Hospice and the ICD-10 Transition Impact

WEDI

June 9th, 2015
Presented by DecisionHealth

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Review of the Hospice Billing Process

• Benefit election
  – Beneficiary certified with terminal illness with life expectancy of 6 months or fewer
  – Notice of Election filed within 5 days, beneficiary waives all Part B rights related to terminal (except physician services)
  – First time hospice beneficiaries, provider may bill for Pre-election evaluation not subject to cap
Review of the Hospice Billing Process

• Payment of the Hospice Claim
  – Paid at daily Rate, One of 4 rates
  – Paid rate for each day beneficiary remains on hospice care, based upon claim code
    • Routine Home Care
    • Continuous Home Care
    • Inpatient Respite Care
    • General Inpatient Care
Review of the Hospice Billing Process

“For each day that a Medicare beneficiary is under the care of a hospice, the hospice is reimbursed an amount applicable to the type and intensity of the services furnished to the beneficiary for that day. For continuous home care the amount of payment is determined based on the number of hours, reported in increments of 15 minutes, of continuous care furnished to the beneficiary on that day. For the other categories a single rate is applicable for the category for each day.” (Chapter 11, CMS Hospice Claims Processing Manual)
Current Coding Issues & Hospice

- Hospice payment is not currently *DIRECTLY* impacted by ICD code assignment
- CMS has, however, increased pressure on hospices related to coding of claims since 2013
  - Pressure to include related diagnoses
  - RTP of claims with vague diagnoses as terminal (unspecified dementia, FTT, Debility) (almost 40% since 10/1/14)
  - Claim edits for incorrect use of etiology/manifestation pairing
  - Proposed rule implications
Current Coding Issues & Hospice

• Reasons for increasing pressure related to coding accuracy in the hospice setting
  • CMS has plans to implement PPS payment system for hospice
  • Payment data to link diagnostic data to other patient care factors will be needed to develop system of payment
  – Ongoing reviews of hospice claims have found lack of comprehensive diagnostic information within the claim and plan of care
Hospice FY2016 Proposed Rule

• Clarifies “that hospices must report all diagnoses of the beneficiary on the hospice claim as a part of the ongoing data collection efforts for possible future hospice refinements. We believe that reporting of all diagnoses on the hospice claim aligns with current coding guidelines as well as admission requirements for hospice certifications.”
  
  (CMS Federal Register, 5/5/15)

• In addition to rate updates, includes clarification (as above) regarding diagnosis coding practice within the hospice setting
Hospice FY2016 Proposed Rule

- CMS seeks to endorse a “philosophy of holistic, comprehensive, virtually all-inclusive hospice care”
- Previous investigation has found that current payment system incentivizes underreporting of diagnoses and provision of fewer services than needed by hospice agencies
- “$1.3 billion is being paid outside of the Medicare hospice benefit for those under an active hospice election.”
  - Includes home health benefit services being provided to hospice beneficiaries
  - Significant increase in ADRs/Medical reviews with payment denials in recent years
  - More than 60% of hospice providers continue to report only one diagnosis
Hospice FY2016 Proposed Rule

- Current hospice practices fail to provide all medically necessary services related to terminal illness
- CMS proposes:
  - Hospice to include all related and current diagnoses on hospice claim and plan of care
  - Hospice to address all relevant diagnoses as part of a holistic and comprehensive approach to end of life care
  - Billing practices should not reflect hospices’ attempts to reduce costs by pushing these on to other providers
ICD-10-CM and Hospice Readiness

• Hospice historically has been less prepared regarding coding practices
• Increasing focus by CMS on hospice coding practices will continue with ICD-10 implementation
• Training availability for hospices has been limited over time
  – New Opportunities, Industry needs education regarding need
  – Lack of understanding of importance to claims management as the codes do not directly tie to payment
ICD-10-CM and Hospice Readiness

• Hospices continue to struggle with particular coding issues related to ICD-9, which will spill over into ICD-10 readiness
  – Terminal illness coding when manifestation/etiology pair is required (sequencing guidelines- e.g. Hypertension with ESRD, when ESRD is terminal)
  – Requirement to code terminal diagnosis, often restricted by limited information available
ICD-10-CM and Hospice Readiness

• Hospice Specific Coding Issues Continued
  – Hospices may not code V codes as primary in ICD-9, limiting their ability to code fractures that have resulted in terminal prognosis. This will change in ICD-10 as fractures are not coded using aftercare, but the practice of avoiding fractures as a terminal diagnosis has been longstanding and requires re-education.

