EPEC

Education for **P**hysicians on **E**nd-of-life **C**are

Trainer's Guide

Procedure/Diagnosis Coding and Reimbursement Mechanisms for Physician Services in Palliative Care

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Objectives

The objectives of this section are to:

- understand how to code for physician services related to palliative care, including hospice
- understand the differences between the reimbursement mechanisms to be used when the patient is enrolled in the Medicare hospice benefit and the usual reimbursement mechanisms

Physicians can code and bill for services related to palliative care by using existing mechanisms. This section first discusses coding for physician services by standard coding approaches. Then it presents how those same approaches need to be adapted when a patient has elected the Medicare hospice benefit. Finally, it describes how palliative care services other than physician services are paid.

Coding for physician services related to palliative care

Coding for physician services, whether the patient is enrolled under the Medicare hospice benefit or receives health care services through other funding mechanisms, almost always uses the same coding technique. Physicians code for their service to an individual patient in two parts: 1) a procedure or service code and 2) a diagnosis code.

1) Procedure or service codes

The physician selects a procedure code from the Current Procedural Terminology (CPT)^{TM} codes published by the American Medical Association. For physicians involved in palliative care, the most frequently used codes are the evaluation and management (E/M) codes (code range, 99201-99499). There are evaluation and management codes for each of the usual settings in which physicians provide services: ambulatory outpatient, acute inpatient hospital, extended care institutions, or patients' homes. Within each general category of codes (by setting) there is a hierarchy of codes from least intensive to most complex.

The Health Care Financing Administration (HCFA) has promoted extensive guidelines for the documentation that must support the use of each of the E/M codes. Related to palliative care, a little-known and underappreciated provision of current E/M coding guidelines often applies. When more than 50% of the patient-physician interaction is composed of counseling and/or information giving, then *time* becomes the factor that determines the level of service that is coded. As palliative care consultations and services often incorporate extensive amounts of information giving and/or counseling as part of the physician-patient interaction, then the time it takes to complete the activity determines which E/M code will be chosen. Each of the E/M codes is associated with a time element for this purpose. Table 1 indicates current codes with an amount of time associated with each.

When time is used to determine which E/M code to use, the documentation must indicate that more than 50% of the interaction was related to counseling or information giving. In the inpatient setting, the time is defined as floor or unit time, which includes the time that the physician is present on the patient's hospital unit and at the bedside rendering services for that patient. This includes time in which the physician establishes and/or reviews the patient's chart, interviews and examines the patient, writes notes, and communicates with other professionals and the patient's family.

Physicians who provide palliative care may also report codes for specific procedures or tests that they may perform (such as anesthetic injections, paracentesis, and thoracentesis). The time required to provide these procedures or tests is not included in the time used to establish the appropriate E/M code.

An example

You are asked to provide palliative care consultation for an 86-year-old former schoolteacher who has been admitted to the hospital for exacerbation of congestive heart failure. The attending physician would like advice on managing her dyspnea. You spend an hour on the unit reviewing the chart and interviewing/examining the patient and an additional 20 minutes writing your note and conferring with the attending physician. The majority (more than 50%) of your interaction with the patient was related to eliciting her values and care goals, clarifying her understanding of her diagnosis and prognosis, and giving information and counseling. You had some specific suggestions about the use of morphine to relieve her dyspnea.

You would code 99254 for this initial consultation in the hospital. In the note documenting the consultation, you would indicate the name of the referring physician, the reason for the consultation, the recommendations for medical management of the dyspnea, the fact that the majority of the interaction was related to counseling and information giving, and a summary of the situation and the information around which counseling or information giving was required. The note should indicate that the total time spent on the consultation, including the time spent in documentation and discussing the case with the referring physician, was 80 minutes.

2) Diagnosis codes

Besides the CPT code, the physician describes the reason for the service by using one of the International Classification of Disease—Clinical Modification (ICD-9-CM) codes promulgated by the National Center for Health Statistics (NCHS). These diagnosis codes are published by several publishers, including the American Medical Association. The ICD-9-CM book contains not only disease codes but also many symptom codes. A few examples are indicated in Table 2.

Many physicians, particularly internists, are concerned about reimbursement for concurrent care; that is, if they see a patient on the same day as another internal medicine

specialist or subspecialist, only one of them will have their services reimbursed. In October 1995, HCFA published new rules that permit concurrent care by two or more physicians on the same day, even if they are of the same specialty. In order to describe the legitimate differences in evaluation and management services that multiple physicians may provide to a single patient, physicians need to use different ICD-9-CM codes for diagnosis as appropriate.

