Coding has never been so important for the hospice industry.
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Firm Background

About McBee Associates

- Recognized leader in the health care consulting industry
- Established in 1973
- Over 3,500 health care provider clients in acute, post-acute, and long-term care
- Serving clients in all 50 states from 4 offices
- One of the nation’s largest, independent health care financial consulting practices
- Reputation for expertise and high-quality service
What you will learn today

- The Centers for Medicare and Medicaid Services’ (CMS’) final rule for hospice coding
- Clarified coding recommendations as stated by the final rule
- Recommendations for changes in current hospice diagnoses/coding
- How to determine a hospice primary diagnosis
- Methods for properly coding hospice claims
- Utilizing the most current recommendations in the coding industry
- Sample scenarios
- How to prepare for the future of ICD-10
On May 10, 2013, CMS issued a proposed rule, and on August 7, 2013 the final rule titled “Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform” was issued.

In this update, CMS stated some clarifications about a number of coding requirements that include direction to hospices stating they may no longer use non-specific diagnoses, such as debility or adult failure to thrive (AFTT) as a principle diagnosis on the hospice claim.

Starting with October 2014 claims, CMS states that the claims submitted with these diagnoses would be considered questionable encounters for hospice care, and would be returned to the provider (RTPd) for a more definitive hospice diagnosis.
CMS’ final rule

- Debility and AFTT can and should be listed on the claim as secondary (related) conditions when appropriate.

- CMS expects providers to code the most definitive terminal diagnosis using ICD-9 codes (ICD-10 codes once they are implemented) with all other related conditions in the additional diagnosis fields.

This was a clarification, not a new regulation, so immediate compliance is recommended.
Why the need for clarification?

- CMS provided data showing the changes in diagnosis patterns among Medicare hospice enrollees, with a **growing percentage** of beneficiaries being admitted under the non-specific diagnosis of debility and AFTT.

- The same data reported that **over 77%** of the hospice claims reported only a principal diagnosis.
Why the need for clarification?

- In 2012, debility and AFTT, were the number one and number three most common hospice diagnoses, accounting for about one in five hospice patients.

- Patients with debility and AFTT tend to have a longer length of stay.
  - This may partially be due to earlier identification of patients who are eligible for hospice services and an increased awareness of hospice services, or the increased number of patients being admitted with these diagnosis.
Debility

- In the past 10 years, debility unspecified has moved from the third most common hospice diagnosis (6% of all patients) to the number one most common diagnosis, accounting for 12% of hospice patients.

- Simultaneously, the average lifetime length of stay (LOS) for beneficiaries has increased 51 days in 1998 to 83 days in 2009, an increase of 62.7%.

- Data analysis using FY 2012 claim data for those patients with a reported principal hospice diagnosis of debility, and reported secondary diagnoses shows that congestive heart failure, coronary artery disease, heart disease, atrial fibrillation, Parkinson’s disease, Alzheimer’s disease, renal failure, chronic kidney disease, and chronic obstructive pulmonary disease are among the most common secondary diagnoses reported.
AFTT

- AFTT has moved from number eight (3% of all patients) up to number three (7% of all patients).

- Simultaneously, the average lifetime length of stay (LOS) for beneficiaries has increased from 50 days in 2001 to 84 days in 2009, an increase of 68%.

- Data analysis using FY 2012 claim data for patients with a reported principal hospice diagnosis of AFTT and reported secondary diagnoses shows that pneumonia, cerebral vascular accident (stroke), atrial fibrillation, heart disease, and Parkinson’s disease are among the most common secondary diagnoses reported.
Determining hospice primary diagnoses

- The principal diagnosis listed should be the diagnosis that is determined to be the most contributory to the terminal condition.

- Medicare coverage of hospice depends on the physician’s certification that an individual's prognosis is a life expectancy of six months or less, if the terminal illness runs its normal course.

