ISSUES The

ASP+4 percent in Final CMS Hospital Outpatient Department Rule

On Oct. 30, 2008, the Centers for Medicare & Medicaid Services (CMS) released its final rule establishing Medicare payment and policy changes for services in hospital outpatient departments and ambulatory surgical centers for 2009. The final hospital outpatient prospective payment system (OPPS) rule will take effect on Jan. 1, 2009. Here are the highlights.

Payment for separately payable drugs and biologicals. CMS will pay for separately payable drugs and biologicals at the manufacturer's average sales price (ASP)+4 percent in CY 2009, a reduction from the current rate of ASP+5 percent. ACCC and others have calculated that hospital pharmacy departments would lose about $22 million at ASP+4 percent compared to ASP+5 percent. ACCC has urged that OPPS rates adequately reimburse hospitals for the costs of providing advanced cancer therapies.

Pharmacy overhead costs. CMS is not adopting the proposed changes to the Medicare cost report that would have established two cost centers for reporting drugs with high and low pharmacy overhead costs. ACCC and other organizations have submitted comments and expressed concerns about increasing administrative burdens on hospitals.

Packaging threshold for drugs and biologicals. Under the OPPS, CMS includes payment for many drugs and biologicals in the payment for the associated procedure in which the drug is administered. However, CMS makes separate payment for drugs and biologicals with estimated per day costs greater than the OPPS drug packaging threshold, which is a dollar amount specified in the rule. For 2009, the OPPS drug packaging threshold is $60. CMS will continue to exempt oral and injectable 5HT3 anti-emetics from packaging.

Payment for intravenous immune globulin preadministration-related services. For 2009, CMS is packaging payment for IVIG preadministration-related services, rather than making a separate payment for these services as the agency did on a temporary basis from 2006 to 2008. Because it appears that the market for IVIG has become more stable, the OPPS will now package the payment for IVIG preadministration-related services with the payment for the associated IVIG drug administration procedures, consistent with the OPPS rule for the administration of other drugs and biologicals.

Payment for drug administration services. CMS is restructuring the drug administration APCs from a 6-level into a 5-level structure for CY 2009 to more closely align payment to hospital claims data. This structure places the Current Procedural Terminology (CPT) codes for drug administration into 5 levels that "are consistent with observed differences in hospital resource costs, both across levels and within each level." Hospitals will continue to report CPT codes for drug administration services, and the 5-level APC structure will continue to pay hospitals separately for each additional hour of infusion, in addition to the initial hour payment.

Quality reporting. Hospitals reporting seven outpatient quality measures in 2009 will receive a 3.6 percent inflation update, while eligible hospitals not submitting data will receive just a 1.6 percent update. The final rule adopts four new quality measures for imaging efficiency.

Imaging services. CMS is changing how it pays for imaging services when two or more imaging procedures from an imaging family are provided in one session to encourage greater imaging efficiency. The final rule creates five imaging composite APCs, such as multiple computed tomography (CT) procedures, performed in a single hospital session.

Radiopharmaceuticals and brachytherapy sources. As required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), CMS is extending payment for therapeutic radiopharmaceuticals and brachytherapy sources provided in hospital outpatient departments based on individual hospital charges adjusted to cost until December 31, 2009.

ACCC is analyzing the final rule and will soon report to its members.

CMS Releases Final 2009 Changes to Payment Policies and Rates under Medicare Physician Fee Schedule

Also on Oct. 30, 2008, CMS issued a final rule for the Medicare Physician Fee Schedule (MPFS) for 2009. The final rule establishes payment rates and policy changes that will go into effect for services furnished by physicians and non-physician practitioners to people with Medicare on or after Jan. 1, 2009. The final rule also includes policies on other subjects including changes to payment rates for end-stage renal disease facilities, and improvements to enrollment and billing rules.

