Determining Primary and Related Diagnoses

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Disclosure

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Objectives

• Define and discuss “Relatedness” to prognosis
• Recognize recent changes in coding nuances
• Code “correctly” primary and related diagnoses ...
• ... So we can be paid for our hospice work

What Changed in 2013-15?

• Can’t use AFTT, debility or other ‘general symptoms’ (R50-R69) as “Primary Diagnosis”
• Can’t use dementia, ‘mental Dx secondary to medical conditions’ (F01-F09) as Primary Dx
• All conditions related to “Terminal Prognosis” must be coded in billing, and pay for Rx/Tx
• All conditions unrelated must be listed in chart and justified by MD why they are NOT related

CMS on RELATED VS. UNRELATED

• “It is our general view that … hospices are required to provide virtually all the care that is needed by terminally ill patients” (48 FR 56010 – 56011)
• Therefore, unless there is clear evidence that a condition is unrelated to the terminal illness, all services would be considered related. It is also the responsibility of the hospice physician to document why a patient’s medical needs would be unrelated to the terminal illness/prognosis.

CMS expectation

“We have previously acknowledged that there are those rare circumstances in which a service may not be related to the patient’s terminal prognosis and that this determination is to be done on a case-by-case basis by the hospice physician with input from the IDG.”

More on “Relatedness”

• There is no standardized definition of ‘relatedness’
• Discussion among experts reveals considerable variance in practice
  • Part of CMS’ motivation for these proposed rules is that some providers have used “debility” as a diagnosis and then managed every other diagnosis as unrelated
  • If a diagnosis contributes to the patient’s terminal prognosis, then it should be considered related
• Pain and symptom management should always be considered covered, regardless of relatedness
  – This includes pain, nausea, shortness of breath, anxiety, constipation, diarrhea, and depression, plus disease-specific medications
What Changed for 2016?

- Implication that ALL diagnoses need to be coded, not just related to terminal prognosis.
- Physician still has to justify Dx not related.
- Dx sequence follows ICD rules (cause), not prior CMS rules to list most terminal Dx first.
- No “Manifestation Codes” as Primary Dx
- Code as specifically as possible in ICD 10

CMS inconsistency

CMS claims manual:
“the principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient’s admission”

But the manual also says to follow ICD-9/10 coding guidelines. e.g., Hospices generally list ESRD is the cause for a patient’s terminal prognosis and use the LCD to support this choice; diabetes listed 2nd as a related but non-terminal diagnosis
This is apparently no longer the correct choice

The CMS Hospice Claims Processing manual (Pub 100-04, chapter 11) requires that hospice claims include other diagnoses “as required by ICD-9-CM Coding” and the Medicare hospice claims processing manual also require that these ICD-9-CM Coding Guidelines be applied to the coding and reporting of diagnoses on hospice claims.

Who Pays for Medications?

- May 2014 ruling: need prior authorization (PA) for all unrelated meds (did not last-ridiculous)
- 4 categories did last:
  - Related: Hospice pays (Can use formulary)
  - Unrelated but necessary: Part D pays
  - Not medically necessary (e.g. statin): Patient pays
  - Related but not on formulary: Patient pays*
- Patient pays for nonformulary or unnecessary meds if unwilling to stop or trial formulary meds*

Prior Auth: Final Rule

- Now PA will only be required for 4 classes of medications:
  - Analgesics
  - Antiemetics
  - Laxatives
  - Anti-anxiety
- Hospice pays for ALL symptom medications, plus meds related to terminal prognosis (all related diagnoses)

The Down-and-Dirty

Medication is Related to the Terminal Prognosis (and paid by Hospice):
- If it is directly related to treating the principal diagnosis (organ system?)
- AND Is used to treat symptoms related to principal diagnosis
- AND Is used to treat symptoms related to therapies (chemo) used to treat principal diagnosis
- AND/OR Is used to treat secondary conditions related to principal diagnosis (aspiration pneumonia/pressure ulcers) for dementia patients
- AND/OR Arises as a consequence of principal diagnosis (bone fracture secondary to metastatic bone lesion)
- OR ANY secondary diagnosis which affects prognosis of ≤ 6 months
- OR The hospice physician cannot make compelling reason why it is not related to the terminal prognosis

Example 1

Batty N Belfry is a 97 yo woman with end stage (NYHA Class 4) Heart Failure, with dyspnea and chest pain at rest, moderate COPD, Type 2 Diabetes, Hypothyroidism and Hyperlipidemia, the latter 3 controlled with oral medications.

What is coded, what is related, and how would the hospice physician specify the unrelated diagnoses?
Example 1

CHF
COPD
Diabetes
Hypothyroidism
Hyperlipidemia

Example 2 – Memories...

Donna R Member is a 92 yo woman with moderate Dementia, and since a cold 6 weeks ago she has lost 15 lbs (128 to 113 lbs, BMI 17), PPS 50% to 40%, ADL’s now 4/6 assisted and she doesn’t care to live. She has A-fib and takes thyroid medication (who doesn’t lately?).

What is her primary diagnosis? What’s related?

Dementia Sticking Points

• “Dementia” codes not generally primary
• Alzheimer’s Dz, Lewy Body Dementia, Pick’s Dz or other specific dementia Dx is OK as primary.
• Vascular Dementia, though a reasonable Dx, is excluded from Primary Dx by coding rules
• Etiology for Vascular Dementia becomes first, eg, cerebral atherosclerosis, CVA sequelae, A-fib, hemorrhage, etc.

Example 2 - Continued

• If Donna’s diagnostic history is consistent with Alzheimer’s Dz, that becomes primary Dx, with AFTT as secondary.
• If clinical pattern is consistent with Vascular dementia, then Atrial Fibrillation is primary, Vascular Dementia and AFTT follow.
• Thyroid is rarely related to terminal prognosis

Example 3

94 yo woman with mild dementia, osteoporosis and hypothyroidism.
• She has gone to ER for falls x 3, and sustained a wrist fracture
• PPS declined from 60% to 40%
• Weight loss 10 lbs, BMI 19. Eating 20% meals
• Now dependent 3/6 ADL’s

Example 3 – Now What?

• Admitting nurse calls HMD, “this patient is clearly appropriate for hospice with rapid decline. What primary diagnosis should I use?
• Abnormal wt loss?
• Osteoporosis?
• Dementia?
• Hypothyroidism?
• Debility?
Example 3 – Which Diagnosis?

- Principle Dx: Osteoporosis
- Secondary Dx: Wrist Fracture, AFTT
- Unrelated Dx: Dementia, Hypothyroidism — Not contributing to her terminal prognosis now

This question was posed to one of the MAC’s, who confirmed osteoporosis as principal Dx.

Example 4

Patient referred to hospice from dialysis center. He has ESRD secondary to longstanding type I diabetes and wishes to stop dialysis. What diagnosis should you use?

- Diabetes primary, ESRD Secondary?
- ESRD Primary alone?
- ESRD Primary, Diabetes Secondary?

Example 4 – Cause or Effect?

ICD 10 Guidelines

- Diabetes Primary
- ESRD Secondary

ESRD is a “manifestation” of diabetes
ICD rules state that the etiology is listed as principal and follow proper “sequencing rules”. Large change from traditional Hospice practices.

Example 10 - Dialysis

Diabetic patient (A1c 7.2) has Poststreptococcal Glomerulonephritis ESRD and develops Pancreatic Cancer. He wants to continue dialysis.

- Can he receive Hospice?
- What is Related to his terminal prognosis?
- What is coded and what must be explained by MD?

One Method of Dx Documentation

Questions? Ideas? …?

THANK YOU!
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