ICD-10-CM Coding for Hospice
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Regulatory Background

Hospice Care

- Hospice care is an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus *from curative care to palliative care* for relief of pain and for symptom management.
- The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through use of a broad spectrum of professionals and other caregivers, with the goal of making the individual as physically and emotionally comfortable as possible.

Palliative Care

Medicare regulations define ''palliative care'' as:

- ''patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.''

Palliative Care

- Goal: Improve the quality of life of individuals, and their families
  - prevention and relief of suffering
- This is achieved by the hospice interdisciplinary team working with the patient and family to develop a comprehensive care plan focused on coordinating care services, reducing unnecessary diagnostics or ineffective therapies, and offering ongoing conversations with individuals and their families about changes in their condition. It is expected that this comprehensive care plan will shift over time to meet the changing needs of the patient and family as the individual approaches the end of life.

Medicare Hospice Coverage

- Prognosis of living 6 months or less if the terminal illness runs its normal course.
- When an individual is terminally ill, many health problems are brought on by underlying condition(s), as bodily systems are interdependent. In the June 5, 2008 Hospice Conditions of Participation final rule (73 FR 32088), CMS stated that ''the medical director must consider the primary terminal condition, related diagnoses, current subjective and objective medical findings, current medication and treatment orders, and information about unrelated conditions when considering the initial certification of the terminal illness.''

Certificate of Terminal Illness

- The certification of terminal illness (CTI) must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, as set out at § 418.22(b)(3).
- Although, the principal diagnosis is not a required component of the CTI, the narrative needs to explain why the patient has a six month prognosis and it should take into account the principal diagnosis and other conditions that together make the patient terminal, but it does not require that each be listed separately or that the principle diagnosis be specifically listed.
- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

CoP

- "Initial certification of terminal illness. The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that it is anticipated that the patient's life expectancy is 6 months or less if the illness runs its normal course. The physician must consider the following criteria when making this determination:

(1) The primary terminal condition.

(2) Related diagnosis(es), if any.

(3) Current subjective and objective medical findings.

(4) Current medication and treatment orders.

(5) Information about the medical management of any of the patient's conditions unrelated to the terminal illness."

Comprehensive Assessment

- Medicare requires that the hospice complete a comprehensive hospice assessment that identifies the patient's physical, psychosocial, emotional, and spiritual needs *related to the terminal illness and related conditions*, and address those needs in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.

Comprehensive Assessment

- The comprehensive assessment must take into consideration the following factors:

1) the nature and condition causing admission (including the presence or lack of objective data and subjective complaints);
2) complications and risk factors that affect care planning;
3) functional status;
4) imminence of death; and
5) severity of symptoms (§ 418.54(c)).

Interdisciplinary Group

- Information about related and unrelated diagnoses should already be included as part of the plan of care, and determined by the hospice interdisciplinary group (IDG).
  - The hospice conditions of participation (CoPs) at § 418.54(c)(2) require that the comprehensive assessment include "complications and risk factors that affect care planning".

Interdisciplinary Group

13

- The CoPs at § 418.56(e)(4) require that the hospice IDG "provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions."
- The existing standard practice for hospices is to include the related and unrelated diagnoses on the patient's plan of care in order to assure coordinated, holistic patient care and to monitor the effectiveness of the care that is delivered.

Who Decides Relatedness?

- Medical Director should have major role along with IDG
- So IDG staff will need to determine specifically which diagnoses are related each month
- Those diagnoses are placed on the claim
- Those diagnoses will be used to manage ALL covered services
  - Physician visits
  - ED/hospital visits
  - Procedures/interventions
  - Tests/labs
  - Equipment
  - Medications

14

Coverage

- Hospice Conditions of Participation (CoPs) at §418.56(c) require that the hospice *must provide all reasonable and necessary services for the palliation and management of the terminal illness, related conditions and interventions to manage pain and symptoms*. Therapy and interventions must be assessed and managed in terms of providing palliation and comfort without undue symptom burden for the hospice patient or family.

15

Related vs Unrelated

16

Related Conditions

- *'Related conditions'*: "Clinically, related conditions are any physical or mental condition(s) that are related to or caused by either the terminal illness or the medications used to manage the terminal illness."
- Paolini, DO, Charlotte. (2001). Symptoms Management at End of Life. JAOA. 101(10). p609–615

Related Conditions CMS Definition

Those conditions that result directly from terminal illness; and/or result from the treatment or medication management of terminal illness; and/or which interact or potentially interact with terminal illness; and/or which are contributory to the symptom burden of the terminally ill individual; and/or are conditions which are contributory to the prognosis that the individual has a life expectancy of 6 months or less.

