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EDUCATIONAL RESOURCES

HOSPICE

HOSPICE CODING UPDATES:

ICD-10 CM Code Updates Effective October 1, 2019

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OBJECTIVES

Terminal Diagnosis Coding Issues

Coding Guidelines Specific to Hospice

October Changes to ICD 10

2016 Hospice Wage Index states to code ALL unresolved diagnoses on a hospice patient's claim, not just those related to the terminal diagnosis.

The Index stated the importance of a comprehensive approach to the hospice patient's care.

You should code ***all*** diagnoses related to the terminal diagnosis and ***all*** diagnoses that are not related to the terminal diagnosis.

This coding could help support the terminal condition of the patient.

HOSPICE CODING

- The Medical Director and the clinician decide on and document the primary terminal diagnosis and the secondary diagnoses before the assessment goes to the coder.

- Many software systems require the related diagnoses be entered prior to the unrelated diagnoses, so it is helpful if the diagnoses are listed in that order for the coder. It could also save time in having to go back and re-sequence the codes.

HOSPICE MUST FOLLOW ALL CODING RULES

- The primary and all other diagnoses must be as specific as possible.
  - **Example:** Unspecified cerebrovascular disease is not a preferred code. You need to query the physician, the Medical Director, and the Interdisciplinary Group (IDG) to get a more specific code, if possible.
- If the patient has more than one chronic diagnosis or symptomatic condition that, when combined, lead to the patient having a life expectancy of six months or less, the Interdisciplinary Group (IDG) makes a clinical decision on which is the most contributory to the terminal prognosis.
- If the clinician/Medial Director states ESRD is the primary terminal diagnosis and the patient has HTN, the HTN in CKD is coded following coding guidelines. HTN must be coded prior to CKD. In this case the ESRD is the terminal diagnosis, the HTN is the primary diagnosis, and coded I12.0 followed by N18.6.

SPECIFIC PATIENT INFORMATION UPON REFERRAL

- Getting specific information and diagnoses in the referral information is especially important for coding.
- Resources can include:
  - H&P, consultation reports, Face to Face, discharge summaries from physicians.
- Intake staff need to work closely with referral sources to get complete information at referral.
- Request documents that will give physician-confirmed information and diagnoses.
- Look for underlying disease processes:
  - e.g., is vascular dementia the sequela of CVA with cognitive residuals?

PHYSICIAN CONFIRMATION OF DIAGNOSIS

- All diagnoses on the plan of care must be documented in the medical record by the physician.
- If the diagnoses are not documented by the physician, the agency must confirm the diagnoses with the physician and document that the diagnoses were confirmed.
- Diagnoses are not coded based solely on the clinician documentation, medications, treatments, or patient/caregiver report.

CODING BASED ON CLINICIAN DOCUMENTATION

- There are only three items that can be coded based on the clinician's assessment and documentation:
  1. BMI
  2. Stage of pressure injury
  3. Depth of tissue damage in a non-pressure chronic ulcer

BODY MASS INDEX (BMI)

- Hospice patients should have a BMI documented by the clinician at SOC and recertification, at minimum.
- BMI should be coded at SOC and recertification.
- This code supports the decline of the patient over time.
- The physician does not have to confirm the BMI.

CHALLENGES IN ASSESSMENT & CODING OF WOUND TYPES

- Lack of information regarding wound types and incomplete wound assessments are among the most common problems seen by coders.
  - The wound type should be confirmed in the physician's documentation, referral information, or wound clinic documentation.
  - If the wound type is not documented by the physician, this should be clarified with the physician and documented.
- Teach clinicians to document the appearance of a wound using terms in the code.
- Wound documentation should always include specific information such as site-laterality, part of the extremity, depth, and stage if pressure injury.

WOUND TYPES

- Diabetic, Arterial, Venous are all Non-Pressure Ulcers
  - Document the severity using terms as seen the code description for coding efficiency and accuracy.
- Pressure Injury
  - Always document stage of the wound.
  - Stay current with updates from WOCN and NPUAP.
- Trauma wounds
  - Open wounds from laceration, abrasion, puncture, burn etc.
  - Skin tears are generally coded as lacerations.
- Surgical wounds
  - Is the surgical wound routine aftercare or is there a complication?
- Superficial injuries
  - Contusions and abrasions are generally not coded, especially if they are associated with a more severe injury at the same site.

CODING TRAUMA WOUNDS

- There are no new trauma wound codes added to ICD-10-CM for 10/01/2019.
  - There were many more specific codes for trauma injuries added last year.
- Active treatment is coded with the Seventh Character "A" for a wound that is being treated with antibiotics (IV or oral) or a wound vac.
  - Continue to code with the seventh character of "A" as long as these treatments are used.
- The Seventh Character "D" is used when the complication or injury has moved on to the healing phase.

ICD-10-CM CODING GUIDELINES

- ICD-10-CM Coding Guidelines require reporting the diagnosis coding on your hospice claim.
- Hospice providers may not report diagnosis codes that cannot be used as the principal diagnosis, according to ICD-10-CM Coding Guidelines.
  - Some codes require further compliance with various ICD-10-CM coding conventions, such as those that have principal diagnosis code sequencing or etiology/manifestation guidelines.

ICD-10-CM CODING GUIDELINES

- The principal diagnosis reported on the claim should be the diagnosis most contributory to the terminal prognosis and cannot be a symptom code (Code from Chapter 19).
- According to the ICD9CM/ICD-10-CM Coding Guidelines, both "debility" and "adult failure to thrive" are considered nonspecific, symptom diagnoses.
  - Specifically, you should not use ICD-10-CM code R53.81 (Other malaise) and CM10-CM code R62.7 (adult failure to thrive) as principal hospice diagnoses on a hospice claim form.
  - If these diagnoses are reported as a principal diagnosis, the claim will be returned to the provider for a more definitive hospice diagnosis.

PRINCIPAL DIAGNOSIS

- The principal diagnosis is defined as the condition established to be mainly responsible for the patient's admission to hospice and the diagnosis most contributory to the patient having a life expectancy of six months or less if the illness runs its normal course

HOSPICE ITEM SET (HIS)

- The Hospice Item Set (HIS) is intended for use in quality reporting.
  - The HIS does not imply acceptability for payment purposes.
- The HIS is not intended to be a complete patient assessment, just as OASIS items alone are not a complete assessment for home health.

HOSPICE ITEM SET (HIS)

- Section 1 of the Hospice Item Set (HIS) has only one item, the Active Diagnosis.
  - I0010 must be based only on the clinical record.
    - Response 01-Cancer
      - Select response 01 if the patient's principal diagnosis is cancer (including leukemia).
    - Response 02-Dementia/Alzheimer's
      - Select response 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).
    - Response 99-None of the above
      - Select response 99 if the patient's principal diagnosis is a disease or condition other than cancer or dementia/Alzheimer's.

DEMENTIA CODING

- Follow the coding guidelines for manifestation/etiology for all coding, especially when coding dementia,
- There are several dementia codes that cannot be used as a principal diagnosis, and have additional compliance issues with various coding conventions, such as using an unspecified code or sequencing guidelines,
- Dementia codes are mostly found in the "Mental, Behavioral, and Neurodevelopmental Disorders" chapter, and are usually manifestations from an underlying physiological condition.
  - Manifestation codes require sequencing of the etiology code first.
  - Code the underlying condition as the principal diagnosis, and the dementia itself would be coded as a secondary diagnosis.

