

**American Academy of  
Hospice and Palliative Medicine**

**Hospice Medical Director Billing Guide**

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Bruce H. Chamberlain, MD FACP FAAHPM  
Director  
Palliative Consulting  
Orem, UT

**Update based on the 2006 current procedure terminology (CPT) billing codes**

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*Disclaimer*

*Medicare Fiscal Intermediaries differ in their interpretation and application of billing rules and regulations. This book is provided as a guideline but not a payment guarantee. You are advised to check with the payer in your area for specific billing questions.*

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# Chapter 1

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## Reimbursement for Physician Services

*As a hospice medical director, you provide three types of services: administrative, technical, and professional. These services are reimbursed in different ways.*

Throughout this manual I will refer to “hospice medical directors.” I am using this term in the generic sense of a physician who is employed or contracted to provide core physician services for a hospice. The actual title used varies from agency to agency, e.g., “team physician,” “hospice doctors,” and “medical directors” will all be considered as a medical director for purposes of this guide. The billing issues are the same, so I will not differentiate between the site or branch medical director and associate or team physician, even though an agency may have both.

The Medicare Hospice Benefit (MHB) pays certified hospice agencies on a per diem basis for almost all the services that the hospital provides its patients. This includes medications, supplies, durable medical equipment, and professional services from all team members except the medical director. The per diem rate does cover the medical director’s administrative duties, including team and other administrative (ethics, continuous quality improvement [CQI]/quality assurance [QA], etc.) meetings, eligibility assessments, and marketing activities. Medicare reimburses separately for patient visits that are made for reasons other than simple eligibility assessment.

There will be circumstances where the primary payor for a hospice patient is not Medicare (Medicaid, insurance, private pay, VA benefit, etc.) This manual is directed towards billing for patients who are receiving their Medicare hospice benefit. Other payors may be similar, but there may also be specific billing issues which are significantly different and which I will not attempt to cover in this manual.

### Administrative Services

Your administrative activities consist of everything that you do for your agency that does not involve direct patient contact, plus any patient visits that are made solely for the purpose of eligibility assessment. As a hospice medical director you are expected to participate in interdisciplinary group (IDG) meetings, CQI meetings, various educational and marketing meetings, ethics committee meetings, as well as certifying terminal illness and providing clinical support for the staff. Your contracted pay (hourly or salary) covers all of these activities. Your hospice does not bill Medicare or receive any additional reimbursement for providing these services. The hospice per diem is intended to include these expenses.

### Technical Services

These services generally do not involve direct physician-patient contact, and do not require your professional expertise as a physician. Examples would be radiology and laboratory services provided in a physician’s office. Technical services are not included in your administrative reimbursement and are billable to your hospice agency. However, they are included in the hospice per diem and the hospice cannot bill Medicare separately for them. For this reason, you should obtain prior approval from your agency administrator before ordering or billing for these services.

## Professional Services

These are the services you perform directly on the patient. With the single exception of visits made strictly for eligibility assessment, which, as previously indicated, are covered in your administrative pay, these visits are billed and reimbursed based on the appropriate Current Procedure Terminology (CPT) codes for the visit. As a medical director you will submit your billing for these visits to your agency and your agency will then directly bill Medicare A for the visits. Medicare A reimburses at 100% of the allowable rate and your agency then reimburses you at your contracted reimbursement rate.

### **If Medicare A reimburses at 100%, why don't I get paid 100%?**

Medical director compensation packages are structured in different ways. The three most common options are:

- *Higher salary with little or no compensation for patient visits.* The visits are billed to Medicare but the agency keeps the proceeds to offset part of the medical director's salary. This type of compensation usually includes a requirement for a minimum number of visits.
- *Lower salary and the medical director is reimbursed a high percentage of visit reimbursement (80% to 90% is common).* This type of package can be attractive in that it results in lower overhead while giving the medical director incentive to visit more patients.
- *A compromise package between salary and percentage of reimbursement.* This may be the best option if the medical director has significant administrative responsibilities that prevent him or her from doing enough visits to make the other two options viable.

To put the reimbursement percentage in perspective, most medical directors are involved or have been involved in a clinic setting. In a clinic, Medicare B is billed and reimburses 80% of the allowable billing; the patient is then expected to provide 20% as the co-pay. Thus the clinic, in the end, collects a 100% reimbursement for your services. However, the average clinic operates at a 40% (or higher) overhead, which means that you are actually taking home only 60% (or less) of the actual reimbursement for the visit. Your hospice agency also has overhead associated with billing and other medical director services, so some percentage of withholding is reasonable to cover their billing expenses. Even with this withholding, your per-visit compensation is much higher when you make a hospice home visit than when you see a patient in your clinic.

## Chapter 2

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# Billing Implications of Physician-Patient-Hospice Relationships

*Your status as a medical director, attending, or consultant in relation to the patient affects the way you bill for services.*

There are several types of physician-hospice-patient relationships; each has a different billing implication. If you have a relationship with a hospice agency as a medical director, whether paid or volunteer, Medicare regards you as a “hospice medical director.”

