THE SCIENCE OF DIAGNOSTIC CODING PART 2

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HOSPICE FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

Objectives: Part 2 of 2 part series

- Identify why we need to code thoroughly
- Highlight basic rules for coding that apply to all settings
- Discuss sample of key coding guidelines: where they come from, where you can find them, and how do you apply them?
- Review reporting diagnoses related to the terminal condition versus non-related diagnoses
- Provide examples to show coding of multiple related diagnoses
- Identify the need for a process to make changes in the diagnoses on the claim
- Identify resources related to improving coding accuracy

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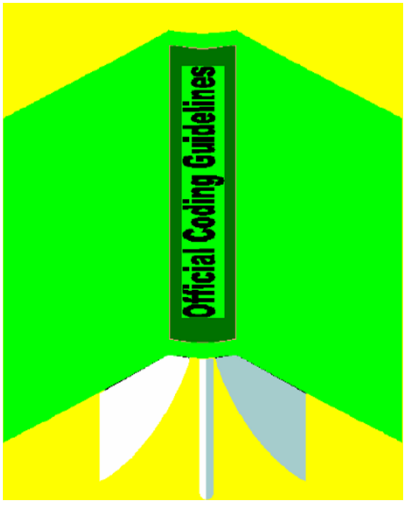
Introduction

- Diagnosis Coding plays a critical role in hospice services ensuring compliance with regulations as well as ensuring coverage and thus, payment for the services provided.
  - Main purpose of diagnosis codes is to provide an updated, accurate picture of the patient's health status that supports the appropriateness of their admission to hospice.
  - Diagnosis code selection should be determined based on the seriousness of the diagnoses to the primary hospice diagnosis/reason for terminal illness.
  - Coding must **always** be in compliance with the official coding guidelines!
- Ensuring that diagnosis coding is accurate is imperative in this era of health care reform and increased audit and review activities.

Coding Resources

- Justify your coding choices by going straight to the official sources!



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Official Sources

- Official Coding Guidelines
- Coding Conventions
- Coding Clinic
  - Approved publication by CMS
  - Published by the American Hospital Association
  - Provides clarification and guidance to further expand the Official Guidelines and Coding Manual
- Other CMS Guidance
  - Hospice Conditions of Participation
  - Medicare Benefit Integrity Manual
  - Medicare Reimbursement Manual
  - 2013/2014 Hospice Wage Index Final Rules

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Differences in Coding Manuals

- All official coding manuals have the same basic information related to the official codes and conventions
  - Individual publishers offer different combinations
    - individual volumes, just Volume 1 and 2 or all three volumes in one book
    - Unique aides to assist you in coding
  - All publishers now offer a specialized home care version
  - Some are hard copy, some are electronic versions
- Choice is made based on price and coder's preference
  - Some have additional helpful tools such as coding tips, references to Coding Clinic citations, diagrams/illustrations, definitions, flags related to age groups and sex,

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Basic Rules for Coding

- Only list diagnoses that are **relevant** to the primary reason the patient requires hospice.
- All diagnoses **must be established or verified** by a physician.
  - Documented in a copy of a physician summary in the medical record or verified with the MD via phone or fax.
- Impact of diagnoses on care to be provided must be clearly documented on the POC or within the medical record.
  - All of the diagnoses must be addressed in the plan of care through assessment/evaluation or treatment.
  - Primary diagnosis should always be the primary reason that a patient needs hospice care.

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General Coding Guidance

- Code to the greatest degree of specificity possible – avoid unspecified codes whenever possible.
- Follow direct guidance in the coding manual
  - E.g., sequence codes together that are part of a mandatory multiple coding situation.
  - Assign the proper number of digits to the diagnosis code.
  - Code first, add an additional code.
- Do not make assumptions of linkage between diagnoses except in the very limited situations where coding guidance allows.
  - Diabetes plus osteomyelitis or gangrene are assumed related unless stated otherwise; DM with all other conditions must be stated.
  - Hypertension and CKD are assumed vs CKD and HF must be a stated relationship.

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Changing the Order

- The order of diagnoses may change for a:
  - Significant change in the patient's condition
  - New certification period
- It is imperative that the medical record reflect the patient's current status at all times.
  - As a hospice patient's physical condition deteriorates, there may be other conditions that become relevant to the primary diagnosis.
  - Updates to diagnoses may occur in the interim between completing a comprehensive assessment and may be shown along with orders for new treatments or changes in the services being provided and can be added to the interim order making these changes as well as to the care plan updated by the Interdisciplinary team.

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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.

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Selecting "Other" Diagnoses

- Other Diagnoses are defined 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".
- For reporting purposes the definition for "other diagnoses" is interpreted as *additional conditions that affect patient* care in terms of requiring:
  - clinical evaluation; or
  - therapeutic treatment; or
  - diagnostic procedures; or
  - extended length of hospital stay; or
  - increased nursing care and/or monitoring.

