NHPCO GRAB & GO TOOLKIT

Palliative Care Billing Toolkit

NHPCO
National Hospice and Palliative Care Organization

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Introduction to the Palliative Care Billing Toolkit

The National Hospice & Palliative Care Organization (NHPCO) added the term "palliative care" to its name almost 20 years ago. Then, as now, NHPCO, is interested in as many people receiving person-centered, interdisciplinary care as possible. Despite the growth of palliative care programs across the country over the last few decades, palliative care continues to be defined and delivered in diverse ways by different people and entities, which can result in confusion. One of the most challenging aspects that most organizations struggle with when they are delivering palliative care, is how to bill for palliative care services. This toolkit is intended to support NHPCO's Palliative Care Playbook for Hospices by addressing various ways palliative care is delivered and can be compensated.

To ensure definition alignment, NHPCO defines palliative care as: patient and family-centered care provided by an interdisciplinary team that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care services are based on the needs of the patient and not on the patient's prognosis and can be provided throughout the continuum of illness; it involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice; it provides management of symptoms and helps reduce stress related to the illness. Palliative care can be provided concurrently with curative treatments, and can be helpful for people at any age, or at any stage of a serious illness although a best practice would be to introduce palliative care soon after a person is diagnosed with a serious illness. In contrast to the hospice benefit, there is no requirement for a certification of terminal illness, there are no benefit periods and patients are typically only discharged from palliative care when they are admitted to a hospice program or at death.

Acknowledgements

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Setting Up a Palliative Care Practice

Needs Analysis and Business Plan

The most crucial step in your palliative care program development process is the needs assessment. It provides your organization with data regarding the populations that have unmet needs and ways palliative care can address those needs. Prior to starting the needs assessment, it is important to clarify what specific questions your organization wants to address. A palliative care needs assessment may answer all or many of the following questions:

- How does offering palliative care align with our vision, mission, and strategic goals?
- What are the overarching, fundamental, and enduring reasons why palliative care is needed in our community?
- How will our palliative care program improve the care people receive in the community?
- Are we the right organization to provide palliative care?

Tip: Ask key decision makers (CEO, leadership team, and/or board) to answer the following: What data or information do you need to decide whether and how to develop a palliative care service line?

The answers to these questions shape the needs assessment in terms of who to engage, the type and volume of data to collect, and the presentation of the results. To help programs with the needs assessment, programs can review the chapter "Determining the Need for Palliative Care" which can be found in NHPCO's Palliative Care Playbook for Hospices.

Once a needs assessment is completed, it is critical to present a Business Case to key stakeholders. Creating a comprehensive Business Case provides a blueprint for the implementation and sustainability of your palliative care program. You can find an example of a business care template in the chapter "Developing the Business Case" of NHPCO's Palliative Care Playbook for Hospices. The palliative care Business Case is a detailed description of your palliative care program. Informed by the Needs Assessment, the initial Business Case outlines:

- Palliative care program needs
- Program description
  - Specific community of focus
  - Healthcare team members
  - Components of the program
- Initial costs and anticipated return on investment
- Key performance indicators based education strategy

Upon acceptance of the Business case, the next step is a formal Business Plan. The Business Plan will define the vision and mission of the program, define the scope and specific services it will provide, and specifics related to the community the program will serve. The need for creating a financial plan will determine the number of patients, providers, and supportive staff needed and the type of reimbursements to pursue such as Medicare, Medicaid, Third-party payers, private pay, etc.

There are several ways to establish a palliative care line of business, such as setting the program up as a group (medical) practice, or under their home health or hospice lines of business. Key risks and benefits of each approach are outlined below.

Palliative Care as a Group Practice

A Part B clinic/group practice requires a Medical Director to oversee all clinical decisions. Nurse Practitioners can provide visits, prescribe medications (as allowed by state regulations), and clinically manage the patient. Licensed Clinical Social Workers can complete counseling visits for psychoanalysis or support groups for example. These services may be negotiated when credentialling with Medicare Advantage and commercial insurance plans. Due to the individuality of the insurers and plans, one could anticipate bundled services payments.

Benefits: The preferred path for many Palliative Care programs is a stand-alone group/clinic practice, where house calls are included under Medicare Part B provides reimbursement for physician, nurse-practitioners, physician-assistants, and licensed clinical social workers. In contrast to home health or hospice programs, a standalone program is not subject to a survey process from Medicare, does not have to untangle bundled payments, and can engage in simple Part B billing. Additional benefits include, any financial risks that may be uncovered during billing audits will not impact the hospice or home health program, maintenance of long-term patients on a panel without penalty, and increased time to build rapport with patients and families , which result in earlier clinical interventions, increased patient and family satisfaction, and often earlier transitions to a hospice level of care when appropriate.

Cons: In many states, the corporate practice of a professional service prohibits business entities from practicing medicine or other health professions such as nursing, social work, pharmacy, or enlisted individuals to practice a health profession through the business entity. The degree varies by state. Most states allow professionals to provide these services through some form of professional organization, such as a professional corporation or professional limited liability company. The structure and requirements of valid professional organizations also vary by state, but the primary requirement is that the owners/shareholders/partners must be licensed to practice that profession. Additional information can be found under the Corporate Practice of Medicine Laws section. , Regulations related to establishing the program can also be found in the "Regulations, Licensure, and Credentialing" chapter of NHPCO's Palliative Care Playbook for Hospices.

Palliative Care Under Home Health NPI

For programs under a home health line of business, patients must meet the requirements for home health, such as a medically necessary skilled need and homebound status.

Benefits: Patients may already be eligible for palliative care if receiving services for Home Health. Palliative care clinicians can assist patients and responsible parties with goals of care, as patients begin to plateau, or when Home Health services are no longer beneficial.

Cons: Beneficiaries must meet the requirements for home health services; they must have skillable needs. Home Health typically does not have a physician, Nurse Practitioner, or Licensed Clinical Social Worker on staff; these roles may need to be supplemented under the Palliative Care program. Home Health organizations will need to be able to establish Part B billing for reimbursement of professional services. At times, programs established under Home Health struggle getting reimbursed for services. Alternatively, they may use non-billable staff and/or provide non-reimbursable care.

Palliative Care Under Hospice NPI

Hospices would set up Part B billing with Medicare and would bill for professional services.

Benefits: Palliative Care can provide patients with more information prior to needing hospice care and work on goals of care and quality of life before the patient and family are in a crisis. Hospice providers, especially certified hospice physicians and advanced practice providers (APPs), are already providing symptom management and have a strong understanding of end-of-life signs and symptoms.

Cons: Later referrals to hospice may occur as patients want to maintain care through the current Palliative Care team. Hospice programs that provide more than the billable services may eliminate the patient's desire to switch to hospice. While the decision to provide RN/LPN visits, aide visits, social work support, and chaplain visits should be based on need, programs must understand that these visits are not currently reimbursable under Medicare Part B.

Home Health and Hospice Challenges

Additional financial risks may exist for the Palliative Care programs set up under a home health or hospice tax ID. For instance, if Medicare demands an overpayment return from a hospice program, they may deduct this from both the hospice and the palliative claims in the future.

A Palliative Care program set up as a clinic/group practice utilizing both a clinic setting and house-call service line with Nurse Practitioners would provide the most reliable reimbursement, eliminating bundled services and provide an individualized level of care to patients for years before the patient may qualify for hospice care.

Corporate Practice of Medicine Laws

The Internal Revenue Service (IRS) states the following requirements: "a Corporate Practice of Medicine Laws require corporations created to employ physicians in an outpatient clinic to be incorporated under the state's professional service corporate laws. The laws also require all providers of medical services to be licensed. Often, the laws mandate that all stock in the corporation providing the services be held by a physician licensed in the state and all members of the board of directors be physicians licensed by the state. Generally, one physician holds all the stock, but New York state law indicates all physicians employed by the professional service corporation may be shareholders."[1]

The American Medical Association (AMA) states, "The corporate practice of medicine doctrine prohibits corporations from practicing medicine or employing a physician to provide professional medical services. This doctrine arises from state medical practice acts and is based on a number of public policy concerns, such as (1) allowing corporations to practice medicine or employ physicians will result in the commercialization of the practice of medicine, (2) a corporation's obligation to its shareholders may not align with a physician's obligation to his patients, and (3) employment of a physician by a corporation may interfere with the physician's independent medical judgment. While most states prohibit the corporate practice of medicine, almost every state has broad exceptions, such as for professional corporations and employment of physicians by certain health care entities."[2]

The specifics of the law vary by state. Although some changes to state laws and enforcement have occurred since its completion, the American Health Lawyers Association (AHLA) Corporate Practice of Medicine Doctrine 50 State Survey Summary is available for purchase and provides a foundation for, corporate practice of medicine laws.[3] The key to the Corporate Practice of Medicine Laws is to examine the state practice laws for any such restrictions on ownership of the practice of medicine and other healthcare professionals. It is imperative to seek legal counsel about the corporate structure of the practice.

Below are examples of specific state prohibitions:

- **New York:** Only a person, including a compliant professional corporation, licensed or otherwise authorized as a physician may practice medicine in New York State. N.Y. Educ. Law § 6522. Similar restrictions apply to other categories of licensed professionals. However, New York has several exceptions to this prohibition. For example, "a not-for-profit medical or dental expense indemnity corporation or a hospital service corporation organized under the insurance law may employ licensed physicians and enter into contracts with partnerships or medical corporations organized under article forty-four of the public health law, health maintenance organizations possessing a certificate of authority pursuant to article forty-four of the public health law, professional corporations organized under article fifteen of the business corporation law or other groups of physicians to practice medicine on its behalf for persons insured under its contracts or policies." N.Y. Educ.Law § 6527.

1 Corporate Practice of Medicine, Kaiser III, Charles F. and Friedlander, Marvin. p.1. C:\Work\TopicF00.prn.pdf (irs.gov)
2 Issue brief: Corporate practice of medicine. AMA Advocacy Resource Center. https://www.ama-assn.org/media/7661/download
3 https://store.lexisnexis.com/products/ahla-corporate-practice-of-medicine-a-fifty-state-survey-ahla-members-skuusSku20740358?gclid=EAIaIQobChMI7Pyk0LSx_wIV_BetBh0n2gbYEAAYASAAEgIA7vD_BwE

- **California:** Under California's Medical Practice Act, "[C]orporations and other artificial legal entities shall have no professional rights, privileges or powers." See Cal. Bus. & Prof. Code § 2400.
- **Texas:** It is a violation of the doctrine for a corporation comprised of lay persons to hire licensed physicians to treat patients and receive fees for these services. Texas Admin Code.
- **Florida:** Although no state statutes or regulations exist that expressly prohibit the corporate practice of medicine, an early Florida Attorney General Opinion prohibited the corporate practice of medicine. However, various Florida case laws and Florida Board of Medicine statements and orders have established permitted professional practices by specific business entities. Contact your legal counsel for permissive practices related to specific cases.
- **Ohio:** A corporation can practice a profession, but cannot control the professional clinical judgment exercised by the professional in rendering care, treatment or professional advice to the individual patient. Ohio Statement on Corporate Practice of Medicine.
- **Washington:** Neither a corporation nor any unlicensed person or entity may engage, through licensed employees, in the practice of the learned professions. See Morelli v. Ehsan, 756 P.2d 129 (Wash. 1988).