- Coders should refer to their Medicare Administrative Contractor’s (MAC’s) local coverage determination (LCD) to determine if the patient meets the clinical criteria for admission to hospice.
Determining hospice primary diagnoses

- When admitting a hospice patient whose terminal diagnosis is not cancer, make sure you code all the relevant co-morbidities that support the physician’s determination that the patient’s disease is likely to cause death within six months or less.
Determining hospice primary diagnoses

- By using the LCDs, it provides the reviewer guidance to aide in consistency of reviews. LCDs help show:
  - Related decline
  - Related functional limitations
  - Co-morbidities to support terminal prognoses
Determining hospice primary diagnoses

- Once the terminal diagnosis has been established, documentation **must** support it.

- The MACs have reported **insufficient documentation** to support the terminal diagnosis as the **top reason** for hospice claim denials.
Reason for change:

What does your hospice need to DO?

New Admissions

- Try to reduce or even cease the use of debility and AFTT as a primary hospice diagnosis for newly admitted patients.
- Select a primary diagnosis that is most contributory to the patient’s terminal disease trajectory and requires end-of-life palliative interventions.
- Use other health conditions (including debility, AFTT, etc), whether related or unrelated to the hospice-qualifying terminal diagnosis, to support the prognosis as needed. *(This is especially important if the primary diagnosis does not have an LCD guideline associated with it or if the patient’s clinical status is such that he or she does not meet the LCD guideline in its entirety.)*
- Include all prognosis-impacting conditions on the claims form.
Reason for change:

What does your hospice need to DO?

Current Patients with a Primary Diagnosis of Debility or AFTT

- Perform a census analysis to identify all patients that fall into the ICD-9 category of “symptoms, signs and ill-defined conditions” (ICD9-780-799).
- Have your medical director or hospice team physician review each patient’s clinical record to identify an alternative primary diagnosis.

**Tip:** Use the plan of care (POC) to see what body system requires the greatest amount of palliative interventions; use the drug profile; and ask yourself, if the patient died tomorrow what the cause of death would be listed on the death certificate.
Changing a patient’s primary diagnosis

- Obtain a physician order for the new diagnosis.
- Obtain a new physician narrative that supports eligibility for the new diagnosis.
- Ensure that the new diagnosis is supported by documentation in the clinical record.
- Develop a new POC based on an updated comprehensive assessment.
- Update the drug profile with appropriate designations of related/covered or unrelated/non-covered.
- Change billing codes.
Changing a patient’s primary diagnosis

- The diagnosis can be changed on the next claim, or an adjustment may be made to a prior claim if needed. It is not necessary to cancel any claims already processed with the original diagnosis.

- If the patient has no clear alternate diagnosis that can be supported by clinical documentation, and the POC has not changed over time to reflect end-of-life symptom management, consideration should be given to discharge the patient.
Changing a patient’s primary diagnosis

- Draft and send a letter to all attending physicians to explain the reason for these changes.

- Discuss these changes with staff members and referral sources, including contracted nursing facilities and assisted living facilities.

- If processes are changed now, all billing claims for hospice services will be in full compliance by the time the first 2014 claim is submitted.
The August 2013 final CMS rule has given clear guidelines:

“Hospice coders must follow official ICD–9–CM guidelines for coding and reporting.”
Methods for proper coding: Coding guidelines

- In order to code a hospice claim accurately, the coder must:
  - Have a primary diagnosis that reflects the terminal diagnosis and an up-to-date history that reflects the co-morbidities impacting the primary diagnosis.
The First and Most Important Rule

- Coding guidance directs that the coder should **always code to the highest specificity possible** based on diagnosis information provided by the doctor of medicine (MD).
Official ICD-9-CM Coding Guidelines

- These coding and reporting guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided with ICD–9–CM.

