

## ACCC Submits Comments to CMS on FDG PET

**O**n Sept. 11, 2009, the Association of Community Cancer Centers (ACCC) submitted comments to the Centers for Medicare & Medicaid Services (CMS) about its proposed national coverage decision (NCD) on positron emission tomography (FDG PET) to guide initial management of cervical cancer. ACCC urged the agency to finalize its proposal to cover the use of FDG PET to help determine the appropriate initial treatment strategy for beneficiaries who have biopsy proven cervical cancer.

ACCC believes that the proposal to cover FDG PET only for biopsy proven cervical cancer is a valid proposal and agrees that this pro-

cedure can be effective in the following areas:

- To determine whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure; or
- To determine the optimal anatomic location for an invasive procedure; or
- To determine the anatomic extent of tumor when the recommended anti-tumor treatment reasonably depends on the extent of the tumor.

The full comments are available online at: <http://www.accc-cancer.org/advocacy/pdf/2009PETcomments.pdf>.



PHOTOGRAPHS/ISTOCKPHOTO

## ONS and ASCO Release New Safety Standards for Chemotherapy Administration

**O**n Sept. 28, 2009, the American Society of Clinical Oncology (ASCO) and the Oncology Nursing Society (ONS) released national standards for safe administration of chemotherapy drugs. These policies seek to serve as a benchmark for providers of adult cancer care and were developed to reduce the risk of errors and provide a framework for best practices in cancer care. The 31 standards cover a range of processes related to chemotherapy, including:

- Training and educating staff
- Ordering, preparing, and administering chemotherapy
- Carrying out patient education and informed consent
- Assessing how patients respond to treatment
- Monitoring toxicity of the treatment to the patient.

ASCO and ONS also recommend increased use of electronic medical record systems, which may lead to improvement in the safety and quality of outpatient chemotherapy administration. E-prescribing, for example, may prove to be a tool for reducing errors in chemotherapy ordering, as automated systems can reduce errors in regimen selection in a busy clinical setting.

ASCO has developed an online guide at: [www.asco.org/safety](http://www.asco.org/safety), to help oncology practices review and develop policies and procedures needed to adhere to these chemotherapy safety standards. The standards are also available on the ONS website at: <http://www.ons.org/clinical/Treatment/Chemotherapy/news.shtml>.



## Comparative Effectiveness Report Finds Proton Beam Radiation Therapy Promising but Unproven for Treating Cancer

Proton beam radiation therapy, a technology used to treat several types of cancer, is considered by some clinicians to be better than traditional radiation, but there is limited evidence about its safety compared with other types of radiation therapy, according to a new comparative effectiveness report funded by the Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ).


The technical brief did not indicate that proton beam radiation therapy is riskier than conventional radiation therapy. However, most studies about the therapy were conducted on small numbers of patients and did not compare the safety of proton beam radiation therapy against other therapies. For many cancers other than head and neck cancers, there are not enough comparative studies in the literature to base an evaluation of the clinical or

cost effectiveness of proton beam radiation therapy compared with other treatments. AHRQ is currently reviewing scientific studies on radiation therapies for head and neck cancers that will evaluate the clinical effectiveness of particle beam radiation therapy—also known as charged particle radiation therapy or proton beam therapy—for those cancers.

The report is the agency's first in a series of technical briefs—rapid-turnaround reports that summarize key issues regarding emerging treatments. Technical briefs highlight where more research is needed and where research may be sufficient to warrant a full systematic review. Future technical briefs will describe the evidence on fetal surgery, stereotactic surgery for non-brain cancers, and percutaneous heart valves.

AHRQ's new report, *Technical Brief: Particle Beam Radiation Therapies for Cancer*, is the newest research review from the agency's Effective Health Care Program. That program, authorized by the Medicare Prescription Drug,

Improvement and Modernization Act (MMA), represents an important federal effort to compare alternative treatments for health conditions and make the findings public. The program is intended to help patients, doctors, nurses, pharmacists, and others choose the most effective treatments. For more information go to: <http://www.effectivehealthcare.ahrq.gov/>.

For more on proton beam radiation therapy and its implications, see page 23, "Horizons in Proton Therapy." 