### Medical Director and Attending Physician

“Attending of record” is a very important concept in billing for hospice patients. For Medicare purposes, the hospice identifies this as the physician who is primarily responsible for managing the patient’s terminal illness. This person is the “hospice attending of record.” The attending of record may not—and sometimes should not—be the patient’s primary care physician. For example, if a patient is on service for cancer with an oncologist who is still actively following her for the cancer, the oncologist should be listed as the hospice attending of record. If a specialist is not involved, then the primary care physician should be listed. In the common situation, in which patient does not have a physician or the patient’s physician asks you to assume care, you as the medical director may be listed as the hospice attending of record.

As a hospice medical director who is also the patient’s attending physician of record, any care you provide that is related to your role as a hospital medical director must be billed through the hospice. Care for unrelated conditions is billed as though your patient were not receiving hospice services, except that you use the coding modifier **GW**. This indicates that the condition being billed for is not related to the hospice condition.

### Examples

1. Your patient, who is receiving hospice services for lung cancer, presents to your clinic for follow-up on long-standing diabetes, which is unrelated to the cancer. You bill Medicare B for your services and indicate that this condition is not related to the hospice diagnosis by using the **GW** modifier in box 24b of the billing form.
2. Your patient with lung cancer comes into your clinic for follow-up on the treatment of his pain from the cancer. You bill your hospice agency, who will then bill Medicare A and reimburse you per your compensation agreement.
3. You see a patient during a routine nursing facility visit. The primary purpose of the visit is to fulfill the nursing facility administrative requirements for number of visits. You may address topics related to the terminal illness, but the visit was not requested or approved by the hospice IDG. Bill this visit as you normally would, through Medicare B, but do not list the hospice diagnosis. Instead, use an ICD-9 code for the symptoms related to the diagnosis (or for another unrelated diagnosis), and use the coding modifier **GW**.

## Medical Director and Consulting Physician

When you are not the attending of record and are asked to see a hospice patient to render an opinion or provide recommendations to the attending physician on the management of a medical problem, you will bill the visit and use the consultation codes. There should be a written or verbal request for the consult by the attending physician, or other appropriate source, documented in the patient's medical record.

Reimbursement also requires that you submit a copy of your opinion and any services ordered to the requesting physician or other appropriate source. It is acceptable for you to order tests and to initiate treatment as long as it is clear that the intent is for the attending physician to provide ongoing management of the problem. Follow-up consultation codes have been discontinued as of 2006, so any follow-up visits should be billed using the site-appropriate, established patient codes.

If the request is for you to assess and manage the problem, then the patient has been "referred" to you for management, and you become an attending/managing physician, rather than a consultant, and should bill with the appropriate attending/managing physician visit codes.

All visits made as a consulting medical director are billed to Medicare A through your hospice agency.

### Examples

1. The attending physician has requested that you manage the patient's pain. Your initial and any subsequent patient visits for this problem will be billed using the appropriate attending/managing physician CPT code.
2. The IDG team is not sure whether a patient is eligible for care; you make a visit to assess eligibility. You do not make any other type of assessment or recommendations. This is not a billable visit; eligibility assessments are covered under your administrative pay.
3. The attending physician has made a request to remain involved in the patient's clinical management but has not had much experience with aggressive pain management. She asks you to assess the patient's pain and to make recommendations for a treatment plan, but she would like to make the final decision about implementing the plan. You need to document this consult request in the patient's chart, assess the patient, and provide a written summary of your findings and recommendations to the attending physician. You will bill for this visit using the appropriate consultation CPT code.

## Nonmedical Director and Attending Physician

This applies if you are the hospice attending physician for a patient who is receiving hospice services and you have no financial or other (volunteer) relationship with the hospice as a medical director.

Specifically, your patient is on service with a hospice other than the one for which you work. All professional services performed by the (nonmedical director) hospice attending of record are billed as though the patient were not receiving hospice services, with two exceptions. First, when billing for care related to the hospice diagnosis, you must indicate that you are not employed by the hospice by using the coding modifier **GV**. Second, any technical services (procedures, labs, radiology) related to the hospice diagnosis must be pre-approved by the hospice and are billed to the hospice, which reimburses the services from their Medicare per diem payment.

The above statements assume that you are the "hospice attending of record." If you encounter problems with billing, first check with the hospice to verify that you are listed as the attending of record. You may be the patient's primary care physician, but if most of the care related to the terminal illness is coming

from another physician (e.g., an oncologist), then that physician may be listed as the attending of record. Occasionally, errors are made and a covering physician, emergency room doctor, or hospital is named in the Medicare records as the hospice attending of record.

