More Than Code Revisions in the 2004 Changes to ICD-9-CM

by Kathy Giannangelo, RHIA, CCS

Coding professionals in acute care hospitals know that ICD-9-CM code modifications are implemented every October 1. This year, however, changes taking place will have far-reaching effects. The reason? The diagnosis portion of ICD-9-CM named under HIPAA has become the standard code set for reporting diseases, injuries, impairments, other health-related problems, and their manifestations and causes across all healthcare providers, not just hospitals.

Elimination of the 90-day Grace Period

Until this year, Medicare has permitted physicians, practitioners, and suppliers a 90-day grace period after implementation of an updated medical code set, such as ICD-9-CM diagnosis codes. This time allowed providers to obtain the new codes, learn about the discontinued codes, and implement changes in their information systems. The grace period covered all physicians, practitioners, and suppliers who used ICD-9-CM codes in billing Medicare carriers and durable medical equipment regional carriers (DMERCs).

The grace period ran from October 1 through December 31. During this period, physicians, practitioners, and suppliers were able to use either the previous or new ICD-9-CM diagnosis codes. For claims received on or after January 1, the updated ICD-9-CM codes were required, and claims received with discontinued diagnosis codes were rejected.

The Centers for Medicare and Medicaid Services (CMS) eliminated the 90-day grace period because the HIPAA transaction and code set rule requires use of the valid medical code set at the time of the provided service. Therefore, effective for dates of service on and after October 1, 2004, Medicare systems will enforce HIPAA standards requiring that ICD-9-CM codes submitted on claims must be valid at the time the service is provided.

As a result of this change, physicians, practitioners, and suppliers must adopt the code revisions in their billing processes every October 1 and begin using them for services rendered on or after that time to ensure prompt and accurate payment. If this is not done, claims will be returned by the carriers or DMERCs as unprocessable.

Code Changes Affect NCDs

National coverage decisions (NCDs) identify the specific services, procedures, and technologies Medicare will or will not cover on a national basis. Medicare contractors are required to abide by NCDs. Many of the NCDs include a list of ICD-9-CM codes that do or do not support medical necessity or are otherwise noncovered for the service, procedure, or technology being discussed. Given this connection, come October 1, changes will occur to the NCDs as well.

For example, there are 23 NCDs for clinical diagnostic laboratory services. Many of these NCDs require revision due to the codes effective this October (see below). Those providers who submit bills for clinical diagnostic laboratory services must update their systems to reflect the changes to secure timely and correct payment, otherwise a claim will be denied as not reasonable and necessary. Medicare has edits in place for laboratory claims subject to the 23 NCDs to ensure they are processed uniformly throughout the nation.

Biannual Updates of ICD-9-CM

Section 503(a) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 requires updating ICD-9-CM codes biannually, instead of the current annual October 1 updates. As part of the amendments to the act relating to recognition

of new technology under the inpatient prospective payment system (IPPS), it will provide information on new technologies at an earlier date.

This change affects healthcare providers, coding staff, publishers, system maintainers, software systems, and many others. For example, while the new requirement states that there is no change in the payment of the DRG for the April 1 new codes, the DRG software and encoders will still need updating in order to recognize, capture, and report the new codes. This requirement will improve the recognition of new technologies under the IPPS by providing information on these new technologies six months earlier than would be possible with annual updates.

According to the August 11 *Federal Register*, other adjustments are necessary in order to implement this requirement:

- **Review of the code proposals**. Topics considered during the October ICD-9-CM Coordination and Maintenance Committee meeting (previously held in November) would be considered for an April 1 update if a strong and convincing case is made by the requester. The request must identify why a new code is needed in April for purposes of the new technology process.
- **Publicize the code changes.** CMS plans to have the April 1 updates available five months prior to implementation (early November of the previous year). They will continue to use the same means of notifying and disseminating information on new, revised, and deleted ICD-9-CM codes to providers, publishers, software vendors, contractors, and others of changes to the ICD-9-CM codes that will be implemented in April. Some of these include sending copies of all ICD-9-CM coding changes to its contractors for use in updating their systems and providing education to providers and Web posts such as www.cms.hhs.gov/payment systems/icd9 for current addendum and code title information, www.cms.hhs.gov/med learn/icd9code.asp for summary tables showing new, revised, and deleted code titles, and www.cdc.gov/nchs/icd9.htm for information on ICD-9-CM diagnosis codes.

