Physician Contracting and Billing: Dotting “I’s”, Crossing “T’s”

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Disclaimer

- This presentation is meant to be an overview of some of the legal, billing and compliance issues that hospices face when billing for physician services and structuring arrangements with physicians.
- This presentation does not constitute advice, legal or otherwise, and is not intended to take the place of such advice. Hospices are encouraged to consult with a health care attorney to review their financial arrangements with hospice physicians to ensure compliance with federal, state and local laws and seek the assistance of a qualified biller and coder to address specific billing questions.

Overview

- The Balancing Act—Regulatory Requirements v. Compliance Risks
- The Contract as a Regulatory and Compliance Tool
  - The Anti-Kickback Statute
  - Duties—Administrative, Patient Care, Compliance
  - Compensation
- Key Billing Issues
- Implementation Challenges and Considerations
- Concluding Thoughts
- Questions

The Balancing Act—Regulatory Requirements v. Compliance Risks

- Regulatory changes have expanded the role of physicians in hospice leading to a growth in the number and scope of physician relationships
- Physician Roles
  - Physician as gatekeeper (admissions, discharges)
  - Physician as care provider (call coverage, attending, IDG, consulting)
  - Physician as supervisor (the medical director, physician designee, physician oversight, QAPI)

Regulatory Requirements (cont.)

- Hospices often have arrangements with multiple physicians to provide various components of these services
  - Medical director/physician designee
  - Team physician services
  - Professional consultations in particular specialties
  - Patient visits for eligibility assessments
  - Call coverage
  - Administrative services
Compliance Risks

- The hospice industry is under more intense scrutiny by more contractors
  - General Compliance (MACs, RACs)
  - Fraud Concerns (ZPICs, MICs)
- Physician billing on radar screen
  - OIG Work Plan 2010 – Physician double billing
  - OIG Memorandum Report: Questionable Billing for Physician Services for Hospice Beneficiaries, OIG-02-08-00224
- Expanded relationships with physicians can raise regulatory scrutiny
  - Billing issues—data analysis used to identify audit targets
  - Kickback issues

Anti-Kickback Statute

- AKS has identified certain safe harbors—if all elements of a safe harbor are met, the arrangement is immune from prosecution
  - Employment safe harbor
    - Protects any amount paid by an employer to an employee who has a bona fide employment relationship with the employer for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs
    - State corporate practice of medicine laws may prohibit the employment of physicians
    - A written contract is not specifically required, but can be helpful

Anti-Kickback Statute (cont.)

- Personal services and management contract safe harbor (independent contractor). Key elements include:
  - The agreement must cover all of the services the physician provides to the hospice and specify the services provided
  - The services performed under the agreement must be reasonably necessary to accomplish the business purposes of the arrangement
  - The aggregate amount of compensation must be based on fair market value

Anti-Kickback Statute (cont.)

- Given that physicians can be referral sources, hospice financial arrangements with physicians should be reviewed under the federal Anti-Kickback Statute (AKS) and other state fraud laws, if applicable
  - AKS makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration (i.e., anything of value) to induce referrals of, or recommend items of services reimbursable by, a federal health care program (42 U.S.C. § 1320a-7b(b))
  - Stark law not specifically discussed, as hospice is not a “designated health service”, if an organization provides other services, Stark may need to be considered

Contracting Considerations: Duties

- Define the services/duties:
  - Administrative—Not separately billable; included in the per diem
    - Physician as gatekeeper—Certifications, recertifications, admissions (upon recommendation), narratives, face-to-face visits, discharges (written order from medical director)
    - Physician as supervisor—Medical director responsible for medical component of program, medical director supervise all employed/contracted physicians, participation in QAPI
  - Patient Care—May be separately billable if medically necessary
    - Physician as care provider—attending v. consulting
Contracting Considerations: Duties (cont.)

