HOW TO APPLY KEY CODING CONCEPTS IN ESTABLISHING A PRINCIPAL HOSPICE DIAGNOSIS

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Background

- FY2015 Final Rule

- Principle and all related diagnoses on hospice claims
  - CMS 2012-2014
  - Will continue to monitor

- CR 8877
Hospice Coverage

- FY2015 Final Rule – RTP October 1, 2014
  - Debility (799.3 and 780.79)
  - Adult failure to thrive (783.7)
  - Various dementia codes in the range of 290.0 through 290.9, 293 and 310
  - CMS will implement edits related to etiology/manifestation code pairs from the Medicare code editor (MCE)

Communication

- With the provider is essential
  - Need the clinical information
  - Confirm diagnosis information
- With the assessing clinician is essential
  - Assessments must be complete
  - An idea of the Plan of Care
Communication

- Joint effort between the medical director, clinicians, the provider, and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses.

- Accurate, consistent, complete documentation cannot be overemphasized.

Basic Facts About Coding

Learning to code is difficult enough, but a hospice coder also needs to consider:

- Eligibility and coverage issues
- Terminal illness vs related conditions
- Billing
### Basic Facts About Coding

- Coding contributes to the:
  - Patient’s Plan of Care
  - Correct reimbursement
- Establishes medical necessity

### Hospice Coding Issues

- Hospice Information Set
- Correctly identifying the terminal illness
- Correctly identifying and coding related diagnoses
- Compliance with applicable coding guidelines (e.g., etiology/manifestation convention)
- Avoidance of prohibited primary diagnoses
The HIS is intended for use in quality reporting; it does not imply acceptability for payment purposes. Most common principal diagnoses among hospice patients.

- 01. Cancer
- 02. Dementia/Alzheimer’s
- 99. None of the above

- Review the clinical record for information regarding principal diagnosis.
- Item completion (coding) must be based on what is indicated in the clinical record. Do not use sources external to the clinical record.
- This item should be completed based on the patient’s principal diagnosis at the time of admission to hospice.
I0010

- Code 01, Cancer: Select code 01 if the patient’s principal diagnosis is cancer (including leukemia).
- Code 02, Dementia/Alzheimer’s: Select code 02 if the patient’s principal diagnosis is dementia (Alzheimer’s Disease; frontotemporal dementia; Pick’s disease; other frontotemporal dementia; senile degeneration of brain; dementia with Lewy bodies). Note that some dementia codes have ICD-9-CM and ICD-10-CM manifestation/etiology or sequencing conventions; ensure that coding guidelines have been met for reporting principal diagnosis.
- Code 99, None of the above: Select code 99 if the patient’s principal diagnosis is a disease/condition other than cancer or dementia/Alzheimer’s.

Principal Diagnosis

- The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient’s admission. For hospice patients, this is the diagnosis most contributory to the patient having a life expectancy of six months or less if the illness runs its normal course.
- May be more than one, so answer accordingly.
Timepoints

- Start of Care
  - Establishes plan of care
- Monthly or Per Benefit Period
  - Update as necessary to current condition

The First Step...

A Great Assessment!
Assessment Strategies

- Interview patient/caregiver to obtain past health history.
- Additional information may be obtained from the physician.
- Review current medications and other treatment approaches to determine if additional diagnoses are suggested by current treatment regimen.
- Verify this information with the patient/caregiver and physician.

The Next Step...

Determine the relevant diagnoses!
Sources of Information

- Hospital/physician documentation
- Intake/Referral form
- Disciplines and services ordered
- Nursing assessment
- Other disciplines’ assessments
- Medication list
- Mental status
- Plan of Care interventions and goals

Then...

