Your Speaker

Bonny Kohr, RN, CHCE, HCS-D
AHIMA approved ICD-10 trainer
Senior Manager
Marcum LLP
111 S. Pfingsten Road, Suite 300
Deerfield, IL 60015
Direct: (847) 282-6511
Bonny.kohr@marcumllp.com

Marcum is a top national accounting and advisory services firm with 1500 professionals and 29 offices in major business markets throughout the U.S., Grand Cayman and China.
Excerpt FY2016 Final Rule

“based on the numerous comments received in previous rulemaking, and anecdotal reports from hospices, hospice beneficiaries, and non-hospice providers discussed above, we are concerned that hospices may not be conducting a comprehensive assessment nor updating the plan of care as articulated by the CoPs to recognize the conditions that affect an individual’s terminal prognosis.”

Medicare Hospice Coding Requirements

- Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements – Final rule
  - Included clarification related to diagnosis reporting on hospice claims effective October 1, 2015
  - Hospices must report all diagnoses on the hospice claim based on current coding guidelines
  - Hospices must report all diagnoses identified in the initial and comprehensive assessments, whether related or not to the terminal prognosis (including mental health disorders and conditions that would affect the plan of care)
Coding Requirements

- Health Insurance Portability and Accountability Act (HIPAA) requires providers to adhere to the ICD-10-CM Official Guidelines for Coding and Reporting when assigning ICD-10-CM diagnosis codes
- June 5, 2008 Hospice Conditions of Participation final rule stated that the hospice must report all related diagnoses in addition to the primary terminal condition

Coding Requirement Compliance

- 2010 over 77 percent of hospice claims continued to include only one diagnosis
- FY 2013 Hospice wage index notice instructed hospices to report all coexisting diagnoses “related to the terminal illness” (coding guidelines required the reporting of all diagnoses that affect the patient)
  - Additional hospice rules continued to discuss the requirements and importance for diagnosis reporting
Coding Requirement Compliance

- 2014 - 49 percent of hospice claims continued to report only one code
  - CMS analysis of the claims found 50 percent of these patients had, on average, eight or more chronic conditions
  - 75 percent had, on average, five or more chronic conditions

ICD-10-CM PRINCIPAL (Primary) DIAGNOSIS
Definition of Principal (Primary) 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”
- In the case of selection of a principal diagnosis for hospice care, this would mean the diagnosis most contributory to the terminal prognosis of the individual

Trends in Hospice Principal Diagnoses

- Increase in neurologically-based diagnoses from 2002-2007
  - Various dementia diagnoses
  - Increase in use of non-specific, symptom-classified diagnoses (debility and adult failure to thrive)
- By 2007 debility was the first and adult failure to thrive diagnoses was the sixth most common principal diagnoses

During this same period hospice spending increased partly due to an increased length of stay
  - 2000 the average lifetime length of stay was 54 days
  - 2013 the average lifetime length of stay was 98.5 days – a 82% increase
Diagnoses Which May Not Be Principal

- Edits for Hospice diagnoses
- October 2014 debility and adult failure to thrive as a principal diagnosis were returned to provider
- Claim edits were also implemented to eliminate submission of claims were the ICD-9-CM (now ICD-10-CM) codes were not permitted as a principal diagnosis according to coding guidelines

Top 10 Principal Diagnoses

<table>
<thead>
<tr>
<th>Rank</th>
<th>ICD-9 Reported principal diagnosis</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
</table>
| Year: FY 2002
| 1    | 162.9 Lung Cancer                 | 75,760| 11         |
| 2    | 428.0 Congestive Heart Failure    | 45,991| 7          |
| 3    | 789.3 Dehydration Unspecified     | 36,999| 6          |
| 4    | 496.0 COPD                        | 35,197| 5          |
| 5    | 331.0 Alzheimer's Disease         | 28,707| 4          |
| 6    | 436.0 CVA/Stroke                  | 20,262| 3          |
| 7    | 146.0 Prostate Cancer             | 18,304| 3          |
| 8    | 783.7 Adult Failure To Thrive     | 17,812| 3          |
| 9    | 290.0 Senile Dementia, Uncomp.    | 16,999| 3          |
| 10   |                                   |       |            |
| Year: FY 2007
| 1    | 162.9 Lung Cancer                 | 90,150| 9          |
| 2    | 789.3 Dehydration Unspecified     | 85,954| 9          |
| 3    | 428.0 Congestive Heart Failure    | 77,836| 8          |
| 4    | 496.0 COPD                        | 60,816| 6          |
| 5    | 783.7 Adult Failure To Thrive     | 58,303| 6          |
| 6    | 331.0 Alzheimer's Disease         | 37,687| 4          |
| 7    | 290.0 Senile Dementia, Uncomp.    | 31,800| 3          |
| 8    | 436.0 CVA/Stroke                  | 22,170| 2          |
| 9    | 429.9 Heart Disease Unspecified   | 22,098| 2          |
| 10   | 165.0 Prostate Cancer             |       |            |
### Top 10 Principal Diagnoses

