ICD-10 Coding
Clarifications
for Hospice: Part 1

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ICD-10-CM Has Been Here for 9 Months

• The implementation of ICD-10-CM has generally gone smoother than many expected.
• However, as with anything new, there have been many changes in interpretation and guidance.
• The more we get into ICD-10, the more questions have arisen about how best to code or sequence hospice situations.
• To add to the uncertainty, there continues to be new expectations from CMS regarding coding for hospice.
• Today’s session is aimed at trying to tackle some of the questions that are common to many hospice programs.
Coding for Hospice Patients

• CMS continues to “clarify” diagnosis reporting on hospice claims, moving from a primary hospice diagnosis to including all related and non-related conditions that impact the terminal condition or prognosis of each hospice patient.

• Hospice programs, as all health care settings, are required to follow the ICD-10-CM Official Guidelines for Coding and Reporting Diagnoses, published by the Coordination and Maintenance Committee, often referred to as the Cooperating Parties.
  – A copy of the Official Guidelines is located in the front of every coding manual.
  – An updated version for 2017 is expected to be released anytime between now and October 1, 2016.

ICD-10-CM 2016 Official Guidelines

For Coding and Reporting Diagnoses: Selection of the Principal Diagnosis

• The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

• In the case of selection of the principal diagnosis for hospice care, this would mean the diagnosis most contributory to the terminal prognosis of the individual.

• In the instance where two or more diagnoses equally meet the criteria for principal diagnosis, ICD-10-CM coding guidelines do not provide sequencing direction, and thus, any one of the diagnoses may be sequenced first, meaning to report all of those diagnoses meeting the criteria as a principal diagnosis.
  (Section II)
Assigning Diagnoses

All health settings, including hospice, must code all conditions/diagnoses that are related to the reason you are seeing the patient.

- If the hospice patient has diagnoses non-related to their terminal condition, the hospice physician should document why those diagnoses or conditions are not related to the patient’s terminal status and that information should be in the medical record.

Hospice personnel should add additional documentation to the medical record to fully explain each patient’s situation such as documentation of recent history and the physical and mental status.

Diagnosis codes can be changed at any time the patient’s condition changes, but should be documented in the medical record along with the rationale for making the change.

Guidelines to Apply in Designating "Other Diagnoses"

The listing of the diagnoses in the patient record is the responsibility of the hospice medical director and the attending physician.

Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admissions that have no bearing on the current stay.

- Such conditions are not to be reported.
- History codes may be used as secondary codes if the historical condition has an impact on the current care or influences treatment.

History codes should not be coded if they have no impact on the patient’s current situation.
Guidelines (continued)

Abnormal findings (lab reports, x-rays, pathologic and other results are not coded and required unless the provider indicates their clinical significance and plans to continue monitoring diagnostic studies (a rare situation in hospice).

Uncertain diagnoses, qualified as probable, suspected, likely, questionable or other similar terms can only be coded by short-term, acute, long-term care and psychiatric hospitals.

What about Determining Terminal Prognosis?

The basic foundation of the hospice benefit is that it is designed to provide palliative and symptom management to a patient who has a life expectancy of six months or less (prognosis).

Most patients have multiple diagnoses or needs that are based on their unique physical and mental health history and current status.

– Some of these needs no long impact or have an increased impact on the patient as he or she progresses to the terminal stage of life.
– Treatments directed at some long term conditions may present more harm than benefit or are determined to be ineffectual or not palliative therapy within the terminal phase of life.
– Some chronic diagnoses are long-standing and stable and have no impact on (no contribution to) the terminal prognosis.
View Each Patient as A Unique Individual

- A shift to viewing each patient as a unique and individual situation as they approach the terminal phase of life enables the hospice of today to see the patient in a holistic manner and recognize that many conditions and factors affect the care of the patient during this last stage of life.
  - Even patients with the same or a similar array of long-term chronic conditions may have a different impact from their diagnoses on their terminal prognosis.
  - A clear and complete documentation of the patient’s current and ongoing physical, mental, spiritual and social functional level goes further to establish their appropriateness for hospice care than any specific diagnoses.