• Hospices often have fewer financial resources for coding education available
Impact of the ICD-10 delay to 2015 on Hospice providers

• Many hospice providers have been behind in coding education
  – Increasing education with recent RTP claims issues related to coding in ICD-9
  – Focus on ICD-9 claims issues for hospice has distracted from ICD-10 coding education among hospice providers

• Those that invested in earlier training have limited resources to repeat this education
Impact of the ICD-10 delay to 2015 on Hospice providers

• Hospice Coding Practices
  – Many are changing coding practices
  – Existing hospice coding often completed by home health coder, hospital coder, or clinicians/administrator/director of nurses, or other professional (no dedicated “coder”)
  – Workflow changes in light of upcoming ICD-10
    • Training to 1 responsible employee/coder
    • Outsourcing
    • Cross training current employee/coder
Issues Particular to Hospice and the ICD-10 Transition

• Increasing need for hospice specific training
  – Payer specific guidelines address specific guidelines that MUST be followed to assure accurate payment
  – FY2016 Proposed Rule implicates that final rule will likely include language requiring changes in hospice coding practices for FY2016
    • Increased inclusion of ALL unresolved diagnosis
    • Increased holistic care by hospice and less overlap with other providers
Issues Particular to Hospice and the ICD-10 Transition

• Increasing need for hospice specific training
  – Avoiding ADRs and Medical Review is critically linked to coding practices and increasingly more detailed with reorganization of code categories in ICD-10
    • Reorganization of some dementia codes
    • Increasingly specific Neoplasm coding
    • Guideline changes with Fractures in Neoplastic Disease
    • Changes in coding of fractures, no longer using aftercare
<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Ims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
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<td>81X</td>
<td>Hospice-Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>82X</td>
<td>Hospice – Non hospital</td>
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MM7492 Revised 2/20/15
Specifics for Hospice Dual Coding

- Certifications will have to be reviewed and dual coded for any that will have monthly billing in both September AND October.
  - September dates of service (*remember hospice is paid a daily rate) through 9/30 on one claim in ICD-9
  - October dates of service, beginning 10/1 on monthly claim in ICD-10
- Hospices require education in not using GEMs, dual coding processes
Specifics for Hospice Dual Coding

• Vendor issues
  – Hospice EMR Vendors, like Home Health EMR Vendors are using “translators” to automatically dual code claims
    • GEMs based
    • Hospices less educated generally in not using GEMs for dual coding purposes.
    • Will require manual review by either biller or coder for appropriateness
      – Verification against Certification of Terminal Illness, Plan of Care, Claim form
Hospice Support Needs with ICD-10

• CMS is calling on hospices to “do a better job in the provision and coordination of care than conventional Medicare services for those who were at the end of life.” (Federal Register, 5/5/2015)

• Increasing need for hospice specific coding education
  – Need for payer specific resources and education
  – Need for advocacy for coding accuracy among hospices
Hospice Support Needs with ICD-10

• Education needs
  – Implications of dual coding/claims impact/management of monthly billing with ICD-10 transition
  – Training for accuracy in coding within the ICD-10 code set, considering current “hot” issues in coding for hospices
    • RTP of claims issues
    • Coding terminal diagnosis – understanding when manifestation/etiology pairing
    • Assigning codes for all related and unresolved diagnosis
Hospice Support Needs with ICD-10

- **Education needs**
  - Understanding translation of diagnoses as assigned on admission prior to 10/1 on Certification of Terminal illness to ICD-10 Codes
  - Comprehensive Workflow process review to assure accurate and timely coding of plan of care, claims
    - Hospices should already have clear plans and workflow in place, but many do not.
    - Backup plan for workflow process
Hospice Support Needs with ICD-10

• Vendor support and education
  – EMR Vendors to the hospice industry are limited and many are still working out issues with other areas of documentation
  – Need for accurate translators- not relying on GEMs based translation of ICD-9 to ICD-10 codes
    • Both vendor and hospice agency MUST understand this
  – Vendor testing with monthly billing and translation of codes to claim forms.
Hospice Support Needs with ICD-10

- Quality Assurance Education
  - Hospices should be planning ahead to review claims during and after the 10/1 implementation of ICD-10
    - Reviewing a % of claims for accuracy
    - To identify risk of claims errors
    - To cross reference accurate coding on ICD-10 against CTI, POC, prior monthly bills on ICD-9
    - To identify accuracy in coding all relevant diagnoses including unresolved and related diagnosis
    - To identify accurate coding of terminal diagnosis, accurate coding against coding guidelines
Final Points

• Hospice Faces current ongoing scrutiny related to coding practices
  – This will only increase with ICD-10
• Traditionally, hospices have been less prepared in relation to coding and have coded fewer diagnoses and less accurately than other providers
• Hospice EMR Vendors and Hospice Agencies will require testing, education and support now, during and following transition
• Hospice generally needs greater support and advocacy for coding within its setting
Questions??
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