



American Academy of Hospice and Palliative Medicine

Quick Reference Guide

For Physician Coding, Billing, and Reimbursement for Hospice and Palliative Medicine Services

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Disclaimer

Coding rules and regulations continue to change and fiscal intermediaries interpret these rules differently. We encourage physicians to refer to the following resources as well as other sources, including the Centers for Medicare & Medicaid Services (CMS) Web site, and collaborate with billing experts. In particular, effective January 1, 2006, significant changes were made to three sets of CPT® codes routinely used in palliative care. Specific references to CPT codes in previously published materials could be outdated.

Navigation Tips

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Introduction

AAHPM believes that physicians practicing hospice and palliative care medicine should obtain fair reimbursement for their services, so these valuable skills will become more available to patients. The goal of this tool is to provide billing and coding resources to physicians who are providing palliative care services to both hospice and non-hospice patients.

This tool uses Medicare regulations to define physician billing, coding, and reimbursement. Medicaid regulations vary from one state to another. Private payers may have different requirements.

Billing for Physician Services in Hospice and Palliative Medicine

As in all areas of medicine, physicians must document the patient care provided and submit billing for that care to the appropriate payer. Palliative medicine physician services, whether for hospice or non-hospice palliative care patients, are reimbursed using the same billing and coding guidelines that apply throughout the health care system.

Two sets of codes are used to describe physician services to payers. **Current Procedural Terminology (CPT) codes** (1) describe the type and extent of service provided, the location of the service, and the relationship of the physician to the patient. The **International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes** (2) define the medical diagnosis for which the physician service was required.

Medicare, Medicaid, and most private payers use these codes for physician reimbursement. Under traditional Medicare (MC), physician services are billed to Medicare Part B (MC-B).

Physicians bill for **non-hospice palliative medical services** directly through their MC-B carrier or other payer, in the usual manner.

For patients receiving the Medicare Hospice Benefit (MHB), many physician services must be billed to the hospice provider. The hospice may then bill their Medicare Part A (MC-A) fiscal intermediary. The hospice is paid 100% of the MC allowable rate for the billable service. This payment is in addition to the hospice per diem reimbursement. The hospice then pays the physician, based on his or her contractual agreement. **Physician direct patient care is the only service that is separately billed and reimbursed under the MHB.**

CPT Codes

Introduction to CPT Coding for Evaluation and Management (E/M) Services

Evaluation and management (E/M) services refer to visits and consultations provided by a physician or non-physician provider (NPP). Most services by a hospice or palliative medicine physician will be in this category. These codes describe the location where the service was provided, the type of service provided, and the level or complexity of the service provided. In most cases, the complexity of care is controlled by the history, examination, and medical decision making. In palliative medicine, the complexity of care often is best described by the time spent in counseling and coordinating the patient and family care.

Selecting the Proper E/M code

In order to select the proper E/M codes, one must look at the following:

- **Where was the service provided?**
 - Office
 - Hospital
 - Nursing facility
 - Rest home or assisted living facility
 - Home
- **What type of service was provided?**
 - New or established patient?
 - Initial or subsequent care in a hospital or nursing facility?
 - Managing or consulting care?
- **What is the key or controlling factor that defines the level of service?**
 - Complexity of the history, examination, and medical decision making?
 - Time spent in counseling and coordinating care?

CPT Codes to Describe the Location of E/M Service

Different sets of CPT codes are used to describe physician services in different locations of care. The following CPT codes describe the locations of service where most palliative medical services are delivered and apply to care of both hospice and non-hospice patients. For CPT billing, the location status of a free-standing hospice inpatient unit is defined differently by the various Medicare A fiscal intermediaries (FI). It is advisable to check with the hospice program's FI to clarify which CPT codes to bill for physician services to patients in a free-standing hospice inpatient unit.

Outpatient/Office (99201-99215)

Inpatient hospital (99221-99236)

Nursing Facility (99304-99318)

Domiciliary/Rest Home or ALF (99307-99337)

Home (99341-99350)

CPT Codes to Describe the Type of E/M Service

Within each location of service, different codes are used to describe the physician services delivered, depending on whether the patient is new or established, whether the facility service is the initial admission or subsequent care, and whether the service was done as a treating or managing physician or as an advising consultant physician.