As required by MIPPA, which became law on July 15, 2008, payment rates for physician fee schedule

services will be increased by 1.1 percent in 2009, rather than being reduced by 5.4 percent as would have happened if CMS had applied the physician fee schedule conversion factor projected in the proposed rule. Total Medicare spending under the 2009 Physician Fee Schedule is projected at $61.9 billion, up 4 percent from the $59.5 billion projected for 2008.

MIPPA required that the budget-neutrality adjustment be applied to the conversion factor, resulting in a lower conversion factor. CMS removed the adjustment to the work RVUs, and, therefore, the agency maintains that the overall level of payments under the physician fee schedule is not affected. However, initial analysis shows that the impact of work RVU changes, practice expenses changes, and MIPPA changes results in a total allowed charge decrease of 1 percent for hematology/oncology and a decrease of 3 percent for radiation oncology. IMRT (77418), for example, will decrease 13.7 percent. Also, many related services (planning, dosimetry, consults, etc.) will decrease.

Physicians and other eligible professionals who adopt and use qualified electronic prescribing (e-prescribing) systems to transmit prescriptions to pharmacies may earn an incentive payment of 2.0 percent of their total Medicare allowed charges during 2009. This incentive is in addition to a 2.0 percent incentive payment for 2009 for physicians who successfully report measures under the Physician Quality Reporting Initiative (PQRI), and both incentive payments are in addition to the 1.1 percent fee schedule update required by MIPPA. Thus, a physician who successfully reports under both the e-prescribing and PQRI initiatives could receive up to a 5.1 percent pay boost for 2009.

In the final rule, CMS also adopts improvements to the PQRI, which allow eligible professionals to report quality measures relating to their clinical practice. Physicians who successfully report on quality measures during 2009 will be able to earn an incentive payment, in addition to the e-prescribing incentive payment of 2.0 percent of their total Medicare allowed charges.

ACCC is analyzing the final rule and will soon report to its members.

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PHOTOGRAPH/FOTOLIA

CMS Releases Guidance on Use of Drug Compendia

The Centers for Medicare & Medicaid Services (CMS) has released a Change Request (CR) regarding the newly recognized drug compendia and how compendia information should be interpreted. The CR instructs contractors to accept indications that:

- Are favorably listed in one or more of the approved compendia OR
- The contractor determines from a review of the peer-reviewed literature that it is a medically accepted indication, unless CMS has determined that the use is not medically accepted, or any of the recognized compendia list the use as not medically accepted.

"Medically accepted" indications are those in which: 1) the indication is a Category 1 or 2A in the National Comprehensive Cancer Network's *NCCN Drugs & Biologics Compendium,* or Class I, Class IIa, or Class IIb in *DrugDex*; or, 2) the narrative text in the American Hospital Formulary Service's (AHFS's) *Drug Information* or Elsevier Gold Standard's *Clinical Pharmacology* is supportive.

A use is *not* medically accepted if 1) the indication is a Category 3 in the NCCN compendium or a Class III in *DrugDex*; or, 2) the narrative text in AHFS *Drug Information* or *Clinical Pharmacology* is "not supportive."

The CR does not mention Category 2B listings from the NCCN compendium in either the accepted or non-accepted category. It is likely, therefore, that coverage for a 2B indication will be left to the discretion of local Medicare contractors.

The four nationally recognized drug compendia are authoritative drug reference books that include information about off-label indications, particularly with regard to anti-cancer drugs and biologicals. Recently, the list of compendia recognized by CMS was changed to include three new compendia in addition to the already recognized American Hospital Formulary Service *Drug Information (AHFS-DI)* published by the American Society of Health-System Pharmacists. The three newly recognized compendia are the National Comprehensive Cancer Network's (NCCN's) *Drugs & Biologics Compendium*™, Thomson Micromedex's *DrugDex*®, and Elsevier Gold Standard's *Clinical Pharmacology.*

CMS Says "More Compendia Out There"

The process of recognizing the new compendia "went quite well," according to CMS's Louis B. Jacques, MD. "We had very collaborative discussions with the publishers of the compendia."