COMORBIDITY CODING

- It is important to code comorbidities to support the patient's life expectancy of six months or less.
  - Although not the primary hospice diagnosis, the presence of comorbid diseases, the severity of which are likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility.
- Common diagnoses
  - Chronic obstructive pulmonary disease
  - Congestive heart failure
  - Ischemic heart disease
  - Diabetes mellitus
  - Neurologic disease (CVA, ALS, MS, Parkinson's)
  - Renal failure
  - Liver Disease
  - Neoplasia
  - Acquired immune deficiency syndrome
  - Dementia

CLINICIAN ASSESSMENT & DOCUMENTATION

- Clinicians need to thoroughly assess and clearly document detailed information about the patient's status.
- The clinician should keep in mind what the coder will be looking for to provide the most accurate coding.
- If the clinician is unsure about a diagnosis, or knows the diagnosis is not specific, they need to contact the physician for clarification prior to sending to coding.
  - Example: wound types, stasis ulcers vs. arterial ulcers vs. diabetic ulcers vs. pressure ulcers.
  - The coder cannot decide the etiology of the wound.
- It is a good practice to contact the physician's office after the initial visit and confirm diagnoses while giving report.

CODING GUIDELINES

- Coding guidelines are at each code set and must be followed.
  - Do not code from memory or rely on codes used in the reviewed documentation.
- Always look up the code in the Alpha index and go to the Tabular index to verify the code is the one you need.
- Always look for Excludes 1 or Excludes 2 notes and sequencing requirements for Code first and Use additional code instruction.
- Always use as many characters as needed to complete your code. Some codes are complete with three characters and others require up to seven characters. Be sure your code is complete and as specific as possible.

MEDICARE ADMINISTRATIVE CONTRACTOR (MAC)

- Use the Local Coverage Determinations (LCD) reference for your Medicare Administrative Contractor (MAC) to verify the code used is an allowed code if you are not sure.
- Each MAC publishes the Local Coverage Determination on its website.
- You can find a list of allowed codes as well as codes that are not allowed by your MAC on the site.

CODING SPECIFICS

- Hemiplegia
  - Guidance instructs us to code right or left and dominant or nondominant.
    - The assessing clinician should document this if known.
    - If dominant or nondominant cannot be determined, guidance tells us right or ambidextrous is dominant as a default.

CODING SPECIFICS

- Laterality
  - Laterality should always be documented and should never be unspecified.
  - Laterality is apparent during the clinician's assessment.
- Bilateral Conditions
  - If a condition is bilateral but the focus of care is on one side, code the bilateral condition.
    - Example: M17.0 - Primary OA of the knee- bilateral.
  - Some conditions do not include a bilateral code and if the condition is present bilaterally you will need to use two codes.
    - Primary OA of the shoulder doesn't have a bilateral code and if the condition is bilateral you would need both codes.

    M19.011 Primary OA of right shoulder and M19.012 Primary OA of left shoulder
- There an unspecified shoulder code M19.019 - YOU SHOULD NEVER USE!

SEQUELA CODING

- A sequela is a condition that is a result of a condition or injury that is now resolved.
  - For example, a contracture related to scar tissue from a burn.
- There is no time frame for a sequela. It can happen immediately after the injury or years later.
- There should be documentation the sequela is related to the injury.
- The condition is coded prior to the sequela code (except CVA coding).

SEQUELA CODING

- To code a sequela, look under sequela in the alpha index.
  - Example: A contracture after a third degree burn injury left elbow is healed.
    - L90.5 Scar conditions and fibrosis of skin
    - T22.322S Burn of third degree left elbow sequela
- For CVA coding, the I69 codes are themselves sequela codes. If you are instructed to code also at the I69 code, the condition follows the I69 sequela code.
  - Example: A patient with a CVA and pseudobulbar effect is coded.
    - I69.398 Other sequela of cerebral infarction
      - Instruction - **Use additional code** to identify the sequela.
        - F48.2 Pseudobulbar effect - also has instruction to code first the underlying cause.
- You can see why it is so important to read the instruction at the code!

EXCLUDES NOTES

- Excludes 1 note indicates the conditions do not occur together and should not be coded together.
  - Example: F11.92 Opioid use, unspecified with intoxication
  - Excludes 1 Opioid use, unspecified with withdrawal (F11.93)
- Most obvious would be a congenital condition coded with the same condition as acquired.

EXCLUDES NOTES

- The Excludes 1 note has been revised to state that the 2 codes can be used together if the conditions are not related.
  - Example: I80.12 is Phlebitis and thrombophlebitis of left femoral vein
  - Excludes 1 note states venous embolism and thrombosis of lower extremities, codes at I82.4-, I82.5- and I82.81 are excluded.
- Patient could have I80.12 and a chronic embolism of the deep veins of the right lower extremity also which would be coded to I82.501.
- Excludes 2 note indicates the conditions can occur and be coded together if appropriate.
  - Example: K85.22 Alcohol-induced acute pancreatitis with infected necrosis
  - Excludes 2 alcohol-induced chronic pancreatitis (K86.0)
- A patient could have both acute and chronic pancreatitis, so both would be coded if supported by physician documentation.

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CODING CHANGES FOR FISCAL YEAR (FY) 2020

CODING CHANGES FOR FY 2020

- 273 New Codes
- 30 Changed Codes
- 98 Tabular Instruction Changes
- 21 Deleted Codes

CODING CHANGES FOR FY 2020

- The new fiscal year of 2020 begins on October 1, 2019.
- This year CMS continues to make coding changes for greater specificity in coding.
- Among the new codes are 25 specifically to capture deep tissue injury detail and improve consistency between coding and documentation.
  - Right now deep tissue injuries are coded as unstageable pressure ulcers.
  - The new codes will allow coders to more accurately report pressure-induced deep tissue injuries.
- There are 18 new T codes for reporting underdosing, adverse effects, and poisoning. The new poisoning codes will include indications for accidental, intentional, related to an assault, or undetermined.
- With the new Z codes, coders will be able to report factors influencing health status and the patient's contact with health services.
  - This is CMS's attempt to encourage a holistic approach to patient care with a focus on reporting all circumstances and conditions which could have an impact on the patient's recovery and overall outcomes.

CHAPTER 1

CERTAIN INFECTIOUS AND PARASITIC DISEASES (A00-B99)

- **B97.4** Respiratory syncytial virus as the cause of diseases classified elsewhere
  - ***New**
    - **Code first** related disorders, such as:
      - otitis media – H65.-
      - upper respiratory infection– J06.9
        - Be aware of the new instruction to code first those conditions listed if documented.
  - ***New**
    - **Excludes 2:**
      - acute bronchiolitis due to respiratory syncytial virus (RSV-J21.0)
      - acute bronchitis due to respiratory syncytial virus (RSV-J20.5)
      - respiratory syncytial virus (RSV) pneumonia (J12.1)
        - Any Excludes 2 notes can be coded together if appropriate.
          - For instance if the patient has RSV and pneumonia you would code the B97.4 and J12.1

CHAPTER 2

NEOPLASMS

- **C91.0** Acute lymphoblastic leukemia (ALL)
  - ****Revised - Note:** Codes in subcategory C91.0- should only be used for T-cell and B-cell precursor leukemia.
    - The change at C91.0, Acute Lymphoblastic Leukemia is to clarify that ALL codes at C91.0 should only be used with B or T cell leukemia not just C91.0.
- **D04.0** Carcinoma in-situ of skin
  - ***New - Excludes 2:** carcinoma in-situ of vermilion border of lip (D00.01)
    - The carcinoma of skin code previously had an Excludes 1 note for the D00.01 code; now they can be coded together if appropriate.