New vs. Established Patient

A **new** patient is defined as one that has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. All other patients are considered **established** patients in the physician practice.

Initial vs. Subsequent Care

For patients admitted to hospitals or nursing facilities, one asks if this is the **initial** visit for that admission. Only one initial visit may be billed per patient per facility admission. This set of codes is usually used by the admitting physician. Unless the service is a consultation, all other facility visits are considered **subsequent** care.

Managing vs. Consulting Service

Most E/M codes describe the services of a **managing** or treating physician. In certain situations, physician may provide **consulting** services. There are growing restrictions surrounding the use of consulting physician codes for billing, so when in doubt, bill as a managing physician, using the E/M codes appropriate for the type and location of care.

CPT Codes for Physician E/M Services

[Outpatient/Office](#) (99201-99215)

[Inpatient hospital](#) (99221-99236)

[Nursing Facility](#) (99304-99318)

[Domiciliary or Rest Home or ALF](#) (99307-99337)

[Home](#) (99341-99350)

Requirements for [Consulting](#) Physician Services

In December 2005, the Centers for Medicare & Medicaid Services (CMS) issued new and more restrictive guidelines defining physician and non-physician provider (NPP) consultations.

Both physicians and NPPs can perform consultations. Although only the term “physician” is used, the documentation requirements apply to both groups of providers. Requirements for a consultation include the following:

- A consult must be requested by a physician or other appropriate source. **There must be written documentation that identifies the request and reason for the consultation in both the requesting and consulting physicians’ medical records.**

Although the request may be verbal, the discussion, including the request and reason for the consult, must be documented in both the consulting physician's medical record and in the requesting physician's medical record. The request may be documented on a physician order form in a shared medical record.

- **The consult must be documented in writing and communicated to the requesting physician.** This documentation can be included as part of a shared medical record or in a separate letter to the requesting physician or NPP.
- In an inpatient setting (99251-99255), an initial consultation may be reported only once per physician per patient per facility admission.
- In an outpatient setting (99241-99245), another consultation may be requested of the same consultant physician if the consultant has not been providing ongoing management of the patient for this condition after the initial consultation.
- **Following the initial consultation, ongoing management is reported using the subsequent care visit codes.**
- Diagnostic services and treatments can be initiated at the initial consultation service or during follow-up visits.
- **A qualified NPP can request and/or perform a consultation service** within the scope of practice and licensure requirements for the NPP in the state where he/she practices.

CPT Codes for Consultation Services

[Outpatient/Office Consultation](#) (99241-99245)

[Inpatient Consultation](#) (99251-99255)

CPT Codes to Describe the Level of E/M Service

Components of Service

Most physicians' billing is described by the extent of the service provided and the complexity of the medical decision making. Determining the E/M coding level for a specific visit is based on six components: history, physical examination, medical decision making, counseling, coordination of care, nature of the presenting problem, and time spent. The first three are considered "**key**" components to determining the level of coding and are required when billing for a given E/M service. The last four are considered "**contributory**" and their documentation is not required for billing a specific code. Each of the E/M codes has specific guidelines for the level of documentation that must be met or exceeded in order to be reimbursed.

Key or Controlling Elements (required except when counseling/coordination of care are the controlling elements)

- History
- Examination
- Medical decision making

Contributory Factors (optional)

- Counseling
- Coordination of care

- Nature of the presenting problem
- Time

Documenting Based on the Key or Controlling Elements

There are two sets of Medicare guidelines that define the components of documentation needed to qualify for given level of service: 1995 Documentation Guidelines for Evaluation and Management Services (3) and 1997 Documentation Guidelines for Evaluation and Management Services (4). The physician may choose either set. **For most physician services, the 1995 guidelines more accurately apply.** The 1995 Guidelines are used in the following definitions.

The key or controlling elements for choosing a CPT code are history, physical examination, and medical decision making. For new and initial services, the documentation requirements for all three elements must be met. For subsequent or established services, two of three elements must be documented.