Sorting Through Potential Diagnoses

Delete diagnoses that are not true diagnoses or that no longer apply now that the patient is at the terminal stage of life.

- Many times medical records list a diagnosis of an event in the past, but there is no current treatment and has been no recurrence – this is a history diagnosis and coding guidelines instruct not to code these unless it somehow impacts the patient’s current condition.
- Examples – hyperlipidemia, hypercholesterolemia potentially a patient who developed adult onset type 2 diabetes primarily due to life style factors and now that the patient is no longer overeating, using excessive alcohol, overweight, etc., they no longer require any treatment for the diabetes nor exhibit any symptoms.
Basic Coding Reminders

All diagnosis or condition codes must be stated or confirmed by a physician or other qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis. (Introduction to ICD-10CM Official Guidelines for Coding and Reporting)

The term “in conditions classified elsewhere” is a convention that requires the coder to follow the same sequencing rules as etiology/manifestation convention:

**Code the etiology (cause) first!**

The term, “use an additional code …” is also a convention and means to add an additional code.

Who is Responsible for Ensuring Eligibility?

The hospice agency is ultimately responsible for ensuring that all patients served by the hospice meet the eligibility criteria for the Medicare (and other payer) eligibility criteria and that the services provided are medically reasonable and necessary.

Hospice is based on the fundamental principles of providing holistic care utilizing an interdisciplinary team, which includes the medical director, to manage and monitor the care to each patient throughout their length of service.

The IDG team should also use their collective knowledge and experience to determine what diagnoses actually are currently active for each patient.
Diagnoses Are Not Static

As a patient moves through the terminal phase of life, diagnoses may change - some no longer appropriate and new diagnoses appear.

No changes in the diagnoses or order of diagnoses over a prolonged period can send a message of stability and lack of change occurring in the patient’s condition.

The Hospice Medical Director is primarily responsible to identify the terminal prognosis for each hospice patient, by identifying the contributing diagnoses, the appropriate treatment and determine and document what diagnoses are unrelated to the terminal prognosis.

Each of the members of the IDT/IDG has unique perspectives to contribute to the patient and caregiver and the evaluation and development of the overall plan of care.

Guide to Sequencing Diagnoses

Sequencing diagnoses is influenced by:

- Instructional notes within the code set (code first, add an additional code, etc.)
- Ordering the diagnoses based on the level of contribution toward the terminal prognosis.
- General order sequence:
  - Principal diagnosis or multiple diagnoses that meet the requirement as principal diagnosis.
  - Other active diagnoses that are related to and impact the current care
  - Z codes can be useful to describe a patient’s condition, but are less specific than medical diagnoses
  - Non-related diagnoses
How Many Diagnoses Should Be Coded?

There is no magical number of diagnoses that should be coded

– Claims can accommodate up to 25 diagnoses
– Many software systems limit the number of diagnoses that can be listed to 10.
– If there are additional diagnoses that that cannot be placed in the diagnoses section, they can be added as a narrative to the plan of care in the orders section.
– CMS requires hospice to code all diagnoses, related and non-related that a patient has that are current or active diagnoses.
– Many information systems automatically pull the diagnoses listed on the Plan of Care to the claim form.
– Use critical thinking when determining current diagnoses and avoid listing unnecessary history codes or codes for conditions that no longer exist.

Key Problematic Areas
Some Coding Topics Lead to Many Questions

Some of the top problematic areas in hospice coding

- Use of Symptom Codes
- Dementia
- Use of combination codes, particularly Hypertension and chronic kidney disease and hypertensive heart failure and heart diseases
- Sequencing primary and secondary cancers
- How to code diagnoses that do not have a listing in the coding manuals such as “end stage” liver or heart failure.
- Use of acute cerebrovascular diagnoses versus sequela (late effect) codes
- Fractures as a primary diagnosis for hospice

General Coding Guidelines

Signs and Symptoms

Codes that describe symptoms and signs, as opposed to diagnoses are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of the ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00.0-R99) contains many, but not all codes for symptoms (General Coding Guidelines, Section I.B.4)