NEOPLASMS

- **D12** Benign neoplasm of colon, rectum, anus, and anal canal unspecified and D12.6 Benign neoplasm of colon, unspecified have been revised to state:
  - ***New - Excludes 1:** polyp of colon NOS (K63.5)
    - D12 code for benign neoplasms has a new Excludes 1 note indicating the code "polyp of the colon NOS," K63.5 should not be coded with D12 if they are related.
    - An Excludes 1 note indicates the codes should never be coded together unless the conditions are not related.
- **D21.6** Benign neoplasm of connective and other soft tissue of trunk, unspecified
  - ****Revised -** description is changed **from** Benign neoplasm of back NOS **to** Benign neoplasm of connective and other soft tissue back NOS.
    - If your documentation only states benign neoplasm of the back, code to D36.7. If you have a description of a more invasive process into the connective tissue, code to D21.6.

NEOPLASMS

- **D36.7** Benign neoplasm of other specified sites description is added to this item.
  - ***New -** Benign neoplasm of back NOS
- **D23** Other benign neoplasms of skin
  - ***New - Excludes 2:** melanocytic nevi (D22.-)
    - Previously D23 code included Excludes 1 note for melanocytic nevi; now it can be coded together if appropriate.

CHAPTER 3

DISEASES OF THE BLOOD & BLOOD-FORMING ORGANS & CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM (D50-D89)

- **D55.0** Anemia due to glucose-6-phosphate dehydrogenase [G6PD]
  - ***New - Excludes 1:** glucose-6-phosphate dehydrogenase [G6PD] deficiency without anemia (D75.A)
- ***New –D75.A Glucose 6-phosphate dehydrogenase (G6PD) deficiency without anemia**
  - ***New Excludes 1: glucose-6 phosphate dehydrogenase (G6PD) deficiency without anemia (D75.A)**
    - D75.A is a new code indicating the patient has G6PD (Glucose-6-Phosphate dehydrogenase deficiency) but not anemia. If anemia is documented with the G6PD code D55.0. Conversely, the D75.A code includes an Excludes 1 instruction to not code with D55.0. So if documentation states the patient has G6 PD and anemia code D55.0. If only G6PD is documented an no anemia use the new code D75.A.

DISEASES OF THE BLOOD & BLOOD-FORMING ORGANS & CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM (D50-D89)

There are new codes for more specific forms of Adenosine deaminase deficiency (ADA).

- ***New - D81.30** Adenosine deaminase deficiency, unspecified
  - ADA deficiency NOS
- ***New - D81.31** Severe combined immunodeficiency due to adenosine deaminase deficiency
  - ADA deficiency with SCID
  - Adenosine deaminase [ADA] deficiency with severe combined immunodeficiency
- ***New - D81.32** Adenosine deaminase 2 deficiency
  - ADA2 deficiency
  - Adenosine deaminase deficiency type 2
    - ***New - Code Also,** if applicable, any associate manifestations, such as:
      - polyarteritis nodosa (M30.0)
      - stroke (I63.-)

DISEASES OF THE BLOOD & BLOOD-FORMING ORGANS & CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM (D50-D89)

All of the descriptors under code D81.39 are new for 2020

- ***New - D81.39** Other adenosine deaminase deficiency
  - Adenosine deaminase [ADA]deficiency type 1, NOS
  - Adenosine deaminase [ADA]deficiency type 1, without SCID
  - Adenosine deaminase [ADA]deficiency type 1, without severe combined immunodeficiency
  - Partial ADA deficiency (type 1)
  - Partial adenosine deaminase deficiency (type 2)

CHAPTER 4

ENDOCRINE, NUTRITIONAL & METABOLIC DISEASES (E00-E89)

- Prader-Willi syndrome and Russel Silver syndrome codes each have a specific code after 10/01/2019.
- **E23.3** Hypothalamic dysfunction, not elsewhere classified
  - ****Revised -** Excludes 1:
    - Prader-Willi syndrome- code is **revised from** Q87.1 **to** Q87.11
    - Russell Silver syndrome- code is **revised from** Q87.1 **to** Q87.19
- **E34.3** Short stature due to endocrine disorder
  - ****Revised -** Excludes 1:
    - Russel Silver syndrome-code is **revised from** Q87.1 **to** Q87.19

ENDOCRINE, NUTRITIONAL & METABOLIC DISEASES (E00-E89)

- **E66** Overweight and obesity
  - ****Revised -** Excludes 1:
    - Prader-Willi syndrome- code is **revised from** Q87.1 **to** Q87.11
- **E79** Disorders of purine and pyrimidine metabolism
  - ****Revised -** Excludes 1:
    - Ataxia-telangiectasia code is **revised from** Q87.1 **to** Q87.19
    - Cockayne's syndrome code is **revised from** Q87.1 **to** Q87.19

CHAPTER 6

DISEASES OF THE NERVOUS SYSTEM (G00-G99)

- **G31** Other degenerative diseases of nervous system, not elsewhere classified.
  - **** Revise – revise from** use additional code to identify dementia with/without behavior problems **revise to** For codes G31.0-G31.83, G31.85-G31.9 Use additional code to identify dementia with/without behavior problems.

DISEASES OF THE NERVOUS SYSTEM (G00-G99)

- G43.A code description has been revised to only include vomiting related to migraines and since the migraine is included in the code it excludes the R11.15 code (new code for Cyclical vomiting syndrome unrelated to migraine).
- **G43.A** Cyclical vomiting- Incomplete code
  - ***New - Excludes 1**: cyclical vomiting syndrome unrelated to migraine (R11.15)
- ****Revised - G43.A0** Cyclical vomiting, not intractable **revise to** Cyclical vomiting, in migraine, not intractable
- ****Revised - G43.A1** Cyclical vomiting, intractable **revise to** Cyclical vomiting, in migraine, not intractable

DISEASES OF THE NERVOUS SYSTEM (G00-G99)

- **G63** Polyneuropathy in diseases classified elsewhere
  - ****Revised -** Excludes 1: rheumatoid arthritis (M05.33) is **revised to** rheumatoid arthritis (M05.5-)
- Minor change to the manifestation code G63 the M05.33 (rheumatoid heart disease with arthritis code is no longer in the Excludes list and M05.5 (rheumatoid polyneuropathy with arthritis) codes are added.

CHAPTER 7

DISEASES OF THE EYE & ADNEXA (H00-H59)

- H47.6 Disorders of visual cortex
  - **Revised - Excludes 1: Code S04.04 is **revised to** S04.04-
- The Excludes 1 note is expanded, previously only included S04.04 injury to visual cortex. It is now expanded to reflect the codes for right and left and unspecified (which are not new codes).

CHAPTER 8

DISEASES OF THE EAR & MASTOID PROCESS (H65-H75)

- **H81.4** Vertigo of central origin
  - Increased specificity for laterality all four of the codes for right, left, bilateral and unspecified have been **deleted:**
    - H81.41 Vertigo of central origin, right ear
    - H81.42 Vertigo of central origin, left ear
    - H81.43 Vertigo of central origin, bilateral
    - H81.49 Vertigo of central origin, unspecified ear

CHAPTER 9

DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)

- I21.A1 Myocardial infarction type 2

***New -** Code first the underlying cause, such as:

- The new instruction is to **Code First** the conditions listed.
  - Anemia (D50.0-D64.9)
  - Chronic obstructive pulmonary disease (J44.-)
  - Paroxysmal tachycardia (I47.0-I47.9)
  - Shock (R57.0-R57.9)
- The "Code Also" instruction and all the codes following I21.A1 Myocardial infarction type 2 code were changed or deleted. The heart failure I50.- and renal failure N17.0-N19 that were indicated as "code also" codes previously are removed from this new instruction.

DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)

- I25 Chronic ischemic heart disease
  - I25.81 Atherosclerosis of other coronary vessels without angina pectoris
    - ****Revised -** Excludes 2: atherosclerotic heart disease of native coronary artery without angina pectoris
- Code instruction for coding I25.10 (atherosclerotic heart disease) with the I25 Chronic ischemic heart disease is no longer excluded and can be coded together when appropriate.
- I26.9 Pulmonary Embolism without acute cor pulmonale
  - ***New -** I26.93 Single subsegmental pulmonary embolism without acute cor pulmonale
    - Subsegmental pulmonary embolism NOS
  - ***New -** I26.94 Multiple subsegmental pulmonary emboli without acute cor pulmonale
- 2 new codes for more specific coding of Pulmonary Embolism without cor pulmonale. The codes are for single or multiple pulmonary emboli.

DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)

There are four new codes to indicate more specific types of atrial fibrillation.

- I48.1 Persistent atrial fibrillation is no longer a complete code and instruction now contains a new Excludes1 note for specific types of atrial fibrillation which now have their own new codes.
- I48.1 Persistent atrial fibrillation – no longer a complete code
- ***New-** Excludes 1: Permanent atrial fibrillation (I48.21)
  - ***New-** I48.11 Longstanding persistent atrial fibrillation
  - ***New-** I48.19 Other persistent atrial fibrillation
    - Chronic persistent atrial fibrillation
    - Persistent atrial fibrillation, NOS

DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)

- I48.2 Chronic atrial fibrillation - no longer a complete code
  - ***New -** Excludes 1: Chronic persistent atrial fibrillation (I48.19)
  - ***New -** I48.20 Chronic atrial fibrillation, unspecified
  - ***New -** I48.21 Permanent atrial fibrillation
- New code for Chronic atrial fibrillation, unspecified is I48.20 and excludes I48.19
- New code for Permanent atrial fibrillation is I48.21
- Do not code Persistent atrial fibrillation with Chronic atrial fibrillation, clarify which and only use one code

DEFINITIONS FOR ATRIAL FIBRILLATION

- Persistent - the heart rhythm doesn't return to normal on its' own and electric shock or meds are needed.
- Longstanding persistent - has been an issue for 12 months or longer
- Permanent - Abnormal heart rhythm that can't be returned to normal.
- The physician documentation must state these conditions, if not, the I48.91 unspecified code must be used or physician queried.

DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)

- Eight new codes for reporting phlebitis and thrombophlebitis of the peroneal vein and calf muscle vein.
- New codes allow for greater specificity including right vs left vs bilateral to each of the veins
  - ***New-** I80.24 Phlebitis and thrombophlebitis of peroneal vein - Incomplete code
    - ***New-** I80.241 Phlebitis and thrombophlebitis of right peroneal vein
    - ***New-** I80.242 Phlebitis and thrombophlebitis of left peroneal vein
    - ***New-** I80.243 Phlebitis and thrombophlebitis of peroneal vein, bilateral
    - ***New-** I80.249 Phlebitis and thrombophlebitis of unspecified peroneal vein

DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)

Continued

- ***New-** I80.25 Phlebitis and thrombophlebitis of calf muscular vein - Incomplete code
  - *Phlebitis and thrombophlebitis of calf muscular vein, NOS
  - *Phlebitis and thrombophlebitis of gastrocnemial vein
  - *Phlebitis and thrombophlebitis of soleal vein
- ***New-** I80.251 Phlebitis and thrombophlebitis of right calf muscular vein
- ***New-** I80.252 Phlebitis and thrombophlebitis of left calf muscular vein
- ***New-** I80.253 Phlebitis and thrombophlebitis of calf muscular vein, bilateral
- ***New-** I80.259 Phlebitis and thrombophlebitis of unspecified calf muscular vein

DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)

Continued

- ***New-** I80.25 Phlebitis and thrombophlebitis of calf muscular vein - Incomplete code
  - *Phlebitis and thrombophlebitis of calf muscular vein, NOS
  - *Phlebitis and thrombophlebitis of gastrocnemial vein
  - *Phlebitis and thrombophlebitis of soleal vein
- ***New-** I80.251 Phlebitis and thrombophlebitis of right calf muscular vein
- ***New-** I80.252 Phlebitis and thrombophlebitis of left calf muscular vein
- ***New-** I80.253 Phlebitis and thrombophlebitis of calf muscular vein, bilateral
- ***New-** I80.259 Phlebitis and thrombophlebitis of unspecified calf muscular vein

DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)

Continued

New codes in this section are all more specific

- I82.41 Acute embolism and thrombosis of femoral vein
  - *** New-** Acute embolism and thrombosis of common femoral vein
  - *** New-** Acute embolism and thrombosis of deep femoral vein
- I82.42 Acute embolism and thrombosis of iliac vein
  - *** New-** Acute embolism and thrombosis of common iliac vein
  - *** New-** Acute embolism and thrombosis of external iliac vein
  - *** New-** Acute embolism and thrombosis of internal iliac vein

DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)

Continued

Code I82.46 includes three new descriptions and five new codes in order to provide more specificity

- *I82.46 Acute embolism and thrombosis of calf muscular vein – Incomplete code
  - * Acute embolism and thrombosis of calf muscular vein, NOS
  - * Acute embolism and thrombosis of gastrocnemial vein
  - * Acute embolism and thrombosis of soleal vein
- *** New-** I82.461 Acute embolism and thrombosis of right calf muscular vein
- *** New-** I82.462 Acute embolism and thrombosis of left calf muscular vein
- *** New-** I82.463 Acute embolism and thrombosis of calf muscular vein, bilateral
- *** New-** I82.469 Acute embolism and thrombosis of unspecified calf muscular vein

DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)

Continued

I82.51 and I82.52 codes have new descriptions but no change to codes

- I82.51 Chronic embolism and thrombosis of femoral vein
  - *** New-** Chronic embolism and thrombosis of common femoral vein
  - *** New-** Chronic embolism and thrombosis of deep femoral vein
- I82.52 Chronic embolism and thrombosis of iliac vein
  - *** New-** Chronic embolism and thrombosis of common iliac vein
  - *** New-** Chronic embolism and thrombosis of external iliac vein
  - *** New-** Chronic embolism and thrombosis of internal iliac vein

DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)

Continued

New descriptions added to the I82.54 codes

- I82.54 Chronic embolism and thrombosis of tibial vein
  - *** New -** Chronic embolism and thrombosis of anterior tibial vein
  - *** New -** Chronic embolism and thrombosis of posterior tibial vein
- New codes at I82.55 to indicate laterality
- *** New -** I82.55 Chronic embolism and thrombosis of peroneal vein
  - *** New -** I82.551 Chronic embolism and thrombosis of right peroneal vein
  - *** New -** I82.552 Chronic embolism and thrombosis of left peroneal vein
  - *** New -** I82.553 Chronic embolism and thrombosis of peroneal vein, bilateral
  - *** New -** I82.559 Chronic embolism and thrombosis of unspecified peroneal vein

DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)

Continued

New descriptions added to the I82.56 codes

- *** New -** I82.56 Chronic embolism and thrombosis of calf muscular vein – Incomplete code
  - * Chronic embolism and thrombosis of calf muscular vein NOS
  - * Chronic embolism and thrombosis of gastrocnemial vein
  - * Chronic embolism and thrombosis of soleal vein
- *** New -** I82.561 Chronic embolism and thrombosis of right calf muscular vein
- *** New -** I82.562 Chronic embolism and thrombosis of left calf muscular vein
- *** New -** I82.563 Chronic embolism and thrombosis of calf muscular vein, bilateral
- *** New -** I82.569 Chronic embolism and thrombosis of unspecified calf muscular vein

CHAPTER 10

DISEASES OF THE RESPIRATORY SYSTEM

- J06.9 Acute upper respiratory infection, unspecified
  - *** New -** Use additional code (B95-B97) to identify infectious agent, if known, such as: respiratory syncytial virus (RSV) (B97.4)
- J12.1 Respiratory syncytial virus pneumonia
  - *** New -** RSV pneumonia
- J20.5 Acute bronchitis due to respiratory syncytial virus
  - *** New -** Acute bronchitis due to RSV
- J21.0 Acute bronchiolitis due to respiratory syncytial virus
  - *** New -** Acute bronchiolitis due to RSV

DISEASES OF THE RESPIRATORY SYSTEM

Major change to this Chapter is in the description at J44.0. The word "acute" is placed in parenthesis which indicates it is not an essential modifier and you may code acute regardless if the physician has documented it as acute.