Related vs Unrelated

- Existing standard practice for hospices: include the related and unrelated diagnoses on the patient's plan of care in order to assure coordinated, holistic patient care and to monitor the effectiveness of the care that is delivered.
- The terminal illness and all other diagnoses should be coded and be placed on the plan of care and the claim. The hospice processes/workflow will determine how the diagnoses information is gathered, the sources and the responsibility of each task. Generally, diagnosis selection is a task assigned to the assessing clinician (usually an RN), medical director and Interdisciplinary Group/Team ("IDT").
- CMS indicates that the medical director has the final decision on determining unrelated diagnoses. There should be clear documentation indicating the rationale why a condition is considered unrelated.

Related vs Unrelated

- CMS stated: ''. . . we believe that the unique, physical condition of each terminally ill individual makes it necessary for these decisions to be made on a case-by-case basis. It is our general view that hospices are required to provide *virtually all* the care that is needed by terminally ill patients.'' Therefore, unless there is *clear evidence that a condition is unrelated to the terminal prognosis; all conditions are considered to be related to the terminal prognosis*.
- It is also the responsibility of the hospice physician to document why a patient's medical needs will be unrelated to the terminal prognosis.

FY 2016 FINAL Rule

"…we are clarifying that 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."

80 FR 47201

Code them all!

- Includes 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.
- Regulations at § 418.25(b) state, ''in reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:
  - Diagnosis of the terminal condition of the patient.
  - Other health conditions, whether related or unrelated to the terminal condition.
  - Current clinically relevant information supporting all diagnoses.
  - ICD–10–CM Coding Guidelines state that diagnoses should be reported that develop subsequently, coexist, or affect the treatment of the individual.

Coding Hospice

Much Ado About…

- CMS believes that reporting of all diagnoses on the hospice claim aligns with current coding guidelines, as well as, admission requirements for hospice certifications.
- Ongoing data collection efforts for possible future hospice refinements, including a case mix system for payment.
- Non-hospice payments for DME, medications, treatments, inpatient stays, etc. provided to patients who had elected hospice that appear to be related to the terminal illness.
- Cost-sharing liabilities incurred by hospice patients who were charged copayments and deductibles for services that were potentially related to the terminal illness.

Conventions and Guidelines Apply

- When coding for hospice services (all levels of care), regardless of the setting where the services are provided, coders generally should follow Sections I, Conventions, General Coding Guidelines and Chapter-Specific Guidelines, II, Selection of Principal Diagnosis, and III, Reporting Additional Diagnoses, of the Official Guidelines for Coding and Reporting.

Cannot Code Based on Probable, Suspected, etc

- Please note the exception that the guideline regarding coding of uncertain diagnosis (diagnoses documented at the time of discharge as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", or other similar terms indicating uncertainty) as if the condition existed or was established, is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.
- *Cannot code "suspected" cancer as cancer.*

Excerpt from the Guidelines

- The *ICD-10-CM Official Guidelines for Coding and Reporting* (*ICD-10-CM Coding Guidelines)* are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction.
- Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA).
- The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings.

Selection of Primary Diagnosis

- The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
  - The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.
- Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc). **The UHDDS definitions also apply to hospice services (all levels of care).**

Selection of Other Diagnoses

- The UHDDS item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." UHDDS definitions apply to inpatients in acute care, short-term, long term care and psychiatric hospital setting, and are used by acute care short-term hospitals to report inpatient data elements in a standardized manner.
- The UHDDS definitions have been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc). **The UHDDS definitions also apply to hospice services (all levels of care).**

Excerpt from the Guidelines

- A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.
- These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported.
- The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

Principal Diagnosis

- Principal diagnosis describes the terminal illness of the hospice patient; the condition chiefly responsible for patient's admission to hospice
- Must be determined by certification of patient's attending physician or the hospice medical director

Principal or Terminal Diagnosis

- Hospices may not report Z-codes as the primary diagnosis on hospice claims.
- Do not list symptoms when the under-lying condition/disease is known
- Other diagnoses are entered per official guidelines for coding and reporting.
  - Hospice claims currently include a field for the patient's principal diagnosis, but allow for up to 17 additional diagnoses to be included on a paper UB-04 claim, or up to 24 additional diagnoses on the 837/ 5010 electronic claim."

Terminal Illness Definition

33

Abnormal and advancing physical, emotional, social and/or intellectual processes which diminish and/or impair the individual's condition such that there is an unfavorable prognosis and no reasonable expectation of a cure; not limited to any one diagnosis or multiple diagnoses, but rather it can be the collective state of diseases and/or injuries affecting multiple facets of the whole person, are causing progressive impairment of body systems, and there is a prognosis of a life expectancy of six months or less.

Principal Diagnosis

- Avoid codes considered non-reportable as principal diagnosis for hospice (debility, FTT, unspecified dementia)
- Follow ICD-10-CM coding conventions and guidelines
  - No V, W, X,Y codes or Z-codes as the principal diagnosis
  - Follow sequencing rules: no manifestation codes as principal diagnosis

34

What is a comorbidity?

