHS could recommend that ICD-10-CM not be adopted. Even if NCVHS submits a recommendation in favor of adoption, the secretary of HHS could still decide against it. Already, influential organizations have spoken out in opposition to adopting ICD-10-CM because they view the implementation costs as outweighing the perceived advantages of improved clinical data.

It is important to keep in mind that ICD-10-CM and ICD-10-PCS (the proposed replacement for ICD-9-CM Volume III procedure coding system) will not necessarily be implemented at the same time. ICD-10-PCS must follow the same HIPAA process prior to any decision for adoption being made by the secretary. Ultimately, based on input from the healthcare industry, the secretary could decide to implement one of these systems and not the other one, to implement them at different times, or to implement them at the same time.

Better Data Can't Wait

AHIMA believes that adoption of a replacement for the ICD-9-CM diagnosis codes is an absolute necessity, because the code set is more than 20 years old and has become obsolete. It is no longer able to meet the many needs for accurate and complete data in this country. In fact, terminology used in ICD-9-CM and the classification of some conditions are outdated and inconsistent with current medical knowledge. The system is rapidly running out of space and cannot accommodate many new codes to address the need for greater specificity, advances in medicine, and new diseases. In some cases, meritorious new code proposals have not been implemented simply because there is insufficient space for a new code.

While there are significant costs associated with adopting a new coding system, there are also cost savings in improved clinical data. Better data will:

- improve payers' ability to forecast the healthcare needs of their covered lives and trend and analyze healthcare costs

- reduce payers' and providers' costs due to improved ability to effectively monitor service and resource utilization, analyze healthcare costs, monitor outcomes, measure performance, and detect fraud and abuse
- improve providers' and payers' ability to negotiate reimbursement rates
- reduce requirements for manual review of medical records to support claims and for research and "data mining" purposes

Once it's publicly available, all AHIMA members should become familiar with ICD-10-CM's features and characteristics and stay abreast of activities and discussions related to its potential adoption. HIM professionals need to advocate changes in medical code set standards that will significantly improve the quality of coded data. We must educate the government and the healthcare industry on the advantages, including reduced healthcare costs, of better coded data.

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In May, at a National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards and Security hearing, AHIMA testified in favor of adoption of ICD-10-CM as a replacement of the ICD-9-CM diagnosis codes. The Association recommended that final regulations promulgating adoption be issued in 2003 with an implementation date no later than 2005. The subcommittee decided to recommend to the full NCVHS that a letter be sent to the secretary of Health and Human Services requesting that proposed regulations be published naming ICD-10-CM (for diagnoses in all healthcare settings) and ICD-10-PCS (for procedures in the hospital inpatient setting only) as new code set standards, to be implemented no earlier than October 1, 2005. At press time, this recommendation was expected to be presented for a vote at the June NCVHS meeting.

10 Benefits of I-10

ICD-10-CM offers many advantages over ICD-9-CM. Below are some of the most exciting features:

- ICD-10-CM has the same hierarchical structure as ICD-9-CM. The codes are alphanumeric and all letters except U are used. The codes corresponding to ICD-9-CM V and E codes are incorporated into the main classification
- Newly recognized conditions and conditions that are not uniquely identified in ICD-9-CM have been given codes
- Conditions with a recently discovered etiology or new treatment protocol have been reclassified to a more appropriate chapter. For example, gout is classified to the Endocrine System chapter in ICD-9-CM, but is classified to the Musculoskeletal System chapter in ICD-10-CM. Similarly, Bradycardia is classified to the Circulatory System chapter in ICD-9-CM, but is classified to the Symptom chapter in ICD-10-CM
- Injuries are grouped by body part rather than by categories of injury
- Excludes notes were expanded to provide guidance on the hierarchy of chapters and to clarify priority of code assignment
- Combination codes have been created, such as arteriosclerotic heart disease with angina and pathological fractures with their underlying cause
- The concept of laterality has been added, particularly in the Neoplasm and Injury chapters
- The codes for postoperative complications have been expanded and a distinction has been made between intraoperative complications and post-procedural disorders
- The obstetric codes no longer identify whether the patient has delivered or not, but instead indicate which trimester the patient is in
- The diabetes category will include codes for insulin-requiring and noninsulin-requiring types

(Note: these ICD-10-CM examples are based on the initial draft of the system, not the final version that was developed after the comment period.)

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