Referrals – Anti Kick Back/Stark Law

Consider how prohibitions under federal and state fraud and abuse laws apply to palliative care offerings. Federal fraud and abuse laws, such as the False Claims Act (FCA), Anti-Kickback Statute (AKS), and Physician Self-Referral Law (Stark Law), apply to health care entities and individuals who participate in federal health care programs like Medicare and Medicaid. States often have similar versions of these federal laws, although the state laws vary and can have broader applicability than the federal laws.

Anti-Kickback Statute (AKS) [42 U.S.C. § 1320a-7b(b)]

The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.[4]

Physician Self-Referral Law [42 U.S.C. § 1395nn]

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. For example, if a physician invests in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception, not refer patients to the facility, and the entity may not bill for the referred imaging services.

Designated health services include:

- clinical laboratory services;
- physical therapy, occupational therapy, and outpatient speech-language pathology services;
- radiology and certain other imaging services;
- radiation therapy services and supplies;
- DME and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.[5] For more information, see CMS's Stark law Web site or review the "Regulations, Licensure, and Credentialing" chapter of NHPCO's Palliative Care Playbook for Hospices.

4 Fraud and Abuse Laws. The Office of Inspector General (OIG). https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/#:~:text=The%20AKS%20is%20a%20criminal,for%20Medicare%20or%20Medicaid%20patients).

5 Physician Referral Law. The Office of Inspector General (OIG). https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/#:~:text=The%20AKS%20is%20a%20criminal,for%20Medicare%20or%20Medicaid%20patients).

Enrollment/Credentialling

Medicare Part A does not have a dedicated palliative care benefit like the hospice benefit, and therefore palliative care is not reimbursed. Medicare does not the term palliative care beyond the Hospice Conditions of Participation and the Long-Term Care Facilities Final Rule. Medicare reimbursement is dictated by the specific services covered under the standard Medicare Part B benefit, such as physician services.

Therefore, to bill and receive payment for covered palliative care services from Medicare, an entity offering palliative care services must enroll in Medicare Part B (or contract with another entity that is enrolled in Part B). The Part B enrollment process involves obtaining a National Provider Identifier (NPI) number and completing one or more Medicare supplier enrollment applications, as outlined below.

Each insurance plan will have its own process for credentialling and/or enrolling in their provider network. Payers to consider include, but are not limited to:

- Medicare
- Medicaid
- Medicare Advantage Plans
- Medicare Railroad
- Commercial Plans:
  - PPO/POS
  - HMO
- Military/Veteran Plans:
  - Tricare
  - CHAMPVA

Initially start with Medicare. Some plans will ask for the Medicare CCN during their enrollment process.

Medicare

Billing Number and National Provider Identifier (NPI)

The Provider Transaction Access Number (PTAN) is also known as a Medicare Supplier Number or Medicare Billing Number. The PTAN is used by a supplier to bill the Medicare Program.

The NPI is the standard unique health identifier for health care providers and suppliers and is assigned by the National Plan and Provider Enumeration System (NPPES). To enroll in Medicare, a provider must obtain an NPI.[6]

Taxonomy Codes

When setting up the organization's NPI for a Palliative Care program, use the Single Specialty Group taxonomy code 193400000X and the H&PC taxonomy code based on the Medical Director's specialty. For example, the MD is a Family Medicine doctor, the organization would use 193400000X and 207QH0002X.

This is a list of the taxonomy codes related to Hospice and Palliative Care:

- **207LH0002X:** Hospice and Palliative Medicine (Anesthesiology) Physician
- **207PH0002X:** Hospice and Palliative Medicine (Emergency Medicine) Physician
- **207QH0002X:** Hospice and Palliative Medicine (Family Medicine) Physician
- **207VH0002X:** Hospice and Palliative Medicine (Obstetrics & Gynecology) Physician
- **2080H0002X:** Pediatric Hospice and Palliative Medicine Physician
- **2081H0002X:** Hospice and Palliative Medicine (Physical Medicine & Rehab) Physician
- **2084H0002X:** Hospice and Palliative Medicine (Psychiatry & Neurology) Physician
- **207RH0002X:** Hospice and Palliative Medicine (Internal Medicine) Physician

6 Medicare Enrollment Application: Clinics/Group Practices and Other Suppliers. CMS-855B. http://www.cms.gov/MedicareProviderSupEnroll.

Medicare Enrollment

The priority enrollment is Medicare Part B as some of the other insurance plans will ask for the Medicare CCN during their enrollment process. Required forms include Palliative Care program structure and licensing.

Enrolling in Medicare Part B can be completed electronically through the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) or on a paper form then mailed or couriered to the Medicare Administrative Contractor (MAC). The Organization will need to register for an account in the system on the website to complete the application online. https://pecos.cms.hhs.gov/pecos/login.do#headingLv1.

Processing of the 855B application by MACs typically takes sixty calendar days in most cases but can take up to 180 calendar days or more in certain circumstances. For applications that do not require a site visit, the MAC is required to process at least 80 percent of all CMS-855 initial applications within sixty calendar days, 90 percent within 120 calendar days, and 95 percent within 180 calendar days of receipt. Failure to furnish all the required supporting documents and/or failure to fill out the application accurately and completely will delay Medicare enrollment.

Completing the Enrollment application on paper typically requires more time for the MAC to approve the enrollment. At the time of this writing, the time expectation is 15 days longer for paper applications. Completing the application through PECOS runs between 15-50 calendar days.

Forms for Medicare Part B enrollment include:

- **CMS-855B** – Enrollment application for Clinics, Group Practices and Certain Other Suppliers
- **CMS-855I** – Individual Enrollment Application for physicians and non-physicians not already enrolled, if applicable
- **CMS-855R** – Reassignment of Medicare Benefits (allows the organization to bill on behalf of the provider. At least physician 855R is required)
- **CMS-588** – Electronic Funds Transfer (EFT) Authorization Agreement
- **CMS-460** – Medicare Participating Physician or Supplier Agreement

Documents that, if applicable, must be submitted with the completed enrollment applications include:

- Completed Form CMS-855R, Individual Reassignment of Medicare Benefits, for the individual practitioner(s) if you will be submitting claims and receiving payments for the individual practitioner(s) who will be rendering services as part of your group/clinic or other health care organization. A CMS-855I is necessary if the individual practitioner does not have a current Medicare enrollment in the state.
- Copies of all final adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).
- Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement. **NOTE:** *The CMS-460 must be submitted for all initial enrollments or reactivations only to be a participating supplier in Medicare.*
- Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement. Include a voided check or bank letter. **NOTE:** *Required only if making changes to banking information or not currently receiving payments electronically.*
- If Medicare payments due are being sent to a financial institution where there is a lending relationship, a statement in writing from the financial institution) should waive its right of offset for Medicare receivables.
- Written confirmation from the IRS confirming Tax Identification Number and Legal Business Name provided in section 2A (e.g., IRS form CP-575). **NOTE:** *This information is needed if the applicant is enrolling in their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.*

- Written confirmation from the IRS if a business is registered as a Limited Liability Company (LLC), including single member LLCs, confirming your LLC is automatically classified as a Disregarded Entity (e.g., IRS Form 8832). **NOTE:** *A Disregarded Entity is an eligible entity that is not treated as a separate entity from its single owner for income tax purposes.*
- Copy of IRS Determination Letter if registered with the IRS as non-profit (e.g., IRS Form 501(c)(3)). **NOTE:** *Government-owned entities do not need to provide an IRS Form 501(c)(3).*
- The provider must submit an organizational structure diagram/flowchart identifying all the entities listed in section 5 and their relationships with the provider and each other.[7]

Medicaid

After there is an established enrollment with Medicare Part B, then an application for Medicaid can proceed. Each state controls its Medicaid program. For Medicaid enrollment applications, verification is needed with each individual state provider(s). If coverage areas overlap, enrollment is necessary with each Medicaid payer individually. Straight Medicaid, managed care, or special programs such as CHIP, disease specific will have their own credentialling process and criteria to follow. Most states have websites for providers to complete enrollment/ credentialling online.

Medicare Advantage/ Medicare Railroad/Commercial and Other Insurances

Medicare Railroad also has a separate enrollment process which can only be completed after the initial Medicare enrollment has been completed.

Most of the other types of insurance plans have their own unique enrollment and credentialling processes. Many have online access to complete the application, some will require phone calls and paper applications. Each insurance company has multiple plans that may have different processes, different patient responsibility plans. Research the service area(s) to determine which plans are available in these areas and prioritize these plans to begin the credentialling process.

Council for Affordable Quality Healthcare (CAQH)

CAQH is a non-profit alliance of health plans and related associations working together to achieve the shared goal of streamlining the business of healthcare.

CAQH enables provider and group administrators to enter information once and share it with all the plans they authorize. The system provides verification of the information, as well as monitoring for sanctions and updates to licenses with live data from licensing boards, medical schools, government registries, and more.[8]

Utilizing CAQH will streamline the credentialling process for the program and ensure up-to-date information for revaluations and managing this data. Providers create their own account, and the program administrator creates an account for the practice. The providers data can be connected to the practice and then submitted to participating insurance plans. Not all plans participate. Most of the larger plans do participate, such as Blue Cross, Aetna, Cigna, Humana, United Health Group, Tricare, some state Medicaid programs, and Veterans Affairs.

7 Medicare Enrollment Application: Clinics/Group Practices and Other Suppliers. CMS-855B. http://www.cms.gov/MedicareProviderSupEnroll
8 www.Caqh.org/solutions/credentialing-suite

Commercial Insurance Plans

Insurance credentialing or Provider Enrollment refers to the process of applying to health insurance networks for inclusion in their provider panels. For Commercial Insurance networks, this process involves two steps, 1) Credentialing and 2) Contracting. The provider submits a participation request to the health plan using the plan's credentialing application process. Insurance credentialing application processes vary from completion of a unique credentialing application, use of CAQH, or acceptance of a state standardized credentialing application. When the health plan receives a credentialing application, they will perform a thorough credentials verification of the provider to ensure he/she meets their credentialing requirements. When all credential verification, Primary Source Verification, is complete, the credentialing file goes to a Credentialing Committee for approval. This process may take up to 90 days to complete.

In the Contracting phase of enrollment, the provider is provided a contract for participation. Most commercial insurance networks have staff dedicated to the contracting process and it is separate from the credentialing step. In the contracting phase, the provider will need to review the language of the participating provider contract, reimbursement rates, and all the details and responsibilities of participation, then sign the agreement. This is the time for negotiation of rates if the standard reimbursement rates do not meet the provider's expectations. Once the agreement is signed and returned to the network, the provider is given an effective date and provider number so that the provider can begin billing the plan and receiving In-Network reimbursement for claims. This may take 30 – 45 days for this phase of the process.[9]

Some third-party payers will offer out-of-network benefits to their beneficiaries. Providers may see these patients even if there is no contract. Providers must remind patients they will be responsible for a higher out-of-pocket cost if the patient chooses to see this provider.