- In medicine, **comorbidity** is the presence of one or more additional disorders (or diseases) *co-occurring with* a primary disease or disorder; or the effect of such additional disorders or diseases.
- NHPCO definition: known factors or pathological disease impacting on the primary health problem and generally attributed to contributing to increased risk for poor health status outcomes.

Secondary Diagnoses

- Gather and consider information about related and unrelated co-existing diagnoses, which should be addressed as part of the hospice Plan of Care as determined by the IDT discussion
- CMS expects the hospice agency to provide for all aspects of care that impact the patient's complex condition and overall prognosis as a terminally ill patient

36

Secondary Diagnoses

- Report all comorbid, unresolved diagnoses pertinent to POC
- Do not list symptoms when under-lying condition/disease is known
- May code debility, FTT and/or unspecified dementia as secondary
- Avoid listing a diagnosis that is resolved (History codes are OK)

Sequencing on POC

- Prioritize the care to be provided under hospice
- All *pertinent* diagnoses must be listed on the Plan of Care in order of their seriousness related to the care plan
- Sequencing of Z codes for hospice is discretionary; may be sequenced after the codes for specific diagnoses or symptoms (chapter A-T codes)

Plan of Care Diagnosis List

- Principal diagnosis
  - Terminal condition
- Related Conditions
  - Other diagnoses affected by the terminal condition or contributing to prognosis
- Applicable Z codes
- Unrelated Conditions
  - Additional diagnoses that impact the care or are impacted by it, even if no active interventions

Diagnoses Must be Consistent

- The principal diagnosis must be the same across the Certification of Terminal Illness (CTI), the Hospice Plan of Care, and the UB-04 Claim Form / Notice of Hospice Election (NOE)

CR8877

- Hospice providers may not report diagnosis codes that cannot be used as the principal diagnosis according to ICD-10-CM Coding Guidelines and require further compliance with various ICD-10-CM coding conventions, such as those that have principal diagnosis code sequencing or etiology/manifestation guidelines.
- Effective for dates of service on/after October 1, 2014

Invalid Principal Diagnoses

- CR8877, Attachment A

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3032CP.pdf

Implications of CR8877

- "Manifestation code as principal diagnosis" edit in the Integrated Outpatient Code Editor (IOCE)
- Other diagnoses that shouldn't be primary (ex: vascular dementia)
- Diagnoses in the SSI chapter when a related definitive diagnosis has been established or confirmed by the provider —Adult failure to thrive (R62.7) and debility (R53.81)

Implications of CR8877

- Etiology/Manifestation (covered in Sequencing)
- Other conditions with conventions for sequencing such as 'code first…'
- Signs and symptoms—covered in section regarding Chapter 18—Signs, Symptoms

Coverage Considerations

- MACs have edits set to flag some diagnoses used as the terminal condition for hospice claims
- Keep up to date with your MAC's local coverage determinations and eligibility considerations for hospice

The Coder's Role

Step One: Intake

- Check the intake information:
  - What is the terminal illness?
    - Not a symptom code
  - What kind of heart disease?
    - Is there hypertension?
  - What kind of dementia?
    - Vascular dementia? Has the patient had cerebral infarctions?
  - Any pressure ulcers? Closed and open
  - What is the etiology of any wounds?
  - Where is the neoplasm?
    - Behavior? Primary site? Secondary sites?

Diagnoses may need clarification

- Example- lung cancer is given as a diagnosis. The intake person should ask for specifics: which lung or part of lung affected, any metastasis?
- Diabetes is given as a diagnosis: type of diabetes and any manifestations?
- What kind of heart failure?
- What type of dementia?

Step Two: Assessment

- Check the initial assessment documentation
  - Physical assessment, including emotional state, behavior and coping of patient and family.
  - Review medical record to obtain past health history and details of current problems.
  - Review current medications and other treatment approaches to determine if additional diagnoses are suggested by current treatment regimen.
  - Verify diagnoses are documented in the medical record or confirmed with the physician. *Never list a diagnosis that is not confirmed by physician*

HIS I0010

I0010. Principal Diagnosis	
Enter Code ☐☐	01. Cancer 02. Dementia/Alzheimer's 99. None of the above

The HIS is intended for use in quality reporting; it does not imply acceptability for payment purposes.
Most common principal diagnoses among hospice patients.

I0010

- Review the clinical record for information regarding principal diagnosis.
- Item completion (coding) must be based on what is indicated in the clinical record. *Do not use sources external to the clinical record.*
- This item should be completed based on the patient's principal diagnosis at the time of admission to hospice.

