Hone Hospice Coding Skills & Prep for the HCS-H Exam

A WEBINAR PRESENTED ON MAY 16, 2023

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Presented By

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Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - Identify the importance of understanding how to appropriately code the principal hospice diagnosis.
  - Discuss required documentation to support coding the primary diagnosis with accuracy.
  - Identify ICD-10 coding rules and terminology to better understand their application to hospice coding.
  - Review key concepts & allowed materials needed to pass the HCS-H exam

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*"**CMS is looking closely at the hospice industry, as we have increasing concerns about fraud, waste and abuse in this space**. While this rule takes initial steps, this is part of a larger effort by CMS to address hospice fraud, waste and abuse that will continue this year."*

2024 CMS Proposed Hospice Payment Rule

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Table 3: Top Root Causes for Hospice

Root Cause Description	Error Category	Sample Claim Count
Physician's Certification/Recertification - Inadequate	Insufficient Documentation	34
Documentation does not support medical necessity for the service or item billed	Medical Necessity	31
Service intensity add-on (SIA) services documentation - Missing	Insufficient Documentation	18
Beneficiary election form - Inadequate	Insufficient Documentation	11
Physician narrative as part of the certification/recertification supporting terminal illness - Inadequate	Insufficient Documentation	10
Service intensity add-on (SIA) services documentation - Inadequate	Insufficient Documentation	9
Face to face documentation - Inadequate	Insufficient Documentation	7
Physician's Certification/Recertification - Missing	Insufficient Documentation	7
Face to face documentation - Missing	Insufficient Documentation	6
Physician certification was signed and dated after the claim was submitted	Other	6

Source: CERT improper payment reports

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Environment

Source: OIG

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Review of Hospices: Compliance with Medicare Requirements

Hospice provides palliative care for terminally ill beneficiaries and supports family and other caregivers. When a beneficiary elects hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary's terminal illness and related conditions. Federal regulations address Medicare conditions of and limitations on payment for hospice services (42 CFR Part 418, Subpart G). We will review hospice medical records and billing documentation to determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.

Source: OIG

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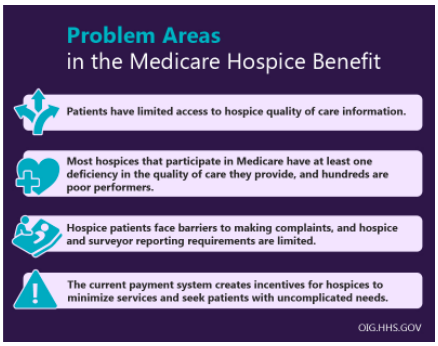
Hospice—OIG Workplan 2023

- Nationwide Hospice audit 2023
- Beneficiary Eligibility
- Focus on patients without inpatient or outpatient hospital services prior to admission to hospice



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Hospice Overview—Comprehensive Plan

- Hospice is a comprehensive, holistic program of care and support for terminally ill patients and their families. Hospice care changes the focus to comfort care (palliative care) for pain relief and symptom management instead of care to cure the patient's illness.
- Patients with Medicare Part A can get hospice care benefits if they meet the following criteria:
  - They get care from a Medicare-certified hospice
  - Their attending physician (if they have one) and the hospice physician certifies them as terminally ill, with a medical prognosis of 6 months or less to live if the illness runs its normal course
  - They sign an election statement to elect the hospice benefit and waive all rights to Medicare payments for the terminal illness and related conditions

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Hospice Overview—Benefit Periods

- After certification, the patient may elect the hospice benefit for:
  - Two 90-day periods followed by an unlimited number of subsequent 60-day periods.
  - After the second, 90-day period, the recertification associated with a hospice patient's third benefit period, and every subsequent recertification, must include documentation that a hospice physician or a hospice nurse practitioner had a face-to-face (FTF) encounter with the patient. The FTF encounter must document the clinical findings supporting a life expectancy of 6 months or less.
- All hospice care and services offered to patients and their families must follow an individualized written plan of care (POC) that meets the patient's needs. The hospice interdisciplinary group establishes the POC together with the attending physician (if any), the patient or representative, and the primary caregiver.

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Hospice Overview—Items and Services

- The Medicare hospice benefit includes these items and services to reduce pain or disease severity and manage the terminal illness and related conditions:
- Nursing care
- Medical equipment
- Medical supplies
- Drugs to manage pain and symptoms
- Hospice aide and homemaker services
- Physical therapy
- Occupational therapy
- Speech-language pathology services
- Medical social services
- Dietary counseling
- Spiritual counseling
- Individual and family or just family grief and loss counseling before and after the patient's death
- Short-term inpatient pain control and symptom management and respite care

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Hospice Overview—Levels of Care

Hospice Levels of Care

- **Routine home care**: A day the patient elects to get hospice care at home and isn't getting continuous home care. A patient's home might be a home, a skilled nursing facility (SNF), or an assisted living facility. Routine home care is the level of care provided when the patient isn't in crisis.
- **Continuous home care**: A day when both of these apply:
  - The patient gets hospice care in a home setting that isn't an inpatient facility (hospital, SNF, or hospice inpatient unit)
  - The care consists mainly of nursing care on a continuous basis at home

  Patients can also get hospice aide, homemaker services, or both on a continuous basis. Hospice patients can get continuous home care only during brief periods of crisis and only as needed to maintain the patient at home.
- **Inpatient respite care**: A day the patient elects to get hospice care in an approved inpatient facility for up to 5 consecutive days to give their caregiver a rest.
- **General inpatient care**: A day the patient elects hospice care in an inpatient facility for pain control or acute or chronic symptom management, which can't be managed in other settings.