. Credentialing the practice with payers can be tedious and time consuming. If the organization can contract with a credentialing service, it may be beneficial. Often, these credentialing businesses also provide billing services. Contracting these services usually costs approximately 4% to 7% of collections. They will usually do the credentialing for no cost. Their incentive is to credential as many payers as possible for you – the more payers they can credential and the more billing that can be submitted.

9 What is Insurance Credentialling. 2017. National Credentialing Solutions. https://nationalcredentialing.com/what-is-insurance-credentialing/

Reimbursement

Medicare Part B

Medicare Part B billing differs from Part A billing. Part B billing is fee-for-service, utilizing Current Procedure Terminology (CPT-4)/Healthcare Common Procedure Coding System (HCPCS) codes. CPT© codes were developed by the AMA and first published in 1966. CPT is a registered trademark of the AMA. These codes are a uniform coding system used to identify medical services and procedures furnished by physicians and other healthcare professionals. HCPCS is a collection of standardized coded that represent supplies, products, and services not included in the CPT© codes, such as ambulance services, durable medical equipment, and supplies. Quality codes for Merit-based Incentive Payment System (MIPS) are also found in the HCPCS codes.

ICD-10 codes are used for diagnoses covered during a visit. In Palliative Care, the focus would be on the symptoms managed during a visit, following coding rules. ICD-10 codes are to be attached to each CPT© and/or HCPCS code on the claim. Typically, the healthcare provider will choose the codes to use for each visit. It is recommended to have a coder review documentation to ensure accurate coding and documentation to support the codes. This requires clear, non-judgmental communication between the provider and the coding staff.

Claims

Claims for Part B billing are completed on the Health Insurance Claim Form 1500 and are used for each visit. These claims can be submitted daily. Each CPT© code must have a corresponding ICD-10 code(s) to support the reason for the visit. Unlike Part A billing, the diagnosis codes for each visit can be different depending on the reason for the visit. Typically, only signs, symptoms, and conditions addressed during the visit are reported. There are, however, some coding rules that require the disease process be billed prior to the symptom code. Some MACs, such as CGS and NGS provide step by step instructions for completing this form.

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500.pdf

Medicare claims are submitted to the specific regional Medicare Administrative Contractor (MAC) for processing and payment. This may or may not be the same as the Part A provider for Home Health and Hospice Programs. Specific Contractors and contact information can be found here.

https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/downloads/contact_list.pdf

Medicaid

Medicaid billing varies by state. Most will use CPT©/HCPCS codes like Medicare. Some states will have different modifiers or codes. If a Palliative Care program chooses to participate in a Medicaid program, it is imperative that provider's coders and billers understand the requirements and codes and the EMR/billing system is set up correctly to support those codes.

Commercial Insurance and Medicare Advantage Plans

Most commercial payers will pay for Palliative Care when set up as a practice and will pay like any other provider practice. Commercial payers, however, can set their own reimbursement fee schedules and are not obligated to pay at Medicare rates. Some payers will require a program to be credentialed as an in network, participating provider to be paid. This is especially true for HMO plans. PPO/POS plans typically allow their beneficiaries to see any provider of their choice and the beneficiary may pay more to see a provider that is out of network. Any financial agreements with patients must specify what the costs will be.

Medicare Advantage plans are also third-party insurance companies working with Medicare. These are plans that are Medicare-approved from a private company offering alternatives to Original Medicare. They are typically bundled plans which include Part A, Part B, and usually Part D. Each plan will be unique in the specifics of coverage for its members. A Palliative Care program will need to negotiate a contract with each plan for reimbursement rates. These plans typically use CMS-1500 forms for billing.

Many plans use Per Patient Per Month (PPPM) or Per Member Per Month (PMPM) agreements. These plans pay a provider a set monthly amount per each insured beneficiary on the provider's panel. The capitated payment is typically based on the expected cost of providing healthcare services that may include preventive care, acute care, and chronic care services. The benefits of PMPM are a stable revenue stream and incentives for cost-effective care; many of these plans offer quality or cost target bonuses.

Value-Based Care models focus on rewarding providers for delivering high-quality care and achieving positive health outcomes. These are typically focused on population health management or chronic disease management.

A Shared Savings Program is a voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an Accountable Care Organization (ACO) to give coordinated, high-quality care to their Medicare Beneficiaries.

There are also insurances that have multiple plans specific to employer policies, locations, or level of coverage. It is imperative to verify eligibility and understand the specifics of each patient's insurance plan to ensure proper reimbursement for services. Enter negotiations for contracts with insurance plans with clear information as to what the Palliative Care Program offers to the beneficiaries and the insurer. Understand the patient costs for the services provided. Know the bottom line for financial success and hold firm on that bottom line. Be prepared to walk away and regroup if necessary.

Patient Billing Requirements

Medicare Part B, Medicaid, and Commercial insurance typically have some patient responsibility for their medical claims. Patients may have a deductible, copay, and/or coinsurance. A Palliative Care provider is required to collect this money from the patient. This is done via a patient invoice/statement, and most practice management software/EMRs have a method of setting this up automatically once all other payers have responded to the claim with a payment or a denial.

The explanation of benefits from the insurer will provide the reason for any denials, any contractual adjustments, and any patient responsibility. Some patients will have a secondary or gap insurance that may pay for the patient responsibility portion of the claim. Ensure the EMR system is set up to bill the secondary insurance after a response from the primary insurer is received. Medicare Part B will automatically forward any patient responsibility portions to a secondary insurer if they have the information regarding a secondary insurer.

Eligibility Verification

Verifying insurance eligibility is a crucial step to receiving reimbursements for visits and procedures. Typically, EMR systems will have an eligibility component built in either with direct connections to Medicare's FISS system or through a vendor such as MyAbility or Waystar. EMR systems designed for medical practices may also verify secondary insurances.

It is important to ask patients/responsible parties if there are any secondary insurances or medigap plans. Completing a Medicare Secondary Payor form is recommended. All primary, secondary, and tertiary insurances should be added to the patient's chart to ensure any monies not paid by the primary are submitted to the next responsible payer.

Eligibility verification varies from hospice programs. Educate the billing team on secondary and tertiary insurance plans and ensure the verification processes include these payers.

Coding

Visit Codes

Fee for service billing requires the use of Evaluation and Management (E/M) Coding. Visit and procedure codes are created by the American Medical Association (AMA) and utilize Current Procedural Terminology (CPT). CMS offers a Physician Fee Schedule lookup tool to look up current and past adjusted pricing amounts for these codes.

For 2023, the American Medical Association revised some of the Evaluation and Management Codes. Along with the time changes noted in red, Domiciliary visit codes were removed and are now captured with the home visit codes.

Office Visit	**Risk of Complications/morbidity/mortality**	
New Patient	**Place of Service Code 11 (Office)**	
99202 Straightforward (1 problem)	Minimal risk	15-29 min
99203 Low	Low risk	30-44 min
99204 Moderate	Moderate risk	45-49 min
99205 High	High risk	60-74 min
Established Patient		
99211 usually a nurse visit in the office		
99212 Straightforward (1 problem)	Minimal risk	10-19 min
99213 Low	Low risk	20-29 min
99214 Moderate	Moderate risk	30-39 min
99215 High	High risk	40-54 min
Prolonged services	**Direct Patient Care with Provider Supervision**	
99415 1st hour	Beyond the highest time in the range of total time of E/M	
99416 each add'l 30 min		
Provider Prolonged visit		
99417 For services 75 minutes or longer	With 205/215 only	G2212

Home Visit	**Risk of Complications/morbidity/mortality**	
Place of service codes: 02 (telehealth), 12 (home), 13 (ALF), 14 (Group Home, 33 (Custodial Care)		
New Patient	**Risk**	**Time**
99341 straightforward (limited 1 system)	Low risk	15 min
99342 low (limited 2-7 systems)	Low risk	30 min
99344 high (8 or more organ systems)	Mod to high risk	60 min
99345 unstable (8 or more organ systems)	High risk	75 min

Established Patient		
99347 straightforward (limited 1 system)	Low risk	20 min
99348 low (limited 2-7 systems)	Low risk	30 min
99349 mod-high (extended 2-7 systems)	Mod risk	40 min
99350 unstable (8 or more organ systems) High risk	60 min	
Prolonged Services	**Prolonged total time is time that is 15 minutes beyond the time required to report the highest-level primary service. (99345/99350)**	
99417 For services 75 minutes or longer	Coded with E/M code	G0318 (Medicare)

Facility VISIT	**Risk of Complications/morbidity/mortality**	
Initial Visit	**place of service codes 31 (SNF) 32 (LTCFs) 54 (ICF/ MR) 56**	**Time**
99304 low (limited 2-7 systems)	Low risk	25 min
99305 moderate (extended 2-7 systems)	Mod risk	35 min
99306 high (8 or more organ systems)	High risk	45 min
Subsequent Visits		
99307 straightforward (limited 1 system)	Low risk	10 min
99308 low (limited 2-7 systems)	Low - mod risk	15 min
99309 moderate (extended 2-7 systems)	Mod risk	30 min
99310 high (8 or more organ systems)	High risk	45 min
Prolonged Services	**Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using**	
99418 total time, each 15 minutes of total time (code w E/M)	G0317 (Medicare)	

Inpatient Visits/Hospital	Risk of Complications/morbidity/mortality	
Initial Visit	**Place of service Hospice (34) Hospital (21)**	**Time**
99221 low risk		40 min
99222 mod risk		55 min
99223 High risk		75 min
Subsequent Visits		
99231 low risk		25 min
99232 mod risk		35 min
99233 High risk		50 min
Prolonged Services		
99418 coded with E/M code	G0316 (Medicare)	

**The prolonged visit codes continue to be billable codes by AMA, CPT® and coding practices. However, as of January 2023, CMS' Physician Fee schedule states "the current Physician Fee Schedule does not price the requested HCPCS code". Medicare will recognize the G-codes when attached to the highest-level visit code.*

Prolonged visit codes for Medicare

CMS created HCPCS codes when billing Medicare for prolonged Evaluation and Management (E/M) services which exceeds the **maximum** time for the highest level (99205, 99215, 99223, etc.) E/M visit in each category by at least 15 minutes on the date of service. CMS prolonged service guidelines are different from the American Medical Association (AMA). Medicare Administrative Contractors (MACs) will process claims per the Internet Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 12, section 30.6.15. (Noridian Healthcare Solutions). Medicare is no longer paying for the AMA codes.

G2212

Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact list separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services.

- Do not report G2212 on the same date of service as 99415, 99416
- Do not report G2212 for any time unit less than 15 minutes

G0316

Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service when the primary service has been selected using time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services.

- Do not report G0316 on the same date of service as other prolonged services for evaluation and management.
- Do not report G0316 for any time unit less than 15 minutes

G0317

Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service when the primary service has been selected using time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact list separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services.

- Do not report G0317 on the same date of service as other prolonged services for evaluation and management.
- Do not report G0317 for any time unit less than 15 minutes

G0318

Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service when the primary service has been selected using time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact list separately in addition to CPT® codes 99345, 99350 for home or residence evaluation and management services.

