NHPCO's Webinar Series:  
Physician and Nurse Practitioner Billing: Ensuring Understanding and Compliance

Challenges and Opportunities
Presented by:
Edward Martin, MD, MPH  
Christopher P. Acevedo, CHC, CPC

PART 1: BILLING NUANCES IN HOSPICE AND PALLIATIVE CARE

Why is Hospice Billing Different?
• Comprehensive benefit, covering “all care related to the terminal illness”
  – Coordinate and PLAN care, including physician care
  – EXCEPT the patient’s Attending physician or NP
    • “… identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in determination and delivery of their medical care.”

Attending Physician or NP
• ONLY physician who can bill MC-B for care related to terminal illness
  – Must use the same ICD-9/10 as Hospice
  – Adds modifier “GV”
    • This is a Hospice patient
    • I am the Attending for this Hospice patient
    • The care given was related to the terminal illness
    • I am not an employee of the Hospice providing care
• When billing for care to a Hospice patient that is NOT related to terminal illness, use modifier “GW”

Non-Attending Physician Services
• Must be coordinated and PLANNED by Hospice
• Like any service related to terminal diagnosis, Hospice is responsible for payment
  – UNLIKE any other service related to terminal illness, physician services can be billed in ADDITION to the daily Hospice payment
  – Hospice submits bill for physician services to MC-A intermediary as part of monthly bill for Hospice care

Disclaimer
• The information enclosed was current at the time it was presented. Medicare and other payer policy changes frequently; links to the source documents have been provided within the document for your reference. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations.
• Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
• Neither Acevedo Consulting Inc., Hospice and Home Care of Rhode Island, nor their employees, agents, and staff make no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results or consequences of the use of this information.
• This presentation is a general summary that explains certain aspects of the Medicare Program and other reimbursement and compliance information, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.
Non-Attending Physician Services

- Physician has a “contract” with Hospice that defines payment arrangement
- Physician submits bill to Hospice
- Hospice submits physician bill to MC-A intermediary as part of the monthly bill for Hospice care
- MC-A intermediary pays Hospice 100% of allowable fee schedule
- Hospice pays physician according to the contractual agreement

Hospice Physician

- Employed or contracted with Hospice to provide patient care
- Physician submits a bill for direct patient care to Hospice; hospice bills MC-A intermediary; MC-A pays 100% of physician fee schedule for service
- Physician can be paid in a number of ways
  - Straight salary
  - Straight fee-for-service
  - Combination of the two

Non-Covered Services

- Administrative and general supervisory activities
  - Included in Hospice payment
  - Establishing and updating plan of care, supervising care, establishing governing policies
  - Certification and recertification of terminal illness
- Technical component of diagnostic services
  - For example, radiologist fee for interpreting X-ray, pathologist fee for interpreting CBC, etc.
- These are included in daily Hospice payment

Take Home Message

- Almost ALL direct patient care by a physician can be billed to Medicare, in addition to daily rate
  - Attending physician (not employed by Hospice) bills MC-B carrier
  - All other physicians bill Hospice; hospice bills MC-A intermediary
    - Physicians employed by hospice
      - Even if they are the Attending
    - Physicians providing care related to terminal diagnosis as part of the plan of care
      - Need a contract before delivering/billing care

Polling Question

- All visits for related care to a patient seen by their non contracted AOR should be billed with the –GW modifier?
  - True
  - False

Hospice Patients

- Attending Physician
  - Bill Medicare with – GV modifier for “related” care
  - Bill Medicare with – GW modifier for “non-related” care
  - Do not include terminal Dx!
- Non-Attending Physicians
  - Bill the Hospice
NonPhysician Practitioners

Physician Assistants – Palliative Care

- Unless state law/scope of practice says otherwise
- Have same ability to provide billable services as an ARNP
- Even Medicare
  - Except must be employed by a physician or physician group.

Nurse Practitioners- Palliative Care

- NP "physician" services are reimbursable (albeit at a lesser amount) just as physicians’ services are, with minimal exceptions:
  - State law/scope of practice issues
  - Non-Medicare credentialing
    - BCBS of FL now requires credentialing of NPs/PAs
    - Must check with commercial/MAP payers

Physician Assistants – Palliative Care

- Unless state law/scope of practice says otherwise
- Have same ability to provide billable services as an ARNP
- Even Medicare
  - Except must be employed by a physician or physician group.

Polling Question

The following is true of Nurse Practitioners in hospice?

