

# Hospice Coding

**Presented by**

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## Excerpt From FY2016 Final Rule

*“based on the numerous comments received in previous rulemaking, and anecdotal reports from hospices, hospice beneficiaries, and non-hospice providers discussed above, we are concerned that hospices may not be conducting a comprehensive assessment nor updating the plan of care as articulated by the CoPs to recognize the conditions that affect an individual’s terminal prognosis.”*

## Objectives

- CMS 2016 Final Rule
- Recommendations
- How to decide what diagnosis should be primary
- What about comorbidities & symptoms
- ICD-10 & Hospice Coding
- Sample Scenarios

## What Are the Official Guidelines?

- Included clarification related to diagnosis reporting on hospice claims effective October 1, 2015
- Hospices must report all diagnoses on the hospice claim based on current coding guidelines
- Hospices must report all diagnoses identified in the initial and comprehensive assessments, whether related or not to the terminal prognosis (including mental health disorders and conditions that would affect the plan of care)

## History

- Health Insurance Portability and Accountability Act (HIPAA) requires providers to adhere to the ICD-10-CM Official Guidelines for Coding and Reporting when assigning ICD-10-CM diagnosis codes
- June 5, 2008 Hospice Conditions of Participation final rule stated that hospice must report all related diagnoses in addition to the primary terminal condition
- 2010 over 77% of hospice claims continued to include only one diagnosis
- 2014 – 49% of hospice claims continued to report only one code
  - CMS analysis of the claims found 50 percent of these patients had, on average, eight or more chronic conditions
  - 75 percent had, on average, five or more chronic conditions

## What Are the Official Guidelines?

- A set of rules that have been developed to accompany and complement the official conventions and instructions provided with ICD-10-CM.
- Adherence to these guidelines when assigning ICD-10-CM diagnosis and procedure codes is required under The Health Insurance Portability & Accountability Act (HIPAA).
- 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
  - + Coding of secondary codes and comorbidities

### **CMS 2013 Hospice Final Rule**

- CMS released the hospice 2013 Final Rule on August 7, 2013 titled: **“Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform”**
- CMS made updates to hospice coding requirements regarding the use of non-specific codes such as: debility and adult failure to thrive (AFTT) as primary diagnoses.
- Rule states that effective October 1, 2014 any hospice claims submitted with the above diagnoses would be returned to the provider (RTPd).
- **Debility & AFTT** can and should not be listed on the claim as a primary diagnosis but can be used as a secondary (related) diagnosis when applicable
- CMS clarified (**not a new guideline**) that agencies are expected to code the most definitive terminal diagnosis with all other related conditions in the additional diagnoses fields.

### **Why the Changes?**

- Patients with debility and AFTT tend to have a longer length of stay (LOS).
- In 2012, debility (12% of all patients) and AFTT (7% of all patients) were the number one and number three most used hospice diagnoses regardless of the terminal illness causing the condition.
- Data shows that for patients with debility or AFTT as the primary diagnosis, the secondary diagnoses, CHF, CAD, heart disease, atrial fib, Parkinson's, Alzheimer's, CKD, COPD, were the most commonly used secondary diagnoses yet these additional codes were not listed in many cases.

### **2015 Final Rule**

- CMS implemented certain edits from Medicare Code Editor (MCE), which detect and report errors in the coding of claims data, for all hospice claims effective October 1, 2014 (for those claims submitted on or after October 1, 2014).
- Hospice claims containing inappropriate principal or secondary diagnosis codes, per ICD-10-CM coding conventions & guidelines, will be returned to the provider and will have to be corrected and resubmitted to be processed and paid.
- CMS implemented edits related to etiology/manifestation code pairs from the MCE.
- Effective for all claims received Oct. 1, 2014 or afterward, CMS will Return to Provider (RTP) hospice claims using “debility” or “adult failure to thrive” as the principal diagnosis.
- Additionally, CMS will RTP claims using an inappropriate dementia code as a principal diagnosis – including those that require that the underlying causal condition be coded first.
- CMS reminds hospice providers to include ALL appropriate diagnoses that describe a patient's terminal condition and related conditions on claims.

