Palliative Care Billing, Coding and Reimbursement

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Kentucky
Objectives

- Review coding and set fee schedule.
- Anticipate palliative revenue & expenses
- Prepare for billing palliative services.
- Understand reimbursement for MDs, NPs, and LCSWs.
- Discuss options for pall services in different settings.
- Begin data collection.

Setting Up A FEE SCHEDULE

- Inpatient Consultations
- Outpatient Clinic Visits
- Long-Term Care Consultations
- Home Visits
- Domiciliary, Rest Home, Assisted Living
Fee Schedule

- Study similar physician practices and regional fees.
- Study Medicare, Medicaid and Private Insurance fee for service schedules.
- PCCB based fee schedule on Medicare allowable - 145%.

CPT = Current Procedural Terminology

CPT™’s are descriptive terms and identifying codes for reporting medical services and procedures by physicians and other health care professionals. – American Medical Association
### 2011 Outpatient Codes

<table>
<thead>
<tr>
<th>Outpatient Services</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient Visits</td>
<td>99201-99205</td>
</tr>
<tr>
<td>Established Visits</td>
<td>99211-99215</td>
</tr>
</tbody>
</table>

### PCCB 2011 Inpatient Codes

<table>
<thead>
<tr>
<th>Inpatient Services</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Care</td>
<td>99221-99223</td>
</tr>
<tr>
<td>Subsequent Hospital Care</td>
<td>99231-99233</td>
</tr>
</tbody>
</table>
# PCCB 2011 Long-Term Care Codes

<table>
<thead>
<tr>
<th>Codes</th>
<th>Initial Nursing Facility Care</th>
<th>99304-99306</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent Nursing Facility Care</td>
<td>99307-99310</td>
<td></td>
</tr>
</tbody>
</table>

# PCCB 2011 Home Codes

<table>
<thead>
<tr>
<th>Codes</th>
<th>Initial New Patient Visits</th>
<th>99341-99345</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established Patient Visits</td>
<td>99347-99350</td>
<td></td>
</tr>
</tbody>
</table>
PCCB 2011 Domiciliary, Rest Home or Custodial Care Services (e.g. assisted living facility)

<table>
<thead>
<tr>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial New Patient Visits</td>
</tr>
<tr>
<td>Established Patient Visits</td>
</tr>
</tbody>
</table>

Consultation Codes for Medicare Eliminated on 1/1/2010

- We still provide Medicare the name of the physician who requested the consultation.
- We continue to document reason for consultation and are careful to return a report on the consultation back to the requesting physician.
Coding/Documentation/$$

- Documentation must support coding/billing. Are you auditing these?
- Use templates
- CMS’ CERT programs are focused on E/M Codes.
- RAC is focused on physician billing

Documentation Components

- Each E&M code has three basic components. (Is this in your EMR?)
  - History
  - Examination
  - Medical Decision Making
- Use the Domains of Quality Palliative Care to organize plan of care
  (www.NationalConsensusProject.org)
Documentation Guidelines (from a Medicare Auditor)

- Documentation must be legible.
- Documentation must support all of the services billed.
- Date of service must match record.
- Document time in medical record for time based services. CMS prefers “time in” and “time out” as well as “total time.”

Prolonged Services Codes

Inpatient:
- 99356 (30 min.)
- 99357 (+30 min.)

Outpatient:
- 99354 (30 min.)
- 99355 (+30 min.)

These codes are used when a physician provides prolonged service involving direct (face to face) patient contact that is beyond the usual service (typical time) in either the inpatient or outpatient setting.
- The prolonged time does not have to be continuous.
- Each code is reported separately in addition to appropriate E/M service code.
Extending an E/M code that is based on components/intensity is different than “time based coding”

Time Based Coding
PCC encounters with patients frequently involve the multiple domains of whole-person palliative care.

Much of MD/NP time is spent
- counseling and educating patients and families
- formulating and communicating prognosis and goals of care
- exploring burden/benefit of various approaches to the patient’s goals of care
When these activities and/or coordination of care constitute more than 50% of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility) **time may be considered the key or controlling factor to qualify for a particular level of E/M service.**

This includes time spent with those individuals who have assumed responsibility for the care of the patient or decision making, regardless of whether they are family members (e.g., child’s parents, foster parents, person acting *in locum parentis*, legal guardian).


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**ICD-9 and ICD-10**

- **ICD** = International Classification of Diseases (diagnoses)
- **ICD-9-Clinical Modification (ICD-9-CM)** – what we are using now.
- **ICD-10-CM** – begins October 1, 2013
How are Claims Processed?

- Patient name, dob, etc.
- Date of service
- CPT Code
- ICD-9-CM (primary and other)
- Provider (NPI and Specialty)
- To name a few demographics….

