CHCPP NEWS
COMMISSION ON
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HCFA's New ICD-10 Procedure Coding System

In 1995, the Health Care Financing Administration (HCFA) contracted with 3M HIS to develop a new procedure coding system which will replace Volume 3, Procedures, of the current ICD-9-CM. The new system is referred to as the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) and will be used by hospitals to report inpatient procedures (Medicare Part A). The goal of ICD-10 is to improve accuracy and efficiency of coding while improving communication with physicians. ICD-9-CM has exceeded its capacity and cannot be expanded. The new system will be complete and each substantially different procedure will have a unique code. In addition, the structure of the ICD-10 system allows incorporation of new procedures as unique codes (expandability).

3M HIS has a 3 year contract with HCFA to develop the new ICD-10 coding system. During year one, 3M was charged with completing the first draft of ICD-10. This has been completed and the manuals were distributed last December (an electronic version of the manual is available). During 1997, ICD-10 will undergo extensive revision, evaluation and testing. 3M will develop a training program and provide informal testing of the system. In year 3, formal testing will be conducted by an independent contractor and a final version will be written in early 1998.

Patricia Brooks, Co-Chair of the ICD-9-CM Coordination and Maintenance Committee of HCFA, stated that this system will not be implemented prior to the year 2000. She reported that there would be a two year minimum between the release of the final version and implementation. She explained that HCFA wants to ensure enough lead time to train coders on the new system. It is not clear whether the ICD-10 coding system will be used in conjunction with the Current Procedural Terminology (CPT) or is intended to replace it. An updated version of CPT is currently under development at the American Medical Association. The AMAs CPT has over 7,000 procedure codes and ICD-10 will have hundreds of thousands.

ICD-10-PCS has several guidelines that were followed during development: diagnostic information is not included in the procedure description; not otherwise specified options were not provided; except for devices and radiopharmaceuticals, not elsewhere classified were not provided; and based on the combinations of the seven character codes, all possible procedures were defined (specificity).

ICD-10 is divided into 17 sections, including a section specifically for nuclear medicine, apart from radiology. The Society of Nuclear Medicine, American College of Radiology and the Council on Radionuclides and Radiopharmaceuticals were instrumental in the development of the nuclear medicine section. ICD-10 defines nuclear medicine as the introduction of radioactive material into the body in order to create an image, to diagnose and treat pathologic conditions and to assess metabolic functions.

All ICD-10 procedure codes have seven characters. Nuclear medicine procedures will be designated by the number 6 for the first character. The second character represents the body system on which the procedure is performed. The third character indicates the type of nuclear medicine procedure (i.e., planar, tomographic, positron emission tomographic [PET], nonimaging uptake, nonimaging probe, nonimaging assay or systemic therapy.) The fourth character indicates the body part or body region being studied. The fifth and sixth characters together specify the radiopharmaceutical used in the nuclear medicine procedure. The seventh character is a qualifier and provides further details on the specific nuclear medicine procedure.

Character 5 specifies the radionuclide which is the source of the radiation and character 6 specifies the radiopharmaceutical agent. All radiopharmaceuticals which are included in the nuclear medicine section meet one of the following criteria: 1) approved by the FDA for any nuclear medicine procedure or indication; or 2) included in the United States Pharmacopoeia and their use has been documented in peer-reviewed medical publications for any nuclear medicine procedure or indication. As with devices in the medical and surgical section, a not elsewhere classified (NEC) option is included in the nuclear medicine section to be used for newly approved radiopharmaceuticals until they can be explicitly added to the coding system.

The American Medical Association (AMA) has raised some key questions and potential system criticisms concerning this new coding system.

- An overwhelming number of codes are being introduced into the health care system.
- The potential for the system to result in invalid data bases by, for example, allowing coders to assign what appears to be legitimate codes to procedures that do not actually exist.
- The introduction of significant and uneven limitations in expandability, that will certainly curtail the ability to report new medical advances.
- The system disallows the usage of many terms commonly used in clinical practice, for example, it appears that the commonly used term hysterectomy would be called a resection of the uterus under the new system.
- Lack of provisions of the NOS and NEC conventions may force coders into assigning inaccurate codes, when full information is not readily available.
- Rules that prohibit usage of commonly accepted terms in descriptors. For example the common term cleft lip repair would not be allowed.
- The inherent difficulty, if not impossibility, of creating crosswalks to any existing systems.
- Limitation of the index.