## Most Important Rules to Remember

To code a Hospice claim accurately, the coder **must**:

- Determine and document the primary diagnosis that reflects the terminal diagnosis and a current history that list all of the co-morbidities impacting the primary diagnosis.
- Always code to the highest level of specificity possible which is based on the information obtained from the patient's provider

## Principal Diagnosis and the CTI

- Certification of Terminal Illness (CTI)
- To reach a decision of terminal illness the medical director (in consult with the attending) must consider
  - + The diagnosis of the terminal condition (not the diagnosis code)
  - + Other health conditions/diagnoses
  - + Clinically relevant information supporting the diagnoses
  - + The physician is not required to provide diagnoses code(s)
  - + Avoid principal diagnoses which contradict the CTI
  - + Avoid diagnoses which do not support the terminal condition

## Principal Diagnosis and the NOE

- Notice of Election (NOE)
- The NOE must contain HIPAA approved codes
  - + Full diagnoses codes including all applicable digits
  - + The principal diagnosis listed is the condition most contributory to the terminal prognosis
  - + Do not report principal diagnosis codes that are non-reportable – they will be returned to the provider (RTP)
    - Z codes
    - Unspecified codes
    - Diagnosis codes prohibited by ICD-10-CM coding guidelines & conventions as principal diagnosis

## Other Diagnoses

- 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

## Determining Primary Diagnosis

- The diagnosis that most contributes to the terminal condition should be listed as the primary diagnosis. What is the underlying medical condition that led to the debility or AFTT? (Malignant neoplasm, CHF, COPD, ESRD, etc.)
- When admitting a patient to hospice care and the terminal diagnosis is not cancer, code all of the related comorbidities that support the physician's certification that the patient is likely to die within six months due to his disease. (i.e., CHF, ESRD, COPD)
- Using local coverage determinations (LCDs), provides the MAC reviewer guidance in consistency of reviews. LCDs help show:
  - + Related decline
  - + Related functional limitations
  - + Comorbidities to support terminal prognoses

- If the primary reason was for debility or AFTT, determine the cause of either of these conditions:
  - + Patient unable to tolerate food resulting in AFTT because of severe weakness due to CHF
  - + Dementia due to Alzheimer’s
  - + Debility due to end stage neoplasm for which patient has declined further treatment.
- 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.*

**Correct Use of Manifestation Codes**

- As per the Official ICD-10-CM coding guidelines, certain conditions have both an underlying etiology and multiple body system manifestations (listed in italics and brackets) .
- Coding conventions require that the underlying condition be sequenced first followed by the manifestation.
- **Note:** wherever such a requirement exists, there is a “use additional code” note at the etiology and an instructional note to “code first the underlying condition”. There will usually be a capital M next to the manifestation code in the alphabetical index also.
- The manifestation code can never be listed as the primary diagnosis

**Example:** Patient with severe dementia due to Parkinson’s Disease

- Code as primary – Parkinson’s Disease **G20** (ICD-10)
- Code as Secondary – Dementia in conditions classified elsewhere **F02.81** (ICD-10) note the capital M simply means that even though dementia may be the primary reason for referral, the Parkinson’s must be coded as primary.

**Manifestations**

- In some cases, there are some manifestation codes that that do not have “in diseases classified elsewhere” in the title. There may be a “use additional code” present in the Tabular list and the sequencing rules still apply.

**Example:** Severe Sepsis **R65.2** – note instruction to use additional code to identify specific organ dysfunction.

**Coding “Related” Conditions**

For the purpose of defining which conditions should be considered as related, CMS listed these conditions:

- Conditions that result directly from the terminal illness
- Conditions that result from treatment or medication management of terminal illness
- Conditions which interact or potentially interact with terminal illness
- Conditions which are contributory to the symptom burden of the terminally ill individual
- Conditions which are contributory to the prognosis of 6 months or less

### Coding Neoplasms

- Advanced metastatic disease with unknown primary and secondary sites has its own code **C80.0** – Disseminated malignant neoplasm, unspecified
- This should not be used due to lack of documented primary and/or secondary site
- This should be used when the physician is unable to specify the primary or secondary site

### Encounter for Primary Malignancy

Code first the primary neoplasm followed by any metastatic sites

**Example:** Left lower lobe lung neoplasm with metastasis to bone & pancreas

Code: **C34.32** (malignant neoplasm of LLL or bronchus)  
**C79.51** (2nd malignant neoplasm of bone NOS)  
**C78.89** (2nd malignant neoplasm of pancreas NOS)

### Treatment for Secondary Site

When a primary neoplasm has metastasized to a secondary site and the focus is secondary site, it is sequenced first followed by primary malignancy.