With ICD-9-CM being used extensively, it is vital to not only understand the revisions to the codes themselves, but also be aware of the impact that these changes can have on other aspects of the healthcare system. Doing so will ensure a smooth transition for all, compliance with HIPAA requirements, timely and correct payment, and improved recognition of new technologies.

ICD-9-CM Changes to NCDs for Clinical Diagnostic Laboratory Services

The following are changes in the NCD for clinical diagnostic laboratory services based on the ICD-9-CM changes that are effective for services furnished on or after October 1, 2004. Other revisions were also made.

- ICD-9-CM code 788.38 has been added to the list of codes covered by Medicare for urine culture NCD.
- ICD-9-CM codes 070.70, 070.71, 588.81, 588.89, V01.71, and V01.79 have been added to the list of codes covered by Medicare for HIV testing (diagnosis). Coverage of ICD-9-CM codes V01.7 and 588.8 are being terminated.
- The following have been added to the list of ICD-9-CM codes that do not support medical necessity for the blood counts NCD: 521.06, 521.07, 521.08, 521.10–15, 521.20–25, 521.30–35, 521.40–42, 521.49, 524.07, 524.20–37, 524.39, 524.50–57, 524.59, 524.64, 524.75, 524.76, 524.81, 524.82, 524.89, 525.20–26, 618.00–05, 618.09, 618.81–83, 618.89, 692.84, V72.40, and V72.41. The following ICD-9-CM codes that are no longer valid have been removed from that list: 521.1, 521.2, 521.3, 521.4, 524.2, 524.3, 524.5, 524.8, 525.2, 618.0, 618.8, and V72.4.
- ICD-9-CM codes have been added to the list of codes covered by Medicare for the partial thromboplastin time NCD: 070.70, 070.71, and 453.40–42.
- ICD-9-CM codes that have been added to the list of covered diagnoses for the prothrombin time NCD: 070.70, 070.71, 453.40–42, 530.86, and 530.87.
- ICD-9-CM codes that have been added to the list of covered diagnoses for the serum iron studies NCD: 070.70 and 070.71.
- ICD-9-CM codes that have been added to the list of covered diagnoses for the collagen crosslinks NCD: 252.00–02, and 252.08. ICD-9-CM code 252.0, which is no longer a valid code, was removed from the list.
- ICD-9-CM codes have been added to the list of covered diagnoses for the blood glucose testing NCD: 491.22, 707.00–07, 707.09, and V58.67. ICD-9-CM code 707.0, which is no longer a valid code, was removed from that list.
- ICD-9-CM code V58.67 was added to the list of covered diagnoses for glycated hemoglobin.
- ICD-9-CM codes have been added to the list of covered diagnoses for the lipid testing NCD: 588.81 and 588.89. ICD-9-CM code 588.8, which is no longer a valid code, was removed from the list.

- ICD-9-CM codes have been added to the list of covered diagnoses for the digoxin therapeutic drug assay NCD: 588.81 and 588.89. ICD-9-CM code 588.8, which is no longer a valid code, was removed from that list.
- ICD-9-CM code 273.4 was added to the list of covered diagnoses for alpha-fetoprotein.
- ICD-9-CM codes have been added to the list of covered diagnoses for the gamma glutamyl transferase NCD: 070.70, 070.71, 252.00–02, 252.08, 273.4, 453.40–42, 588.81, and 588.89. ICD-9-CM code 252.0 and 588.8, which are no longer valid codes, were removed from that list.
- ICD-9-CM codes have been added to the list of covered diagnoses for the hepatitis panel NCD: 070.70 and 070.71.
- V58.66 was added to the list of covered diagnoses for the fecal occult blood test.

References

Centers for Medicare and Medicaid Services (CMS). Available online at www.cms.hhs.gov/coverage/default.asp.

CMS Manual System. Pub. 100-04 Medicare Claims Processing, Transmittal 95. Available online at www.cms.hhs.gov/manuals/pm_trans/R95CP.pdf.

Federal Register, August 11, 2004. Available online at www.access.gpo.gov/su_docs/fedreg/a040811c.html.

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