History

The levels of E/M services are based on four types of history:

- Problem-focused (P)
- Expanded problem-focused (E)
- Detailed (D)
- Comprehensive (C).

Each type of history includes some or all of the following:

- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family, and/or social history (PFSH).

The extent of history obtained and documented depends on the clinical judgment of the physician and the nature of the presenting problems.

Chief Complaint (CC)

- This is a concise statement describing the reason for the physician visit. Reasons for the encounter might include: a symptom, problem, diagnosis, physician-recommended return, or other factor.

History of Present Illness (HPI)

- HPI is a chronological description of the patient's present illness. It includes the following elements:
 - Location
 - Quality
 - Severity
 - Duration
 - Timing
 - Context

- Modifying factors
- Associated signs and symptoms
- There are two levels of HPI: brief and extended
 - Brief HPI: one to three elements
 - Extended HPI: four or more elements

Review of Systems (ROS)

- ROS is an inventory of body systems that seeks to identify signs and/or symptoms the patient is experiencing or has experienced. The following organ systems are recognized:
 - Constitutional symptoms (e.g., fever, weight loss)
 - Eyes
 - Ears, nose, mouth, throat
 - Cardiovascular
 - Respiratory
 - Gastrointestinal
 - Genitourinary
 - Musculoskeletal
 - Integumentary (skin and/or breast)
 - Neurological
 - Psychiatric
 - Endocrine
 - Hematologic, lymphatic
 - Allergic, immunologic
- There are three levels of ROS: problem-pertinent, extended, and complete
 - Problem-pertinent ROS: one system directly related to problem in HPI
 - Extended ROS: two to nine systems
 - Complete ROS: 10 or more systems

Past, Family, and/or Social History (PFSH)

- PFSH includes a review of three areas
 - Past history (illnesses, operations, injuries, treatments)
 - Family history (medical events in the patient's family)
 - Social history (age-appropriate review of past and current activities)
- There are two levels of PFSH: pertinent and complete
 - Pertinent PFSH: one item from any of three history areas
 - Complete PFSH: two or all three of history areas
 - two items for most subsequent care services
 - three items for most new or initial services

| HPI | ROS | PFSH | Type of History |
|----------|-------------------|-----------|------------------------------|
| Brief | N/A | N/A | Problem focused (P) |
| Brief | Problem-pertinent | N/A | Expanded problem-focused (E) |
| Extended | Extended | Pertinent | Detailed (D) |
| Extended | Complete | Complete | Comprehensive (C) |

Physical Examination

The second key component defining an E/M code is the physical examination. There are four types of examination:

- Problem-focused examination (P)
 - Limited examination of the affected body area or organ system
- Expanded problem-focused examination (E)
 - Limited examination of the affected body area or organ system and other symptomatic or related organ system(s)
- Detailed examination (D)
 - Extended examination of the affected body area(s) and other symptomatic or related organ system(s)
- Comprehensive examination (C)
 - General multisystem examination (more than eight organ systems); **only organ systems apply for the comprehensive exam**

For E/M purposes, the following organ systems are recognized:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic, lymphatic, immunologic

For E/M purposes, the following body areas are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks

- Back, including spine
- Each extremity

Medical Decision-making

Medical decision-making (MDM) refers to the complexity of establishing a diagnosis or selecting a management option. There are four levels of MDM:

- Straightforward (S)
- Low complexity (L)
- Moderate complexity (M)
- High complexity (H).

Each level of MDM includes the following three elements:

- Number of possible diagnoses and/or the number of management options;
- Amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- Risk of significant complications, morbidity and/or mortality

| Diagnosis or Management Options | Data Review | Complication Risk | Level of Decision Making |
|--|------------------------|--------------------------|---------------------------------|
| Minimal | Minimal or none | Minimal | Straightforward (S) |
| Limited | Limited | Low | Low (L) |
| Multiple | Moderate | Moderate | Moderate (M) |
| Extensive | Extensive | High | High (H) |

