THE ART OF DIAGNOSTIC CODING PART 1

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Background

- Every health care setting has gone through similar changes in the need to code more thoroughly.
- We can learn from the experiences of others.
  - Coding has changed in nearly every health care setting over the past 30+ years
  - 15-20 years ago there were coding specialists, but they were primarily only in hospitals and large physician practices and, did not know anything about the post acute/home care setting
  - There is a need to understand the unique differences of settings to understand the impact of coding.
  - Today there are coding specialists in MD offices, rehab centers, SNFs and home health agencies, and a few in hospices, but primarily those that are dually certified.

What Does CMS Want?

- A case mix system that can be used to differentiate the resource needs of beneficiaries in different settings.
- What is needed to accomplish this?
  - Real data and information.
  - What makes one beneficiary differ from another in their terminal condition?
  - Who can provide this information?

  CMS cannot design an accurate and fair case mix system on its own!

The Role of the Cooperating Parties

- Actual codes and official guidelines are developed and maintained by 4 Cooperating Parties

  - Centers for Medicare and Medicaid Services (CMS)
  - American Hospital Association (AMA)
  - American Health Information Management Association (AHIMA)
  - National Center for Health Statistics (NCHS)

The Art & Science of Coding

- Coding is made up of 2 distinct skill sets comprising the art and science of coding.

  - Critical thinking to identify diagnoses that contribute to a person's terminal condition.

  - Science or technical aspects of finding the correct codes.

Sections of the Official Guidelines for Coding and Reporting

- Section I. Conventions, General Coding Guidelines and Chapter Specific Guidelines
  - Applicable to all health care settings unless otherwise indicated,
- Section II. Selection of Principal Diagnosis
  - Principal diagnosis is defined as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to (the hospital) for care". Uniform Hospital Discharge Date Set (UHDDS) elements are defined July 31, 1985, Federal Register (Vol 50, No 147), pp31038-40.
- Section III. Reporting Additional Diagnoses
- Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services.

Was CMS Too Rigid re: Section II, Assigning the First Listed/Principal DX?

- Code is assigned based on the reason, after study, that was most responsible for the admission to the hospital.
  - Main reason for an acute inpatient stay may be resolved when the patient leaves the facility. (e.g., surgery may correct the reason a patient went to the hospital)
- That reason for admission to hospice or other settings may be different due to the focus of care.
  - Hospice: reason that contributes the greatest to the need for terminal care.
  - Rehabilitation: primary diagnosis requiring rehabilitation.
  - Home health; care and teaching in the recovery phase of an illness or injury.
- Bottom line: When selecting and sequencing diagnoses, decisions are based on why you are seeing that patient.

ICD-9-CM Official Guidelines for Coding and Reporting

- Adherence to these Guidelines when assigning ICD-9-CM diagnoses (and procedure) codes is required under the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct (HIPAA).
  - The diagnosis codes (Volumes 1 and 2) apply to all healthcare settings.
  - Volume 3, procedure codes have been adopted for inpatient procedures reported by hospitals.

Overarching Principles of Coding

- The term *encounter* is used for **all** settings, including hospital admissions.

- In the context of the Official Coding Guidelines in ICD-9 (and ICD-10) CM, "the term *provider* is used throughout the guidelines to mean physician or other health care practitioner who is legally accountable for establishing the patient's diagnosis."

- "A joint effort between the health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures."

(Source: Introductory page of ICD-9-CM Official Guidelines for Coding and Reporting)

Official Guidelines and Conventions

- The guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM manual.
  - The guidelines provide additional instruction and are to be used as a companion to the official coding manual.
  - The rules are applicable to all health care settings, unless otherwise indicated.
  - Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

- The Guidelines include:
  - Conventions for the ICD-9-CM
  - General Coding Guidelines
  - Chapter Specific Guidelines

- Accurate coding requires an understanding of the coding conventions and guidelines and how to use the code book.