- Do not report G0318 on the same date of service as other prolonged services for evaluation and management.
- Do not report G0318 for any time unit less than 15 minutes[10]

Telehealth Codes (Phone only)

- **99441** – Phone Encounter and Management Physician/Qualified Health Provider 5-10 min
- **99442** – Phone Encounter and Management Physician/Qualified Health Provider 11-20 min
- **99443** – Phone Encounter and Management Physician/Qualified Health Provider 21-30 min

Modifiers that may be used:

- **Modifier 25** – significant, separately identifiable e/m service by the same provider on the same day as the procedure or other service i.e., an annual visit with a problem visit on the same day or a visit for back pain and removed ear wax.
- **Modifier 26** – professional component only of a test (physician interprets results only). Modifier TC is used if provider only performs the test, but does not do the interpretation
- **Modifier 59** – different procedure, different site, separate injury done on same date. Code it with the procedure code, not the E/M code
- **Modifier QW** – CLIA waived tests - code with test CPT® code
- **Modifier GY** – ABN - item or service statutorily excluded, does not meet the definition of any Medicare Benefit
- **Modifier GZ** – ABN - item or service expected to be declined as not reasonable or necessary

Procedure codes used by some Palliative Care providers include, but are not limited to:

- **36415** – Venipuncture
- **69209** – Removal of impacted cerumen
- **69210** – Removal of impacted cerumen/irrigate
- **93792** – Pt/CG training in the home INR
- **93793** – Anticoag mgmt pt warfarin (nonF2F)
- **G0250** – F2F verification that pt can use PT device
- **87804** – Influenza A/B
- **81003** – U/A, dip stick
- **82272** – Occ Blood Fecal

10 Prolonged Service Codes: Procedure Codes. Noridian Healthcare Solutions. Jurisdiction E – Medicare Part B. https://med.noridianmedicare.com/web/jeb/specialties/em/prolonged-service-code

LCSW Visit Codes

CSW visit codes	
90791	Psychiatric Diagnostic Interview.
90832	Psychotherapy, 30 minutes with patient and/or family member.
90834	Psychotherapy, 45 minutes with patient and/or family member.
90837	Psychotherapy, 60 minutes with patient and/or family member
90839	Psychotherapy for crisis; first 60 minutes.
90840	Psychotherapy for crisis; each additional 30 minutes.
90845	Psychoanalysis.
90846	Family psychotherapy (without the patient present).
90847	Family psychotherapy (conjoint psychotherapy, with the patient present).
90849	Multiple-family group psychotherapy.
90880	Hypnotherapy.
90785	Interactive complexity (Use only as an add-on code with the following new and existing psychotherapy codes: Psychiatric CPT codes for telehealth are from above: 90832, 90834, 90837, 90839, 90840, 90845, 90847, 90791, 90785. Place of

LCSW visit codes will require DSM-V diagnostic codes. An example of some common codes include:

- **F41.1** – Generalized anxiety disorder
- **F05** – Delirium due to another medical condition
- **F06.31** – Depressive disorder due to another medical condition, with depressive features
- **F43.10** – Posttraumatic stress disorder

Complexity/Medical Decision-Making vs Time

It is strongly recommended that Palliative Care providers document based on Medical Decision Making rather than time, especially when visits are conducted in the home. Home visits tend to be longer by nature and do not always reflect the time spent on the reason for the visit. When a visit audit was done by the OIG, 30-40% of findings show the documentation does not support the codes billed. Many of these audit requests are related to the higher risk codes and Advance Care Planning Codes.

Coding the actual face-to-face time by complexity and adding ACP codes and the non-Face-to-Face codes when appropriate may provide a more accurate accounting of the visit on the claim.

Location

The location of the patient during the visit is crucial to choosing the correct group of visit codes. Beginning in January 2023, prior ALF/Domiciliary visit codes have been deleted and the home visit codes will be used. The place of service codes has not changed.

Advance Care Planning (ACP)

ACP is a face-to-face service between a Medicare physician or other qualified health care professional and a patient to discuss the patient's health care wishes if they become unable to make decisions about their care. As part of this discussion, a provider may talk about advance directives (ADs) with or without completing legal forms. An AD appoints an agent and/or records the person's wishes about their medical treatment based on their values and preferences. Advance Directive documents may be found both on NHPCO's CaringInfo site (CaringInfo: Resources for Serious Illness & End-of-Life Care) as well as on the State attorney generals' office website. Examples of ADs include:

- Living wills
- Instruction directives
- Health care proxy
- Health care power of attorney

Medicare pays for ACP as either:

- An optional element of a patient's Medicare Wellness Visit (MWV)
- A separate Medicare Part B medically necessary service

When billing this service more than once, document the change in the patient's health status and/or wishes about their end-of-life care. There is no limit on the number of times a provider can report ACP for a patient. Providers can offer ACP services in facility and non-facility settings.

- **99497:** Advance care planning including the explanation and discussion of advance directives such as standard forms, with completion of such forms, when performed, by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- **99498:** Advance care planning including the explanation and discussion of advance directives such as standard forms, with completion of such forms, when performed, by the physician or other qualified health care professional: each additional 30 minutes. List separately in addition to code for primary procedure.

Only Physicians (MD/DO) Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists my bill for these codes. All other providers (social work, psychology, chaplains) may participate in the provision of ACP under the order and medical management of the beneficiary's treating provider but may not report ACP codes independently.

Documentation of Advance Care Planning Services

Thorough documentation of advance care planning services can assist both the facilitator and patient recall the details of all conversations, inform the managing provider and other care team members of the result of patient wishes, and ensure that services are billed properly. This must be a separate, identifiable section in the visit note or can be a separate note. Documentation should include:

- Who was included in the advance care planning session: patient, family, health care team, and others.
- What was discussed during the advance care planning session.
- Time spent face-to-face with the patient, separate from other services on the same date of service. Best practice is to state the start and end time of this service.
- Presence of an advance directive, health care proxy, or medical orders.
- Code status, types of medical care preferred, preferred comfort level, and other wishes of the patient.
- Need for further sessions, either scheduled immediately or upon certain changes in illness or treatment.
- Referrals to social work, psycho-oncology, palliative care, hospice care, or other services based on patient needs uncovered during advance care planning.

Along with documentation within a visit note, all resulting legal and supporting documents should be uploaded to a specified location in the electronic health record and uploaded into available advance directive or medical order registries.

CPT® codes 99497-99498 should not be reported by the same physician/qualified health provider on the same date of service as the following E/M services: **99291-99292, 99468-99469, 99471-99472, 99475-99480** and **99483**.

CPT® instructions note that CPT® codes 99497 and 99498 may be billed on the same day or a different day as most other E/M services, and during the same service period as transitional care management services or chronic care management services and within global surgical periods.

These codes may be separately reported when performed on the same date of service in conjunction with the following E/M services: **99201-99215, 99217-99226, 99231-99236, 99238-99239, 99241-99245, 99251-99255, 99281-99285, 99304-99310, 99315-99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99381-99397,** and **99495-99496**. Both codes should be reported with modifier-25 added presuming the requirements for use of modifier-25 are met.[11]

Transitional Care Management

Transitional Care Management (TCM) addresses the hand-off period between the inpatient and community setting. Many Primary Care Providers (PCP) will manage their patient's transitional care. Best practice is to reach out to the patient's PCP to ask if they will be providing this care or if they would like assistance with this from Palliative Care, especially if the patient is bed-bound or it is too difficult for them to get to the PCP's office.

The two CPT codes used to report TCM are:

- **99495:** moderate medical complexity requiring a face-to-face visit within 14 days of discharge
- **99496:** high medical complexity requiring a face-to-face visit within seven days of discharge

TCM consists of one face-to-face visit within the specified times, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction.

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

- communication with patient, family members, guardian or caretaker, surrogate decision makers, and/ or other professionals regarding aspects of care,
- communication with home health agencies and other community services utilized by the patient,
- patient and/or family/caretaker education to support self-management, independent living, and activities of daily living,
- assessment and support for treatment regimen adherence and medication management,
- identification of available community and health resources,
- facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care provider may include:

- obtaining and reviewing the discharge information (e.g., discharge summary, as available, or continuity of care documents),
- reviewing need for or follow-up on pending diagnostic tests and treatments,
- interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems,
- education of patient, family, guardian, and/or caregiver,
- establishment or reestablishment of referrals and arranging for needed community resources,
- assistance in scheduling any required follow-up with community providers and services.[12]

11 Billing and Coding: Advance Care Planning. www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=58664

12 Transitional Care Management Services. MLN Booklet 908628. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf

Chronic Care Management

CMS created Chronic Care Management (CCM) to provide care for eligible patients with two or more chronic conditions. These conditions are expected to last at least 12 months or until the patient's death and/or place the patient at significant risk of death, acute exacerbation and/or decompensation, or functional decline. The services included in CCM are not typically face-to-face and allow eligible practitioners to bill at least 20 minutes or more of care coordination services per month.

- **99491:** Chronic care management services, **provided personally by a physician or other qualified healthcare professional, at least 30 minutes of physician or other qualified healthcare professional time,** per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored
- **99487:** Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline, **establishment or substantial revision of comprehensive care plan,** moderate or high complexity medical decision making; **first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month**
- **99489:** Complex chronic care management services, as above, **each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional,** per calendar month (List separately in addition to code for primary procedure)
- **99490:** Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, **comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time** directed by a physician or other qualified health care professional, per calendar month[13]

Before CCM services can begin, a patient will need to have an initiating visit if the practitioner has not seen the patient within 1 year. This visit is not part of CCM and can be billed separately. Be sure to document the conversations regarding CCM services, get a written or verbal consent for CCM service prior to billing.

Of note, a program providing CCM services will be required to provide 24/7 access to physician or other qualified practitioners or clinical staff, provide continuity of care with the designated practitioner or member of the care team with whom the patient can get successive routine appointments, and provide communications through secure messaging, web, or other methods, such as email or patient portal.

Principal Care Management

In 2020, CMS introduced Principal Care Management (PCM) services to provide Chronic Care Management for patients with a single chronic condition or multiple chronic conditions but focused on a single high-risk condition. Services are expected to last 6 months to 1 year or until the patient's death.[14]

PCM services follow the same requirements of CCM services, except for only needing a single chronic condition. This includes 24/7 access to practitioners, access to enhanced communication methods, and continuity of care with a designated practitioner or member of the care team with whom the patient can get successive routine appointments.

13 Chronic Care Management Services. MLN Booklet. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

14 Chronic Care Management Services: Principal Care Management. MLN Booklet. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

- **99424:** Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; **first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month**
- **99425:** As above. Each **additional 30 minutes provided personally by a physician or other qualified health care professional,** per calendar month (List separately in addition to code for primary procedure)
- **99426:** Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, **the condition requires development, monitoring, or revision of disease-specific care plan,** the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; **first 30 minutes of clinical staff time directed by physician or other qualified health care professional,** per calendar month
- **99427:** As above. **each additional 30 minutes of clinical staff time** directed by a physician or other qualified health care professional per calendar month (List separately in addition to code for primary procedure)[15]

Incident to Billing

Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services during diagnosis or treatment of an injury or illness.[16]

These services are commonly performed in a clinic/office setting, must have direct physician supervision of the auxiliary staff.