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### At the Very End of Life

#### Empowering terminally ill cancer patients with the option of aid in dying

by Kathryn L. Tucker, JD, and Paul V. O'Donnell, MD, PhD, FACP

Aid in dying refers to the prescribing of medication to a mentally competent terminally ill patient who can self-administer it to bring about a peaceful death. (See companion article on page 11.) Four major national medical and health policy organizations, after closely examining Oregon's decade of experience with the practice, adopted formal policies of support for aid in dying.<sup>1</sup> In November 2008, Washington adopted a measure modeled after Oregon's, the Washington Death with Dignity Act.<sup>2</sup> And in December 2008, a Montana court held that a terminally ill patient has a fundamental right to choose aid in dying as a matter of state constitutional law.<sup>3</sup>

What accounts for this development of broad-based support of aid in dying? The single most influential factor appears to be that data from the State of Oregon

have put to rest past claims that aid in dying would jeopardize patient care or undermine the ethical integrity of physicians. After more than ten years, it has become clear that making the option of aid in dying available has not put patients at risk;

indeed the evidence is that it galvanized improvements in end-of-life care, and eliminated the underground and unregulated practice of aid in dying known to be prevalent in other jurisdictions.<sup>4</sup>

#### Aid in Dying and Oncology

Oncology organizations have been largely absent from public discussion of aid in dying, despite the fact that most patients seeking the intervention are dying of cancer.<sup>5</sup> It is time for these groups to speak up in support of this option being available to those patients who desire it.

Over the decade that Oregon's Dignity Act has been in effect, an average of about 30 terminally ill patients per year have gone through the process, obtained and taken the medication, and died peacefully.<sup>6</sup> Family members and others present at these deaths report that the patient was enormously relieved to be able to choose this option. On a date chosen by the patient, loved ones may gather for a final goodbye. The patient consumes the medication, becomes drowsy, falls deeply asleep, and after a short period of time ceases to breathe. In 2007 *The Oregonian* published a detailed account of one such death, that of Lovelle Svart dying of inoperable, metastatic lung cancer.<sup>7</sup> The long road from diagnosis to curative treatment to palliative care to death ended on terms acceptable to this patient.

More patients obtain the medication than go on to use it: some fraction each year get the medication, put it in the medicine cabinet, feel comforted to know it is there, and never take it.<sup>8</sup> Oregon's demographic data about

the patients who make use of the Dignity Act show that most patients have cancer. Patients who choose aid in dying are insured, well educated, and receiving comprehensive pain and symptom management, typically through hospice services.<sup>8</sup> Opponents

of the Dignity Act argued that such a law would be forced on uninsured, the poor, minorities, or disabled persons. The evidence is to the contrary.<sup>9</sup>

A number of unexpected but important developments have occurred in Oregon following the Dignity Act's passage. Referral of patients to hospice is more frequent and earlier, and physician enrollment in continuing education courses on how to treat pain and symptoms associated with terminal illness has increased dramatically.<sup>10</sup> It is likely that physicians want to ensure that no patient makes use of the Dignity Act due to inadequate pain and symptom management; this legislation appears to have galvanized the increase in hospice referrals, earlier referrals, and physician efforts to learn more about treating pain and symptoms.

#### Public Support for Aid in Dying

Public support for aid in dying is strong. The Pew Research group reported in 2006 that 60 percent of Americans believe a person has a right to end his or her life if suffering great pain with no hope of improvement, an increase of nearly 20 percentage points since 1975.<sup>11</sup> A poll conducted in March 2006 showed that 70 percent of Californians favored passage of a law similar to Oregon's Dignity Act.<sup>12</sup> Another survey, published in January 2002, found 65 percent support legalization of the right to aid in dying.<sup>13</sup>


Certain religious groups continue to oppose passage of laws permitting physician aid-in-dying for religious reasons, although it should be noted that this opposition does not appear to reflect the views of most religious persons.<sup>14</sup> Vocal, well-funded opposition from such groups succeeded in limiting the legal practice to the state of Oregon for many years. That situation is changing with passage of Washington's law and recognition of a constitutional right in Montana.

