Delayed or Not: ASA Will Help You Transition to ICD-10

Jason Byrd, J.D. Associate Director of Practice Management and Quality Initiatives

Sharon Merrick, CCS-P Coding and Reimbursement Manager

Many of you have probably heard rumblings about a transition from ICD-9 to ICD-10 for some time now. Many of those rumblings may not have prophesized the end of the world, but certainly a substantial and costly headache for physicians and their practices.

Developed by the World Health Organization (WHO), the International Classification of Diseases (ICD) is the medical data code set used for coding diagnoses and inpatient hospital procedures in the United States and many other countries. ICD-9-CM was adopted in 2000 as a Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard. ICD-10-CM is to replace ICD-9-CM Volumes 1 and 2 (the diagnosis codes used by physicians). ICD-10-PCS is to replace ICD-9-CM Volume 3 (the procedure codes used by hospitals). Physicians will continue to use CPT® (Current Procedural Terminology) to report their professional services but will need to switch to ICD-10-CM to report diagnoses.

Why ICD-10?

In 1997, the National Committee on Vital and Health Statistics (NCVHS), one group upon which the Secretary of Health and Human Services must rely as part of consultation efforts under section 1172 of the Social Security Act, began to review reported limitations of ICD-9-CM and determine the need for a transition to a potential new code set. Based on testimony received from a variety of interested organizations and a RAND Corporation study, the NCVHS concluded there is an immediate need for a new code set. The Centers for Medicare & Medicaid Services (CMS) reviewed the report and developed the proposal advocating for use of the ICD-10 system.

In its proposed rule, CMS offers a number of justifications for the transition to ICD-10.

- The ICD-9 code set is limited to approximately 13,000 diagnoses codes and 3,000 procedure codes. While this may sound like a large number, the code set is quickly reaching its threshold where no additional new codes would be possible.
- CMS contends that the ICD-10 code set will allow for accurate descriptions of diagnoses and procedures that will ultimately help to improve the quality of health care and cost containment through research opportunities.
- The ICD-10-CM code set will allow more detail on many aspects of a case, including socioeconomic, family relationships, ambulatory care conditions, problems related to lifestyle, and the results of screening tests. In addition, ICD-10-CM will provide for laterality, or specification of whether the organ or part of the body is located on the left, right or bilateral. The ICD-9-CM set does not permit such a distinction.

As of October 2002, 138 countries have adopted ICD-10 for coding and reporting mortality data, and 99 countries have adopted ICD-10 or a clinical modification for coding and reporting morbidity data. The United States adopted ICD-10 only for mortality reporting in 1999; thus, the U.S. data is incomparable with many countries throughout the world, including Great Britain, Canada, France, Germany, Japan and Italy, unless the United States adopts ICD-10 for morbidity reporting.

Due to the increased information and detail captured by the ICD-10 code set, CMS also believes that the transition to ICD-10 will facilitate timely electronic processing of



Jason Byrd, J.D., is the Associate Director of Practice Management and Quality Initiatives for ASA in its Washington, D.C. office.



Sharon Merrick, CCS-P, is Coding and Reimbursement Manager for ASA in its Washington, D.C. office.

medical claims since requests for additional information will presumably decrease.

ICD-10-PCS (Procedure Code Set)

The American Hospital Association estimates that procedure codes will be exhausted in the appropriate sections of ICD-9-CM Volume 3 and overflow chapters in 2009. Due to space limitations, CMS has already begun assigning new codes to inappropriate sections (e.g., codes for heart procedures are being placed in the chapter reserved for eyes). Location of codes in inappropriate sections could challenge coders in identifying and assigning proper codes, and researchers and statisticians in identifying applicable cases for research purposes.

In addition, the ICD-9-CM code set is not capable of providing detailed information needed to support emerging needs such as biosurveillance and pay-for-performance programs. For instance, ICD-9-CM contains a single procedure code describing endovascular repair or occlusion of head and neck vessels (39.72); however, the code does not describe the artery or vein repaired, the nature of the repair, or whether the approach is percutaneous or transluminal with a catheter.