A) Any nurse practitioner may treat and bill for the patient when treating an illness related to the terminal diagnosis.
B) A nurse practitioner must provide visits to hospice in only an IPU setting.
C) Only the nurse practitioner elected by the patient as the hospice AOR may treat and bill for the patient when treating an illness related to the terminal diagnosis.
D) A nurse practitioner may never bill for the patient when treating an illness related to the terminal diagnosis.
E) Both B & C

Ch. 11 Hospice Claims Processing Manual

When hospice coverage is elected, the beneficiary retains all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an attending physician, which may include a nurse practitioner. If the attending physician, who may be a nurse practitioner, is an employee of the designated hospice, he or she may not receive compensation from the hospice for those services under Part B. Those professional services are billed to Medicare Part A by the hospice.

- No payment is made for nurse practitioner services that can be performed by a registered nurse, nor is payment made for nurse practitioner services that are performed outside of the attending physician role. Nurse practitioner services are generally encompassed in the per diem payment rate. The only payment that can be made for services of a nurse practitioner is made for services furnished in the role of an attending physician.
Nurse Practitioners - Hospice

- Append modifier -GV when using revenue code 0657 (Physician Services) for NP’s “physician” services – required for proper payment
- NP may not serve as or replace medical director of physician member of IDG

40.1.3b - Nurse Practitioners as Attending Physicians, Ch 9, Benefit Policy Manual

If a beneficiary does not have an attending physician or a nurse practitioner who has provided primary care prior to or at the time of the terminal diagnosis, the beneficiary may choose to be served by either a physician or a nurse practitioner who is employed by the hospice. The beneficiary must be provided with a selection of a physician or a nurse practitioner.

Services provided by a nurse practitioner that are medical in nature cannot be reasonable and necessary, be included in the plan of care and must be services that, in the absence of a nurse practitioner, would be performed by a physician. If the services performed by a nurse practitioner are such that a registered nurse could perform them in the absence of a physician, they are not considered attending physician services and are not separately billable. Services that are duplicative of what the hospice nurse would provide are not separately billable.

Infamous Transmittal 1885

Great deal of discussion about what to do when a patient is admitted to GIP & has a community Attending.
Do you "switch" Attending physician to the hospice Medical Director?
Before you answer…

HOSPICE MEDICAL DIRECTORS

42 CFR Part 418
Medicare and Medicaid Programs: Hospice Conditions of Participation: Final Rule, June 5, 2008, pg 32090

“...If the attending physician is unable to fulfill his or her duties, then the hospice physicians are responsible for fulfilling the attending physician’s duties in his or her absence in accordance with § 418.64(a)(3) of the final rule. Therefore, there is no need for the attending physician to designate another individual to cover his or her hospice patients.”
“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

Billing for Contract Physicians

Ch. 9, CMS Benefit Policy Manual

40.3 - Contracting With Physicians

(Rev. 22, Issued: 09-30-04, Effective: 12-06-03, Implementation: 06-28-04)

Section 1886(h)(2) of the Act allows hospices to contract for physician services. Medical directors and physician members of the interdisciplinary group (IDG) are not required to be employed by the hospice. These physicians can be “under contract” with the hospice. Although the Act does not specify what the terms of that contract must be, requirements at 42 CFR 418.55 and 113.19 are applicable to hospice, as well as all other requirements under the hospice conditions of participation. Hospices retain professional management responsibilities for these services and must ensure that qualified persons furnish them in a safe and effective manner. Since nurse practitioners are not included in the definition of a physician, this section does not apply to nurse practitioners.

Getting Community Consultant Paid

• Have an agreement/contract between the physician and the hospice
  – Hospice agrees to pay physician X% of Medicare allowable fee for service provided
  – Patient cannot be billed for balance
  – Physician submits bill/documentation to Hospice
  – Time frame in which physician will be paid
• Should be in place BEFORE care provided

Old Days

• Hospice Doc tries to get to IDG once a week if possible to sign paperwork

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
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

Example 1 – Attending Related

- A hospice patient is seen by your physician, who is the patients attending physician, for a problem related to the patient’s terminal illness. How is this billed?
  - Bill as you would bill any other encounter with any other patient except – append –GV modifier to the encounter.

Example 2 – Attending Non-Related

- A hospice patient is seen by your physician, who is the patients attending physician, for a problem not related to the patient’s terminal illness (i.e., patient terminal illness is COPD & patient is seen for an ear infection). How is this billed?
  - Bill as you would bill any other encounter with any other patient except – append –GW modifier to the encounter.
  - Remember to bill the appropriate dx!

