Hospice: Diagnosis Coding for Hospice Cases

This section of the *Home Health ICD-9-CM Diagnosis Coding Manual* is designed for home health coders who are responsible for coding hospice cases. This section contains tips and strategies on how to avoid denials of your hospice claims, and hospice patient scenarios.

Although the regional home health intermediaries (RHHIs) – with the exception of Palmetto – have switched over to ***new*** Medicare administrative contractors (MACs)*, home health experts believe that many of the red flags and past medical edits on claims will remain the same. Therefore, it's important to take note of the recent edits on hospice patient claims – regardless of which intermediary and/or MAC used them – along with the guidance provided on how to keep your coding and claims in compliance.

Attention home health coders

Take extra care when coding hospice cases

Do ***not*** code the terminal illness as the primary diagnosis for a hospice patient receiving services by your home health agency, or you could trigger a claim denial.

"A patient who chooses hospice benefits cannot also receive home health care for the same condition, and ... all services related to the terminal condition must be provided/billed by the hospice provider," according to local intermediary Cahaba.

A patient receiving Medicare hospice benefits still can receive home health services, as long as those services are not directed at the terminal diagnosis, says Maurice Frear, HCS-D, coder for Bon Secours Home Health and Hospice in Virginia Beach, Va.

For example, consider a hospice patient with terminal lung cancer who falls from his bed and breaks his hip. Your home health agency may be ordered to provide physical therapy – as a result of the ***fracture*** – to the patient.

When coding this case, your primary code would be V57.1 (Other physical therapy), followed by V54.13 (Aftercare for healing traumatic fracture of hip), and other codes related to the therapy.

In this case, physical therapy could help the patient gain enough strength to be able to transfer safely, with the purpose of making the patient's last months more comfortable.

Tips for accurately coding hospice cases

- **Make sure that your documentation clearly states why you're seeing the patient,** and that you're ***not*** treating the terminal diagnosis, which is a considered a duplication of services and will be denied.
- **Code the terminal illness as a secondary diagnosis, if it's relevant to the plan of care,** says Cahaba.
- **Use condition code "07" on the CMS-1450 claim form** for home health services that are unrelated to the terminal diagnosis, Cahaba says. Have your billing department enter a note in the remarks section indicating that its home health services were not connected to the hospice diagnosis.
- **Use the scenarios below to gain a better understanding of this guidance and how to apply it in your everyday coding.**

Scenario: Femur fracture, end-stage breast cancer

A 50-year-old woman who is dying of end-stage breast cancer was admitted to hospice. Soon after, she tripped while in her kitchen, fell and fractured the intratrochanteric portion of her femur. Home health is ordered to provide physical therapy to assist the patient with ambulation and strengthening, and the patient will continue with hospice services while receiving therapy. The physician approved the extension of the patient's services to include physical therapy. The patient also has hypertension and decompensated COPD, and is on oxygen.

Code the scenario:

Primary and Secondary Diagnosis	M1024 Case-Mix Diagnoses	
	3	4
M1020a: V57.1		
M1022b: V54.15		
M1022c: 401.9		
M1022d: 491.21		
M1022e: V46.2		
M1022f: 174.9		

- V57.1 – Other physical therapy
- V54.15 – Aftercare for healing of traumatic fracture of upper leg
- 401.9 – Essential hypertension, unspecified
- 491.21 – Decompensated chronic obstructive pulmonary disease

- V46.2 – Supplemental oxygen
- 174.9 – Malignant neoplasm of female breast, unspecified

Rationale: Consider the following reasons for the coding of this scenario:

- The focus of home health care is physical therapy following the femur fracture to help the hospice patient develop strength so she can ambulate better during the last few months of her life. Thus, V57.1 is coded primary.
- The patient's hypertension, decompensated COPD and oxygen are coded as well because they are important for the therapist to take into account while providing care.
- The agency is not addressing the terminal cancer, but the diagnosis is coded on the claim because it will have an impact on the plan of care.

Scenario: Sepsis, wound care, stasis ulcers

A 76-year-old woman was admitted to hospice with a terminal diagnosis of sepsis related to diabetic gangrene. She went into hospice for palliative care only. Home health is ordered to provide wound care for stasis ulcers on the patient's legs. The focus of home health is to keep the wounds clean and provide care related to the stasis ulcers. Because the patient has elected palliative care only, the physician has discontinued the antibiotics previously used to treat the sepsis.