A relatively small fraction of terminally ill cancer patients—including those who have excellent pain and symptom management—confront a dying process so prolonged and marked by such extreme suffering and deterioration that they decide that aid in dying is preferable to any other alternatives. Having the



Public support for aid in dying is strong.

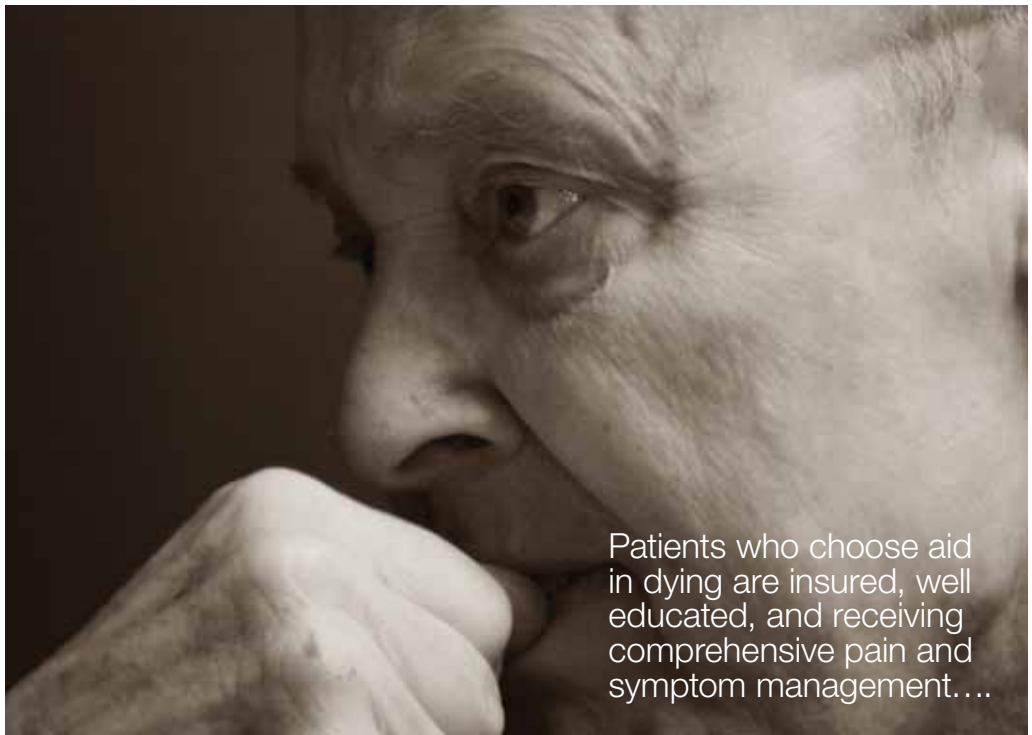
option of aid in dying greatly benefits both the relatively few patients *in extremis* who make use of it and a great many more who draw comfort from knowing it is available should their dying process become intolerable.

Oncologists and others involved in the care of terminally ill cancer patients should support and advocate for adoption of policy by their organizations expanding freedom in end-of-life decision making, including aid in dying. Such policy statements are likely to be influential in both judicial and legislative forums, where aid in dying is under consideration and prompt legislative action and judicial decisions that expand patient choice in treatment decisions. 

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## References

- <sup>1</sup>These organizations include the American Medical Women's Association, <http://www.amwa-doc.org/>, <http://www.amwa-doc.org/index.cfm?objectId=242FFEF5-D567-0B25-585DC5662AB71DF9>; the American Medical Student Association, <http://www.amsa.org/>; the American College of Legal Medicine, <http://www.aclm.org/resources/articles/ACLM%20Aid%20in%20Dying%20Policy.pdf>; and the American Public Health Association, <http://www.apha.org/>.
- <sup>2</sup>The full text of I-1000 is available from the Washington Secretary of State's office at: <http://wei.secstate.wa.gov/osos/en/Documents/I1000-Text%20for%20web.pdf>. Last accessed Aug. 11, 2009.
- <sup>3</sup>Baxter v. Montana, No. ADV-2007-787 (Mont. 1st Jud. Dist. December 5, 2008).



Patients who choose aid in dying are insured, well educated, and receiving comprehensive pain and symptom management...

