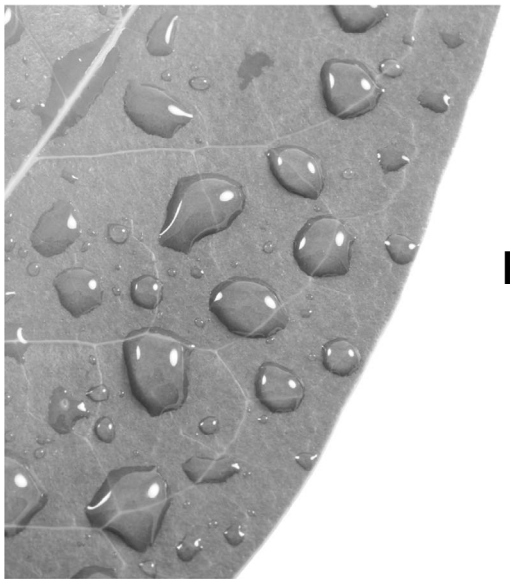

Hospice Coding Tips

MAHC, April 2020

SELMAN HOLMAN™ A BRIGGS HEALTHCARE COMPANY

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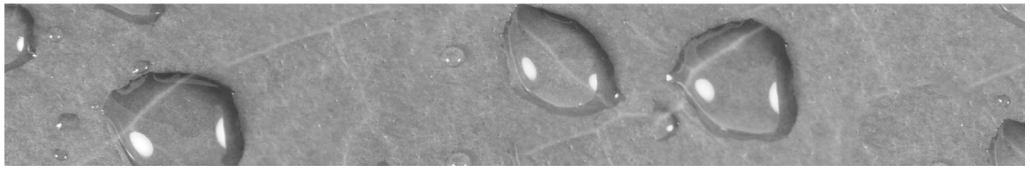
Learning Outcomes

- Apply current guidance to determine appropriate hospice diagnosis selection
- Identify diagnosis codes that are prohibited from use as a terminal diagnosis
- Explain related vs unrelated conditions in hospice coding
- Describe one coding update for 2020 that affects hospice



Regulatory Background

Definitions, CoPs, Related vs Unrelated Diagnoses

Hospice Care

- Change in focus *from curative care to palliative care* for relief of pain, symptom management
- Goal: help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. Hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through use of a broad spectrum of professionals and other caregivers, with the goal of making the individual as physically and emotionally comfortable as possible.

Medicare Hospice Coverage

- An individual must have a prognosis of living 6 months or less if the terminal illness runs its normal course.
- The June 5, 2008 CMS Hospice Conditions of Participation final rule (73 FR 32088) states ''the medical director must consider the primary terminal condition, related diagnoses, current subjective and objective medical findings, current medication and treatment orders, and information about unrelated conditions when considering the initial certification of the terminal illness.''

Certificate of Terminal Illness

- The certification of terminal illness (CTI) must include a *brief narrative explanation of the clinical findings* that supports a life expectancy of 6 months or less as part of the certification and recertification forms, as set out at § 418.22(b)(3).
- Although the principal diagnosis is not a required component of the CTI, the *narrative needs to explain why the patient has a six month prognosis and it should take into account the principal diagnosis and other conditions that together make the patient terminal, but it does not require that each be listed separately or that the principle diagnosis be specifically listed.*

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

Conditions of Participation

- Initial certification of terminal illness: The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification it is anticipated the patient's life expectancy is 6 months or less if the illness runs its normal course. The physician must consider the following criteria when making this determination:

(1) The primary terminal condition.
(2) Related diagnosis(es), if any.
(3) Current subjective and objective medical findings.
(4) Current medication and treatment orders.
(5) Information about the medical management of any of the patient's conditions unrelated to the terminal illness."

Comprehensive Assessment

- Medicare requires that the hospice complete a comprehensive hospice assessment that identifies the patient's physical, psychosocial, emotional, and spiritual needs *related to the terminal illness and related conditions*, and address those needs in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.

Comprehensive Assessment

The comprehensive assessment must take into consideration the following factors:

- The nature and condition causing admission (including the presence or lack of objective data and subjective complaints)
- Complications and risk factors that affect care planning
- Functional status
- Imminence of death
- Severity of symptoms (§ 418.54(c)).

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." ((COORDINATION))
- 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.

Who Decides Relatedness?

- Medical Director should have major role, along with the IDG
- So IDG 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
  - Physician visits
  - ED/hospital visits
  - Procedures/interventions
  - Tests/labs
  - Equipment
  - Medications

Hospice Coverage

- Hospice Conditions of Participation (CoPs) at §418.56(c) require that the hospice *must provide all reasonable and necessary services for the palliation and management of the terminal illness, related conditions and interventions to manage pain and symptoms.* Therapy and interventions must be assessed and managed in terms of providing palliation and comfort without undue symptom burden for the hospice patient or family.

Related Conditions

- *'Related conditions'*: "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."
- Paolini, DO, Charlotte. (2001). Symptoms Management at End of Life. JAOA. 101(10). p609–615

Related Conditions CMS Definition

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.