If you are the primary care physician and you find that a specialist has been named as the attending of record, you should still be able to bill Medicare as usual for visits and care unrelated to the terminal illness. However, for any care related to the terminal condition, you will need a contract with the hospice and must bill through the hospice using attending/managing CPT codes. In this circumstance, you are considered a “consultant” from the perspective of the hospice and Medicare billing purposes—but don’t confuse this with using the consult CPT codes. See the next section (on nonmedical director and nonattending physician) for more details.

## Care Plan Oversight

As a nonmedical director, attending physician, you may bill for care plan oversight (CPO) for interactions with the hospice in managing the patient’s care plan. There are several requirements that must be met:

- You must *not* be a medical director for the hospice that is providing the care
- You must document in the patient’s chart that you spent 30 minutes or more in a calendar month in CPO
- You must have had face-to-face contact with the patient in the last 6 months

Activities that are acceptable as CPO include:

- Activities directly related to the coordination of a patient’s care
- Review of charts, reports, treatment plans, or lab or diagnostic study results
- Telephone or face-to-face discussions with a pharmacist
- Medical decision-making
- Documentation of the service provided in the patient’s chart
- Communication with healthcare professionals involved with the patient’s care—including hospice staff (face-to-face or telephone)
- Adjustment of medical therapies

When any of these activities occur as a follow-up to a clinic or home visit, they are not billable as CPO. For example, reviewing the labs ordered during a clinic or home visit does not count toward CPO; this time is counted in your reimbursement for the visit.

If these requirements are met, you can bill Medicare B for CPO. There are several codes based on the patient location, time involved, and whether a hospice or home healthcare agency is involved in the patient care. However, not all of these codes are actually reimbursed.

**99339:** 15–29 minutes of CPO provided to a patient who is *not* receiving home health, hospice, or nursing facility care. The patient may be at home or in an assisted living or domiciliary care environment (not reimbursed).

**99340:** 30 minutes or more of CPO provided to a patient who is *not* receiving home health, hospice, or nursing facility care (not reimbursed).

**99374:** 15–29 minutes of CPO provided to a patient who is receiving healthcare services in a home or domiciliary care environment or in an assisted living or other facility that does not provide a medical component with its services (not reimbursed).

**99375:** 30 minutes or more of CPO of home healthcare for a patient can be documented. G0181 is the actual Medicare HCPCS billing code.

**99377:** 15–29 minutes of CPO is provided to a patient who is receiving hospice services (not reimbursed).

**99378:** 30 minutes or more of CPO for a hospice patient can be documented. G0182 is the actual billing code for Medicare

**99379:** 15–29 minutes of CPO can be documented for a patient resident in a skilled nursing facility (not reimbursed).

**99380:** 30 minutes or more of CPO can be documented for a skilled nursing facility (SNF) patient (not reimbursed).

## Examples

1. The family of your patient with end-stage chronic obstructive pulmonary disease has enrolled her with another hospice agency. The family brings the patient into your clinic for a follow-up visit because of her progressive dyspnea. You bill Medicare B using the appropriate CPT code for the visit and use the coding modifier **GV**, indicating that you are not the hospice medical director.
2. In Example 1, you decide to get an x-ray for this patient in your clinic to rule out pneumonia as a cause of progressive dyspnea. The test must be preauthorized by the hospice, and the technical fee should be billed to the hospice.
3. In Example 1, during the course of one calendar month, you document 35 minutes of CPO activities, including talking with your patient’s nurse by phone, reviewing the care plan, and reviewing some lab tests the hospice staff drew for you. You can bill Medicare B for CPO using code **G0182**.

## Nonmedical Director and Nonattending Physician

This can occur in two ways. First, you are a partner with the attending of record and see a patient *who is receiving care from a hospice agency other than the one with which you are working*, while covering for the attending. In this situation, bill Medicare B as though you were the attending of record, but use the coding modifier **Q5** to show that you are acting on behalf of the attending. This is called reciprocal billing and is approved as long as the period of care does not exceed 60 days.

The second situation occurs if you are asked to see a hospice patient for symptoms related to the hospice diagnosis, but you are not the attending physician and the patient is not receiving hospice services from your hospice agency. In this situation you are acting as a consultant. A consulting physician must have a contract with the hospice agency to provide services related to the hospice diagnosis. This contract may be as simple as a one-page reimbursement agreement. As a consultant, you can then bill the agency for both professional and technical services. The hospice bills Medicare A for professional services, and you are reimbursed at the contracted rate. Technical services are paid by the hospice (from their per diem reimbursement), but cannot be not separately billed to Medicare by the hospice.

## Examples

1. Your partner goes on vacation. While covering for him you see a hospice patient in your clinic for symptoms that are related to the hospice diagnosis. The patient is receiving services from a hospice agency other than the one with which you have a relationship. You bill Medicare B as usual but need to indicate on the billing form that you are acting for the attending by using the modifier **Q5** on box 24d. You should also append a second modifier, **QV**, as discussed above to indicate you are not the attending physician with the patient's hospice.
2. In your role as a palliative-care physician, a patient who is receiving hospice services from another hospice agency is referred to you for evaluation of poorly controlled symptoms related to their hospice diagnosis. To bill for this service, you need to have a contract with the hospice agency, and you need to bill the hospice for any professional or technical services provided to the patient.

