PUBLICATION

Adult Failure to Thrive and Debility Can No Longer Be Principal Diagnoses on Hospice Claim Forms [Ober|Kaler]

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Hospices will have until October 1, 2014, to ensure they conform their coding practices to comply with a "clarification" issued by the Centers for Medicare and Medicaid Services (CMS) in its final FY2014 Hospice Wage Index and Payment Rate Update, published in the Fed. Reg. on August 7, 2013.1 CMS's policy, as clarified, is that the ICD-9 codes for "adult failure to thrive" and "debility" are not to be used as principal diagnoses on the hospice Medicare claim form when a related definitive diagnosis has been established or confirmed by the provider. Any claims submitted after October 1, 2014 that have debility or adult failure to thrive as the principal diagnosis will be returned to the provider to resubmit with a more definitive principal diagnosis coding.

CMS first gave notice of this clarification in the proposed rule for FY 2014, published in the Federal Register on May 10, 2013 2. In doing so, CMS asserted that this was not a new proposal. Rather, CMS indicated that this clarification was merely being consistent with ICD-9-CM Coding Guidelines, which provide that "Symptoms, Signs, and Ill-defined Conditions," including adult failure to thrive and debility, are not to be used as principal diagnoses. 3

CMS's motivation for this clarification apparently was the changes in diagnosis patterns over the years. At the beginning of the hospice benefit in 1983, the most commonly reported principal diagnoses for hospice were cancer diagnoses. 4 Over time, non-cancer diagnoses have become more commonly reported. In 2002, adult failure to thrive and debility together accounted for 9% of the top 20 principal diagnoses. Ten years later, these two diagnoses were the first and third most commonly reported diagnoses, accounting for 19% of the top 20. 5 They thus captured the attention of CMS and lead to the clarification of policy.

CMS's Justification for Policy Clarification

CMS's primary justification for this clarification was concern that the use of non-specific diagnoses of adult failure to thrive and debility, without any other diagnoses, means that Medicare hospice beneficiaries are not being thoroughly assessed and therefor may not be receiving the full range of services the Medicare Hospice benefit envisioned.

More significantly, CMS expressed its concern that use of a non-specific diagnosis such as adult failure to thrive or debility indicates that the "multiple comorbid conditions" that accompany these diagnoses may not be adequately diagnosed, thereby depriving beneficiaries of an informed understanding of their condition and of all the possible options available to them. CMS believes this clarification will encourage hospices to be "more intentional about addressing all of the beneficiary's identified needs" as the end of life approaches.

CMS acknowledges that, where a patient has multiple coexisting conditions, no one condition, individually, may deem the patient as terminally ill; however, the collective presence of them and the progressive nature of some of them will contribute to the terminal diagnosis. In such instances, CMS states that the physician should "select the condition he or she feels is most contributory to the terminal prognosis, based on information in the comprehensive assessment, other relevant clinical information supporting all diagnoses, and his or her best clinical judgment."

Commenters questioned CMS's concern with diagnoses, when hospice eligibility is based on the terminal *prognosis* of a patient, and not on *diagnosis*. CMS confirmed that hospice eligibility is based on a terminal prognosis. However, CMS pointed to the requirements for certifications and recertifications – that clinical information in the medical record must support the medical prognosis, and that the physician include a narrative of the clinical findings supporting the terminal diagnosis. CMS indicated that it is not seeing the level of completeness of diagnosis reporting as is required for the certifications and recertifications. Further, CMS stated that many hospices have been coding "a single terminal diagnosis" when eligibility "should always have been based on the terminal prognosis of the patient, and this prognosis would typically involve more than one diagnosis."

CMS also discussed what conditions are "related" versus "unrelated" to the terminal illness by quoting the 1983 policy that "…hospices are required to provide virtually all the care that is needed by terminally ill patients." CMS reiterated that "unless there is clear evidence that a condition is unrelated to the terminal prognosis, all services would be considered related. It is also the responsibility of the hospice physician to document why a patient's medical need(s) would be unrelated to the terminal prognosis."

Many of the commenters on the proposed rule expressed concern that this clarification would limit or prohibit access to hospice care for many Medicare beneficiaries. CMS denied this assertion, noting that certifications for hospice eligibility are based on prognosis, not diagnosis, and are completed no more than 15 days prior to the start of the benefit period. Diagnosis coding on the hospice claim form is not done until after the patient has been informed of his or her choices and accepted into hospice. Similarly, CMS rejected comments saying that this clarification was a change of coverage that should go through the National Coverage Determination process. CMS denied it was making any changes in coverage or eligibility policies but only making a coding clarification "to request more clarity and detail on the hospice claims to reflect a complete picture of the Medicare hospice population and the hospice services rendered."