#### Year: FY 2013

<table>
<thead>
<tr>
<th>Rank</th>
<th>Code</th>
<th>Diagnosis</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>799.3</td>
<td>Dementia unspecified</td>
<td>127,415</td>
</tr>
<tr>
<td>2</td>
<td>428.0</td>
<td>Congestive Heart Failure</td>
<td>96,171</td>
</tr>
<tr>
<td>3</td>
<td>152.9</td>
<td>Lung Cancer</td>
<td>91,598</td>
</tr>
<tr>
<td>4</td>
<td>486.0</td>
<td>COPD</td>
<td>62,154</td>
</tr>
<tr>
<td>5</td>
<td>331.0</td>
<td>Alzheimer's Disease</td>
<td>76,826</td>
</tr>
<tr>
<td>6</td>
<td>783.7</td>
<td>Adult Failure to Thrive</td>
<td>71,122</td>
</tr>
<tr>
<td>7</td>
<td>550.0</td>
<td>Severe Dementia, uncontrolled</td>
<td>60,579</td>
</tr>
<tr>
<td>8</td>
<td>429.9</td>
<td>Heart Disease Unspecified</td>
<td>56,914</td>
</tr>
<tr>
<td>9</td>
<td>436.0</td>
<td>CVA/Stroke</td>
<td>34,429</td>
</tr>
<tr>
<td>10</td>
<td>204.10</td>
<td>Dementia in Other Diseases w/o Behavioral Dist.</td>
<td>30,563</td>
</tr>
</tbody>
</table>

#### Year: FY 2014

<table>
<thead>
<tr>
<th>Rank</th>
<th>Code</th>
<th>Diagnosis</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>281.0</td>
<td>Alzheimer's disease</td>
<td>129,844</td>
</tr>
<tr>
<td>2</td>
<td>428.0</td>
<td>Congestive Heart Failure</td>
<td>107,540</td>
</tr>
<tr>
<td>3</td>
<td>162.9</td>
<td>Lung Cancer</td>
<td>90,689</td>
</tr>
<tr>
<td>4</td>
<td>498.0</td>
<td>COPD</td>
<td>79,249</td>
</tr>
<tr>
<td>5</td>
<td>699.0</td>
<td>Severe Dementia, uncomplicated</td>
<td>65,269</td>
</tr>
<tr>
<td>6</td>
<td>429.9</td>
<td>Heart Disease Unspecified</td>
<td>37,129</td>
</tr>
<tr>
<td>7</td>
<td>436.0</td>
<td>CVA/Stroke</td>
<td>33,759</td>
</tr>
<tr>
<td>8</td>
<td>204.20</td>
<td>Dementia, uncomplicated, without behavioral disturbance</td>
<td>33,329</td>
</tr>
<tr>
<td>9</td>
<td>332.20</td>
<td>Parkinson's Disease</td>
<td>30,292</td>
</tr>
<tr>
<td>10</td>
<td>153.9</td>
<td>Colon Cancer</td>
<td>23,634</td>
</tr>
</tbody>
</table>

### Diagnoses and Medicare Payment

- All services related to the principal diagnosis must be provided by the hospice
- Medicare payment may be made outside the hospice benefit for conditions that are unrelated to the terminal illness and related conditions (that is, unrelated to the terminal prognosis)
  - Professional claims with GW modifier
  - Institutional claims with 07 condition code
  - Prescription drug events (PDEs) do not require a modifier or condition code
  - Part D plan sponsors have prior authorization requirements on four classes of drugs (analgesics, antinauseants, laxatives and antianxiety)
Concurrent Payments for DME during Hospice Stay, CY2013