I0010

- Code 01, Cancer: Select code 01 if the patient's principal diagnosis is cancer (including leukemia).
- Code 02, Dementia/Alzheimer's: Select code 02 if the patient's principal diagnosis is dementia (Alzheimer's Disease; frontotemporal dementia; Pick's disease; other frontotemporal dementia; senile degeneration of brain; dementia with Lewy bodies). Note that some dementia codes have manifestation/etiology or sequencing conventions; ensure that coding guidelines have been met for reporting principal diagnosis.
- Code 99, None of the above: Select code 99 if the patient's principal diagnosis is a disease/condition other than cancer or dementia/Alzheimer's.

Step Three: IDT Meeting

- Check the IDT meeting minutes
  - Identify the terminal condition, query physician when terminal diagnosis doesn't meet criteria for hospice admission
  - Identify related and unrelated conditions
  - Clarify missing information (ex: dementia type)
  - Confirm the specific type of wound – i.e., whether ulcers are pressure, arterial, stasis, diabetic, etc.
  - Confirm the type and locations of tumors—i.e., primary malignancy vs metastasis and location
  - Confirm "suspected" diagnoses
- Check for documentation of all communication with physician!

Your Role

- Intake
- Reviewing the assessment
- Verification of information with attending physician (all dx verified with physician)
- Working with medical director and IDT to determine acceptable terminal illness, identify related conditions and document rationale of unrelated conditions
- Code the Plan of Care and claim
  - Static or ongoing process
- The process may differ depending on the hospice, however the basics remain the same.

Sources of Information

- Intake/Referral form
- Hospital/physician medical record
- Nursing and other discipline assessments
  - Physical, mental, emotional status
  - Patient / caregiver interview, history
- Medication list
- Inter-Disciplinary Team meeting minutes
- Plan of Care interventions and goals
  - Disciplines and services ordered
- Bring it all together in one place and get the necessary verifications.

Time Points for Diagnosis Coding

- Start of Care
  - Establishes plan of care
- Monthly or Per Benefit Period
  - Update as necessary to current condition: terminal condition doesn't usually change, but other diagnoses may resolve or exacerbate in the course of hospice services

Challenges

Hospice Coding Challenges

- Accurately completing items on Hospice Information Set
- Correctly identifying the terminal illness, related and unrelated diagnoses
- Complying with applicable coding conventions and guidelines
- Avoiding prohibited principal diagnoses
- Impact of FY 2016 Hospice Final Rule on diagnosis selection

Common Coding Errors

- Listing only the terminal condition on the Plan of Care
- Listing a prohibited principal diagnosis
- Failure to list other conditions that co-exist, impact patient's care or have the potential to affect response to treatment
- Listing symptom codes when the medical record identifies a definitive diagnosis causing the symptoms

Common Coding Errors

- Listing diagnoses that are not documented in the medical record or confirmed by the physician
- Utilizing non-specific codes when the medical record has more detailed info
- Listing codes for resolved conditions
- The medical record indicates etiology-manifestation, but conditions are coded as separate unrelated diagnoses & v.v.

Common Coding Errors

- Listing incomplete codes, omitting required characters
- Failure to include Tobacco exposure, use, dependence or history as required for cardiopulmonary conditions
- Omitting or using incorrect 7th character
- Utilizing 'Z' codes for complicated wounds or other inappropriate situations

Communication is Essential

- With the provider:
  - Obtain the clinical information
  - Confirm diagnosis information
- With the assessing clinician (RN):
  - Assessment must be complete
  - Develop an idea of the Plan of Care
- Accurate, consistent, complete documentation can't be overemphasized

Overview Conventions & Official Guidelines

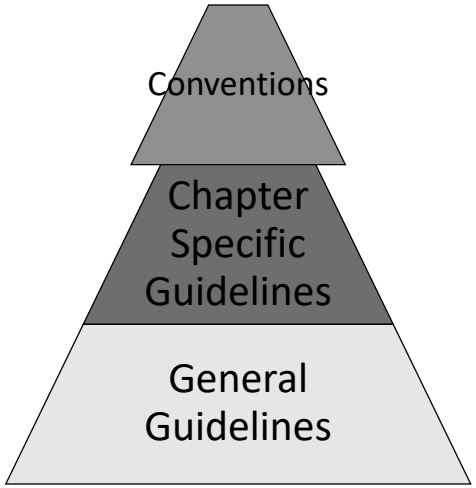
Official Coding Guidelines

- Effective each year on Oct 1 (Current guidelines are 2018)
- Section I
  - Official Conventions
  - General Guidelines
  - Chapter Specific Guidelines
- Section II
  - How to choose a primary diagnosis
- Section III
  - How to choose secondary diagnoses
- *Section IV and the Appendix do not apply to HH or Hospice*

About those Conventions

- The conventions are the general rules for use of the classification independent of the guidelines.
- Conventions are incorporated within the index and tabular list as instructional notes

Hierarchy of Importance



Why so many rules?

- Besides the coding guidelines and conventions, we have payment policy and each setting must comply with set rules from payors (mostly Medicare) for that setting.
- Other rules/codes we do not deal with in home care or hospice: CPT, HCPCS

Other or Other Specified

Codes titled “other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist (ICD-10-CM coding guideline I.A.9.a).