Jacques spoke on Sept. 24, 2008, at the "First Annual Forum on Off-Label Therapy," sponsored by the Foundation for Evidence-Based Medicine. More than 150 cancer care providers, pharmaceutical company executives, and insurers gathered in Washington, D.C., for the meeting.

"Apparently there are more compendia out there. I would not be surprised if we [CMS] are not reviewing more compendia applications in January," said Dr. Jacques. He is director, Division of Items and Devices, Coverage & Analysis Group in the Office of Clinical Standards and Quality at CMS.

For Jacques the biggest issue CMS is struggling with is conflict of interest—"slicing and dicing clinical trials in an effort to publish positive results." He was speaking about the need for honest, open transparency in clinical research and in published literature and guidelines. And the same honest, open transparency on the part of the recognized drug compendia.

"We are concerned about potential conflicts on the part of authors who contribute to the compendia. As you are no doubt aware, conflicts of interest in peer-reviewed studies can have a significant impact on scientific outcomes and medical care." Jacques urged the compendia to ask such questions as: Who is involved in the drug-review process, who

attended the meetings, who voted, and who abstained? And to make that information available to ensure "public transparency."

Speaking directly to representatives from the recognized four compendia, Jacques said: "Congress is saying…you have about 16 months left to clean up your shop."

Under the Medicare Improvements for Patients and Providers Act of 2008 (known as MIPPA), Section 182, on and after January 1, 2010, no compendia may be included on the list of compendia unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.

In addition to Jacques, the forum included presentations by a panel of representatives from each of the CMS-recognized drug compendia. They provided an overview of their publication, details about the application and review process, and information about their conflict-of-interest policy. Each was different.

Although each of the four drug compendia is available online, only NCCN's drug compendium has open access. The others are available by subscription only, and some, like *DrugDex,* can cost in the thousands of dollars. Jill Sutton of *DrugDex* said she recognizes the need for a lower cost option and a way to provide information to a broader base, but she gave no indication of how *DrugDex* might tackle the problem.

All four compendia representatives spoke of clearly defined conflict-of-interest policies and differing committee and review structures. Do any of the compendia attempt to reconcile the many differences in recognized indications or narratives? No, they answered. They do not review other compendia. They do look directly at the relevant research.

Does economics play into any drug review discussions? No, they again answered. "Our primary purpose is not reimbursement recommendations. We present the information only," said Kathleen J. Vieson, PharmD, BCOP, from *Clinical Pharmacology.* Her view was shared by the other panel members. *AHFS-DI* does include a descriptor of "reasonable choice" under strength of recommendation, and that might have relevance to cost, said Gerald K. McEvoy, PharmD, when choosing between two comparable therapies.

"Cost is not integrated into our guidelines, though it will have an importance in the future," said NCCN's Kristina Gregory, RN, MSN, OCN.

Forum sponsor, the Foundation for Evidence-Based Medicine (FEBM), is a non-profit organization designed to provide educational materials and programs to providers and their patients to facilitate the use of evidence-based medicine. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

CAP Program Kaput for 2009!

The Competitive Acquisition Program (CAP) that allows physicians to obtain in-office drugs for Medicare beneficiaries from an approved vendor will not be available next year, CMS announced in a Sept. 10 statement. CAP will continue through Dec. 31, 2008. Prior to this end date, the agency will provide guidance for participating physicians on how to transition out of the program.

Earlier this year, CMS accepted bids for vendor contracts for 2009-2011. While the agency received several qualified bids, contractual issues with the successful bidders resulted in CMS postponing the 2009 program. CMS plans to seek feedback on CAP from participating physicians, potential vendors, and other interested parties. The agency will assess the information and consider implementing changes to CAP before proceeding with another bid solicitation. As part of the process, CMS is interested in hearing from the public about a range of issues, including, but not limited to, the categories of drugs provided under CAP, the distribution of areas that are served by CAP, and procedural changes that may increase the program's flexibility and appeal to potential vendors and physicians.