Example 3 – Non-Attending

- A hospice patient is seen by your physician, who is not the patients attending physician, for any problem How is this billed?
  - Bill as you would bill any other encounter with any other patient except – Bill the Hospice!
  - Hospice of Wichita Falls pays based on the Medicare Fee Schedule

Question 1

- QUESTION: For modifier - GV, can you please clarify the following. a) If Dr. Chan enrolls a terminal breast cancer patient in hospice, he is listed as the attending physician and he may bill Medicare for payment of his professional services (no labs, etc) with modifier –GV:
  - FOR THE EXAMPLE PROVIDED, DR. CHAN IS LISTED AS THE HOSPICE ATTENDING AND ALL VISITS DR. CHAN RENDERS RELATED TO THE TERMINAL DIAGNOSIS WOULD BE BILLED WITH ONLY THE –GV MODIFIER. SHOULD DR. CHAN SEE THE PATIENT FOR AN UNRELATED REASON, THEN THE –GW MODIFIER WOULD BE USED.
Question 2

- If our Nurse Practitioner or other physicians sees the hospice patient, she/he may not bill Medicare with modifier -GV because she/he is not listed on the hospice enrollment as the attending physician?
  - Correct: The way to bill when a physician in the group practice is covering for Dr. Chan, is as follows: If that physician service is related to the terminal diagnosis it would be billed under Dr. Chan using the -GV and Q5 (reciprocal billing) modifiers. This does not apply to an NP covering for a related diagnosis. An NP is not permitted to cover for a hospice attending for a related service.
  - If the service is unrelated to the terminal diagnosis, then the service would be billed by the rendering provider using the -GW modifier. This does apply to NPs/PAs as visits for unrelated services are not subject to limitations.

Question 3

- When can my NP/PA bill for a service rendered to a hospice patient for related care?
  - An NP can only have their professional service billed if they are personally elected by the patient as the hospice attending (NPs may not cover for each other) additionally it should be noted that PAs can never render a billable service to a hospice patient for a visit related to the terminal diagnosis.

What to Consider

- Implementation Challenges and Considerations
  - How would you contract with:
    - Current medical staff
      - Make sure current contract accounts for
        - Field visits
        - Inpatient visits
    - Solo doctors in the community
      - Use one of our contracts
        - Field Doc
        - Team Doc
        - Medical Director
        - Consulting Doc
    - Physicians employed by someone else
      - Same as above – entity changes
    - Visiting physician groups
      - Are we credentialing all, or some of the docs in the group?
    - Nurse practitioners
      - What’s wrong with this picture?

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

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 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?

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

Part Time Relationships to Other Setting

- Opportunity to generate relationships and referrals
Compensation

• Salary
• Salary with incentives
• Fee for Service
• On call

Salary

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

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

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 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 Home Visit Fees

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

Initial Nursing Home Visit fees

- 99304 $91 (25 min)
- 99305 $128 (35 min)
- 99306 $163 (45 min)

Subsequent Nursing Home Visit Fees

- 99307 $43 (10 min)
- 99308 $67 (15 min)
- 99309 $88 (25 min)
- 99340 $131 (35 min)

Initial Hospital Visit Fees

- 99221 $101 (30 min)
- 99222 $137 (50 min)
- 99233 $201 (70 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+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)
Happy Docs = Happy Hospice

Let's take a look at MD/Do potential revenue...

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

Time spent by physician/nurse practitioner can be a challenge to bill for

- Extended visit codes require the presence of the patient at the family meeting.
- Often not possible in more seriously ill patients

99366

- Medical team conference with patient and or family
- No reimbursement

Family meeting held on day of consult

- Extended time cannot be used on day of initial visit unless patient is present
  - 99223 $185 initial visit
  - Next day 99231 $38
  - $223 for initial visit and f/u in hospital
  - 99306 $147 initial visit
  - Next day 99307 $41
  - $188 for initial visit and f/u in NH
Family meeting held the next day

- Time easily runs over the maximum on that day
- 99223 $185 initial visit
- 99233 $98 (35 minutes)
- 283 for initial visit and f/u in hospital
- 99306 $147 for initial visit
- 99310 $122 (35 minutes)
- $269 for initial visit and f/u
- hospital $60 difference, nh $81 difference

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?

