Objectives

Coding Conventions & Guidelines
Hospice Coding - Primary Diagnosis/Terminal Illness
Hospice Coding - Secondary/Comorbid Diagnosis
Disease Specific Criteria for Hospice
The ICD-10-CM Conventions and Guidelines

- The conventions are the general rules for use.
  - They are incorporated into the Alphabetic Index & Tabular List as instructional notes
- Guidelines were developed to assist the healthcare provider and the coder to determine diagnoses.
  - Consistent, complete documentation is important. Without this documentation accurate coding cannot be achieved.
  - Review the entire record to see the whole picture.

ICD-10-CM Official Guidelines for Coding and Reporting

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

An exception to the Excludes 1 note is when the 2 conditions are not related.

- Example: I80.12 - 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 Notes

Excludes 2 note indicates the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time.
- 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

Etiology/manifestation convention

“Code first”, “use additional code” and “in diseases classified elsewhere” notes
- Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology.
  - Coding convention requires the underlying condition be sequenced first, if applicable, followed by the manifestation.
  - Wherever a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code.
  - These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation
Etiology/manifestation convention

“Code first”, “use additional code” and “in diseases classified elsewhere” notes

- There are manifestation codes that do not have “in diseases classified elsewhere” in the title.
- For these codes, there is a “use additional code” note at the etiology code and a “code first” note at the manifestation code, and the rules for sequencing apply.

Etiology/manifestation convention

See category F02, Dementia in other diseases classified elsewhere, for an example of the Etiology/manifestation convention.

Code First

The underlying physiological condition, such as:

- Alzheimer's (G30.0)
- Cerebral lipidosis (E75.4)
- Creutzfeldt-Jakob disease (A81.0)
- Dementia with Lewy bodies (G31.83)
- Dementia with Parkinsonism (G31.83)
- Epilepsy and recurrent seizures (G40.0)
- Frontotemporal dementia (G31.09)
- Hepatolenticular degeneration (E83.0)
- Human immunodeficiency virus [HIV] disease (B20)
Etiology/manifestation convention

In addition to the notes in the Tabular List, these conditions also have a specific Alphabetic Index entry structure.

Both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.
- Example: of the etiology/manifestation convention is dementia in Parkinson’s disease.
  - In the Alphabetic Index, code G20 is listed first, followed by code F02.80 or F02.81 in brackets.
  - Code G20 represents the underlying etiology, Parkinson’s disease, and must be sequenced first, and code F02.80 and F02.81 represent the manifestation of dementia in diseases classified elsewhere, with or without behavioral disturbance.

Manifestation coding conventions:
- Manifestation codes are in italics in slanted brackets [ ] in the Alphabetic index following the etiology code
- Example Alzheimer's G30.0 [F02.80]

- In most cases, a manifestation code will have in the code title "In diseases (or conditions) classified elsewhere" This identifies it as part of an etiology/manifestation pair
- Example J99 Respiratory disorders in diseases classified elsewhere
Etiology/manifestation convention

- Some diagnosis codes may be manifestation codes only in certain situations.
- Potential manifestation codes may include the Tabular List instructions "Code first any associated underlying condition, such as" followed by a list of possible, not mandatory etiologies.
- In these situations, the manifestation is not always tied to another condition, therefore it can be coded alone and if not the manifestation of another condition, it can be coded as a primary diagnosis.
- Example L97 Non-pressure chronic ulcer of lower limb, not elsewhere classified

Etiology/manifestation convention

"Code first" and "Use additional code" notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/manifestation combination.

A diagnosis that is a strictly manifestation may NEVER be the principal or terminal diagnosis or be coded by itself.

Ex: **J12.82** Pneumonia due to coronavirus disease 2019
**Code First**
COVID-19 (U07.1)
"And"

The word “And” should be interpreted to mean either “and” or “or” when it appears in a title.

