Palmetto GBA has previously published guidelines for the use of ICD-9-CM Code 799.3 Debility Unspecified. See Palmetto GBA’s Focused Medical Review (FMR) - Non-Cancer Hospice Claims Symptoms, Signs and Ill-Defined Conditions (ICD-9-CM 780 - 799) (December 1998 Monthly Medicare Advisory (98-12)). The guidelines encouraged hospice providers to document how multiple conditions were contributing to the beneficiary’s medical prognosis of ‘six months or less.’ This was to be accomplished by specifically identifying the impairments, activity limitations and disability associated with the principal diagnosis identified by the hospice provider (i.e., the condition that was impacting most acutely on the beneficiary’s clinical course).

Palmetto GBA published an article titled The ICF: A Taxonomy for the 21st Century. The article opened by acknowledging that the documentation of impairments, activity limitations and disability is a complex task. The fruits of which are clinical records that support both the implementation of a beneficiary-specific care plan and Medicare reimbursement. The International Classification of Functioning, Disability and Health (ICF) was proposed as a comprehensive, valid and reliable way of classifying both ‘functioning and disability’ and ‘contextual and personal factors’ relevant to therapeutic care plans throughout the continuum of care. It was noted that the incorporation of ICF domains and categories into clinical documentation would increase not only the specificity, but also the quality of clinical records. If available, such information could be used to create decision-support systems for your organization.

The following case scenario underscores the importance of going beyond diagnosis when documenting personal health care services provided to Medicare beneficiaries. This case scenario demonstrates how seemingly innocuous decisions made at the operational level of your organization can hamper your strategic plan. In this case study both the hospice and hospital provider must determine the correct method for submitting a claim to Medicare. The hospice is responsible for providing any and all Medicare covered services indicated in the plan of care as necessary for the palliation and management of the terminal illness and related conditions. The hospital may only submit a claim to Medicare if the services were not related to the terminal illness. How would your organization respond to the three questions at the end of the case?

Palmetto GBA has answered the three questions. Please feel free to distribute this case to both your clinical and management staff. You may want to initially withhold the Palmetto GBA responses and determine how your organization would currently respond to this case. If you determine that your organization would benefit from a more specific documentation strategy, please consider the ICF.

**Palmetto GBA Going Beyond Diagnosis Case Scenario**

NP is an 87-year-old Medicare beneficiary who is dependent in all activities of daily living (ADLs), resides in a nursing home and has elected the Medicare hospice benefit based on the cumulative effects of multiple chronic conditions. The hospice uses ICD-9-CM code 799.3 (‘Debility, unspecified’) as the admitting diagnosis most reflective of the terminal illness. The following conditions are documented as contributing to the terminal illness:

- S/P CVA
- Cerebrovascular Disease with cognitive deficits (ICD-9-CM 438.0)
- Obstructive chronic bronchitis without exacerbation (ICD-9-CM 491.20)
- Dysphagia (ICD-9-CM 787.2)
- Anorexia (ICD-9-CM 783.0)

NP is described as having a 'mild dementia.' Mental status is described as 'alert, oriented x 2 with occasional episodes of confusion and lethargy.' She is noted to have a persistent cough, productive of greenish-yellow sputum, but denied dyspnea. She is maintained on Albuterol tablets. NP is also noted...
to be 'mostly bed and wheelchair-bound', which requires a wheelchair or walker for mobility. Her appetite is described as 'poor to fair' and she is reported to have 'difficulty swallowing at times.' Hypertension and a past right hip fracture are noted in her medical history. NP is maintained on Valsartan for hypertension and Lortab for right hip pain. NP is also maintained on Zoloft at hour of sleep.

Two weeks into the hospice stay NP is transferred to the hospital for evaluation of respiratory symptoms (i.e., shortness of breath, cough). Two days prior to transfer, she had been started on an antibiotic for symptoms. The admitting hospital physician documented the following as the rationale for inpatient admission:

- Myocardial Infarction
- Dyspnea
- Bacterial Pneumonia
- Dehydration

The medical documentation and laboratory tests confirmed the physician's evaluation.

Questions for Discussion:

1. What was the terminal illness?
   Debility, unspecified
2. Would you classify the acute hospitalization for cardio-pulmonary impairment as being related to the terminal condition?
   Yes.
3. Would the care provided by the hospital be related to the palliation or management of the terminal illness?
   Yes. In order to make an informed decision, however, you would need to have access to the nursing facility, hospice, and hospital medical records. The beneficiary's hospice record documents the following pieces of additional information:

Five days prior to inpatient admission home health aide documented that 'Patient complains of stomach pain; not feeling well; refused shower; coughing some and cold chills'. Previous notes indicate that the patient has a chronic cough at baseline. Vital signs were as follows: Temp 97.8; pulse = 80; respiratory rate = 20; BP = 150/70

Four days prior to inpatient admission nurse documented new complaint of shortness of breath with activity and non-productive cough. Vital signs: Temp 98.4; pulse = 110; respiratory rate = 20; BP = 133/77.