- Following the assessment and review of documentation, communicate with the physician to clarify diagnoses or confirm suspected diagnoses.
  - Confirm the specific type of wound – i.e., whether ulcers are pressure, arterial, stasis, diabetic or chronic.
  - Confirm the type and locations of tumors—i.e., primary malignancy vs metastasis and location
  - Verify related conditions.
  - Establish rationale for unrelated conditions.
  - Clarify manifestations such as dementia.
  - Query physician when diagnosis doesn’t meet criteria
- Document all communication with physician!
Hospice providers may not report diagnosis codes that cannot be used as the principal diagnosis according to ICD-9-CM/ICD-10-CM Coding Guidelines and require further compliance with various ICD-9-CM/ICD-10-CM coding conventions, such as those that have principal diagnosis code sequencing or etiology/manifestation guidelines.
Implications

- “Manifestation code as principal diagnosis” edit in the Integrated Outpatient Code Editor (IOCE)
- Other diagnoses that shouldn’t be primary
- Diagnoses in the SSI chapter when a related definitive diagnosis has been established or confirmed by the provider — Adult failure to thrive (783.7/R62.7) and debility (799.3, 780.79/R53.81)
What is a Manifestation?

- When one disease or condition causes another disease or condition, the two conditions are to be coded with the cause (etiology) first and the resulting second condition coded next.
  - There are conventions to indicate when this rule applies.
  - Etiology/manifestation coding is called mandatory sequencing or mandatory multiple coding.
  - They must be coded together and in a certain order.

Etiology/Manifestation

- Need to follow coding guidelines
- Buddy codes—have to be sequenced together with etiology preceding the manifestation
- Conventions
  - Alphabetical index two codes with second one within [italicized brackets] called manifestation
  - Tabular List: Code title in italics (a code in italics in the tabular may NEVER be coded without its cause preceding it).
  - Tabular List: Code first underlying condition at manifestation
  - Tabular List: Use additional code to identify manifestation (not always) at etiology
Alphabetical Index

- Alzheimers dementia
  - Dementia
    - In
      - Alzheimers 331.0 [294.10]

Italics

- Alzheimers dementia
  - Dementia
    - In
      - Alzheimers 331.0 [294.10]

- 294.10 Dementia in conditions classified elsewhere
**Code first underlying disease**

- Signifies a manifestation code
- Even though a condition is the primary focus of care, it may have to be coded second according to the coding rules
- This instruction tells you that the underlying condition (or etiology) has to be coded first before the manifestation (which is in italics)
- Code first does NOT mean code primary

**Italics**

- Alzheimers dementia
  - Dementia
    - In
      - Alzheimers 331.0 [294.10]

- 294.10 Dementia in conditions classified elsewhere
- Code first underlying physical condition
Tabular List

- Alzheimers
  - Use additional code for dementia

In Summary

- Alpha index
  - Alzheimers without behaviors 331.0 [294.10]
  - Alzheimers with behaviors 331.0 [294.11]
- Tabular list
  - 294.10 Dementia in conditions classified elsewhere without behavioral disturbance (Code first underlying condition)
  - 294.11 Dementia in conditions classified elsewhere with behavioral disturbance (Code first underlying condition)
  - Use additional code, where applicable, to identify:
    - wandering in conditions classified elsewhere (V40.31)
- 331—Use additional code for dementia
Scenario

Alzheimers patient, now bedbound with dementia
- 331.0 Alzheimers
- 294.10 dementia without behaviors
- V49.84 bed confinement

“Use Additional Code”
“Code first”

- “Code first” and “Use additional code” notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/manifestation combination.
- The sequencing requirements are the same.
- Hint: The second code to be sequenced is not in italics.
Looking at the Manual

290 Dementias
- Code first the associated condition. Sometimes the associated neurological condition is not documented. If documentation indicates presenile or senile dementias, the appropriate 290 codes should be used.

Looking at the Manual

290 Dementias
- Excludes:
  - Dementia due to alcohol
  - Dementia not classified as senile, presenile, or arteriosclerotic (294.10-294.11)
  - Psychoses classifiable to 295-298 occurring in the senium without dementia or delirium
  - Senility with mental changes of nonpsychotic severity (310.1)
Looking at the Manual

37

☐ In addition to the ‘Code first the associated condition’ instruction at the category 290, vascular dementia (Multi-infarct dementia or psychosis) instructs to “use additional code to identify cerebral atherosclerosis”