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Hospice Coding

- Terminal Prognosis
- Principle Diagnosis Code
- Non-reportable Primary Diagnosis
- Secondary/Comorbid Diagnosis
- Diagnosis Change

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Terminal Prognosis

- Review specific documentation regarding the patient's terminal prognosis.
- Prognosis and terminal diagnosis are not the same thing.
- How are you documenting overall outcome of the patient's terminal state?
- Does your documentation clearly support that the terminal prognosis continues to be 6 months or less?

Life expectancy of six months or less if the terminal illness runs its normal course.

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Terminal Prognosis—Part I. Decline in Clinical Status Guidelines

- Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results
- Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) from <70% due to progression of disease.
- Increasing emergency room visits, hospitalizations, or physician's visits related to hospice primary diagnosis
- Progressive decline in Functional Assessment Staging (FAST) for dementia (from ≥7A on the FAST)
- Progression to dependence on assistance with additional activities of daily living (See Part II, Section 2)
- Progressive stage 3-4 pressure ulcers in spite of optimal care

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Terminal Prognosis—Part II. Non-disease Specific Baseline Guidelines

- 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

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Terminal Prognosis—Part III. Co-morbidities

- 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

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Principle Diagnosis Code

- Hospice enters diagnosis coding as required by ICD-10 Coding Guidelines.
- The principal diagnosis listed is 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 diagnoses, ICD-10 coding guidelines do not provide sequencing direction, and therefore, any one of the diagnoses may be sequenced first.

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Principle Diagnosis Code

- The principal diagnosis must be the same across the Certification of Terminal Illness (CTI), the Hospice Plan of Care, and the UB-04 Claim Form
- When are the diagnoses inconsistent?
  - Primary changes
  - Primary on CTI does not meet criteria and need new CTI
  - Coding guidelines must be applied

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Non-reportable Primary Diagnosis Codes

Hospice codes that will be returned to the provider for correction:

- Any Z Code listed as the principal diagnosis on hospice claims
- Debility, Failure to Thrive, Unspecified Dementia

Hospices may not report diagnosis codes that cannot be used as the principal diagnosis according to ICD-10-CM Coding Guidelines or diagnoses that require further compliance with coding conventions such as those with sequencing guidelines.

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Non-reportable Primary Diagnosis Codes Dilemma of Dementia

- "Dementia" is unacceptable as a terminal diagnosis for hospice. (F03.9-)
- Senile dementia or vascular dementia are also excluded as a terminal diagnosis for hospice.
- Query "Is this dementia of the Alzheimer's type?"
- G31.1 Senile degeneration of the brain, not elsewhere classified may be an acceptable option if physician confirmed.

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Secondary/Comorbid Diagnosis

- Hospice will report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual. This includes the reporting of any mental health disorders and conditions that would affect the plan of care.

- If the hospice patient has diagnoses unrelated 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.

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Diagnosis Change

- 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.
- Should the physician determine a need for change in the terminal condition, a physician order should be obtained if this is not done in conjunction with the recertification process.
- Documentation in the medical record to clinically support the change in diagnosis should be evident.

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Related vs Unrelated

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Hospice Coverage of Services

Hospice Conditions of Participation (CoPs) at §418.56(c) require that the hospice must provide all reasonable and necessary services for the palliation and management of the terminal illness, related conditions and interventions to manage pain and symptoms.

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Related Conditions

"Clinically, related conditions are any physical or mental condition(s) that are related to or caused by either the terminal illness or the medications used to manage the terminal illness."

Paolini, DO, Charlotte. (2001). Symptoms Management at End of Life. JAOA. 101(10). p609–615

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Related Conditions as Defined by CMS

Those conditions that result directly from terminal illness; and/or result from the treatment or medication management of terminal illness; and/or which interact or potentially interact with terminal illness; and/or which are contributory to the symptom burden of the terminally ill individual; and/or are conditions which are contributory to the prognosis that the individual has a life expectancy of 6 months or less.

CMS indicates that the medical director has the final decision on determining unrelated diagnoses. There should be clear documentation indicating the rationale why a condition is considered unrelated.

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Related Versus Unrelated

CMS says: ". . . we believe that the unique, physical condition of each terminally ill individual makes it necessary for these decisions to be made on a case-by-case basis. It is our general view that hospices are required to provide virtually all the care that is needed by terminally ill patients." Therefore, unless there is clear evidence that a condition is unrelated to the terminal prognosis; all conditions are considered to be related to the terminal prognosis.

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From the 2024 Proposed Rule

TABLE 2—TOP TWENTY PRINCIPAL HOSPICE DIAGNOSES
[FY 2022]