Three days prior to inpatient admission patient is observed to be 'coughing and spitting'; nursing note documented 'bilateral rales' and productive cough. Vital signs: Temp 98; pulse = 84; respiratory rate = 20; BP = 104/68.

Two days prior to inpatient admission patient is empirically started on an antibiotic for respiratory symptoms.

Patient transferred to hospital after no improvement in respiratory symptoms.

The initial 'stomach pain' may have actually been related to the MI, with subsequent events being secondary to the functional impairments and activity limitations stemming from the MI. Alternatively the individual may have developed pneumonia, delirium, dehydration and finally myocardial infarction.

Regardless of the mechanism, cardio-pulmonary impairment is the principal factor contributing to this individual's terminal prognosis. Given the broad hospice diagnosis of 'Debility, unspecified,' cardio-pulmonary impairment would be considered a 'related condition.' The hospitalization would, therefore, be related to the terminal illness.

Below is a description of this case scenario using both ICD-9-CM diagnoses and the ICF. The medical records were abstracted using the ICF and relevant impairments, activity limitations, and
environmental factors impacting on the plan of care were identified. Chapter and page numbers refer to the following reference:


This reference is available through the WHO at the following address or telephone number:

WHO Publications Centre, USA
49 Sheridan Avenue
Albany, NY 12210
Telephone: (518) 436-9686

For more information on the background of the ICF and to view the ICF online you may visit the WHO Web site at the following URL: [www.who.int/classifications/icf/en/](http://www.who.int/classifications/icf/en/).

ICD-9-CM Diagnoses:

- Debility, unspecified
- Hypertension
- S/P CVA
- Cerebrovascular Disease with cognitive deficits
- COPD
- S/P Hip Fracture
- Anorexia
- Myocardial Infarction
- Bacterial Pneumonia
- Dehydration

**Going Beyond Diagnosis**

A) ICF Impairments

**Chapter 1 - Mental Functions: Pages 48 to 61**

- b144 Memory functions (Page 53)
- b1141 Orientation to place (Page 49)
- b1302 Energy and drive functions – appetite (Page 51)
- b1100 State of consciousness (Page 48)

**Chapter 2 – Sensory Functions and Pain: Pages 62 to 70**

- b28016 Pain in joints (Page 69)
- b28012 Pain in stomach or abdomen (Page 69)

**Chapter 4 – Functions of the Cardiovascular...and Respiratory Systems: Pages 74 to 80**

- b450 Additional respiratory functions – cough (Page 79)
- b4402 Depth of respiration (Page 79)
- b4100 Heart rate – tachycardia (Page 74)
- b4400 Respiratory rate – tachypnea (Page 78)
- b460 Sensations associated with cardiovascular and respiratory functions – dyspnea (Page 80)
- b4103 Blood supply to the heart (Page 75)
- b4201 Blood pressure functions - Decreased blood pressure (Page 76)

**Chapter 5 – Functions of the Digestive, Metabolic, and Endocrine Systems: Pages 81 to 88**

- b51059 Swallowing, unspecified (Page 82)
- b5253 Fecal continence (Page 84)

**Chapter 6 – Genitourinary and Reproductive Function: Pages 89 to 93**

- b6202 Urinary functions – urinary continence (Page 90)
- B) ICF Activity Limitations and Participation Restrictions
Chapter 4 – Mobility: Pages 138 to 148

- d4103 Changing basic body position - Sitting (Page 139)
- d4104 Changing basic body position - Standing (Page 139)
- d4209 Transferring oneself, unspecified (Page 140)
- d4500 Walking short distance (Page 144)
- d460 Moving around in different locations – within the home (Page 145)

Chapter 5 – Self-care: Pages 149 to 163

- d510 Washing oneself, unspecified (Page 149)
- d5309 Toileting, unspecified (Page 151)
- d5409 Dressing, unspecified (Page 151)
- C) Environmental Factors

Chapter 1 – Products and technology: Pages 173 to 181

- e1201 Assistive products and technology for personal indoor and outdoor mobility and transportation (Page 174)
- e5802 Health policies (Page 204)

last updated on 09/24/2010
ver 1.0.43