The three to four digit ICD-9-CM Volume 3 code will be replaced by a seven-character alphanumeric code. The hospital coder will build the code by reviewing medical record documentation and selecting code digits based on various categories, including body system, root operation and type of approach. We are limiting our discussion of ICD-10-PCS because, as we previously mentioned, physicians will continue to report using CPT® codes.

ICD-10-CM (Diagnosis Code Set)

All physicians will need to transition to the ICD-10-CM code set. However, there is no need to panic, as the method used to determine a code under ICD-9-CM is applicable to ICD-10-CM. Though there are some differences in the details with which physicians, coders, and other staff will need to become familiar, many organizations, including ASA, will offer assistance in this transition period.

Table 1 highlights some of the major differences between the two diagnosis code sets.

Though the code numbers will change, some of the code descriptors will remain very similar; however, other codes will require additional detail. [Table 2, page 22].

Alternatives Considered by CMS

CMS considered alternative approaches to ICD-10 before ultimately recommending its adoption. Among the choices considered were:

- Maintain ICD-9-CM and continue to assign new codes to inappropriate sections.
- Use the American Medical Association CPT® coding system.
- Wait and adopt ICD-11 when available.

TABLE 1

ICD-9-CM Diagnosis Codes	ICD-10-CM Diagnosis Codes	
3-5 characters in length Approximately 13,000 codes	3-7 characters in length Approximately 68,000 codes	
Limited space for new codes	Flexible for new codes	
Lacks detail	Very specific	
Lacks laterality	Has laterality	
Analysis difficult due to non-specific codes	Specificity improves coding accuracy and richness of data for analysis	
Codes do not adequately define diagnoses needed for research	Detail improves the accuracy of data used for research	
Does not support interoperability because not used by other countries	Supports interoperability between other countries and the U.S.	

The choice to maintain the current ICD-9-CM system was ruled out based on the reasoning articulated here. CMS did not view the CPT system as a reasonable alternative based on various findings by NCVHS and the Government Accountability Office that structural problems and serious flaws exist with CPT-4, CPT does not meet all of the criteria for standard code sets under HIPAA, and that it lacks laterality and a predictable syntax. Finally, while CMS acknowledged that ICD-11 is currently under development by WHO, it expressed concern over the lack of a firm timeline for completion and implementation. Since ICD-11 will build upon ICD-10, CMS believes it is logical to transition to ICD-10 now and mitigate any future transitions to ICD-11.

How Will This Impact You?

The majority of concerns in regard to the proposed ICD-10 transition revolve around either financial, human resource or both constraints. Under section 1172(b) of the Social Security Act, the Secretary of the Department of

Continued on page 22

TABLE 2

	ICD-9-CM	ICD-10-CM		
Example 1				
Code	Descriptor	Code	Descriptor	
338.18	Other acute postoperative pain	G89.18	Other acute postprocedural pain	
	Postoperative pain NOS		Postoperative pain NOS	
			Postprocedural pain NOS	
Example 2				
Code	Descriptor	Code	Descriptor	
813.41	Colles' fracture	S52.531	Colles' fracture of right radius	
	Smith's fracture	S52.532	Colles' fracture of left radius	
		S52.539	Colles' fracture of unspecified radius	
		S52.541	Smith's fracture of right radius	
		S52.542	Smith's fracture of left radius	
		S52.549	Smith's fracture of unspecified radius	

Health and Human Services (HHS) must ensure that any standard adopted is consistent with the objective of reducing the administrative costs of providing and paying for health care. CMS recognizes that the transition to ICD-10 will cost a substantial sum, but estimates those costs will be offset by the benefits of the code set within four years of implementation.

In addition, the ICD-10 system is contingent upon the implementation of the new Version 5010 of the Accredited Standards Committee, which is also currently out for public comment. Thus, practices will need to implement and learn the new 5010 standard and then implement and learn the ICD-10 system in relatively quick succession. Under the proposed rules, the compliance date for 5010 is April 1, 2010, for all covered entities, and the compliance date for ICD-10 is October 1, 2011, also for all covered entities. This means that physicians and hospitals will need to report ICD-10 codes to Medicare, Medicaid and third-party payers for services provided on and after that date.

