Eli's Hospice Insider

Compliance: Comply With Hospice Diagnosis Coding Changes Now, CMS Says

Hospices seek clarification on diagnosis coding provisions in proposed rule.

The hospice industry is still reeling from provisions in the 2014 proposed payment rule that will change the amount and types of codes they can report on patients' claims. Providers sought answers to their outstanding coding questions in the **Centers for Medicare & Medicaid Services'** May 8 Open Door Forum for home care providers.

Recap: In the rule published in the May 10 Federal Register, CMS tells hospices that "All providers should code and report the principal diagnosis as well as all coexisting and additional diagnoses related to the terminal condition or related conditions." And the agency tells hospices they no longer will be allowed to use adult failure to thrive (783.7) and debility (799.3) as primary diagnoses on the claims.

Some provisions in the rule may be proposed, but the coding sections are a "clarification" of existing policy and guidelines and hospices should be complying with them already, said CMS's **Randy Throndset** in the forum.

Coding more than one diagnosis for hospice patients and using another diagnosis that is causing the debility or AFTT are all required by ICD-9 coding guidelines, insisted CMS officials in the call.

Watch for edit deadline: CMS says in the rule it plans to implement an edit that will return hospice claims that use debility or AFTT as the principal diagnosis. CMS has not yet issued a date those edits will take effect, but pending instructions including the date will be coming out soon, said CMS's **Wendy Tucker** in the forum.

While the policies are already in effect, CMS is taking feedback on the clarification, Throndset allowed. Comments on the rule are due June 28.

Note: For more information and analysis on the new coding requirements for hospice, see the next issue of Eli's Hospice Insider.