Codify
BY AAPC

Eli's Hospice Insider

Diagnosis Coding: Lack Of Coding Specificity In Feds' Crosshairs, Rule Indicates

Plus: Skyrocketing utilization shows one reason why the industry is singled out for scrutiny.

Don't be surprised to see Medicare start putting certain diagnoses on the no-code list for hospice patients.

In the rule published in the April 14 Federal Register, the Centers for Medicare & Medicaid Services "provides analysis as it relates to hospice utilization such as Medicare spending, utilization by level of care, lengths of stay, live discharge rates, and skilled visits during the last days of life using the most recent, complete claims data," the rule says. "Such data can be used to educate hospices on Medicare policies to help ensure compliance."

Included in those stats are the top 20 diagnoses for hospice patients. The top five are:

- G30.9 (Alzheimer's disease, unspecified) at 9.2 percent of all reported hospice principal diagnoses;
- G31.1 (Senile degeneration of brain, not elsewhere classified), 5.8 percent;
- J44.9 (Chronic obstructive pulmonary disease, unspecified), 5.3 percent;
- I50.9 (Heart failure, unspecified), 3.7 percent; and
- C34.90 (Malignant neoplasm of unspecified part of unspecified bronchus or lung), 3.2 percent.

"It's interesting that the No. 1 principal diagnosis - by far at 9.2 percent - is an unspecified Alzheimer's disease [code]," points out **M. Aaron Little** with BKD in Springfield, Missouri. That is "followed by a 'not elsewhere classified' and three 'unspecifieds,'" he adds. "So, four of the top five principal diagnosis codes lack specificity."

Watch for: "CMS historically doesn't like to see non specific codes being used as primary," Little tells AAPC. "It will be interesting to see over time if CMS issues changes in how it expects principal and other diagnoses to be reported on claims."

On the home health side, CMS has banned a number of unspecified diagnosis codes from payment. For example, CMS said home health agencies could not use M06.9 (Rheumatoid Arthritis, unspecified) to qualify patients for the MS Rehab group under the Patient-Driven Groupings Model.

Other stats CMS included in the rule are:

- The number of Medicare beneficiaries receiving hospice services has grown from 584,438 in fiscal year 2001 to more than 1.6 million in FY 2019.
- Medicare hospice expenditures have risen from $3.5 billion in FY 2001 to about $20 billion in FY 2019.
- Aggregate hospice expenditures are expected to continue to increase by about 7.6 percent annually, CMS estimates.
- Average spending per beneficiary has increased from about $11,158 in FY 2010 to $12,687 in FY 2019.
- The percentage of Medicare decedents who died while receiving hospice services has increased from 43.6 percent in 2010 to 52.0 percent in 2019. "It's encouraging to see the small but steady increase of Medicare beneficiaries utilizing the benefit," Little observes.
- In FY 2019, 68 percent (3,254 out of 4,811) of hospices were for-profit and 21 percent (987 out of 4,811) were non profit, whereas in FY 2014, 61 percent (2,513 out of 4,108) were for-profit and 25 percent (1,029 out of

4,108) of hospices were non profit.
- In FY 2019, for-profit hospices provided about 58 percent of all hospice days while non-profit hospices provided 31 percent of all hospice days.
- There have been only slight changes in care levels, with routine home care making up 98.3 percent of hospice days
- in 2019 compared to 97.2 percent in 2010. Continuous home care fell from 0.4 percent to 0.2 percent in that time period, inpatient respite care stayed the same at 0.3 percent, and general inpatient care dropped from 2.1 percent in 2010 to 1.2 percent in 2019.
- The percentage of hospice reimbursement by care level in 2019 was 93.8 percent for RHC, 0.9 percent for CHC, 0.3 percent for IRC, and 4.9 percent for GIP. The GIP figure is down from 8.5 percent in 2010.
- Average length of stay continues to climb. ALOS went from 74 days in 2016 to 77 days in 2019.
- Patients with Alzheimer's, dementia, and Parkinson's have the highest average length of election at 126.9 percent. Chronic kidney disease and kidney failure patients have the shortest ALOE at 35.6 days.
- Live discharge rates have hovered in the 16-to-17 percent range for the last six years. That's down from 19.3 percent in 2010.
- In FY 2019, 37.5 percent of live discharges were because of revocations, 37.2 percent were because the beneficiary was determined to no longer be terminally ill, 10.7 percent were because beneficiaries moved out of the service area without transferring hospices, and 12.9 percent were because beneficiaries transferred to another hospice. The remaining 1.6 percent were discharged for cause.
- Patients in the highest LOS category, over 180 days, made up the largest percentage of live discharges for each of the four years from 2016 to 2019.
- Before CMS implemented the Service Intensity Add-on payment for RN or social worker visits in the last seven days of life, the percentage of decedents not receiving skilled care in the last days of life was 22.7 percent in FY 2015. In FY 2019, it was 19.6 percent.
- SIA payments increased from $88 million in FY 2016 to $150 million in FY 2019.

Caveat: The stats don't include any 2020 data. "We are still analyzing the effects of the COVID-19 [public health emergency] ... and whether those effects are likely to be temporary or permanent and if such effects vary significantly across hospice providers," CMS notes in the rule. "Therefore, for the purposes of providing routine analysis on utilization and spending, in this proposed rule, we used the most complete data we have from FY 2019."

Note: See the data in pp. 5-18 of the rule at www.govinfo.gov/content/pkg/FR-2021-04-14/pdf/2021-07344.pdf.