(**Official ICD-9-CM Coding Guidelines)**

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Significance of Co-morbid Conditions

- Best described by defining the structural/functional impairments, together with any limitation in activity and restriction in participation, related to the co-morbid condition.
  - Example: a beneficiary with a primary cardiopulmonary condition and ESRD could have specific ESRD-related impairments of water, mineral and electrolyte balance functions coexisting with the cardiopulmonary impairments associated with the primary cardiopulmonary condition (e.g., Aortic stenosis, Chronic Obstructive Pulmonary Disease, or Heart Failure).
  - The identification of structural/functional impairments and activity limitations facilitate the selection of the most appropriate intervention strategies (palliative/hospice vs long-term disease management) and provides objective criteria for determining the effects of such interventions. The documentation of these variables is thus essential in the determination of reasonable and necessary Medicare Hospice Services.

(**Source: PGBA Hospice Training 2013**)

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Secondary Conditions

- The occurrence of secondary conditions in beneficiaries with cardiopulmonary conditions results from the presence of impairments in such body functions as heart/respiratory rate and rhythm, contraction force of ventricular muscles, blood supply to the heart, sleep functions, and depth of respirations.
- These impairments contribute to the increased incidence of secondary condition(s) such as delirium, pneumonia, stasis ulcers and pressure ulcers observed in Medicare beneficiaries with cardiopulmonary conditions. Secondary conditions themselves may be associated with a new set of structural/functional impairments that may or may not respond/be amenable to treatment.
- Ultimately, in order to support a hospice plan of care, the combined effects of the primary cardiopulmonary condition and any identified secondary condition(s) should be such that most beneficiaries with the identified impairments would have a prognosis of six months or less.

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Not All Diagnoses Have the Same Impact

- Hospice is responsible for furnishing and paying for all care related to the terminal condition, but is not required to code diagnoses that are <u>not related to the terminal condition.</u>
  - Therefore, it is critical to determine what other diagnoses and conditions are and are not related to the primary diagnosis most associated with a prognosis of six months or less, if the terminal illness runs its normal course.
  - The hospice team will need to engage in critical thinking to determine which co-morbid conditions are and are not related to care for the terminal condition on a case by case basis.

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Hypothetical Cases Example

- 96 year old male patient admitted to hospice with Renal failure, PVD with stasis ulcers, and diabetes. The Renal failure and PVD are felt to be from long standing uncontrolled Diabetes Mellitus. Patient wants to continue on Insulin and glucometer checks.
  - What would your hospice cover under palliation and management of the terminal illness?
  - What diagnoses would you list on the POC to go forward to the claim?

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Hypothetical Scenario

Primary & other Dx	Diagnosis	ICD-9-CM Code
Primary	Diabetes Mellitus with renal complications, stated as uncontrolled	250.42
Other	Renal failure	586
Other	Diabetes with peripheral circulatory disorder, stated as uncontrolled	250.72
Other	Peripheral vascular disease	443.81
Other	Venous (peripheral) insufficiency/Stasis Ulcers	459.81
Other	Ulcers of lower leg	707.19
Other	Long term (current) use of insulin	V58.67

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Critical Thinking Mini Exercise

- Patient with a recent traumatic hip/pelvic fractures that contribute to their enrollment into hospice, but are not the terminal diagnosis. Patient continues to have pain, but no therapy is being provided.
  - Would the fracture be a related condition to hospice?
  - How would you code this?

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More Critical Information Needed

- Increasingly, hospices will need to go back to the attending physician and any other medical care that has been involved with a new patient to obtain more details about the patient's current situation, medical history and help in determining the specific diagnoses and which are inter-related.
- ***Diagnoses to avoid*** for a hospice patient:
  - COPD, need a more specific diagnosis than 496 and whether the condition is decompensated or exacerbated.
  - Symptom codes when they are inherent in the known diagnoses.
- Coding is rarely an "always" or "never" situation" – appropriate codes are based on individual assessments and the unique situation of the patient.
- Only the physician or other person legally authorized to diagnose can provide medical diagnoses.

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Alzheimer's Dementia

- An 88 year old female, diagnosed by her physician as terminal, is admitted with end stage Alzheimer's dementia. She is non-communicative, but very combative when touched, has dysphagia and is given ensure by her family through a PEG tube twice a day, is bedbound and has a stage 4 sacral decubitus.

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Primary other Dx	Diagnosis	ICD-9-CM Code
Primary	Alzheimer's disease	331.0
Other	Dementia in conditions classified elsewhere with behavioral disturbance	294.11
Other	Dysphagia, unspecified	787.20
Other	Decubitus Pressure ulcer lower back	707.03
Other	Pressure ulcer, stage 4	707.24
	Gastrostomy tube status	V44.1
Other	Bed confinement status	49.84
Other	Encounter for palliative care	V66.7
	Are these V codes mandatory?	