Conditions that are an integral part of a disease process

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification. (General Coding Guidelines Section I.B.5)
General Coding Guidelines (continued)

Conditions that are not an integral part of a disease process (General Coding Guidelines, Section I.B.6)

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

Example: signs integral part of a disease process

- Edema, SOB, or pleural effusion in CHF
- Dyspnea in COPD
- Ascites or jaundice in liver failure
- Pain or joint stiffness due to osteoarthritis
- Nausea and vomiting with gastroenteritis
- Gait abnormality or muscle weakness with hemiplegia

Signs/Symptoms/Unspecified Codes

Signs/Symptoms and “unspecified codes have acceptable, even necessary uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choice for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified code.
Unspecified Codes (continued)

Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient’s condition at the time of that particular encounter.

It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

General Coding Guidelines Section I.B.18

Case Example 1

Patient referred to hospice who is declining years after a stroke with residual deficits of right sided weakness, dysphagia; CAD, HTN, cerebral vascular disease, incontinence of bowel and bladder, stage I pressure ulcer on sacrum, hyperlipidemia, hypercholesterolemia, H/O recurrent pneumonia, H/O recent UTI, and H/O CVA with residual effects.

• What is the best way to code this situation?
• Additional information is needed: What type of cerebral vascular disease does this patient have – without additional information, you would be limited to code I67.9, Cerebrovascular disease, unspecified
Case Example - Discussion

H/O CVA with residual effects is not an existing code. Hx of CVA without residual effects is an inappropriate code to use.

If the patient has residual effects from a CVA, the residuals should be listed as sequela of non-traumatic cerebrovascular diseased and listed in order of their contribution to the terminal prognosis.

The choice of the 4th character following I69. depends on the underlying cause of the CVA – specific type of hemorrhage, or infarction

- I69.3: used if all that is know is that the patient had a stroke or a non-traumatic cerebral infarction
- I69.8: used if the patient had an other type of non-traumatic CV disease other than stroke, infarction or hemorrhage (subarachnoid, intracerebral, or intracranial)
- I69.9: used if the patient has unknown/unspecified CVA disease

Case Example – Discussion (continued)

History codes mean that a patient had a condition, but it is now gone and are only coded if needed to explain the patient’s current situation or condition is expected to reoccur.

It would be highly unusual for Hyperlipidemia and hypercholesterolemia to be listed as the principal diagnoses indicating they are the most contributory to a life expectancy of 6 months or less.

IDG will need to determine the degree of impact of HTN and CAD on the terminal prognosis to determine in what order to sequence these diagnoses.

Stage I pressure ulcer and incontinence can be appropriate secondary codes to illustrate a patient’s decline as well as the need for additional care.
**Suggested Case Example Answer**

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysphagia following non-traumatic cerebral infarction</td>
<td>I69.391</td>
</tr>
<tr>
<td>Dysphagia, unspecified</td>
<td>R13.10</td>
</tr>
<tr>
<td>CAD without angina pectoris</td>
<td>25.10</td>
</tr>
<tr>
<td>Hypertension</td>
<td>I10</td>
</tr>
<tr>
<td>Stage 1 pressure ulcer on sacrum</td>
<td>L89.151</td>
</tr>
<tr>
<td>Incontinence bowel and bladder</td>
<td>R32, R 15.9</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>E78.5</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>E78.0</td>
</tr>
<tr>
<td>Hemiplegia &amp; hemiparesis following cerebral infarction - R dominant side</td>
<td>I69.351</td>
</tr>
<tr>
<td>H/O recent UTI</td>
<td>Z87.440</td>
</tr>
<tr>
<td>H/O recurrent pneumonia</td>
<td>Z87.01</td>
</tr>
</tbody>
</table>

**Combination Codes & Clinical Concepts**

An increase in combination codes for certain conditions and common associated symptoms and manifestations

- I25.110 = Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
- E11.319 = Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema

Combination codes for poisonings and their external causes

- T42.3X2S = Poisoning by Barbiturates, intentional self harm, sequela

Added clinical concepts – e.g., underdosing, blood type, blood alcohol level, coma scale

- T45.526D = Underdosing of antithrombotic drugs, subsequent encounter
**Combination Code**

A combination code is a single code used to classify:
- Two or more diagnoses; or
- A diagnosis with an associated secondary process (manifestation); or
- A diagnosis with an associated complication.