Code the scenario:

Primary and Secondary Diagnosis	M1024 Case-Mix Diagnoses	
	3	4
M1020a: 459.81		
M1022b: 707.19		
M1022c: 250.70		
M1022d: 785.4		
M1022e: 038.9		
M1022f: 995.91		

- 459.81 – Chronic venous insufficiency NOS
- 707.19 – Ulcer of other parts of lower limb
- 250.70 – Diabetes with peripheral circulatory disorders, type 2 or unspecified type, not stated as uncontrolled
- 785.4 – Gangrene
- 038.9 – Septicemia NOS
- 995.91 – Sepsis

Rationale: Consider the following reasons for the coding of this scenario:

- The purpose of home health is to clean and care for the stasis ulcers on the patient's legs, and thus is coded primary.
- The terminal diagnosis of sepsis due to diabetic gangrene is coded because the conditions are co-morbidities that will impact the home health plan of care. But because they are the hospice diagnoses, they are only coded as ***secondary diagnoses***.
- The patient's stasis ulcers are not related to her terminal diagnosis because the gangrene is associated with peripheral angiopathy, which is arterial, not venous. Venous stasis is ***not*** a manifestation of diabetes.
- There is an assumed relationship between diabetes and gangrene, unless the physician specifically states that the two conditions are unrelated. Thus, code gangrene in a diabetic patient as a manifestation of the diabetes absent another etiology.
- Gangrene is a case-mix diagnosis when it is a manifestation of another condition, in this case, diabetes.

Top reason for hospice claim denials: Insufficient documentation

Insufficient documentation to support the terminal prognosis was the top reason for hospice claim denials for April, May and June 2011, according to Palmetto GBA. The following information, taken from Palmetto's September 2011 Medicare Advisory newsletter, provides the top hospice denial reasons and how to avoid them.

Top Hospice Denial Reason Codes	
1. 5CF36/5FF36	6. 5CFH7/5FFH7
2. 5CFH9/5FFH9	7. 5CFH6/5FFH6
3. 5CFNP/5FFNP	8. 5CF92
4. 56900	9. 5CNOE/5FNOE
5. 5CFH3/5FFH3	10. 5CF70

1. 5CF36/5FF36 – Documentation Submitted Does Not Support Prognosis of Six Months or Less

Reason for Denial

The claim has been fully or partially denied because the documentation submitted for review did not support prognosis of six months or less.

How to Avoid a Denial

- Ensure a legible signature is present on all documentation necessary to support six-month prognosis.
- Submit documentation for review to provide clear evidence the beneficiary has a six-month or less prognosis which supports hospice appropriateness at the time the benefit is elected,

and continues to be hospice appropriate for the dates of service billed.

- Palmetto GBA has a Local Coverage Determination (LCD) for some non-cancer diagnoses. Submit documentation which supports the coverage criteria outlined in the policy. LCDs may be viewed on the Palmetto GBA Web site at *www.PalmettoGBA.com/HHH/lcd*. If documenting weight loss to demonstrate a decline in condition, include how much weight was lost over what period of time, past and current nutritional status, current weight and any related interventions.
- Document any co-morbidity, which may further support the terminal condition of the beneficiary and the continuing appropriateness of hospice care.

For more information, refer to:

- CMS Internet-Only Manuals (IOMs), Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 10.
- CMS Internet-Only Manuals (IOMs), Publication 100-04, Medicare Claims Processing Manual, Chapter 11, Section 10.
- Palmetto GBA Local Coverage Determinations (LCDs), which are available at *www.PalmettoGBA.com/HHH/lcd*.

2. 5CFH9/5FFH9 – Physician Narrative Statement Not Present or Not Valid

Reason for Denial

The claim has been denied as the physician narrative statement is not present or not valid.

How to Avoid a Denial

- The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of six months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms.
- If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the legible physician's signature.
- If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.
- The narrative shall include a statement under the legible physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient.
- The narrative must reflect the patient's individual circumstances and cannot contain check boxes or standard language used for all patients.

For more information, refer to:

- Code of Federal Regulations, 42 CFR – Section 418.22
- CMS Internet-Only Manuals (IOMs), Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.