Looking at the Manual

38

☐ 293 Transient mental disorders due to conditions elsewhere
    ☐ Not associated with drugs
    ☐ Code first the associated physical or neurological condition
Looking at the Manual

- 310 Specific nonpsychotic mental disorders due to brain damage
- Conditions like Frontal lobe syndrome and post concussion syndrome should have documentation of the underlying brain damage.
- 310.89 Other specified nonpsychotic mental disorders following organic brain damage
- Hints: ALS, MS, CVA, Late effect of traumatic brain injury

Dementia

Dementia is a deterioration of previously acquired intellectual abilities, with memory impairment, and evidence of an underlying organic cause. One of three factors must also be present:
- impairment of abstract thinking as manifested by reduced capacity for generalizing,
- differentiating,
- concept formation, or logical reasoning;
- impairment of judgment, and
- impairment of impulse control, or
- Personality changes.
Delirium

Delirium is defined as a disturbance of attention by either impaired ability to sustain attention or impaired goal directed thinking or behavior. Also, at least two of the following must be present in delirium:

- Reduced wakefulness or insomnia,
- Perceptual disturbance (illusions or hallucinations);
- Or an increase or decrease in psychomotor activity.

Delirium also develops over a short period of time and fluctuates rapidly.

Depression

- Multiple somatic complaints, sleep disturbance, constipation, dyspnea, weight loss, appetite disturbance, weakness and fatigue may be the chief complaints, and depression the diagnosis. Poor concentration, lack of interest, lack of ambition or motivation, indecisiveness and poor memory may be present. There may be a slowing down of movement, or agitation.
Dementia, unspecified

- 294.8 no longer means dementia as of October 2011.
- 294.20 (F03.90) Dementia, unspecified, without behavioral disturbance
  - Dementia NOS
- 294.21 (F03.91) Dementia, unspecified, with behavioral disturbance
  - Aggressive behavior
  - Combative behavior
  - Violent behavior
  - Use additional code, where applicable, to identify:
    - wandering in conditions classified elsewhere (V40.31)

Dementia, unspecified

- Senile and presenile dementia will be classified as dementia, unspecified in ICD-10-CM (F03.90)
- Senile—65 and older
- Presenile—Under the age of 65
- Sometimes documented as ‘senile dementia of the Alzheimers type’
Senile Dementia

Senile dementia is actually a group of several different diseases.

- Alzheimer's disease,
- Vascular dementia,
- Parkinson's disease, and
- Lewy body disease.

Alzheimers

- Commonest form of dementia.
- Brain atrophies and abnormal proteins, called amyloid, accumulate in the brain substance, in the form of senile plaques.
- Abnormal filaments appear in the brain cells called neurofibrillary tangles.
- Gradual deterioration
Vascular Dementia

Sudden post-stroke changes in thinking and perception may include:

- Confusion
- Disorientation
- Trouble speaking or understanding speech
- Vision loss
- Changes in a “ladder” fashion

Vascular dementia

(290.4x/F01.5-)

- Being rejected as a primary diagnosis in hospice.
- Occurs as a result of infarction of the brain due to vascular disease, including hypertensive vascular disease
- Autoregulation may be lost in individuals with severe hypertensive arteriosclerotic vascular disease, abrupt lowering of blood pressure may lead to infarct.

Let’s look at the conventions.

- Code first the underlying physiological condition or sequelae of cerebrovascular disease. (ICD-10)
- Use additional code to identify cerebral atherosclerosis.
**Parkinson’s Dementia**

- 332.0 [294.1x] G20/F02.8-
- Brain changes begin in a region that plays a key role in movement.
- As brain changes gradually spread, they often begin to affect mental functions, including memory and the ability to pay attention, make sound judgments and plan the steps needed to complete a task.
- Abnormal microscopic deposits called “Lewy bodies” composed chiefly of alpha-synuclein, a protein that's found widely in the brain but whose normal function isn't yet known.