Clinical documentation should support the condition is acute.

J44.1 currently has the acute as a nonessential modifier and continues to after 10/01/2019

- ****Revised-J44.0** Chronic obstructive pulmonary disease with **(acute)** lower respiratory infection

CHAPTER 11

DISEASES OF THE DIGESTIVE SYSTEM (K00-K95)

- K59.0 Constipation
- The "use additional code" for adverse effect of a drug instruction is **deleted** from this code.

CHAPTER 12

DISEASES OF THE SKIN & SUBCUTANEOUS TISSUE (L00-L99)

- There are several additions and revisions to descriptions and Excludes notes in this chapter.
- You must look at the alpha and the tab to code wounds!
- Encourage clinicians to use the wording at the code when describing the wound.
- There are 25 new codes for deep tissue injuries. This slide is an example of 2 of the additional deep tissue damage codes. These deep tissue codes are added to each site for pressure injuries.
- L89.13 Pressure ulcer of right lower back
  - ***New -** L89.136 Pressure-induced deep tissue damage of right lower back
- L89.14 Pressure ulcer of left lower back
  - ***New -** L89.146 Pressure-induced deep tissue damage of left lower back

CHAPTER 13

DISEASES OF THE MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE (M00-M99)

The changes in this chapter are mostly in verbiage.

- M50.120 Mid-cervical disc disorder, unspecified, is revised to state:
  - ****Revised-** M50.120 Mid-cervical disc disorder, unspecified level
- M66.88 Spontaneous rupture of other tendons, other, is revised to state:
  - ****Revised-** M66.88 Spontaneous rupture of other tendons, other sites
- M67.839 Other specified disorders of synovium and tendon, unspecified forearm, is revised to state:
  - ****Revised-** M67.839 Other specified disorders of synovium and tendon, unspecified wrist
- M77.50, M77.51, M77.52 wording is revised at all from "foot" to include "foot and ankle"

CHAPTER 14

DISEASES OF THE GENITOURINARY SYSTEM (N00-N99)

There is an added note to Excludes 1 for UTI site not specified, to exclude pyuria.

- N39.0 Urinary tract infection, site not specified
  - ***New -** Excludes 1: pyuria (R82.81)
- New codes N63. - codes for unspecified lump in the right or left breast with overlapping quadrants
- N63.1 Unspecified lump in the right breast
  - ***New -** N63.15 Unspecified lump in the right breast, overlapping quadrants
- N63.2 Unspecified lump in the left breast
  - ***New -** N63.25 Unspecified lump in the left breast, overlapping quadrants

DISEASES OF THE GENITOURINARY SYSTEM (N00-N99)

- New code N99.85, which is an intraoperative and postprocedural complication code.
- There are many complication codes that are coded to the body system and not the T codes.
- It is very important to use your coding resource to be sure you are using the correct complication codes.
- There must be physician documentation stating a complication.
- **N92.4** Excessive bleeding in the premenopausal period
  - ***New -** Perimenopausal bleeding
  - ***New -** Perimenopausal menorrhagia or metrorrhagia
- ***New-** N99.85 Post endometrial ablation syndrome

CHAPTER 18

SYMPTOMS, SIGNS AND ABNORMAL CLINICAL & LABORATORY FINDINGS, NOT ELSEWHERE CLASSIFIED

- Cyclical vomiting in migraine was discussed in Chapter 6, there are new codes in order to code this condition with specific symptoms.
- ***New -** R11.15 Cyclical vomiting syndrome unrelated to migraine
  - Cyclic vomiting syndrome NOS
  - Persistent vomiting
    - ***New -** Excludes 1: cyclical vomiting in migraine (G43.A-)
    - ***New -** Excludes 2: bulimia nervosa (F50.2)
    - diabetes mellitus due to underlying condition (E8.-)
- ***New -** R82.81 Pyuria
  - Sterile pyuria
- ***New -** R82.89 Other abnormal findings on cytological and histological examination of urine

CHAPTER 19

INJURY, POISIONING & CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES (S00-T88)

- There are several new codes in order to more specifically code orbital fractures.
- There are also new Excludes notes which indicate to use the more specific codes or not to use the new NOS codes with the specific code.
  - For example, the new Excludes 1 note at S02.85 Fracture of orbit unspecified, states not to use this code with the medial orbital wall, orbital floor or orbital roof codes, as you have a specific code for those conditions now.
- Any fracture not indicated as open or closed is coded as closed.
- For the orbital fracture codes you should also code any other intracranial injury.
- Never use an aftercare code for a fracture, use the D for a 7th character to indicate home care.
- If the fracture is healed but there is a condition treated that is a result of the fracture use the S for sequela.

INJURY, POISIONING & CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES (S00-T88)

- ***New -** S02.84 Fracture of lateral orbital wall
  - ***New -** S02.841 Fracture of lateral orbital wall, right side
  - ***New -** S02.842 Fracture of lateral orbital wall, left side
  - ***New -** S02.849 Fracture of lateral orbital wall, unspecified side
- ***New -** S02.85 Fracture of orbit, unspecified
  - ***New -** Fracture of orbit NOS
  - ***New -** Fracture of orbit wall NOS

INJURY, POISIONING & CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES (S00-T88)

- ***New -** S02.12 Fracture of orbital roof
  - ***New -** S02.121 Fracture of orbital roof, right side
  - ***New -** S02.122 Fracture of orbital roof, left side
  - ***New -** S02.129 Fracture of orbital roof, unspecified side
- ***New -** S02.83 Fracture of medial orbital wall
  - ***New -** S02.831 Fracture of medial orbital wall, right side
  - ***New -** S02.832 Fracture of medial orbital wall, left side
  - ***New -** S02.839 Fracture of medial orbital wall, unspecified side

INJURY, POISIONING & CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES (S00-T88)

- There are seven new codes to indicate poisoning, underdosing, and adverse effect of medications and substances or multiple medications that are unspecified.
- If you have identified specific medications involved (**multiple** drugs) you would also code those.
- ***New -** T50.91 Poisoning by, adverse effect of and underdosing of multiple unspecified drugs, medicaments, and biological substances
  - Multiple drug ingestion NOS
  - Code Also any specific drugs, medicaments and biological substances

INJURY, POISIONING & CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES (S00-T88)

Continued

- ***New -** T50.911 Poisoning by multiple unspecified drugs, medicaments, and biological substances, accidental (unintentional)
- ***New -** T50.912 Poisoning by multiple unspecified drugs, medicaments and biological substances, intentional self-harm
- ***New -** T50.913 Poisoning by multiple unspecified drugs, medicaments, and biological substances, assault
- ***New -** T50.914 Poisoning by multiple unspecified drugs, medicaments and biological substances, undetermined
- ***New -** T50.915 Adverse effect of multiple unspecified drugs, medicaments and biological substances
- ***New -** T50.916 Underdosing of multiple unspecified drugs, medicaments and biological substances

INJURY, POISIONING & CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES (S00-T88)

- There are three new codes for heatstroke and the T67.0 code is revised to reflect the new codes.
- ****Revised -** T67.0 Heatstroke and sunstroke
- ****Revised -** Use additional rhabdomyolysis (M62.82)
- ***New -** T67.01 Heatstroke and sunstroke
  - Heat apoplexy
  - Heat pyrexia
  - Siriasis
  - Thermoplegia
- ***New -** T67.02 Exertional heatstroke

INJURY, POISIONING & CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES (S00-T88)

- The Excludes 1 note at T79.A is changed to an Excludes 2 note for T79.6 traumatic ischemic infarction of muscle which can be coded with T79.A if appropriate now.
- T79.A Traumatic compartment syndrome
  - **Revised-Excludes 2: traumatic ischemic infarction of muscle (T79.6)

CHAPTER 20

EXTERNAL CAUSES OF MORBIDITY (V00-Y99)

- Use of codes in this chapter are voluntary unless required by certain payers or to meet coding convention instruction.
  - The tabular instruction may indicate to use an additional code from this chapter.
    - For example, L57 code (Skin changes due to chronic exposure to nonionizing radiation) states Use additional code to identify the source of the ultraviolet radiation (W89).
- While the codes are voluntary they can be important to explain circumstances and for data collection for injury prevention.
- External cause codes can be coded based on other documentation than the physician's documentation.