<table>
<thead>
<tr>
<th>DMEPOS BETOS category</th>
<th>Total payment for related DME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Beds</td>
<td>5,643,731</td>
</tr>
<tr>
<td>Wheelchairs</td>
<td>2,395,038</td>
</tr>
<tr>
<td>Oxygen and Supplies</td>
<td>2,413,281</td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
<td>4,400,353</td>
</tr>
<tr>
<td>Medical/Surgical Supplies</td>
<td>7,467,616</td>
</tr>
<tr>
<td>Other DME</td>
<td>9,585,003</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27,104,032</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principal diagnosis</th>
<th>Total payment for related DME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart failure</td>
<td>$3,365,348</td>
</tr>
<tr>
<td>Malignant neoplasm of trachea, bronchus, and lung</td>
<td>1,519,514</td>
</tr>
<tr>
<td>Other cerebral degenerations</td>
<td>2,979,939</td>
</tr>
<tr>
<td>Other organic psychotic conditions (chronic)</td>
<td>2,940,146</td>
</tr>
<tr>
<td>Chronic airways obstruction, not elsewhere classified</td>
<td>2,010,629</td>
</tr>
<tr>
<td>Severe and persistent organic psychotic conditions</td>
<td>3,688,760</td>
</tr>
<tr>
<td>Other ARF-defined and ARF-related causes of morbidity</td>
<td>2,209,526</td>
</tr>
<tr>
<td>Acute and ARF-defined cardiovascular disease</td>
<td>2,493,772</td>
</tr>
<tr>
<td>Other diseases of lung</td>
<td>415,507</td>
</tr>
<tr>
<td>Chronic renal failure</td>
<td>415,800</td>
</tr>
<tr>
<td>Symptoms concerning nutrition, metabolism, and development</td>
<td>1,380,685</td>
</tr>
<tr>
<td>Malignant neoplasm of pancreas</td>
<td>207,573</td>
</tr>
<tr>
<td>Malignant neoplasm of female breast</td>
<td>488,919</td>
</tr>
<tr>
<td>Malignant neoplasm of colon</td>
<td>521,690</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>950,990</td>
</tr>
<tr>
<td>Malignant neoplasm of prostate</td>
<td>312,754</td>
</tr>
<tr>
<td>Late effects of cardiovascular disease</td>
<td>559,259</td>
</tr>
<tr>
<td>Other forms of chronic ischemic heart disease</td>
<td>676,847</td>
</tr>
<tr>
<td>Malignant neoplasm of liver and intrathoracic bile ducts</td>
<td>170,470</td>
</tr>
</tbody>
</table>

Concurrent Payments for Part D drugs potentially related to Hospice Stay, Top Four Principal Diagnoses CY2013

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral Degeneration</td>
<td>$10.3 million</td>
</tr>
<tr>
<td>COPD</td>
<td>$8.6 million</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>$3.8 million</td>
</tr>
<tr>
<td>Malignant Neoplasm, Trachea, Bronchus and Lung</td>
<td>$2.1 million</td>
</tr>
</tbody>
</table>
CMS Concurrent Payment Case Study
CHF as Principal Diagnosis

Table 10—Concurrent Payments for Services Provided to Hospice Beneficiaries With Congestive Health Failure, CY 2013

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Description</th>
<th>Total payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs/Part D</td>
<td>Common Palliative Drugs</td>
<td>$1,229,748</td>
</tr>
<tr>
<td>Drugs/Part D</td>
<td>Diuretics</td>
<td>$33,760</td>
</tr>
<tr>
<td>Drugs/Part D</td>
<td>Beta Blockers</td>
<td>$383,480</td>
</tr>
<tr>
<td>Drugs/Part D</td>
<td>Anti-hypertensives</td>
<td>$584,799</td>
</tr>
<tr>
<td>Drugs/Part D</td>
<td>Anti-inflammatory Agents</td>
<td>$468,533</td>
</tr>
<tr>
<td>Drugs/Part D</td>
<td>Cardiovascular Agents—Misc</td>
<td>$799,695</td>
</tr>
<tr>
<td>Drugs/Part D</td>
<td>Vasopressors</td>
<td>$43,696</td>
</tr>
<tr>
<td>DME</td>
<td>Oxygen Equipment and Supplies</td>
<td>$471,276</td>
</tr>
<tr>
<td>DME</td>
<td>Hospital Beds</td>
<td>$96,219</td>
</tr>
<tr>
<td>DME</td>
<td>Wheelchairs</td>
<td>$275,040</td>
</tr>
<tr>
<td>Part B Inst</td>
<td>Diagnostic Imaging</td>
<td>$690,720</td>
</tr>
<tr>
<td>Part B Inst</td>
<td>EKG</td>
<td>$72,000</td>
</tr>
<tr>
<td>Part B Inst</td>
<td>Cardiac Devices</td>
<td>$242,919</td>
</tr>
<tr>
<td>Part B Inst</td>
<td>Diagnostic Clinical Labs</td>
<td>$79,899</td>
</tr>
<tr>
<td>Part B Inst</td>
<td>Diagnostic Clinical Labs</td>
<td>$54,696</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$5,818,071</td>
</tr>
</tbody>
</table>

“Services that are potentially related to this condition”
$3.8 million in drugs
$1.2 million in Part B institutional settings
$843,534 in DME

Other Diagnoses Definition

- All conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay
- All diagnoses affecting the management and treatment of the individual within the healthcare setting are required to be reported
Diagnoses: Impact on Certification, NOE, Care Plan and Payment

Principal Diagnosis and the CTI

- To reach a decision of terminal illness the medical director (in consult with the attending) must consider
  - The diagnosis of the terminal condition (not the diagnosis code)
  - Other health conditions/diagnoses
  - Clinically relevant information supporting the diagnoses
  - The physician is not required to provide diagnoses code(s)
- Avoid principal diagnoses which contradict the CTI
- Avoid diagnoses which do not support the terminal condition
Principal Diagnosis and the NOE