Rank	International classification of diseases, tenth revision (ICD–10)/reported principal diagnosis	Number of beneficiaries	Percentage of all reported principal diagnoses (%)
1	G30.9—Alzheimer disease, unspecified	135,910	7.4
2	G31.1—Senile degeneration of brain, not elsewhere classified	124,365	6.8
3	J44.9—Chronic obstructive pulmonary disease, unspecified	78,630	4.3
4	G30.1—Alzheimer disease with late onset	63,980	3.5
5	I50.9—Heart failure, unspecified	52,375	2.8
6	G20—Parkinson disease	52,155	2.8
7	I25.10—Atherosclerotic heart disease of native coronary artery without angina pectoris	47,117	2.6
8	C34.90—Malignant neoplasm of unspecified part of unspecified bronchus or lung	44,093	2.4
9	U07.1—Emergency use of U07.1	43,505	2.4
10	I67.2—Cerebral atherosclerosis	38,543	2.1
11	I11.0—Hypertensive heart disease with (congestive) heart failure	36,860	2.0
12	I67.9—Cerebrovascular disease, unspecified	35,120	1.9
13	E43—Unspecified severe protein-energy malnutrition	33,111	1.8
14	I63.9—Cerebral infarction, unspecified	29,291	1.6
15	I13.0—Hypertensive heart and renal disease with (congestive) heart failure	27,455	1.5
16	C61—Malignant neoplasm of prostate	24,806	1.3
17	N18.6—End stage renal disease	24,565	1.3
18	J96.01—Acute respiratory failure with hypoxia	23,329	1.3
19	C25.9—Malignant neoplasm: Pancreas, unspecified	22,128	1.2
20	J44.1—Chronic obstructive pulmonary disease with acute exacerbation, unspecified	20,928	1.1

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Determining Terminal Prognosis

- The hospice benefit is designed to provide palliative and symptom management to a patient who has a life expectancy of six months or less if the disease follows the normal course.
- Most patients have multiple diagnoses or needs that are based on their individual health history and current status.
- Patients with the same or similar chronic diagnoses may have a different impact on their terminal prognosis.
- Current and ongoing documentation of the functional and structural impairments as related to their disease process goes further to establish appropriateness for hospice care than any specific diagnosis.

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Code only Confirmed Diagnoses

- **ALL** diagnoses must be stated or confirmed by a physician or other qualified health care practitioner who is legally accountable for establishing the patient's diagnosis.

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Problematic Areas in Hospice Coding

- Use of symptom codes inherent to the disease processes
- Not correctly capturing dementia
- Incorrect use of combination codes, particularly hypertension and chronic kidney disease and hypertensive heart failure.
- Sequencing primary and secondary cancers
- Lack of understanding in coding "end stage" liver or heart failure
- Use of acute cerebrovascular diagnoses versus sequela (late effect) codes

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General Coding Guidelines

- Codes for signs and symptoms, as opposed to diagnoses are acceptable for reporting purposes when a related definitive diagnosis has not been established or confirmed by the provider but generally should not be used as primary.
- Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.
- Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

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Signs Integral to a Disease Process

- Edema, muscle weakness, SOB, or pleural effusion not requiring continued intervention in CHF
- SOB or muscle weakness in COPD or other respiratory condition
- Jaundice or ascites or liver failure
- Pain due to osteoarthritis
- Nausea and vomiting with gastroenteritis
- Gait issues with dementia
- Weakness or gait issues with hemiplegia

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Signs Supportive of the Terminal Condition

- Incontinence
- Anasarca
- Anorexia
- Wheelchair Bound
- Bedbound
- Oxygen Use

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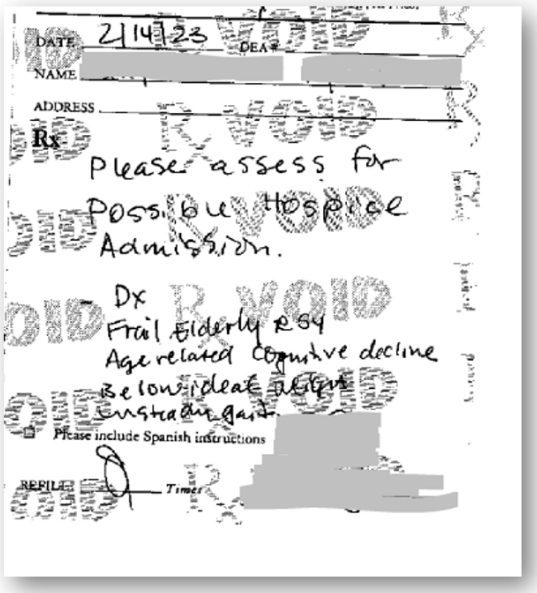
Hospice Referrals



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Hospice Admission Summary

Admission Narrative

Patient admitted to hospice after discharge back to the [redacted] with diagnosis of CHF and other comorbidities ESRD, Htn, DM, and chronic wounds/pressure ulcers. Her wounds were covered with dressings from 1/17 & 1/18 from the hospital. Full body inspectio performed with bruising to arms from labs/IV from the hospital, pressure ulcers with scabbing to right heel and left anterior foot. Her coccyx was covered with dressing marked 1/17 & R great toe/2nd toe area covered with 1/18. Her dtr reported they had both been removed and this was over the wound. Her groin and labia are red and excoriated from moisture & urine and will require attention from cleaning and zinc cream and advised staff of in between visits from hospice to provide this care. I will set up for wc schedule. She would also benefit from airflow bed with wounds. She needs MSW for help with Medical & durable POA. She will benefit from aide and chaplin for physical & spiritual needs. SN instructed over SOC paperwork with copies for NH facility left with them and CG signed copies and openly talked while mother was alert and talking to dtr in law with agreeance. Reports to be given to IDT staff and MH facility. Pt remained in stable condition and family at side.