Incident to billing can also apply to home settings as follows:

The direct supervision above is not applicable to individual or intermittent services when they are performed by personnel meeting any pertinent State requirements (e.g., a nurse, technician, or physician extender) and where the criteria listed below also are met:

1. The patient is homebound, i.e., confined to his or her home, place of residence
2. The service is an integral part of the physician's service to the patient and is performed under general physician supervision by employees of the physician or clinic. General supervision means that the physician need not be physically present at the patient's place of residence when the service is performed; however, the service must be performed under his or her overall supervision and control.
3. The physician orders the service(s) to be performed, and contact is maintained between the nurse or other employee and the physician, e.g., the employee contacts the physician directly if additional instructions are needed, and the physician must retain professional responsibility for the service. All other incident to requirements must be met.
4. The services are included in the physician's/clinic's bill, and the physician or clinic has incurred an expense for them.
5. The services of the paramedical are required for the patient's care; they are reasonable and necessary.
6. When the service can be furnished by an HHA in the local area, it cannot be covered when furnished by a physician/clinic to a homebound patient under this provision.

Be sure to familiarize the billing team and providers with Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services, Section 60

15 Chronic Care Management Services: Principal Care Management. MLN Booklet. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

16 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

Documentation to Support Evaluation & Management Visit Codes

Documentation is key to reimbursement and avoidance of paybacks or denials. Medicare and insurers may request additional documentation to support the codes on the claims. Many insurers will follow the American Medical Association's Current Procedural Terminology code and Medical Decision-Making guidelines when reviewing documentation. January 1, 2023, changes were made to the Evaluation & Management (E/M) codes.

The levels of E/M services codes are formatted based on medical decision making (MDM) or time. This format includes the unique code number, the place and/or type of service specified, the content of the service and time.

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs.[17]

New and Established Patients

A new patient is one who has not received any professional services from any provider of the exact same specialty or subspecialty who belongs to the same group practice, within the past three years.

Facility visit coding uses the terms Initial and Subsequent Services. These categories apply to both new and established patients e.g., hospital inpatient or observation care. These categories differentiate services by whether the service is the initial service or a subsequent service. Professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and/or subspecialty who belongs to the same group practice, during the inpatient, observation, or nursing facility admission and stay."[18] A subsequent service is a professional service from a provider of the exact same specialty, same group practice, during the admission and stay.

Services Reported Separately

There may be some circumstances that require a procedure to be performed on the same day as the E/M Service. There are many procedures and services that could be performed on the same day, such as paracentesis, cerumen removal, or joint injections. In Palliative Care, one of the most common is Advance Care Planning. If this service is performed on the same day as the E/M visit, a modifier -25 would be added to the E/M service code.

For example: a home visit is conducted for a patient with multiple symptoms and conditions requiring Palliative Care services. A moderate visit code in the home for an established patient would be 99344. ACP services were provided for 30 minutes and well documented. The procedure codes would be:

- **99344 – 25**
- **99497**

17 CPT® Evaluation and Management (E/M) Code and Guideline Changes.p3. American Medical Association. 2022.
18 CPT® Evaluation and Management (E/M) Code and Guideline Changes.p4. American Medical Association. 2022.

Medical Decision Making (MDM)

There are four types of MDM: straightforward, low, moderate, and high. MDM includes diagnosing, assessing the status of a condition/symptom, and/or selecting a management option. The AMA and CPT define MDM by *all three* elements:

- The number and complexity of problem(s) that are addressed during the encounter.
- The amount and/or complexity of data to be reviewed and analyzed.
- The risk of complications and/or morbidity or mortality of patient management.

The data to be reviewed and analyzed includes information from multiple sources or communications and interpretation of tests that are not reported separately. Risks include management options selected and those considered but not selected after shared decision making with the patient and/or family.

The American Medical Association (AMA) has provided a guide for determining risk and medical decision making to assist providers when choosing the visit codes to use for their visits.

The levels of Medical Decision Making (MDM) are straightforward, low, moderate, and high.

Straightforward:

- Minimal Complexity with one self-limited or minor problem
- Minimal risk of morbidity from testing or treatment.

Low:

- Two or more self-limited or minor problems, or one stable chronic illness, or one acute, uncomplicated illness, or injury or one stable, acute illness, or one acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
- At least one out of two categories of amount and/or complexity of data to be reviewed and analyzed
  - **Category 1:** Tests and documents: any combination of two
    - Review of prior external note(s) from each unique source
    - Review of the result(s) of each unique source
    - Ordering of each unique test
  - **Category 2:** Assessment requiring an independent historian
- Low risk of morbidity from additional diagnostic testing or treatment

Moderate:

- One or more chronic illnesses with exacerbation, progression, or side effects of treatment, or two or more stable, chronic illnesses, or one undiagnosed new problem with uncertain prognosis, or one acute illness with systemic symptoms, or one acute, complicated injury
- At least one out of three categories of amount and/or complexity of data to be reviewed and analyzed
  - **Category 1:** Tests, documents, or independent historian(s), any combination of three from the following
    - Review of prior external note(s) from each unique source
    - Review of the result(s) of each unique test
    - Ordering of each unique test
    - Assessment requiring an independent historian(s)
  - **Category 2:** Independent interpretation of tests
    - Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)
  - **Category 3:** Discussion of management or test interpretation
    - Discussion of management or test interpretation with external physician/other qualified healthcare professional/appropriate source (not separately reported)

- Moderate risk of morbidity from additional diagnostic testing or treatment examples:
  - Prescription drug management
  - Decision regarding minor surgery with identified patient or procedure risk factors
  - Diagnosis or treatment significantly limited by social determinants of health

High:

- One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment, or one acute or chronic illness or injury that poses a threat to life or bodily function
- At least 2 out of 3 categories of amount and/or complexity of data to be reviewed and analyzed
  - **Category 1:** Tests, documents, or independent historian(s) any combination of three from the following:
    - Review of prior external note(s) from each unique source
    - Review of the result(s) of each unique test
    - Ordering of each unique test
    - Assessment requiring an independent historian(s)
  - **Category 2:** Independent interpretation of tests
    - Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)
  - **Category 3:** Discussion of management or test interpretation
    - Discussion of management or test interpretation with external physician/other qualified healthcare professional/appropriate source (not separately reported)
- High risk of morbidity from additional diagnostic testing or treatment examples:
  - Drug therapy requiring intensive monitoring for toxicity
  - Decision regarding hospitalization or escalation of level of care
  - Decision not to resuscitate or to de-escalate care because of poor prognosis
  - Parenteral controlled substances[19]

Definitions Related to MDM Table

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, which poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity.[20]

Independent historian(s): An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.[21]

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.[22]

19 https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
20 https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
21 https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
22 https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Documentation Based on Time

Documentation on time includes both face-to-face time with the patient/family/caregiver and non-face-to-face time spent with the provider on the day of the encounter. It does not include any time spent on other services that would be separately reported, such as Advance Care Planning.

Professional time includes the following activities:

- Preparing to see the patient (such as reviewing test results)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate exam and/or evaluation
- Ordering medications, test, procedures
- Referring and communicating with other health professionals (when not separately reported)
- Documenting clinical information in the health record
- Independently interpreting results and communicating result to the patient/family/caregiver
- Care coordination not separately reported

Activities that do not count towards time include:

- Performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to a discussion required for managing the specific patient

Practitioner's choosing to use time as the supporting factor:

- Must document time spent in counseling not just a percentage of time in the
- patient's medical record
- Documentation MUST support in sufficient detail the nature of the counseling
- Code selection based on total time of the face-to-face encounter (floor time),
- the medical record review MUST be documented in sufficient detail to justify the code selection

Coding based on time is more reliable when seeing patients in a hospital or clinic setting. Home/Domiciliary visits tend to be longer in time by nature and documentation of these visits has been found to be less supportive of the higher-level codes when using time as the decision for codes. This can be a financial and legal risk.

Medical Necessity

Each visit performed must support medical necessity. Documentation must include the need for the visit. Medicare allows only the medically necessary portion of a face-to-face visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level/medical necessity of any service.

Considerations for home/domiciliary visits:

- Document if the home visit is based upon a one-time, ongoing, or permanent need.
- Documentation should state why the patient is not physically capable of traveling to the office. This may be based on physical or mental issues, not financial or personal matters.
- Home services cannot be for the convenience of the provider.
- Patients do not need to be home-bound for physicians to provide services billed under CPT codes 99341 through 99350.

Common Errors

Upcoding: Billing for a higher level than the documentation and service can support. Even when coding by time, the documentation must support the level of coding. MDM must be evident in the documentation to support the codes.

Not documenting medical necessity on each visit: Documentation for each date of service must be able to stand alone to support the codes used. Why is the patient being seen medically? Visiting and billing a patient just to check in does not support medical necessity. Frequencies for Palliative Care visits are based on symptom management and medically required follow up of those symptoms.

Vagueness about reason for follow up visits: Document the specific condition for a follow up visit. Just noting follow-up may not justify medical necessity.

Not referencing previous history: Be specific in the review of history. Refer to the date the history was noted, such as history unchanged since [date of previous note].

Documentation for Advance Care Planning codes: Documentation for ACP must be a separate section of the note or a separate note. Time spent must be clearly identified as well as the other components listed under ACP codes previously discussed.

For more extensive examples of documentation, you can review the Documentation chapter of NHPCO's Palliative Care Playbook for Hospices.

ICD-10 Codes for Palliative Care

Coding diagnoses for Palliative Care is quite different from Hospice or Home Health coding. Diagnosis coding on the claims should reflect the reason for the visit. Therefore, the ICD-10 codes will be symptom codes rather than disease codes with a few coding rule exceptions. If the Palliative program also includes becoming the Primary Care Provider for the patient, diagnosis codes would still reflect the reason for the visit and would include more disease codes along with the symptom codes. Z51.5 (Encounter for Palliative Care) should be on all the claims but should not be the primary code.

Some common ICD-10 Codes seen in Palliative Care include:	
R53.0	Neoplastic (malignant) related fatigue
R53.1	Weakness
R53.2	Functional quadriplegia
R53.81	Other malaise
R53.82	Chronic fatigue, unspecified
R53.83	Other fatigue
M25.5	Pain in joint
M54.5	Low back pain
R10	Abdominal and pelvic pain
R52	Pain, unspecified
N64.4	Breast pain

F43.22	adjustment disorder with anxiety
F41.1	Generalized anxiety disorder
R45.1	Restlessness and agitation
R11.0	Nausea
R11.1	Vomiting
I69.391	Dysphagia following cerebral infarction
I69.991	Dysphagia following unspecified cerebrovascular disease
I69.321	Dysphasia following cerebral infarction
R53.1	Weakness
M62.81	Muscle weakness, generalized
M62.83	Muscle spasm
M62.84	Sarcopenia (This is a code that requires any underlying disease, if applicable, such as disorders of myoneural junction, other myopathies, primary disorders of muscles prior to Sarcopenia).