- The NOE must contain HIPAA approved codes
  - Full diagnoses codes including all applicable digits
  - The principal diagnosis listed is the condition most contributory to the terminal prognosis
  - Do not report principal diagnosis codes that are non-reportable – they will be returned to the provider (RTP)
    - Z codes
    - Unspecified codes
    - Diagnosis codes prohibited by ICD-10-CM coding guidelines and conventions as principal diagnosis

*See attachment: Hospice Invalid Principal Diagnosis*

Other Diagnosis

- Help to support the terminal prognosis
- Include all conditions which may impact the palliative care of the patient’s terminal condition
Provision of Service to Support the Diagnoses or Diagnoses to Support the Services Provided?

- IDG based on the comprehensive assessment(s) should assist the medical director in updating which conditions are contributing to the patient’s deteriorating status
- Care plan development must be based on the hospice patient’s/caregiver’s assessed needs
- Services must be related to the terminal condition

Updating Diagnoses and the Plan of Care

- Most hospice patients don’t get better
- Condition worsens
- New symptoms
- Exacerbation of conditions
- Clinical care documentation supports what was done for the patient – don’t be afraid to add diagnoses to support the further deterioration
### Palmetto GBA Hospice Top Denial Reasons
TOB 81X

<table>
<thead>
<tr>
<th>Rank</th>
<th>Denial Code</th>
<th>Denial Code Description</th>
<th>Count of Claims Denied</th>
<th>Percent of Claims Denied to total claims denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SCF36</td>
<td>Not Hospice Appropriate</td>
<td>79</td>
<td>24.5</td>
</tr>
<tr>
<td>2</td>
<td>SCFN1</td>
<td>No Plan of Care Submitted</td>
<td>52</td>
<td>16.1</td>
</tr>
<tr>
<td>3</td>
<td>S6900</td>
<td>Auto Denial - Requested Records not Submitted</td>
<td>51</td>
<td>15.8</td>
</tr>
<tr>
<td>4</td>
<td>SCNOE</td>
<td>No Valid Election Statement Submitted</td>
<td>41</td>
<td>12.7</td>
</tr>
<tr>
<td>5</td>
<td>SCF01</td>
<td>General Inpatient Services Not Reasonable and Necessary _ Beneficiary Liable</td>
<td>29</td>
<td>9</td>
</tr>
<tr>
<td>5</td>
<td>S5503</td>
<td>LCD Denial - no medical necessity</td>
<td>29</td>
<td>9.0</td>
</tr>
<tr>
<td>6</td>
<td>SCFH9</td>
<td>Physician Narrative Statement Not Present or Not Valid</td>
<td>11</td>
<td>3.4</td>
</tr>
<tr>
<td>7</td>
<td>SCFH6</td>
<td>Initial Certification Not Timely</td>
<td>8</td>
<td>2.5</td>
</tr>
<tr>
<td>8</td>
<td>SCFH2</td>
<td>No Certification Present</td>
<td>6</td>
<td>1.9</td>
</tr>
<tr>
<td>9</td>
<td>SCFTF</td>
<td>Face to Face Encounter Requirements Not Met</td>
<td>5</td>
<td>1.5</td>
</tr>
</tbody>
</table>

### Palmetto GBA Hospice Top Denial Reasons
TOB 82X (hospital based)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Denial Code</th>
<th>Denial Code Description</th>
<th>Count of Claims Denied</th>
<th>Percent of Claims Denied to total claims denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SCFN1</td>
<td>No Plan of Care Submitted</td>
<td>5</td>
<td>38.5</td>
</tr>
<tr>
<td>2</td>
<td>S6900</td>
<td>Auto Denial - Requested Records not Submitted</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>3</td>
<td>SCF36</td>
<td>Not Hospice Appropriate</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>4</td>
<td>SCFH6</td>
<td>Initial Certification Not Timely</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>5</td>
<td>SCFH2</td>
<td>No Certification Present</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>5</td>
<td>SCNOE</td>
<td>No Valid Election Statement Submitted</td>
<td>1</td>
<td>7.7</td>
</tr>
</tbody>
</table>
ICD-10-CM Official Guidelines for Coding and Reporting

- CMS and the National Center for Health Statistics (NCHS) provide guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
- Set of rules to be used along with the official conventions and instructions found within the ICD-10-CM (code books, encoders etc.)
  - Rules are approved by four organizations: American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS
  - The AHA coding clinic is the “official” coding advice. They work with NCHS and CMS to provide guidance on questions related to coding in the U.S.
2016 ICD-10-CM Official Guidelines for Coding and Reporting

- Located in the front of every published code book
- Included as part of encoder software
- Free for download at http://www.cdc.gov/nchs/icd/icd10cm.htm