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Hospice Admission Summary

Visit Notes/Ongoing Comprehensive Assessment 86 year old caucasian female patient being admitted with End Stage Respiratory Failure

Comorbidities: Protein Calorie Malnutrition, CAD, HTN, CKD IIIA, Chronic Respiratory failure, Emphysema, Pulmonary HTN, Hypothyroidism, DMII, AAA, Pressure Ulcer to sacrum with MRSA, COVID, Cerebral Artery Occlusion with cerebral infarct, Bacterial Pneumonia, Left hip fracture, Acute on chronic diastolic CHF, COPD, Sepsis pneumonia

PPS: 30, LMAUC: 33.3, Height: 62", Weight: 171.8, BMI 33.55

Why hospice: Patient has been hospitalized 5 times in the past 6 months. 2/09/2023- 02/17/2023 for Pneumonia, 02/19/2023 - 02/23/2023 for left hip fracture. She was receiving PT at [redacted] Health and Rehab and went to for follow up for hip fracture on 03/23/2023 and found to have a pressure ulcer to sacrum that was positive for MRSA. While hospitalized found to have COVID and COVID pneumonia superimposed with bacterial pneumonia, Acute on chronic diastolic CHF and respiratory failure. She was found to have albumin of 2.9 and was treated with midodrine and Albumin and LR. Albumin levels improved to 3.1. She was treated with antibiotics and steroids for pneumonia. While hospitalized she declined and was transferred to ICU and placed on BiPap. Patient was weaned off but now requires 2L O2 continuously. Since hospitalization the patient's PO intake declined and she was only eating bites of food with sips of liquids. After discussing options the patient verbalized that she did not wish to return to therapy and wanted to go home and no longer seek aggressive treatment.

Mental Status: 6 months ago the patient was AOx3-4. Able to have a meaningful conversation and make her basic needs known. She was able to make her own decisions. This remains the same. She was slow to answer questions but was able to make her needs known and participate in own care decisions.

Functions: 6 months ago the patient was high functioning. She was able to stand independently and was ambulatory in her home with walker for stability. She required wheelchair for mobility outside of home related to SOB. She was continent of bowel and bladder with intermittent stress urinary incontinence. She was able to toilet herself, shower and dress herself. She was able to participate in ADLs. Now patient is bed bound. She is minimally able to assist with turning. She becomes easily fatigued with minimal exertion. She appears weak. She has a foley catheter in place with light yellow urine output. She now has chronic constipation. Daughter reports she had to be disimpacted on 04/02/23. She requires total care with ADLs.

Respirations: 6 months ago the patient had a history of COPD and Emphysema. She had shortness of breath with minimal exertion and talking. She required 2L O2 intermittently during the day for dyspnea and at night while sleeping. She had a chronic cough. Now the patient requires 2L O2 continuously. Her lung sounds are diminished to bases and clear to upper lobes. She becomes easily short of breath with any exertion and with talking. O2 sats at 94% at rest with O2 and dropped with 92% with talking.

Cardiac: 6 months ago the patient had a history of HTN and CAD. She was diagnosed with AAA in September. Her family reports she would have intermittent swelling of her feet and ankles. Now the patient has 1+ generalized edema. Her heart rate is sluggish at 50 BPM. Her hands and feet are warm to touch. Pedal pulses were palpable.

Sleeping: 6 months ago the patient was sleeping 10-12 hours per day and taking no naps. Now the patient is sleeping 14-16 hours per day in 3-4 hour increments.

Eating: 6 months ago the patient was eating 3 small meals per day. She was able to feed herself with setup assist. Now the patient is only taking bites of food with sips of liquids. She has been drinking Ensure for supplements. She has visible muscle wasting. She appears fluid overloaded.

Skin: 6 months ago the patient had no skin issues. Now the patient has an unstageable wound to her sacrum measures 5.5 X 5.8 X 3.5 with excoriation to surrounding tissues. She has large number of scattered bruises to arms. She has a 4.0 X 3.2 skin tear to her left upper arm. Her skin is pale with poor turgor.

Pain: 6 months ago the patient had chronic pain to lower back. Now the patient has pain to her left hip related to previous fracture. Continues to have chronic lower back pain

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Scenarios

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Dementia Scenario

- Patient was referred to hospice care for Alzheimer's Dementia and a recent decline including increased confusion from her baseline. Gait and balance issues leaving her unsafe to walk and she has become bedbound. Requires assistance with all ADLs and has stopped eating solid foods. Drinks only supplements and has had a significant weight loss with BMI only at 17. History indicates UTI x 2 in the last 3 months in addition to pneumonia 30 days ago that she just hasn't recovered from.

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Dementia Answer

- G30.9 Alzheimer's Disease
- F02.80 Dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
- R63.0 Anorexia
- R63.4 Abnormal loss of weight
- Z68.1 BMI less than 19
- Z74.01 Bed confinement status
- Z87.440 Hx of UTI
- Z87.01 Hx of Pneumonia
- Z51.5 Encounter for palliative care

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Traumatic Brain Injury Scenario

- Patient with a history of Parkinson's was referred to hospice services after a fall at home resulting in traumatic subarachnoid hemorrhage. She is unresponsive and family requested hospice services at the recommendation of the physician.

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Traumatic Brain Injury Answer

- S06.6X9D Traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, subsequent encounter.
- G20 Parkinson's
- Z51.5 Encounter for palliative care
- W19.XXXD Fall

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Acute Cerebrovascular Diagnoses Versus Sequela (Late Effect) Scenario

- Patient was referred to hospice services for CVA with Dysphagia. He is no longer able to eat and refuses feeding tube. Swallowing evaluation in the hospital revealed oropharyngeal dysphagia. He has a previous history of CVA two years ago that left him with right-sided hemiparesis and wheelchair bound. His medical history also includes Hypertension and Type 2 DM. Out of Hospital DNR in place.