Basically, these run through payer’s system to determine if claim is paid.
Avoiding concurrent billing issues…….
Constructing a PC Budget

- Revenue
  - CPT Codes
  - Fee Schedule
  - Partner Contribution
- Expenses
  - Personnel
  - General

Revenue Budget Assumptions

- Based on careful analysis of the CPT code usage in previous year, the CPT projections were estimated for coming year.
- Areas of the program development should project growth.
- Revenue projected based on Medicare allowable
### Sample Budget for Hospital Visits

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>MD Visits per Year</th>
<th>Medicare Allowable</th>
<th>$ Total per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial</td>
<td>99221</td>
<td>81</td>
<td>$94.15</td>
</tr>
<tr>
<td>Visit</td>
<td>99222</td>
<td>333</td>
<td>$127.86</td>
</tr>
<tr>
<td></td>
<td>99223</td>
<td>486</td>
<td>$188.53</td>
</tr>
<tr>
<td>Subsequent</td>
<td>99231</td>
<td>81</td>
<td>$37.56</td>
</tr>
<tr>
<td>Visit</td>
<td>99232</td>
<td>1944</td>
<td>$68.13</td>
</tr>
<tr>
<td></td>
<td>99233</td>
<td>675</td>
<td>$97.86</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3600</td>
<td></td>
</tr>
</tbody>
</table>

### Revenue

- Revenue is taken from the CPT worksheet and calculated at 88% collectible of Medicare allowable.
- Net collection percentage is 82% of charges less contractual adjustments.
- Contributions from partners.
Expense Budget:
Staff FTE on PCCB Personnel

- 2.9 Physician
- 4.8 Nurse Practitioners
- 1.6 Social Worker (clinic)
- 1.0 Nurse (clinic)
- 0.2 Clinical Psychologist
- 0.5 Practice Manager
- 1.0 Receptionist
- 2.0 Billing Specialist

Expense Budget

Will your program have these budget expenses?
What will be your overhead?

- Personnel
- Patient Service Expenses
- Office Supplies (printing/duplicating, postage)
- Telephone
- Rent
- Insurance
- Equipment (copiers, computers)
- Education
- Administration (billing, finance, audit)
- Facilities (utilities, janitorial, maintenance)
- Allocated Indirect Costs
Budget

Net Revenue
- Expenses
Profit (Deficit)

<table>
<thead>
<tr>
<th>Funding Sources</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HOB</td>
<td>28%</td>
</tr>
<tr>
<td>Partners</td>
<td>31%</td>
</tr>
<tr>
<td>Billings</td>
<td>41%</td>
</tr>
</tbody>
</table>

Billing & Reimbursement
Physician Practices

- Corporate Practice of Medicine
- Iowa - state statutes and regulations do not address CPOM.  (CAPC, 2006)
- See Iowa Op. Att'y Gen. 91-7-1 (July 12, 1991) for more information.  (CAPC, 2006)
- Medical Practice becomes a Part B Provider (handout)
- Medical Practice becomes a Medicaid provider

Hospital Privileges

All providers need to have courtesy and/or admitting privileges at your partner hospitals.

This can take 30 to 120 days! Start soon!

Provider Enrollment

You should enroll all physicians and nurse practitioners in Medicare, Medicaid, and private insurance companies with whom you wish to participate.

This can take from 60 days to 6 months!
Billing & Reimbursement for Physicians

- Practice management software
- Outsource billing
- Getting billing information from partner hospitals and nursing facilities
- Billing primary, secondary & patient
- Collections of past due accounts (OIG)
- Preauthorization processes

Inpatient Billing

- Pocket size “charge” records
- Patient demographics and insurance information
- Documentation
LTC Billing Info is on Clinical Note

CMS 1500

- Electronic Billing
  - We are now using a clearing house for claims transmission.
- Paper Claims
- (handout)
Advanced Registered Nurse Practitioner (ARNP)

- Established minimum qualification for NP to apply for direct reimbursement under Medicare:
  - Be a registered professional nurse meeting State law regs
  - Be a certified NP by a recognized national certifying body
  - Possess a master’s degree in nursing

Steps Towards Billing for a Nurse Practitioner

- Collaborative Agreement – required by Medicare
- Liability Insurance
- Prescriptive authority
- Hospital privileges strongly linked to MD follow-up in 48 hours. (Hospital Bylaws)
Billing Considerations for ARNPs

- Medicare fee schedule for ARNPs is 85% of MD’s allowable.
- “Incident to” billing and “Shared Visits”.
- ARNPs use the same E&M codes as MDs.

Clinical Psychologist (CP)

- To qualify as a clinical psychologist (CP), a practitioner must meet the following requirements:
  - Hold a doctoral degree in psychology;
  - Be licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.
- Modifier AH (e.g. 90801AH)
Iowa: Licensed Independent Social Worker

Medicare defines CSW as an individual who:

- possesses a master’s or doctoral degree in social work
- has performed at least 2 yrs of supervised clinical social work
- licensed or certified by state as LCSW or CSW

Modifier AJ (e.g. 90801AJ)

Medicare does not cover LISW services in hospital or SNF.

Things to consider for LISW or Psy.D.