**Lewy Body Dementia**

- Also called Parkinsonism dementia or Dementia with Lewy bodies
- 331.82 [294.1x] G31.83 [F02.8-]
- Third most common cause of dementia after Alzheimer’s disease and vascular dementia, accounting for 10 to 25 percent of cases.
### Symptoms

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>Changes in thinking and reasoning</td>
</tr>
<tr>
<td>□</td>
<td>Confusion and alertness that varies significantly from one time of day to another or from one day to the next</td>
</tr>
<tr>
<td>□</td>
<td>Parkinson's symptoms, such as a hunched posture, balance problems and rigid muscles</td>
</tr>
<tr>
<td>□</td>
<td>Visual hallucinations</td>
</tr>
<tr>
<td>□</td>
<td>Delusions</td>
</tr>
<tr>
<td>□</td>
<td>Trouble interpreting visual information</td>
</tr>
<tr>
<td>□</td>
<td>Acting out dreams, sometimes violently, a problem known as rapid eye movement (REM) sleep disorder</td>
</tr>
<tr>
<td>□</td>
<td>Malfunctions of the &quot;automatic&quot; (autonomic) nervous system</td>
</tr>
<tr>
<td>□</td>
<td>Memory loss that may be significant but less prominent than in Alzheimer's</td>
</tr>
</tbody>
</table>

### Huntington’s Disease

**333.4 [294.1x] G10 [F02.8-]**

- Progressive brain disorder caused by a single defective gene on chromosome 4
- Defective huntingtin protein leads to brain changes that cause abnormal involuntary movements, a severe decline in thinking and reasoning skills, and irritability, depression and other mood changes.
- Anxiety, and uncharacteristic anger and irritability.
- Another common symptom is obsessive-compulsive behavior, leading a person to repeat the same question or activity over and over.
So what’s the key???

- Cannot accept “dementia” as a terminal diagnosis.
- Cannot accept senile dementia or vascular dementia as a primary diagnosis. What caused the condition?
- Remember that Alzheimer’s is the most common. Should you ask?
- Parkinson’s vs Parkinsonism

SSI Prohibited from Primary
Single Diagnosis as Terminal Illness

☐ It is often not a single diagnosis that represents the terminal illness of the patient, but the combined effect of several conditions that makes the patient’s condition terminal. We are restating what we communicated in the December 16, 1983 Hospice final rule regarding what is related versus unrelated to the terminal illness: “. . . we believe that the unique physical condition of each terminally ill individual makes it necessary for these decisions to be made on a case–by-case basis. It is our general view that . . . ‘‘hospices are required to provide virtually all the care that is needed by terminally ill patients’’ (48 FR 56010 through 56011).

Warning! Warning! Signs and Symptoms as Primary Diagnoses
Guidelines

- Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 - 799.9) contain many, but not all codes for symptoms.

Guidelines

- **Conditions that are an integral part of a disease process** Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

- **Conditions that are not an integral part of a disease process** Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.
### Symptoms, Signs and Ill-Defined Conditions

- Generally do not code a SSI if the definitive diagnosis is known.
  - CHF with SOB and edema—NO!!
- If the SSI is not always part of the condition then add the code for the SSI along with the condition
  - Look up the condition for presenting signs and symptoms
- Sometimes the coding manual states to also code the symptoms
  - BPH and benign localized prostatic hyperplasia

### What is integral?

- What are the usual signs and symptoms of that particular condition?
  - If usually part of the condition, do not code separately.
  - If not always part of the condition, then code separately.
- CHF
- Liver failure
Table 2—The Top Twenty Principal Hospice Diagnoses, FY 2002, FY 2007, FY 2012