Assign only a combination code when that code fully identifies the diagnostic conditions involved, or when directed by the Alphabetic Index to do so.

When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.

➢ **Note:** Assigning a combination code, if available, instead of multiple codes, is required!

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**For Example...**

All elements identified in one combination code:
- I69.351, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side

Combination code lacks necessary specificity:
- I69.361, Other paralytic syndrome following cerebral infarction affecting right dominant side.
- Subcategory I69.36 instructs to “Use additional code to identify type of paralytic syndrome, such as:”
  - locked-in state (G83.5)
  - quadriplegia (G82.5-)

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**Coding Convention**

The term “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the tabular List.

The word “with” in the Alphabetic Index is sequenced immediately following the main term, not in alphabetic order.

Example under the main term hypertension

- Hypertension with heart involvement (conditions in I51.4-I51.9 due to hypertension) see Hypertension, heart
- Kidney involvement – see Hypertension, kidney

Hypertension

heart (disease) (conditions in I51.4-I51.9 due to hypertension) I11.9
kidney I112.9

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**Circulatory System Questions**
New Coding Clinic Clarification

The Editorial Advisory Board for Coding Clinic for ICD-10-CM/PCS has reconsidered previously published advice about coding heart failure with preserved ejection fraction (HFpEF), and heart failure with reduced ejection fraction (HFrEF) based on input from the American College of Cardiology.

- HFpEF, heart failure with preserved Ejection Fraction may be referred to as heart failure with preserved systolic function, or diastolic heart failure.
- HFrEF, heart failure with reduced or low Ejection fraction may also be referred to as heart failure with reduced systolic function, or other similar terms meaning systolic heart failure.

Coding End Stage Heart Failure

- There is no specific code for indicating End Stage Heart Failure.
- Clarifications that have been provided:
  - If a provider has documented and clarified the patient has end stage heart failure without further specification of the type of HF, it is appropriate to code I50.9, HF unspecified.
  - The provider must specify if the HF is acute, chronic or acute on chronic.
  - Acute on chronic or acute cannot be assumed based on the term “end stage”.
Coding CVAs in Hospice

Hospice is a palliative care and symptom management program versus a program directed at curative or rehabilitative care.

If a patient with a new CVA is admitted to GIP or any other level of hospice care, the most appropriate code(s) are sequela of a non-traumatic cerebrovascular disease with the 4th character specifying the type of cerebrovascular disease as:

- hemorrhage (subarachnoid, intracerebral, or intracranial),
- infarction (or stroke),
- other CV disease, or
- unspecified CV disease

Coding CVAs in Hospice

The only time it is appropriate to code an acute code for a CVA in Hospice is if the patient has a current bleed that has not stopped or the patient has refused treatment to stop the hemorrhage.

For all other situations the sequela codes describe the current conditions that require symptom management or palliative care followed by any other related and unrelated conditions

- Many are combination code; others require an additional code to describe the current residual
- Example: A patient who is referred to hospice in a coma following a nontraumatic subarachnoid hemorrhage would be coded:
  - I69.0198, Other sequelae following nontraumatic subarachnoid hemorrhage
  - R40.20, unspecified coma
**Question from Coder**

If the patient has a primary diagnosis of cerebrovascular disease, but aspirates and gets sepsis which will not be treated and will lead to the patient’s demise, should the primary diagnosis change to sepsis or just reflect a complication of the primary CV disease?

1. The primary diagnosis should be that diagnosis that is contributing the most to the patient’s terminal prognosis.

**Question from Coder (continued)**

2. Based on this example, it appears that the sepsis is considered to represent the greatest reason this patient is terminal. Therefore the diagnoses should be updated through the IDG minutes and an interim order for changes in the interventions for this patient.