## Chapter 3

### Specific Billing Issues

*Care in using the correct codes and documentation to support the codes used will reduce your risk of having your billing reviewed or down-coded.*

- Remember that, as with all the members of the IDG, your patient visits need to be approved by the IDG, and that approval should be documented in the patient chart. Physician visits need to be included in the care plan frequencies like all other team member visits. Other than for a patient who is on general inpatient (GIP) status for medical problems, routine rounding on hospice patients, without medical necessity for the visits, should not occur. When billing for approved visits, the time spent with the patient, the location, and the intensity of care being provided to the patient are key factors in determining the appropriate CPT billing codes.

**Table 1. Physician-Patient-Hospice Relations and Associated Billing Practices**

Relation to Hospice	Relation to Patient	Service	Billed To	Codes	Issues
Medical Director	Attending	Professional	Hospice		
		<ul style="list-style-type: none"> <li>Hospice diagnosis.</li> <li>Unrelated diagnoses</li> </ul>	As usual <sup>1</sup>	Modifier GW	From per diem
	CPO	Not billable			
	Consulting	Prof. & Tech	Hospice	Consult	Documentation
	Attending/ Managing	Prof. & Tech	Hospice	Attend./ Manage.	
Non-Medical Director	Attending	Professional	As usual	Modifier GV	
		Technical	Hospice		Pre-approval
		CPO	Medicare B		Criteria
	Non-Attending—Covering	Prof. & Tech.	Medicare B	Modifier Q5	
	Non-Attending—Consult.	Prof. & Tech.	Hospice		Contract

<sup>1</sup> Medicare B, insurance, etc.. as though the patient were not on hospice

#### Time vs. Complexity

One important provision of the evaluation and management (E&M) coding system is the distinction between time and complexity, which is particularly relevant to physicians performing palliative care visits. When more than 50% of the patient-physician interaction is counseling, provision of information, coordination of care, or some combination of these, the time spent with the patient, rather than the problem complexity, becomes the factor used to determine the coded level of service. This option is

available even if the visit lacks the otherwise required history, exam, or decision-making complexity for the given billing code. This is particularly relevant to physicians performing palliative-care visits.

When using time as your guide to billing, note that the definition of “time spent” is based on whether the patient is in an inpatient or outpatient setting. In the hospital, time spent means the total time spent on the hospital unit for the patient and includes chart review, patient history and physical (H&P), communication with other caregivers and family to coordinate care, and writing your note. In a home or other outpatient setting, the time spent is determined only by the face-to-face time spent with the patient and/or caregivers. In either case, any time before or after visits are not part of time billed. This includes travel time, reviewing labs or x-rays off the unit, or communicating with other family members or caregivers prior to or after your patient visit. There is one exception: Coding based on time spent is presently not an option available for visits to patients residing in skilled nursing facilities (SNFs). The SNF billing codes were changed in 2006 and guidelines for time were not provided with the new codes. Prior to 2006, there were no time guidelines provided for assisted living facility (ALF) visits, however, with the 2006 changes, time guidelines have been added.

### ***Choosing the Right Code Based on Time***

When billing based on time, the suggested times provided with the codes in the CPT book should be considered averages rather than thresholds. If your actual time spent does not exactly match one of the suggested times, you should round up or down to the nearest suggested average.

#### **Example**

You see a patient at home and the visit lasts 73 minutes. You are billing as a consultant seeing a new patient and you can document that you spent at least 50% of the time in teaching and counseling with the patient. Your coding choices are **99244** (60 minutes) and **99245** (80 minutes). The correct choice would be to round up to the 80-minute code.

### ***Coding Based on Problem Complexity***

New in 2006, the typical times for nursing facility visits have been removed. Billing for these visits should be based on the E&M guidelines provided with each code. For any of your other patient visits, you have the option to code your visit based on time, if you can document that more than half of the time spent was in teaching or counseling, or using the more common E&M code documentation, based on problem complexity. When billing based on the complexity of E&M services, your documentation must support the level of service billed based on the following components of your visit:

- History (problem focused, expanded problem focused, detailed, or comprehensive)
- Examination (problem focused, expanded problem focused, detailed, or comprehensive)
- Medical decision making (straightforward, low complexity, moderate complexity, or high complexity)
- Counseling, coordination of care, the nature of the presenting problem and time are secondary considerations

Further detail on billing based on E&M services is beyond the scope of this manual. For additional information please refer to *CPT 2006: Current Procedural Terminology* (AMA, 2006). This manual is updated annually, so be sure to check a current edition.

## **Prolonged Service Codes**

### **Face-to-Face Visits**

The prolonged service codes are to be used when the patient encounter lasts *at least* 30 minutes longer than a typical visit. These codes are used in addition to the appropriate E&M code for the provided service. Prolonged service codes can only be used for additional time spent face-to-face with the patient or caregiver, even in an inpatient setting.