<table>
<thead>
<tr>
<th>Rank</th>
<th>ICD-9/Reported Principal Diagnosis</th>
<th>Total Patients</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Lung Cancer</td>
<td>73,769</td>
<td>11</td>
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<tr>
<td>2</td>
<td>Congestive Heart Failure</td>
<td>45,951</td>
<td>7</td>
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<tr>
<td>3</td>
<td>Dementia Unspecified</td>
<td>36,909</td>
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<tr>
<td>4</td>
<td>COPD</td>
<td>22,170</td>
<td>3</td>
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<tr>
<td>5</td>
<td>Alzheimer’s Disease</td>
<td>20,197</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>CVA/Stroke</td>
<td>19,066</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Prostate Cancer</td>
<td>16,832</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>Adult Failure To Thrive</td>
<td>16,924</td>
<td>3</td>
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<tr>
<td>9</td>
<td>Breast cancer</td>
<td>17,812</td>
<td>3</td>
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<tr>
<td>10</td>
<td>Senior Dementia, Uncomp.</td>
<td>16,999</td>
<td>3</td>
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<tr>
<td>11</td>
<td>Colon Cancer</td>
<td>16,539</td>
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<tr>
<td>12</td>
<td>Pancreatic Cancer</td>
<td>15,427</td>
<td>3</td>
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<tr>
<td>13</td>
<td>Organic Brain Synd Nec</td>
<td>10,241</td>
<td>2</td>
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<td>14</td>
<td>Heart Disease Unspecified</td>
<td>10,322</td>
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<td>15</td>
<td>Rectosigmoid Colon Cancer</td>
<td>9,552</td>
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<td>16</td>
<td>Parkinson’s Disease</td>
<td>8,805</td>
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<td>17</td>
<td>Renal Failure Unspecified</td>
<td>8,764</td>
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<td>18</td>
<td>Chronic Renal Failure (End 2005)</td>
<td>8,599</td>
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<td>19</td>
<td>Ovarian Cancer</td>
<td>7,432</td>
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<tr>
<td>20</td>
<td>Bladder Cancer</td>
<td>6,916</td>
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Year: 2002  Total Patients = 663,406

<table>
<thead>
<tr>
<th>Rank</th>
<th>ICD-9/Reported Principal Diagnosis</th>
<th>Total Patients</th>
<th>Percentage</th>
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<tr>
<td>1</td>
<td>Dementia Unspecified</td>
<td>90,150</td>
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<tr>
<td>2</td>
<td>Lung Cancer</td>
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<td>3</td>
<td>Congestive Heart Failure</td>
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<td>4</td>
<td>COPD</td>
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<td>Adult Failure To Thrive</td>
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<td>Alzheimer’s Disease</td>
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<td>Senior Dementia, Uncomp.</td>
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<td>8</td>
<td>CVA/Stroke</td>
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<td>9</td>
<td>Heart Disease Unspecified</td>
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<td>Prostate Cancer</td>
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<td>Breast cancer</td>
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<td>Pancreatic Cancer</td>
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<td>Colon Cancer</td>
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<td>Organic Brain Syndromes NEC</td>
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<td>15</td>
<td>Parkinson’s Disease</td>
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<tr>
<td>16</td>
<td>Dementia In Other Diseases w/o Behav Dist</td>
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<tr>
<td>17</td>
<td>Renal Failure Unspecified</td>
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<tr>
<td>18</td>
<td>End Stage Renal Disease</td>
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<td>19</td>
<td>Bladder Cancer</td>
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<tr>
<td>20</td>
<td>Ovarian Cancer</td>
<td>8,454</td>
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Year: 2007  Total Patients = 1,039,098
Medicare’s Argument

- “Symptoms, Signs, and Ill-Defined Conditions”, such as “debility” or “adult failure to thrive,” does not encompass the comprehensive, holistic nature of the assessment and care to be provided under the Medicare hospice benefit.
Debility

"Debility" is medically defined as: an unspecified syndrome characterized by unexplained weight loss, malnutrition, functional decline, multiple chronic conditions contributing to the terminal progression, and increasing frequency of outpatient visits, emergency department visits and/or hospitalizations.

Debility

- May have multiple comorbid conditions that individually, may not deem the individual to be terminally ill. However, the collective presence of these multiple comorbid conditions will contribute to the terminal status of the individual.
- Secondary diagnoses of CHF, 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.
- Usually coded after the conditions causing the debility.
Scenario

- Patient is currently in hospice with diagnosis of debility. She went to the hospital, was diagnosed (after many tests) with hydronephrosis, and the doctors wanted to do even more testing to find out the "definitive diagnosis" as to why she has the hydronephrosis. She is 86, very weak and does not WANT to have any more tests. She is now 76 pounds, having lost 20 pounds in 2 months time. Hospice has spoken to doctors and are trying to find another diagnosis. They are going to draw blood to see if anything is bad enough to possibly be diagnosed with renal failure.