Reasons Why Claims Are RTP’d

- Failure to follow Official Guidelines for Coding and Reporting
  - Code edit for manifestation codes listed as principal
  - Examples of manifestation codes:

<table>
<thead>
<tr>
<th>Manifestation</th>
<th>Manifestation Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F0280</td>
<td>Dementia in other diseases classified elsewhere, without behavioral disturbance</td>
</tr>
<tr>
<td>M381</td>
<td>Arthropathy in neoplastic disease</td>
</tr>
<tr>
<td>M01x8</td>
<td>Direct infection of vertebrae in infectious and parasitic diseases classified elsewhere</td>
</tr>
<tr>
<td>M9989</td>
<td>Osteopathy in diseases classified elsewhere, multiple sites</td>
</tr>
</tbody>
</table>
Official Guidelines Conventions

- Explain that all characters must be assigned for the code to be a valid code - codes may have 3-7 characters
- Explain the use of placeholder character X - to allow for further expansion of codes (new with ICD-10-CM)
- Explain the use of Episode of care - seventh character codes (new with ICD-10-CM)

Official Guidelines Conventions

- Explain abbreviations, punctuation and specific terms used throughout the code book
  - Ex: NOS, NEC, “and”, “with”, “see”, “see also”, “code also”
- Provide etiology and manifestation conventions
  - “code first”, “use additional code” and “in diseases classified elsewhere”
- Explain Inclusion terms and Exclusion Notes (“Excludes 2” notes new with ICD-10-CM)
**Excludes 1 Notes - Updated Coding Advice**

- "Question: We have received several questions regarding the interpretation of Excludes 1 notes in ICD-10-CM when the conditions are unrelated to one another. How should this be handled?
  - Answer: If the two conditions are not related to one another, it is permissible to report both codes despite the presence of an Excludes 1 note.

- For example, the Excludes 1 note at code range R40-R46, states that symptoms and signs constituting part of a pattern of mental disorder (F01-F99) cannot be assigned with the R40-R46 codes. However, if dizziness (R42) is not a component of the mental health condition (e.g., dizziness is unrelated to bipolar disorder), then separate codes may be assigned for both dizziness and the mental health condition.

- In another example, code range I60-I69 (Cerebrovascular Diseases) has an Excludes 1 note for traumatic intracranial hemorrhage (S06.-). Codes in I60-I69 should not be used for a diagnosis of traumatic intracranial hemorrhage. However, if the patient has both a current traumatic intracranial hemorrhage and sequela from a previous stroke, then it would be appropriate to assign both a code from S06- and I69-.

---

**NOS versus NEC Discussion**

- NOS = Unspecified and NEC = Other Specified
  - NEC: Senile degeneration of brain, not elsewhere classified = G31.1 = the patient’s diagnosed condition does not have a code to assign
  - NOS: Dementia NOS = F03.90 = I don’t know

- Must obtain as much information as possible, however some codes will still have NOS as part of the description: ex: I11.9 = Hypertensive Heart Disease without heart failure OR Hypertensive heart disease NOS
General Coding Guidelines

- How to find a code
- Use of signs and symptoms codes
- Multiple coding for a single condition
- Acute and chronic conditions
- Combination codes
- Sequela
- Laterality (new with ICD-10)
- BMI, non-pressure chronic and pressure ulcer documentation
- Complications of care
- Borderline diagnosis

Chapter Specific Coding Guidelines

- Most chapters have additional guidelines for specific diagnoses - Examples:
  - Dementia in diseases classified elsewhere
    - Codes may never be a principal diagnosis
    - They must be listed after the underlying condition code
  - HIV
    - Patients admitted with unrelated conditions (ex: trauma), the code for the trauma must be coded first
    - Patients admitted to treat the HIV-related condition (ex: Pneumocystis Carinii Pneumonia), the principal diagnosis should be B20 HIV followed by the related condition
  - Acute MI (STEMI and NSTEMI)
    - Unspecified MI defaults to STEMI of unspecified site I21.3
    - Acute defined as 28 days or less from onset
Use ICD-10-CM Official Guidelines for Coding and Reporting to Make Decisions

- When unsure look to guidelines and conventions
- Some assumptions in relationships to other conditions may be made
  - Hypertension and Chronic Kidney Disease
    - I12 Hypertensive chronic kidney disease
    - Use an additional code for the stage of chronic kidney disease (N18.5, N18.6)
  - Osteoporosis and Fractures
    - M80.0- Osteoporosis with current pathological fracture
  - Atherosclerotic heart disease with angina
    - I25.11 native artery or I25.7 bypass graft or transplanted heart

Chapter Specific Coding Guidelines Example
Chapter 10: Diseases of the Respiratory System

- Chronic Obstructive Pulmonary Disease [COPD] and Asthma
  1) Acute exacerbation of chronic obstructive bronchitis and asthma

