Home Health ICD-9/ICD-10 Alert

Coding Errors Can Cost Your Hospice Agency

It's clear from the **Centers for Medicare & Medicaid Services**'s proposed rule for hospice payment in fiscal year 2015 that they mean business when it comes to improved hospice coding. Make certain you know which hotspots to avoid and how you can prepare for the new hospice coding landscape.

Avoid these Coding Errors

In last year's final rule, CMS delayed their plan to return claims to providers when debility and adult failure to thrive are listed as principal diagnoses, says **Judy Adams, RN, BSN, HCS-D, HCS-O**, with **Adams Home Care Consulting** in Asheville, N.C. "It appears that plan may be implemented this year."

In addition the rule was clear that CMS plans to implement edits related to the improper use of manifestation codes on hospice claims and has grave concerns about the high use of unspecified codes as principal diagnoses, Adams says.

In fact for 2013, debility was listed as the leading principal diagnosis on nine percent of claims, adult failure to thrive continues to be used as a principal diagnosis in five percent of claims and unspecified codes such as 496 (Chronic airway obstruction not elsewhere classified), 290.0 (Senile dementia, uncomplicated); and 429.9 (Heart disease unspecified) "are still used pretty frequently as principal diagnoses," Adams says.

"I am quite amazed to continue to see 436 (Acute but ill-defined cerebrovascular disease) as a principal diagnosis since this code has not been approved as a diagnosis for CVA for several years now," Adams says.

"436 stopped meaning CVA in 2004, but that's not the only problem. Hospices should be coding the residual deficits of the CVA with 438.x (Late effects of cerebrovascular disease) codes, not the acute CVA," says **Lisa Selman-Holman, JD, BSN, RN, COS-C, HCS-D, HCS-O**, AHIMA Approved ICD-10-CM Trainer/Ambassador of **Selman-Holman & Associates, LLC**, **CoDR□Coding Done Right and Code Pro University** in Denton, Texas. "The acute CVA has already been treated by the time the patient elects hospice. There are usually multiple residual deficits when 438 is chosen as the terminal illness. All of the residual deficits should be coded."

Tip: "From reading the proposed rule, it appears that dementia as a manifestation of specific neurological disease is about the only dementia code CMS seems to want to accept as a principal focus for terminal patients," Adams notes. As a principal focus, the dementia would still be coded as second after the underlying condition as the cause of the condition.

Follow Four Steps to Prepare

How can your agency prepare for the increased coding scrutiny your hospice claims will face if the proposed rule is passed as-is? The following steps from **Denise Caposella**, CPC, with **Acevedo Consulting Incorporated** in Delray Beach, Fla will help you to be ready for the new hospice coding environment:

1. Consider hiring coders with particular expertise in ICD-9-CM and/or seek additional focused education for your existing coding and billing staff. Prepare now for these additional staffing expenses.
2. Plan for increased time spent on coding. The requirement of assigning additional and coexisting diagnoses will most likely mean more work for your billing and coding staff.
3. Improve documentation. Additional and coexisting diagnoses must be clearly documented so that billing and coding staff can easily and efficiently assign the appropriate codes.
4. Consider setting certain internal edits in your billing software to catch single diagnosis reporting prior to claim submission in order to avoid claim denials.