Available online at: [http://compassion-andchoices.org/documents/Opinion\\_Montana.pdf](http://compassion-andchoices.org/documents/Opinion_Montana.pdf).

<sup>4</sup>Infra.

<sup>5</sup>The Oncology Nursing Society "Position on the Nurse's Responsibility to the Patient Requesting Assistance in Hastening Death" recognizes: "Individual nurses may encounter agonizing clinical situations", and acknowledges: "Requests for assistance in hastening death are not uncommon for healthcare professionals treating patients with advanced cancer and other life-limiting illnesses." The ONS recognizes that "Physical suffering may not always be alleviated, and only a dying individual can judge what is a tolerable or acceptable level of personal suffering."

<sup>6</sup>The Oregon Death with Dignity Act requires the Oregon Department of Human Services to collect information about the patients that make use of the Act, and publish an annual statistical report. These reports are accessible at State of Oregon, Death with Dignity Act, at: <http://oregon.gov/DHS/ph/pas/index.shtml>.

<sup>7</sup>Colburn D. She chose it all on the day she died. *The Oregonian*. September 30, 2007. Available online at: <http://www.deathwithdignity.org/news/news/oregonian093007.asp>.

<sup>8</sup>Death with Dignity Act. Records and Report Data on the Act. Available online at: <http://oregon.gov/DHS/ph/pas/index.shtml>. Last accessed Sept. 17, 2009.

<sup>9</sup>Battin MP, et al. Legal physician-assisted dying in Oregon and the Netherlands: Evidence concerning the impact on patients in "vulnerable" groups. *J. Med.*

*Ethics*. 2007;33: 591.

<sup>10</sup>See, e.g., Ganzini L, et al. Oregon physicians' attitudes about and experiences with end-of-life care since passage of the Oregon death with dignity act. *JAMA*. 2001; 285: 2363 and Lee MA, Tolle SW. Oregon's Assisted Suicide Vote: The Silver Lining. *Ann Intern Med*. 1996;124: 267.

<sup>11</sup>More Americans Discussing—and Planning—End-of-Life Treatment: Strong Public Support for Right to Die [news release]. Pew Research Center, For The People & The Press; January 5, 2006. Available online at: <http://people-press.org/reports/pdf/266.pdf>. Last accessed Aug. 11, 2009.

<sup>12</sup>Field M. Field Research Corp., Release #2188; March 15, 2006. Available online at: <http://www.field.com/fieldpollonline/subscribers/RLS2188.pdf>. Last accessed Aug. 11, 2009.

<sup>13</sup>Harris Interactive, 2-to-1; January 9, 2002. Available online at: [http://www.harrisinteractive.com/harris\\_poll/index.asp?PID=278](http://www.harrisinteractive.com/harris_poll/index.asp?PID=278). Last accessed Aug. 11, 2009.

<sup>14</sup>For example, Roman Catholics (64%), Protestants (65%), people who subscribe to non-Christian faith or no single religion (80%), and even born-again Christians (54%) all support aid in dying. See California Progress Report, Opponents of AB 651 Include Extremists with Agenda to Dictate Patients' Dying Choices (citing Mark DiCamillo and Mervin Field) [press release] Field Research Corp., Release #2188; (Mar. 15, 2006). Available online at: [http://www.californiaprogressreport.com/2006/04/opponents\\_of\\_ab.html](http://www.californiaprogressreport.com/2006/04/opponents_of_ab.html).

*continued on page 11*

## A Question of Terminology

Opponents of aid in dying typically refer to the practice as “assisted suicide.” However, the terminology used to refer to this intervention has evolved, and it has become widely recognized that the term “assisted suicide” is neither neutral nor accurate.