NEC—Not elsewhere classified
I25.89 Other forms of chronic ischemic heart disease
4th digit usually “8” (but doesn’t have to be)

The physician has specified something but that something is not included in the other codes in that section.

Unspecified

"Unspecified" codes are used when the information in the medical record is insufficient to assign a more specific code (ICD-10-CM coding guideline I.A.9.b).

NOS—Not Otherwise Specified

J12.9 Viral pneumonia, unspecified (contrast that with J12.89)

4th digit usually "9"

Unspecified

- When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient's condition at the time of that particular encounter. *It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.*

Conventions—Relational Terms

- And—interpreted to mean 'and/or' when it appears in a code title within the tabular list (C34 Malignant neoplasm of bronchus and lung)
- The word "with" **or "in"** should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.

Addition of 7th Character

- Used in certain chapters to provide information about the characteristic of the encounter
- Must always be used in the 7th character position
- Can be a letter or a number
  - S02.110D (Occipital fracture)
  - R40.2310 (Coma scale, best motor response, none, unspecified time)
- If a code has an applicable 7th character, the code must be reported with an appropriate 7th character value in order to be valid

7th Character—Injuries

Awful needs **A**ctive Treatment

- A, initial encounter, is used while the patient is receiving active treatment for the injury.

Default

- D, subsequent encounter, is used for encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase.
- S, sequelae, is used for complications or conditions that arise as a direct result of an injury (ICD-10-CM coding guideline I.C.19.a).

Sometimes

7th Character Fractures

- A = Initial encounter for closed fracture
- B = Initial encounter for open fracture

Default

- D = Subsequent encounter for fracture with routine healing
- G = Subsequent encounter for fracture with delayed healing
- K = Subsequent encounter for fracture with nonunion
- P = Subsequent encounter for fracture with malunion
- S = Sequela

Sequencing

Sequencing in Hospice

- Terminal illness
  - Using conventions and guidelines
  - May take more than one diagnosis code
- Related conditions in order of importance to plan of care (using conventions and guidelines)
- Z codes adding information (never primary)
  - Z51.5 Encounter for palliative care
- Unrelated diagnoses

What do the guidelines say about sequencing other diagnoses?

- Other diagnoses
- Secondary diagnoses
- Coexisting diagnoses
- Comorbidities

Previous Conditions

- If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded.
- Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.
- However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Abnormal Findings

- Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

Etiology/Manifestation Guideline

- An example of the etiology/manifestation convention is dementia in Parkinson's disease. In the Alphabetic Index, code G20 is listed first, followed by code F02.80 or F02.81 in brackets. Code G20 represents the underlying etiology, Parkinson's disease, and must be sequenced first, whereas codes F02.80 and F02.81 represent the manifestation of dementia in diseases classified elsewhere, with or without behavioral disturbance.

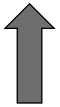
Etiology/Manifestation

- Need to follow coding guidelines
- Buddy codes—have to be sequenced together with etiology preceding the manifestation
- Conventions
  - Alphabetical index two codes with second one within *[italicized brackets]* called manifestation
  - Tabular List: Code title *in italics* (a code in italics in the tabular may NEVER be coded without its cause preceding it).
  - Tabular List: Code first underlying condition at manifestation
  - Tabular List: Use additional code to identify manifestation (not always) at etiology

Alphabetical Index

Disease

Alzheimer's G30.9 *[F02.80]*



Tabular

F02.80 Dementia in other diseases classified elsewhere…

F02 Dementia in other diseases classified elsewhere

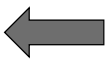
Code first: the underlying physiological condition, such as:

Alzheimer's (G30.-)

Tabular

G30 Alzheimer's disease

Use additional code to identify:

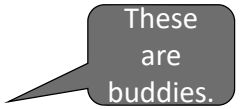


dementia…(F02.80)

So…

Alzheimer's dementia G30.9

F02.80



Teenage Buddy

- "Code, if applicable, any associated condition first", notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.
  - L97

So what does 'teenage buddy' mean?

- If cause is known, code with buddy preceding…
  - E11.621 Type 2 DM with foot ulcer
  - L97.421 non-PU of left heel and midfoot limited to breakdown of skin
- If cause is unknown, sometimes teenagers can be alone.
  - L97.421 non-PU of left heel and midfoot limited to breakdown of skin

Multiple coding for a single condition

- In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code.
- "Use additional code" notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition.
- The sequencing rule is the same as the etiology/manifestation pair, "use additional code" indicates that a secondary code should be added.