- Define the services/duties (cont.):
  - Are the services commercially reasonable?
  - What expertise does the physician have?
  - How many other physicians are providing the service?
  - Consider specifying obligations related to key compliance and/or quality issues:
    - Timesheets
    - Responsiveness to calls
    - Timeliness of documentation
    - Compliance training attendance

Contracting Considerations: Compensation

- Specify compensation:
  - While employees are generally paid a salary, consider how to pay physicians who are independent contractors.
  - What is fair market value given general market, credentials, experience, compensation being paid to other physicians in the organization.

Contracting Considerations: Compensation (cont.)

- Specify compensation (cont.):
  - Consider limiting the number of hours physician may work per month and requiring hospice authorization for any additional hours worked.
  - Importance of timesheets in verifying services provided.
  - Flat Fee:
    - Should be reasonable in view of time actually spent providing services.
    - Timesheets may help support reasonableness of rate.
  - Call coverage:
    - Include of flat fee or separate compensation (hourly rate when activated).
  - Face-to-Face Visits:
    - Include of flat fee, hourly rate or per visit rate.
  - Ensure no double payment if medically necessary visit occurs.

Contracting Considerations: Compensation (cont.)

- Specify compensation (cont.):
  - Specifying obligations related to key compliance and/or quality issues:
    - Timesheets
    - Responsiveness to calls
    - Timeliness of documentation
    - Compliance training attendance

Contracting Considerations: Compensation (cont.)

- Patient Care Services
  - Part A—Physician services are a core hospice service and generally covered under the per diem, except a hospice may separately bill Part A for:
    - Reasonable and necessary patient care services (attending or consulting) provided by physicians employed or under arrangement with a hospice.

Contracting Considerations: Compensation (cont.)

- Specify compensation (cont.):
  - Patient Care Services (cont.):
    - Hourly:
      - Consider limiting the number of hours physician may work per month and requiring hospice authorization for any additional hours worked.
      - Importance of timesheets in verifying services provided.
    - Flat Fee:
      - Should be reasonable in view of time actually spent providing services.
      - Timesheets may help support reasonableness of rate.
    - Call coverage:
      - Include of flat fee or separate compensation (hourly rate when activated).
    - Face-to-Face Visits:
      - Include of flat fee, hourly rate or per visit rate.
    - Ensure no double payment if medically necessary visit occurs.

Key Billing Issues
CMS’s FAQs (#8913)

- Are attending physician visits by a physician not employed by or under contract with a hospice included on the claims data?
  - Answer: No. The physician visits on the hospice claims are for reasonable and necessary visits by the hospice medical director or a physician who is employed by or under contract with the hospice. This includes any services provided by the hospice medical director or physician who is serving as the patient’s attending physician. Services provided by a physician not employed by or under contract with a hospice are submitted on Part B claims and as such do not fall under the requirements of change request (CR) 5567. (Revised)

Contract/Consulting Physician Services

- Where are the checks & balances?
  - Do you receive any documentation to back up charges?
    - Even a random check
    - Do you think these physicians understand physician coding and documentation any more than your own physicians?
  - Is another physician practicing with the contract physician actually seeing your patient?
  - Are they being paid according to the contract?

“Switching” Attending

- No need to “switch” Attending on GIP admission, need for home visit, etc.
  - If Attending cannot/will not see patient in that setting
  - Hospice is required to send a hospice physician
  - No other justification seems needed
    - Other than, of course, medical necessity for a billable service

NON-Billable Physician Services

- Do you know who is seeing the patient?
  - Consultant vs. partner?
  - Do they employ ARNPs?
  - PAs?
- Consultant may not be familiar with OUR industry rules/limitations
- Independent Attending May not be familiar with OUR industry rules/limitations

Administrative Activities

- Activities covered by the Medicare Part A per diem rate.
  - They consist of “participating in the establishment, review and updating of plans of care, supervising care and services, and establishing governing policies.”
  - “Generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group.”
  - Visits performed solely to comply with Medicare’s upcoming “face-to-face encounter” at 180 days and at every subsequent 60-day recertification would fall under this category.