Number of Diagnoses or Management Options

- The 1995 guidelines presume that:
 - An undiagnosed problem is more complex than one with an established diagnosis
 - The number and type of diagnostic studies needed indicate the number of diagnoses considered
 - Problems that are resolving or improving are less complex than those that are worsening or failing to respond
 - The need to seek advice from others is an indication of complexity

Amount and/or Complexity of Data Reviewed

- Complexity is increased by
 - Number and types of diagnostic testing ordered or reviewed
 - Decision to obtain and review old medical records or to obtain history from sources other than the patient
 - Must document relevant new information learned; or
 - Must document that NO new relevant information was added
 - Must not note that “Old records reviewed” or “additional history obtained from family” (this is insufficient)
 - Reviewing the image or specimen personally to supplement information obtained from the physician preparing the report

Risk of Significant Complications, Morbidity, and/or Mortality

- The assessment of risk is based on the risk related to the disease process anticipated between the present encounter and the next one. The highest level of risk in any one category determines the overall risk.

Example

You are asked to see a 78-year-old man receiving hospice care for end-stage lung cancer; this will be your first visit with this patient. Use of the overhead trapeze bar on his bed has caused acute pain in his right shoulder. On examination, he demonstrates evidence of impingement in the right shoulder. You diagnose a bursitis and prescribe an appropriate course of treatment.

History: problem focused

Exam: problem focused

Complexity: limited number of diagnoses or management options, no data for review, minimal risk of complications. You must meet or exceed at least two of the three so this would be considered straightforward decision-making.

Billing options: Because he is a new patient, you must meet the threshold of all three key criteria (history, exam, complexity). The appropriate CPT code would be: New Outpatient 99201

Comments: This example assumes that the only thing done at this visit was to assess the shoulder pain. Although his lung cancer is a serious underlying condition, it would play no part in determining the appropriate CPT code other than giving consideration to a possible metastasis as a cause of his pain (part of limited rather than minimal diagnostic options).

Documenting Based on Contributory Factors

The **nature of the presenting problem** always should contribute to the type of E/M service provided. Evaluation and management of a minor medical problem usually does not require a comprehensive history and examination. It is important to remember that a patient's other medical conditions are not considered as part of the decision-making complexity unless they directly impact the complexity of the decision-making process for the presenting problem. A hangnail is only a hangnail, no matter how detailed the documentation. In palliative medicine, however, what appears to be a minor medical problem may be very complex

because of the context of the advanced medical illness or treatment plan. For example, constipation may result in pain, nausea, and delirium; its cause may be diet, bowel obstruction, or opioids. In your documentation, ensure that your description of the presenting problem supports the level of service billed.

Counseling and **coordinating care** become important factors when they comprise more than 50% of the time spent with the patient and family. **Time** then becomes the key controlling factor in determining the level of E/M service.

Documenting Time as the Key or Controlling Element

Defining and Documenting the Level of Service Based on Time Spent

Physician estimation of **intraservice time** is a variable that is predictive of the **work** of E/M services. Intraservice time is defined as **face-to-face** time in the office or other outpatient setting and the unit/floor time in the hospital or nursing facility. If the physician visit consists predominantly (more than 50%) of counseling or coordination of care with the patient and/or family, **time may be considered the key or controlling factor** for choosing the correct E/M code.

- **Face-to-face time** is only that time that the physician spends face-to-face with the patient and/or family. This includes time spent obtaining a history, doing an examination, and counseling the patient/family. This is the time used to define an office visit, office consultation, or other outpatient service, including home and assisted living facility services.
- **Unit/floor time** includes the time that the physician is present on the patient's hospital unit and at the bedside. In the inpatient units, this time includes reviewing the medical record, obtaining a history, doing an examination, counseling the patient, and coordinating care with the other professionals and the patient's family.
- **Non-face-to-face time** is physician time spent working before or after an outpatient encounter or working off the inpatient unit/floor. This time is **not** included in the calculation of intraservice time.

Counseling and Coordination of Care

Many of the patient visits that a palliative medicine (PM) physician will bill are likely to involve time-dependent interventions, such as understanding the patient's experience of a life-limiting illness, clarifying goals of care, counseling patients and families about treatment choices, assisting with advance care planning, and just plain empathic listening and psychosocial/spiritual support. As such, the practitioner bears the responsibility of being familiar with the essential elements of coding and billing for time-based E&M services. The outline provided explains specifics of CPT requirements for time-dependent coding.