CAP never really caught on with physicians or vendors. A CMS spokesman estimated that only about 4,000 physicians are participating out of a potential 200,000.

Medicare Publishes Billing Edits to Help Reduce Payment Errors

Starting Oct. 1, 2008, CMS began publishing most of the edits utilized in its Medically Unlikely Edit (MUE) program to improve the accuracy of claims payments. These edits check the number of times a service is reported by a provider or supplier for the same patient on the same date of service. Providers and suppliers report services on claims using HCPCS/CPT codes along with the number of times (i.e., units of service) that the service is provided.

[Medicare billing] edits check the number of times a service is reported by a provider or supplier for the same patient on the same date of service.

"It is always our aim to ensure that CMS pays for appropriate services, at the same time protecting the Medicare Trust funds and the American taxpayer," said CMS Acting Administrator Kerry Weems. "This pro-

gram is going to help us dramatically reduce costly payment errors."

The Oct. 1, 2008, version of MUE contained edits for about 9,700 HCPCS/CPT codes that have been assigned unit values for MUEs. MUEs are cumulative for each quarter. However, CMS did not publish all of the MUEs.

CMS established the MUE program to reduce payment errors for Medicare Part B claims. Claims processing contractors use these edits to assure that providers and suppliers do not report excessive services. The edits are applied during the electronic processing of all claims.

The edits, FAQs, and additional information about the MUE program are published at *http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage.*

PHOTOGRAPH/BIGSTOCKPHOTO

New Voluntary Clinician-level Standards for Cancer Care

This year, the National Quality Forum (NQF) endorsed 16 new national voluntary consensus standards focused on patient safety, overuse, and patient engagement in cancer care. These standards can be used to evaluate the performance of clinicians caring for patients with cancer for general hematology, radiation oncology, prostate cancer, and pathology:

1. Hematology: Myelodysplastic syndrome (MDS) and acute leukemias – baseline cytogenetic testing performed*
2. Hematology: Documentation of iron stores in patients receiving erythropoietin therapy*
3. Hematology: Chronic lymphocytic leukemia (CLL) – baseline flow cytometry*
4. Hematology: Multiple myeloma – treatment with bisphosphonates*
5. Radiation oncology: Treatment summary documented and communicated*
6. Medical oncology: Radiation dose limits to normal tissues*
7. Medical oncology and radiation oncology: Plan of care for pain*
8. Medical oncology and radiation oncology: Pain intensity quantified*
9. Medical oncology: Chemotherapy for stage IIIA through IIIC colon cancer patients*
10. Medical oncology: Cancer stage documented*
11. Medical oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
12. Prostate cancer: Three-dimensional radiotherapy*
13. Prostate cancer: Avoidance of overuse measure—isotope bone scan for staging low-risk patients*
14. Prostate cancer: Adjuvant hormonal therapy for high-risk patients*
15. Pathology: Breast cancer resection pathology reporting—pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade*
16. Pathology: Colorectal cancer resection pathology reporting—pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade*

*Time-limited

The purpose of these consensus standards is to improve the quality of healthcare—via accountability and public reporting—by standardizing quality measurement in all care settings. These voluntary consensus standards measure cancer care at a clinician level, and are intended for use at all levels, including individual practitioners and small and large groups. Measures were developed by the American Medical Association's Physician Consortium for Performance Improvement, the American Society for Therapeutic Radiology and Oncology, the American Society of Clinical Oncology, the American Society of Hematology, the American Urological Association, and the College of American Pathologists.

ILLUSTRATION/GETTY IMAGES

E-Prescribing Update

Under the 2009 MPFS, CMS implemented a five-year program of incentive payments to eligible professionals who are "successful electronic prescribers." In order to qualify for an incentive payment, a "successful e-prescriber" is defined as an eligible professional who reports the e-prescribing measures in at least 50 percent of the applicable cases.