CMS’ FAQ

- Q: For hospice services, why are rounds not considered a patient care visit?
- A: Rounds are an administrative activity rather than a patient care activity. A visit provided during rounds would not be considered a patient care visit unless a patient required a physician’s assessment and/or intervention during the visit. Rounds performed in a facility for the purposes of writing orders or any other non-patient care required services, do not count as visits. (Revised)
“Professional” services

- Billable to Medicare above the per diem
  - When medically necessary and documented, include:
    - E/M services
    - Therapeutic procedures such as I&D, paracentesis, debridement, surgery.
    - Professional component of diagnostic tests, for example:
      - 93010 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
        - Code itself describes a professional service
      - 71020 -26: Radiologic examination, chest, 2 views, frontal and lateral
        - Code describes a global service; modifier -26 required to indicate professional component only for proper payment.

Separately Billable Services

- Patient Care Services
  - CMS states that payment for services rendered by physicians or nurse practitioners who (1) provide direct patient care services and (2) are hospice employees or under arrangement with the hospice, is made in the following manner:
    - Hospices establish a charge and bill the Fiscal Intermediary (FI) for these services.
    - The FI pays the lesser of the actual charge or 100%/85% of the Medicare physician fee schedule in addition to the daily hospice rates.
    - Payment is counted toward cap amount.

Dual Threat Visits

- Can an administrative visit be combined with a patient care visit?
  - Initial Certification?
    - Who initiates the visit?
      - Referring MD/DO?
      - Hospice Liaison?
    - Recertification?
    - 90/180/60???

- Dual Threat Visits: CMS’ Stance
  - If a physician or nurse practitioner provides reasonable and necessary non-administrative patient care such as symptom management to the patient during the visit (for example, the physician or NP decides that a medication change is warranted), that portion of the visit would be billable.
  - We believe that allowing for this type of billing will not only increase the quality of patient care, but also will help defray the costs to hospices of meeting this requirement.

Patient Care Services

- The hospice can bill Medicare for these services separately.
  - Consists of medical services that relate to the treatment and management of the patient’s terminal illness and are rendered by a physician who is either employed by or has contracted with the hospice to provide the services.
  - What about services provided by consulting physicians?
    - When a consulting physician sees a hospice patient about his/her terminal diagnosis or illness, the hospice must bill Medicare, not the physician.
    - Consulting physician must have an arrangement with the hospice “in place” before the hospice can bill for the services.

Dual Threat Visits: CMS’ Stance

- Billing for medically necessary care provided during the course of a face-to-face encounter should flow through the hospice, as the physician or NP who sees the patient is employed by or where permitted, working under arrangement with the hospice (for example, a contracted physician).
  - If there is a billable portion attributable to the visit, hospices must maintain medical documentation that is clear and precise to substantiate the reason for the services that went beyond the face-to-face encounter, and which apply to the billed services; this can be done in one note.
“Medically Necessary” Defined*

MEDICALLY NECESSARY
Services or supplies that are needed for the diagnosis or treatment of your medical condition, meet the standards of good medical practice in the local area, and aren’t mainly for the convenience of you or your doctor.”

Medical Necessity

- Patient may have Dx of Metastatic Ca
  - Is that why you are in the room?
  - Typically not seen daily to manage the Ca

Medical Necessity

- Reason for visit
  - May/May Not Mirror Subjective Complaint
  - May/May Not be Related to Terminal Dx
  - May/May Not be Related to Level of Care

Medical Necessity

- Be Specific!
  - RN reported restless night
  - Patient has had a loss of function
  - Patient requested visit

Medical Necessity

- Why should this visit be billable?
- Substantiate the reason you are seeing the patient TODAY!

Medical Necessity

- Why is room 12 still here?
  - If the reason is related to disposition/placement can you bill for the visit?
  - What about the next day?
HPI & Impression/Plan the Most Important?

- **HPI**
  - Description of the illness/problem from its onset or since the last time patient seen…

- **Impression/Plan**
  - Not only indicates what today’s findings and thought processes, but substantiates future intervention!

**Prognosis**

All of these factors help substantiate physician intervention!

- Symptoms
- Co-morbid illnesses
- Rate of decline
- Cognitive/Functional/Nutritional status

**Medical Necessity**

- **Inpatient setting - Hospice**
  - No problems
    - You can cover for the AOR

- **Outpatient setting (and Inpatient PC)**
  - Be aware of duplicative care!