When counseling and coordination of care are more than 50% of the physician/patient and/or family encounter, then time is considered the key or controlling factor to qualify for a particular level of E/M service. Because of the nature of physician services in hospice and palliative medicine, this may be the controlling factor in choosing the level of E/M service provided by the physician or NPP. There are several restrictions to using time for physician billing. Accurate documentation is critical.

- The 50% rule
 - If more than 50% of the intraservice time is spent in counseling and coordinating care, time can be used as the key or controlling factor for the level of E/M service, regardless of whether or not the traditional complexity elements for that service were met
- Counseling is discussion with the patient and/or family concerning one or more of the following areas:
 - Diagnostic results, impressions, and/or recommended diagnostic studies
 - Prognosis
 - Risks and benefits of management or treatment choices
 - Instructions for management, treatment, or follow-up
 - Importance of compliance with management or treatment chosen
 - Risk factor reduction
 - Patient and family education
- Non-face-to-face time cannot be included in calculating the physician intraservice time when time is used as the key or controlling factor.
 - Examples
 - Excluded: IDG meeting, telephone calls to team after leaving the patient's home, dictation of a note in your office after the patient has left
 - Included: Telephone call made to the attending physician while the patient is sitting with you in the office (face-to-face), dictation of a hospital consultation done while still on the patient's unit
- **Both the extent of counseling and coordination of care and the total length of the visit must be documented in the medical record.** It is recommended that this be recorded in one of the following manners:
 - **Over 50% of an X minute visit** was spent in counseling and coordinating care, including (e.g., review of the patient/family understanding of the disease process and prognosis, discussing the role of artificial nutrition and hydration, and obtaining informed consent for a home do-not resuscitate order [DNRO]); or
 - **X minutes of a less than 2X total visit** were spent in counseling and coordinating care, including (see above)
 - There does not need to be a word-for-word transcription of the discussion, but **enough documentation should be included to support the length of time spent** in counseling and coordinating care. Here are examples of discussion elements that may be included in a hospice and palliative medicine visit.
 - Review of patient/family understanding of disease
 - Prognosis discussion
 - Risks and benefits of proposed treatment
 - Review of treatment/medication instructions
 - Management strategies for expected symptoms
 - Role of artificial nutrition/hydration at end of life
 - Goals of care
 - DNRO discussions

When time is the controlling factor for an E&M service, you are required to “document the extent of counseling and/or coordination of care in the medical record.” While it is impractical to

provide a complete narrative of every topic discussed during an encounter, a reasonable synopsis can explain elements of the visit. We all have practice patterns that develop as we gain experience with family meetings and patient assessments. The topics that we cover in our pattern of communication with patients then can be succinctly described. An example of a succinct statement that implicitly expresses the time and intensity of a new patient encounter would be as follows: "Reviewed disease processes, clinical course, management complexity, and treatment considerations in the context of end-stage disease." Implicit documentation should provide the reviewer with a clear understanding of the broader topics of discussion and provide sufficient detail to serve as a trigger for recalling what was done during the encounter in case the physician is ever required to defend a claim in an audit. From a medico-legal perspective, the physical assessment should contain explicit and detailed information, such as pertinent negatives, exam findings and acknowledgement of important diagnostics.

Additionally, the actual template for our visit note can be helpful in conveying to coders and reviewers what important elements were accomplished in the encounter that justify the level of service and the extended service time involved. Broader implicit time-dependent elements can be documented as part of the assessment and plan. Using prognosis or prognostic uncertainty as a bullet or numbered item in your assessment makes apparent to the reviewer and other colleagues that this is a problem requiring specific intervention. By following this heading with the implicit statement (above example), you have documented a very time-consuming intervention in just a single sentence.

Extended Service Billing

Prolonged service codes are reported when the intraservice time exceeds the level of E/M service by at least 30 minutes. It is not necessary for the time spent to be continuous. Prolonged service of less than 30 minutes is not separately billable.