EXTERNAL CAUSES OF MORBIDITY (V00-Y99)

- The codes all start with V, W, X, or Y and indicate cause, intent, place and patient status.
- *Only* cause and intent are allowed to be coded in home health and hospice, and are never primary.
  - Cause is how it happened.
  - Intent is whether it was accidental or an assault.
  - These are the only 2 codes that can be coded by home health.
    - The place and patient status (civilian or military) are provided by the initial contact provider.
    - If it is not known if it was an assault or accident code it as an accident.

EXTERNAL CAUSES OF MORBIDITY (V00-Y99)

Changes are at the V86.- codes, descriptions were deleted and not replaced.

- There are 26 new codes at Y35 Legal intervention
- *Y35.00 Legal intervention involving unspecified firearm discharge
  - ***New** - Y35.009 Legal intervention involving unspecified firearm discharge, unspecified person injured
- Additional codes in this family of codes indicate injury by machine gun, handgun, rifle pellet, rubber bullet or other firearm.

EXTERNAL CAUSES OF MORBIDITY (V00-Y99)

- Y35.1 - Legal intervention involving explosives-these are broken down to dynamite, explosive shell and other explosives
- Y35.2 - Legal intervention involving unspecified gas- tear gas, other gas
- Y35.3 - Legal intervention involving blunt objects-batons and other or unspecified blunt objects
- Y35.4 - Legal intervention involving sharp objects-unspecified, bayonet, other sharp objects

EXTERNAL CAUSES OF MORBIDITY (V00-Y99)

There are many additional new codes in this family of codes so coders can be specific in coding injuries occurring in circumstances involving the police.

- ***New -** Y35.819 Legal intervention involving manhandling, unspecified person injured
- ***New -** Y35.83 Legal intervention involving a conducted energy device
  - ***New -** Electroshock device (taser)
  - ***New -** Stun gun
  - ***New -** Y35.831 Legal intervention involving a conducted energy device, law enforcement official injured
  - ***New -** Y35.832 Legal intervention involving a conducted energy device, bystander injured,
  - ***New -** Y35.833 Legal intervention involving a conducted energy device, suspect injured,
  - ***New -** Y35.839 Legal intervention involving a conducted energy device, unspecified person injured.
  - ***New -** Y35.99 Legal intervention, means unspecified, unspecified person injured

CHAPTER 21

FACTORS INFLUENCING HEALTH STATUS & CONTACT WITH HEALTH SERVICES (Z00-Z99)

- There are a few new codes for eye examinations and screening of infectious diseases. Since we don't often provide these services, be aware and refer to your coding book if you ever need to code these services.
- There is a new code to indicate carrier of latent tuberculosis. Be aware of the Excludes 1 Instruction for coding positive TB test without active tuberculosis.
- The most common codes used in home health or hospice from Z22 would be the MSSA or MRSA infection carrier codes which are not revised.

FACTORS INFLUENCING HEALTH STATUS & CONTACT WITH HEALTH SERVICES (Z00-Z99)

- New code for Latent Tuberculosis with an Excludes 1 note is under the Z22 Carrier of Infectious Disease stem code.
- ***New - Z22.7 Latent Tuberculosis**
  - ***New -** Latent Tuberculosis infection (L TBI)
  - ***New - Excludes 1:** nonspecific reaction to cell mediated immunity measurement of gamma interferon antigen response without active tuberculosis (R76.12) nonspecific reaction to tuberculin skin test without active tuberculosis(R76.11)
- *** New -** Z86.15 Personal history of latent tuberculosis infection

FACTORS INFLUENCING HEALTH STATUS & CONTACT WITH HEALTH SERVICES (Z00-Z99)

- From Z22 we jump all the way to Z45 where there are several changes and additions.
- Do not include or use the status Z95.0 code for a cardiac pacemaker as it is included in the Z45.018 code.
- Z45.018 Encounter for adjustment and management of other part of cardiac pacemaker
  - ***New - Excludes 1:** presence of other part of cardiac pacemaker (Z95.0)
  - ****Revised - Excludes 2:** presence of prosthetic and other devices (Z95.1-Z95.5, Z95.811-Z97)

FACTORS INFLUENCING HEALTH STATUS & CONTACT WITH HEALTH SERVICES (Z00-Z99)

- The Z45.42 Encounter code is revised to further define the organ of placement for the neurostimulator.
  - These codes are used if you are instructing the management or managing the devices, otherwise use a status code.
- ****Revised -** Z45.42 Encounter for adjustment and management of neuropacemaker (brain) (peripheral nerve) (spinal cord) now includes the specific types of stimulators and is revised to
- Z45.42 Encounter for adjustment and management of neurostimulator
  - ***New -** Encounter for adjustment and management of brain neurostimulator
  - ***New -** Encounter for adjustment and management of gastric neurostimulator
  - ***New -** Encounter for adjustment and management of peripheral nerve neurostimulator
  - ***New -** Encounter for adjustment and management of sacral nerve neurostimulator
  - ***New -** Encounter for adjustment and management of spinal cord neurostimulator
  - ***New -** Encounter for adjustment and management of vagus nerve neurostimulator

FACTORS INFLUENCING HEALTH STATUS & CONTACT WITH HEALTH SERVICES (Z00-Z99)

- Use this new status code if you are not instructing the patient on or managing any of these types of stimulators.
- ***New** - Z96.82 Presence of neurostimulator
  - ***New** - Presence of brain neurostimulator
  - ***New** - Presence of gastric neurostimulator
  - ***New** - Presence of peripheral nerve neurostimulator
  - ***New** - Presence of sacral nerve neurostimulator
  - ***New** - Presence of spinal cord neurostimulator
  - ***New** - Presence of vagus nerve neurostimulator

FACTORS INFLUENCING HEALTH STATUS & CONTACT WITH HEALTH SERVICES (Z00-Z99)

- Z68 BMI codes are not changed but the age to use the adult BMI chart is changed from 21 to 20 years of age.
- The pediatric age code instruction is changed from 2-20 to 2-19 years.