If your practice would like to review the clinical content of the nuclear medicine section of ICD-10 this spring, please contact Wendy Smith, Associate Director of Health Care Policy at (703) 708-9000 x 242 or via e-mail at wsmith@snm.org.

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SNM and EANM Focus on Collaboration

The Society of Nuclear Medicine (SNM) has always had an international membership, but new programs are being developed to enhance services to international members. Utilizing current communications technology, key leaders of the SNM and the European Association of Nuclear Medicine (EANM) participated in a video conference call on January 16, 1997 to discuss areas of collaboration.

Prior to the video conference, Peter J. Ell, MD, EANM president, and William H. Strauss, MD, SNM president-elect, developed an agenda, which they then discussed with the participants from their own organizations. In addition to Ell, the other EANM representatives were Angelique Bischof-Delaloye, MD, Michel Bourginon, MD and Ignasi Carrio, MD. SNM representatives also included Michael D. Devous, PhD, SNM president, Peter T. Kirchner, MD, immediate past-president and James W. Fletcher, MD, vice-president elect. Mallinckrodt Medical Inc., St. Louis, MO served as the hosts for the video conference call.

The participants decided on three main areas of collaboration:

1. Development of a utilization analysis database to determine the use of nuclear medicine, with administration of a single-dose of radiopharmaceutical as the indicator, as well as collect data on rare procedures. Differences in the regional structures of participating countries necessitate support from local nuclear medicine societies in each country as well as from department chairs in participating institutions. The conference participants plan to develop a widespread public relations campaign to ensure project support.

Although the form is subject to revision for each country, all participating countries would have an opportunity to review the forms and provide input. In the U.S., the data would be supplied by technologists, but in Europe, physicians or physicists would fill out the form.

This proposed program also raised other issues: ownership of the data and funding for the project. One possibility is industry funding to refine specific data to be collected. To that end, Kirchner proposed a pilot project in which data would be collected from 20 institutions to demonstrate the project's feasibility and to test the forms.

Top: SNM video conference participants (from left to right): William H. Strauss, MD, James W. Fletcher, MD, Peter T. Kirchner, MD and Michael D. Devous, PhD. Bottom: EANM video conference participants (from left to right, as seen through the television screen): Michel Bourginon, MD, Peter J. Ell, MD, Angelique Bischof-Delaloye, MD and Ignasi Carrio, MD.

2. Continuing education presentations by EANM and SNM members at each other's 1998 annual meetings.

3. Develop an outcome/efficacy study for FDG-PET tumor imaging.

"This is the beginning of an effort at [an] international outreach program on the part of both organizations, one which we hope eventually to extend even further to our colleagues in the Pacific Rim," says Strauss.

Planning continues for each of these action items. A follow-up conference call will be held in March. ■

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Stark Introduces Legislation for APGs

On February 4, 1997, Representative Pete Stark (D-Calif.) introduced a bill, the Medicare Hospital Outpatient Reform Act of 1997 (H.R. 582), that would modify Medicare reimbursement for outpatient services by mandating a prospective payment system (PPS). The bill will amend title XVIII of the Social Security Act to correct beneficiary overcharges for hospital outpatient department services and to provide for prospective payment for such services and to eliminate the formula-driven overpayments for certain hospital outpatient services. The legislative language in this bill is similar, except for the implementation date, to the PPS proposed by President Clinton's budget. The President has proposed a 10-year phase-in of the PPS while the Stark proposal is effective January 1, 1998. The bill has been referred to the Committee on Commerce and the Committee on Ways and Means.

Last month in CHCPP News, we introduced ambulatory patient groups (APGs), which is the outpatient PPS that HCFA is currently developing. Based on our concerns with the current version 2.0 of APGs, the Society of Nuclear Medicine submitted comments to HCFA in early February. Comments included a proposed classification system for nuclear medicine procedures and a separate payment system for radiopharmaceuticals. The Society in conjunction with the American College of Nuclear Physicians and the Council of Radionuclides and Radiopharmaceuticals have formed an APG Task Force which will continue to monitor and address this issue.

—Wendy J.M. Smith, MPH, is the associate director of health care policy