3. 5CFNP/5FFNP - No Plan of Care

Reason for Denial

The claim has been fully or partially denied as documentation submitted for review did not include a plan of care for all or some of the dates billed.

Claims with dates of service beginning July 19, 2010, require that a valid plan of care (POC) be included as part of the medical review process according to Change Request 6982.

How to Avoid a Denial

- The hospice must submit POCs for dates of service billed when responding to an ADR request.
- All dates billed must be covered by a plan of care to be payable under the Medicare hospice benefit.
- If more than one plan of care covers the dates of service in question, submit all the related plans of care for review.
- The POC must contain certain information to be considered valid. This includes:
  a) Scope and frequency of services to meet the beneficiary's/family's needs
  b) Beneficiary specific information, such as assessment of the beneficiary's needs, management of discomfort and symptom relief
  c) Services that are reasonable and necessary for the palliation and management of the beneficiary's terminal illness and related conditions

The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment.

All hospice care and services must follow an individualized written plan of care.

The plan of care must be reviewed, revised and documented as frequently as the beneficiary's condition requires, but no less frequently than every fifteen (15) calendar days.

For more information, refer to:

- Change Request 6982
- "Did You Know: Hospice Plans of Care Must Be Submitted When Medical Records are

Requested?" This article is available on the Palmetto GBA Web Site (*www.PalmettoGBA.com/HHH*) using the Palmetto GBA Web site Search feature.

- Code of Federal Regulations, 42 CFR – Section 418.56 and 418.200
- CMS Internet-Only Manuals (IOMs), Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4

4. 56900 - Lack of Response to Medical Record Request

5. 5CFH3/5FFH3 - No Certification for Dates Billed

Reason for Denial

The claim has been fully or partially denied as documentation submitted for review did not include a certification covering all or some of the dates billed.

How to Avoid a Denial

- The hospice must obtain written certification of terminal illness for each benefit period.
- All dates billed must be covered by a certification to be payable under the Medicare hospice benefit.
- If more than one certification covers the dates of service in question, submit all the related certifications for review.

For more information, refer to:

- CMS Internet-Only Manuals (IOMs), Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Sections 10 and 20.1
- Code of Federal Regulations, 42 CFR – Section 418.22
- "Common Technical Hospice Medical Review Denials and How to Avoid Them." This article is available on the Palmetto GBA Web Site (*www.PalmettoGBA.com/HHH*) using the Search feature.

6. 5CFH7/5FFH7 - Subsequent Certification Not Timely

Reason for Denial

The claim has been fully or partially denied as the documentation submitted for review did not include a certification that was signed and dated timely.

How to Avoid a Denial

- Certifications for subsequent benefit periods must be obtained no later than two days after the beginning of the new benefit period. Only one physician's signature is required on a subsequent certification.
- Verbal certification may be submitted; however, there must be documentation in the medical records to indicate the certification was obtained within the time frame indicated above.
- Verbal certification must be followed by a written certification, signed and dated by the physician prior to billing Medicare for the hospice care.
- If no verbal certification is present and the written certification is signed later than two days after the beginning of the benefit period, allowable days will begin with the date of the physician's signature.

For more information, refer to:

- CMS Internet-Only Manuals (IOMs), Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.1
- Code of Federal Regulations, 42 CFR – Section 418.22
- "Common Technical Hospice Medical Review Denials and How to Avoid Them". This article is available on the Palmetto GBA Web Site (*www.PalmettoGBA.com/HHH*) using the Palmetto GBA Web site Search feature.

7. 5CFH6/5FFH6 - Initial Certification Not Timely

Reason for Denial

The claim has been fully or partially denied, as the documentation submitted for review did not include an initial certification signed timely by the medical director and attending physician.

How to Avoid a Denial

- For the first 90-day period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, (that is by the end of the third day), oral or written certification of the terminal illness by the medical director of the hospice or the physician member of the hospice interdisciplinary group ***and*** the beneficiary's attending physician (if the beneficiary has an attending physician)
- Written certification must be on file in the hospice beneficiary's record prior to submission of a claim to the Medicare Administrative Contractor.
- If these requirements are not met, the payment begins with the day of certification. The initial certification may be completed up to two weeks before hospice care is elected.
- If the attending physician and the medical director are the same, the certification must clearly identify this information.

