You know incorrect coding hurts your reimbursement.
Did you know it also shapes CMS rules?

Coding and the Future of Hospice

Prepared by DECISIONHEALTH
In this white paper, we will:

➢ Compare and contrast the requirements in the hospice conditions of participation (CoPs) versus the Medicare hospice medical policies and claims processing requirements to ensure you’re using the right information to accurately code your hospice cases.

➢ Discuss the coding guidelines for coding neoplasms and how they differ from how clinicians consider cancers. Also, review the coding guidelines for coding non-cancer diagnoses and how they differ from the medical policies.

➢ Explain how your current hospice coding could impact the future development of a hospice case-mix payment system. Learn how the home health payment system was impacted by a pattern of incomplete and inaccurate coding.

➢ Discuss the steps you need to take to improve documentation of the patient’s terminal illness and other conditions impacting care to ensure your hospice claims will stand up to a review.

Starting Oct. 1, 2014, CMS won’t allow hospice agencies to use the codes for either unspecified debility or adult failure to thrive as the principal diagnosis code on a hospice claim.
Improve the way you select diagnosis codes for hospice services

CMS is tired of seeing just one diagnosis code used on claims to support the medical necessity of hospice care – and even more tired of that code being either unspecified debility (799.3) or adult failure to thrive (783.7).

Starting Oct. 1, 2014, CMS won’t allow hospice agencies to use either of these codes as the principal diagnosis code on a hospice claim. When a hospice agency uses either one as the principal, the claim will be returned to the provider for additional information. They can be used as secondary codes to support the need for hospice care.

The Medicare agency is using evidence to back its decision. These two diagnoses were first and third on the list of top-used hospice principal codes in 2012, appearing on over 245,000 hospice claims, according to CMS data. In addition, in half of the instances where these codes appeared alone as principal hospice diagnoses, other CMS claims data revealed that 75% of the patients had four or more chronic conditions and half had seven or more. The inability to use these codes as primary diagnoses starting in October should push hospice agencies to revisit all of their coding practices to get a better picture of why patients need hospice services.

The hospice conditions of participation (CoPs) and billing guidelines both require hospice agencies to include the diagnosis code for the terminal illness and all of the diagnosis codes for the co-morbidities that impact hospice care. Yet a recent study done by Abt Associates for CMS revealed that 77.2% of all hospice claims from 2010 included only a single diagnosis code, despite the fact that patients undergoing hospice care for a terminal illness almost always have more than one diagnosis.

CMS’s response to encourage more accurate coding is to develop and deploy a case-mix adjusted payment system, similar to the way home health services are now paid, to weight hospice payments based on the complexity of the treatments provided to each individual patient.

As the case-mix payments are based on typical claims encounters, CMS needs hospices to accurately code the co-morbidities related to the hospice care being provided so it
can develop the case-mix scoring system using accurate information. Hospices that want to be paid fairly under a case-mix system now have new motivation to code correctly.

As hospices attempt to comply with the CoPs, coding guidelines and Medicare payment policy, they also face the challenge of determining exactly what it means to code hospice services correctly.

Coding guidelines, which require that all diagnosis codes related to the hospice care be included as diagnoses to support hospice treatment, often conflict with hospice medical review policies. Hospices are encouraged to consider every patient condition when certifying a patient for hospice service, though the per diem payment rate is based on only the diagnoses related to the need for hospice care.

Figuring out which diagnoses are related and which aren’t is harder than it seems. The result is a significant majority of hospice claims include only the diagnosis code that the hospice believes is the direct cause of the terminal illness. As you’ll see in this white paper, that assumption is not always correct.

When a hospice codes only one diagnosis, it appears to CMS regulators that the door is open for additional services for related diagnoses to be separately paid as unrelated services, instead of being included in the hospice per diem rate. Under a case-mix system, coding only one diagnosis will lower the hospice payment by making the patient’s care appear less complicated than it actually is for the hospice.

The bottom line is that inaccurate or haphazard, sloppy coding may hurt hospice payments now, under the per diem, and will definitely hurt hospice payments once a case-mix system is implemented. Hospice operators who also own home health agencies know this already.

A hospice agency’s best option for fair payment, now and in the future case-mix payment system, is to know how to correctly code hospice services, including those diagnoses related to the terminal illness and knowing when not to include diagnoses the patient has that are unrelated to the terminal diagnosis.

Hospice agencies need to know how to properly reconcile conflicts between the CoPs, Medicare hospice medical policies and claims policies requirements, how to sequence diagnoses when neoplasms and cancers are involved and how to properly structure a hospice claim for non-cancer services that adequately supports the patient’s terminal illness – this report will give you tips and strategies to do that.

Understanding related conditions for hospice services

Medicare’s CoPs for hospice require a hospice medical director to consider the patient’s terminal diagnosis, other health conditions whether related or unrelated to the diagnosis, and current clinically relevant information supporting all diagnoses.
When it comes to diagnoses codes on the UB-04 claim form, however, the only codes to include are the diagnosis code for the terminal illness itself, and comorbidities of the terminal illness. This is closer to the true definition of the word comorbidity, which is not every single condition the patient may have.