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Acute Cerebrovascular Diagnoses Versus Sequela (Late Effect) Answer

- I69.391 Dysphagia following cerebral infarction
- R13.12 Dysphagia, oropharyngeal phase
- I69.351 Hemiplegia following cerebral infarction affecting right dominant side
- I10 Hypertension
- Z99.3 Dependence on wheelchair
- Z66 Do not resuscitate
- Z51.5 Encounter for palliative care
- E11.9 DM Type 2

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HTN, CKD, and ESRD Scenario

- Patient was referred to hospice services for ESRD. She is a long-term diabetic but there is no cause stated as to the reason for the renal failure. She has refused to continue with dialysis and wants to be at home. Her medical history also includes hypertension.

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HTN, CKD, and ESRD Answer

- I12.0 Hypertensive chronic kidney disease w/stage 5 chronic kidney disease or end stage renal disease.
- E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease
- N18.6 End stage renal disease
- Z51.5 Encounter for palliative care

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Hypertensive Heart Disease—End Stage Heart Failure Scenario

- Patient was referred to hospice services for acute exacerbation of congestive heart failure. The medical record indicates that she has chronic diastolic heart failure. She has 4+ pitting edema to her lower extremities and abdominal ascites. She requires oxygen continually and becomes short of breath with any activity. Her medical history also includes HTN. Physician documents End Stage Heart Failure in the medical record.

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Hypertensive Heart Disease—End Stage Heart Failure Answer

- I11.0 Hypertensive heart disease w/heart failure
- I50.84 End stage heart failure
- I50.33 Acute on chronic diastolic (congestive) heart failure
- R18.8 Other ascites
- Z99.81 Dependence on supplemental oxygen
- Z51.5 Encounter for palliative care

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End Stage Liver Disease Scenario

- Patient is being admitted to hospice services related to his unspecified liver cirrhosis which has caused hepatic failure. He has ascites, jaundice, weakness and a loss of appetite. Assessment reveals and confirmed with physician that patient has a stage 2 pressure ulcer to the coccyx.

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End Stage Liver Disease Answer

- K74.60 Unspecified cirrhosis of liver
- K72.90 Hepatic failure, unspecified without coma
- R53.1 Weakness
- R63.0 Anorexia
- L89.152 Pressure ulcer of sacral region, stage 2
- Z51.5 Encounter for palliative care

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Primary Versus Secondary Cancer Scenario

- Patient was referred to hospice services for metastatic breast cancer. She has a history of cancer to the right breast 6 years ago and underwent chemotherapy after a mastectomy. She recently went to the ER for a seizure after which testing revealed metastasis to her brain and bone. She has elected hospice care for symptom management. She is now struggling with pain related to the metastasis and nausea.

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Primary Versus Secondary Cancer Answer

- C79.31 Secondary malignant neoplasm of brain
- C79.51 Secondary malignant neoplasm of bone
- Z85.3 Personal history of malignant neoplasm of breast
- G89.3 Neoplasm related pain
- G40.89 Other seizures
- R11.0 Nausea
- Z90.11 Acquired absence of right breast
- Z92.21 Personal history of antineoplastic chemotherapy
- Z51.5 Encounter for palliative care

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How to Code This One?

Summary of Visit: Patient is an 81 y/o male living in his own home with his wife. Patient is admitted to hospice with terminal diagnosis Heart Disease, Co mobids Anemia, CAD, CABG x 3, A-Fib, Removal of infected ICD, DM type II, Parkinson's Disease, Hypercholesterolemia, COPD, Esophageal Stenosis, recurrent aspiration pneumonia, Chronic Kidney disease.
Weight 158
BMI 21.5
MUAC
PPS 30
NYHA IV
ADL Minimal assist with feeding, Moderate assist all other ADL's
ADLscore 11/18
Patient is A/O x 4, very HOH has hearing aides but, refuses to wear them. Seems very well aware of his current situation. Discussion was had with family and decision was made to stop all medication except comfort medications and be discharged home with hospice. Patient ambulates with his walker and assist of 1-2, uses w/c for longer distances. Patient had a long standing history of coronary disease, Device implanted 5/13/11 removed 8/8/2019 due to infection, admitted to LTAC for IV antibiotic therapy,Patient has had failure to thrive, poor appetite, some difficulty swallowing. He is continent of bowel if he can get up and to the restroom in time same with urination, he reports feeling tired and weak most days and sleeps off and on during the day totaling 18/24 hours a day of sleep.

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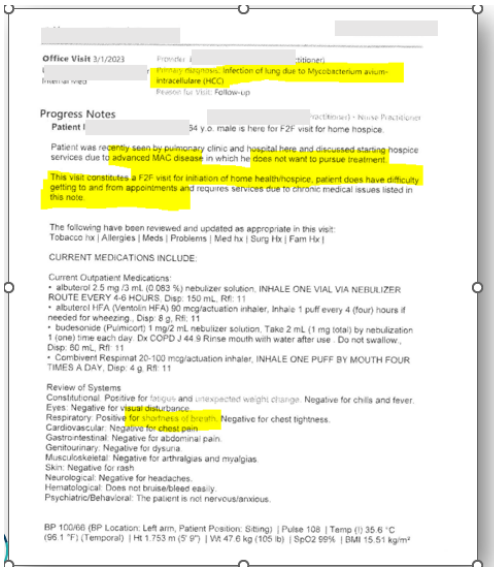
Hospice Eligible?