- Patients must have a DSM-IV diagnosis.
- Concurrent appointment or counseling session.
- Most private insurance companies have a separate HMO Mental Health company.
- Congress has passed the Mental Health Parity and Addiction Equity Act.
  (On CMS website: CMS Home>Regulations & Guidance > Health Insurance Reform for Consumers > Mental Health Parity and Addiction Equity Act.)
CPT Codes for Psy.D./LISW

Psy.D./LISW’s do not use E/M codes.
Psychotherapy services are based on time.
ICD-9-CM and DSM-IV diagnoses
Example:
309.xx  Adjustment Disorder

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
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<tbody>
<tr>
<td>90801</td>
<td>Initial Diagnostic Interview</td>
</tr>
<tr>
<td>90804</td>
<td>Individual Therapy (20-30 min)</td>
</tr>
<tr>
<td>90806</td>
<td>Individual Therapy (45-50 min)</td>
</tr>
<tr>
<td>90847</td>
<td>Family Psychotherapy</td>
</tr>
</tbody>
</table>

Palliative Care Settings

- **Inpatient** (acute care hospital)
- **Nursing Home** (SNF)
- Assisted Living
- **Outpatient Clinic**
- Patient’s Home
PCCB’s Inpatient Palliative Consultation Model

- Request for consult in patient chart.
- Team notified.
- Physician often first to see patient.
- Orders vs. Recommendations
- Daily Team meetings: physician, nurse practitioner, nurse coordinator, social worker, chaplain
Long-Term Care Facility Consultation

- Order in chart requesting Palliative Care
- Team notification
- Physician or nurse practitioner visit
- Documentation / Billing
- Follow-up

Palliative Outpatient Clinic

**PCCB Team:**
physician, nurse case manager, social worker, psychologist, receptionist
Eligibility for Clinic or Home Visit

- Adults or children with complex or life threatening illnesses are eligible to receive palliative care.
- Patients and families making end-of-life decisions about advance directive issues and goals of care.
- Primary care physician’s medical records on the patient.
- What does requesting physician want you to do? (Medical Necessity)

Outpatient Palliative Care Clinic

- Proximity to laboratory
- Proximity to referral sources
- Proximity to hospital
- Exam rooms sized for families
- Nurse case manager
- Clinical charts
Outpatient Referral Policy

New Referral
1. Regardless of diagnosis, must review records prior to scheduling patient.
2. Patient must have a primary care physician or a treating physician willing to resume care after symptoms managed.

Outpatient Office Procedures

Scheduling:
1. New patients are scheduled for one hour appointment.
2. Follow-up patients are scheduled for $\frac{1}{2}$ hour appointment.
3. After patient symptoms are stable, nurse practitioner can see patient for follow-up.
Outpatient Office Procedures

- Medication Agreement
- Patient instructions written by physician.
- Copies of prescriptions are kept in chart.
- Physician dictates progress note and letter to referring physician(s).
- Medication pre-authorizations.
- Collect co-payment.

Outpatient Consultation

Team Visits

<table>
<thead>
<tr>
<th>Year</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits</td>
<td>644</td>
<td>890</td>
<td>925</td>
<td>801</td>
<td>739</td>
<td>443</td>
<td>242</td>
<td>475</td>
<td>690</td>
<td>878</td>
</tr>
</tbody>
</table>
Benefits of Outpatient Services

- Provides continuity of care flowing from inpatient consultations.
- Provides physician office space to see ambulatory hospice patients.
- Adds overhead to consultation practice, but also provides headquarters for billing and management personnel.
- Pre-employment physicals.

Total PCCB Visits
MD, NP, Psy.D., LCSW

![Chart showing total PCCB visits from 2003 to 2011*]
PCCB Data Collection

- Demographics
- Primary Diagnosis (ICD-9 Code)
- Symptom Diagnosis
- Referral to Hospice of the Bluegrass (HOB)
- LOS in HOB
- Referral to Hospice Care Center (HCC)
- LOS in HCC
- Payer Source
- Referring physician

PCCB Data Collection

Patient satisfaction surveys:
- Outpatient clinic
- Hospital inpatients after discharge
- Hospital inpatients family satisfaction
- Referring physicians in hospital
2011 Diagnoses for PCCB
Inpatient, Nursing Home, & Clinic

2011 PCCB: Referring MD Specialty
2011 PCCB: Number of Days from Hospital Admit to Consult Visit

PCCB Patients 2010

1. 1,829 New Patients
2. Age 67 years (mean) (71 = median)
3. Age Range 0-104 years
4. 56% Female 44% Male
5. 2,050 Total Patients Served
Palliative Care of the Bluegrass
2011 Payer Sources

**Medicare**  64%
**Private Insurance**  22%
**Medicaid**  9%
**Self Pay**  5%

Hospice Length of Stay Data for PCC Patients

In 2010 YTD, 528 new PCC patients were referred to Hospice of the Bluegrass.

- 55% went to hospice inpatient unit or UK inpt
- 45% went to hospice at home or nursing home

**29% of new pts**
Anne Monroe, MHA

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