**Duplicative vs. Concurrent Care**

- **Concurrent Care**
  - "reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient’s treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services."
  - 1) Does the patient’s condition warrant the services of more than one physician on an attending (rather than consultative) basis?; and
  - 2) are the services provided by each physician/NPP "reasonable and necessary?"

- **Duplicative Care**
  - Medicare Benefit Policy Manual: Chapter 15, Section 30 E.
    - clearly warns Medicare contractors to "assure that the services of one physician do not duplicate those provided by another."
Today’s Visit

- Thorough, concise documentation is best ally
- Coordinate the care with physician colleagues
  - They should have a clear understanding of your/their role

Interdisciplinary Approach

- Hospice
  - At what point does the service of the physician cross the line?
    - Family Discussions
    - Inpatient Team Meetings vs. IDG (IDT) Coordination
    - POC vs. Treatment Plan

Common Errors Identified by MACs”

- Services were rendered by one provider and billed by another provider.
- Documentation does not support a face-to-face encounter between physician and patient.
- Conflicting information in the medical record (e.g., the diagnosis on the claim is not consistent with the diagnosis in the medical record; documentation in the patient’s history conflicts with the examination; the date of service in the documentation is different from the date of service billed).
- The service is not performed on the date of service billed, not dictated on the date of assessment or not documented on the date of the visit.
- Medical documentation does not support medical necessity for the frequency of the visit.

Patient & Family as One Unit

- Billable physician services are provided directly to the patients
  - POAs or acting caregivers may be considered the “patient”
    - Must be collaborating on treatment decisions
    - May not be for counseling of the family member!

Interdisciplinary Approach

- Hospice
  - Included in Hospice Benefit Per Diem
  - Patient and family considered one unit
  - Not included as part of physician visit

Counseling

- What time may be counted?
  - Who can I talk to?
  - How many times can I talk to them?
Guidelines

Counseling and/or coordination of care
- Must be provided at bedside or on patient's hospital floor or unit
  - Time spent counseling patient or coordinating patient's care after physician has left patient's floor or begun to care for another patient on floor not considered when selecting level of service
- Level of service is chosen based on total physician time.
- Cannot round up

Current Regulatory Environment

- Dramatic increase in the requirement for MD time and presence
- Decision to admit
- Narratives at each certification
- Face to Face Visits
- QAPI

Implementation Challenges and Considerations

Other Physician Activities

- Other time with IDG including the weekly meeting
- Visits to patients at home and in the nursing home needing MD evaluation for symptoms/medical care
- Management of formulary/medications
- Management of symptoms/medical care
- Taking phone calls from physicians, pharmacists, nurses....

Other Physician Activities (cont.)

- Seeing patients in an inpatient unit
- Palliative care consultations in the hospital, LTC and home settings
- Serving on committees
- Giving presentations to physicians, other groups

Old Days

- Hospice Doc tries to get to IDG once a week if possible to sign paperwork
Full Time v. Part Time Physicians

- May not have an option
- Needs may differ if not the only physician
- Contracting Options
- Salary
- Salary with incentives
- Fee for Service

Part Time from Private Practice

- Will the physician be an employee or work under a contract?
- If solo may still have coverage issues
- Group practice: will partners cover?
- Do they understand what it means to cover?
- Will they be involved in admission decisions, covering meds etc when attendings not available?
- Will MD become a hospice champion for the group?
- Will group become a champion for hospice?

Part Time from Large Group

- Is the contract with the individual or the group?
- Group practice: will partners cover?
- Do they understand what it means to cover?
- Will they be involved in admission decisions, covering meds etc when attendings not available?
- Will MD become a hospice champion for the group?

Part Time from Academic Medical Center

- Will other AMC physicians cover?
- Do they understand what it means to cover?
- Will they be involved in admission decisions, covering meds etc when attendings not available?
- Opportunities for teaching and exposure of students, residents and fellows to hospice
- Opportunities for research
- Will MD become a champion at the AMC?

