

Starting on October 1, 2014, all healthcare transactions in the United States must use the clinical modification of the tenth version of the International Classification of Disease, commonly known as ICD-10-CM. This version will replace ICD-9-CM which has been used in the United States since 1979. ICD-10-CM, like ICD-9-CM, will be used to code diagnoses in all healthcare settings and procedures in the inpatient hospital setting. Physicians will still report CPT codes for procedures and other services that they perform.

For most working in healthcare, ICD9 is the only coding system for diagnoses that they have ever known so this change needs to go about carefully. Because of the nature of the change, there is not going to be a widespread testing of claims transmissions. This means that claims submitted for September 30, 2014 must use ICD-9 and those submitted for services on October 1, 2014 must use ICD-10.

There has been a great deal of concern about the transition to ICD-10 and continued delays of implementation. But it appears as though the delays are over. So what do hematologists need to know? Since hematologists would not typically be involved in the selection of ICD-10 procedure codes in hospitals, we'll focus on the use of diagnosis codes.

There is really only major difference between the ICD-9 and ICD-10 that hematologists need to understand. That difference is found in the sheer number of codes. ICD-9 contains approximately 13,000 diagnosis codes and ICD-10 contains approximately 68,000 codes. In most cases, this is just an increase in the specificity of the codes available, rather than a radical reclassification of the diseases.

For example, myeloid leukemia can be coded using 24 different ICD-9 codes (205.xx). In ICD-10, myeloid leukemia is coded using 40 different codes (C92.xxxx). [See the full list](#). The difference is found in specificity. As you can see in the comparison for myeloid leukemia, there are ICD-10 codes that allow one to report the disease with the presence or absence of certain genetic markers. You'll note that the number of characters available for diagnoses has expanded from five to seven. However, in many cases, diagnoses in ICD-10 will be reported with five characters.

There is meaning behind each of the characters in digits within the codes, although most physicians will not need to understand the theory to properly code. If you wish to learn more about the underlying intention of the ICD-10 coding system, the Centers for Medicare and Medicaid Services (CMS) has a great resource at http://www.cms.gov/eHealth/downloads/eHealthU_IntroICD10.pdf

Implications for hematologists

The effect of ICD-10 on hematologists remains to be seen. While there are many more specific diagnosis codes available, there are also ICD-10 codes available with a level of specificity that is similar to that found in ICD-9. There are two areas where that specificity could be demanded of hematologists. The first is in coverage determinations. Payers could require a disease to be coded to the highest level of specificity to approve a certain treatment. This is particularly important in hematology with developing genetically-focused resources. The second area in which this specificity can be important is with the ongoing move towards more episode-based payments. With more specific clinical information, payers may be able to adjust bundles based on severity in a more accurate fashion.

ASH resources

In the time leading up to the implementation of ICD-10, ASH will release a comparison of two diagnosis coding sets per month, each covering a major hematological illness. These resources will give hematologists an example of the kind of information they will need to document and consider in coding their records. We understand that there may be a desire for a “crosswalk” of codes from ICD-9 to ICD-10. However, we believe it is important for physicians to code in ICD-10 not based on their understanding of ICD-9. In many cases, a single ICD-9 code will “crosswalk” to more than one ICD-10 code.