The new Electronic Prescribing Incentive increases Medicare payments 2 percent in 2009 and 2010, 1 percent in 2011 and 2012, and 0.5 percent in 2013 for physicians who are "successful" e-prescribers. Beginning in 2012, payments will be reduced by 1 percent for those who are not successful e-prescribers; the reduction will be 1.5 percent in 2013 and 2 percent each year thereafter.

For 2009 the e-prescribing measure requires that an eligible professional use a "qualified" e-prescribing system that must be able to:

- Generate a medication list
- Allow eligible professionals to select medications, print prescriptions, transmit prescriptions electronically, and conduct safety checks (including automated prompts that offer information on the drug being prescribed, potential inappropriate dose or problems in how the drug comes in contact with the patient's body [the "route of administration"], drug-to-drug interactions, allergy concerns, and warnings/cautions)
- Provide information on lower cost alternatives
- Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan.

CMS will update and finalize the e-prescribing measures on its website at: *www.cms.hhs.gov/eprescribing* no later than Dec. 31, 2008.

Impact of Payer Coverage and Reimbursement Policies on Off-Label Use of Anticancer Therapies

A report from the Association of Community Cancer Centers (ACCC) and Covance Market Access Services, Inc.

In 2008, ACCC and Covance Market Access Services, Inc., with assistance from the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Biotechnology Industry Organization (BIO), sent survey invitations to nearly 3,500 office-based oncology practices. The goal: to see how payer coverage and reimbursement policies are affecting how physicians prescribe off-label.

Nearly half of the respondents report that their practice's frequency of off-label use of anticancer therapies has decreased over the past five years. Coverage and reimbursement challenges were the overwhelming reasons cited by oncology practices for their decreased use of anticancer therapies for off-label uses. Those oncology practices that reported an increase in off-label use attribute their increased utilization to the availability of more drugs that have been shown to be effective in uses that are not yet FDA-approved.

Other key study findings involved the importance of off-label drug use, drug compendia and peer-reviewed medical literature, and payer policies.

About Off-label Drug Use…

- Off-label use is extremely important to 50 percent of oncology practices surveyed, and is at least somewhat important to 79 percent of oncology practices.
- Approximately 87 percent of oncology practices have prescribed at least one anticancer drug for an off-label use.
- Oncology practices rely on a variety of sources of information to make off-label treatment decisions for anticancer therapies.

About Drug Compendia and Peer-reviewed Medical Literature…

- More than half of oncology practices surveyed consider drug compendia extremely important to their practice's use of off-label anticancer therapies; 81 percent consider drug compendia at least somewhat important.
- Drug compendia are the primary sources of information that Medicare contractors use to support coverage and reimbursement for off-label uses of anticancer drugs.
- For nearly 40 percent of oncology practices, 25 percent or less of off-label use is supported by drug compendia.
- Although they rely on drug compendia, private payers place almost equal emphasis on clinical guidelines and peer-reviewed medical literature to support coverage and reimbursement for off-label uses of anticancer drugs. For nearly 60 percent of respondents, peer-reviewed medical literature is extremely important to their practice's use of off-label anticancer therapies.

About Public and Private Payers…

- More than half of respondents report that local Medicare contractors' coverage and reimbursement policies frequently or very frequently restrict their practices' off-label use of anticancer therapies; 40 percent report that private payers restrict off-label use.
- Claims denials are the primary method Medicare contractors have used to become more restrictive with coverage and reimbursement for off-label uses of anticancer drugs.
- Prior authorizations, claims denials, and requests for medical records are the primary methods private payers have used to become more restrictive with coverage and reimbursement for off-label uses of anticancer drugs.
- Oncology practices report that more than 60 percent of off-label uses are at least occasionally denied, despite being supported by compendia listings or peer-reviewed medical literature.
- Off-label coverage and reimbursement policies at least occasionally result in treatment delays for 74 percent of oncology practices, and frequently or very frequently result in treatment delays for 27 percent of practices.