Related vs Unrelated

- **The terminal illness and *all other diagnoses* should be coded and be placed on the plan of care and the claim.** The hospice processes and workflow will determine how the diagnoses information is gathered, the sources and the responsibility of each task. *Generally, diagnosis selection is a task assigned to the assessing clinician (usually an RN), medical director and the Interdisciplinary Group/Team ("IDG or IDT").*
- CMS indicates that the medical director has the final decision on determining unrelated diagnoses. *There should be clear documentation indicating the rationale why a condition is considered unrelated. Rationale for related/unrelated based on clinical literature and practice guidelines.*

Related vs Unrelated

- CMS stated: "... 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." Therefore, unless there is *clear evidence that a condition is unrelated to the terminal prognosis, all conditions are considered to be related to the terminal diagnosis.*
- It is also the responsibility of the hospice physician to document why a patient's medical needs will be unrelated to the terminal diagnosis.

So...Code them all!

- CMS says: "*we are clarifying that hospices will report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual.*" 80 FR 47201
  - ...as a part of the ongoing data collection efforts for possible future hospice payment refinements.
- Includes the reporting of any mental health disorders and conditions that would affect the plan of care, as hospices are to assess and provide care for identified psychosocial and emotional needs, as well as for the physical and spiritual needs.

Code them all!

- Regulations at § 418.25(b) state, "in reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:
  - Diagnosis of the terminal condition of the patient.
  - Other health conditions, whether related or unrelated to the terminal condition.
  - Current clinically relevant information supporting all diagnoses.
  - *ICD–10–CM Coding Guidelines state that diagnoses should be reported that develop subsequently, coexist, or affect the treatment of the individual.*

ALL Diagnoses Reported (effective October 1, 2015)

FY 2017

- 100% of hospice claims were reporting more than 1 diagnosis
- 89% of hospice claims were reporting at least 2 diagnoses
- 81% of hospice claims were reporting at least 3 diagnoses

FY 2019

- 100% of hospice claims were reporting more than 1 diagnosis
- 95.3% of hospice claims were reporting at least 2 diagnoses
- 84.1% of hospice claims were reporting at least 3 diagnoses

Much Ado About…

- CMS believes that reporting of all diagnoses on the hospice claim aligns with current coding guidelines, as well as admission requirements for hospice certifications.
- Ongoing data collection efforts for possible future hospice refinements, including a case mix system for payment.
- Non-hospice payments for DME, medications, treatments, inpatient stays, etc. provided to patients who had elected hospice that appear to be related to the terminal illness.
- Cost-sharing liabilities incurred by hospice patients who were charged copayments and deductibles for services that were potentially related to the terminal illness.

Anecdotal Information

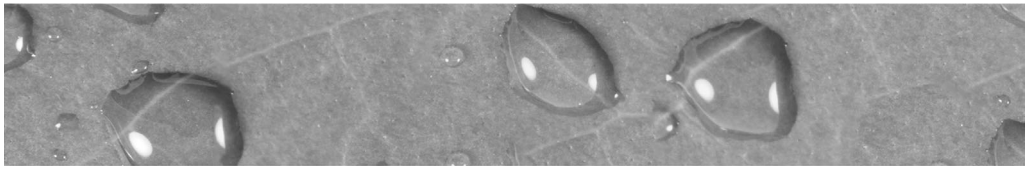
- Palliative chemo or palliative radiation for pain and symptom management needed. Told not covered by Medicare because "curative." Patients revoked hospice benefit in order to receive treatments to alleviate pain. (Medicare says these treatments ARE covered under the hospice benefit.)
- Patient admitted for sepsis related to UTI. Hospice would not pay for BPH medication, which helped relieve significant discomfort.
- Hospice refused to provide seated walker because unrelated to terminal illness. Patient unable to ambulate without having to stop and sit down because of SOB due to end stage Lung Ca.
- CHF as terminal illness; also had diabetes. Hospice would not pay for supplies. Did not inform patient until after she elected hospice benefit.

Addendum Greater Coverage Transparency

(October 1, 2021)

"Patient Notification of Hospice Non-Covered Items, Services, and Drugs."

- Identification of the beneficiary's terminal illness and related conditions;
- A list of the beneficiary's current diagnoses/conditions present on hospice admission (or upon plan of care update, as applicable) and the associated items, services, and drugs, not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions;
- A written clinical explanation, in language the beneficiary and his/her representative can understand, as to why the identified conditions, items, services, and drugs are considered unrelated to the terminal illness and related conditions and not needed for pain or symptom management. This clinical explanation would be accompanied by a general statement that the decision as to whether or not conditions, items, services, and drugs is related is made for each patient and that the beneficiary should share this clinical explanation with other health care providers from which they seek services unrelated to their terminal illness and related conditions;



Coding for Hospice

Guidance, Role of the Coder, Challenges

Conventions and Guidelines Apply

- When coding for hospice services (all levels of care), regardless of the setting where the services are provided, coders generally should follow Sections I, Conventions, General Coding Guidelines and Chapter-Specific Guidelines, II, Selection of Principal Diagnosis, and III, Reporting Additional Diagnoses, of the Official Guidelines for Coding and Reporting.
- Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

Cannot Code Based on Probable, Suspected, etc

- Please note the exception: the guideline regarding coding of uncertain diagnosis (diagnoses documented at the time of discharge as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", or other similar terms indicating uncertainty) as if the condition existed or was established, is *applicable only to inpatient admissions* to short-term, acute, long-term care and psychiatric hospitals.
- *So hospice cannot code "suspected" cancer as cancer.*