For more information, refer to:

- CMS Internet-Only Manuals (IOMs), Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Sections 10 and 20.1
- Code of Federal Regulations, 42 CFR – Section 418.22

"Common Technical Hospice Medical Review Denials and How to Avoid Them". This article is available on the Palmetto GBA Web Site (*www.PalmettoGBA.com/HHH*) using the Palmetto GBA Web site Search feature.

F92 – Hospice Continuous Care Hours Reduction

on for Denial

spice Continuous Care hours have been reduced e routine care rate.

o Avoid a Denial

mit documentation to provider clear evidence ntinuous care is being provided during a period s.

period of crisis is defined as a time in which e beneficiary requires predominately nursing re to achieve palliation or management of ute medical symptoms.

or continuous care to be covered, care must provided for a minimum of 8 hours during a hour day which begins and ends at midnight.

e documentation submitted for review should ect the care provided was predominately sing care by either a registered nurse (RN) or nsed practical nurse (LPN), which means at t half of the hours of care were provided by an or LPN.

ure documentation submitted for review udes the number of hours of care provided by n discipline and it should match the number of s of continuous care hours billed.

information, refer to:

Internet-Only Manuals (IOMs), Publication 2, Medicare Benefit Policy Manual, Chapter 9, on 40.2.1

Internet-Only Manuals (IOMs), Publication 4, Medicare Claims Processing Manual, pter 11, Section 30.1

5FNOE - No Valid Election Submitted

r Denial

vices billed were not covered, as there was Notice of Election statement included with ted documentation.

oid a Denial

care beneficiary must complete an election (Notice of Election or NOE) before the edicare Benefit (HMB) can begin. An who meets the eligibility requirement of the n 418.20, may file an election statement with r hospice.

The representative for this individual may file if the beneficiary is physically or mentally incapacitated. The election statement must be signed no later than the first day for which the payment is claimed, and must also be signed if the beneficiary is re-electing the Hospice Medicare Benefit after a revocation or discharge from hospice.

The provider must submit a NOE to the intermediary for every beneficiary who elects the Hospice Medicare Benefit. An individual (or his/her representative) must elect hospice care to receive it. Once the decision to receive hospice care is made, an election statement must be filed with a particular hospice.

All election statements must include the following information:

1. Identification of the particular hospice that will provide care.
2. The individual's or representative's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, particularly the palliative rather than the curative nature of treatment.
3. Acknowledgement that certain Medicare services, set forth in paragraph (d) of Section 418.24 of the 42 CFR, are waived by the election.
4. The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement.
5. The signature of the individual or representative.

The duration of election will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual remains in the care of a hospice and does not revoke the election under the provision of 42 CFR 418.28.

When a Medicare beneficiary or authorized representative elects the Hospice Medicare Benefit, a NOE must be submitted to the Medicare Administrative Contractor prior to the submission of the first bill.

For more information, refer to:

- CMS Internet-Only Manuals (IOMs), Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Sections 10, 20.2 and 20.2.1
- Code of Federal Regulations, 42 CFR - Sections 418.20, 418.24 and 418.28
- "Common Technical Hospice Medical Review Denials and How to Avoid Them." This article can be located on the Palmetto GBA Web Site (*www.PalmettoGBA.com/HHH*) using the Palmetto GBA Web site Search feature.

10. 5CF70 – Continuous Care Hours Not Documented

Reason for Denial

The continuous care hours were denied as the documentation submitted for review did not include documentation of services provided for these hours.

How to Avoid a Denial

Ensure documentation for all hours billed is submitted. Documentation submitted for review should illustrate the following:

For more information, refer to:

- CMS Internet-Only Manuals (IOMs), Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 40.2.1
- CMS Internet-Only Manuals (IOMs), Publication 100-04, Medicare Claims Processing Manual, Chapter 11, Section 30.1

3 important aspects of documenting terminal illness

When documenting the terminal illnesses for hospice patients with those conditions, cover three main points – decline, impairments and co-morbidities – which are outlined in the local coverage determinations (LCDs), advised Cahaba educator Annette Lee. Documenting that information can help support claims and prevent denials.

- **Document the patient's decline in clinical status** based on patient signs and symptoms and results of standardized tests. For example, clinicians can show the patient's decline through documentation of recurrent infections, such as pneumonia, weight loss or dysphagia leading to recurrent aspiration.