Frequently Asked Questions (FAQs)

What is the best way to account for phone calls (e.g., to family who were not present) which occur on the same day as a visit with a patient?	When family phone calls occur on the same day - before or after a patient encounter, there are 3 options: 1.) roll that time into the original encounter 2.) use a prolonged visit code (for high risk/complex visits only) or 3.) add an Advance Care Planning code (if the conversation related to patient goals of care and the time/discussion meet requirements).
Is it true that medical decision-making drives selection of an accurate E/M code?	Medical decision-making is a thought process driven by the patient's presenting problem(s). The severity of the patient's condition(s) will begin this thought process and should lead to taking a history and performing an examination that is medically necessary for the condition. The MDM is critical to selecting an accurate code. Example: you should not see an expanded problem focused history and physical when high complexity MDM is documented and medically necessary. Medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option. Medical Decision-Making is the element most likely to prevent upcoding because it considers the nature of the presenting problem(s) – something outside the physician's control.
If a patient is intubated/cannot speak, but then the physician calls the family – is the in-person portion a 99xxx?	See above response. This scenario fits the description of independent historian to satisfy the medical decision-making component of coding the visit.

How do you account for circumstances when an exam is unable to be completed (e.g., patient is restricted in isolation)?	▮ If exam element states "Deferred," no credit is given for the exam. ▮ If exam element states "Refused" or otherwise makes it clear that the physician intended to perform the exam, but the patient could not tolerate the exam because of pain or refused to cooperate due to mental or emotional issues or could not cooperate due to health issues or age, credit is given for the element. If the patient refuses the entire exam or could not be examined for some documented reason, credit can be given for the comprehensive exam.
When billing an ACP code, should additional verbiage be added regarding counseling time >50%?	Beginning in 2023, the ">50% counseling" documentation requirement has gone away. There should be specific language regarding the **amount of time spent engaged in advance care planning activities:** *"advance care planning was performed during this visit accounting for xx minutes of time."* As well as details of the discussion, people involved, etc. **NOTE:** *while ACP can be used multiple times, CMS does expect an explanation of why – such as documentation of continued decline/ significant change of condition, new clinical finding that could possibly change plan of care, etc.*
What is the best way to document components of the visit without appearing to have not completed specific sections?	Document any positives found on exam, histories, etc. If there are portions for which a patient cannot answer or cannot be examined, document the reason - such as *"patient is unable to answer questions as patient is obtunded, nonverbal, etc."*
Is it acceptable to use "noncontributory, unremarkable or negative" when reporting past, family, or social history?	No. The statement "noncontributory, unremarkable or negative" does not indicate what was addressed. Did the nurse or physician ask specific conditions (e.g., any family history or coronary artery disease?) If for some reason you cannot obtain the family history, the documentation must support the reason (e.g., the patient was adopted.)

Billing Case Studies

Case #1

Medical History - Chief Complaint/HPI

Chief Complaint, History of Present Illness

Primary Diagnosis: OA
Chief Complaint: Pain

HPI: Palliative care visit made on this patient to assess pain and condition. Patient states tramadol working, but she is taking it 50mg Q6hrs and 100 mg at bedtime. She is also taking Tylenol prn. She does get pain at night frequently. She is also having a hard time sleeping and will take Ambien with help. Nystatin powder was irritating to the rash, and patient went back to the Desitin cream and using different pull-ups. She says rash is better.

Review of Systems - Palliative Assessment

Symptom Assessment

Reported by: Patient alone
Pain Assessment completed: No
Palliative Assessment: Patient very anxious today about pain. Unable to discuss scale. She states get good relief with tramadol.
Constitutional: + Weakness
Eyes: Reviewed and negative
ENMT: Reviewed and negative
Respiratory: Reviewed and negative
Cardiovascular: Reviewed and negative
Gastrointestinal: + Constipation, + Diarrhea
Describe/Other: Takes Lomotil as this works well, but sometimes it causes diarrhea.
Genitourinary: Reviewed and negative
Musculoskeletal: + Joint swelling, + Joint pain
Neurological: Reviewed and negative
Integumentary: 1 / 3, + Rashes
Heme/Lymphatic: Reviewed and negative
Psychiatric: Reviewed and negative

Disease Process - Physical Exam

Eyes: PERRL
Nose Findings: No erythema.
Mouth Findings: MMM
Respiratory Findings: Good air movement
Cardiovascular: Regular Rate, Murmur present
Gastrointestinal: Soft, Non-distended, non-tender
Bowel Sounds: WNL/Present in all quadrants
Genitourinary Findings: Voiding normal
Integumentary: + Warm, + Dry, Describe/Other: Rash improved
Extremities Findings: Warm and dry, No edema
Neurological: No focal deficits
Psychiatric: Alert and oriented x3, Mood good, affect normal, well-groomed, and appropriately dressed

Visit Plan - Assessment/Plan

Impression, Assessment and Plan

Problem (1): Osteoarthritis
Plan: Provided with script for tramadol 50 mg QID and Inst that she can take another one during the night if she wakes up with pain. C/W Tylenol 500mg prn also.

Problem (2): Fungal rash
Plan: Nystatin powder was not effective. Using Desitin with good relief.

Problem (3): Insomnia
Plan: Instruct to use Ambien 5mg QHS prn. Instruct to not take Advil PM. Patient agrees with plan. She also has Xanax at home 0.25mg. Instruct she can take also but call if not effect and taking both frequently.

Prognosis: Fair
Plan for follow up: Monthly and prn

Visit Summary

Time Spent: Patient/family has been educated about current condition, prognosis, medications, and treatment plan. More than 50% of the time was spent on reviewing the disease process, medications, treatment plan, counseling, and coordination of care. The discussion of goals of care/advance care planning was completed face to face with the patient and/or surrogate decision maker and was voluntary in nature. This portion of the discussion occupied the following number of minutes of the total encounter.
Total encounter minutes: 40

Submitted for billing: 99347 E/M code: **this chart would be a LOW RISK for audit.**

LOW	Includes: 99304, 99308, 99221, 99231, 99342, 99348, 99203, 99213	Documented
# problems at visit	Two or more self-limited or minor problems, OR 1 stable, chronic illness, OR 1 acute, uncomplicated illness or injury, OR 1 stable, acute illness, OR 1 acute uncomplicated illness or injury requiring hospitalization	YES
Must meet 1 of 2 categories	**Cat 1:** (Any 2): review of prior external notes from each source, review of the results of each test, ordering of each test **Cat 2:** Assessment requiring an independent historian(s)	YES
Risk of Complications	Low risk of morbidity from addition diagnostic testing or treatment	YES

If this had been coded 99349 based only on time: this chart would be a MODERATE RISK for audit.

MODERATE	Includes: 99305, 99309, 99222, 99232, 99344, 99349, 99204, 99214	Documented
# problems at visit	One or more chronic illnesses with exacerbation, progression, or side effects of treatment, OR 2 or more stable, chronic illnesses, OR 1 undiagnosed new problem with uncertain prognosis OR 1 acute illness with systemic symptoms, OR 1 acute, complicated injury	NO

Must meet 1 of 3 categories	**Cat 1:** (Any 3): review of prior external notes from each source, review of the results of each test, ordering of each test, assessment requiring independent historian. **Cat 2:** Independent interpretation of tests performed by another qualified healthcare professional **Cat 3:** Discussion of management or test interpretation with external qualified health care professional	NO
Risk of Complications	Moderate risk of morbidity from addition diagnostic testing or treatment example: prescription drug management, diagnosis or treatment significantly limited by social determinants of health	NO

A Medicare audit could result in down coding the visit and resulting in less than expected reimbursement had the visit been coded by time.

Case Study #2

Past Medical History

Medical history: traumatic brain injury, cognitive deficit, dementia, depressive disorder, past subdural hemorrhage, hypertension, anemia, anxiety disorder, urinary retention, hypothyroidism,
Surgical history: G-tube placement, craniotomy for subdural hematoma, bowel resection, colonoscopy,
Social History: Has two other siblings. One sister is deceased from cancer.
Family: Diabetes - mother and brother, Lung CA, Secondary Mets to the brain - father.

Narrative Notes

Patient, 50-year-old female is seen with caregivers at Facility for palliative care follow up on bloating, behavioral problems with tube feeding and frequent urinary infections. Patient has multiple health conditions, and she requires 24-hour care. Today Patient is smiling and cooperative. Staff are constantly challenged with providing personal space and providing necessary hygiene and tube feeding care. She was last seen by palliative care one month ago. Patient continues on a high-volume tube feeding due to problems with Hypernatremia, frequent UTIs and constipation. She also is on a strict bowel regime that staff report compliance. Staff report that without this strict routine Patient becomes severely constipated. At present she has loose high-volume stools daily. No problems with her suprapubic catheter reported. The patient is reportedly sleeping well and enjoys quiet time in her bed. Diabetes is controlled with X units Lantus insulin daily. Readings are between 80-150 each morning. Staff report difficulty with checking her blood glucose each day due to increased agitation and hitting.

Review of Systems:

General: smiling, interactive today, nods agreement to all questions.
HEENT: tongue pink, dry.
Cardiovascular: Staff deny any syncope, periods of unresponsiveness.
Respiratory: Staff deny shortness of breath, cough, or fevers.
Gastrointestinal: Staff report episodes of loose explosive stool initiated by a 3-x week suppository.
Genitourinary: Supra-pubic catheter, clear, yellow urine.
Musculoskeletal: Constant movement. Hoyer lift, non-weight bearing. Broad chair
Skin: Staff deny rashes or ulcerations.
Vital signs: Not obtained due to pushing and increased agitation. Difficult physical assessment due to agitation.
General: Alert and interactive, pleasant.

Physical Exam:

HEENT: Normocephalic, mouth dry, nasal mucosa is pink and moist. External ear canals are clear and clean.
Cardiovascular: Regular rate and rhythm, no murmur, gallop, or rub.
Respiratory: Diminished but clear lung sounds posteriorly in all lung fields. No wheeze, or rales.
Gastrointestinal: Soft, active bowel sounds. G-tube intact without redness.
Genitourinary: suprapubic catheter with scarring around insertion. Urine is clear and yellow.
Musculoskeletal: Moving frequently. Staff report he is very strong when agitated taking 2-3 staff for some cares.
Psychiatric: liable mood with periods of agitation, worse at night. Extensive psychiatric history with multiple drug therapies.

Impression

Patient continues to be happy in her facility environment. She is maintaining weight with a stable blood glucose level. Patient continues with high volume tube feeding per her PCP request. She has no acute infections or medical concerns at this time. Staff report she is observed to be happy and content when up in her chair or lying in her bed.

Encounter for Palliative care

- Guardian in place
- DNR status
- No change in medical needs since last visit. The patient appears happy and comfortable with her current care setting and treatments.

Agitation

- multi factorial history with cognitive deficits. Hx subdural hematoma and dementia.
- full care requiring two staff as pt pushes, hits and resists care. Staff have worked with the patient for a long time and have set routines for him.
- Limited language to occasional words. Had limited speech as a child. Staff report occasional words.
- Managed by Dr, on multiple therapies at maximum dosing.
- Recommend consistent care as provided by staff.

Gastronomy tube feeding

- tube in place 18 French 5 cc tube.
- Increased agitation observed when staff need to administer free water as they are in her personal space.