Codes **99354** (home/office) and **99356** (inpatient) should be used to document the first hour (30–74 minutes) of prolonged service. Each additional 30 minutes beyond the first hour are billed using codes **99355** (home/office) or **99357** (inpatient). You can use as many of these codes as necessary to cover the time spent.

### **Prolonged Services not Provided Face-to-Face**

These codes have been provided by the AMA but they are not reimbursed by Medicare so should not be billed.

### **Examples**

1. You spend 1 hour and 40 minutes doing a follow-up home visit on a patient for whom you are managing several symptoms. You are billing based on time spent. You bill using **99350** (established home 60 minutes), and because your prolonged service was 30 minutes or more, you add **99354** (prolonged service home/office 30 minutes). You would not add the **99355** (prolonged service home/office additional 30 minutes), because the 40 extra minutes spent are within the 30 to 74 minutes of prolonged service covered by the initial prolonged service code.
2. You admit a patient to GIP care due to a pain crisis. Your initial admission takes 1 hour and 30 minutes of time on the unit (doing orders, talking with the family, and so forth). An hour later, you are called back to the unit because the patient is having a reaction to the medication. You spend 30 minutes of face-to-face time with the patient. That afternoon you return to check on the patient and spend 40 minutes with her reviewing the plan for the hospital stay and symptom management. Your billing for this patient is based on the total time spent during the day, as follows: admission, 90 minutes (assuming you are billing the admission based on time rather than E&M complexity); first follow-up, 30 minutes; second follow-up, 40 minutes. The total time was 160 minutes. The coding is **99223** (initial hospital 70 minutes), plus **99356** (prolonged service 30–74 minutes)—this covers the first 144 minutes—the final 16 minutes can not be billed using **99357** (prolonged service additional 30 minutes) because the initial and the final blocks of time billed for prolonged service must each be at least 30 minutes.
3. You see a new patient in their home and spend 60 minutes with them obtaining their history, performing the examination, and counseling the patient. Over half of the time is spent teaching and counseling. The patient requests that you review your assessment and recommendations with his son, who has come to the home; you do so and the conversation with the son lasts 40 minutes. You will bill for the visit using **99205** (new outpatient for a 60-minute visit) then add **99354** (prolonged service 30-74 minutes) to cover the 40 minutes of time spent with the son. The conversation with the son and its duration need to be documented in your note to support this billing.

## ***Documenting Time Spent***

When billing based on time spent, your documentation should clearly state the total time of the encounter (face-to-face or on unit, as appropriate); the fact that more than 50% of the time was spent in teaching, counseling, or coordinating care; and the nature of the teaching, counseling, or care coordination.

### **Example**

A documentation entry might read as follows: “64 minutes of face-to-face time with the patient, >50% of the time was spent in reviewing the hospice philosophy of care and instructing the patient on proper medication usage.”

## **New vs. Initial Codes**

### **New Patient Visits**

When billing for home or other outpatient visits, a patient is considered to be a “new” patient for billing purposes, if this is the first visit made with (or by) you or any member of your group/practice of the same specialty within the past three years. If the patient does not meet these criteria, then you must bill using established visit codes even if the patient is new to you.

### **Initial Patient Visits**

When billing for inpatient services, an initial patient visit is generally the first or admission visit made to the patient. The patient may be either new or established to use this code. Any physician seeing the patient following the admission will need to use either a consult or a subsequent billing code. They are not doing the “initial H&P” even if the patient is a new patient to them.

## **Visit Location**

### ***Home or Office Visits***

If you are the attending of record and are seeing the patient for the first time, you will use the new office or other outpatient (**99201–99205**) or new home (**99341–99345**) codes. If you are the attending of record seeing the patient for a follow-up visit, you will use attending/managing physician established codes for home (**99347–99350**) or office or other outpatient (**99211–99215**) visits.

**New Home**      99341 (20 minutes)  
                      99342 (30 minutes)  
                      99343 (45 minutes)  
                      99344 (60 minutes)  
                      99345 (75 minutes)

**New Office**     99201 (10 minutes)  
                      99202 (20 minutes)  
                      99203 (30 minutes)  
                      99204 (45 minutes)  
                      99205 (60 minutes)

**Established  
Home**            99347 (15 minutes)  
                      99348 (25 minutes)  
                      99349 (40 minutes)  
                      99350 (60 minutes)

<b>Established</b>	99211 (5 minutes)
<b>Office</b>	99212 (10 minutes)
	99213 (15 minutes)
	99214 (25 minutes)
	99215 (40 minutes)

If you are not the attending of record but have been asked to assume any part of the patient's care, then the initial visit will be billed using the appropriate attending/ managing codes, depending on whether this patient meets the criteria for a "new" or "established" patient with your practice. Any follow-up visits will be billed using the appropriate attending/managing physician codes either for established patient office or other outpatient services (**99211–99215**) or for an established home visit (**99347–99350**).