  Scores from standardized tests also can support decline. The Palliative Performance Scale, for instance, measures patients' ability to care for themselves and ambulate, and the FAST test measures functional abilities of dementia patients.

- **Report impairments based on disease-specific guidelines.** Impairments alone are not enough to qualify patients for hospice. Hospices also should include disease-specific information for cancer and non-cancer patients found in the LCD appendices. Note: Non-cancer diagnoses, such as heart disease, could require more detail because patients with those diseases might not be appropriate for hospice until the illnesses are in the end stages.

  All patients must meet two impairment criteria: Functional impairments as demonstrated by scores of 70% or below on the Karnofsky Performance Status Scale or Palliative Performance Scale and assistance needed for two or more activities of daily living.

- **Support the diagnosis with documentation of co-morbidities.** Co-morbidities will not qualify a patient for hospice, but they show reviewers the complexity of the case. Multiple chronic conditions can decrease the length of the prognosis and illustrate why the patient is at greater risk.

Focus on documentation at 4 time points

Watch for these documentation traps throughout the episode, Lee pointed out.

- **Admission** – Documentation should detail the symptoms and changes in the patient's condition or needs that triggered the hospice admission. Include the patient's history and course of the illness in the past year, and establish baselines of the patient's condition by using standard tests.
- **During care** – When patients show improvement, hospices need to explain why. Use words that reflect how patients responded to interventions. For example: "The patient is experiencing pain relief on pain regime of Oxycodone 10 mg q 6h. Acceptable pain level maintained at 2. Tolerates visits with grandchildren and walk around the yard."

  Visit notes should include objective data that continuously support the terminal diagnosis, such as vital signs and patient weight. Clinicians should avoid terms such as "doing well" or "stable" because they don't support hospice care.
- **Change in level of care** – A change in a patient's condition could prompt the move from continuous home care to general inpatient care, for example. Hospices should document the change in condition to support the change in care.
- **Recertification** – Explain the course of the illness, your interventions and why, even with all of the hospice interventions, the patient continues to decline. The documentation should show the patient still has a prognosis of six months.

How to keep your hospice claims in compliance

Justify hospice care in patients with a non-cancer terminal diagnosis by coding the patient's co-morbid conditions and other complicating factors.

Whether you're a coder at a home health agency that also provides hospice care, or you work for a stand-alone hospice, there are certain rules you need to be aware of when coding hospice cases.

When admitting a hospice patient whose terminal diagnosis is ***not*** cancer, make sure you code all the relevant co-morbidities that support the physician's determination that the patient's disease is likely to cause death within six months or less, says Maurice Frear, HCS-D, coder for Bon Secours Home Health and Hospice in Virginia Beach, Va.

For example, in diagnoses like congestive heart
re (CHF) and chronic obstructive pulmonary
ease (COPD), the rationale for hospice may be less
r than with a cancer diagnosis, he says. This is
use not everyone with CHF or COPD is considered
ve a life expectancy of six months or less.

However, the patient also may have co-morbid
ditions, such as Alzheimer's and dementia, ischemic
diomyopathy, diabetes or late effects of CVA – and
the reasons for an expected decline within six
ths could become clearer, he says.

ote that listing co-morbid conditions helps
ort the terminal prognosis of hospice patients,
oes not mean that the hospice has to address
e conditions, according to fiscal intermediary
ba's April 2010 "Home Health & Hospice Medicare
sline."

Check out CMS's list of various co-morbid
tions and other complicating factors that can help
ify hospice care for patients with non-cancer
al diagnoses. These are listed in the hospice
overage determinations (LCDs).

ing the other co-morbidities isn't going to result
e revenue for the agency, because, unlike coding
e health where diagnoses carry points and
to payment, hospices are paid one flat fee for
tient, Frear says.

ever, careful documentation of all relevant
ons that add up to determine a patient's
ty for hospice care can help keep ADRs away,

hor's note: The regional home health
diaries (RHHIs) have switched over to
re administrative contractors (MACs). National
e Insurance Corporation (NHIC) has assumed
onsibility of jurisdiction A in New England;
GBA still is responsible for jurisdiction 11; and
Government Services has taken over Cahaba
risdiction 15. CMS awarded Jurisdiction D to
n Administrative Services, but that bid is under
and CMS was rewriting the bid.

ospice Patient Scenarios

Malignant Neoplasm

Scenario: Mr. N (68 years old) was diagnosed a ar ago with colon cancer that had metastasized to e liver. He underwent two courses of chemotherapy t was recently hospitalized for severe back pain and gnosed with bone mets of the spine. He received liative radiation therapy for the bone mets and pain ociated with them while in the hospital. Mr. N also diagnoses of HTN, CAD, and BPH.