For example, cases of “tuberculosis of bones”, “tuberculosis of joints” and “tuberculosis of bones and joints” are classified to subcategory A18.0, Tuberculosis of bones and joints.

For example, cases of “open wound of lower back”, “open wound of pelvis”, and open wound of lower back and pelvis” are classified to subcategory S31.0 Open wound of lower back and pelvis.

“With" or "In"

Guideline

The word “with” or “in” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index (either under a main term or subterm), or an instructional note in the Tabular List.

The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List.

- Example: "with" appears under the main term "Diabetes" but it appears under the sub term “buttock" in the alphabetic index listing for "ulcer, buttock"
“With” or “In” Example

Patient with diagnoses of Type 2 Diabetes and CKD 2 would be coded
- E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease
- N18.2 Chronic kidney disease, stage 2
  - In the alphabetic index, under Diabetes type 2, Chronic kidney disease is listed under “with”. The 2 conditions are assumed related, unless the physician documents that they are unrelated.

Patient with Type 2 Diabetes and Acute kidney failure would be coded
- E11.9 Type 2 diabetes mellitus without complications
- N17.9 Acute kidney failure, unspecified
  - In the alphabetic index, under Diabetes type 2, you will not find “Acute kidney failure” listed under “with”, therefore they are not assumed related.

“With” or “In”

These conditions should be coded as related even in the absence of provider documentation explicitly linking them,
- unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for “acute organ dysfunction that is not clearly associated with the sepsis”).

For conditions not specifically linked by these relational terms in the classification or when a guideline requires that a linkage between two conditions be explicitly documented, provider documentation must link the conditions in order to code them as related.

The word "with" in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.
Coding Specifics

Laterality
- Laterality should always be documented and should never be unspecified.
- Laterality must be 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 is 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 that 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.

- Examples:
  - 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
  - Cognitive communication deficit due to a traumatic brain injury
    - R41.841 Cognitive communication deficit
    - S06.9X9S Unspecified intracranial injury with loss of consciousness of unspecified duration sequela

Sequela Coding

For CVA coding the I69 codes are the sequela codes:

- **I69.3** Sequelae of cerebral infarction
- **I69.351** Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side

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!
Documentation by Clinicians Other than the Patient's Provider

Code assignment is based on the documentation by patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis).

- There are a few exceptions, such as codes for:
  - Body Mass Index (BMI)
  - Depth of non-pressure chronic ulcers
  - Pressure ulcer stage
  - Coma scale
  - NIH stroke scale (NIHSS) codes

- Code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient.

- Examples:
  - Dietitian often documents the BMI
  - Nurse often documents the pressure ulcer stages
  - Emergency medical technician often documents the coma scale
Documentation by Clinicians Other than the Patient's Provider

- The associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) **must** be documented by the patient’s provider.
- Ex: patient’s BMI is 36, but the physician has not documented obesity.
  - BMI cannot be coded without an associated diagnosis from the physician or NPP
- If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient’s attending provider should be queried for clarification.

Social Determinants of Health

- Information found in categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient’s provider since this information represents social information, rather than medical diagnoses.

The BMI, coma scale, NIHSS codes and categories Z55-Z65 should only be reported as secondary diagnoses.
Primary Diagnosis/Terminal Illness

The diagnosis that *most* contributes to the terminal condition should be listed as the primary diagnosis

- This diagnosis is identified by the hospice physician and any non-hospice attending physician the patient identifies on the EOB (election of benefits) form.

The physician writes a Certificate of Terminal Illness (CTI) that identifies the terminal illness and provides clinical information about how it contributes to the patient's prognosis of six months or less if the terminal illness runs its normal course.
Primary Diagnosis/Terminal Illness

If the physician lists a manifestation diagnosis as the terminal illness on the CTI, the coder must follow CMS hospice billing guidelines and ICD-10-CM official coding guidelines by reporting the appropriate etiology code as the first-listed (principal)diagnosis, followed by the manifestation code indicated as the terminal condition.