Selection of Primary Diagnosis

- The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS, July 31, 1985 Federal Register) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc). **The UHDDS definitions also apply to hospice services (all levels of care).**

Selection of Other Diagnoses

- UHDDS item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." UHDDS definitions apply to inpatients in acute care, short-term, long term care and psychiatric hospital settings.
- UHDDS definitions have been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc). **The UHDDS definitions also apply to hospice services (all levels of care).**

Excerpt from the Guidelines

- A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.
- These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported.
- The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

Hospice Principal or Terminal Diagnosis

- Principal diagnosis describes the terminal illness of the hospice patient; the condition chiefly responsible for patient's admission to hospice
- Must be determined by certification of patient's attending physician or the hospice medical director

Principal or Terminal Diagnosis

- Hospices may not report Z-codes as the primary diagnosis on hospice claims.
- Do not list symptoms (R codes) when the underlying condition or disease is known.
- Other diagnoses are entered per official guidelines for coding and reporting.
  - 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."

- Claims Processing Manual

Terminal Illness Definition

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.

Principal Diagnosis

- Avoid codes considered non-reportable as principal diagnosis for hospice (debility, FTT, unspecified dementia)
- Follow ICD-10-CM coding conventions and guidelines
  - No V, W, X,Y codes or Z-codes as the principal diagnosis
  - Follow sequencing rules: no manifestation codes as principal diagnosis

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.
- NHPCO definition: known factors or pathological disease impacting on the primary health problem and generally attributed to contributing to increased risk for poor health status outcomes.

But CMS says:

- The presence of comorbidities is recognized as an important factor contributing to the overall status of an individual and should be considered when determining the terminal prognosis. It is well documented that comorbidities affect overall general health, treatment choice, prognosis and is a predictor of poor survival.

Secondary Diagnoses

- Gather and consider information about related and unrelated co-existing diagnoses, which should be addressed as part of the hospice Plan of Care as determined by the IDT discussion
- CMS expects the hospice agency to provide for all aspects of care that impact the patient's complex condition and overall prognosis as a terminally ill patient

Secondary Diagnoses

- Report all comorbid, unresolved diagnoses pertinent to the plan of care
- Do not list symptoms when underlying condition/disease is known
- May code debility, FTT and/or unspecified dementia as secondary diagnoses (Never primary)
- Avoid listing a diagnosis that is resolved (History codes are OK)

Sequencing on POC

- Prioritize the care to be provided under hospice
- All *pertinent* diagnoses must be listed on the Plan of Care in order of their seriousness related to the care plan
- Sequencing of Z codes for hospice is discretionary; may be sequenced after the codes for specific diagnoses or symptoms (chapter A-T codes)

Plan of Care Diagnosis List

- Principal diagnosis
  - Terminal condition
- Related Conditions
  - Other diagnoses affected by the terminal condition or contributing to prognosis
- Applicable Z codes
- Unrelated Conditions
  - Coordinate care with other providers
  - *Notify patient that care, medications, equipment, etc. for these conditions will not be covered under hospice*

Diagnoses Must be Consistent

- The principal diagnosis must be the same across the Certification of Terminal Illness (CTI), the Hospice Plan of Care, and the UB-04 Claim Form / Notice of Hospice Election (NOE)

CR8877

- Hospice providers may not report diagnosis codes that cannot be used as the principal diagnosis according to ICD-10-CM Coding Guidelines and require further compliance with various ICD-10-CM coding conventions, such as those that have principal diagnosis code sequencing or etiology/manifestation guidelines.
- Effective for dates of service on/after October 1, 2014

Implications of CR8877

- "Manifestation code as principal diagnosis" edit in the Integrated Outpatient Code Editor (IOCE)
- Other diagnoses that shouldn't be primary based on coding conventions and guidelines (ex: vascular dementia)
- Diagnoses in the SSI chapter when a related definitive diagnosis has been established or confirmed by the provider —Adult failure to thrive (R62.7) and debility (R53.81)
- CR8877, Attachment A

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3032CP.pdf

Coverage Considerations

- MACs have edits set to flag some diagnoses used as the terminal condition for hospice claims
- Keep up to date with your MAC's local coverage determinations and eligibility considerations for hospice

Excerpt from 2019 final rule

- There have been changes in diagnosis patterns among Medicare hospice enrollees. In 2002, lung cancer was the top principal diagnosis; neurologically based diagnoses have topped the list for the past 5 years.
- Additionally, in FY 2013, "debility" and "adult failure to thrive" were the first and sixth most common hospice claims-reported diagnoses, respectively, accounting for approximately 14% of all diagnoses. Effective October 1, 2014, these diagnoses are no longer permitted as principal diagnosis codes on hospice claims. As a result of this, ***the most common hospice claims-reported diagnoses have changed from primarily cancer diagnoses to neurological and organ-based failure diagnoses.***

Your Role as a Coder

- Review of intake documentation and the assessment
- Verification of information with attending physician (all dx must be verified by physician)
- Work with medical director and IDT to determine acceptable terminal illness, identify related conditions and obtain documentation of rationale for unrelated conditions
- Code the Plan of Care and claim
  - Static or ongoing process

Step One: Intake/CTI

- Check the intake information:
  - What is the terminal illness?
    - Not a symptom code
  - What kind of heart disease?
    - Is there hypertension?
  - What kind of dementia?
    - Vascular dementia? Has the patient had cerebral infarctions?
  - Any pressure ulcers? Closed and open
  - What is the etiology of any other wounds?
  - Where is the neoplasm? Behavior? Primary site? Secondary sites?