Oregon’s Death with Dignity Act explicitly states: “Actions taken in accordance with [the Dignity Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.” The Oregon Department of Human Services has explicitly rejected the term “assisted suicide” in describing deaths under the Dignity Act.<sup>1</sup>

The nation’s leading health policy organization, the American Public Health Association, addresses this terminology issue:

*[t]he term ‘suicide’ or ‘assisted suicide’ is inappropriate when discussing the choice of a mentally competent terminally ill patient to seek medications that he or she could consume to bring about a peaceful and dignified death.*<sup>2</sup>

Mental health professionals readily appreciate that “suicide” and the decision of a dying patient to choose a peaceful and dignified death are starkly different and that profound psychological differences distinguish these choices:

*The term ‘assisted suicide’ is inaccurate and misleading with respect to the [Oregon Dignity Act]. These patients and the typical suicide are opposites: The suicidal patient has no terminal illness but wants to die; the death with dignity patient has a terminal illness and wants to live. Typical suicides bring shock and tragedy to families and friends; death with dignity deaths are peaceful and supported by loved ones. Typical suicides are secretive and often impulsive and violent. Death in death with dignity is planned; it changes only timing in a minor way, but adds control in a*

*major and socially approved way. Suicide is an expression of despair and futility; death with dignity is a form of affirmation and empowerment.*<sup>3</sup>

The Washington State Psychological Association advises:

*A person with a terminal illness is going to die even with, or despite, the best medical treatment available. The designation of suicide is disrespectful to individuals with terminal illness who wish to have choice regarding death with dignity, and can be distressing and problematic emotionally, socially, psychologically, and financially, for family members and loved ones of dying individuals.*<sup>4</sup>

The American Medical Women’s Association, Position Statement on Aid in Dying states:

*The terms “assisted suicide” and/or “physician assisted suicide” have been used in the past, including in an AMWA position statement, to refer to the choice of a mentally competent terminally ill patient to self administer medication for the purpose of controlling time and manner of death, in cases where the patient finds the dying process intolerable. The term “suicide” is increasingly recognized as inaccurate and inappropriate in this context and we reject that term. We adopt the less emotionally charged, value-neutral, and accurate terms ‘Aid in dying’ or ‘Physician Assisted Dying’.*<sup>5</sup>

Legal commentators have also noted the inappropriateness of the word “suicide” to refer to the choice of a dying patient for a peaceful death:

*The word ‘suicide’ is well suited to the description of a distraught individual with his whole life ahead of him, who in a moment of despair commits a completely senseless and utterly tragic act. In contrast, ‘suicide’ is not well suited to describe a cancer patient who in the final days of a horrible and agonizing struggle simply wishes to avoid more needless suffering and indignity. The first individual’s act destroys what could be a long and productive life. The elderly cancer patient does not extinguish the*

*hope of a bright future, but rather avoids the last painful and undignified moments of a life already fully lived. ... Use of the word “suicide...arouses the images of tragic loss of life in a situation where the tragedy may be the continuation of life.*<sup>6</sup>

## References

- O’Reilly KB. Oregon nixes use of term “physician assisted suicide.” *American Medical News*. November 6, 2006. (Quoting Katrina Hedberg, MD, MPH, a DHS Public Health Division medical epidemiologist.) Available online at: <http://www.ama-assn.org/amed-news/2006/11/06/prsc1106.htm>. Last accessed Aug. 11, 2009.
- American Public Health Association. Statement. *Patients’ Rights to Self-Determination at the End of Life*. October 28, 2008. Policy number 20086. Available online at: <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1372>. Last accessed Aug. 11, 2009.
- Lieberman EJ. Death with Dignity [Letter to the editor]. *Psychiatric News*, August 14, 2006; Vol. 41, Issue 15, 29. Available online at: <http://pn.psychiatryonline.org/cgi/content/full/41/15/29>. Last accessed Aug. 11, 2009.
- Gordon JR. New WSPA Policy on Value-Neutral Language Regarding End-of-Life Choices. Washington State Psychological Association. Available online at: <http://www.wapsych.org/displaycommon.cfm?an=1&subarticlenbr=252>. Last accessed Aug. 11, 2009. See also, Brief of Amicus Curiae of Coalition of Mental Health Professionals. *Gonzales v. Oregon*, 126 S. Ct. 904 (2006) (No. 04-623), WL 1749170 at 1.
- American Medical Women’s Association. Aid in Dying. Available online at: <http://www.amwa-doc.org/>, <http://www.amwa-doc.org/index.cfm?objectid=242FFEF5-D567-0B25-585DC5662AB71DF9>. Last accessed Aug. 11, 2009. Similarly, the American Academy of Hospice and Palliative Medicine rejects the term physician assisted suicide as “emotionally charged” and inaccurate. American Academy of Hospice and Palliative Medicine. Physician-Assisted Death. [Position Statement]. Available online at: <http://www.aahpm.org/positions/suicide.html>. Last Accessed Aug. 11, 2009.
- Dallner J. Death with Dignity in Montana. 65 Mont. L.Rev. 309, 314-315 (2004).