- Adherence to these guidelines when assigning ICD–9–CM diagnosis and procedure codes is required under The Health Insurance Portability and Accountability Act (HIPAA).
ICD-9 Coding Guidance

- These rules include specific instructions on ICD coding conventions including:
  - Abbreviations—Not elsewhere classifiable (NEC) and not otherwise specified (NOS)
  - Punctuations—Brackets, parentheses, and colons
  - Instructional notations—Includes and excludes
  - Compliance with correct usage of manifestation codes
Special Note: on manifestation codes

- The 2013 hospice proposed/final rule noted “incorrect use of manifestation code 294.10 for dementia.”
- 294.10 is a manifestation code (identified in the numerical index by a capital M). This means the dementia diagnosis 294.10 is used as an additional code when a patient with Alzheimer’s or Parkinson’s disease also has dementia.
Correct use of manifestation codes

- In accordance with the 2012 ICD–9–CM coding guidelines, certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology.

- For such conditions, the ICD–9–CM has a coding convention that requires the underlying condition to be sequenced, first followed by the manifestation. Wherever such a combination exists, there is a “use additional code” note at the etiology.
What co-morbidities should be coded on the hospice claim?

- The decision of what additional coexisting or additional diagnosis to be coded should be decided by the hospice director, attending physician, and the hospice interdisciplinary team (IDT).

- These additional diagnosis included on the hospice claim should be related to the terminal illness and will be considered when managing all covered services, including MD/ER visits, interventions, medications, and equipment.
Utilizing the current recommendations: Correct use of the coding manual

- A diagnosis must first be looked up in Volume Two in the alphabetic index.

- Then, go to the numerical index to cross reference and verify this is the correct ICD-9 code by reading any additional instructions, including coding tips, includes, and exclude comments.

- If using electronic coding software, confirm it has the latest update.
Incorrect use of ICD-9 coding

- Will put your agency at **an increased risk** of ADRs and denied claims.
Tips on how not to use Debility or AFTT

As directed by coding guidance, a symptom code such as debility or AFTT should not be coded when documentation supports a specific diagnosis causing these symptoms.

The most specific diagnosis should always be coded and the remaining codes should present a clear picture of the patient’s condition (terminal illness).
An 87-year-old man with end stage AFTT. Weight loss 50 pound in last year, current BMI- 17.5, no longer ambulatory. Recent hospitalization for aspiration pneumonia. Patient and family continue to decline PEG feeding tube. History of Parkinson’s disease.
SN Admission Narrative

Admission to hospice for 87-year-old man with recurrent and increasing hospitalizations for aspiration pneumonia. He has lost 50 pounds in the last year, current BMI 17.5 due to dysphagia related to his advanced Parkinson’s disease. He is now chair fast d/t weakness and has orthostatic hypotension with multiple falls in the last 3 months. He is dependent in bathing, dressing, and transfers. Patient and family decline further active intervention for disease process.
What is this patient’s primary diagnosis?

- After conferencing with referring MD and hospice director it is decided this patient’s adult failure to thrive (AFTT) is d/t end stage Parkinson’s disease
How to code this scenario

Primary and Secondary Diagnosis
- Primary Code: 332.0, Parkinson’s disease
- Other (secondary) codes: 787.20, dysphagia
- Other codes: 783.21, weight loss
- Other codes: 458.0, orthostatic hypotension
- Other codes: V12.61, history of pneumonia
- Other codes: V85.0, adult BMI below 19
Patient scenario #2: Debility

MD Verbal Order Documents
- End stage debility

MD CTI Narrative

A 67-year-old woman with debility. Recent decline bed to chair existence, now totally dependent in all ADLs, anorexia, new stage 2 pressure ulcer. History of COPD and CAD.
Patient scenario #2: Debility

SN Admission Narrative

Hospice admission for a 67-year-old woman with recent declines in mobility and ADLs d/t incapacitating dyspnea related to her COPD and Asthma. She now also has angina daily with any exertion that causes her O2 saturations to drop. She has a history of CAD with a 4 vessel CABG 12 years ago, PAD with constant leg pain at rest. Her appetite has decreased, BMI is 15.5 with multiple boney prominences noticed, her albumin is 1.2 and she has developed a pressure ulcer stage 2 to her sacrum as she has to have her head elevated at all times.
What is the primary diagnosis for hospice?

- After case conferencing with the referring MD and hospice director, it is decided this patient’s debility is d/t end stage pulmonary and cardiovascular disease.
How would you code this scenario?