Multiple coding for a single condition

- A "use additional code" note will normally be found at the infectious disease code, indicating a need for the organism code to be added as a secondary code.
- Find acute cystitis caused by E. coli

Sequencing

- "Code first" notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a "code first" note and an underlying condition is present, the underlying condition should be sequenced first.
  - L89

Sequencing

- ICD-10-CM coding guideline I.A.17 states a "code also" note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction. (J44.- states to code also asthma J45.-)
- In contrast, the Code First/Use Additional Code notes provide sequencing order of the codes (underlying condition followed by the manifestation).

Neoplasm Table

- Classifies by site (topography) with broad groupings for behavior (malignant, benign, etc)
- The Neoplasm Table should be referenced first.
  - Lung cancer in the right lung
- However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate.
  - Example: Adenoma of right lung
  - But what if the physician documents malignant adenoma?

Coding Malnutrition

- Must have a specific diagnosis of malnutrition documented in medical record or verified with physician
  - Cannot list diagnosis based on lab results; low albumin level can be an *indicator* of protein deficiency, must query physician to confirm *diagnosis* of protein-calorie malnutrition

Malnutrition Considerations

- Marasmus and kwashiorkor (E40-42) affect primarily children with profound low protein and calorie intake
- If the patient is dying of malnutrition, it isn't mild (E44.1) or moderate (E44.0)
- What about T73.0 starvation noted in Excludes 2 note?
  - This is under injuries, "deprivation of food" infers by another person

Malnutrition Considerations

- What about E43 Unspecified severe protein-calorie malnutrition?
  - What is *starvation edema?*
- What about cachexia?
  - General physical wasting with loss of weight and muscle mass due to a disease
  - R64 Cachexia
    - Wasting syndrome
    - Code first underlying condition, if known
    - Excludes 1: abnormal weight loss R63.4
      nutritional marasmus E41

Diagnosis of "VSED"

- Physician documented terminal diagnosis of "VSED - Voluntarily Stopped Eating and Drinking"
- *Is there a code for this??*
  - *Check out F50.89*

Malnutrition

- "Unspecified malnutrition" E46 as a terminal diagnosis has been RTP
- Query type of protein-calorie malnutrition from physician
- Also code loss of weight and BMI

97

Hospice SSI "R" Codes

- R62.51 Failure to thrive
- R62.7 Adult failure to thrive
- R53.81 Debility Unspecified
- R99 Other unknown and unspecified cause of morbidity or mortality
  - *used only for those who have already died*
- R54 Age related physical debility (old age)
  - Don't use as terminal dx for hospice

Signs/Symptoms and Unspecified

- Sign/symptom and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.
- If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.

Symptoms, Signs and Ill Defined Conditions

Code the Symptoms

- When that's all we have
- When the patient has a symptom not routinely associated with the condition
  - Pneumonia with hemoptysis
- When there is an instruction to code the symptoms

Do not code the symptoms

- When the patient has a symptom that IS routinely associated with the condition
  - Pneumonia with dyspnea

99

Functional quadriplegia

- Functional quadriplegia (code R53.2) is the lack of ability to use one's limbs or to ambulate due to extreme debility. It is not associated with neurologic deficit or injury, and code R53.2 should not be used for cases of neurologic quadriplegia. It should only be assigned if functional quadriplegia is specifically documented in the medical record.

Z Codes used for Hospice

- Z51.5 Encounter for palliative care
  - End-of-life care
  - Hospice care
  - Terminal care
- Z66 Do Not Resuscitate status
- Z74.01 Bed Confinement status
- Z98.85 Transplanted organ removal status
- Z76.82 Awaiting Transplant
- Z99.3 Wheelchair dependence
- Z99.81 Dependence on oxygen
- But NEVER use a Z-code as PRINCIPAL!

Requires Coding Skills and…

- Eligibility and coverage for the setting
- Medical Terminology
- Anatomy and Physiology
- Pathophysiology
- Pharmacology
- How to use Google or Bing

Coding Scenarios

Sepsis Scenario

- Patient admitted to hospice with a terminal diagnosis of sepsis with acute respiratory failure due to proteus miribilis and pseudomonas aeruginosa. He also has diagnoses of aspiration pneumonia and COPD.

Code it…

ICD-10-CM Code	Diagnosis

Scenario Answer

- A41.52 Sepsis due to pseudomonas
- A41.59 Other Gram-negative sepsis
- R65.20 Severe sepsis without septic shock
- J96.00 Acute respiratory failure
- J69.0 Aspiration pneumonia
- J44.9 COPD unspecified

Coding Rationale

- Sepsis with acute organ failure is coded as "severe" sepsis; sequence the A41.- code first, followed by R65.- to indicate severe sepsis, then the code to identify the associated organ failure.
- Pneumonia is an inflammation/swelling in lung tissue, can be caused by bacteria, virus or aspiration of foreign substance (like food/liquid). One of the complications of aspiration pneumonia is a secondary bacterial infection, so aspiration pneumonia itself isn't always a lower respiratory infection – so don't code with the J44.0 code for the COPD. Use J44.9 since not documented as exacerbated.

