ICD-10-CM

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In September 1994 NCHS awarded a contract to the Center for Health Policy Studies (CHPS) to evaluate ICD-10 focusing on the suitability of ICD-10 as a statistical classification for morbidity reporting in the U.S., specifically emphasizing comparisons with ICD-9-CM. The initial purpose of this comprehensive evaluation was to:

- verify whether ICD-10 was a significant enough improvement over ICD-9-CM to warrant its implementation for morbidity reporting in the U.S.
- develop recommendations to improve ICD-10 and to correct any problems identified during the course of the evaluation.
- develop a revised index and a crosswalk

The Technical Advisory Panel (TAP) convened under the contract consisted of 20 members representing a broad cross-section of the health care and coding community: federal members (HCFA, NCHS [Office of Analysis and Epidemiology and the Division of Vital Statistics], Agency for Health Care Policy and Research); classification experts; hospital representatives; and physician representatives. Considerable effort, from a diverse group of knowledgeable classification experts, was necessary to ensure that the results of the ICD-10 evaluation and the recommendations for clinical modification meet or exceed the high standards of previous revisions, adaptations, and modifications.

The TAP, in conducting the U.S. evaluation recognized the many advantages of the ICD-10 structure over ICD-9-CM, but also were cognizant of some deficiencies as a morbidity classification. These deficiencies included: the continued use of the dagger and asterisk convention (this convention was modified in ICD-9-CM by introducing combination codes for many conditions--the dagger asterisk was never introduced in the U.S. with the implementation of ICD-9-CM); the need to return to the level of specificity implemented in ICD-9-CM; the need to facilitate Alphabetic Index use to assign codes; need to modify code titles and language to enhance consistency with accepted U.S. clinical practice; the need to remove codes unique to mortality coding, those designed specifically for the needs of emerging nations.

The TAP concluded that there were compelling reasons for recommending an "improved" (clinical modification) version of ICD-10 (ICD-10-CM) which would overcome most of the limitations. Therefore, the TAP strongly recommended that NCHS proceed with implementation of a revised version as soon as possible, stating:

> "ICD-10-CM represents a significant improvement in the clinical specificity, ease of use, and accessibility over both ICD-10 and ICD-9-CM. Hence, we make the strongest possible recommendation that the ICD-10-CM Tabular List and Alphabetic Index be adopted and implemented as the standard U.S. classification as soon as practical."

Following receipt of the final report, NCHS staff began further evaluation of the draft of ICD-10-CM developed under the contract. This second phase builds upon the completed evaluation study and the draft of ICD-10-CM. The focused reviews have concentrated on the following areas: (1) evaluation of residual categories ("Other") to determine whether further specificity is needed; (2) further evaluation of ICD-9-CM expansions that may not have achieved the desired effect or may require revision because of new data needs (e.g., insulin maintenance in non-insulin-dependent diabetes mellitus); (3) review of previous ICD-9-CM Coordination and Maintenance committee recommendations that could not be incorporated into ICD-9-CM due to space limitations; and (4) further evaluation of ICD-10 categories that may not have the desired specificity to provide information for ambulatory and managed care encounters, clinical decision-making and outcomes research. These areas are important to ensure the practical utility of a classification that is used for multiple morbidity applications.

During this second phase of modifications we have worked closely with speciality societies, to ensure clinical utility. We have held discussions and meetings and received comments from a number of medical clinical specialty groups and organizations. To date we have worked with the American Academy of Pediatrics, the American Academy of Neurology, the American College of Obstetricians and Gynecologists, the American Urological Association, the National Association of Childrens Hospitals and Related Institutions, the American Burn Association, the Burn Foundation, the National Center for Injury Prevention and Control, the Office of Analysis and Epidemiology, the National Center for Infectious Diseases, the ANSI Z16.2 workgroup, the American Psychiatric Association, the American Academy of Dermatology, the CDC Diabetes Program, and the VA's National Diabetes Program, to discuss specific concerns or perceived unmet clinical needs encountered with ICD-10-CM. We have also had preliminary discussions with other users of the classification, specifically nursing, rehabilitation, primary care providers, NCQA, and the long-term care, home health care and managed care organizations to solicit their comments about the classification.