Diagnoses may need clarification

- Lung cancer is given as a diagnosis. The intake person should ask for specifics: which lung or part of lung is affected, behavior, primary site, any metastasis?
- Diabetes is given as a diagnosis: type of diabetes and any manifestations? (many are assumed related)
- Heart failure is given as a diagnosis: what type, acute and/or chronic, identified as end-stage?
- Dementia given as a diagnosis: what type, underlying cause, any CVA, any wandering or delusions or behaviors?

Step Two: Assessment

- Check the initial assessment documentation
  - Physical assessment, including emotional state, behavior and coping of patient and family.
  - Review medical record to obtain past health history and details of current problems.
  - Review current medications and other treatment approaches to determine if additional diagnoses are suggested by the current treatment regimen.
  - Verify diagnoses are documented in the medical record or confirmed with the physician. ***Never list a diagnosis that is not confirmed by the physician.***

Step Three: IDT Meeting

- Check the IDT meeting minutes
  - Identify the terminal condition, query physician when terminal diagnosis doesn't meet criteria for hospice admission
  - Identify related and unrelated conditions
  - Clarify missing information (ex: dementia type)
  - Confirm the specific type of wound – i.e., whether ulcers are pressure, arterial, stasis, diabetic, etc.
  - Confirm the type and locations of tumors—i.e., primary malignancy vs metastasis and location
  - Confirm "suspected" diagnoses
- Check for documentation of all communication with physician!

Sources of Information

- Intake/Referral form
- Hospital/physician medical record
- Nursing and other discipline assessments
  - Physical, mental, emotional status
  - Patient / caregiver interview, history
- Medication list
- Inter-Disciplinary Team meeting minutes
- Plan of Care interventions and goals
  - Disciplines and services ordered
- Bring it all together in one place and get the necessary verifications.

Time Points for Diagnosis Coding

- Start of Care
  - Establishes plan of care
- Monthly or Per Benefit Period
  - Update as necessary to current condition: terminal condition doesn't usually change, but other diagnoses may resolve or exacerbate in the course of hospice services

Hospice Coding Challenges

- Accurately completing items on Hospice Information Set
- Correctly identifying the terminal illness, related and unrelated diagnoses
- Complying with applicable coding conventions and guidelines
- Avoiding prohibited principal diagnoses (CR8877)
- Impact of FY 2016 Hospice Final Rule on diagnosis selection

Common Coding Errors

- Listing only the terminal condition on the Plan of Care
- Listing a prohibited principal diagnosis
- Failure to list other conditions that co-exist, impact patient's care or have the potential to affect response to treatment
- Listing symptom codes when the medical record identifies a definitive diagnosis causing the symptoms

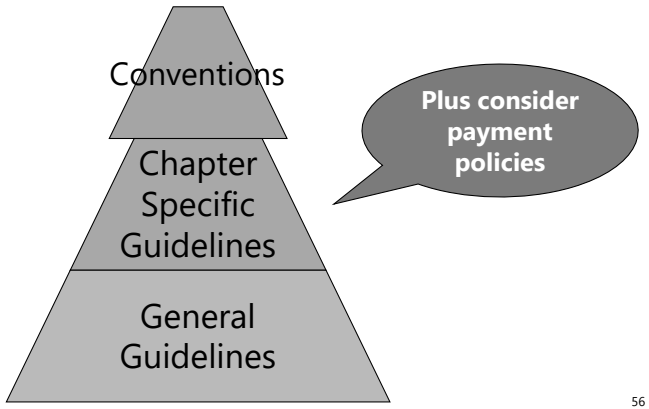
Common Coding Errors

- Listing diagnoses that are not documented in the medical record or confirmed by the physician
- Utilizing non-specific codes when the medical record has more detailed information
- Listing codes for resolved conditions
- The medical record indicates etiology-manifestation, but conditions are coded as separate unrelated diagnoses & v.v.

Communication is Essential

- With the provider:
  - Obtain the clinical information
  - Confirm diagnosis information
- With the assessing clinician (RN):
  - Assessment must be complete
  - Develop an idea of the Plan of Care
- Accurate, consistent, complete documentation can't be overemphasized

Hierarchy of Importance



Use of Unspecified Codes

- When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (e.g., a diagnosis of pneumonia has been determined, but not the specific type).
- Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient's condition at the time of that particular encounter.
- *It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.*

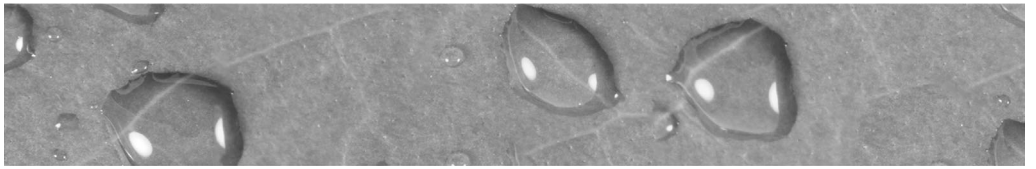
Sequencing in Hospice

- Specific sequencing rules in conventions and guidelines
- Terminal illness
  - Must follow coding conventions and guidelines
  - May take more than one diagnosis code
- Related conditions in order of importance to plan of care (using conventions and guidelines)
- Z codes never primary; history codes (categories Z80-Z87) may be used as secondary codes if the historical condition has an impact on current care.
  - Z51.5 Encounter for palliative care
- Unrelated diagnoses