Full Time

- May be a stretch for a small program
- Great way to grow program
- Limit conflicts with other commitments
- Goal to hire HPM certified MD
- Who covers time off?
- Malpractice insurance, medical education time and expenses

Part Time

- Hospice may compete with other responsibilities
- Degree of expertise in HPM
- May provide opportunities based on where physician is based
- AKS
Part Time from Nursing Home
- Will the physician be an employee or work under a contract?
- If solo may still have coverage issues
- Well defined scope of responsibilities to avoid appearance of simply aiding referrals

Salary
- Most common for full time physicians
- Ideal for the highly motivated with a strong commitment to hospice

Part Time Relationships to Other Setting
- Opportunity to generate relationships and referrals

Salary with Incentives
- Take advantage of human nature
- Provide extra compensation for “more productive” employees
- Often based on visits
- Home/NH/IPU visits VERY DIFFERENT

Compensation
- Salary
- Salary with incentives
- Fee for Service
- On call

Fee for Service
- Usually visit-based
- May be a helpful system for coverage of hospital or ipu
- May be helpful for face-to-face
- May promote limited enthusiasm for all of the things that improve quality
Physician Fees
- May help to defray costs
- Travel time will not be compensated by payors
- Physician visits to hospice patients can be a source of revenue
- Medically necessary clinical service provided at the time of the face-to-face visit can be billed

Initial Nursing Home Visit fees
- 99304 $91 (25 min)
- 99305 $128 (35 min)
- 99306 $163 (45 min)

Initial Home Visit Fees
- 99341 $56 (20 min)
- 99342 $82 (30 min)
- 99343 $134 (45 min)
- 99344 $180 (60 min)
- 99345 $217 (75 min)
- (Medicare fees: will vary by region)
- (Times are estimates of how long visit will take)

Subsequent Nursing Home Visit Fees
- 99307 $43 (10 min)
- 99308 $67 (15 min)
- 99309 $88 (25 min)
- 99340 $131 (35 min)

Subsequent Home Visit Fees
- 99347 $56 (15 min)
- 99348 $85 (25 min)
- 99349 $126 (40 min)
- 99350 $175 (60 min)

Initial Hospital Visit Fees
- 99221 $101 (30 min)
- 99222 $137 (50 min)
- 99233 $201 (70 min)
Subsequent Hospital Visit Fees
- 99231 $40 (15 min)
- 99232 $72 (25 min)
- 99233 $103 (35 min)

Sample Half Day of Home Visits
- One new comprehensive visit, 2 expanded follow-up visits and one detailed follow-up visit
- 216 + 85 + 85 + 126 = $512
- 75 min + 25 min + 25 min + 40 min = 165 minutes
- (Does not include travel time, time taking phone calls etc)

Sample Half Day of ipu Visits
- Visit codes determined by site of ipu
- Hospital:
  - 2 initial comprehensive visits, 1 problem focus visit, 2 expanded follow up visits, 1 detailed visits
  - 201 + 201 + 39 + 72 + 103 = $688
  - 70 min + 70 min + 15 min + 25 min + 25 min + 35 min = 240 min
- No travel but may have calls and other responsibilities (completing death certs other documentation)

Practice Managers
- Some programs have hired practice managers to manage the physician and np visits and coordinate billing
- Schedules visits
- Can oversee billing activity
- Helps to maximize efficiency, establish accountability

Concluding Thoughts
- Evaluate the physician component of the hospice program
- Physician as Gatekeeper
  - Are physicians actively exercising their responsibility for certifications
  - Are certifications being obtained from the right physicians
  - Is the physician narrative really meeting its intended function
Concluding Thoughts (cont.)

- Physician as Care Provider
  - Are physicians actively participating in IDG and care planning
  - How are you billing for these services
  - How are you ensuring that patient choice drives the attending physician decision

Questions?

Concluding Thoughts (cont.)

- Physician as Supervisor
  - How are physicians participating in the oversight and evaluation of services
  - Do other physician relationships complement, but not duplicate or replace, the role of the medical director and physician designee

Concluding Thoughts (cont.)

- Compliance Plan
  - How are physician risk areas addressed in the hospice’s compliance plan and related policies and procedures