# ICD-9-CM Code Updates

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

Transitions are associated with each season of the year. “Spring fever” brings to mind flowers, warmer weather, and outside activities after months of “cabin fever” during the winter. Summer brings sunshine and family vacations, while autumn means back to school, fall jackets, football, and...new diagnosis codes.

Not all of the 2010 diagnosis code or code descriptor changes that went into effect Oct. 1, 2009, relate to oncology, but some significant new codes were added to charge tickets, electronic medical records, and charge description masters.

## Tumor Lysis Syndrome

Tumor lysis syndrome develops when cytotoxic therapies cause the destruction of a large number of rapidly dividing malignant cells. In the past, codes were assigned for each symptom of tumor lysis. Effective Oct. 1, 2009, a single code describes this condition:

- 277.88: Tumor lysis syndrome.

In addition to the code for tumor lysis, an appropriate E-code, such as E933.1 (drugs, medicinal, and biological substances causing adverse effects in therapeutic use, antineoplastic, and immunosuppressive drugs), should be reported to further describe the patient’s medical condition.

## Antineoplastic Chemotherapy Induced Anemia

Over the years medical coders have often debated the appropriate code(s) to report anemia resulting from chemotherapy drug administration. Effective Oct. 1, 2009, report the following code for anemia that develops in response to chemotherapy administration:

- 285.3: Antineoplastic chemotherapy induced anemia.

The exception would be if the patient has developed *aplastic* anemia (a form

of anemia in which the capacity of the bone marrow to generate red blood cells is defective) caused by the administration of chemotherapy. This condition would be reported with the following diagnosis code:

- 284.89: Other specified aplastic anemia.

As in the case of tumor lysis syndrome, the appropriate E-code is reported in addition to the code for anemia to designate the nature of the drug that caused this condition. The ICD-9-CM Official Guidelines state that encounters for management of an anemia associated with chemotherapy or immunotherapy, where the only treatment is for the anemia, should list first the code for the anemia and code E933.1, followed by the diagnosis code for the site of the malignancy.

## Merkel Cell Carcinoma

Prior to Oct. 1, 2009, there were no specific codes for Merkel cell carcinoma, a neuroendocrine cancer of the skin. Instead, the ICD-9-CM Alphabetic Index stated to code this condition by referring to the Neoplasm Table, by site, malignant column. Effective Oct. 1, specific codes were created for Merkel cell carcinoma. Primary Merkel cell carcinoma is reported with codes:

- 209.31: Merkel cell carcinoma, face
- 209.32: Merkel cell carcinoma, scalp and neck
- 209.33: Merkel cell carcinoma, upper limb
- 209.34: Merkel cell carcinoma, lower limb
- 209.35: Merkel cell carcinoma, trunk
- 209.36: Merkel cell carcinoma, other sites.

The “other sites” code 209.36 includes Merkel cell carcinoma of the buttock, genitals, or any other anatomic area not defined by the

more specific codes.

There is also a unique code to report a metastatic Merkel cell malignancy: 209.75: secondary neuroendocrine malignancy, Merkel cell. The ICD-9-CM Tabular List indicates that this code includes secondary Merkel cell carcinoma that presents in the nodes, visceral metastatic presentation, or any secondary site.

Finally, ICD-9-CM has added a diagnosis code to report personal history of a malignant neuroendocrine tumor, including personal history of Merkel cell carcinoma: V10.91: secondary neuroendocrine tumors.

In addition to codes for primary neuroendocrine cancers, here is a new set of codes for secondary (metastatic) neuroendocrine malignancies:

- 209.70: Secondary neuroendocrine malignancy, unspecified site
- 209.71: Secondary neuroendocrine malignancy, distant lymph nodes
- 209.72: Secondary neuroendocrine malignancy, liver
- 209.73: Secondary neuroendocrine malignancy, bone
- 209.74: Secondary neuroendocrine malignancy, peritoneum
- 209.79: Secondary neuroendocrine malignancy, other sites.