**Example:** R breast neoplasm with metastasis to brain (focus of care is brain mets)

Code: **C79.31** (second malignant neoplasm of brain)  
**C50.911** (malignant neoplasm of unspecified part of R breast)

### Previously Excised Primary Malignancy

If malignancy was excised and no further treatment is planned and no evidence of existing neoplasm, use **Z85** code for personal history of neoplasm

**Example:** Breast cancer removed with no evidence of any remaining neoplasm

Code: **Z85.3** (history of breast cancer)

If after a primary site neoplasm is removed but a secondary site remains that metastasized or extended from the primary site, code secondary site as primary followed by the **Z85** code.

**Example:** R lung removed due to neoplasm. No indications of neoplasm in lung and no further treatment directed at lung but neoplasm has metastasized to liver

Code: **C78.7** (secondary malignant neoplasm of liver)  
**Z85.118** (personal hx of neoplasm of lung)

### Anemia Due to Chemo or Immunotherapy

When encounter is for anemia due to chemo or radiation, and anemia is the focus, code the anemia first followed by the neoplasm code followed by the T code for the adverse effect.

**Example:** anemia due to chemo for neoplasm of thyroid

Code: **D64.81** (anemia due to chemo or immunotherapy)  
**C73** (primary neoplasm of thyroid)  
**T45.1X5D** (adverse effect of antineoplastic or immunosuppressive drugs)

### Dehydration Due to Neoplasm

When encounter is for dehydration due to malignancy, sequence the dehydration code first followed by the neoplasm code.

**Example:** Focus of care is to maintain IV fluids via PICC line for a patient with colon (Sigmoid) cancer

Code: **E86.0** (dehydration)  
**C18.7** (malignant neoplasm of sigmoid colon)  
**Z45.2** (adjustment & management of vascular device)

### Aftercare

When focus of care is for routine aftercare following surgery for neoplasm, code aftercare first followed by neoplasm code if still applicable or history code if no longer applicable

**Example:** Patient admitted for routine aftercare following surgery to remove a basal cell carcinoma on neck. Patient still receiving radiation

**Code: Z48.3** (aftercare following surgery for neoplasm)

**C44.41** (basal cell carcinoma of skin on scalp & neck)

### Pathological Fracture Due to Neoplasm

- Guidelines indicate that when the focus of treatment is for the fracture a code from M84.5, Pathological fracture in neoplastic disease, should be sequenced first followed by the code for the neoplasm
- Hospice focus of treatment and reason for the patient's terminal condition would NOT be the fracture, the neoplasm would be
- The neoplasm should be sequenced first, followed by the associated pathological fracture

### Neoplasm Related Pain

- Neoplasm Related Pain Code G89.3
- Pain documented as related to the cancer
  - + Pain can be acute or chronic
  - + Coding guidelines indicate that the code may be the principal code when the reason for the admission is control of the pain, the neoplasm would be coded as an additional diagnosis
  - + In hospice part of the care is to control the pain, the reason for the admission is the terminal diagnosis

### Who Decides on Comorbidities?

- 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.

### Symptom Coding

- Any code listed under "Symptom, Sign and Ill-defined Conditions" may not be used as a principal diagnosis when the provider has confirmed a related, definitive diagnosis.
- 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).
- Other sign and symptom codes such as SOB, pain, nausea should be omitted also when definitive diagnosis is known.

### "With" Guidelines

#### June 2016 – Coding Clinic confirmed new guidelines for causal conditions

- The sub-term "with" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetical Index, or an instructional note in the Tabular Index.
- Any condition listed under a sub-term "with" in the index should be interpreted as linked to the main term when both conditions are present.
- "The classification presumes a causal relationship between the two conditions linked by these terms unless a provider has specifically documented an alternative etiology.