Office Visit 3/1/2023

Primary diagnosis: Infection of lung due to Mycobacterium avium-intracellulare (HCC)

Progress Notes

Patient

54 y.o. male is here for F2F visit for home hospice.

Patient was recently seen by pulmonary clinic and hospital here and discussed starting hospice services due to advanced MAC disease in which he does not want to pursue treatment.

This visit constitutes a F2F visit for initiation of home health/hospice, patient does have difficulty getting to and from appointments and requires services due to chronic medical issues listed in this note.

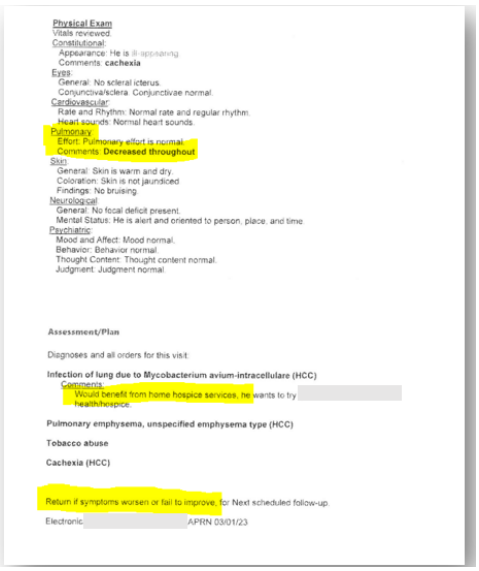
The following have been reviewed and updated as appropriate in this visit:
Tobacco hx | Allergies | Meds | Problems | Med hx | Surg Hx | Fam Hx |

CURRENT MEDICATIONS INCLUDE:

Current Outpatient Medications:
- albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution, INHALE ONE VIAL VIA NEBULIZER ROUTE EVERY 4-6 HOURS. Disp: 150 mL, Rfl: 11
- albuterol HFA (Ventolin HFA) 90 mcg/actuation inhaler, Inhale 1 puff every 4 (four) hours if needed for wheezing., Disp: 8 g, Rfl: 11
- budesonide (Pulmicort) 1 mg/2 mL nebulizer solution, Take 2 mL (1 mg total) by nebulization 1 (one) time each day. Dx COPD J 44.9 Rinse mouth with water after use . Do not swallow., Disp: 60 mL, Rfl: 11
- Combivent Respimat 20-100 mcg/actuation inhaler, INHALE ONE PUFF BY MOUTH FOUR TIMES A DAY. Disp: 4 g, Rfl: 11

Review of Systems
Constitutional: Positive for fatigue and unexpected weight change. Negative for chills and fever.
Eyes: Negative for visual disturbance.
Respiratory: Positive for shortness of breath. Negative for chest tightness.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for abdominal pain.
Genitourinary: Negative for dysuria.
Musculoskeletal: Negative for arthralgias and myalgias.
Skin: Negative for rash.
Neurological: Negative for headaches.
Hematological: Does not bruise/bleed easily.
Psychiatric/Behavioral: The patient is not nervous/anxious.

BP 100/66 (BP Location: Left arm, Patient Position: Sitting) | Pulse 108 | Temp (!) 35.6 °C (96.1 °F) (Temporal) | Ht 1.753 m (5' 9") | Wt 47.6 kg (105 lb) | SpO2 99% | BMI 15.51 kg/m²



Physical Exam
Vitals reviewed.
Constitutional:
Appearance: He is ill-appearing.
Comments: **cachexia**
Eyes:
General: No scleral icterus.
Conjunctiva/sclera: Conjunctivae normal.
Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Heart sounds: Normal heart sounds.
Pulmonary:
Effort: Pulmonary effort is normal.
Comments: **Decreased throughout**
Skin:
General: Skin is warm and dry.
Coloration: Skin is not jaundiced.
Findings: No bruising.
Neurological:
General: No focal deficit present.
Mental Status: He is alert and oriented to person, place, and time.
Psychiatric:
Mood and Affect: Mood normal.
Behavior: Behavior normal.
Thought Content: Thought content normal.
Judgment: Judgment normal.

Assessment/Plan

Diagnoses and all orders for this visit:

Infection of lung due to Mycobacterium avium-intracellulare (HCC)
Comments:
Would benefit from home hospice services, he wants to try health/hospice.

Pulmonary emphysema, unspecified emphysema type (HCC)

Tobacco abuse

Cachexia (HCC)

Return if symptoms worsen or fail to improve, for Next scheduled follow-up.

Electronic APRN 03/01/23

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True Case Scenario

Follow-up visit today.

Palliative NP visited patient this morning.
Patient is familiar to our services from previous admission earlier this March.
Son at the bedside.
Rounded with bedside RN this morning.
Patient is transferred out of ICU over the weekend. Patient reports he is feeling much better.
Patient and his son both stated that according to GI doctor they were not able to find any bleeding source, GI recs are "Consultation with surgery as well as wound care strongly recommended to prevent yet another recurrence of ostomy related bleeding". Patient is instructed to return back to the hospital if bleeding occurs again.
Patient verbalizes understanding and agreement.
Patient anticipating to be discharged home with home hospice today.
Patient and his son given opportunity to ask questions. No further questions or concerns voiced by the patient today.