## Unspecified Nature, Retina and Choroid

A patient may have a suspicious area on the retina that requires ongoing observation, but not necessarily a biopsy. The new diagnosis code for these retinal spots is:

- 239.81: Neoplasms of unspecified nature, retina and choroid.

Cross-references added to the Tabular List of ICD-9-CM indicate that this code is reported for a dark area on the retina or for a retinal freckle.

As of Oct. 1, code 239.8: neoplasm of unspecified nature of other specified sites is *no longer effective*.



### Pre-Operative and/or Pre-Procedural Examination

In some circumstances, the code itself has not changed, but the code descriptor has been altered. Patients who receive certain chemotherapy drugs require monitoring of the effects of these substances. For example, a MUGA scan may be performed prior to the first dose of chemotherapy to establish baseline cardiac function, rule out a pre-existing cardiac disease, and clear the patient to receive a cardiotoxic drug. Effective Oct. 1, 2009, the Tabular List of ICD-9-CM specifically states that the following code includes “Examination prior to chemotherapy”:

- V72.83: Other specified pre-operative examination.

In addition to this descriptor change, there is a new code to report blood tests prior to a treatment or procedure:

- V72.63: Pre-procedural laboratory examination.

Specifically, this code is reported when routine blood testing is performed for a patient with no underlying signs, symptoms, or conditions present to justify the service.

### Signs and Symptoms Codes

Another code with an altered coding instruction is:

- 790.01: Precipitous drop in hematocrit.

In addition to the traditional code descriptor relating to hematocrit level, this code may now also be reported for a “drop in hemoglobin” recorded as a laboratory result.

### A Time to Review

The annual update to ICD-9-CM diagnosis codes provides an opportunity to review existing code capture documents and programs. In addition to the new codes and verbiage changes listed in this article, there are

**Table 1. New Diagnosis Codes for Oncology\***

Diagnosis Code	Description
209.31	Merkel cell carcinoma of the face
209.32	Merkel cell carcinoma of the scalp and neck
209.33	Merkel cell carcinoma of the upper limb
209.34	Merkel cell carcinoma of the lower limb
209.35	Merkel cell carcinoma of the trunk
209.36	Merkel cell carcinoma of other sites
209.70	Secondary neuroendocrine tumor, unspecified site
209.71	Secondary neuroendocrine tumor of distant lymph nodes
209.72	Secondary neuroendocrine tumor of liver
209.73	Secondary neuroendocrine tumor of bone
209.74	Secondary neuroendocrine tumor of peritoneum
209.75	Secondary Merkel cell carcinoma
209.79	Secondary neuroendocrine tumor of other sites
239.81	Neoplasms of unspecified nature, retina and choroid
239.89	Neoplasms of unspecified nature, other specified sites
277.88	Tumor lysis syndrome
279.41	Autoimmune lymphoproliferative syndrome
279.49	Autoimmune disease, not elsewhere classified
285.3	Antineoplastic chemotherapy induced anemia
V10.90	Personal history of unspecified malignant neoplasm
V10.91	Personal history of malignant neuroendocrine tumor
V72.63	Pre-procedural laboratory examination
V87.43	Personal history of estrogen therapy
V87.46	Personal history of immunosuppressive therapy

\*Effective October 1, 2009

many other alterations to “Includes” and “Excludes” notes, clarifying verbiage and descriptor changes that became effective Oct. 1, 2009. This updated reporting information is essential for obtaining medical necessity information, capturing patient diagnoses for research purposes, and tracking patient care. 📄

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### Resources

- Centers for Medicare & Medicaid. New, Deleted, and Revised ICD-9-CM Codes: Summary Tables. Available online at: [www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage). Last accessed Sept. 14, 2009.
- Centers for Disease Control and Prevention. Clarification of Diseases, Functioning, and Disability. Available online at: <http://www.cdc.gov/nchs/icd.htm>. Last accessed Sept. 14, 2009.