### So What Does This Mean

- If a physician documents another etiology for the condition the coder should not code to a complication or assume the link.
- The entire record should be reviewed to determine whether a relationship between the two conditions exists.
- The sub term "with" in the index should be interpreted as a link between diabetes and any of these conditions indented under the word "with".
- The physician documentation does not need to provide a link between (for example) the diagnoses of diabetes & CKD.
- This link can be assumed since the chronic kidney disease is listed under the sub term "with".
- These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated and due to some other underlying cause.

### Specifically "With" Conventions

#### Reference Diabetes in the Alpha Index

- Diabetes
  - with
    - Amyotrophy
    - Arthropathy
    - Autonomic (poly) neuropathy
    - Cataracts
- Convention not limited to Diabetes. This convention applies to all conditions.
  - See Dementia
  - See Hypertension

#### "With" Examples

- No previous assumption could be made with Diabetes & Osteomyelitis.
- Under new guideline, osteomyelitis is now listed under the sub-term "with" for Diabetes. Therefore, coders can assume that there is a causal relationship.
  - E11.69** – Diabetes, Type II with other specified manifestations
  - M86.-** – Osteomyelitis

#### Other Assumptions

- Hypertension and Chronic Kidney Disease
  - Hypertensive chronic kidney disease (**I12**)
  - Use additional code for the stage of chronic kidney disease (**N18.5, N18.6**)
- Osteoporosis and Fractures
  - Osteoporosis with current pathological fracture (**M80.0**)
- Atherosclerotic heart disease with angina
  - Native artery (**I25.11**) or bypass graft or transplanted heart (**I25.7**)

#### Excludes 1 Notes

**Excludes 1** – Not coded here! Any diagnoses listed here cannot be coded with the diagnosis you have selected. These two codes cannot be used together.

**Example:** Type 2 DM (**E11**)

**Excludes 1:** Diabetes due to underlying conditions (**E08.-**)  
Gestational diabetes (**O24.4-**)



### Update to Excludes 1:

- Many confusing & ambiguous excludes notes in 2016 Manual
- Some of the Excludes 1 notes didn't make sense. For example, codes **R40-R46** (signs & symptoms of emotional state and behavior) contained excludes notes for the entire group of codes **F01-F99** (All mental, behavioral & neuro development disorder codes) indicating that these two groups of codes could not be coded together.

**Solution:** If the two conditions are not related to one another, it is permissible to report both codes together despite the Excludes 1 notation.

### Excludes 2 Notes

**Excludes 2** – Not included here! Means that the condition included here is not part of the condition represented by the code you have chosen and you may use these together.

**Example:** Acute sinusitis (**J01.1-**)

**Excludes 2:** Chronic sinusitis (**J32**)

### Using the 7th Character "A" in Hospice

- Physician determines whether the patient is receiving active treatment for the condition or ongoing care for the condition
- Initial encounter of care may continue for certain complication and injury categories for example:
  - + Complication codes such as surgical wound infections or dehiscence
  - + Some injury codes such as puncture wounds and lacerations
  - + Burns and corrosion wounds
- Not to be used with fracture codes

### Appropriate 7th Character "A" Use in Hospice

- Patient with deep right lower quadrant stab wound of abdomen. Treated in hospital with wound Vac® and discharged with hospice and continue wound Vac® care
  - + Use code **S31.613A** Laceration without foreign body of abdominal wall right lower quadrant, with penetration into the peritoneal cavity, Initial encounter
- Patient discharged with hospice to manage ongoing antibiotic treatment and wound care of a dehisced surgical wound
  - + Use code **T81.31xA** Dehiscence of a surgical wound

### Updating Diagnoses and the Plan of Care

- Most hospice patients don't get better
- Condition worsens
- New symptoms
- Exacerbation of conditions
- Clinical care documentation supports what was done for the patient – don't be afraid to add diagnoses to support the further deterioration

### Challenges

- Until 2015, 49% of hospice claims contained only one diagnosis
- As a result, most hospice coders learned only a few ICD-9 or ICD-10 codes
- Failure to follow Official Guidelines for Coding and Reporting is often the reason claims are RTP'd