- Prolonged service, with direct face-to-face patient contact
 - Office or other outpatient setting (99354-99355)
 - Inpatient setting (99356-99357)
- Prolonged service, without face-to-face patient contact
 - At this time, there is no valuation or reimbursement for these services

Modifier 21

- When the face-to-face or floor/unit time for an E/M service is greater than that usually required for the highest level of E/M service within a given category, it may be identified by appending modifier 21 to the E/M code.
 - If the service does not exceed 30 minutes beyond the highest level of E/M, then modifier 21 should be appended to indicate the extended service
 - Time is reported in minutes beyond that usually required for the highest level of E/M service
 - Most payers do not reimburse this service

Procedure Service CPT Codes

- The procedures common to hospice and palliative medicine physicians are listed in the section describing CPT codes. If an E/M service and a procedure are billed on the same day by the same physician, the E/M service must be significant and separately identifiable.
- Modifier 25 is appended to the E/M service code to indicate a service above and beyond that normally provided before and after the procedure.
- Common Procedures in Palliative Medicine
 - Abdominal paracentesis (49080-49081)
 - Thoracentesis (32000-32002)

Other Documentation Suggestions

Psychosocial issues are almost universally a focus for the palliative medicine physician. This is a topic or category that may be included as a standard item in the assessment and plan, for example, “Disease-related psychosocial issues.” This category also lends itself to implicit statements that will further support documentation of counseling and care coordination when time dependent coding is used. Examples of an implicit intervention under this assessment item are:

- Advance directives and code status were reviewed
- End-of-life issues were discussed
- Detailed explanation of the Medicare Hospice Benefit was provided

It may also be useful to include an implicit statement that indicates that interdisciplinary care coordination is part of the palliative medicine consultation. Under the heading of “Disease-related psychosocial issues” the following examples can be used:

- Several clinically relevant psychosocial issues were identified which the palliative care team will address
- The palliative care team will assess and assist with support interventions as indicated

Descriptive adjectives provide another effective mechanism for conveying the extent of time involved in counseling and coordinating care. For example, modifiers like “extended” discussion of..., or “detailed” review of..., or “prolonged” discussion regarding..., may all be helpful to convey the detail that is often required for conducting a patient encounter as a palliative medicine specialist.

Billing Issues Specific to Non-Hospice Palliative Medicine

Concurrent Care

Other elements to consider for inclusion in documenting palliative medicine physician services are those things that distinguish the specialist-level services provided. Because the palliative medicine specialist often shares the same primary medical specialty as the physician who requests the consultation, it is important to establish that the primary reason for consultation is for a different problem than that being treated by the attending or other consulting physicians. For billing purposes, this means using a different ICD-9 code that describes the specific symptom addressed. This symptom should be listed first under the “Impression and Plan” section of the consultation. Examples include “shortness of breath” instead of congestive heart failure; “decreased level of consciousness” not uremia (or other causes for encephalopathy); or as is often the case, “pain” due to the primary disease.

Consultation

Billing Issues Specific to Hospice Physicians

Most billing questions encountered by hospice physicians are common to other billing situation and are covered elsewhere in this monograph. However, some issues are unique to physicians employed by a hospice agency, especially if they are part-time hospice doctors and continue to see patients in clinical practice. The four most common are addressed here.

Eligibility Assessments

You visit a hospice patient to determine if he or she still is eligible: how should you bill for the visit?

- If the visit is **only** for eligibility assessment, then it is considered an administrative rather than clinical visit and is **not billed to Medicare**. You will bill for the visit as you would a meeting or other administrative activity (either based on your hourly administrative reimbursement rate or covered under your salary). If, in addition to the eligibility assessment, you also provide clinical evaluation and management or patient education and counseling tasks, you can bill the visit as you normally would for a hospice patient visit, using the appropriate CPT code and billing Medicare A through your hospice agency.
- If CPT code is chosen based on time spent in counseling and coordinating care, remember that the time spent in assessing patient eligibility should be **subtracted** from the total time spent

Private Patients Receiving Hospice Services

You see one of your regular patients who also receive the Medicare Hospice Benefit with your hospice: how should you bill for the visit?