### ***Hospital Visits***

If you are assuming any part of the care of a patient who has already been admitted to the hospital, then your first hospital visit and any follow-up visits with the patient should be billed using the appropriate attending/ managing physician codes for subsequent hospital visits (**99231–99233**). Remember that the initial codes are only used once during a hospitalization, by the admitting physician. Time with the patient on the hospital floor or unit can be counted when billing based on time.

### ***Nursing Facility Visits***

For billing purposes, a nursing facility is considered any one of the following:

- skilled nursing facilities (SNFs)
- intermediate care facilities (ICFs)
- long-term care facilities (LTCFs).

As of 2006, the comprehensive (**99301–99303**) and subsequent (**99311–99313**) nursing facility codes have been discontinued. The new coding groups are initial, subsequent, and annual. As with previous codes, the initial and subsequent codes can be used for new or established patients. If you are the physician admitting the patient to the nursing facility, you may bill using the initial care codes (99304-99306). If you are not the admitting physician for the nursing facility, then you must bill using subsequent care codes, even if this is your first visit to the patient.

The annual nursing facility assessment now has its own code. One of the coding changes for 2006 was the removal of typical times from the skilled nursing facility codes, even though *CPT 2006* specifically includes nursing facilities in its description of using time as the controlling factor to qualify for a particular E&M code. Therefore, this type of billing has become more challenging. At present, I do not recommend billing based on time for SNF visits.

### **Initial Nursing Facility Care (99304–99306)**

The initial codes used to report visits to a new or established patient in a nursing facility are based on the complexity of the E&M services provided. Only the physician admitting the patient to the nursing facility bills the initial care codes. This parallels the use of initial visit codes in the hospital.

**99304:** Requires documentation of a detailed or comprehensive history and examination and medical decision-making that is straightforward or of low complexity. The problems are usually of low severity.

**99305:** Requires a comprehensive history and examination and medical decision-making of moderate complexity. The problems are usually of moderate severity.

**99306:** Requires a comprehensive history and examination and medical decision-making that is of high complexity. The problems are usually of high severity.

### **Subsequent Nursing Facility Care (99307–99310)**

These codes are used to report visits to new or established patients in a nursing facility and are based on the complexity of the E&M services provided. If you are not the admitting physician and your visit does not meet the requirements for a consultation, then you must use subsequent visit codes, even if this is your first visit to the patient.

**99307:** Requires a problem focused interval history and examination and straightforward medical decision-making. The patient is usually stable, recovering, or improving.

**99308:** Requires two of the following components: expanded, problem focused interval history; expanded problem focused examination; medical decision-making of low complexity.

**99309:** Requires two of the following components: detailed interval history, detailed examination, or medical decision-making of moderate complexity. Usually the patient has developed a significant, new problem or complication.

**99310:** Requires two of the following components: comprehensive interval history, comprehensive examination, or medical decision-making of high complexity. Usually the patient will be unstable or has developed a significant, new complication requiring immediate medical attention.

### **Annual Nursing Facility Assessments (99318)**

This visit requires documentation of three components: detailed interval history, comprehensive examination, and medical decision-making of low to moderate complexity. Usually the patient will be stable, recovering, or improving.

### **Assisted Living Facility Visits**

To qualify as an assisted living facility rather than a nursing home, the services provided by the facility cannot be for medical care or assistance. Most frequently such residences will be called assisted living facilities or domiciliary rest homes, the name and licensure varies from one state to another. *CPT 2006* provides “usual times” as well as codes that allow for medical management services with higher complexities. The new patient (**99321–99323**) and established patient (**99331–99333**) codes have been discontinued.

### **New Assisted Living Facility Visits (99234-99238)**

If you are the hospice attending of record and it is your first visit with the patient, the visit should be billed based on the domiciliary, rest home, or assisted living facility services new patient codes.

- **99324:** Requires a problem-focused history and examination, problem(s) of low severity, and straightforward medical decision-making. Typical time spent with the patient and family/caregiver is 20 minutes.
- **99325:** Requires an expanded problem-focused history and examination, medical decision-making is of low complexity. The problem(s) are of moderate severity. Typical time spent with the patient and family/caregiver is 30 minutes.

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- **99326:** Requires a detailed history and examination, problem(s) of moderate complexity, and medical decision-making of moderate complexity. The problem(s) are of moderate to high severity. Typical time spent with the patient and family/caregiver is 45 minutes.
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- **99327:** Requires a comprehensive history and examination, and medical decision-making of moderate complexity. The problem(s) are of high severity. Typical time spent with the patient and family/caregiver is 60 minutes.
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- **99328:** Requires a comprehensive history and examination, and medical decision-making of high complexity. The patient is usually unstable or has developed a significant new problem(s) requiring immediate medical attention. Typical time spent with the patient and family/caregiver is 75 minutes.