An example

For the 86-year-old woman with congestive heart failure described above, if both her general internist and the palliative care specialist use the ICD-9-CM code for congestive heart failure, only one submission for reimbursement is likely to be accepted and the other denied. However, if you are being consulted for advice related to management of shortness of breath, you would use the ICD-9-CM diagnosis code for dyspnea (286.6).

Reimbursement for physician services related to palliative care

Medicare hospice benefit background

The Medicare hospice benefit was established in 1982 to pay for hospice services at home for Medicare beneficiaries. Provision is also made for brief periods of inpatient services. A patient is eligible to elect the Medicare hospice benefit if the patient is confirmed by two physicians to have a prognosis of less than or equal to 6 months if the disease follows its usual course. The patient must acknowledge the terminal nature of the illness and sign election forms that indicate that care will be directed toward comfort, not cure of the disease. When a patient elects the Medicare hospice benefit, care for the patient that is related to the terminal illness is the direct responsibility of the hospice program. The benefit pays 100% for intermittent nursing, social work, chaplain, nurse aide, physical/occupational therapy, medication and therapy related to the terminal illness, and durable medical equipment. The hospice agency receives a per diem rate to cover these costs. This rate is set by the federal government and is not influenced by the particular treatments or services that the patient receives. As such, it is an example of capitated medical care. Many commercial payers have adopted similar approaches to covering home hospice care. If a patient needs medical care that is not related to the terminal illness, then that care can be provided and reimbursed by standard Medicare mechanisms. It is the responsibility of the hospice physician to determine whether care is related or unrelated to the terminal illness.

Payment and coding for physician services under the Medicare hospice benefit

1) Administrative/supervisory activities

As a part of the benefit, the services of the hospice medical director that relate to the administrative and general supervisory activities of the hospice are included in the *per diem*. "These activities include participating in the establishment, review, and updating of plans of care, supervising care and services and establishing governing policies" (Medicare Regulations, Section 406). Therefore, the medical director should expect his or her administrative services to be reimbursed from the hospice program in addition to fee-for-service billing for direct patient care.

2) Direct physician services to Medicare hospice patients

Physician services related to direct patient care under the Medicare hospice benefit are not covered as part of the *per diem* rate. Any physician who provides direct care, whether the hospice medical director or other physicians caring for the patient, needs to code for his or her services separately. The precise mechanism for reimbursement depends on whether or not the physician is associated with the hospice program either as an employee or as a volunteer.

3) Attending physician, not associated with the hospice

At the time the patient elects the Medicare hospice benefit, the patient indicates who his or her attending physician will be. The attending physician for the patient who is not associated with the hospice continues to code for physician services using CPT and ICD-9-CM in the way described above and submits bills for reimbursement to Medicare under Part B (the federal Medicare program that funds physician services from payments made by beneficiaries). However, for paper claims, the physician must indicate on the HCFA-1500 claim form that he or she is the attending physician and not an employee of the hospice program that is caring for the patient when each claim is submitted. If this statement is not present, the services are likely to be denied. For physicians who submit bills electronically (EMC), an HC modifier must be appended to the CPT code. The fiscal intermediary will then telephone the physician's office for further information. When the carrier calls, the information they need is, "This is a hospice patient; Dr. X is the attending physician and is not employed by the hospice."

4) Attending physician associated with the hospice

If the attending physician is associated with the hospice agency (eg, medical director or hospice physician), as a salaried employee or even as a nonsalaried volunteer, then codes for physician services are submitted to the hospice agency and submitted by the agency to Medicare under Part A (the federal Medicare program that covers institutional and

nonphysician services funded by payroll deductions). This is a marked departure from other standard approaches to coding and billing for physician services. The hospice agency will submit these bills and are paid at 100% of the usual and customary fee reimbursed under Medicare Part B schedules. The hospice agency then can pass this reimbursement on to the physician as part of his or her negotiated salary or fee-for-service arrangement.

5) Consulting physicians

Consulting physicians who are asked to see the patient by the attending physician can also submit claims for the services they have provided to patients who have elected the Medicare hospice benefit. However, they must submit their code claims directly to the hospice agency, which in turn submits the claims for reimbursement under Part A. The consultants must have a contract with the hospice agency in order for this to occur.