Figure 1. Oncology Patients (Not Patient Visits) Seen by Oncology Practices Surveyed (per Month)

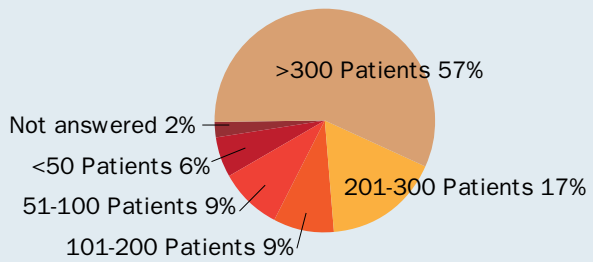


Figure 2. Number of Physicians Per Oncology Practice Surveyed

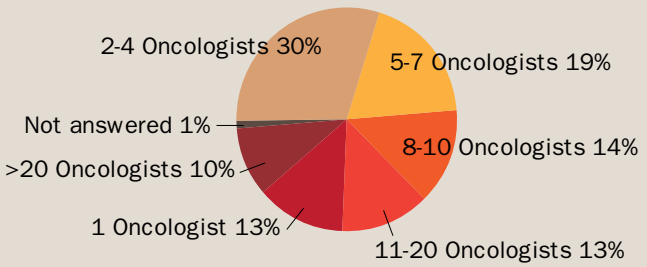
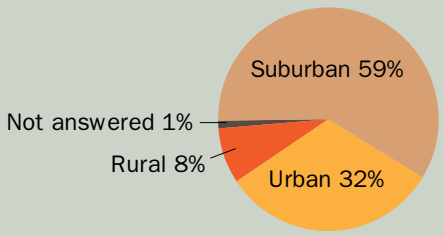


Figure 3. Distribution of Oncology Practices by Urban/Suburban/Rural Status



A Perfect "10"?

by Cindy C. Parman, CPC, CPC-H, RCC

If the proposed regulation to replace ICD-9-CM with ICD-10-CM is finalized, the clock starts ticking. Healthcare entities will have until Oct. 1, 2011, to migrate to the new coding classification. Rather than treat this change as an "800-pound gorilla," (a seemingly unbeatable presence always to be reckoned with), it's time to prepare for one of the biggest coding changes ever!

Currently, ICD-9-CM includes approximately 17,000 diagnosis codes, and this 30-year-old classification should have been replaced at least 10 years ago. The current code set has no room to add new codes that accurately reflect new terminologies, advances in medicine, and diseases encountered subsequent to the adoption of ICD-9. With the advent of ICD-10-CM, medical coders will have more than 68,000 diagnosis codes to choose from when reporting a patient's medical condition. (See Table 1 for a limited comparison of ICD-9-CM and ICD-10-CM characteristics.)

The impact of transitioning to ICD-10-CM will vary by practice, program, or facility. The best way to minimize any negative impact in the transition to ICD-10-CM is to start early. In moving over to this new diagnosis code set, an ounce of preparation will certainly be worth a pound of cure!

One of the biggest concerns relating to the adoption of ICD-10-CM is impact to the oncology provider in terms of staff training requirements, charge ticket updates, computer system changes, and complete medical record documentation. Sufficient preparation, a documented timeline, and change management controls can minimize these concerns. A secondary, but critical, issue is communication before, during, and after the transition. According to Canadian and Australian participants in the change to ICD-10, the single most important factor of the conversion process was clear, concise, and complete communication across the organization.