FACTORS INFLUENCING HEALTH STATUS & CONTACT WITH HEALTH SERVICES (Z00-Z99)

- Z69 and Z71 codes are encounters for mental health and counseling codes and are seldom used in home health.
- Changes in descriptions of abuse victim and perpetrator and health counseling related to international travel.
- See the coding manual if these codes are appropriate for your services.
- There are added definitions to the Z86.0– codes
  - Z86.000 Personal history of in-situ neoplasm of breast
    - ***New -** Conditions classifiable to D05 (carcinoma in-situ of breast)
  - Z86.001 Personal history of in-situ neoplasm of cervix uteri
    - ***New -** Conditions classifiable to D06 (carcinoma in-situ of cervix uteri

FACTORS INFLUENCING HEALTH STATUS & CONTACT WITH HEALTH SERVICES (Z00-Z99)

- * **New** - Z86.002 Personal history of in-situ neoplasm of other and unspecified genital organs
  - * **New** - Conditions classifiable to D07
  - * **New** - Personal history of high-grade prostatic intraepithelial neoplasia III [HGPIN III]
  - * **New** - Personal history of vaginal intraepithelial neoplasia III [VAIN III]
  - * **New** - Personal history of vulvar intraepithelial neoplasia III [VIN III]
- * **New** - Z86.003 Personal history of in-situ neoplasm of oral cavity, esophagus and stomach
  - * **New** - Conditions classifiable to D00 (carcinoma in-situ neoplasm of oral cavity, esophagus and stomach)
- * **New** - Z86.004 Personal history of in-situ neoplasm of other and unspecified digestive organs
  - * **New** - Conditions classifiable to D01 (Carcinoma in-situ of other and unspecified digestive organs)

FACTORS INFLUENCING HEALTH STATUS & CONTACT WITH HEALTH SERVICES (Z00-Z99)

- *** New -** Z86.005 Personal history of in-situ neoplasm of middle ear and respiratory system
  - *** New -** Conditions classifiable to D02 (Carcinoma in-situ of middle ear and respiratory system)
- *** New -** Z86.006 Personal history of melanoma in-situ
  - *** New -** Conditions classifiable to D03 (Melanoma in-situ)
  - *** New - Excludes 2**: sites other than skin-code to personal history of in-situ neoplasm of the site
- The Z86.008 code is not changed but the descriptions currently are deleted and the new instruction - Conditions classifiable to D09 is added
  - Z86.008 Personal history of in-situ neoplasm of other site
    - *** New -** Conditions classifiable to D09 (Carcinoma in-situ of other and unspecified sites)

FACTORS INFLUENCING HEALTH STATUS & CONTACT WITH HEALTH SERVICES (Z00-Z99)

- Z90.41 code and Use Additional is not changed but the previous sequence given in the coding book listed Z79.4 prior to E13.-, this revision sequences the DM first.
- Z90.41 Acquired absence of pancreas
  - Use Additional -
    - **Revised - Diabetes mellitus, post pancreatectomy (E13.-)
    - ** Revised - Insulin use (Z79.4)

DISEASE SPECIFIC CRITERIA FOR HOSPICE

DISEASE SPECIFIC CRITERIA FOR HOSPICE

- Review the most common hospice diagnoses and the criteria expected to be met to qualify for hospice care.
- The amount and detail of documentation will differ in different situations.
  - A patient with metastatic small cell CA may be hospice eligible with less documentation than a chronic lung disease patient.
  - Patients with chronic lung disease, long term survival in hospice, or who appear stable can still be eligible for hospice benefits, but documentation for a less than six month prognosis should appear in the record.
- These guidelines are to be used in conjunction with the "Non-disease specific baseline guidelines".

DISEASE SPECIFIC CRITERIA FOR HOSPICE

- Both of these conditions should be met, however if the documentation is supportive enough one can be met
  - Physiologic impairment of functional status as demonstrated by: Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) <70%.
    - Note that two of the disease specific guidelines (HIV Disease, Stroke and Coma) establish a lower qualifying KPS or PPS
  - Dependence on assistance for two or more activities of daily living (ADLs)
    - Feeding
    - Ambulation
    - Continence
    - Transfer
    - Bathing
    - Dressing

CANCER DIAGNOSES

- Disease with distant metastases at presentation OR
- Progression from an earlier stage of disease to metastatic disease with either:
  - A continued decline in spite of therapy
  - Patient declines further disease directed therapy

Note: Certain cancers with poor prognoses (e.g., small cell lung cancer, brain cancer and pancreatic cancer) may be hospice eligible without fulfilling the other criteria in this section.

AMYOTROPHIC LATERAL SCLEROSIS (ALS)

- **Amyotrophic Lateral Sclerosis**
  - ALS tends to progress in a linear fashion over time.
  - Multiple clinical parameters are required to judge the progression of ALS.
  - The location of initial presentation does not correlate with survival time.
  - Progression of disease differs markedly from patient to patient.
    - Some patients decline rapidly and pass away quickly, others progress more slowly
  - In end-stage ALS, two factors are critical in determining prognosis: ability to breathe, and to a lesser extent ability to swallow.
    - While not necessarily a contraindication to Hospice Care, the decision to institute either artificial ventilation or artificial feeding will significantly alter six-month prognosis.
  - Examination by a neurologist within three months of assessment for hospice is advised, both to confirm the diagnosis and to assist with prognosis.

AMYOTROPHIC LATERAL SCLEROSIS (ALS)

Continued

- Criteria to be met for terminal diagnosis of ALS
- Patient should demonstrate critically impaired breathing capacity as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:
  - Vital capacity (VC) less than 30% of normal (if available)
  - Dyspnea at rest
  - Patient declines mechanical ventilation; external ventilation used for comfort measures only
- Patient should demonstrate both rapid progression of ALS and critical nutritional impairment. All the following characteristics occurring within the 12 months preceding initial hospice certification:
  - Progression from independent ambulation to wheelchair to bed bound status
  - Progression from normal to barely intelligible or unintelligible speech
  - Progression from normal to pureed diet
  - Progression from independence in most or all activities of daily living (ADLs) to needing major assistance by caretaker in all ADLs

AMYOTROPHIC LATERAL SCLEROSIS (ALS)

Continued

- Critical nutritional impairment as demonstrated by **all** the following characteristics occurring within the 12 months preceding initial hospice certification:
  - Oral intake of nutrients and fluids insufficient to sustain life
  - Continuing weight loss
  - Dehydration or hypovolemia;
  - Absence of artificial feeding methods, sufficient to sustain life, but not for relieving hunger
- Patient should demonstrate both rapid progression of ALS and life-threatening complications as demonstrated by one of the following characteristics occurring within the 12 months preceding initial hospice certification:
  - Recurrent aspiration pneumonia (with or without tube feedings)
  - Upper urinary tract infection, e.g., pyelonephritis
  - Sepsis
  - Recurrent fever after antibiotic therapy
  - Stage 3 or 4 decubitus ulcer(s)

DEMENTIA DUE TO ALZHEIMER'S DISEASE

- **Dementia due to Alzheimer's Disease and Related Disorders**
  - *This section is specific for Alzheimer's Disease and related disorders, and is not appropriate for other types of dementia, such as multi-infarct dementia.
- Patients are considered to be in the terminal stage of dementia (life expectancy of six months or less) if they meet the following criteria:
  - Patients with dementia should show all the following characteristics:
    - Stage seven or beyond according to the Functional Assessment Staging Scale
    - Unable to ambulate without assistance
    - Unable to dress without assistance
    - Unable to bathe without assistance
    - Urinary and fecal incontinence, intermittent or constant
    - No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words

DEMENTIA DUE TO ALZHEIMER'S DISEASE

Continued

- Patients should have had one of the following within the past 12 months:
  - Aspiration pneumonia
  - Pyelonephritis or other upper urinary tract infection
  - Septicemia
  - Decubitus ulcers, multiple, stage 3-4
  - Fever, recurrent after antibiotics
  - Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin

HEART DISEASE

Patients are in the terminal stage of heart disease if they meet the following criteria:

- Criteria for 1 and 2 should be present, factors from 3 will lend supporting documentation

1. At the time of initial certification or recertification for hospice, the patient is or was already optimally treated for heart disease or is not a candidate for a surgical procedure or has declined a procedure
    - Optimally treated means that patients who are not on vasodilators have a medical reason for refusing these drugs, e.g., hypotension or renal disease
2. The patient is classified as New York Heart Association (NYHA) Class IV and may have significant symptoms of heart failure or angina at rest
    - Class IV patients with heart disease have an inability to carry on any physical activity without discomfort.
    - Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