When the principal terminal diagnosis must be changed to comply with coding guidelines, a note should be entered into the patient chart to explain why the primary diagnosis on the care plan does not match the initial CTI form.

Primary Diagnosis/Terminal Illness

Example

- If chronic combined systolic and diastolic heart failure is the terminal diagnosis for a patient who also has hypertension, you must follow the coding guidelines.
- The subcategory for Heart Failure has an instructional note to “Code first heart failure due to hypertension (I11.0).”
- And I11.0 Hypertensive heart disease with heart failure has an instructional note “Use additional code to identify type of heart failure (I50.-).”
- These instructions require the coder to list the etiology/manifestation pair with I11.0 (Hypertensive heart disease with heart failure) first, followed by the manifestation code I50.42 (chronic combined systolic and diastolic heart failure).
Primary Diagnosis/Terminal Illness

Codes not reportable as Principal Terminal Diagnoses (First Listed)
- There are several diagnosis codes that are not reportable as principal terminal diagnoses on the hospice claim:
  - Any diagnosis codes that cannot be used as the principal diagnosis according to ICD-10-CM coding guidelines, or those that require further compliance with ICD-10-CM coding conventions, such as those that have principal diagnosis code sequencing guidelines
  - Debility
  - Dementia codes classified as unspecified (most are manifestation codes)
  - Failure to Thrive
  - V, W, X OR Z Codes

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
Hospice Invalid Principal Diagnosis Codes

The following is a list of specific invalid primary codes from the CMS transmittal 8877:

**F01.50** Vascular dementia without behavioral disturbance  
**F01.51** Vascular dementia with behavioral disturbance  
**F03.90** Unspecified dementia without behavioral disturbance  
**F03.91** Unspecified dementia with behavioral disturbance  
**F05** Delirium due to known physiological condition  
**F06.0** Psychotic disorder with hallucinations due to known physiological condition  


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**F06.1** Catatonic disorder due to known physiological condition  
**F06.2** Psychotic disorder with delusions due to known physiological condition  
**F06.30** Mood disorder due to known physiological condition, unspecified  
**F06.31** Mood disorder due to known physiological condition with depressive features  
**F06.32** Mood disorder due to known physiological condition with major depressive-like episode  
**F06.33** Mood disorder due to known physiological condition with manic features  

Hospice Invalid Principal Diagnosis Codes

- **F06.34** Mood disorder due to known physiological condition with mixed features
- **F06.8** Other specified mental disorders due to known physiological condition
- **F07.0** Personality change due to known physiological condition
- **F07.81** Postconcussional syndrome
- **F07.89** Other personality and behavioral disorders due to known physiological condition
- **F09** Unspecified mental disorder due to known physiological condition


Primary Diagnosis/Terminal Illness

**Assigning primary diagnoses**

- When the information documented on the CTI or on the nursing admission assessment is different from what is documented in the patient's medical records,
- or if more specific information is needed to determine the principal diagnosis code, **you must query the physician for clarification**.
- Do not list symptoms when the condition/disease is known.
- Never assign a manifestation code as a principal diagnosis code.
- No circumstance allows principal diagnosis code assignment to violate ICD-10-CM official coding guidelines.
Secondary/Comorbid Diagnoses

It is important to code comorbidities to support the patient’s life expectancy of 6 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

Hospices are to identify and code on both the plan of care and the claim all of a patient’s coexisting diagnoses, both related and unrelated to the terminal prognosis.

The interdisciplinary group must address and include all related and unrelated coexisting diagnoses in the hospice plan of care

This coding could help support the terminal condition of the patient
- The hospice claim will allow up to 24 additional diagnoses on an electronic claim.
- There is no indicator on the claim to identify a diagnosis as related or unrelated to the terminal prognosis.
Secondary/Comorbid Diagnoses

Secondary Diagnosis are additional (co-morbid) conditions that affect patient care.