Coding

- Hydronephrosis
- Wt loss
- BMI
- Debility
- Other possibilities: Palliative care, DNR
Scenario

- Female patient had cobalt radiation therapy in the 70s for uterine cancer. Turned her intestines to “mush.” Multiple adhesions resulting in bowel obstructions and multiple surgeries including colostomies over the years. Patient (with current bowel obstruction) wants to remain comfortable at home with no further surgeries and refuses to eat. Physician provides terminal diagnosis of “debility with failure to thrive.”

Coding

- 564.89 Other functional disorders of intestine (atony)
- E879.2 abnormal reaction to medical test or therapy
- 560.81 Intestinal or peritoneal adhesions with obstruction
- V10.43 History of ovarian cancer
- Feeding difficulties, debility and failure to thrive
Failure to Thrive

- “Adult Failure to Thrive” is defined as undefined weight loss, decreasing anthropomorphic measurements, and a Palliative Performance Scale < 40 percent. It is also associated with multiple primary conditions contributing to the physical and functional decline of the individual.

- Four syndromes known to be individually predictive of adverse outcomes in older adults are repeatedly cited as prevalent in patients with “adult failure to thrive” impaired physical functioning, malnutrition, depression, and cognitive impairment.

Medicare says:

- Result of multiple primary conditions that contribute to the terminal decline. If any or all of these multiple primary conditions have been or are being treated or managed by a health care provider, or if medications have been prescribed for the patient to treat or manage any or all of these multiple primary conditions, we believe that these conditions meet the criteria of being established and/or confirmed by the beneficiary’s health care provider and, thus, “debility” or “adult failure to thrive” would not be listed as the principal hospice diagnosis per ICD–9–CM coding guidelines.
Medicare says...

- “Debility” and “adult failure to thrive” are not appropriate principal diagnoses in the terminally ill population as these diagnoses are incongruous to the comprehensive nature of the hospice assessment, the specific, individualized hospice plan of and care, and the hospice services provided.

Action

- “Debility” and “adult failure to thrive” would not be used as principal hospice diagnoses on the hospice claim form. When reported as a principal diagnosis, these would be considered questionable encounters for hospice care, and the claim would be returned to the provider for a more definitive principal diagnosis.
Gathering More Information

- Referring physicians
- Indications of other illnesses:
  - Medications
  - Treatments
  - Interview of patient/caregiver
  - And verifying those findings with the physician and/or medical director

Hospice Terminal Illness and Related Diagnoses
Hospice Diagnosis Sequencing

- Hospice terminal illness
- Related diagnoses (secondary or other diagnoses that are related to the terminal illness)
  - POC
  - Claim (covered under the per diem rate)
- Unrelated or Non-related diagnoses (comorbidities)
  - POC
  - Not on claim (do not want them covered under the per diem rate)

What is a comorbidity?

- In medicine, **comorbidity** is the presence of one or more additional disorders (or diseases) *co-occurring with* a primary disease or disorder; or the effect of such additional disorders or diseases.
**Related Conditions Defined**

- Clinically, related conditions are any physical or mental condition(s) that are related to or caused by either the terminal illness or the medications used to manage the terminal illness.


**Proposed Definition (May 2014)**

- **DEFINITION/TERMINAL ILLNESS**: Abnormal and advancing physical, emotional, social and/or intellectual processes which diminish and/or impair the individual’s condition such that there is an unfavorable prognosis and no reasonable expectation of a cure; not limited to any one diagnosis or multiple diagnoses, but rather it can be the collective state of diseases and/or injuries affecting multiple facets of the whole person, are causing progressive impairment of body systems, and there is a prognosis of a life expectancy of six months or less.
Proposed Definition (May 2014)

DEFINITION/RELATED CONDITIONS: Those conditions that result directly from terminal illness; and/or result from the treatment or medication management of terminal illness; and/or which interact or potentially interact with terminal illness; and/or which are contributory to the symptom burden of the terminally ill individual; and/or are conditions which are contributory to the prognosis that the individual has a life expectancy of 6 months or less.