3. If the IDG determines that the patient is likely to continue to aspirate due to the cerebrovascular disease and that is more likely to be the cause of death, a revision to the code sequence to add the aspiration as an other effect of the CVA along with any changes in interventions should be made via interim orders. (This would be coded as other sequela following CV disease).
Hypertension Coding

Hypertension is coded to categories I10-I15

I10 is essential hypertension and includes arterial, benign, malignant, primary and systemic hypertension.

- I11 Hypertensive heart disease – is a combination code that includes any condition in I51.4-I51.9 that the physician links with hypertension
  - I11.0 Hypertensive heart disease with heart failure requires a second code to describe the type of heart failure following the I11.0 code
  - I11.9 Hypertensive heart disease without heart failure
  - Currently, the physician must provide information of the linkage between hypertension and heart disease.

Hypertension Coding Note

Watch for a change in this direction for FY 2017 with the publication of the updated 2017 ICD-10-CM Official Guidelines for Coding and Reporting to be released prior to October 2016.
**Hypertensive Coding**

**I12 Hypertensive chronic kidney disease** is a combination code that is automatically coded if a patient has both hypertension and a condition from N18.- chronic kidney disease present.

- I12.0 is used when the patient has hypertension and chronic kidney disease stage 5 or end stage renal disease with a second code from N18.- to describe the stage of CKD.
- I12.9 is used when the patient has hypertension and CKD stage 1 through stage 4 or unspecified level of CKD with a second code from N18.- to describe the stage of the CKD.
- If the patient has hypertensive CKD and acute renal failure, an additional code is required for the acute renal failure (N17).
- Hypertensive CKD is a Coding Guideline that presumes the hypertension and CKD are related and does not require the physician to state that the two are related.

**Hypertensive Coding**

**I13 Hypertensive heart and CKD** is a combination code when the patient has all three of these conditions:

- I13.0 Hypertensive heart and CKD with heart failure and stage 1-4 or unspecified CKD. An additional code to describe the heart failure (I50.-) and a code from N18.- to describe the stage of CKD are required.
- I13.10 Hypertensive heart and CKD without heart failure, with stage 1 – stage 4 or unspecified CKD. This code requires an additional code from N18.1 –N18-4, N18.9) to identify the stage of CKD.
- I13.11 Hypertensive heart and chronic kidney disease without heart failure, with stage 5 CKD or end stage renal disease. An additional code from N18.5 or N18.6 to identify the stage of CKD is also required.
- I13.2 Hypertensive heart and CKD with heart failure and with stage 5 CKD or end stage renal disease. Additional codes to identify the type of heart failure (I50.-) and to identify the stage of CKD (N18.5 , N18.6) are required with this code.
- Physician must link the HTN and heart failure, but the HTN and CKD are presumed to be related without physician linkage under current Guidelines.
**Hypertension Coding**

I15 Secondary hypertension used whenever hypertension is reported in the record and confirmed by the physician as due to renal dysfunction.

- Requires an additional code to identify the etiology/underlying cause in addition to the code from I15 for the secondary hypertension. Sequence is based on the reason for the admission.
- I15.0 Renovascular hypertension when stated as renovascular or due to renal artery stenosis
- I15.1 Hypertension secondary to other renal disorders
- I15.2 Hypertension secondary to endocrine disorders such as Cushing’s syndrome, primary aldosteronism, acromegaly, hypo/hyperthyroidism or other specified endocrine disorder.

**Coder Question**

If the doctor states in the CTI that CKD and hypertension are not related, I am assuming I cannot establish a relationship between the two codes and code the combination code.

- The combination code for hypertension and CKD is a Coding guideline that automatically presumes these two conditions are related.
- While a physician can override a guideline, physicians are also held to these coding guidelines. Therefore, you will need to be certain whether the physician is saying the HTN and the CKD are not related to one another or whether he is saying the HTN and CKD are not related to the hospice prognosis.
- Since this change violates a Coding Guideline, there must be specific documentation regarding this situation in the medical record.
Fractures as Principal Diagnosis – Hospice

In ICD-10-CM, services related to fractures are codes with the original fracture code and the appropriate 7th character to describe both the sequence of services and any complications.