Table 1. Limited Comparison: ICD-9-CM vs. ICD-10-CM

ICD-9-CM (current)	ICM-10-CM (proposed)
Maximum 5 digits	Maximum 7 digits
No diagnosis code modifiers	Modifiers on certain diagnosis codes
Numeric, except V&E codes	All codes start with a letter
No codes for 'left' and 'right'	Codes for 'left' and 'right'
Limited coding guidelines	Extensive coding and sequencing rules
Approximately 17,000 codes	Approximately 68,000 codes

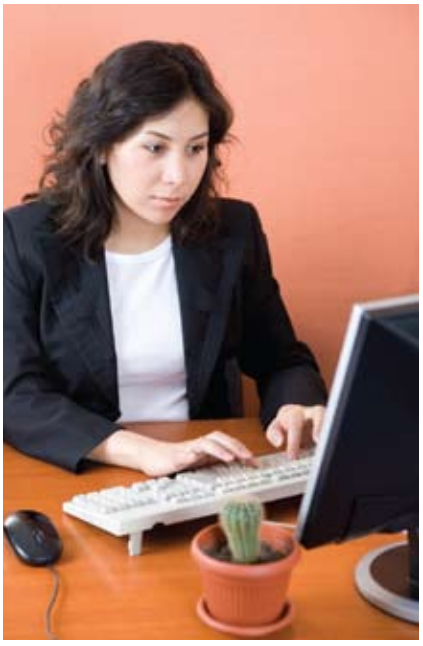
Benefits

The extra detail available with ICD-10-CM codes will benefit researchers, better define quality of care, eliminate diagnosis code ambiguity, and may even result in improved reimbursement. The specificity of the ICD-10-CM codes is designed to accurately report the patient's complete state of health, which may be of great benefit for higher-level patient visit procedure codes.

In addition, the planning phase provides an opportunity for all healthcare providers to review current operations and refine their processes, if necessary. In countries where ICD-10 has already been implemented, results include more accurate payments, fewer denials, and reduced accounts receivable days that can be attributed to greater precision in both documentation and code assignment.

Prepare Now

A number of organizations have published preparation checklists for ICD-10-CM, and a link to the comprehensive American Health Information Management Association (AHIMA) document is included in the resource section on page 12. Before taking any action within the hospital, office, or program, make certain that all staff have been *introduced* to the concept of ICD-10-CM. And be prepared for a variety of responses. For example, medical record coders may be thrilled that the codes they have searched for in vain will now exist, whereas physicians may feel panicked at the thought of new codes to replace those they have carefully memorized over the years. With the implementation



PHOTOGRAPH/BIGSTOCKPHOTO

of ICD-10-CM, every diagnosis code will change—this is *not* an update to the existing diagnosis code classification; it is an entirely new code set. Below is a condensed list of items to include during the preparation process.

Pick your champion. Once everyone is aware of the changes to come, identify your champion. This individual (or small team) will coordinate the education, updates, and troubleshooting that transitioning into an ICD-10-CM environment will require. This individual(s) will read, digest, and communicate written documents; attend seminars; and be the pilot who navigates the uncharted ICD-10 waters. This champion(s) will be the "go to" staff member(s) during the conversion to ICD-10-CM, so they must understand current processes and have the authority to make necessary changes to ensure a smooth

transition. In addition, your program *must* ensure a budget allocation for the education and materials required for ICD-10-CM transition.

Review your current processes for code assignment. Does your program use superbills or charge tickets that have diagnosis codes printed on them? If so, which staff members does this process involve? Which coding manuals are used? Are there computerized coding software programs or an electronic medical record billing module that will require updates? This will also be a good time to eliminate any unnecessary steps in diagnosis code assignment and streamline the coding process. For example, if the receptionist enters a 'dummy' code when the patient is registered, and this code is later updated by the physician or medical coding staff, it may be possible to assign the correct diagnosis code(s) one time and not depend on code correction during the patient care process.

Begin the revision of any necessary paper documents as soon as information is available. This is an excellent time to determine if all the paper forms are necessary, to evaluate any existing job aids (aka, "cheat sheets"), and eliminate duplicative or unnecessary paper during the revision process.

Contact software vendors regarding their timeline for updates and any associated costs. During the preparation stage it may also be prudent to ensure that your contracts with vendors include a clause that states they are responsible for the updates as part of the standard agreement. For the Y2K conversion, a limited number of software vendors charged an additional fee, so contracts should clearly state that it is the vendor's responsibility to transition to ICD-10-CM codes without additional charges to the physician, program, or facility.