Requires Coding Skills and…

Knowledge of:

- Eligibility and coverage for the setting
- Medical Terminology
- Anatomy and Physiology
- Pathophysiology
- Pharmacology
- How to use Google or Bing



Hospice Scenarios

Sequencing Primary and Secondary Neoplasms

- If the primary site of the cancer is identified by the physician as the terminal illness, sequence the primary site first, followed by any metastatic site(s)
- If the terminal illness is identified as a metastatic (secondary) site only, the metastatic site may be designated as the principal/first-listed diagnosis. The primary malignancy is coded as an additional diagnosis after the metastatic site

Primary malignancy previously excised

- When a *primary* malignancy has been previously excised or eradicated *from its site* and there is no further treatment directed *to that site* and there is no evidence of any existing primary malignancy **at that site**, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. 2019
- Any mention of extension, invasion, or metastasis *to another site* is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the Z85 code used as a secondary code.

Neoplasm Example

Grade 4 colon cancer excised and eradicated from ascending and transverse colon with metastasis to liver. Patient has colostomy but no further treatment to colon. Further chemo treatment directed to liver mets has been unsuccessful. Patient is seen for palliative care, caregiver is independent with colostomy care.

- C78.7 Secondary malignant neoplasm of liver…
- Z85.038 Personal history of other malignant neoplasm of large intestine
- Z51.5 Encounter for palliative care
- Z93.3 Colostomy status

Neoplasm Scenario 1

- Mrs. Baskerville is admitted to hospice with terminal diagnosis of secondary metastatic CA of the liver from primary right breast CA. She also has diagnoses of CHF and Diabetes.

Neoplasm Answer 1

- C78.7 Secondary CA of liver
- C50.911 Primary CA of right female breast
- I50.9 Heart failure unspecified
- E11.9 Type II diabetes without complications

Neoplasm Scenario 2

- Mr. Andrews is admitted to hospice with primary CA of the left main bronchus and the upper lobe of the left lung. He also has a history of prostate CA resolved by treatment 10 years ago. The medical record documents he is a "2ppd smoker x 30 years"

Neoplasm Answer 2

- C34.02 Primary CA of left main bronchus
- C34.12 Primary CA of upper lobe, left bronchus or lung
- F17.210 Nicotine dependence, cigarettes, uncomplicated
- Z85.46 Personal history of prostate CA

Neoplasm Scenario 3

- Mr. Poulet is admitted to hospice following exploratory surgery for abdominal obstruction. The surgery was "open and close" - found advanced CA throughout the abdominal cavity and involving multiple organs. A colostomy was performed to relieve the obstruction. POC will address terminal dx of disseminated CA, dressing changes to abdominal incision, colostomy care and pain due to the CA.

Neoplasm Scenario 3

- C80.0 Disseminated CA
- G89.3 Neoplasm related pain
- Z48.3 Aftercare following surgery for neoplasm
- Z43.3 Encounter for attention to colostomy
- Z48.01 Encounter for change of surgical wound dressings

Hypertension

- Hypertension with heart conditions classified to I50.- or I51.4- I51.7, I51.89, I51.9, are assigned to a code from category I11.- Hypertensive heart disease.
- Use an additional code from category I50, Heart failure, to identify the type of heart failure in those patients with heart failure.
- The same heart conditions (I50.-, I51.4-I51.7, I51.89, I51.9) with hypertension are coded separately *if the provider has documented they are unrelated to the hypertension* 2019

Hypertensive Heart Disease

Look at I11

- I51.4-I51.9 (but not I51.81) are included, however use an additional code for heart failure, if present.

Specific sequencing required:

- The hypertension must be coded prior to the heart failure.
  - Note the 'code first' note at I50
- The conditions included in I11 *are not coded separately.*
  - Patient has HTN and cardiomegaly (I51.7), then code I11.9 ONLY

Practice

- Hypertensive left ventricular hypertrophy

a. I11.9
b. I11.9, I51.7

- End stage heart disease patient also has hypertension

a. I11.9
b. I11.9, I51.9

- Senile degeneration of heart with hypertension

a. I11.9
b. I11.9, I51.5

Practice

- Hypertensive left ventricular hypertrophy

a. I11.9

b. I11.9, I51.7

- End stage heart disease patient also has hypertension

a. I11.9

b. I11.9, I51.9

- Senile degeneration of the heart with hypertension

a. I11.9

b. I11.9, I51.5

Persistent A Fib (New codes)

- I48 Atrial fibrillation and flutter
  - I48.1 Persistent atrial fibrillation ***(invalid Oct 1, 2019)***

    Excludes1: Permanent atrial fibrillation (I48.21)

    I48.11 Longstanding persistent atrial fibrillation

    I48.19 Other persistent atrial fibrillation

    Chronic persistent atrial fibrillation

    Persistent atrial fibrillation, NOS

    Persistent AF is a condition in which the abnormal heart rhythm continues for more than a week. It may stop on its own, or it can be stopped with treatment. This code may be assigned only with a supportive confirmation diagnosis by the physician.