Coding Guidelines

- General Guidelines provide instruction for coding a number of special situations, such as:
  - Avoidance of over reliance on use of signs and symptoms rather than actual diagnoses that contribute the most to the terminal condition.
  - Avoid non-specific codes
  - Etiology/Manifestation situations
  - Multiple coding for a single condition to provide a clear picture of the situation
  - Acute and chronic conditions
  - Late effects

Etiology/Manifestation Convention

- Certain conditions require both an underlying etiology and a manifestation
  - The underlying condition must be sequenced first followed by the manifestation code
- The etiology code has a "use an additional code" note
- The manifestation code often contains "in diseases classified elsewhere" in the code title and a "code first the underlying condition" note following the code
  - These codes are never permitted to be used as first listed or principal diagnosis code
  - Must be used in conjunction with an underlying condition code and they must be listed following the underlying condition
- All coding manuals provide additional notes around these codes to aid the coder in proper coding

Case Scenario Reflecting Guidelines

- A patient admitted to hospice with a terminal diagnosis of ESRD due to Diabetes must be coded as follows to be compliant with Coding Guidelines:
  - 250.4x, Diabetes with renal manifestations
  - 585.6, End stage renal disease
- Rationale
  - ESRD due to diabetes is an etiology/manifestation disease that requires the underlying etiology (Diabetes) to be coded first, followed by the manifestation (ESRD).
  - In this etiology/manifestation situations, it is actually the manifestation that is the primary focus of care, but the coding manual and guidelines require that the etiology or underlying cause must be listed first.

More Mandatory Multiple Coding

- Late effect codes = residual effect after the acute phase of an illness or injury has terminated
  - No time limit
    - Residual may be apparent early (e.g., CVA)
    - Residual may not be apparent for months or years (e.g., something due to a previous injury)
  - Sequencing:
    - Condition or nature of late effect is sequenced first
    - Late effect code is sequenced second
- Another mandatory multiple code
  - Location followed by stage of a pressure ulcer

Example

- Patient has CVA as a terminal illness, but coding guidelines require that CVAs be coded as late effect once the patient leaves the acute care setting.
- Patients may have multiple late effects (residual effects) such as:
  - 438.21, hemiplegia affecting dominant side as a late effect of a CVA which is (a single combination code), or
  - a late effect code followed with a more specific code to describe more detail of the late effect(s) such as: 438.82, 787.22 oropharyngeal dysphagia as a late effect of a CVA.
- The hospice staff will need to determine which late effects are most related to the reason for hospice care.

Multiple Diagnoses Meeting Primary Diagnosis Criteria

- The principal diagnosis listed should be determined by the certifying hospice physician(s) as the diagnosis **_most contributory to the terminal condition_**.
- When there are two or more interrelated conditions (such as diseases in the same ICD–9–CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.
(**Official Coding Guidelines Quoted in 2014 Proposed Rule)**

Symptom Coding

- Describe patient problems, not a diseases.
- Code the disease:
  - New diagnosis, exacerbation of an existing disease or multiple aspects of the disease process.
    - Plan of care & documentation must reflect management of the disease, not just a symptom.
    - Ex: management of a neuro patient (MS, Parkinson's)
  - When the symptom is integral to the disease.
- Only code a symptom when:
  - There is no definitive diagnosis,
  - To avoid coding a diagnosis that is not appropriate (gait abnormality for a patient with falls of unknown etiology).
  - The coding manual instructs you to code symptoms (600.01)

Primary Conditions Contributing to Symptom Syndromes

By the nature of the clinical criteria of "debility" and "adult failure to thrive", these symptom syndromes are the result of *multiple primary conditions that* contribute to the terminal decline. If <u>any or all</u> 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.

Proposed FY 2014 Hospice Wage Index Rule
May 2013   77 FR 27831

Black or White or Hospice Gray?