  “The codes in categories J44 and J45 distinguish between uncomplicated cases and those in acute exacerbation. 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.”
New Concepts in ICD -10- CM Bring New Challenges

- Diabetic combination codes (type, body system affected and complications affecting the body system)
- Laterality
- Encounter of Care
- Status codes for fractures

Diabetic Combination Codes

- Diabetic Type
  - E08 Diabetes due to underlying condition
  - E09 Due to drug/chemical
  - E10 Type I
  - E11 Type II
  - E13 Other specified Diabetes
- Body System Affected
  - Kidney, ophthalmic, neurological, etc.
- Complications
  - Diabetic nephropathy
  - Proliferative diabetic neuropathy with macular edema
  - Diabetic neuropathy, etc.
Laterality

- Laterality concerns include misidentification of the side effected, identification of dominance
- Right and left should not be coded separately if a bilateral code is present ("1" usually represents right and "2" represents right)
- Right and left should both be coded when a bilateral code is not present and the condition is present on both sides

Laterality

- Caution with site and “unspecified” codes
  - L89.203 Pressure ulcer of unspecified hip, stage 3 does not mean the ulcer is unspecified or unstageable
  - L89.219 Pressure ulcer right hip, unspecified stage
  - L89.210 Pressure ulcer right hip, unstageable
  - L89.893 Pressure ulcer of other site, stage 3
Encounter of Care

- Many categories have a seventh character which describes the encounter of care for the condition. This is why post acute care providers can now code fractures and injuries.
- Guidelines have changed during post implementation.
- We need to understand when to assign each.
- We must not rely on the previous provider’s code assignments.

Describing the Encounter of Care

- **A = Initial Encounter**
  - Acute phase
  - Surgical intervention
  - ED encounter
  - Initial evaluation and continuing treatment by the same or a different physician
  - Active treatment of the condition

- **D = Subsequent Encounter**
  - Acute phase
  - After initial treatment
  - Used for routine care during healing or recovery phase

- **S = Sequela**
  - Care of a residual effect or condition arising after the acute phase
When Can Hospice Use the Seventh Character A?

- Physician determines whether the patient is receiving active treatment for the condition or ongoing care for the condition
- Initial encounter of care may continue for certain complication and injury categories for example:
  - Complication codes such as surgical wound infections or dehiscence
  - Some injury codes such as puncture wounds and lacerations
  - Burns and corrosion wounds
- Not to be used with fracture codes

Examples of Appropriate Seventh Character “A” Assignment in Hospice

- Patient with deep right lower quadrant stab wound of abdomen. Treated in hospital with wound Vac® and discharged with hospice and continue wound Vac® care
  - Assign code S31.613A Laceration without foreign body of abdominal wall right lower quadrant, with penetration into the peritoneal cavity, initial encounter
- Patient discharged with hospice to manage ongoing antibiotic treatment and wound care of a dehisced surgical wound
  - Assign T81.31xA Dehiscence of a surgical wound
Examples of Inappropriate Seventh Character “A” Assignment in Hospice

- The patient is admitted to hospice with dressing changes and care for a healing postoperative wound infection that was treated during an acute care hospitalization. The patient is no longer receiving antibiotics for the infection. What is the appropriate 7th character for the wound infection code?
  - Assign code T81.4xxD, Infection following a procedure, subsequent encounter-the 7th character is "D" because the patient is no longer receiving active treatment of the infection and is receiving routine care during the healing and recovery phase

Seventh Character Status

- The seventh character may also represent a status
- Encounter of Care plus Status example:
  - M80.051D, Age-related osteoporosis with current pathological fracture, right femur, subsequent encounter with routine healing
    - D indicates subsequent encounter with routine healing
  - S52.132H, Displaced fracture of neck of left radius, subsequent encounter for open fracture Type I or II with delayed healing
    - H indicates type of fracture, subsequent encounter and delayed healing
Pathological or Stress Fracture Seventh Characters

A – Initial encounter

D – Subsequent, routine healing

G – Subsequent, delayed healing

K – Subsequent, nonunion

P – Subsequent, malunion

S – Sequela

Acute/Traumatic Fractures
Fractures – Seventh Character

A – Initial closed

B – Initial open

D – Subsequent routine

G – Subsequent delayed

K – Subsequent nonunion

P – Subsequent malunion

S – Sequela
### Open Fractures – Seventh Character

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial closed</td>
<td>Initial open, Type I or II</td>
<td>Initial open, Type IIIA, IIIB, IIIC</td>
<td>Subsequent, closed, routine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent, open, Type I or II, routine</td>
<td>Subsequent, open, Type IIIA, IIIB, IIIC, routine</td>
<td>Subsequent, closed, delayed</td>
<td>Subsequent, open, Type I or II, delayed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>J</th>
<th>K</th>
<th>M</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent, open, Type IIIA, IIIB, IIIC, delayed</td>
<td>Subsequent, closed nonunion</td>
<td>Subsequent, open, Type I or II, nonunion</td>
<td>Subsequent, open, Type IIIA, IIB or IIIC, nonunion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>P</th>
<th>Q</th>
<th>R</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent, closed, malunion</td>
<td>Subsequent, open, Type I or II, malunion</td>
<td>Subsequent, open, Type IIIA, IIB or IIIC, malunion</td>
<td>Sequela</td>
</tr>
</tbody>
</table>