Information regarding diagnoses may be obtained from several sources:
- Referral Documents
- H&P Documents
- The CTI
- Initial Hospice Orders/Other Physician Orders
- F2F
- Medication Profile
- Nursing Assessment

Assigning secondary/comorbid diagnoses - Sequencing

- Once all of the patient's secondary/comorbid conditions have been identified, the next step is to determine the sequence of the secondary/comorbid diagnoses.
- Hospice coders should be aware of a condition’s potential relevance to the terminal prognosis and sequence diagnoses that are likely related to the terminal prognosis before those that seem to be unrelated.
- Sequence the related diagnoses immediately following the primary diagnosis.
- Sequence Z codes that indicate reasons for encounters, such as Z43.3 Encounter for attention to colostomy, in the order that most accurately reflects the patient's status and needs.
- V, W, X, Y, and Z codes should only be assigned when they provide additional information related to the patient status and/or needs.
Secondary/Comorbid Diagnoses

Assigning Secondary/Comorbid Diagnoses

◦ Do not code symptoms in place of a known condition or disease.
◦ Symptoms may be coded when not integral to an existing diagnosis.
◦ Debility, Failure to Thrive and/or Dementia codes classified as unspecified may be assigned in a secondary position if there is not a more specific diagnosis verified by the physician.

Secondary/Comorbid Diagnoses

◦ Do not code a diagnosis that is resolved.

◦ If the history of the resolved diagnosis impacts the patient’s terminal prognosis (such as Z85.520 History of malignant carcinoid tumor of kidney) then assign the appropriate Z code for history of the resolved diagnosis, if one exists.

◦ Diagnoses obtained from the nursing assessment/care plan that are not substantiated in the patient’s medical records cannot be used in the diagnosis list until they are documented as being confirmed by the hospice physician.
Related & Unrelated Diagnoses

- The Medical Director, along with the Clinician, should be defining & documenting the primary terminal diagnosis before sending to the coder.
- CMS assumes diagnosis is related until physician documents that it is not.
- The physician is responsible to document *why* the diagnosis is not related.
- So, if the clinician / Medical Director hasn’t completed this before the coder codes, they may have to modify codes afterwards.
- 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?

Clinician Assessment and 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 office after the initial visit and confirm diagnoses while giving report.
Physician Confirmation of Diagnoses

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 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 3 characters and others require up to 7 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 their website.

You can find a list of allowed codes as well as codes that are not allowed by your MAC on the site.

Disease Specific Criteria For Hospice
*CGS Hospice Local Coverage Determination guidance was referenced for the following disease specific criteria and should be considered basic guidance. Please be sure to reference the Medicare Administrative Contractor (MAC) for your jurisdiction to ensure accuracy for Hospice Local Coverage Determinations.

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

Amyotrophic Lateral Sclerosis (ALS)

Amyotrophic Lateral Sclerosis
◦ 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

Amyotrophic Lateral Sclerosis (ALS)

Continued

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

Amyotrophic Lateral Sclerosis (ALS)

Continued

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.*

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**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.

1. The patient should show both
   - Prothrombin time prolonged more than 5 seconds over control, INR > 1.5
   - Serum albumin
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

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

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)

Renal Disease

Continued

Acute renal failure:
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)

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 and 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.

**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
Documentation of diagnostic imaging factors which support poor prognosis after stroke include:

For thrombotic/embolic stroke:
- Large anterior infarcts with both cortical and subcortical involvement;
- Large bihemispheric infarcts;
- Basilar artery occlusion;
- Bilateral vertebral artery occlusion.

Coma from any cause
Comatose patients with any 3 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
Stroke and Coma

Continued

Coma from any cause

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

- Follow Coding Guidelines
- Obtain thorough referral information
- Code all of a patient's coexisting diagnoses, both related and unrelated to the terminal prognosis
- Clarify diagnosis with physician and document
- Be sure clinician documentation supports coding
Thank You For Participating!

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