- If the patient is seen for problems that **are related** to their hospice terminal diagnosis, then you need to bill for the visit using appropriate CPT coding through the hospice rather than through your clinic or usual billing service.
- If you are seeing the patient for problems **not related** to the hospice diagnosis (e.g., the patient receives hospice care for lung cancer and you are following up on long-standing diabetes), then you bill for the visit through your usual billing service (rather than the hospice) and use the coding modifier **“GW”** to indicate that the problem is not related to the hospice diagnosis.

Pre-hospice Educational Consults

You are asked to see a patient who is not yet receiving hospice services for a “pre-hospice educational consult”: how do you bill for the visit?

- You must first understand the requirements for this type of consultation. It does not require a formal consult request from an attending physician but can be requested by the patient or family. Next, it is only available to patients who have not already elected their hospice benefit and have not previously received hospice services in the past. Finally, this visit is intended to accomplish three goals: (1) evaluation of the need for pain and symptom management, (2) counseling regarding hospice and other care options and (3) may include advice about advance care planning. Finally, this service

only can be billed to Medicare through a hospice agency by a hospice physician. It is not an option for physicians who are counseling their own patients about end-of-life care. The Educational Consult is billed to the hospice agency, using HCPCS code G0337 and revenue code 0657.

Hospice General Inpatient Level of Care

You visit a hospice patient who was transferred from home to a contracted skilled nursing facility because of a pain crisis. The patient was admitted at the hospice general inpatient (GIP) level of care for pain management. How do you bill for the visit?

- Several issues relate to this type of billing.
 - Is the patient's attending physician also participating in the GIP care?
 - How does your fiscal intermediary (FI) advise you to bill for GIP based on location of service or intensity of care? No consensus exists on this question, so local variations exist.
- If the patient's attending physician will **not** be involved, you become the attending or managing physician for the admission; you should select your CPT codes from that group of E/M codes (as opposed to using consultant codes).
- If the attending is involved and will be seeing the patient in the facility, you might be a consultant if the requirements for billing as a consultant have been met.
 - If these requirements have not been met, you must bill as using "subsequent visit" codes [[link to explanation of this](#)]
- Depending on the advice given to you by your FI, you either will bill for the visit using the appropriate skilled nursing facility codes or the appropriate inpatient visit codes. When uncertain, the most conservative choice is to bill based on location using the nursing facility codes.

Nurse Practitioner Billing

This information applies to Medicare guidelines; Medicaid and private insurers may or may not use similar guidelines.

Introduction

The professional services of a nurse practitioner (NP) might be covered if he/she meets qualifications and is authorized to furnish services in the state where the services are performed. The NP must apply for a billing identification number. Currently, he/she must have a National Provider Identifier as well as a UPIN. The Medicare qualifications for a NP provider are as follows:

- first application January 1, 2001 to December 31, 2002
 - registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law
 - certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners

- first application after January 1, 2003
 - registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law
 - certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners
 - possess a master's degree in nursing

Medicare recognizes these national certifying bodies:

- American Academy of Nurse Practitioners
- American Nurses Credentialing Center
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties
- National Certification Board of Pediatric Nurse Practitioners and Nurses
- Oncology Nurses Certification Corporation
- Critical Care Certification Corporation

The National Board for Certification of Hospice and Palliative Nurses (NBCHPN) purchased the Palliative Care APN exam from ANCC and is currently working to gain recognition as a national organization that certifies advance practice nurses. The approval request was published in the August 22, 2006 Federal Register for public comment. As of December 2006, a stand-alone certification from NBCHPN does not qualify a NP for Medicare reimbursement.