Suprapubic catheter

- managed by home health, changed monthly
- Patent and draining well.
- Long history of pulling out her catheter if she gets her hands on the tubing.
- Home health recommended keeping her hands busy with objects to hold. Staff currently keep catheter covered, under clothes or with a blanket covering her abdomen.

Diabetes

- Currently on X units Lantus daily
- Blood glucose levels well controlled between 80-150.

Constipation

- Bowel regimen in place
- Continue current routine as ordered.

I spent 30 minutes face to face with the patient, her brother, and staff at the Facility. I spent another 15 minutes reviewing her chart and medications. Next visit in one-two months. 40 minutes

Submitted for billing: E/M code 99349; CPT codes Z51.5, J96.11, J44.1, E11.42

MODERATE	Includes: 99305, 99309, 99222, 99232, 99344, 99349, 99204, 99214	Documented
# problems at visit	One or more chronic illnesses with exacerbation, progression, or side effects of treatment, OR 2 or more stable, chronic illnesses, OR 1 undiagnosed new problem with uncertain prognosis, OR 1 acute illness with systemic symptoms, OR 1 acute, complicated injury	YES
Must meet 1 of 3 categories	**Cat 1:** (Any 3): review of prior external notes from each source, review of the results of each test, ordering of each test, assessment requiring independent historian. **Cat 2:** Independent interpretation of tests performed by another qualified healthcare professional **Cat 3:** Discussion of management or test interpretation with external qualified health care professional	YES
Risk of Complications	Moderate risk of morbidity from addition diagnostic testing or treatment **example:** prescription drug management, diagnosis or treatment significantly limited by social determinants of health	YES

Moderate, established patient coding is supported.

Problem: Used Z51.5 Encounter for Palliative Care as primary – this may cause denial. Recommendation is to use Z51.5 as a secondary, not a primary.

Case Study #3

Vital Signs

Temperature: 97.3 Fahrenheit Temporal
Pulse: 69 beats/min, Regular Strong at Rest Apical
Respirations: 20 breaths/min, Regular, Easy at Rest
Blood Pressure: 118/78 mmHg, Left Arm Sitting at Rest
Oxygen Saturation: 92 percent at rest Room air

Location: Home
Reason for Consultation: Coordination of Care

Patient is a 76-year-old male seen at Home for continuation of Palliative Care services. He is seen today for follow up for multiple chronic health conditions. He currently has 2 x 24-hour caregivers. The patient was seen in bed and the exam was challenging due to his size. The patient has had multiple emergency room and hospitalizations over the past few months for atrial fibrillation, CHF exacerbation respiratory failure, a second admission one month later due to a fall.

Chief Complaint/HPI

The patient is bedbound and remains lying on his left side due to pain in the right hip. He sleeps at a 45-degree position in his bed as he cannot breathe if lying flat or rolling over to his back. He is unable to check his weight. His current bed is bowing due to his size. Last recorded weight between 500-530 lbs. Diabetes continues to be poorly controlled. The patient has decided to stop new diabetes injections as he felt nauseous and had trouble eating after each injection. Counseling was provided on taking Zofran for nausea and reducing calories was an option. He has also stopped using his continuous blood glucose monitor as it was beeping high all the time. He reports his

blood glucose level was around 250-400 continuously. He reports frustration and difficulty with counting carbohydrates to calculate his insulin. On review his meals he initially reported an appropriate meal of two eggs, two sausages and one slice bread however by the end of the conservation the meal had grown to epic proportions of multiple eggs and a few sandwiches plus more sausages. He reports he eats snacks continuously throughout the day. He is requesting an antibiotic for increased shortness of breath. He has increased his nebulizer treatments to 3 x day and is using his inhaler. He reports needing oxygen more frequently during the day. He is using a mask at 4 liters and prefers to hold it to his face. Cough is frequent and he reports difficulty expectorating sputum. Sputum has changed from white to brown. No known fevers but does have chills and sweats. He reports chest pain, right side radiating to his shoulder when coughing. Patient request physical therapy as he would like to be able to get up in a chair. He has not walked or sat up for several months. He reports pain with touch and had difficulty bending his knee with passive ROM. His ability to tolerate any activity is extremely poor. He has tried therapy in the past and has quit after a few sessions. He continues to scratch between his skin folds with a wooden scratching tool. Staff are applying nystatin. Patient denies burning with urination this visit.

Past Medical History: COPD, Chronic respiratory failure requiring oxygen, CHF, type 2 diabetes, atrial fibrillation, urinary tract infection, diabetic peripheral neuropathy. BPH, GERD.

Surgical History: none

Social History: Widowed 8 years ago. Has 2 living daughters out of state and a son in state. One son is deceased. Stopped smoking several years ago, 45 years smoking 1.5 ppd. Does not drink alcohol. Lives alone at home with 2 x 24-hour caregivers. Son manages medications.

Family History: unknown.

Review Of Systems:

General: Reports chills and intermittent sweats. Constant fatigue
HEENT: Hearing intact, oral inspection reveals loose and missing teeth. Denies problems swallowing, No nasal congestion.
Cardiovascular: Denies chest pain or palpitations.
Respiratory: Increased thick sputum with difficulty coughing it up. Sputum is brown. SOB at rest.
Gastrointestinal: Denies constipation, diarrhea, abdominal pain, or tenderness.
Genitourinary: Reports frequency and urgency, currently using a urinal.
Musculoskeletal: Bilateral hip pain, knee pain. Generalized weakness. Unable to move himself in bed.
Skin: Denies any open areas. Reports itching between folds.
Psychiatric: Reports frustration with health care system. Denies anxiety or worsening symptoms of depression. Denies thoughts of hurting himself and does not have any plans.

Physical Exam:

General: Alert, oriented and pleasant. Able to answer all questions. Morbid obesity. Unkempt appearance.
HEENT: Missing teeth. No dentures.
Cardiovascular: difficult to hear with regular stethoscope due to morbid obesity. Faint but regular heart sounds. No lower leg edema.
Respiratory: Diminished in all lung fields posteriorly.
Gastrointestinal: Obtunded abdomen with a large pannus. Distant bowel sounds.
Genitourinary: Frequently uses urinal. Urine is clear and yellow without sediment odor. No redness or irritation around scrotum.
Musculoskeletal: Upper body strength 4/5, limited ROM bilateral shoulders due to morbid obesity. Unable to roll in bed. Remains on left side. Unable to move legs in any direction.
Skin: Dry crackled and flakey skin on legs, arms and back. No redness in skin folds however uses nystatin powder regularly.
Psychiatric: Reports feelings of frustration at his situation, lack of ability to get him a new bed and loss of physical function.

Narrative Notes

His diabetes is poorly controlled due to stopping injections and he is no longer monitoring his blood glucose. He reports chills without fever, increased SOB and a change in sputum suggesting COPD exacerbation. Patient remains bedbound, unable to turn himself in bed and is dependent on two caregivers for all care. He is high risk for sudden death but would like to remain a full code.

Encounter for Palliative Care

- Declined hospice services.
- He is alert and oriented x 4 and capable of making his own decisions.
- Does not have a health care power of attorney documented.
- Patient is declining aggressive care such as inpatient rehabilitation, sleep study and psychotherapy.
- the plan is to identify and manage distressing symptoms while promoting healthily choices. At this stage he has many serious health conditions that are not well controlled due to his choice to decline treatments.

COPD

- Reports increased thick sputum and change in color to brown. Has difficulty expectorating sputum.
- reports chills without fever.
- using Oxygen 4 liters via face mask throughout the day and night
- is using albuterol-ipratropium nebulizer 3 x day.
- using Flonase
- Continue albuterol inhaler every 4 hours as needed.
- Start cough medicine extended release every 12 hours for cough
- Start antibiotic twice a day for 5 days.
- Start probiotic daily at noon for 10 days.
- Will not treat with prednisone or systemic steroids due to uncontrolled blood glucose levels.

Diabetes

- poor control of diabetes, reports blood glucose levels greater than 300 at all times. Reports some numbers as high as 500.
- Stopped injections which is likely attributing to the increase in blood glucose.
- taking mealtime insulin sliding-scale
- Stopped monitoring glucose levels
- Recalculate night insulin doses
- He was instructed to locate his continuous blood glucose monitor and change the frequency of the alarm.
- Recommend HbA1C if not obtained in past 3 months.

Chronic pain and immobility

- Continues on Norco 1 tablets every 6 hours as needed for pain. This is managed by his PCP.
- He requests Physical therapy however I would like to see him independently start exercises in bed with his caregivers such as lifting his legs, ankle pumps, upper body exercise and independent turning. Before he can sit up or stand, he needs to be able to move himself around his bed.
- Recommend TSH if not complete in the past year.

Morbid obesity

- Current bed is not holding his weight and is bending.
- coordinators are trying to get a new bed however supply chain problems are delaying progress.
- Plan is to reach out to Coordinating team for an update.
- Plan is discuss calories and intake with patient at the next visit.
- Plan to have Patient and his caregivers complete a food diary at next visit.

Skin abrasions

- Frequent urination
- no burning, urgency. Frequency is baseline.

Plan is to reach out to PCP for recent lab work. If not obtained recently then recommend screening labs of CBC, CMP, TSH, HBA1C.

I spent 50 minutes face to face with the patient and additional time reviewing notes and coordinating care. 55 min total

Submitted for billing: E/M code 99348; CPT codes Z51.5, J44.1, E11.42, E66.01

This visit was coded as an established patient, low complexity encounter. However, this visit was under-coded; in fact, the documentation supports the moderate code of 99349 (see below). For the CPT codes, Z51.5 was listed as primary and should have been listed as a secondary or lower condition. Symptoms documented are not coded.

MODERATE	Includes: 99305, 99309, 99222, 99232, 99344, 99349, 99204, 99214	Documented
# problems at visit	One or more chronic illnesses with exacerbation, progression, or side effects of treatment, OR 2 or more stable, chronic illnesses, OR 1 undiagnosed new problem with uncertain prognosis, OR 1 acute illness with systemic symptoms, OR 1 acute, complicated injury	YES
Must meet 1 of 3 categories	**Cat 1:** (Any 3): review of prior external notes from each source, review of the results of each test, ordering of each test, assessment requiring independent historian. **Cat 2:** Independent interpretation of tests performed by another qualified healthcare professional **Cat 3:** Discussion of management or test interpretation with external qualified health care professional	YES
Risk of Complications	Moderate risk of morbidity from addition diagnostic testing or treatment **example:** prescription drug management, diagnosis or treatment significantly limited by social determinants of health	YES

Quality Incentive Programs

Quality Payment Program (QPP)

The QPP is CMS' payment program for clinicians and creates policies that continue to drive value and improve health outcomes for patients. The QPP has two tracks in which clinicians may participate: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APM). An individual or group will need to register for QPP at https://qpp.cms.gov/login. CMS also provides a quick start guide on this website.

Merit-Based Incentive Payment System (MIPS)

Under MIPS, CMS evaluates the provider's performance across multiple categories leading to improved quality and value in our healthcare system. These categories include quality/ data reporting, improvement activities/ chosen activities, promoting interoperability and cost based on submitted claims.