The major modifications to ICD-10-CM include: combining of dagger/ asterisk codes; the addition of sixth character; incorporation of common 4th and 5th digit subclassifications; plan for full code titles; laterality; creation of combination diagnosis/symptoms codes; reassignment of certain categories to different chapters; deactivation of procedure codes; deactivation of "multiple" codes; and further expansion of post-operative complication codes. Additionally, ICD-10-CM remedies many cumbersome classification dilemmas that have impaired ICD-9-CM, such as a major expansion in the chapter dealing with Factors Influencing Health Status and Contact with Health Services (Z codes) and the musculoskeletal chapter (M codes).

Modifications to the injury chapter include expansion of detail at open wounds and superficial injuries to provide greater specificity: open wounds have been expanded to individually identify lacerations with foreign body; lacerations without foreign body; puncture wounds with foreign body; and puncture wounds without foreign body. Similarly, detail has been added to superficial injuries to identify abrasion, blister, contusion, superficial foreign body and insect bite.

Poisonings in ICD-10-CM have been enhanced to include intent (undetermined, unintentional, intentional self-harm, assault) as a fifth digit (e.g., T39.02, Poisoning by salicylates, intentional self-harm).

In some instances, the ICD-10 has less detail than ICD-9 (and ICD-9-CM). An example of this occurs with carbon monoxide poisonings where specificity as to the source of the carbon monoxide has been omitted. In ICD-10-CM this detail has been returned, added as fourth-digit subcategory to the poisoning codes in the injury chapter (Example: T58.1, Toxic effect of carbon monoxide from utility gas).

In ICD-10, place of occurrence appears as a fourth character subdivision. In ICD-10-CM, a new three-digit code for place of occurrence has been created. This is consistent with the representation place of occurrence in ICD-9-CM (code E849). This unique three and four-digit codes allows for further expansion, where fifth digits have been added to the following subcategories: home, residential institution, school, sports and athletic area, trade/service area, and other specified place). Similarly, ICD-10's optional subclassification for activity appears in ICD-10-CM as a new three-digit category, with expansions at the fourth and fifth-digit levels.

The entire draft of the Tabular List of ICD-10-CM, and the preliminary crosswalk between ICD-10-CM and ICD-9-CM were made available on the NCHS website for public comment. All comments receive during the comment period, which began December 1997 and ended February 27, 1998. More than 1,200 comments were from 22 organizations and individuals were received during the open comment period. Forty-eight percent of those comments focused on the injury and external causes chapter.

Upon the completion of the review of the final report of the public comments NCHS will determine which comments will be incorporated into ICD-10-CM and make changes to the Tabular List. Educational materials, training programs and final crosswalks between ICD-9-CM/ICD-10-CM will be finalized after changes have been made to the Tabular List and Alphabetic Index are completed. A comparability study will also be conducted to assist users of NCHS data (NHDS, NHAMCS, and NAMCS) to discriminate between real changes in utilization by diagnosis and those changes that are artifacts of changes to the classification system. Additionally, NCHS plans to make available electronic formats as well as the traditional printed formats.

No decision has been made regarding the implementation of ICD-10-CM. The designation of standards to be used for administrative and financial transactions now falls under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) and includes standards for medical/surgical code sets. The proposed notice for standards to be used beginning Year 2000, published in a proposed notice of rule making (NPRM) on May 7, 1998 has recommended the use of existing standards, namely ICD-9-CM (for diagnosis and procedures), CPT-4, HCPCS, etc. Once Year 2000 standards are approved, any subsequent recommendations to move to a new standard must go through a new cycle of public hearings, publication of an NPRM and a final notice. Once the final notice has been published, the industry will have 24 months to prepare for the actual implementation date.

Lastly, there will be no changes to ICD-9-CM on October 1, 1999. Even though the ICD-9-CM Coordination and Maintenance Committee conducted public meetings and considered approval of coding changes for FY 2000 implementation, changes to ICD-9-CM codes for FY 2000 will not occur. The Health Care Financing Administration HCFA has undertaken, and continue to undertake, major efforts to ensure that all of the Medicare computer systems are ready to function

on January 1, 2000. Changes to the classification at this time would endanger the functioning of the Medicare computer systems, and, specifically, might compromise HCFA's ability to process hospital bills. Proposals to modify ICD-9-CM presented at the public meetings held in 1998 will be considered for inclusion in the next annual update for October 2000 (FY 2001).