Chronic A Fib (New codes)

- I48 Atrial fibrillation and flutter
  - I48.2 Chronic atrial fibrillation ***(invalid Oct 1, 2019)***

    I48.20 Chronic atrial fibrillation, unspecified

    Excludes1: Chronic persistent atrial fibrillation (I48.19)

    I48.21 Permanent atrial fibrillation

    Permanent AF is a condition in which a normal heart rhythm can't be restored with treatment. Both paroxysmal and persistent AF may become more frequent and, over time, result in permanent AF.

    Cannot assume chronic A Fib; "chronic" must be documented by physician

Updates on Heart Failure

- Pleural effusion is coded in addition to heart failure when it requires separate treatment (2nd Q 2015)
- HFpEF, heart failure with preserved systolic function = diastolic heart failure
- HFrEF, heart failure with low ejection fraction, or heart failure with reduced systolic function = systolic heart failure (1stQ 2016)
- Heart Failure

  Excludes 2: Revised to "fluid overload unrelated to congestive heart failure (E87.70)" (Oct 1, 2019)

Heart Failure

I50.2 Systolic (congestive) heart failure

Heart failure with reduced ejection fraction [HFrEF]

Systolic left ventricular heart failure

- *Code also end stage heart failure, if applicable (I50.84)*

I50.3 Diastolic (congestive) heart failure

Diastolic left ventricular heart failure

Heart failure with normal ejection fraction

Heart failure with preserved ejection fraction [HFpEF]

- *Code also end stage heart failure, if applicable (I50.84)*

Heart Failure

I50.4 Combined systolic (congestive) and diastolic (congestive) heart failure

Combined systolic and diastolic left ventricular heart failure

Heart failure with reduced ejection fraction and diastolic dysfunction

- *Code also end stage heart failure, if applicable (I50.84)*

I50.8 Other Heart Failure

I50.83 High output heart failure

I50.84 End stage heart failure

Stage D heart failure

- *Code also type of heart failure as systolic, diastolic, or combined, if known (I50.2-I50.43)*

Stage D of the ABCD Classification of the American College of Cardiology (ACC)/American Heart Association (AHA)

- Advanced structural heart disease, pronounced symptoms of heart failure at rest or upon minimal physical exertion, despite maximal medical treatment.
- Intolerance to medical therapy, worsening renal function, diuretic resistance
- 1-year mortality rate of approximately 50%, is at highest risk for re-hospitalization and requires special therapeutic interventions such as ventricular assist devices, artificial hearts and heart transplantation *or hospice care.*

I50.89 Other heart failure

Cardiovascular Scenario

- Mrs. Woodford is admitted for acute on chronic combined heart failure, identified as end-stage (Stage D). She has recurrent pleural effusions, had 1.2 liters of fluid removed in a pleural tap, refuses to have any further taps or chest tubes. Other diagnoses of a STEMI of the LADA 5 weeks ago, chronic respiratory failure with hypoxia, and CAD with unstable angina. She is on O2.

Cardiovascular Answer

- I50.84 End-stage (Stage D) heart failure
- I50.43 Acute on chronic combined HF
- J91.8 Pleural effusion in conditions classified elsewhere
- J96.11 Chronic respiratory failure with hypoxia
- I25.110 CAD with unstable angina
- Z99.81 Dependence on oxygen
- What about I25.2?
- What if Mrs. Woodford had a dx of hypertension?

Scenario

- Mr. Jacobson is referred for Hospice with a diagnosis of occlusion (no infarct) of bilateral carotid arteries and vascular dementia. Terminal diagnosis is listed as vascular dementia.
- I65.23 Occlusion and stenosis of bilateral carotid arteries
- F01.50 Vascular Dementia

CVA Scenario

- Mr. Innsbrook is admitted to hospice after a massive CVA, with residual deficits of left-sided hemiplegia, dysphagia, vascular dementia, and pseudobulbar affect– all conditions documented as due to the CVA. He is combative with all care. Advance directive: refuses G-tube, DNR requested and ordered by MD.

CVA Answer

- I69.391 Dysphagia following cerebral infarction
- R13.10 Dysphagia unspecified
- I69.354 Hemiplegia left non-dominant side following cerebral infarction
- I69.318 Cognitive deficit following…
- F01.51 Vascular dementia with behavior disturbance
- I69.398 Other sequela of cerebral infarction
- F48.2 Pseudobulbar affect
- Z66 DNR status

Diabetes with ESRD Scenario

- Mr. Lightwood is admitted to hospice with ESRD as the terminal condition and also has diabetes. He is refusing to continue hemodialysis treatment.