Hospice eligibility: Metastatic colon cancer, PPS 30%

Diagnosis, Assessment & Plan
Problem List/A&P:
1. **Colon cancer**
2. **GI bleed**
3. **Liver metastases**
4. **Palliative care encounter**
5. **Advance care planning**

Free text A&P:
83-year-old Caucasian gentleman with known history of colon cancer with extensive liver metastasis. Recent admission for variceal bleed, receiving banding x4. Now presenting again with c/o bloody output from his ostomy. H/H 5.8/19.1, currently receiving PRBCs. Now admitted to ICU for higher level of care and continued work-up.

True Case Scenario

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Diagnoses

Primary ICD10 - C18.9 Malignant neoplasm of colon, unspecified
Secondary ICD10 - C78.7 Secondary malignant neoplasm of liver and intrahepatic bile duct
Tertiary ICD10 - K94.01 Colostomy hemorrhage
4th ICD10 - D62 Acute posthemorrhagic anemia
5th ICD10 - N17.9 Acute kidney failure, unspecified
6th ICD10 - I85.00 Esophageal varices without bleeding
7th ICD10 - J90 Pleural effusion, not elsewhere classified
8th ICD10 - R18.8 Other ascites
9th ICD10 - K43.5 Parastomal hernia without obstruction or gangrene
10th ICD10 - K44.9 Diaphragmatic hernia without obstruction or gangrene
11th ICD10 - K80.20 Calculus of gallbladder without cholecystitis without obstruction
12th ICD10 - K29.70 Gastritis, unspecified, without bleeding
13th ICD10 - K21.9 Gastro-esophageal reflux disease without esophagitis
14th ICD10 - N40.0 Benign prostatic hyperplasia without lower urinary tract symptoms
15th ICD10 - D72.829 Elevated white blood cell count, unspecified
16th ICD10 - Z46.6 Encounter for fitting and adjustment of urinary device
17th ICD10 - Z92.21 Personal history of antineoplastic chemotherapy
18th ICD10 - Z87.891 Personal history of nicotine dependence
19th ICD10 - Z87.19 Personal history of other diseases of the digestive system
20th ICD10 - Z90.49 Acquired absence of other specified parts of digestive tract
21st ICD10 - Z51.5 Encounter for palliative care
22nd ICD10 - J44.9 Chronic obstructive pulmonary disease, unspecified
23rd ICD10 - I10 Essential (primary) hypertension
24th ICD10 - I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
25th ICD10 - E03.9 Hypothyroidism, unspecified

True Case Scenario

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CHIEF COMPLAINT:
Shortness of breath.

HISTORY OF PRESENT ILLNESS:
This is a 73-year-old male with a history of chronic respiratory failure due to severe COPD, on home oxygen. The patient was on home hospice services. History of hypertension, diabetes, dyslipidemia. Today, was brought to the hospital by his mother as the patient is getting more short of breath and the patient and family revoked hospice. Currently, the patient is on BiPAP.

REVIEW OF SYSTEMS:
Review of 14 systems were reviewed, otherwise negative.

PAST MEDICAL HISTORY:
Hypertension, diabetes, chronic respiratory failure, severe COPD.

PAST SURGICAL HISTORY:
Not significant.

ALLERGIES:
Refer to the chart.

SOCIAL HISTORY:
Former smoker.

FAMILY HISTORY:
Noncontributory.

PHYSICAL EXAMINATION:
VITAL SIGNS: The patient is afebrile, heart rate is in 60, blood pressure 150/70, pulse ox is 94% on BiPAP.
GENERAL: Moderate to severe distress, cooperative.
SKIN: No visible rash, purpura, or icterus.
LYMPH NODE: No lymphadenopathy.
HEAD: Atraumatic, normocephalic.
ENT: Dry mucous membrane.
NECK: Supple. Range of motion normal.
LUNGS: Scattered rhonchi, wheezing.
CARDIOVASCULAR: S1, S2 normal.

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True Case Scenario

Diagnoses

Primary ICD10 - J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
Secondary ICD10 - J96.10 Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
Tertiary ICD10 - R62.7 Adult failure to thrive
4th ICD10 - G47.33 Obstructive sleep apnea (adult) (pediatric)
5th ICD10 - E66.01 Morbid (severe) obesity due to excess calories
6th ICD10 - Z68.41 Body mass index [BMI] 40.0-44.9, adult
7th ICD10 - Z99.81 Dependence on supplemental oxygen
8th ICD10 - Z74.1 Need for assistance with personal care
9th ICD10 - Z74.01 Bed confinement status
10th ICD10 - Z87.440 Personal history of urinary (tract) infections
11th ICD10 - Z87.891 Personal history of nicotine dependence
12th ICD10 - Z91.81 History of falling
13th ICD10 - Z99.89 Dependence on other enabling machines and devices
14th ICD10 - Z51.5 Encounter for palliative care
15th ICD10 - I10 Essential (primary) hypertension
16th ICD10 - I44.0 Atrioventricular block, first degree
17th ICD10 - N40.0 Benign prostatic hyperplasia without lower urinary tract symptoms
18th ICD10 - E78.5 Hyperlipidemia, unspecified
19th ICD10 - E11.65 Type 2 diabetes mellitus with hyperglycemia
20th ICD10 - M16.0 Bilateral primary osteoarthritis of hip
21st ICD10 - I82.412 Acute embolism and thrombosis of left femoral vein
22nd ICD10 - E04.2 Nontoxic multinodular goiter

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True Case Scenario

REVIEW OF IMAGING:
The patient had a CT scan of the chest, abdomen and pelvis on March 23rd 2023, which demonstrates no pulmonary metastasis or effusion or lymphadenopathy of the chest. There is malignant ascites, peritoneal carcinomatosis or dilated loops of the bowel secondary to partial obstruction from carcinomatosis and adhesions. There was enlargement at the left adnexa, concerning for an ovarian neoplasm. Pathology: Verbal report from pathology demonstrates adenocarcinoma of the peritoneal fluid, pending final report.