Though the transition will require some financial and workforce expenditures, anesthesiologists should transition

to ICD-10-CM relatively smoothly. Remember that ICD-10-PCS only applies to hospitals and will not be your headache. If your practice uses a superbill, you will need to update it accordingly with the new code set and add columns to capture additional information, such as laterality. There are resources that provide a linkage between ICD-10-CM and ICD-9-CM, which your practice could use to ensure that the proper codes are used.

Your staff members will need to educate and familiarize themselves with the new code set. An October 2003 study by the Robert E. Nolan Company commissioned by the Blue Cross and Blue Shield Association estimated that full-time coders will need 24-40 hours of training on ICD-10, physicians four to 12 hours, and part-time coders and other clinicians

four to 40 hours. CMS believes these estimates are overstated and the actual training hours will be less. Obviously, losing up to a week of productivity from your coders will have an expense to your practice, but CMS argues that fewer claims errors and increased timeliness of claim payment, along with increased opportunities to improve quality of your practice based on data, will offset these short-term expenditures.

Finally, to illustrate one more time how the new ICD-10 process will work, we present the following example. A patient presents with a ruptured appendix/generalized peritonitis, and an appendectomy is performed.

- The surgeon will report CPT[®] code 44960 Appendectomy; for ruptured appendix with abscess or generalized peritonitis.
- The anesthesiologist will report CPT® code 00840 Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy; not otherwise specified.

Continued on page 34

Delayed or Not: ASA Will Help You Transition to ICD-10

Continued from page 22

- The hospital will report ICD-10-PCS code 0DTJ4ZZ –
 for a percutaneous/endoscopic approach; or
 0DTJ0ZZ for an open approach.
- The ICD-10-CM diagnosis code is K35.0 Acute appendicitis with generalized peritonitis (the ICD-9-CM diagnosis code would have been 540.0 – Acute appendicitis with generalized peritonitis).

We hope that we have provided you with some perspective and a little moment of Zen. The degree of difficulty will be multiplied due to the fact that CMS expects implementation of both the 5010 and ICD-10 within such a limited timeframe. We certainly hope, and ASA will urge, that CMS will rethink the timing; however, regardless of CMS's ultimate decision, you can make this transition – and ASA will help.

Sources:

- CMS Proposed Rule to Adopt ICD10CM:edocket.access. gpo.gov/2008/pdf/E8-19298.pdf.
- RAND Corporation Study:www.rand.org/pubs/technical_ reports/2004/RAND TR132.pdf.
- Robert E. Nolan Company Study: www.renolan.com/healthcare/icd10study_1003.pdf.
- World Health Órganization information on ICD:www.who.int/ classifications/icd/en.
- www.cms.hhs.gov/ICD10.

SPA Annual Update, 2008

Continued from page 27

In conjunction with the World Federation of Societies of Anaesthesiologists, the Society supports international pediatric anesthesia fellowship training in Vellore, India. Members of the Society are very active in leadership roles in a number of other venues of importance to anesthesiology, including advising the FDA as members of the Anesthetic and Life Support Drugs Advisory Committee and the AAP Committee on Drugs. Members are vigorously pursing efforts – including bench research and establishing multicenter trials – to define the possible contribution of exposure to anesthetic agents in infancy and early childhood to impaired neurodevelopmental outcome. The SPA Quality and Safety Committee is engaged in several quality improvement activities. The "Wake up Safe" effort is a quality-improvement initiative to collect and analyze causes of adverse outcomes that occur during anesthesia in children in the United States. We are grateful to the Anesthesia Patient Safety Foundation, which has awarded a sizeable grant to SPA

to assist in the development of "Wake up Safe." The initiative is within several months of beginning data collection at approximately 10 founding centers; the goal is to develop a program of data collection, definitions and root cause analysis that can then be expanded to other institutions.

Finally, as part of our educational mission, SPA will be offering an annual CME course titled "The Fundamentals of Pediatric Anesthesiology" beginning in 2009. The course is designed for general anesthesiologists who provide perioperative care for many common pediatric surgical conditions. The nationally renowned faculty will focus on frequently encountered issues and concerns during preoperative assessment, intraoperative challenges and postoperative care. For more information on the Society for Pediatric Anesthesia, please visit our Web site www.pedsanesthesia.org or contact me at jay.deshpande@vanderbilt.edu.