### Neoplasm Guidelines
Unknown Primary and Secondary Neoplasm

- Advanced metastatic disease with unknown primary and secondary sites has its own code C80.0 – Disseminated malignant neoplasm, unspecified
- This should not be used due to lack of documented primary and/or secondary site
- This should be used when the physician is unable to specify the primary or secondary site

Anemia

- Anemia associated with malignancy
  - Management of anemia associated with malignancy – the appropriate code for the malignancy is sequenced as the principal diagnosis followed by the anemia code (D63.0)
  - Anemia associated with chemotherapy, immunotherapy and radiation therapy, admission for the management of the anemia
    - Adverse effect of chemo or immunotherapy, the anemia code is sequenced first followed by the neoplasm and the adverse effect (T45.1X5)
    - Adverse effect of the radiotherapy, code the anemia, followed by the neoplasm code and code Y84.2, Radiological procedure and radiotherapy as the cause
Dehydration Due to Neoplasm

- Guidelines indicate that when the admission is for management of dehydration due to malignancy and ONLY the dehydration is being treated (IV rehydration), the dehydration is sequenced first followed by the malignancy
- Hospice does NOT treat only the dehydration

Pathological Fracture due to Neoplasm

- Guidelines indicate that when the focus of treatment is for the fracture a code from M84.5, Pathological fracture in neoplastic disease, should be sequenced first followed by the code for the neoplasm
- Hospice focus of treatment and reason for the patient’s terminal condition would NOT be the fracture, the neoplasm would be
- The neoplasm should be sequenced first, followed by the associated pathological fracture
Current Malignancy Versus History

- When the primary malignancy is excised but the patient continues treatment, code the primary malignancy as current
- When the primary malignancy is excised and the patient is no longer receiving treatment of the malignancy (no evidence of the malignancy), personal history should be used
- When coding a secondary malignancy a primary malignancy must also be coded (either current or history)

Heart Failure Guidelines
Heart Disease

- Heart disease and hypertension
  - Should be coded separately UNLESS the physician links them ex: “due to” “with” “hypertensive”
  - Conditions that are linked must be coded to I11.9
    - Hypertensive heart disease without heart failure or I11.0
    - Hypertensive heart disease with heart failure
      - Use an additional code for the type of heart failure I50.-

- What if the note indicated that the patient had CHF with hypertension and chronic kidney disease?
  - The physician linked the heart disease and hypertension
  - We can assume the relationship to the chronic kidney disease
  - We would assign a combination code for Hypertensive heart and chronic kidney disease I13.-
    - Use an additional code for the type of heart failure I50.-
    - Use an additional code for the stage of the chronic kidney disease (N18.5, N18.6)
Symptoms, Signs, and Ill-defined Conditions

- Should be avoided as principal diagnosis, these are the codes from chapter 18 that begin with an “R”
- Should be used when a diagnosis has not been established
- Should not be used when associated with the disease process of a diagnosis already established
- May be used in addition to a diagnosis if the symptom is not routinely associated with the diagnosis
  - The definitive diagnosis should be sequenced first
Coding Pain

- Neoplasm Related Pain Code G89.3
  - Pain documented as related to the cancer
  - Pain can be acute or chronic
  - Coding guidelines indicate that the code may be the principal code when the reason for the admission is control of the pain, the neoplasm would be coded as an additional diagnosis
    - In hospice part of the care is to control the pain, the reason for the admission is the terminal diagnosis

Uncertain Diagnosis

- Diagnosis documented at the time of discharge = “probable”, “suspected”, “likely”, “questionable”, “possible” or “still to be ruled out” etc.
  - May be coded as if the condition was established ONLY for inpatient admissions to short-term, acute long-term care and psychiatric hospitals
  - Hospice does not fall into this category
  - Rather, code the condition(s) to the highest degree of certainty such as symptoms, signs, abnormal test results, or other reason for the visit
  - If the physician documents “evidence of” a condition, it is not considered an uncertain diagnosis and should be coded in the outpatient setting
The following documentation is from the health record of an 85-year-old female patient.

