Bigger than Y2K, and inevitable – ICD-10-CM

— Dawn Holcombe, MBA, FACMPE, ACHE

On August 22, 2008, CMS published a Notice of Proposed Rule Making (NPRM) for the adoption of Accredited Standards Committee (ASC) X12 version 005010 transactions enhancements, pertaining to Health Insurance Portability and Accountability Act (HIPAA) transactions. This simple NPRM has started ripples of protest and critique throughout all segments of the healthcare industry.

It would be easy to get caught up in a litany of technical jargon and abbreviations in a discussion of this NPRM, and produce an article that would quickly make your eyes glaze over. I focus more on the real business implications of this NPRM and will attempt to simplify the jargon and technical references.

On the one hand, it is way beyond time for the United States to get in step with the rest of the world and adopt what has become a global universal approach to coding – the ICD-10-CM code set. Canada and Australia have already been using the ICD-10-CM code set for years (Australia since 1999). Both of these countries found it took about two years to phase in the transition.[1]

On the other hand, as we evaluate how to reform healthcare in the United States, and increasingly try to move to a more evidence-based and outcomes-focused system, the changes to be enacted in the NPRM fall short of providing the real information needed to adequately function in an evidence-based world. ICD-10-CM is a diagnosis coding system, and does not impact the use of CPT for coding procedures. The failures of the CPT coding system, especially for oncology will continue to be felt, especially in management, staging, and other clinical measures.

The ICD-9-CM system is 27 years old and was designed to measure quality, safety, and efficiency of health services, as well as to conduct research, epidemiological studies, and clinical trials. It was also designed to improve clinical, financial, and administrative outcome performances. The newer ICD-10-CM system was developed by the World Health Organization and clinically modified by the National Center for Health Statistics. It sought to improve organizational weaknesses of the ICD-9-CM system, as well as allowing for global reporting and comparison. Noted problems with current use of the ICD-9-CM classification system include limitations on descriptions of ambulatory and managed care encounters, new medical knowledge and diseases, capturing procedures and new technology, and needs for enhanced capability for specificity. The ICD-10-CM also accommodates the entire healthcare continuum, which is more conducive to utilization of clinical pathways and current medical practice.

Do practices need to prepare for this change?

After all, the American Medical Association, and most major health plans are objecting to the NPRM. Practices do need to prepare for this inevitable change, for inevitable it is. Current commentary on the NPRM notes challenges to the rollout of the change and the timing, but does not in any way suggest that ICD-10-CM is not going to be a way of life for United States healthcare in the future. Once the United States converts, we will see increasing data analytics on a global scale, aiding the growth of evidence-based medicine to a far greater degree than now possible.

How can a practice prepare?

As you would have for Y2K, take time now to review the impending ICD-10-CM and its parameters. Identify each of the various systems which you currently use for billing and charting, and how they would be affected. Start discussions with your vendors now to see if they are preparing for these changes. Usually such preparation will need to take a year or more before actual implementation. So many practices are in the middle of a transition toward electronic medical records, and being aware of this pending change can help you to make better-informed decisions now and seek systems flexible enough to accommodate the future coding system.

Start developing the needs for documentation process and training among your staff and physicians. Identify the oncology specific elements of ICD-10-CM, and note how your internal processes and notes may need to adapt. Actual training will not take place until about one year before implementation, but there is much groundwork to be done before that.

ICD-10-CM will not go away, and will be part of our future. It will require massive retooling in the managed care world and force these organizations through as significant a change as our own transitions into electronic health records. We will survive this as we have Y2K, EMRs, HIPAA, and the MMA. Not easily, but we will.

References:

1. Nagel, S., "The Migration to ICD-10-CM Preparing for the Inevitable," For the Record, Vol. 16, No. 12, P. 30. Available at: www.fortherecordmag.com/archives/ftr_06404p30.shtml. Accessed: September 23, 2008.

2. 45 CFR Part 162 Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards; Proposed Rule, Department of Health and Human Services, August 22, 2008. Available at: http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf. Accessed September 23, 2008.

Dawn Holcombe, FACMPE, MBA, ACHE, is president of DGH Consulting and also executive director of the Connecticut Oncology Association. She is a past president of the Administrators in Oncology Hematology Assembly (AOHA) of the Medical Group Management Association (MGMA), a member of the Editorial Advisory Board for Hematology & Oncology News & Issues and currently is serving as one of the HOPE panelists.