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Rationale

- Instructions at category 294.1x tell you to code the underlying etiology first, followed by the appropriate dementia code.
- The patient has dysphagia, unspecified stage, which is a medical condition relevant to the hospice terminal diagnosis.
- Additional V codes provide further clarity about the patient's condition that helps to justify the patient's appropriateness for hospice. In this case, there are a variety of V codes that can be used, but the coder needs to ask do they add any additional useful information to the patient description?
  - V49.84, bed confinement status shows an advanced stage of deterioration.
  - V66.7, encounter for palliative care indicates the patient requires only palliative care.
  - V44.1, gastrostomy status describes that the caregiver is actually caring for the PEG tube, but also demonstrated that the patient is no longer taking food by mouth.
  - V49.86, can be used to indicate the patient/power of attorney has requested & physician has documented a do-not resuscitate order.

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Case Example

- Mrs. O is an 87 year old who is referred for palliative care due to acute on chronic respiratory failure. She experienced aspiration pneumonia during her hospital stay. The pneumonia is now resolved.
- She was discharged home on continuous oxygen at 4 liters/min. Her O2 saturation is 84% on room air and 88% on supplemental oxygen. She is unable to walk any distance without significant dyspnea and is for the most part wheelchair bound. She becomes breathless when talking to others. She remains tachycardic at 100 bpm at rest.
- She experiences chronic fatigue related to her disease. As a result she eats poorly. She is currently 5' 5" tall and weighs 102 pounds.
- Mrs. O also has congestive heart failure, senile dementia, OA, and hypertension.

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Acute on Chronic Respiratory Failure

Primary & other Dx	Diagnosis Description	ICD-9
Primary	Acute on chronic respiratory failure	518.84
Other	Congestive Heart Failure	428.0
Other	Senile Dementia, NOS	290.0
Other	Dependence on Supplemental oxygen	V46.2
Other	History of pneumonia	V12.61
Other	Encounter for palliative care	V66.7
Other	Do I need these V Codes?	

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Rationale

- Primary focus of care is palliative/supportive care for Mrs. O's severe Acute on chronic respiratory failure.
- Her condition is further compromised by CHF which adds to the fatigue and dyspnea she is experiencing.
- Senile dementia is an additional co-morbidity that will impact on this plan of care and require ongoing monitoring.
- Given her heavy dependence on oxygen, the supplemental oxygen code adds to the picture of this patient who is experiencing severe respiratory distress.
- The history of pneumonia highlights that she has recently had pneumonia due to choking and remains at risk for recurrent pneumonia with further deterioration of her terminal condition.
- OA is a co-morbidity that has no impact on her terminal condition and, therefore does not require coding.

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Case Example

- Mrs. Y is a 95 year old pleasant, but frail female referred to Hospice with a loss of weight of 25 pounds over the last month. She has not been interested in eating for the last 4-6 months, she says that she is just tired and whenever she tries to eat, she just cannot force herself to eat. The physician has been unable to identify a physical condition associated with her weight loss other than her increasing depression which does not seem to respond to medical treatment
- The physician has repeatedly recommended enteral nutritional support, but Mrs. Y has refused to even try the therapy. On admission, Mrs. Y is 5 foot 1 inches and weighs 95 pounds. Her MD has validated the following diagnoses: abnormal weight loss, cachexia, depression, mild emphysema and cardiomyopathy.
- On the admission visit, Mrs. Y tells the nurse that she has outlived all of her family and is tired and just plain worn out.

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Case Example

Primary & Other DX	Diagnosis Description	ICD-9
Primary	Severe malnutrition/nutritional marasmus	261
Other	Cachexia	799.4
Other	Depression	311
Other	Emphysema	492.8
Other	Cardiomyopathy	425.4
Other	BMI less than 19, adult	V85.0

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Rationale

- The primary reason for hospice for this patient is the significant weight loss and cachexia.
- Clearly the patient's depression is adding to her lack of desire to eat and weight loss. Medications for her depression do not seem to have any impact to lessen her depression.
- Other co-morbidities that impact this patient are emphysema and cardiomyopathy.
- Based on the patient's height and weight, her BMI is actually 17.9, but the best code for this is V85.0 which can be used for an adult with a BMI of less than 19.

Resources for Coding Help

- Up-to-date coding manual, preferably one that is addressing posy-acute care like hospice, home health, SNF.
- www.medicalspecialtycoding.com
  - List of certified coders by state, resources for becoming certified in coding, coding workshops, cds and books on practicing or improving coding:
    - ICD-9 or ICD-10 Diagnosis coding Answer Book and workbooks.
    - HCS-D Review Guide
    - Many others
- www.ahima.org
  - Coding courses and continuing education for coder
- Local community colleges

Additional Resources

- Team up with other local agencies to pool resources – share information, being in coding resource to work with the group
- Look toward your hospice associations and ask for coding classes.
- Outsource your coding to an external coding group or individual
  - Some experienced coders will take on remote work in coding
  - Many organizations in business of remote coding.

  search on “google, yahoo search” or “Ask.com”, Ask Jeeves

  a few names I am aware of: Coding Done Right, Daymark, McBee Associates, SHP, Foundation Management, Genteva, Contexto, Select data.com, etc.

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Questions?

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