**Example:** Incorrect use of manifestation codes

**F02.80** – Dementia in diseases classified elsewhere as a primary diagnosis

### Coding Conventions & Guidelines

- All characters must be assigned for the code to be a valid code – codes may have 3-7 characters
- The correct use of placeholder character X – to allow for further expansion of codes (new with ICD-10-CM)
- The correct use of Episode of care – seventh character codes (new with ICD-10-CM)
- Use of abbreviations, punctuation and specific terms used throughout code book  
Ex: NOS, NEC, “and”, “with”, “see”, “see also”, “code also”
- Etiology and manifestation conventions  
Ex: “code first”, “use additional code” and “in diseases classified elsewhere”
- Inclusion terms and Exclusion Notes (“Excludes 2” notes new with ICD-10-CM)

### Coding Scenario 1

Referral received for a 90-year-old patient – debility, weight loss and not eating. Had a hospitalization for unresponsiveness. Has end-stage CHF with a past history of CAD, Arthritis; HTN and MI in distant past. Has improved but wants to die at home. Refusing all treatment except palliative measures.

### Coding Scenario Answers

- **I50.9** – Congestive Heart Failure
- **R53.81** – Malaise & Fatigue
- **I25.9** – CAD
- **I10** – Hypertension
- **R63.4** – Loss of Weight
- **Z74.01** – Confined to Bed Status
- **Z51.5** – Encounter for Palliative Care
- **Z66** – DNR Status

### Coding Scenario 2

Referral for a 93-year-old female after three hospitalizations for aspiration pneumonia which is still present. Has severe dementia due to end-stage Alzheimer’s. Has severe dysphagia and has lost 50 pounds recently with a BMI measured at 17. She is virtually bed-bound and has a stage II pressure ulcer on sacrum. She is totally dependent for all ADL’s. Family has declined feeding tube and any other active interventions.

### Coding Scenario Answers

- **G30.9** – Alzheimer’s disease, unspecified
- **F02.80** – Dementia due to Alzheimer’s
- **J69.0** – Aspiration Pneumonia
- **R13.11** – Dysphagia, unspecified stage
- **L89.152** – Stage II pressure ulcer of sacrum
- **R63.4** – Weight Loss
- **Z68.1** – BMI below 19
- **Z74.01** – Bed confinement status

**Let's Code #1**

Hospice admission for 74-year-old woman reports a chronic infection of her amputation stump. She started with a toe amputation 2 years ago due to a diabetic ulcer and now has a R BKA with another ulcer where fat & fascia are exposed. 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 from bed to chair d/t inability to wear a prosthesis and is dependent in all ADLs except feeding. She also has PVD.

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**Let's Code #2**

Hospice admission for a 77-year-old woman with recent declines in ADLs d/t severe dyspnea related to her end-stage COPD. She now also has unstable angina. She has a history of CAD with a 4 vessel CABG 12 years ago, PAD with constant bilateral leg pain at rest. Her appetite has decreased, BMI is 15.5 with multiple boney prominences noticed. She has developed a pressure ulcer stage 2 to her sacrum as she has to have her head elevated at all times.

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**Let's Code #3**

Referral for 84-year-old male with a history of R side hemiplegia 20 years ago. Has become totally dependent for all transfers, mobility and ADLs. Also has a seizure disorder for which he is frequently hospitalized due to poor control of his Dilantin levels. Also has labile HTN. Is totally chair-bound. Refuses all interventions except for palliative care.

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**Let's Code #4**

Referral for 50-year-old with terminal pancreatic cancer. Has decided that he wants only palliative treatment now. Patient has become extremely weak and can only move around out of bed or complete ADLs with assistance. Eating very little and has lost 20 lbs in a month. Is able to tolerate fluid intake.

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**Let's Code #5**

Patient was discharged to hospice immediately following a hospital stay for IV antibiotics for MRSA Pneumonia and a newly diagnosed pathological fracture. She also has Hypertension with Hypertensive Heart Disease and COPD with chronic obstructive bronchitis (on CTI) and is oxygen dependent. Patient was discharged with a new inhaler and the antibiotics were discontinued prior to hospital discharge. The H&P also included notes indicating that the patient needed supervision prior to this hospitalization due to vascular dementia caused by cerebral atherosclerosis. Family has chosen comfort measures only and has signed a DNR.

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**Final Thoughts**

- The diagnosis deemed to be the reason for the terminal condition should always be coded first.
- Symptom codes such as debility or AFTT should not be coded when there is clear documentation of a specific diagnosis that caused the symptom.
- 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.

## **Thanks for Attending!**

**Feel free to contact us with any questions.**

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