Claim Forms

- Hospice claims currently include a field for the patient's principal diagnosis, but allow for up to 17 additional diagnoses to be included on a paper UB-04 claim, or up to 24 additional diagnoses on the 837/5010 electronic claim.
Recently added to Eligibility Manual

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- Only care provided by (or under arrangements made by) a Medicare certified hospice is covered under the Medicare hospice benefit.
- The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any).
- In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:
  - (1) Diagnosis of the terminal condition of the patient.
  - (2) Other health conditions, whether related or unrelated to the terminal condition.
  - (3) Current clinically relevant information supporting all diagnoses.

Recently added to Eligibility Manual

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- For the duration of the election of hospice care, an individual must waive all rights to Medicare payments for the following services:
  1) Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice); and
  2) Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services that are equivalent to hospice care, except for services ...

- **Medicare services for a condition completely unrelated to the terminal condition for which hospice was elected remain available to the patient if he or she is eligible for such care.**
Interdisciplinary Group

- Information about related and unrelated diagnoses should already be included as part of the plan of care, and determined by the hospice interdisciplinary group (IDG).
  - The hospice conditions of participation (CoPs) at § 418.54(c)(2) require that the comprehensive assessment include “complications and risk factors that affect care planning”.

Interdisciplinary Group

- The CoPs at § 418.56(e)(4) require that the hospice IDG “provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.”
- The existing standard practice for hospices is to include the related and unrelated diagnoses on the patient's plan of care in order to assure coordinated, holistic patient care and to monitor the effectiveness of the care that is delivered.
**Related or Non-related**

- Hospices should report on hospice claims all coexisting or additional diagnoses *that are related to* the terminal illness; they should not report coexisting or additional diagnoses that are unrelated to the terminal illness.

**Plan of Care**

- Diagnosis List
  - Principal diagnosis that represents the terminal illness according to coding guidelines
  - Related diagnoses

- Body of POC (FL 21)
  - Other conditions that are unrelated that will be coordinated with other healthcare providers
  - Burden is on the hospice to prove unrelated
  - Should those be *coded*?

- OR Other interdisciplinary POC
Who Decides Relatedness?

- Medical Director should have major role along with IDT
- So IDT staff will need to determine specifically which diagnoses are related each month
- Those diagnoses are placed on the claim
- Those diagnoses will be used to manage ALL covered services
  - MD visits
  - ED/hospital visits
  - Procedures/interventions
  - Tests/labs
  - Equipment
  - Medications

Scenario

- Patient with ALS has dysphagia resulting in loss of weight, decreased respiratory function and dependence on respirator along with emphysema. She is bedbound and has a stage III pressure ulcer on the coccyx.
Diagnoses

- Terminal diagnosis—335.20
- Related Diagnoses
  - Dysphagia 787.20
  - Loss of weight 783.21
  - Pressure ulcer coccyx 707.03
  - Stage III 707.23
  - Bed confinement V49.84
  - Ventilator dependence V46.11
  - Unrelated: Emphysema 492.8

ALS and COPD

- A beneficiary with ALS and clinically significant COPD could have specific ALS-related impairments of respiration function (e.g., impaired respiratory muscle function), coexisting with COPD-related impairments of the respiratory system (e.g., changes in the structure of the bronchial tree and/or alveoli, with associated impaired respiratory functions).
- But the COPD can be considered unrelated. Why?
Scenario

- The patient has cancer of the lung as a terminal diagnosis. The patient has required insulin for his diabetes for several years. The patient is too weak and confused to take his insulin safely and his caregivers are overwhelmed. Home health will see the patient for his diabetes and his use of insulin.
- But note the same scenario would not work if the cancer was of the pancreas.

Sources for Dementia

- http://neurology.health-cares.net/senile-dementia.php
- http://www.alz.org/dementia.asp
- National Institute of Health
What questions do you have??

Selman-Holman & Associates, LLC
CoDR—Coding Done Right
214.550.1477
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