ASSESSMENT AND PLAN:
This is an 83-year-old female gravida 3, para 3, admitted with carcinomatosis and cancer suspected of the ovary, fallopian tube, or primary peritoneal, awaiting final pathologic staining.
1. Ovarian cancer. I reviewed with the patient the treatment strategies. We reviewed her age and her current health status, we discussed the diagnosis of ovarian cancer. We discussed the role of chemotherapy. We discussed the role of surgical intervention. We also discussed the role of best supportive care and the patient elects not to undergo treatment. After a long talk with the patient and family, which included her daughter as well as her husband, the patient did have very strong desire and interest in best supportive care as she is intimated by the efforts and the experience of chemotherapy, as well as surgical intervention. We will arrange for hospice services immediately with the patient today to help her understand this opportunity and their choice. Should they make a decision, we can move forward. Should they change their mind and elect for treatment, I am here and available. Continue her in-house until we can make appropriate plans in care.
2. Genetic testing should be recommended for this patient in the event of

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True Case Scenario

Diagnoses

Primary ICD10 - C56.2 Malignant neoplasm of left ovary
Secondary ICD10 - C78.6 Secondary malignant neoplasm of retroperitoneum and peritoneum
Tertiary ICD10 - C78.4 Secondary malignant neoplasm of small intestine
4th ICD10 - R18.0 Malignant ascites
5th ICD10 - G89.3 Neoplasm related pain (acute) (chronic)
6th ICD10 - Z48.3 Aftercare following surgery for neoplasm
7th ICD10 - Z43.2 Encounter for attention to ileostomy
8th ICD10 - Z90.49 Acquired absence of other specified parts of digestive tract
9th ICD10 - R63.0 Anorexia
10th ICD10 - F41.8 Other specified anxiety disorders
11th ICD10 - Z51.5 Encounter for palliative care
12th ICD10 - K44.9 Diaphragmatic hernia without obstruction or gangrene
13th ICD10 - M47.815 Spondylosis without myelopathy or radiculopathy, thoracolumbar region

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The Patient We All Want to Be!

HPI: Veteran is 101y/o here as new patient.

Son states pt does not eat enough. Receives meals on wheels twice a week. Only eats the sweets- cakes, cupcakes. Has been like this most of his life.

He's also an ex-smoker and only has Hypothryoidism and a history of a heart attack in the 80's 😜

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HCS-H Testing Information

- You must take and pass an exam in order to obtain a BMSC credential. There are 2 ways to take an exam through BMSC: **at a computer-based testing center** OR by **remote proctor**.
- The HCS-H certification exam is 3 hours long and contains 90 questions
- The passing score for the HCS-H exam is 75%.

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HCS-H Exam Allowed Materials

- *Complete Home Health ICD-10-CM Diagnosis Coding Manual, 2023*.
- *Complete Home Health ICD-10-CM Diagnosis Coding Manual, 2022*.
- Any other vendor's ICD-10 coding manual (2022 or 2023 Edition).
- In addition to the above referenced coding manual, for the HCS-H exam, you may take the FY2023 official guidelines **provided here** into the testing room. Please note, only the watermarked guidelines provided through this link will be allowed into the testing room as an additional resource.

  Electronic code look-up systems are *NOT* allowed in the testing room. A hard copy coding manual is the *only* allowed resource.
- The hard copy coding manual may have alphabetic and tabular section dividers (A through Z) that are affixed. You may have annotations written on the coding manual pages including the notes pages at the back of the manual, but they must be free of any notes containing coding rules and guidelines from other reference materials (for example, AHA's *Coding Clinic*, *Home Health ICD-10-CM Coding Answers*, and similar materials).

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HCS-H Exam NOT Allowed Materials

- Post-It notes
- Loose papers or any other papers attached by any means
- The testing center staff or exam proctor reserves the right to deny code books that contain excessive writing and information that may give the candidate an unfair advantage.

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References

https://ahcc.decisionhealth.com/bmsc-exam-information
2023 Complete Home Health ICD-10-CM Diagnosis Coding Manual—Decision Health
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https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8877.pdf
https://www.govinfo.gov/content/pkg/FR-2023-04-04/pdf/2023-06769.pdf

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Questions & Answers

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To Submit a Question: Go to the Q&A box located in the lower left area of your screen. Type your question in the lower text box, then press your "Enter" key.

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We kindly request that this link be forwarded to everyone in your group who attended the program.

This concludes today's program.

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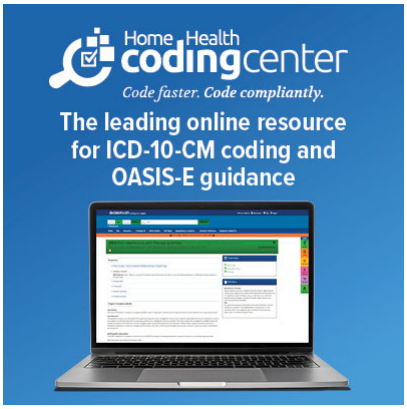

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