- *Note: the terminal condition is the ESRD, BUT…*
- *Look up diabetes in index. What does the subentry 'with' mean?*

DM with ESRD Answer

- E11.22 Diabetes with diabetic CKD
- N18.6 ESRD

- What about these?
  - Z91.15 Patient's non-compliance with renal dialysis
  - Z53.29 Procedure/treatment not carried out for other reasons (patient refusal)

Severe Sepsis Guidelines

- If a patient has sepsis and an associated acute organ dysfunction or multiple organ dysfunction, follow the instructions for coding severe sepsis.
  - *Query if not clear whether the organ dysfunction is related to the sepsis.*
  - *The 'with' doesn't make them related here (chapter guideline).*
- Minimum of two (but usually three) codes
  - Underlying systemic infection A40-A41.-
  - Code from subcategory R65.2-
  - Additional code for the associated organ dysfunction.
    - No need to code circulatory collapse if present

Examples

- Strep sepsis with acute kidney failure
  - A40.9 Streptococcal sepsis, unspecified
  - R65.20 SIRS (severe) without septic shock
  - N17.9 Acute kidney failure, unspecified

Severe because of associated organ failure

- Strep sepsis with septic shock
  - A40.9 Streptococcal sepsis, unspecified
  - R65.21 SIRS (severe) with septic shock

This counts as organ failure

Sepsis with localized infection

- Such as pneumonia, UTI
- If admitted with sepsis ← Usually this one
  - Assign sepsis code first (A40-41)
  - Then localized infection
  - Severe? Add R65.2- & organ dysfunction
- If admitted with localized and develops into sepsis
  - Code localized infection first

Sequencing is dependent on whether the patient was admitted with sepsis or developed sepsis after admission

Sepsis with localized infection

- Sepsis due to Serratia from a UTI
  - Sepsis A41.53
  - Localized infection, UTI N39.0

STOP here for home health patients

- SIRS (R65.2-) if organ dysfunction is related (severe sepsis)
- Organ dysfunction, if applicable.

Change in Guideline

As with all postprocedural complications, code assignment is based on the provider's documentation of the relationship between the infection and the procedure.

For **infections following a procedure**, **a code from T81.40, to T81.43** Infection following a procedure, … **that identifies the site of the infection** should be coded first, **if known**.

Assign an additional code for sepsis following a procedure (T81.44)... Use an additional code to identify the infectious agent.

If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.

Postprocedural Sepsis

- Any complication must be documented by the physician—
- Start with the specific postprocedural infection code (e.g., T81.4-)
- *Code the T81.44x- next.*
- Use appropriate A40-41 code next.

- Patient with postprocedural intramuscular abscess resulting in sepsis caused by MRSA.
  - T81.42xA Post surgical infection, deep incisional surgical site
  - T81.44xA Post-op sepsis
  - A41.02 MRSA sepsis

Sepsis scenario

- Mrs. Brothers is being treated for a peritoneal post-op infection after a cytoreductive surgery involving right ovarian cancer became septic and was admitted to the hospital. She does not respond to treatment, returns home and is admitted to hospice with Staph aureus sepsis and right ovarian cancer with mets.

Answer

Patient being treated for a peritoneal post-op infection after a cytoreductive surgery involving ovarian cancer became septic and was admitted to the hospital. She does not respond to treatment, returns home and is admitted to hospice with Staph aureus sepsis and right ovarian cancer with mets.

- T81.43xa Postoperative infection, intra-abdominal
- T81.44xa Postoperative sepsis
- A41.01 Staph aureus sepsis
- C56.1 Ovarian cancer, right
- C79.9 Metastasis, unknown site(s)

Another Scenario

- Mr. Hudson is admitted to hospice with a terminal diagnosis of sepsis with acute respiratory failure due to pseudomonas aeruginosa. He also has diagnoses of aspiration pneumonia and COPD.

Answer

Patient admitted to hospice with a terminal diagnosis of sepsis with acute respiratory failure due to pseudomonas aeruginosa. He also has diagnoses of aspiration pneumonia and COPD.

- A41.52 Sepsis due to pseudomonas
- R65.20 Severe sepsis without septic shock
- J96.00 Acute respiratory failure
- J69.0 Aspiration pneumonia
- J44.9 COPD unspecified

Coding Rationale

- Sepsis with acute organ failure is coded as "severe" sepsis; sequence the A41.- code first, followed by R65.- to indicate severe sepsis, then the code to identify the associated organ failure.
- Pneumonia is an inflammation/swelling in lung tissue, can be caused by bacteria, virus or aspiration of foreign substance (like food/liquid). One of the complications of aspiration pneumonia is a secondary bacterial infection, so aspiration pneumonia itself isn't always a lower respiratory infection – so don't code with the J44.0 code for the COPD. Use J44.9 since not documented as exacerbated.

HIV—The Guidelines

- Code only confirmed cases.
- Principal diagnosis—B20 followed by related diagnoses
  - Use additional code(s) to identify all manifestations of HIV infection.
- If reason for admission not related to HIV, code HIV and related diagnoses as secondary.
- Patient with any known prior diagnosis of an HIV-related illness should be coded to B20 (even if the manifestation is resolved).

Exception to HIPAA

- Using appropriate code set and following current coding guidelines is a requirement of HIPAA.
- If a state law is stricter than federal law, follow state law.
- Some states restrict the electronic transmission of the code for HIV/AIDS as primary; some states prohibit the electronic transmission of the code HIV/AIDS at all.
  - States include: Texas, California, Massachusetts, New Jersey
- Laws change—contact your state OASIS coordinator for the most current information.
- If the state restricts the use of the HIV/AIDS diagnosis code, code only the manifestations of the HIV/AIDS.