Documentation is Key

Surveys conducted in areas that have already transitioned to ICD-10 indicate that the biggest transition issue was an improvement in documentation. While medical record documentation has always been essential to diagnosis code assignment, it will be even more critical when ICD-10 codes are reported. Buy-in from physicians and other practitioners is critical for this step and documentation improvement initiatives can be implemented immediately. Ensuring that physicians are aware of the documentation required for accurate code assignment may be as simple as discussing the number of available codes for a specific condition. For example, ICD-9-CM offers 9 codes for breast cancer diagnosis. ICD-10-CM will have 54 breast cancer diagnosis codes. The bottom line is that instead of documenting a diagnosis of "breast cancer," ICD-10-CM will require that the physician document a diagnosis of "breast cancer, left breast, upper outer quadrant, ER+" to ensure proper coding.

Phase II and Beyond

As the conversion deadline approaches, widespread staff training will likely be necessary. Depending on the structure of the oncology program, the receptionist, nurse, medical coder, payment poster, mid-level provider, and physician may need some level of education on ICD-10-CM coding. Various trials of ICD-10-CM coding have indicated that experienced coders may require as little as 16 hours of training on the new classification. The coding guidelines remain the same for ICD-10-CM; the essential difference surrounds the specificity of the codes, the need for multiple diagnosis codes to completely report the patient's medical condition, and sequencing rules. Based on studies conducted by AHIMA, the complete education program will be most effective if performed three to six months prior to local implementation.

No doubt the conversion to ICD-10-CM will have an enormous impact and will affect all aspects of healthcare delivery. Those healthcare entities that begin early, develop a clear plan, follow logical implementation, and give themselves plenty of time will successfully improve not just medical coding, but documentation, quality of care, patient safety, and other processes as well.

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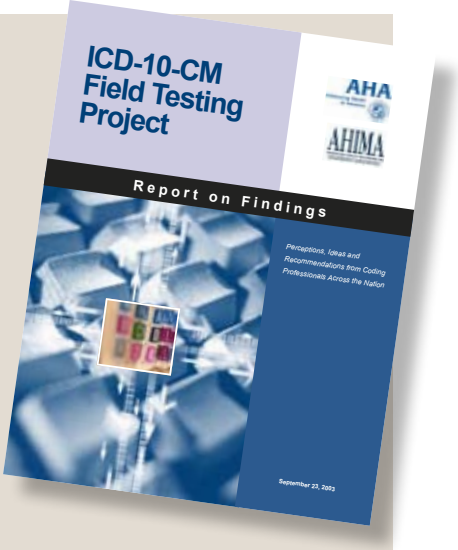
Additional Resources

- U.S. Must Adopt ICD-10-CM and ICD-10-PCS: Immediate Action to Upgrade Medical Code Set Standards Needed. Available online at: *www.ahima.org/icd10/position.asp.*
- Preparing for ICD-10. Available online at: *www.aapc.com/ICD-10/faq.aspx*.
- Collective Strategy for ICD-10-CM & ICD-10-PCS Implementation. Available online at: *www.ahacentraloffice.org/ahacentraloffice/images/ICD10-CM_and_ICD10-PCS.pdf.*
- International Classification of Diseases (ICD). Available online at: *www.who.int/classifications/icd/en/.*



- ICD-10-CM Field Testing Project: Report on Findings. Available online at *www.ahacentraloffice.org/ahacentraloffice/images/2006images/ICD-10-Field%20Testing%20Project%20Summary%20Report%20-%20FINAL%209-19-03.pdf.*
- Transactions and Code Set Regulations. Available online at: *www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp.*
- International Classification of Diseases, Tenth Revision (ICD-10). Available online at: *www.cdc.gov/nchs/about/major/dvs/icd10des.htm.*