CMS supported its decision with an analysis showing that, in 2012, for those beneficiaries with adult failure to thrive or debility reported as the principal hospice diagnosis with no secondary diagnosis, over 50% of them had seven or more chronic conditions, and 75% of them had four or more chronic conditions. CMS noted that many of these chronic conditions are also terminal conditions, or contributory to the terminal prognosis. If multiple conditions are being treated, or if medications have been prescribed to treat or manage them, then CMS said it would be inappropriate to use adult failure to thrive or debility as a principle diagnosis.

As further justification, CMS indicated that it needs more complete diagnosis information on claims as it moves forward with hospice payment reform. Although the precise terms of hospice payment reform have not yet been proposed, CMS's more immediate concern is the trend that some hospice-related drugs used for hospice patients are being charged to Medicare Part D, rather than being covered under the bundled payment of the hospice benefit, causing additional and inappropriate payments to be made. For example, CMS pointed out that nearly 15 percent of hospice patients in 2010 received analgesic prescriptions through Part D; in total Medicare hospice beneficiaries receives prescriptions under Part D totaling over $350,000,000. This echoes the concerns expressed in the OIG Report *"Medicare Could be Paying Twice for Prescription Drugs for Beneficiaries in Hospice."*

In response to comments pointing out that many Local Coverage Determinations (LCDs) by Home Health and Hospice Medicare Administrative Contractors permitted the use of adult failure to thrive or debility as a primary diagnoses, CMS said it would be working with those contractors to ensure all LCDs will reflect these coding clarifications. CMS also noted that LCDs are used to determine *eligibility* for hospice services, and not to determine the appropriate diagnoses codes on hospice claims.

Although recognizing that this clarification would be a significant change for many hospices, CMS denied that this clarification would require hospices to hire professional coders and create a financial burden. CMS said the clarification was made to assist hospices in complying with longstanding coding policy that these two diagnoses should be reported as principal diagnoses, and pointed the hospices to several coding resources on the CMS website to assist them. CMS noted that the paper UC-04 forms have always had space to list up to 17 additional diagnosis fields, and the electronic claim form has up to 24 additional diagnosis fields.

Delayed Effective Date for Return of Claims to Provider

One positive outcome of the rulemaking process was CMS's decision to delay the effective date of this clarification. It was unclear in the proposed rule whether this policy clarification would be applied retrospectively to claims already submitted, or whether it would have prospective effect. Indeed, some Medicare contractors began returning claims to providers prior to the end of the comment period. In the final rule, even though it characterized its statements about failure to thrive and debility as a clarification, CMS acknowledged that this clarification may be a "paradigm shift" for some hospices in the way they have coded claims. CMS therefore made the clarification effective for claims dated on or after October 1, 2014. As of that date, any claims submitted with adult failure to thrive or debility as the principal diagnosis will be returned to the provider for more definitive coding of the principal and additional diagnoses. CMS also expects, however, that hospices will "transition immediately to more thoughtful coding practices in advance of this effective date.

What Hospices Need to Do

- Educate the staff and hospice physicians on this policy clarification:
  - Identify all conditions that contribute to the terminal prognosis.
  - The principal diagnosis should be the diagnosis most contributory to the terminal prognosis, and the one chiefly responsible for the services provided.
- Make sure edits exist in the billing system to identify any claims where adult failure to thrive or debility are listed as the primary diagnosis, Where these are identified, work with the attending physician to determine if there is a more specific principal diagnosis contributing to the terminal prognosis.

NOTES

[1] 78 Fed. Reg. 48234.
[2] 78 Fed. Reg. 27823.
[3] *Id.* at 27832.
[4] *Id.*at 27831.
[5] *Id.* at 27829.
[6] 78 Fed. Reg. at 48244
[7] *Id.*
[8] *Id.* at 48247.
[9] *Id.* at 48248.
[10] *Id.* at 48251.

[11] *Id.* at 48252.
[12] *Id.* at 48244.
[13] *Id.* at 48245
[14] *Id. See also* discussion of status of hospice payment reform at 78 Fed. Reg. 48271-75.
[15] *Id.* at 48245-46. See OIG Report A-06-10-00059, June 2012, available at http://oig.hhs.gov/oas/reports/region6/61000059.pdf.
[16] *Id.* at 48243.
[17] *Id.* at 48247.
[18] *Id.* at 48242.
[19] *Id.* at 48250.
[20] *Id.*
[21] *Id.*at 48246.
[22] *Id.*
[23] *Id.* at 48252.