Payment and coding for physician services outside the Medicare hospice benefit

1) Hospice under Medicaid/public aid

Hospice care is reimbursed by many states for their indigent patients. The Medicaid and public aid budgets are administered by individual states, not the federal government. However, most states have adopted HCFA/Medicare guidelines for patients who are receiving hospice care. Consequently, the coding guidelines outlined for the federal Medicare hospice benefit also apply. In state-managed programs, it is important that practitioners become familiar with the rules and regulations in the individual states in which they are practicing.

2) Private insurance

Most commercial payers (ie, health plans, insurance companies) require physicians to code for their services by means of CPT and ICD-9-CM codes. Physicians code and submit their claims for reimbursement regardless of whether a patient is covered by a hospice benefit. Again, specific regulations regarding coding may apply for an individual payer. Information on these rules should be obtained before claims are submitted.

3) Palliative care services for patients under Medicare

Physicians may see patients for purposes of delivering palliative care services when they are still covered under Medicare. Use the coding procedures outlined in the first part of this document and submit them to the Medicare fiscal intermediary in your area in the usual way.

Funding for nonphysicians providing palliative care services

Under the Medicare hospice benefit, the *per diem* fee covers all services of nonphysician health care professionals who provide care to the patient and family. However, patients who are not eligible or appropriate for enrollment under the Medicare hospice benefit may have legitimate needs for interdisciplinary palliative care services. The challenge is how to pay for the nonphysician component of such services. Many health care professionals, such as nurse practitioners, clinical nurse specialists, social workers, and chaplains, can access fee-for-service billing for patients not enrolled in the Medicare hospice benefit. In many settings, this has not been explored but is available. More commonly, these services are included as part of a larger program of services. For example, when a patient is hospitalized, the hospital reimbursement rate includes nursing, social work, and chaplaincy services.

Table I

Summary of some cpt evaluation/management codes

Attending/managing physician

New/ office	Established office	Initial hospital	Subsequent hospital
99201 10 min	99211 5 min	99221 30 min	99231 15 min
99202 20 min	99212 10 min	99222 50 min	99232 25 min
99203 30 min	99213 15 min	99223 70 min	99233 35 min
99204 45 min	99214 25 min		
99205 50 min	99215 40 min		

Nursing home-C	Nursing home-F	Home— new	Home— established
99301 30 min	99311 15 min	99341 20 min	99347 15 min
99302 40 min	99312 25 min	99342 30 min	99348 25 min
99303 50 min	99313 35 min	99343 45 min	99349 40 min
	99344 60 min	99350 60 min	
		99345 75 min	

Prolonged service face to face office/home	Prolonged service face to face inpatient
99354 30 min	99356 30 min
99355 each subsequent 30 min	99357 each subsequent 30 min

Consultation

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. A physician consultant may initiate diagnostic and/or therapeutic services. The request and the need for consultation must be documented in the medical record. The opinion and any services ordered or performed must also be documented. A "consultation" initiated by a patient and/or family, and not requested by a physician, should be reported by means of the codes for confirmatory consultation or office visits, as appropriate. *The follow-up codes should not be used* if the consultant assumes responsibility for management of a portion, or all, of the patient's condition(s).

Office/home	Initial hospital	Follow-up hospital	Confirmatory
99241 15 min	99251 20 min	99261 10 min	99271
99242 30 min	99252 40 min	99262 20 min	99272 Low severity
99243 40 min	99253 55 min	99263 30 min	99273 Moderate severity
99244 60 min	99254 80 min		99274 Moderate to high
99245 80 min	99255 110 min		99275 Moderate to high

Table 2

Some common ICD-9 codes physicians may use in palliative care*

Anorexia	783.0	Inanition	263.9	Pain: unspecified	780.9
Agitation	307.9	Mental status change	780.9	Pain: abdomen	789.0
Anxiety	300.0	Nausea	787.02	Pain: arm	729.5
Confusion	298.9	Nausea & vomiting	787.01	Pain: back	724.5
Coma	780.01	Vomiting	787.03	Pain: bone	733.90
Cough	786.2	Weakness	780.7	Pain: chest	786.50
Debility	799.3	Weight loss	783.2	Pain: foot	729.50
Dementia	298.9	Shortness of breath	786.09	Pain: hip	719.45
Dyspnea	286.6	Unconscious	780.09	Pain: leg	719.45
Depression	311			Pain: Muscle	729.1
Delirium	780.09			Pain: sacroiliac	724.60
Diarrhea	558.9			Pain: throat	789.1
Fatigue	558.9			Pain: neck	723.1
Fever	780.6				
Headache	784.0				
Hemorrhage	459.0				

* Refer to the full tabular list of ICD-9-CM codes to ensure coding at the highest degree of accuracy.