Eli's Hospice Insider

Diagnosis Coding: Hospices Must Place Unrelated Diagnoses On Claims, New Rule Proposes

CMS accuses industry of gaming the system.

Medicare's proposed instructions for diagnosis coding may put hospices on the hook for significantly increased patient costs.

Old way: In previous guidance, the **Centers for Medicare & Medicaid Services** told hospices that the only diagnoses they had to put on the claim were those for conditions related to the terminal diagnosis, noted CMS's **Randy Throndset** in a May 6 Open Door Forum for hospice providers.

New way: "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," CMS says in the rule published in the May 5 Federal Register. "This is in keeping with the requirements of determining whether an individual is terminally ill. This would also include 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."

Inadequate diagnosis coding continues to be a problem for hospices, CMS says in the rule. Analysis of FY 2014 claims data indicates that 49 percent of hospice claims listed only one diagnosis. That's better than the 77 percent of such claims in 2010, but still far from compliant with coding requirements, CMS says.

Repercussions: Hospices, of course, worry that listing every diagnosis code will open them up to financial liability for medications and services that are unrelated to the terminal illness. One caller in the May 6 forum asked how those decisions would be made.

This rule speaks only to the diagnosis coding issue, not to coverage of drugs, Throndset insisted in response. CMS's message is clear report all of a patient's diagnoses on the claim, whether they are related to the terminal condition or not.

However: Elsewhere in the rule, CMS notes that Medicare regulations "require that hospices provide all services necessary for the palliation and management of the terminal illness and related conditions." CMS cites research and case studies that "highlight the potential systematic unbundling of the Medicare hospice benefit and may be valuable analysis to inform policy stakeholders."

Worry: "There is discussion among hospice providers about how this requirement will work and what the reasons are for collecting the data on the claim form if it is judged to be unrelated," acknowledges **Judi Lund Person** with the **National Hospice & Palliative Care Organization.**

Other Health Care Providers Report Hospice Fraud, Abuse

Later in the rule, CMS goes into more detail on its suspicions of hospices shirking their responsibilities. "There is data suggesting a significant amount of 'unbundling' is occurring for services that should be included in the hospice bundled payment," CMS says. "Our data analysis shows that $1.3 billion is being paid outside of the Medicare hospice benefit for those under an active hospice election. With such a significant amount of services being provided outside of the Medicare hospice benefit, it raises questions whether hospices are providing full disclosure of the nature of hospice care, which focuses on improving quality of life as one is approaching the end of life while eliminating the need for unnecessary, futile and possibly harmful diagnostics, treatments, and therapies."

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CMS is listening: "Additionally, we have received anecdotal reports from non-hospice providers" that "say that they have contacted hospices to coordinate the care of the hospice beneficiary only to be told by those hospices that they disagreed with the non-hospice providers' clinical judgment that the care was related to the terminal prognosis," CMS relates in the rule. They say hospices are refusing to reimburse for care related to the terminal prognosis and the hospices told them to code the claim with a different diagnosis or to code condition code 07 (treatment of Non-terminal Condition for Hospice) or the modifier 'GW' (service not related to the hospice patient's terminal condition) on their claims to ensure that the non-hospice provider would consequently get paid."

"These non-hospice providers stated that they disagreed with this practice, and considered it fraudulent," CMS continues. Hospice patients and their families also have told CMS the hospice told them "to revoke their hospice election to receive high-cost services that should be covered by the hospice, such as palliative chemotherapy and radiation."

Bottom line: "We are concerned that some hospices are making determinations of hospice coverage based solely on cost and reimbursement," CMS says. "It was very clear throughout the development, and years after the implementation, of the Medicare hospice benefit that hospices were expected to make good on their promise to do a better job in the provision and coordination of care than conventional Medicare services for those who were at the end of life. However, if hospices are not making good on that promise, it results in increased burden on hospice beneficiaries and their families both clinically and financially and is not in keeping with the intent of the Medicare hospice benefit as originally developed and implemented in 1983."

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