### **Established Assisted Living Facility Visits (99334-99337)**

If you are managing any of the medical issues involved in the patient's care, subsequent visits should be billed using the established patient codes. To bill for the visit, two of the three criteria (history, exam, problem severity) must be documented.

- **99334:** Requires a problem-focused history and examination, and straightforward medical decision-making. Usually the problem(s) are self-limited or minor. Typical time spent with the patient and family/caregiver is 15 minutes.
- 
- **99335:** Requires an expanded problem- focused history and examination, and medical decision-making of low complexity. The problem(s) are of low to moderate severity. The typical time spent with the patient and family/caregiver is 25 minutes.
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- **99336:** Requires a detailed interval history and examination, and medical decision-making of moderate complexity. The problem(s) are of moderate to high severity. The typical time spent with the patient and family/caregiver is 40 minutes.
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- **99337:** Requires a comprehensive history and examination, and medical decision-making of moderate to high complexity. The problem(s) are of moderate to high severity. The typical time with the patient and family/caregiver is 60 minutes.

### **Consultations**

When your expertise and advice are requested for the evaluation or management of a specific problem in a patient for whom you are not the attending, then you are providing a consultation. A written or verbal request for the consultation and the reason for the consultation, from the attending physician or other appropriate source should be documented by both the requesting and consulting physicians in the patient's medical record. A written report of your opinion and any services that were ordered for the patient must be documented in the patient's record and provided to the requesting physician.

As a consultant you may initiate diagnostic or therapeutic services for the patient. However, if you have been asked to assume the management of any or all of the patient's care, then you are functioning as a "managing" physician, not a consultant, and your visits should be billed using the appropriate (new or established) codes for attending/managing physician. The subsequent consultation codes (**99261–99263**) have been discontinued as of 2006. Follow-up visits for the same problems are billed using the appropriate subsequent visit codes for established patients. If additional requests for consultation on the same or other problems are made by the attending physician, and documented in the chart, the consultation codes may be used again, with some restrictions, described below.

### **Inpatient Consultations (99251-99255)**

These codes are used for consultations provided to patient in a hospital, skilled nursing facility, or partial hospital settings. Only one consultation should be billed per admission. If a second consultation is requested during one inpatient stay, only subsequent care codes can be used to bill for the service. When coding based on time, use both the time spent with the patient and the time spent on the facility floor or unit.

- **99251:** Problem-focused history and examination, straightforward medical decision-making. The typical time spent at the bedside and on the floor or unit is 20 minutes.
- **99252:** Expanded problem-focused history and examination, straightforward medical decision-making. The typical time spent at the bedside and on the floor or unit is 40 minutes.
- **99253:** Detailed history and examination. Low complexity decision-making. The typical time spent at the bedside and on the floor or unit is 55 minutes.
- **99254:** Comprehensive history and examination. Moderate complexity decision-making. The typical time spent at the bedside and on the floor or unit is 80 minutes.
- **99255:** Comprehensive history and examination. High complexity decision-making. The typical time spent at the bedside and on the floor or unit is 110 minutes.

### **Outpatient Consultations (99241-99245)**

These codes are used for consultation on a patient seen in the office, home, or other ambulatory facility. This included assisted living and domiciliary care facilities as well as emergency room visits. When coding based on time, only count face-to-face time spend with the patient or family.

- **99241:** Problem-focused history and examination, straightforward medical decision-making. The typical time spent face-to-face with the patient and/or caregiver is 15 minutes.
- **99242:** Expanded, problem-focused history and examination, straightforward medical decision-making. The typical time spent face-to-face with the patient and/or caregiver is 30 minutes.
- **99243:** Detailed history and examination. Low complexity decision-making. The typical time spent face-to-face with the patient and/or caregiver is 40 minutes.
- **99244:** Comprehensive history and examination. Moderate complexity decision-making. The typical time spent face-to-face with the patient and/or caregiver is 60 minutes.
- **99245:** Comprehensive history and examination. High complexity decision-making. The typical time spent face-to-face with the patient and/or caregiver is 80 minutes.

### **Confirmatory Consultations**

When the patient, family, or third-party payer requests a second opinion consultation, it is called a confirmatory consultation. Prior to 2006, these were billed using specific codes. As of 2006, consultations requested by the family should be billed using the new patient or established patient visit codes. If a confirmatory consultation is required by a third party payer, the coding modifier **32** should be used.

## **GIP Visits**

A patient who is experiencing a physical or psychosocial crisis may be placed on a hospice inpatient status for more aggressive management of the problems than would be routinely available. This may occur in a contracted hospital, transition unit, hospice inpatient facility, or a contracted skilled nursing facility that is able to provide 24-hour skilled nursing care with registered nurses.