- A fracture code is not likely to be accepted as a principal diagnosis to support the hospice benefit because the fracture itself is not the most contributing condition to the terminal prognosis.
- Clinicians and coders need to look at what factors surrounding the fracture or the repair of the fracture are contributing to the terminal prognosis.
  - Complication related to the fracture or its treatment: reaction to anesthetic, infection, venous thrombosis, etc.
- If the complications is a result of the fracture, the fracture with a 7th character S for sequela may be coded after identifying the issues that resulted from the fracture.
**Coding Primary or Secondary Cancers**

**Q.** Patient with metastatic breast cancer listed as the primary S/P mastectomy with mets to the lung. What is coded primary?

**A.** Code the major focus of care (most contributory to terminal status) first. Metastatic CA to lungs would be coded first if no breast tissue present.

If bilateral mastectomy with no breast tissue remaining, code history of breast cancer Z85.3); If single mastectomy and record indicates breast cancer is still present, code as active breast cancer by site.

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**Coding Primary or Secondary Cancers**

**Q.** Metastatic Rectal cancer listed as primary with mets to liver. Which should be listed primary?

**A.** Chapter 2, Neoplasm Guidelines direct when both primary and secondary cancer sites are present, the primary source is to be coded first (Rectal cancer) followed by the secondary site (liver).
Coding Presumed Cancer Diagnoses

Coding Official Guidelines only allow acute short and long term hospitals and psychiatric hospitals to code uncertain diagnoses such as “probably”, ‘suspected’, “likely”, “questionable” and “possible” as confirmed diagnoses.

In hospice, there are some physicians that will provide a confirmed cancer diagnosis based on the patient’s history. In these cases, the physician has provided you with a code so the hospice can code it.

Coding Presumed Cancer Diagnoses (continued)

One cautionary note: be sure the physician confirmation of the diagnosis and as much information from the patient’s medical records as possible that supports that diagnosis is present in the hospice record to support Hospice service eligibility.

Unless there is a confirmed diagnosis by an individual authorized to determine diagnoses, the hospice will have to code the symptoms or other description such as a “mass” when a patient declines diagnostic workup.

Clinical documentation of the patient’s history and changes to their condition is vital to obtain coverage for hospice care in these situations.
Assuming Linkages

Are there other diagnoses where we can assume there is a causal relationship and if we see certain diagnoses, can we link them?

- Example Acute respiratory failure listed as primary diagnosis with related diagnosis of SOB, Dysphagia, Dyspnea and Hypoxia.
  - Dyspnea and SOB are symptom codes that are inherent in acute respiratory failure so they would not be coded separately.
  - Dysphagia would not be inherent to acute respiratory failure and can be coded as a separate comorbidity if it is current and impacts the patient’s care.
- Since Hypoxia is listed as a secondary code, would we link it to the acute respiratory and use the J96.01 code?
  - Hypoxia is listed under the subentry “with” in the Alphabetic Index under acute respiratory failure which establishes a linkage between the two conditions and would be coded correctly as J96.01

Malnutrition, Weight Loss, Anorexia and other Symptoms

These symptomatic codes are used heavily in hospice to describe patients that are elderly, frail, debilitated and are clearly declining, but do not have a definitive disease that primarily supports hospice care.

They may also have a myriad of chronic diagnoses, but no one diagnosis that is clearly responsible for the patient’s terminal prognosis.

Physicians have to establish actual diagnoses, but the hospice team must provide all the evidence to support those diagnoses and the patient’s eligibility for the hospice benefit.
Clinical Documentation Is the Key

Qualifying these patients for hospice requires putting the picture together including:

- Coding Body Mass Index on a regular basis or detailed descriptions that show the loss of weight
- Describing the skin turgor, loss of muscle mass, hanging skin, measure limb circumference
- Identifying the minimal intake of food and fluids
- Describing the patient’s loss of strength and need for increasing assistance with activities of daily living, self care, management of daily activities, etc.
- Describing how the existing chronic conditions are all contributing to the patient’s decline

Questions?

Thank you for attending!

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