**Discharge Summary:** This 85-year-old female patient was noted to have three to four falls in the past two months at ABC Nursing Home. Patient fell yesterday from her parked wheelchair and hit the left frontal temporal area of her head causing a contusion. For this reason, the patient was brought to the hospital for observation and further workup. The patient’s exam was remarkable for moderate ataxia. Past medical history includes senile dementia – Alzheimer’s, late onset type, depression and emphysema. Current medications include Zoloft and Theophylline. CT scan of the brain noted that the patient had multiple masses in the brain due to metastatic disease. It was felt that the patient’s ataxia was most likely due to the metastatic disease of the brain. These results were discussed with the patient’s family. After much discussion regarding the treatment options, the family decided that they did not want the patient to undergo further tests and/or evaluation. It was the family’s decision that the patient be transferred back to the nursing home and put under hospice care.
Case 1

- What is the most likely the principal diagnosis?
- When coding the Neoplasms which one should be listed first?
- Can we code the emphysema without further information?

- C79.31 Secondary malignant neoplasm brain
- C80.1 Primary malignant neoplasm, unspecified
- G30.1 Alzheimer’s, late onset
- F02.80 Dementia in diseases classified elsewhere without behavioral disturbance
- F32.9 Depression NOS
- J43.9 Emphysema NOS
- S00.83XD Contusion head other specified part
- W05.0XXD Fall (accidental) from, off, out of, wheelchair (OPTIONAL)
Coding Case 2
From a discharge summary written by an internal medicine physician.

The patient was admitted for dizziness and a vague feeling of epigastric discomfort. She has a history of duodenal carcinoma which was resected two years ago. The patient underwent chemo and has been in relatively good health over the last year until recently when she took a rapid decline. She no longer has evidence of an existing primary duodenal malignancy. During her hospitalization, she underwent a GI workup to evaluate her current issues. An abdominal ultrasound showed a large liver mass. Oncology was consulted. The mass was further evaluated by needle biopsy and found to be metastatic carcinoma. After lengthy consultation with me and the oncologist, the patient and family wish the patient to be a “Do Not Resuscitate” with no further workup and comfort care only. The patient was transferred from my service on the telemetry unit to the hospice program for ongoing palliative care.

Case 2

- Medical Director confirms that the cancer is the primary reason for the patient’s terminal condition
- Would the primary malignancy be the principal diagnosis be listed first?
- What else should be coded?
Case 2

- C78.7 Secondary malignant neoplasm of liver
- Z85.068 Personal history of small intestine
- Z51.5 Palliative care
- Z66 Do Not Resuscitate (DNR)
- Z90.49 Acquired absence of other parts of digestive tract
- Z92.21 Personal history of antineoplastic chemotherapy

Coding Case 3

Patient was discharged to hospice immediately following a hospital stay for IV antibiotics for MRSA Pneumonia and a newly diagnosed pathological fracture. She also has Hypertension with Hypertensive Heart Disease and COPD with chronic obstructive bronchitis and is oxygen dependent. Patient was discharged with a new inhaler and the antibiotics were discontinued prior to hospital discharge. The H&P also included notes indicating that the patient needed supervision prior to this hospitalization due to memory loss.
Case 3

- What might be the primary reason for hospice care?
- From a coding perspective would Pneumonia be one of the diagnoses?
- Possibilities include:
  - COPD
  - Hypertension
  - Heart Disease
  - Pathological fracture
  - Dementia

Principal Diagnosis

- Medical Director determines the condition which is contributing to the terminal prognosis as COPD
- The patient had COPD with a lower respiratory infection however this does not mean that it is COPD with (acute) exacerbation (J44.1)
  - And the patient no longer has a lower respiratory infection
- Principal Diagnosis = J44.9 COPD (includes chronic obstructive bronchitis OR with further clarification it may be J44.0 Decompensated or Acute COPD
Other Diagnoses?

- Hypertension is not essential hypertension it should be coded to Hypertensive heart disease
- The fracture was pathological and would require further information to identify the pathology
- The memory issues would need further information to identify type of dementia

Other Diagnoses

- M80.08XD Age related osteoporosis with current pathological fracture of vertebra(e), subsequent care w routine healing*
- I11.9 Hypertensive heart disease, NOS (or w/o heart failure)

*Based on a query to the physician to determine cause of pathological fracture.
Other Diagnoses

- I67.2 Cerebral atherosclerosis*
- F01.50 Vascular dementia, without behavioral problems*
- Z99.81 Oxygen dependence
- Z87.01 Personal History of Pneumonia
- Z51.5 Palliative care
- Z66 Status (post), Do Not Resuscitate (DNR)

*Based on a query to the physician to determine cause of memory loss. For Vascular dementia (the underlying condition should be coded first). If diagnosis is unknown may use R41.81 Age-related cognitive decline (Senility NOS)
Disclaimer

This Presentation has been prepared for informational purposes only from sources believed accurate and reliable as of the date of preparation. It is intended to inform the reader about the subject matter addressed. This is not to be used or interpreted as tax or professional advice.

Those seeking such advice should contact a Marcum professional to establish a client relationship.