### **Attending or Consultant?**

If you are not the attending of record but the attending physician will not be making professional visits to the patient during the GIP stay, then you should bill as the attending/managing physician. This situation is analogous to a hospital admitting a patient and billing as the attending for that hospitalization. If the attending will be making and billing for visits, then (as with a hospital patient) you should bill based on the type of care provided. If you are providing advice, bill as a consultant; if you're managing a problem, bill as managing physician. You will need to communicate with the attending physician to make sure that you are not billing the same ICD-9 codes for visits on the same day. As a consultant, you should bill using the codes for the patient's symptoms; the attending should bill using the codes for the patient's actual diagnosis.

### **GIP in a Skilled Nursing Facility**

At present there is no consistent way of billing for a patient in GIP status in a skilled nursing facility; the various fiscal intermediaries have different recommendations. The choices are to bill based on the location of care or on the intensity of care. Palmetto GBS, one fiscal intermediary, has provided guidance to say that the billing should be based on the location of care (i.e., if the patient is in a SNF for GIP, you should bill using SNF codes). Other consultants have recommended billing based on the intensity of care. The rationale for this choice is that the level of care given to a patient on GIP status should be the same no matter what the location of the care, and therefore we bill as if the patient were a hospital inpatient. I recommend you contact your fiscal intermediary for guidance on billing in this situation.

## **Discharge Services**

### **Nursing Facility Discharge Services**

The codes for nursing facility discharge-day management are to be used to cover all physician services provided for a patient on the day of discharge. Such services include final examination of the patient, instructions to patient and staff, completing discharge records, and writing prescriptions as needed. Even if the time spent during the course of the day is not in a single continuous block, only one code may be used for the day. Use code **99315** when you spend 30 minutes or less providing discharge services; use **99316** if you spend more than 30 minutes. Because this is an entirely time-based code, you must document the length of time spent when billing 99316.

### **Hospital Discharge Services**

The codes for hospital discharge-day management are to be used to cover all physician services provided for a patient on the day of discharge. Services include final examination of the patient, instructions to patient and staff, completing discharge records, and writing prescriptions as needed. Even if the time spent during the course of the day is not in a single continuous block, only one code may be used for the day. Use code **99238** if you spend 30 minutes or less providing discharge services; use **99239** if you spend more than 30 minutes. Because this is an entirely time-based code, you must document the length of time spent when billing 99239.

## **The Facility Notation**

On rare occasions, you may perform an outpatient service or procedure in what would otherwise be considered an inpatient setting. Medicare expects that in a facility you will have additional resources available, and reimburses at a lower rate as a result. Any of the following are considered facilities: hospitals, emergency rooms, skilled nursing facilities, and hospice inpatient units. When doing a procedure or outpatient visit in a facility, you must mark the “facility” box on the billing form.

## **Procedures**

Regardless of the location of service, if you perform a procedure on a patient, you should bill using the appropriate procedure code. In certain situations, an E&M visit may be separately billable. Modifier -25 is added to the E&M code to indicate a significant, separately identifiable service. In determining the E&M code, the time spent doing the procedure does not count and is not considered part of the time spent for the E&M service. Medicare presumes that a certain amount of patient evaluation is routinely done as part of the procedure and is included in the reimbursement for the procedure.

### **EXAMPLES**

1. You have been following a patient with hepatoma on your hospice home team. You plan to do a paracentesis at your next visit because of increasing ascites. Unless there is another problem that requires assessment and management, you would bill only for the paracentesis at that visit.
2. You have been following a patient with hepatoma on your hospice team. You schedule a visit to assess the patient’s new complaint of urinary retention. However, on examination, you find that the patient has accumulated a large volume of ascitic fluid and decide that the patient would benefit from a paracentesis. You have a paracentesis tray in the trunk of your car and proceed to do a paracentesis on the same day. You would bill for an E&M subsequent home visit (but not include the time of the paracentesis in determining E&M time), use the -25 modifier, and bill a procedure code for the paracentesis.

### **Procedure Codes Commonly Used**

- Abdominal paracentesis (49080-49081)
- Wound debridement (97602, 97597-97598)
- Thoracentesis (32000-32002)

## Chapter 4

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### Documentation

*Your documentation must not only support the billing codes you have used but must also meet the specific requirements for the type of visit for which you are billing.*

You should already be familiar with the cumbersome and somewhat arcane E&M coding criteria, which give requirements for documenting a visit based on history, examination, and the complexity of the medical decision-making involved. They will not be reviewed in this guide. Documentation of a visit based on time was reviewed in chapter 3. The final area of documentation that needs to be covered is the requirements for billing as a consultant.

#### Consultant Documentation

If your first visit is in the role of a consultant, then your note needs to meet certain criteria established for a consult and should include the following, in addition to the necessary information to support billing by time:

- the name of the referring physician
- the reason for the consultation
- recommendations for the management of the problems for which you were consulted.

## References

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3. Sophocles, A. Time is of the essence: coding on the basis of time for physician services. *Fam Pract Manag*. June 2003;10(6):27–31.
4. von Gunten CF, Ferris FD, Emanuel LL. Coding and reimbursement for physician services in hospice and palliative care. *AAHPM Bull*. 2003 Summer;3(4):1.