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Home Health ICD-9/ICD-10 Alert

Hospice Coding: Prepare to Amp Up Hospice Coding or Pay the Price

The future of your hospice reimbursement depends on the diagnoses you code.

You're used to making the most of the six diagnosis slots on the OASIS for your home health patients, but has your agency been skimping on hospice coding? If so, it's time to make a change.

So warns the **Centers for Medicare & Medicaid Services** in its 2013 hospice wage index notice released July 24. Hospice claims which only report a principal diagnosis are not providing an accurate description of the patients' conditions, CMS chastises in the notice scheduled for publication in the July 27 Federal Register. Providers should code and report coexisting or additional diagnoses to more fully describe the Medicare patients they are treating.

The ICD-9-CM Official Guidelines for Coding and Reporting require reporting of all additional or coexisting diagnoses, CMS points out. HIPAA, federal regulations, and the Medicare hospice claims processing manual all require that these ICD-9-CM Coding Guidelines be applied to the coding and reporting of diagnoses on hospice claims, the agency says in the notice.

Those regulations requiring full coding include the hospice conditions of participation (COPs), points out coding expert **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C,** with **Selman-Holman & Associates** and **CoDR -- Coding Done Right** in Denton, Texas.

Hospices should have been doing this already, emphasizes consultant **Lynda Laff** with **Laff & Associates** in Hilton Head Island, S.C.

But according to claims data analysis from CMS hospice contractor **Abt Associates**, a whopping 77 percent of hospice claims from 2010 include only a principal diagnosis. Hospice patients are at the end-of-life; most are elderly and likely have multiple co-morbidities, CMS observes. All of a patient's coexisting or additional diagnoses should be reported on the hospice claims... Doing so will bring hospices into compliance with existing, longstanding policy.

The Medicare program needs this data to help shape payment reform, CMS says in the notice. We are considering multiple approaches to reform, including case-mix adjustment, the agency reveals. To adequately account for any clinical complexities a given patient might have as a result of related co-morbidities, those co-morbidities must be included on the Medicare hospice claim. CMS is having a hard time figuring out whether or how a case mix system would work for hospice, given the absence of the diagnosis coding data, it says.

Warning: If CMS wants diagnosis information to develop a case mix system, hospice coders need to be diligent in coding correctly or the hospice industry will regret any sloppiness in the years to come, Selman-Holman cautions.

Tip: You don't have to list every single coexisting diagnosis a patient has, CMS reassures in the notice. You must include only coexisting diagnoses related to the terminal illness, the agency instructs.

Coding example: Suppose you're coding for a patient who has cancer. You may also need to list codes for neoplasm-related pain (338.3), hypertension that is uncontrolled because of the pain (401.9) and a stage 3 pressure ulcer on the buttock that has developed because of lack of activity (707.05 and 707.23), Selman-Holman says. Leaving these additional diagnoses off the claims doesn't provide an accurate picture of the care you are providing this patient, she says. Lack of these codes will mean no reimbursement included in any case mix system that CMS develops for hospice in the future.

There are many instances when additional conditions like these may increase the likelihood of a non-cancer terminal diagnosis being paid as well, Selman-Holman says. When the patient's terminal illness is not cancer, additional

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conditions can only help substantiate the care provided.

While it's important to make sure you aren't under-coding your hospice patients, it's equally important to be certain you don't list inappropriate codes. There is no need to code symptoms such as abnormality of gait, muscle weakness, etc. for a cancer patient, Selman-Holman says. In fact, the coding guidelines include rules against coding symptoms integral to a disease process.

Coding Requirement No Extra Burden, CMS Claims

Thanks to the existing requirements under the hospice COPs, for many hospices complying with this rule will necessitate only a claims reporting change -- not a change in clinical practice, believes **Judi Lund Person** with the **National Hospice & Palliative Care Organization**. Hospices are already including information on comorbidities in the record, since they impact the plan of care.

Good news: Hospices affiliated with home health agencies are likely to have an easier time adjusting to this requirement, since they may share with the HHA coders who are used to reporting secondary diagnoses for home health patients, believes **Judy Adams** with **Adams Home Care Consulting** in Chapel Hill, N.C.

Coding guidelines are the same for home health and hospice, Selman-Holman points out.

But whether complying with this requirement will create no burden for hospices, as CMS claims in the notice, is unclear.

Hospices that already include the comorbidity information in the record but not on claims will have to make some adjustments, Selman-Holman tells Eli. Any new requirement requires new processes, she observes.

And coding more completely requires more coding knowledge, Adams concedes. For some hospices that are not part of a home health program, it will mean learning coding as a new skill set.

Use Additional Diagnoses To Bolster Documentation

Bonus: Including comorbidity information on claims will give a boost to coverage. The additional diagnoses help to explain and support the patient's hospice status, Adams cheers.

This will be especially helpful with some widely used weak diagnoses that CMS and other reviewers have been targeting, Laff suggests.

For example: Alzheimer's, dementia, failure to thrive and debility all have been targets of review and have topped the list of diagnoses on denied hospice claims in recent months.

Trouble ahead: Hospice coders are bound to run into some snags as they try to fully comply with both ICD-9 coding guidelines and Medicare coverage policies, Selman-Holman warns. Local Coverage Decisions (LCDs) on non-cancer diagnoses can be particularly problematic. If a coder follows those LCDs, they are many times violating the coding guidelines, she says.

For example: According to official guidance you should never list debility as a primary diagnosis. Instead, you should code for it after the conditions causing the debility, Selman-Holman says. Too many home health agencies and hospices use debility for supporting care, including therapy. Remember that coverage for hospice and home health does not include coverage for the old and feeble, she cautions.

Editor's Note: Have a hospice diagnosis coding question? Email the editor, **Jan Milliman, HCS-D, COS-C** at janm@codinginstitute.com.

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