- Coding is not always black and white.
  - Sometimes it is gray, relying on non-specific codes.
  - Each patient is <u>unique</u> and may not be coded exactly the same way as another person with the same principal diagnosis.
  - Sometimes you will have to use non-specific symptom codes because there is no underlying diagnosis that exists.
    - This should be rare for the principal diagnosis.
    - May apply more to secondary or other diagnoses.

From the 2014 Hospice Wage Index

- 72 percent of providers still only report one diagnosis on the hospice claim.
- Further clarifying the ICD–9–CM coding guidelines and CMS' expectations for diagnosis reporting on the hospice <u>claims</u> in order to ensure the Medicare hospice beneficiaries are receiving holistic comprehensive hospice services.
- Codes under the classification, 'Symptoms, Signs, and Ill-defined Conditions'', are not to be used as principal diagnosis when a related definitive diagnosis has been established or confirmed by the provider.

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A Few Words About Dementia

- Dementia is found in two types of situations:
  - Dementia in conditions classified elsewhere
    - Due to another condition (etiology/manifestation).
    - Examples: Alzheimer's dementia, Parkinson's dementia
  - Dementia, Unspecified
    - Where there is no connection to any other diagnosis or condition
    - Example: a patient has dementia, not otherwise specified

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No Longer Using Debility/Adult Failure to Thrive as Primary Diagnosis

- In this proposed rule, CMS states that "debility" and "adult failure to thrive" would <u>not</u> 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.
- "Debility" and "adult failure to thrive" could be listed on the hospice claim as other, additional, or coexisting diagnoses. (2014 Federal Register)

Did CMS Go Too Far In the Proposed Rule?

- Neither adult Failure to Thrive nor Debility are <u>restricted by the coding manual</u> to being a secondary diagnosis only.

- Is this a program policy issued because these codes were <u>overused and not always the most appropriate principal diagnosis</u>?

- Could there be limited patient situations in your agency when adult failure to thrive is the only appropriate diagnosis for a hospice patient?

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Critical Thinking #1

- Hospice programs need to discuss and determine an internal process for determining which diagnoses will be added to the plan of care as relevant to the terminal diagnoses versus which diagnoses a patient may have that should be referenced within the clinical record as "other diagnoses" that you are aware of, but may not need to be included with the relevant ones.
  - Who should participate in this decision making process?
  - What is the economic impact to the hospice with additional "relevant" diagnoses?
  - What criteria can you use to differentiate relevant to terminal diagnosis versus general co-morbid diagnoses?

Critical Thinking #2

- What model will your program use for assigning Diagnosis codes?
  - Dedicated trained/certified or credentialed coder?
    - Is your program large enough to support a dedicated position?
    - Could this role be combined with another role in the organization? (billing, QI, Manager)
    - What about a designated "go to" person for coding technical expertise?
  - Do you want to outsource the technical component of coding?
  - Do you want all your clinicians to be responsible for assigning ICD-9-CM codes?

What Do You Need to Be Doing Right Now?

1. Avoid using Adult Failure to Thrive and Debility on new admissions as the principal diagnosis.
2. Identifying the patients on your current case load with principal diagnoses of Adult Failure to Thrive, Debility or other symptom codes.
   - Use your IDG or another process to review each patient to identify what other diagnoses exist and which one contributes the greatest to the patient's terminal condition and will be most appropriate as the primary diagnosis.
   - Prepare to change the diagnoses at the next certification time point.
3. Methodically review all of your patients to be sure you have captured all other diagnoses relevant (contributing) to the terminal illness/condition.

Let Your Voice Be Heard!

- Submit Comments to CMS on the Draft Proposal before 5 pm on June 28, 2014.
  - It only takes one voice to be heard & to make a difference!
- Provide examples (without individual patient identifiers) that you truly believe, after study, will only meet the Failure to Thrive diagnosis as the principal diagnosis.
- Debility is such a vague and non-specific code that it is highly unlikely that you will not be able to find a better code to use than debility.
- What other input related to this proposed rule do you want CMS to be aware of?

Questions?

Presenter Information

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