The hospice plan of care would include all unrelated diagnoses to ensure the patient is able to have all needed care coordinated and that the hospice can ensure the care is delivered effectively.

Medicare policies often use the word co-morbidities in a variety of situations, which confuses hospice coders into thinking that comorbidities includes those conditions not related to the terminal illness. Plus, typically when a medical encounter is coded in any other setting, the claim includes all of the conditions the patient has which were relevant to the encounter. Official coding guidelines back a more inclusive approach to diagnosis coding, but remember when it comes to hospice services, that approach applies only to the terminal diagnosis.

HIPAA also plays a role. Under HIPAA, the hospice is required to code all diagnosis codes that impact the patient’s condition. This is one of the biggest problems CMS has with the one-diagnosis hospice claims. For a terminal illness, it is rarely just one diagnosis, because the other manifestations of that root terminal diagnosis are likely impacting the hospice decision. As a result, when the hospice patient requires other medical services, a debate ensues over whether or not the treatments – such as inpatient hospitalizations or physician care – are related to the hospice diagnosis.

When all of the diagnoses related to the terminal illness are established at the point of hospice certification, it provides a lot more clarity about what should and shouldn’t be included in the hospice per diem.

In hospice care, the patient can have a condition that may impact the patient’s need to be in hospice care, but is not a diagnosis related to the terminal illness.

As a part of electing hospice care, the patient agrees to waive his or her Medicare benefits for treatments related to the terminal diagnosis. The patient and the hospice both want to retain access to benefits for medically necessary treatments unrelated to the hospice election. These benefits are available to the patient for his or her medical comfort, and the hospice is not expected to provide for unrelated medical care as part of the per diem.

When the hospice completes the plan of care, only those diagnoses related to the terminal illness should be listed in the diagnosis area – information and planning for other conditions are best captured elsewhere on the form.

In theory, the notion of coding diagnoses related to the terminal diagnosis and not the others makes sense. The reality, as is usually the case with coding, is more complicated. You need to consider what truly is related, and which diagnosis code is listed as the primary diagnosis.

For a terminal illness, it is rarely just one diagnosis.
Neoplasms vs. Cancer

The approach you would take to coding neoplasms and active cancer sites is different for hospice than the way you would think about it as a clinician.

Typically, as a clinician, the primary diagnosis you list for treatment is the one that’s the immediate cause of the patient’s illness. When establishing a terminal diagnosis, particularly with neoplasms and metastasis of cancers, you may look to the original cancer as the primary diagnosis.

Remember, cancer is considered to still be active in a body area or system unless there is evidence it has been eradicated. Consider a patient who has colon cancer with metastasis to the liver. The metastasis is a key factor in the patient’s current condition, but for hospice the primary diagnosis would be the colon cancer, with diagnosis code 153.9. It’s that condition that is killing the patient, in large part due to the supporting diagnosis of the metastasis to the liver, for which you would add 197.7 to the claim for hospice services.

The metastasis takes over as the primary diagnosis for a hospice claim when the neoplasm was eradicated from the site, but the cancer has spread and metastasized elsewhere. That’s where the V codes come into hospice claims – they’re rarely used now, but probably should be supporting hospice claims more often.

Consider the case of a patient who was treated for breast care with a mastectomy, radiation treatments and chemotherapy. The treating physician found no evidence of any remaining breast cancer as it had been eradicated from that site. However, later examination shows that the cancer had metastasized in the liver. It’s that metastasis that is killing the patient in this instance, so the primary diagnosis code would be 197.7, secondary malignant neoplasm of respiratory and digestive systems. But the hospice knows the patient’s medical history included the breast cancer, so a supporting diagnosis would be V10.3, personal history of malignant neoplasm, breast.

Anemia and cancer is another place where hospice has unique coding guidance. A patient seeking medical care who has anemia associated with cancer may find that it is the anemia that is the focus of care, which typically would make it the primary diagnosis. A patient in hospice, however, would have the cancer as the primary diagnosis, and then the anemia-related diagnosis, which could be 285.22, anemia in neoplastic disease, as a supported diagnosis.

In this case, it is a consistent application of how hospice code rules are applied. The cancer, which is killing the patient, is the primary diagnosis. The anemia, which has arisen related to the cancer, is a related condition.

One last unique rule about hospice coding for cancer – when the cancer occurs in a transplanted organ, the primary hospice diagnosis is a complication of a transplanted organ. Consider a patient who gets a transplanted kidney for chronic kidney disease, and the kidney is later found to be cancerous. The first diagnosis for hospice would be 996.81, complications of transplanted organ, kidney. Next is that the complication is that complication of the transplanted organ is cancer (199.2), then the code for kidney cancer (189.0). Then, 585.6 for the end stage kidney disease.