OIG RISK AREA: Medical Record Documentation*

- Validates
  - The site of service
  - The appropriateness of the services provided
  - The accuracy of the billing
  - Identity of the care giver (provider)

*OIG’s Physician Compliance Guidance

PART 2: SUBSTANTIATING BILLABLE PHYSICIAN VISITS

Risk Area: Medical Record Documentation

- Each encounter should
  - Be complete and legible
  - Every page in the chart should have the patient’s name and date of service.
  - Document the reason for the encounter
  - Have a documented impression
  - Have a documented plan of care/f-up
  - Be dated and have the identity of the provider
  - Sign, initial, typed name on dictation
  - All providers and staff

Medical Necessity

(Pub 100-4, Medicare Claims Processing Manual, Ch. 12, §30.6)

“Medical necessity is the overarching criterion for payment, in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of service than is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service billed.”
Medicare PIM, Ch. 13

In order to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under 42 C.F.R. 440.31. Contractors shall consider a service to be reasonable and necessary if it is determined that the service is:

- Safe and effective;
- Not experimental or investigational in comparison to similar services or technology that meet the requirements of the Clinical Trials Act; and
- Appropriate, including the duration and frequency that is considered appropriate for the service, regardless of whether it is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient’s condition or to improve the function of a malformed or injured body member;
  - Furnished in accordance with the patient’s medical needs and conditions;
  - Ordered and furnished by qualified personnel;
  - One that results in or contributes to the patient’s medical needs and conditions;
  - At least as beneficial as an existing and available medically appropriate alternative.

What Physician Services Are NOT/Are Billable?

- **Are NOT:**
  - Administrative Activities
  - Medical director
    - General supervisory services
  - Physician member of IDG (team physician)  
    [CFR 418.304 (a)]
  - Visits to Hospice patients performed by a Nurse Practitioner (NP), if the specific NP has not been formally elected as the Hospice Attending.

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 90 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) Reference:  
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.

Patient Care Services

- The hospice can bill Medicare for these services separately.
  - Consist 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

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.

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
**Med. Necessity – Hospice Attending: Inpatient**

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

**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!

**Physician Documentation Rules to Live By**

- Spell out your advice
- Note patient noncompliance
- Chart negative findings
  - "Patient in apparent good health" vs. "All systems reviewed. Patient denies any complaints."
    - The 1st statement is virtually meaningless
    - The 2nd says you asked the patient if he was having any problems and that the patient said nothing was wrong.
- Don't tolerate bad penmanship
  - Document under the assumption that others will read what you wrote.

*Excerpted from Medical Economics, March 5, 2004

**Prognosis**

All of these factors help substantiate physician intervention!

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

**Med. Necessity – Hospice Attending: Inpatient**

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

- 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?
**Duplicative vs. Concurrent Care**

- Patient in a
  - SNF
  - ALF
  - Home
  - Hospital/IPU

**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"?

**Follow-up Visits**

- Important to document the physician directed follow-up
  - Remember those days in private practice?
  - What did your plan end with…
  - Follow up or return to clinic in X number of days!

**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.

**Interdisciplinary Approach**

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

Counseling

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

Counseling

- Some Common Scenarios…

Common Pitfalls – Documentation

- An Incomplete Hx Can Easily Sabotage an Encounter
  - Example:
    - Upon admission to your IPU, a medically necessary physician visit takes place and an H&P is documented. The physician bills 99223. The documentation consists of a comprehensive Physical Exam and MDM is high, however the Hx lacks a documented Social Hx & Family Hx. How does this effect what should be billed?

Common Pitfalls – Documentation

- Even a 99221 requires these be documented…

- With the minimum documentation requirements not met for even a 99221, all that’s left is 99499: an unlisted E/M service.
  - Good luck getting paid!
**Common Pitfalls – Documentation**

- An Incomplete PE Can Also Easily Sabotage an Encounter
  - Example:
    - A medically necessary MD visit takes place in a patient’s home. The physician bills 99345. The documentation consists of a comprehensive Hx and MDM is high, however the documented PE only consists of 7 OS. How does this effect what should be billed?

- With both a 99344 & 99345 requiring a comprehensive PE the highest level new-pt. home visit supported by the documentation is 99343.

**Common Pitfalls – Type of Patient**

- Established patient billed as New patients
  - Common occurrence as a pt may be “new to me”

**Common Pitfalls – Consulting Physicians**

- Do **YOU** know who is seeing the patient?
  - 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

**Common Pitfalls – Respite**

- The million dollar question…
  - Would I be seeing this patient if they were not under our care for Respite?
  - If yes, it becomes even more essential to document a clear reason for TODAY’s visit.