HEART DISEASE

Continued

3. Documentation of the following factors will support but are not required to establish eligibility for hospice care:
   - Treatment resistant symptomatic supraventricular or ventricular arrhythmias
   - History of cardiac arrest or resuscitation
   - History of unexplained syncope
   - Brain embolism of cardiac origin
   - Comorbidity of HIV disease
     - Significant congestive heart failure may be documented by an ejection fraction of ⩽20%, but is not required if not already available

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

- **Human Immunodeficiency Virus (HIV) Disease**
- Patients are in the terminal stage of their illness if they meet the following criteria:
  - CD4+ Count 100,000 copies/ml, plus one of the following
    - CNS lymphoma
    - Untreated, or persistent despite treatment, wasting (loss of at least 10% lean body mass)
    - Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused
    - Progressive multifocal leukoencephalopathy
    - Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy
    - Visceral Kaposi's sarcoma unresponsive to therapy
    - Renal failure in the absence of dialysis
    - Cryptosporidium infection
    - Toxoplasmosis, unresponsive to therapy

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

Continued

- Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of ⩽50%
- Documentation of the following factors will support eligibility for hospice care:
  - Chronic persistent diarrhea for one year;
  - Persistent serum albumin <2.5;
  - Concomitant, active substance abuse;
  - Age >50 years;
  - Absence of, or resistance to effective antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease;
  - Advanced AIDS dementia complex;
  - Toxoplasmosis;
  - Congestive heart failure, symptomatic at rest;
  - Advanced liver disease.

LIVER DISEASE

Patients are in the terminal stage of liver disease if they meet the following criteria:

- Criteria for 1 and 2 should be present, factors from 3 will lend supporting documentation

1. The patient should show both
   - Prothrombin time prolonged more than 5 seconds over control, INR >1.5
   - Serum albumin
2. End-stage liver disease is present and the patient shows at least one of the following
   - Ascites, refractory to treatment or patient non-compliant;
   - Spontaneous bacterial peritonitis;
   - Hepatorenal syndrome (elevated creatinine and BUN with oliguria)
   - Hepatic encephalopathy, refractory to treatment, or patient non-compliant;
   - Recurrent variceal bleeding, despite intensive therapy.

LIVER DISEASE

Continued

3. Documentation of the following factors will support eligibility for hospice care:
    - Progressive malnutrition;
    - Muscle wasting with reduced strength and endurance;
    - Continued active alcoholism (>80 gm ethanol/day);
    - Hepatocellular carcinoma;
    - HBsAg (Hepatitis B) positivity;
    - Hepatitis C refractory to interferon treatment.

- Patients waiting for a liver transplant who otherwise fit the above criteria may be certified for the Medicare hospice benefit, When the transplant is done the patient should be discharged from hospice.

PULMONARY DISEASE

Criteria refers to patients with various forms of advanced pulmonary disease, but all eventually have end stage pulmonary disease.

1. Severe chronic lung disease as documented by both a and b:
    a. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough
        - Documentation of Forced Expiratory Volume in One Second (FEV1), after bronchodilator of less than 30% of predicted is objective evidence for disabling dyspnea, but is not necessary to obtain
    b. Progression of end-stage pulmonary disease, as evidenced by increasing visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory failure or increasing physician home visits prior to initial certification.
        - Documentation of serial decrease of FEV1>40 ml/year is objective evidence for disease progression, but is not necessary to obtain

PULMONARY DISEASE

Continued

2. Hypoxemia at rest on room air, as evidenced by pO2 ≤55 mmHg; or oxygen saturation ≤88%, determined either by arterial blood gases or oxygen saturation monitors OR Hypercapnia, as evidenced by pCO2 ≥50 mmHg.
   - Arterial blood gases, O2 Sats, and pCO2 can be obtained from recent (within 3 months) hospital records
3. Right heart failure (RHF) secondary to pulmonary disease (Cor pulmonale)
   - Right heart failure cannot be secondary to left heart disease of valvulopathy
4. Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.
5. Resting tachycardia >100/min.

RENAL DISEASE

Patients are in the terminal stage of renal disease if they meet the following criteria:

- Criteria 1 and either criteria 2 or 3 should be present, factors from 4 will lend supporting documentation

- Acute renal failure:
  1. The patient is not seeking dialysis or renal transplant or is discontinuing dialysis
  2. Creatinine clearance
  3. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics)
  4. Comorbid conditions:
     - Mechanical ventilation
     - Malignancy (other organ system)
     - Chronic lung disease
     - Advanced cardiac disease
     - Advanced liver disease
     - Sepsis
     - Immunosuppression/AIDS
     - Albumin i. Cachexia
     - Platelet count <25,000
     - Disseminated intravascular coagulation
     - Gastrointestinal bleeding

CHRONIC RENAL FAILURE

- Criteria 1 and either criteria 2 or 3 should be present, factors from 4 will lend supporting documentation
  1. The patient is not seeking dialysis or renal transplant or is discontinuing dialysis.
  2. Creatinine clearance
  3. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics)
  4. Signs and symptoms of renal failure:
     - Uremia;
     - Oliguria (c. Intractable hyperkalemia (>7.0) not responsive to treatment;
     - Uremic pericarditis;
     - Hepatorenal syndrome;
     - Intractable fluid overload, not responsive to treatment.

STROKE & COMA

Patients are in the terminal stage of stroke or coma if they meet the following criteria:

Stroke:

- Karnofsky Performance Status (KPS) or Palliative Performance Scale (PPS) of 40% or less
- Inability to maintain hydration and caloric intake with one of the following:
  - Weight loss >10% in the last 6 months or >7.5% in the last 3 months
  - Serum albumin
  - Current history of pulmonary aspiration not responsive to speech language pathology intervention
  - Sequential calorie counts documenting inadequate caloric/fluid intake
  - Dysphagia severe enough to prevent the patient from receiving food and fluids necessary to sustain life, in a patient who declines or does not receive artificial nutrition and hydration.

STROKE & COMA

Continued

- Documentation of diagnostic imaging factors which support poor prognosis after stroke include:
- For non-traumatic hemorrhagic stroke:
  - Large-volume hemorrhage on CT
    - Infratentorial: ≥20 ml.
    - Supratentorial: ≥50 ml.
  - Ventricular extension of hemorrhage
  - Surface area of involvement of hemorrhage ≥30% of cerebrum
  - Midline shift ≥1.5 cm.
  - Obstructive hydrocephalus in patient who declines, or is not a candidate for, ventriculoperitoneal shunt
- For thrombotic/embolic stroke:
  - Large anterior infarcts with both cortical and subcortical involvement;
  - Large bihemispheric infarcts;
  - Basilar artery occlusion;
  - Bilateral vertebral artery occlusion.

STROKE & COMA

Continued

Coma from any cause

- Comatose patients with any three of the following on day three of coma:
  - abnormal brain stem response
  - absent verbal response
  - absent withdrawal response to pain
  - serum creatinine >1.5 mg/dl
- Documentation of medical complications, in the context of progressive clinical decline, within the previous 12 months, which support a terminal prognosis/eligibility for hospice
  - Aspiration pneumonia
  - Upper urinary tract infection (pyelonephritis)
  - Sepsis
  - Refractory stage 3-4 decubitus ulcers
  - Fever recurrent after antibiotics

CONCLUSION

- Accurate coding is vitally important in today's Hospice environment.
- To ensure accurate coding:
  - Obtain thorough referral information
  - Clarify diagnosis with physician and document
  - Be sure clinician documentation supports coding
  - Follow Coding Guidelines

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QUESTIONS?

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HOSPICE

THANK YOU!

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