All of those additional diagnoses would be related to the primary diagnosis.
Establishing and supporting a terminal diagnosis becomes more complicated – and attracts more scrutiny – when the patient doesn’t have cancer at all. It’s more common than you might think. A 2013 report from the National Hospice and Palliative Care Organization (NHPCO) reveals that 63% of primary hospice diagnoses are non-cancer.

One quick way for a hospice to land in medical review is to certify patients for hospice care with a vague diagnosis like 783.41, adult failure to thrive. It’s a symptom code that doesn’t conclusively address why the patient is terminally ill – as noted above, it won’t even be allowed as a primary diagnosis after Oct. 1.

What makes coding non-cancer cases unique in hospice is that the patient usually has multiple conditions and the hospice agency’s goal is to code the root condition as the primary diagnosis, then use the other conditions related to the primary diagnosis to support the need for hospice care. At the same time, the hospice wants to exclude conditions present that are unrelated to the need for hospice services.

This is far different from typical coding guidelines, which would call for the condition that is the direct cause of the encounter to be the primary diagnosis. In hospice, the condition that is causing the patient the most distress may not be the primary diagnosis for the certification of hospice services.

Start by looking at strokes. A patient treated for a stroke in a hospital would typically be coded with an acute stroke diagnosis code, such as 436, acute, but ill-defined, cerebrovascular disease. The hospice wouldn’t use an acute code as a primary diagnosis, however, because it is not the stroke killing the patient, it’s the late effects of the stroke. Look at diagnosis code 438.82, for dysphagia, or 438.2 for late effects cerebrovascular disease with hemiplegia. Add weight loss, 738.21, and document the patient’s body mass index. With these supporting diagnosis codes, you are making a case that late effects of the stroke have the patient in hospice, with the other codes as manifestations of the patient’s terminal condition.

When looking at a patient with a coma or head injury, code what you see first as the primary diagnosis code, then code the remainder. If the patient is in a persistent vegetative state, and that’s the first thing you see, code 780.03. Build the comorbidities around it, which could include 907.0, late effects of skull fracture, or 794.02 for an abnormal EEG.

Every condition the patient has isn’t going to be related to the terminal diagnosis. Consider a patient with chronic kidney disease and hypertension. The primary code for the hospice would be the chronic kidney disease code – if it’s malignant stage IV, the code would be 403.00. The hypertension would be coded next, with the appropriate 585 code. If the patient has diabetes, but the physician has not documented
the condition as diabetic chronic kidney disease, then the diabetes would be considered unrelated to the hospice care. The patient would still be able to receive covered Medicare services for the diabetes treatments.

A patient with Alzheimer’s disease can be especially difficult. When the hospice assigns a primary code of 331.0, for Alzheimer’s disease, the ICD-9-CM guidelines direct the hospice to choose another code to describe the dementia. This would definitely be a related diagnosis for hospice, so the coding might be 294.11 for dementia in conditions classified elsewhere with behavioral disturbance and 290.3 for senile dementia.

When this patient also has chronic obstructive pulmonary disease and congestive heart failure, those conditions will certainly impact the patient’s care, but are likely to be unrelated to the patient’s hospice care. Pressure ulcers probably will be related, because they’re almost always considered related to the terminal illness.

Why is it so important to get it right?

Hospices may wonder why the laser sharp specificity for ICD-9-CM coding of hospice services is being demanded. The reality is, accurate coding by hospice agencies is critical to making CMS’s planned case-mix adjustment work in a way that fairly pays hospices for the services provided.

When hospice agencies continue to rely on a single diagnosis — and remember, we told you at the beginning that more than 77% of hospice claims had only one diagnosis and this was pretty much never accurate coding — then the case-mix system will likely underpay hospice by failing to recognize the full range of services provided.

Likewise, when the hospice ties every patient diagnosis to the terminal condition, the case-mix system will be unfairly weighted toward those services that should be separately provided and paid in the patient’s Medicare benefit. Hospice will have a hard time providing quality care and surviving on case-mix payments under that model.

When you consider that CMS is already in the process of collecting the data to be used to establish case-mix payments for hospice care, it’s critical for hospice agencies to code as accurately as possible. Any hospice leader with experience in home health coding understands the flaws with the home health case-mix payment system, and everyone should be motivated not to repeat those data mistakes.

About Kinnser Software

Kinnser is honored to celebrate our 10th anniversary serving post-acute healthcare providers. We deliver easy-to-use software backed by top-rated service teams. Our mission is to help our customers provide great patient care and succeed as profitable businesses. Headquartered in Austin, Texas, we serve more than 1600 post-acute providers across the United States, and we’re recognized as one of the fastest growing healthcare companies by Inc. Magazine. With Kinnser, home health agencies and hospices can more effectively manage their scheduling, billing, compliance and referrals.

For more information, visit www.kinnser.com.