Tests: Liver function tests are abnormal. A CAT scan monstrates the cancer is progressing in the liver. e patient is experiencing significant nausea and iting associated with the liver disease and has lost ounds in the last two months (usual weight 165 lbs., ght is 6' 1").

Mr. N has chosen to stop all curative therapy d to receive only palliative care for his pain and er sequelae of his malignancy. He has elected the dicare hospice benefit.

de the hospice case:

mary: 153.9, Malignant neoplasm of the colon

ers:

- 198.5, Mets to spine
- 197.7, Mets to liver
- 338.3, Neoplasm-related pain
- 401.9, HTN
- 414.00, CAD

ote: When patients have multiple symptoms ciated with a neoplasm, the coder should code neoplasm rather than the signs/symptoms. The ptoms are considered integral to the neoplasm. gn 338.3 (Neoplasm-related pain) since this pain been documented and is under treatment. BPH ot coded because it is not relevant to the hospice n of care.

End Stage Pulmonary Disease

Scenario: Mrs. O is an 87-year-old patient who dmitted to hospice following hospitalization for iration pneumonia due to dysphagia. While Mrs. O s in the hospital she experienced respiratory failure e to an exacerbation of COPD.

The patient was discharged home on continuous ygen at 6 Liters/minute. Her O2 saturation is 84% on m air and 88% on supplemental oxygen. The patient nable to walk any distance without significant pnea and is mainly wheelchair bound. She becomes ort of breath when talking to others. She also is ycardic at 100 bpm at rest. She experiences onic fatigue related to her disease. As a result, she eats poorly. She is currently 5' 5" tall and weighs 102 pounds. Mrs. O also has congestive heart failure, senile dementia, osteoarthritis (OA) and hypertension (HTN).

Code the hospice case:

Primary: 401.91, Exacerbation of COPD

Other:

- 428.0, Congestive heart failure
- 787.20, Dysphagia
- 290.10, Senile dementia
- 401.9, HTN
- V46.2, Dependence on supplemental oxygen
- V12.61, History of pneumonia

Note: OA is not coded since it is not pertinent to the plan of care.

3. End Stage Stroke

Scenario: Mr. V (82 years old) is admitted to hospice from the acute care hospital following a massive CVA six days ago which resulted in him being in a persistent vegetative state. Prior to his stroke Mr. V was in good health. He withdraws from painful stimuli and moans when turned in his bed. He is otherwise unresponsive. Mr. V received IV fluids while in the hospital but they have been discontinued. He is unable to take any oral intake and there is no PEG tube for oral feeding. He is sent home to receive hospice services for end-of life-care. The family has elected to withhold fluids and nutrition. A urinary catheter is in place and will be managed by hospice skilled nursing. The patient has Stage 1 pressure ulcers on both hips and a stage 2 pressure ulcer on the sacrum.

Co-morbid conditions are: HTN, CAD, and dysphagia due to stroke.

Code the hospice case:

Primary: 438.89, Other late effects of CVA

Other:

- 780.03, Persistent vegetative state
- 707.03, Pressure ulcer, sacrum
- 707.22, Stage 2
- 707.05, Pressure ulcer, Hip
- 707.21, Stage 1
- 401.9, HTN
- 414.00, CAD
- V53.6, F/A of urinary catheter

The diagnosis of persistent vegetative state as a late effect of stroke should be confirmed by the patient's physician.

4. End Stage Renal Disease

Scenario: Mrs. S (73 years of age) has received hemodialysis for the last five years for treatment of CKD due to diabetes. She also has hypertension, anemia due to CKD, and is legally blind. The patient has experienced repeated graft and shunt infections since beginning dialysis. The patient has elected to discontinue dialysis treatment. She indicates the treatment regimen and the repeated infections are a burden to her. She would like to die peacefully at home.

Code the hospice case:

Primary: 250.40, Diabetes with renal manifestations

Other:

- 403.91, HTN
- 585.6, ESRD
- 285.21, Anemia in chronic kidney disease
- 369.4, Legal blindness