Morphologic/Histologic Neoplasm Examples to Code

- Benign carcinoid of the rectum (*Tumor, carcinoid)*
- Subacute monocytic *leukemia* with failed remission
- 25 year old with malignant *melanoma* of skin at right breast and left arm

Answers

- Benign carcinoid of the rectum
  - D3A.026
- Subacute monocytic leukemia, failed remission
  - C93.90
- 25 year old with malignant melanoma of right breast and left arm
  - C43.52
  - C43.62

Neoplasm Scenario 1

- Mrs. Rockwell is admitted to hospice with terminal diagnosis of secondary metastatic CA of the liver from primary right breast CA. She also has diagnoses of CHF and Diabetes.

Code it…

ICD-10-CM Code	Diagnosis

Neoplasm Answer 1

- C78.7 Secondary CA of liver
- C50.911 Primary CA of right female breast
- I50.9 Heart failure unspecified
- E11.9 Type II diabetes without complications

Neoplasm Scenario 2

- Mr. Battles is admitted to hospice with primary CA of the left main bronchus and the upper lobe of the left lung. He also has a history of prostate CA resolved by treatment 10 years ago. The medical record documents he is a "2ppd smoker x 30 years"

Code it…

ICD-10-CM Code	Diagnosis

Neoplasm Answer 2

- C34.02 Primary CA of left main bronchus
- C34.12 Primary CA of upper lobe, left bronchus or lung
- F17.210 Nicotine dependence, cigarettes, uncomplicated
- Z85.46 Personal history of prostate CA

Coding Clinic Guidance

- Coding tobacco (nicotine) *use*: may be based on clinician assessment and documentation of cigarette use
- Coding tobacco dependence: may be based on documentation in medical record that patient is a "smoker" or documentation of tobacco or nicotine dependence
- Coding exposure to environmental tobacco smoke: may be based on clinician assessment and documentation of family member/caregiver smoking

Neoplasm Scenario 3

- Mr. Markem is admitted to hospice following exploratory surgery for abdominal obstruction. Surgery found advanced CA throughout the abdominal cavity and involving multiple organs. A colostomy was performed to relieve the obstruction. POC will address terminal dx of disseminated CA, dressing changes to abdominal incision, colostomy care and pain due to the CA.

Code it…

ICD-10-CM Code	Diagnosis

Neoplasm Scenario 3

- C80.0 Disseminated CA
- G89.3 Neoplasm related pain
- Z48.3 Aftercare following surgery for neoplasm
- Z43.3 Encounter for attention to colostomy
- Z48.01 Encounter for change of surgical wound dressings

Pulmonary Scenario 1

- Mr. Newton is admitted to hospice with a terminal diagnosis of end-stage COPD. He has MRSA pneumonia and is on po antibiotics for another 4 days. He has disabling weakness/debility, is on continuous O2. His wife of 45 years is a heavy smoker.

Code it…

ICD-10-CM Code	Diagnosis

Considerations

- Patient currently has pneumonia and COPD dx – code J44.0?
- Can't code "end-stage" as J44.1, but what about coding exacerbated since patient has pneumonia?
- What do you need to do before coding this patient?

Acute exacerbation of chronic obstructive bronchitis and asthma

- An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection. ***Cannot*** assume an infection = exacerbation

Pulmonary Answer 1

- J44.1 Decompensated COPD
  - Document MD verification
- J44.0 COPD w/lower resp. infection
- J15.212 MRSA pneumonia
- R53.81 Debility NOS
- Z99.81 Dependence on oxygen
- Z77.22 Exposure to environmental tobacco smoke

"Code also" instead of "use add'l code."

Heart Failure in Hospice

- Heart failure unspecified not a good choice as terminal diagnosis
- Query physician to verify if patient has End-stage or Stage D heart failure – codes to I50.84, with additional code for type of HF (I50.2-I50.43) if known

Cardiovascular Scenario 1

- Mrs. Portland is admitted to hospice with a terminal dx of acute on chronic combined heart failure. She has recurrent pleural effusions, had 1.2 liters of fluid removed in a pleural tap, refuses to have any further taps or chest tubes. Other dx of a STEMI of the LADA 5 weeks ago, chronic respiratory failure with hypoxia, and CAD. She is on O2.

Code it…

ICD-10-CM Code	Diagnosis

Cardiovascular Answer 1

- I50.43 Acute on chronic combined HF
- J91.8 Pleural effusion in conditions classified elsewhere
- J96.11 Chronic respiratory failure with hypoxia
- I25.10 CAD NOS
- Z99.81 Dependence on oxygen
- What about MI? use I25.2?

CVA Scenario 1

- Mr. Innes is admitted to hospice after a massive CVA, with residual deficits of left-sided hemiplegia, dysphagia, vascular dementia, and pseudobulbar affect– all conditions documented as due to CVA. He is combative with all care. Advance directive: refuses G-tube and DNR requested and ordered by MD.