Coding Malnutrition

- Must have a specific diagnosis of malnutrition documented in medical record or verified with physician
  - Cannot list diagnosis based on lab results; low albumin level can be an *indicator* of protein deficiency, must query physician to confirm *diagnosis* of protein-calorie malnutrition

Malnutrition Considerations

- Marasmus and kwashiorkor (E40-42) affect primarily children with profound low protein and calorie intake
- If the patient is dying of malnutrition, it isn't mild (E44.1) or moderate (E44.0)
- What about T73.0 starvation noted in Excludes 2 note?
  - This is under injuries, "deprivation of food" infers by another person

Malnutrition Considerations

- What about E43 Unspecified severe protein-calorie malnutrition?
- What about cachexia?
  - General physical wasting with loss of weight and muscle mass due to a disease
  - R64 Cachexia
    - Wasting syndrome
    - Code first underlying condition, if known
    - Excludes 1: abnormal weight loss R63.4

Diagnosis of "VSED"

- Physician documented terminal diagnosis of "VSED - Voluntarily Stopped Eating and Drinking"
- *Is there a code for this??*

- *F50.89 Psychogenic loss of appetite*

Malnutrition

- "Unspecified malnutrition" E46 as a terminal diagnosis has been RTP
- Need type of protein-calorie malnutrition from physician
- With the diagnosis of malnutrition, also code loss of weight and BMI

The F Codes

- Parkinsons with dementia G20 F02.8-
- Lewy body dementia G31.83 F02.8-
- Alzheimers dementia G30.-, F02.8-
- Unspecified dementia F03.9-
- What are behaviors?
  - Which behavior gets its own code?
- Sundowning is not part of dementia so F05 is added.
- Depression coded based on physician documentation, not on medications; part of bipolar, coded separately with dementia

Vascular Dementia (F01.5-)

- CMS is rejecting as a primary diagnosis in hospice
- Code first the underlying physiological condition or sequelae of cerebrovascular disease
  - Vascular dementia occurs as a result of infarction of the brain due to vascular disease, including hypertensive vascular disease

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F02.8-Dementia in other diseases classified Elsewhere

- Code first the underlying physiological condition
- This is a manifestation code and REQUIRES an etiology code to be listed first
  - *F02.80 Without behavioral disturbances*
  - *F02.81- with behavioral disturbances*

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More Dementia

- Cannot accept "dementia" as a terminal diagnosis for hospice
- Cannot accept senile dementia or vascular dementia as a primary diagnosis for home health or as a terminal diagnosis for hospice
- ASK: *"Is this dementia of the Alzheimer's type?"*
- Alzheimers (G30.-) requires a dementia code (F02.-)
- #4 G31.1 Senile degeneration of brain, not elsewhere classified

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Alzheimer's Scenario

- Mrs. Turpin is admitted to hospice with terminal dx of Alzheimer's dementia, recent decline with increased confusion, wandering, combativeness, gait/balance problems and is dependent for all ADLs and care. She has stopped eating solid foods, drinks supplements, has lost a lot of weight and BMI is 17.

Alzheimer's Answer

- G30.9 Alzheimer's Disease, unspecified
- F02.81 Dementia with behavioral disturbance
- R26.9 Abnormality of gait
- R63.0 Anorexia
- R63.4 Loss of weight
- Z68.1 BMI 19.9 or less
- Z91.83 Wandering in conditions classified elsewhere

Scenario

Christopher Columbus is referred to hospice with a terminal diagnosis of anoxic brain damage following an extended submersion when his sailboat overturned. He is in a persistent vegetative state and expected to live less than 1 month.

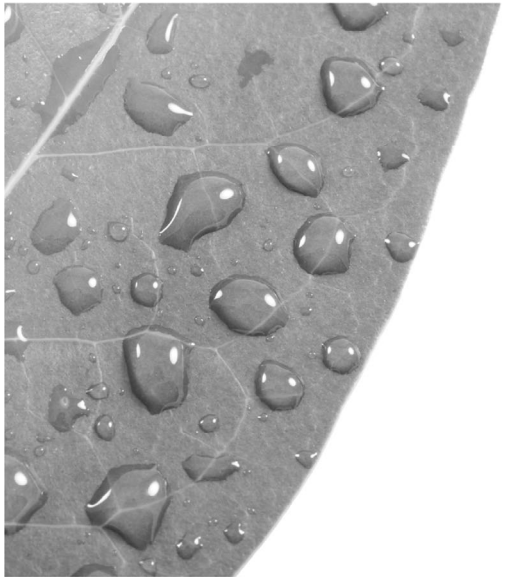
G93.1 Anoxic brain damage

R40.3 Persistent vegetative state

V90.04xS Drowning and submersion due to sailboat overturning, sequelae

Z Codes used for Hospice

- Z51.5 Encounter for palliative care
  - End-of-life care, Hospice care, Terminal care
- Z66 Do Not Resuscitate status
- Z74.01 Bed Confinement status
- Z98.85 Transplanted organ removal status
- Z76.82 Awaiting Transplant
- Z99.3 Wheelchair dependence
- Z99.81 Dependence on oxygen
- But NEVER use a Z-code as PRINCIPAL DIAGNOSIS!



Thank you for attending!

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