Primary and Secondary Diagnosis

- Primary Code: 493.20, COPD and asthma
- Other (secondary) codes: 413.9, angina
- Other codes: 414.00, CAD
- Other codes: 707.03, pressure ulcer sacrum
- Other codes: 707.22, pressure ulcer stage 2
- Other codes: 440.22, PAD of extremities with rest pain
- Additional diagnoses that could be coded: 783.0, anorexia; 262, severe protein malnutrition; V85.0, BMI 15.5
Scenario # 3: Debility

MD Verbal Order Documents
- End stage debility

MD CTI Narrative

A 74-year-old woman with debility. Recent decline transfers bed to chair now totally dependent in all ADL’s. Weakness d/t chronic infection with osteomyelitis and multiple amputations. This lovely woman has a history of diabetes and PVD.
SN Admission Narrative

Hospice admission for 74-year-old woman reports a chronic infection of her amputation stump d/t osteomyelitis. She started with a toe amputation 2 years ago and now has a BKA. D/T on going infection in the stump the MD wanted to perform an AKA. The patient has refused any further active surgery or interventions and requests comfort measures only. She can only transfer bed to chair d/t inability to wear a prosthesis and is dependent in all ADLs except feeding. She also has diabetes and PVD.
What is the primary diagnosis for hospice?

- After case conferencing with the referring MD and hospice director, it is decided the patient has debility d/t a chronic infection of the amputation stump d/t osteomyelitis. The infection’s ability to heal is being affected by both the patient’s diabetes and PVD.
How would you code this scenario?

Primary and Secondary Diagnosis

- Primary Code: 997.62, infection of amputation
- Other (secondary) codes: 250.80, DM with bone changes
- Other codes: 731.8, (manifestation code bone changes)
- Other codes: 730.16, chronic osteomyelitis lower leg
- Other codes: 443.9, PVD
- The V code for an amputation is not used when there is a complication.
Prepare for the future: Achieve compliance through education

Educate Now

- All clinicians, hospice directors, and referral sources need education on the proposed changes.

- Add time during interdisciplinary meetings to focus on all of the patient’s potential additional diagnoses that would be considered “related to the terminal diagnosis” and could impact the patient’s care plan or support the patient’s terminal prognosis.
Prepare for the future:
Achieve compliance through education

Plan Now

- Plan for additional education on disease process progression.

- Plan for additional education on how to document disease progression, including the patient’s co-morbid diagnosis.
Prepare for the future: Achieve compliance through education

Update Quality Assurance Processes

- Update your quality improvement process to include reviews for documentation and care plans that support all diagnoses coded on the hospice claim.
Preparing for ICD-10

**Education**

- Be sure your 2014 coding book includes conversions to ICD-10.

- Some paper and electronic versions of the coding manual have the ICD-10 codes listed on same page with the ICD-9 code. This reference will help you familiarize with some of the most frequently used codes.

- It will be essential that someone in your agency attends a course on ICD-10, as many of the rules will be different.

- CMS has recommended a crosswalk, learning how ICD-9 may or may not match ICD-10, which is recommended to perform dual coding.
Preparing for ICD-10

Planning

- Prepare to unlearn and relearn.
- Even veteran coders will need to start from scratch.
- Start planning now for how to approach ICD-10.
Coding in ICD-10 will require more specificity

- Prepare your referral sources for more specific diagnosis information needed to code in ICD-10.
- Coders need to brush up on their anatomy and physiology.
- Diagnosis coding will require more specificity of site of disease processes, including site and side of body for wound and fracture codes.
Do not transition without official training

- Current coding guidance from the American Hospital Association Coding Clinic may not apply.

- Any current guidance on assumed relationships between diagnoses may no longer apply.

- ICD-10 is owned by the World Health Organization, they will be providing guidance on use of ICD10 codes
Be double-prepared for change

- The new 14-quality-measure data set for hospice will also be released at the same time that ICD-10 starts.
References

- The Federal Register final rule
- More on hospice data
Questions