**Common Pitfalls - Assumptions**

- Most Common Pitfall!
  - Physicians Know How to Document
    - “They run their own private practice, they must know how to do it…”
    - Documentation from a coding/documentation compliance perspective is not inherent to Physicians!
Palliative Care

• Challenges and Opportunities from the Provider Perspective…

Billable Services
above the per diem

“Technical” services

• Technical services included in the hospice per diem include:
  – Clinical lab tests not requiring physician interpretation
  – Hospital, ambulance, etc. charges
  – Technical component of diagnostic tests. For example:
    • 93005: Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report
      – Code itself describes a technical service
    • 71020 -TC: Radiologic examination, chest, 2 views, frontal and lateral
      – Code itself describes a “global service;” modifier TC required to indicate technical component only for proper payment

“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.

Additional Considerations
For Pass Through Billing

• Contract must be in place
• Credentials of provider (MD vs. ARNP/PA) must meet hospice criteria for the circumstance
• Service included in Plan of Care
• Once all is verified (who does this?), do these charges go to
  – a/p?
  – Billing?

Teaching Physician Rules
The 3-Legged Stool

1. Resident - An individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. Medical resident or Fellow
2. Student - An individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by a student.
3. Teaching Physician - A physician (other than another resident) who involves residents in the care of his or her patients.

Documentation

- "Notes recorded in the patient's medical records by a resident, and/or teaching physician or others as outlined in the specific situations below regarding the service furnished. Documentation may be dictated and typed or handwritten, or computer-generated and typed or handwritten. Documentation must be dated and include a legible signature or identity. Pursuant to 42 CFR 415.172 (b), documentation must identify, at a minimum, the service furnished, the participation of the teaching physician in providing the service, and whether the teaching physician was physically present."

Teaching Physician Scenarios

Scenario 1 – Minimal Documentation

Admitting Note: “I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident’s note and agreed with the documented findings and plan of care.”

Follow-up Visit: “Hospital Day #1. I saw and examined the patient. I agree with the diagnosis and the plan of care as documented in the resident’s note.”

Follow-up Visit: “Hospital Day #2. I saw and examined the patient. I agree with the resident’s note except for the laboratory test results, so I will obtain an echo to evaluate.”

(NOTE: In this scenario, if there are no resident notes, the teaching physician must document as he/she would document an E/M service in a non-teaching setting.)
Teaching Physician Scenarios

Scenario 2 – Minimal Documentation

Initial Visit: “I saw the patient in the office during the history and exam. I discussed the case with the resident and agreed with the findings and plan as documented in the resident’s note.”

Follow-up Visit: “I saw the patient with the resident and agreed with the resident’s findings and plan.”

Scenario 3 – Minimal Documentation

Initial Visit: “I saw and evaluated the patient. I reviewed the resident’s note and agreed, except that picture is more consistent with my personal biases. Will begin INSAD.”

Initial or Follow-up Visit: “I saw and evaluated the patient. Discussed with resident and agreed with resident’s findings and plan as documented in the resident’s note.”

Follow-up Visit: “See resident’s note for details. I saw and evaluated the patient and agreed with the resident’s findings and plan as written.”

Follow-up Visit: “I saw and evaluated the patient. Agree with resident’s note, but lower extremities were similar, now 3/5, MRI of L/S spine today.”

Unacceptable Documentation

“Agree with above.,” followed by legible countersignature or identity.

“Round, reviewed, agree.,” followed by legible countersignature or identity.

“Discussed with resident, agreed.,” followed by legible countersignature or identity.

“Seen and agree.,” followed by legible countersignature or identity.

“Patient seen and evaluated.,” followed by legible countersignature or identity, and a legible countersignature or identity alone.

Documentation by Students

Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past medical/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a student in a service meeting the requirements set forth in this section for teaching physician billing.

Students may document services in the medical record. However, the documentation of an E/M service by a student that may be attributed to the teaching physician is limited to documentation related to the review of systems and/or past medical/social history. The teaching physician must verify and re-examine the history of present illness as well as perform and re-evaluate the physical exam and medical decision making activities of the service.

Thank you!

Edward Martin, MD, MPH
Home & Hospice Care of Rhode Island
401-415-4200
EMartin@hhcri.org
www.hhcri.org

Christopher P. Acevedo, CHC, CPC
Acevedo Consulting Incorporated
2605 W. Atlantic Avenue
Suite D-102
Delray Beach, Florida 33445
561-278-9328
cacevedo@acevedoconsulting.com
www.acevedoconsultinginc.com