Interoperability asses a practice's promotion of patient engagement and electronic exchange of health information using certified electronic health record technology (CEHRT). This includes the use of patient portals, email, text messages, and electronic health records. To find a list of certified EHRs, go to https://chpl.healthit.gov/#/search.

A provider or group must participate in MI Sunless otherwise exempt if in both 12-month segments of the MIPS Determination Period, the provider will:

- Bill more than $90,000 for Medicare Part B covered professions services, AND
- See more than two hundred Medicare Part B patients, AND
- Provide more than two hundred covered professional services to Medicare Part B patients.

Clinicians may report as either an individual or a group. For group participation, the practice must exceed the low-volume threshold above AND have at least one clinician who is identified as a MIPS eligible clinician type on Medicare Part B claims, enrolled as a Medicare provider before 2023, AND is not a Qualifying Alternative Payment Model Participant.

A practice or clinician will need to select six quality measures from the approved list of measures and collect data for each measure for the 12-month performance period. The provider will also need to select 2 high-weighted or 4 medium-weighted improvement activities. These activities will need to be performed for a continuous 90-day period in the 2023 calendar year or as indicated in the activity's description.

To submit quality data, sign into the QPP website https://qpp.cms.gov/login, work with a third party intermediary to submit data on behalf of the practice/clinician, or via Medicare Part B claims throughout the performance year (small practices only). To submit the improvement activities, sign into the QPP website https://qpp.cms.gov/login, or work with a third-party intermediary to submit the data. To submit the interoperability information, use the QPP website https://qpp.cms.gov/login and attest to the data required or work with a third-party intermediary.

Following submission of the data, maintain the documentation validating measures and activities. Review performance feedback in summer 2024 on the QPP website, and in late 2024, review public reporting data.

2023 data will impact 2025 payments. In 2025, review claims to determine accurate payment adjustments are made for non-compliance of the 2023 performance measures.[23]

23 Merit-based Incentive Payment System (MIPS): 2023 MIPS Quick Start Guide. https://qpp.cms.gov/

MIPS APM

MIPS APM participants may report the APM Performance Pathway (APP). Per CMS, the APP is a MIPS reporting and scoring pathway for MIPS eligible clinicians who are also participants in MIPS APMs. The APP is designed to reduce reporting burden, create new scoring opportunities for participants, and encourage participation in APMs. Performance is measured across three areas – quality, improvement activities, and promoting interoperability.[24]

A practice/clinician will collect data for a set of three pre-determined quality measures for the 12-month performance period and register for the CAHPS for MIPS survey measure. Shared Savings Program ACOs can also report the 10 CMS Web Interface measures.

MIPS Value Pathways (MVP)

The MIPS Value Pathway offers a more connected assessment of quality care. Each pathway is developed with a given specialty or medical condition in mind. The measures and activities are a more streamlined, reduced set than the traditional MIPS. With streamlined measures, comparisons will be between clinicians who choose to report the same MVP, offering more relevant comparisons.

While MVP is not currently mandatory, the goal is to sunset traditional MIPS through rulemaking in future years. For 2023, there is a choice to report an MVP in addition to traditional MIPS or APP.

A practice/clinician will need to select four measures with the MVP and collect data for each measure for the 12-month period. One high-weighted or two medium-weighted activities will also need to be selected and performed for a continuous 90-day period in the 2023 calendar year.

24 MIPS Alternative Payment Models. https://qpp.cms.gov/apms/mips-apms

Palliative Care Quality Collaborative

The Palliative Care Quality Collaborative (PCQC) is a non-profit membership organization that supports the only national unified specialty palliative care quality data registry and collaborative. The goal of PCQC is to improve the quality of care delivered to people with serious illness and the people that support them.[25]

According to the website, there are three levels of membership: Basic (Annual Program Profile) and Advanced (Annual Program Survey and Reports) which are both free. While the third level is Premium (Clinical Data Capture and Reports) that has a cost determined after a conversation with PCQC.

While membership will not impact reimbursements and quality payments, it may offer opportunities for marketing, improved quality, and research.

25 About. Palliative Care Quality Collaborative. https://palliativequality.org/about

Glossary of Terms

Clinic/Group Practice: A clinic / group practice is established when individuals are employed/contracted and reassign Medicare benefits allowing the clinic / group practice to submit claims and receive payment for their Medicare Part B services. Clinic / group practices can have more than one owner.

Clinical Staff: A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service. Other policies may also affect who may report specified services. - CPT Coding Guidelines, Instructions for Use of the CPT Codebook.

Coinsurance: The percentage of costs of a covered health care service a patient will pay (20%, for example) after the deductible is met.

Copay: A fixed amount ($20, for example) a patient pays for a covered health care service after the deductible is met.

Facility: For coding purposes: Skilled Nursing Facility, Long-term Care Facility, Psychiatric Residential, Intermediate Care Facility for Individuals with Intellectual Disabilities.

Home: A patient's place of residence. For coding purposes: home includes a private residence (House, Apartment, Independent living), Assisted Living Facility, Group Home, Custodial Care residence.

Hospice: Specialized care focused on comfort (as opposed to curative care) for people and their families with a life-limiting illness and have a prognosis of six months or less, based on their physician's estimate if the disease runs its course as expected.

Independent Historian: An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent Interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Insurance Credentialling: Refers to the process of applying to health insurance networks for inclusion in their provider panels. For Commercial Insurance networks, this process involves two steps, 1) Credentialing and 2) Contracting.

Licensed Clinical Social Worker: Clinical social work is a specialty practice area of social work which focuses on the assessment, diagnosis, treatment, and prevention of mental illness, emotional, and other behavioral disturbances. Individual, group, and family therapy are common treatment modalities. Social workers who provide these services are required to be licensed or certified at the clinical level in their state of practice.

Medicare Advantage Plans: a type of Medicare health plan offered by a private company that contracts with Medicare. These plans include Part A, Part B, and usually Part D. Plans may offer some extra benefits that Original Medicare does not cover.

Palliative Care: Care that provides relief from the symptoms and physical and mental stress of a serious or life-limiting illness. Palliative care can be pursued at diagnosis, during curative treatment and follow-up.

Patient Financial Responsibility: Any monies owed by the patient based on the type of insurance(s) they have and/or self-pay if they have no insurance. Typically, copays, co-insurance, and deductibles. Medicare Part B and third-party payers require providers to collect these monies as part of the contract to bill their beneficiaries.

Qualified Health Care Professional: A 'physician or other qualified health care professional' is an individual who by education, training, licensure/regulation, and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports a professional service. These professionals are distinct from 'clinical staff.' - CPT Coding Guidelines, Instructions for Use of the CPT Codebook.

Third-Party Payer: Commercial or private insurers. Employers, unions, and individuals can use these insurance plans. Typically, these beneficiaries are under 65 years of age, work, are covered under family benefits, etc.

Educational Tools for Providers, Caregivers and Patients

- **Advice for Physician Caring for Dying Patients. NHPCO.** https://www.nhpco.org/wp-content/uploads/2019/04/Advice_for_Physicians.pdf
- **Palliative Care: What You Should Know. Handout for Patients and Families. Get Palliative Care.** www.Getpalliativecare.org/handouts-for-patients-and-families.
- **Palliative Care. U.S. Department of Veterans Affairs.** https://www.va.gov/GERIATRICS/docs/Palliative_Care.pdf
- **Palliative Care Office Hours. NHPCO.** https://www.nhpco.org/palliative-care-overview/palliative-care-office-hours/
- **Talking with Others About Their End-of-Life Wishes. CaringInfo. NHPCO.** https://www.caringinfo.org/planning/communicating/talking-with-others-about-their-wishes/
- **Use the Teach-Back Method: Tool #5. Health Literacy Universal Precautions Toolkit, 2nd Edition. Agency for Healthcare Research and Quality.** https://www.ahrq.gov/health-literacy/improve/precautions/tool5.html
- **What is Palliative Care? Information and Resources for Healthcare Professionals. UCLA Health.** https://www.uclahealth.org/sites/default/files/documents/What-is-Palliative-Care.pdf?f=5db024bf

Tools for Palliative Care Programs

- **Clinical Practice Guidelines to Quality Palliative Care, 4th Edition, 2018.** https://www.nationalcoalitionhpc.org/ncp/
- **Competency Tool.** https://aahpm.org/uploads/ICS_A_-_The_SECURE_Framework.doc
- **Hospice and Palliative Medicine Entrustable Professional Activities. American Academy of Hospice and Palliative Medicine.** https://aahpm.org/uploads/HPM_EPAs_Final_120319.pdf
- **Quality Guidelines, Standards, and Measures.** https://aahpm.org/quality/quality-guidelines
- **Should Our Hospice Provide Palliative Care? Conducting an Organizational Assessment. NHPCO.** https://www.nhpco.org/wp-content/uploads/2019/04/PALLIATIVECARE_ShouldHospiceHavePalliativeCare.pdf
- **The Conversation Project** https://theconversationproject.org/get-started

References

- **Advance Care Planning. AAFP/Family Physician. 2023.** https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/advance-care-planning.html
- **Advance Care Planning. Feb. 2023. MLN Fact Sheet.** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf
- **Billing and Coding: Advance Care Planning.** www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=58664
- **Chronic Care Management Services. MLN Booklet.** https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf
- **Chronic Care Management Services: Principal Care Management. MLN Booklet.** https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf
- **CPT® Evaluation and Management (E/M) Code and Guideline Changes.p3. American Medical Association. 2022.**
- **CMS clarifies advance care planning coding and billing requirements. 2023 AAFP Publications.** https://www.aafp.org/pubs/fpm/blogs/gettingpaid/entry/cms-acp-revisions.html
- **Corporate Practice of Medicine, Kaiser III, Charles F. and Friedlander, Marvin. p.1.** www.irs.gove/pub/irs-tege/eotopcf00.pdf
- **Issue brief: Corporate practice of medicine. AMA Advocacy Resource Center.** https://www.ama-assn.org/media/7661/download
- **Medicare Enrollment Application: Clinics/Group Practices and Other Suppliers. CMS-855B.** http://www.cms.gov/MedicareProviderSupEnroll.
- **Merit-based Incentive Payment System (MIPS): 2023 MIPS Quick Start Guide.** https://qpp.cms.gov/
- **MIPS Alternative Payment Models.** https://qpp.cms.gov/apms/mips-apms
- **Prolonged Service Codes: Procedure Codes. Noridian Healthcare Solutions. Jurisdiction E – Medicare Part B.** https://med.noridianmedicare.com/web/jeb/specialties/em/prolonged-service-code
- **Transitional Care Management Services. MLN Booklet 908628**. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf

Website References

- https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
- www.Caqh.org/solutions/credentialing-suite
- https://www.cgsmedicare.com/partb/mr/pdf/99350.pdf
- www.palliativequality.org
- https://store.lexisnexis.com/products/ahla-corporate-practice-of-medicine-a-fifty-state-survey-ahla-members-skuusSku20740358?gclid=EAIaIQobChMI7Pyk0LSx_wIV_BetBh0n2gbYEAAYASAAEgIA7vD_BwE

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