Code it…

ICD-10-CM Code	Diagnosis

CVA Answer 1

- I69.391 Dysphagia following cerebral infarction
- R13.10 Dysphagia unspecified
- I69.354 Hemiplegia left non-dominant side following cerebral infarction
- I69.318 Cognitive deficit following…
- F01.51 Vascular dementia with behavior disturbance
- I69.398 Other sequela of cerebral infarction
- F48.2 Pseudobulbar affect
- Z66 DNR status

CVA Scenario 2

- Mr. Jacques is referred for Hospice with a new diagnosis of occlusion (no infarct) of bilateral carotid arteries and vascular dementia which has resulted in functional decline and lack of oral intake (what does that mean?). Terminal diagnosis is listed as vascular dementia.

Code it…

ICD-10-CM Code	Diagnosis

CVA Answer 2

- Mr. Jacques is referred for Hospice with a new diagnosis of occlusion (no infarct) of bilateral carotid arteries and vascular dementia which has resulted in functional decline and lack of oral intake (what does that mean?). Terminal diagnosis is listed as vascular dementia.
- I65.23 Occlusion and stenosis of bilateral carotid arteries
- F01.50 Vascular Dementia
- R63.3 Feeding difficulties
- R63.0 Anorexia (lack of appetite)

Diabetes with ESRD Scenario

- Mr. Lightwood is admitted to hospice with ESRD and diabetes. He is refusing to continue hemodialysis treatment.

- *Note: the terminal condition is the ESRD*
- *Look up diabetes in index. What does the subentry 'with' mean?*

DM with ESRD Answer

- E11.22 Diabetes with diabetic CKD
- N18.6 ESRD

- What about these?
  - Z91.15 Patient's non-compliance with renal dialysis
  - Z53.29 Procedure/treatment not carried out for other reasons (patient refusal)

Alzheimer's Scenario

- Mrs. Turner is admitted to hospice with terminal dx of Alzheimer's dementia, recent decline with increased confusion, wandering, combativeness, gait/balance problems and is dependent for all ADLs and care. She has stopped eating solid foods, drinks supplements, has lost a lot of weight and BMI is 17.

Code it…

ICD-10-CM Code	Diagnosis

Alzheimer's Answer

- G30.9 Alzheimer's Disease unspec.
- F02.81 Dementia with behavioral disturbance
- R26.9 abnormality of gait
- R63.0 Anorexia
- R63.4 Loss of weight
- Z68.1 BMI less than 19
- Z91.83 Wandering in conditions classified elsewhere

Neuro Scenario 1

Mr. Johnson is admitted after unsuccessful treatment of an extradural intraspinal abscess due to MRSA.

G06.1 Intraspinal Abscess

B95.62 MRSA

Neuro Scenario 2

Christopher Columbus is referred to hospice with a terminal diagnosis of anoxic brain damage following an extended submersion when his sailboat overturned. He is in a persistent vegetative state and expected to live less than 1 month.

G93.1 Anoxic brain damage

V90.04xS Drowning and submersion due to sailboat overturning, sequelae

R40.3 Persistent vegetative state

Neuro Scenario 3

- Patient was hit by a car while riding his scooter down the road sustaining a subdural hemorrhage. He was resuscitated at the scene. He is comatose and his family wants him home to die. The nurse documents eyes open to pain, best verbal response none and best motor response extension. He has a tracheostomy and a G tube feeding that the family will care for.

Code it…

ICD-10-CM Code	Diagnosis

Neuro Answers 3

- S06.5x6S Subdural hemorrhage with loss of consciousness greater than 24 hours without return to pre-existing conscious level
- R40.2124 Coma scale, eyes open, to pain
- R40.2214 Coma scale, best verbal response none
- R40.2324 Coma scale, best motor response extension
- Z93.0 Status tracheostomy
- Z93.1 Status gastrostomy

Rationale

- R40.2 indicates to code the intracranial injury first.
- The coma is a sequela of the head injury, so S is used on the injury.
- Glasgow coma scale scores may be coded based on clinician documentation.
- Status codes for artificial openings

Arthritis Scenario

- Mrs. White admitted to hospice with a terminal dx of Rheumatoid lung disease with rheumatoid arthritis. She is bedfast, curled in fetal position with limbs immobile, dependent for all care and physician verified diagnoses of functional quadriplegia, pharyngo-esophageal dysphagia due to positioning, and a Stage III pressure ulcer on left buttock.

Code it…

ICD-10-CM Code	Diagnosis

Arthritis Answer

- M05.19 Rheumatoid lung disease with R. arthritis of multiple sites
- R53.2 Functional quadriplegia
- R13.14 Pharyngoesophageal dysphagia
- L89.323 Pressure ulcer left buttock stage III
- Z74.01 Bed confinement status

What questions do you have?

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