Covered Services under Medicare

Medicare payment for NP services is limited to services an NP legally is authorized to perform in accordance with state law. Consult your state nursing board or state APN organization for

specific information regarding APN guidelines. To qualify for reimbursement, APN services must:

- be the type considered physician services if delivered by an MD or DO
- be performed by a person who meets the definition of an NP
- be performed by an NP who is legally authorized in the state where services are provided
- be performed in collaboration with a MD/DO
- not otherwise be precluded for coverage (i.e., are reasonable and medically necessary)

Types of services an NP may provide include examinations, minor surgeries, setting casts for fractures, interpreting X-rays, all levels of evaluation and management codes and diagnostic tests. Medicare defines the relationship of the NP with the physician as collaboration. This is a process in which an NP works with one or more physicians to deliver health care services

- with medical direction and appropriate supervision as required by the law of the state in which the services are furnished
- evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice.

Medicare specifies that the physician does not have to be present when the services are provided to meet the definition of collaboration.

Reimbursement Issues

Direct billing

The NP can bill **directly** for services and is reimbursed at 85% of the physician fee schedule amount. In this situation, the NP performs independent of, but in collaboration with, the physician and the service is billed under the NP provider number. All consults and new patient visits must be billed under the NP provider number because they cannot meet the definition of incident-to services.

Incident-to billing

NP services may be billed under the physician billing number and reimbursed at 100% of the physician fee schedule if they meet the following incident-to criteria:

- the visit occurred in the office or clinic, not the hospital, emergency room or nursing facility
- the NP is an employee of or contracted with the physician (an expense to the practice)
- the initial visit for that condition was performed by the physician (a direct, personal professional service furnished by the physician to initiate the course of treatment of which the services being performed by the NP)
- the physician provides direct personal supervision as an integral part of the in-office service
- the physician has an active part in the ongoing care of the patient; physician services must be of a frequency that demonstrates continuing active participation in and management of the course of treatment

- the physician is present in the clinic; telephone availability does not qualify
- the service is not billed in the hospital/inpatient setting

Split/Shared billing

NP services in the hospital setting may be billed under the physician billing number and reimbursed at 100% of the physician fee schedule amount if the physician provides and documents any face-to-face portion of the encounter that day. Split/shared billing

- applies only to Medicare patients
- may not be used if the service rendered meets the incident-to requirements
- may not be used in the office/clinic setting
- may not be used to report a consultation service

Consultation

Consultations may be requested and performed by a NP in any setting if within the scope of practice and state licensure requirements for the NP. Medicare requires that the services meet the general consultation requirements for billing. Consult services may not be billed as split/shared services.

Nursing facility services

The NP may provide services in both the Skilled Nursing Facility (SNF) and the Nursing Facility (NF). In the skilled nursing facility the resident is on the skilled Medicare benefit and his/her stay is covered under Part A. The initial required visit only can be done by the physician. This visit is the comprehensive assessment visit during which the physician completes a thorough assessment, develops a plan of care, and writes or verifies admitting orders for the resident; this visit must occur no later than 30 days after the admission date. This visit may not be delegated but CMS has given further guidance that has clarified that medically necessary visits may be performed by a NP prior to and subsequent to the initial physician visit and billed appropriately using NF codes. The subsequent required visits for a patient on the skilled benefit may be alternated between a physician and NP.

The NP may provide all visits for a resident stay not on the skilled benefit and not covered under Medicare Part A, including the initial visit when state law and facility policies permit. Requirements for collaboration must be met. All subsequent medically necessary or regulatory E/M visits for diagnosis or treatment of an illness or injury may be performed and reported by NP as allowed by state law.

An NP may bill consultation services in the SNF or NF using inpatient consultation codes if the consultation requirements are met.

Employed NP in the hospital or NF:

If the NP is employed by the hospital or SNF/NF, the services he/she provides are covered and reimbursed in the DRG or PPS amount and no additional billing is allowed.

Case management services

The NP may be able to bill for true case management services when he/she is acting as the primary provider for the ongoing care of a patient with chronic illnesses. An NP cannot certify (G0180) or recertify (G0179) home health services or hospice services. But an NP can bill Care Plan Oversight (CPO) services for patients receiving home health (G0181) or hospice (G0182) services if

- the collaborating physician has certified home health or hospice services
- the physician and NP are part of the same practice
- the physician signing the plan of care has a collaborative agreement with the NP and provides ongoing care under the same plan of care as the NP billing for CPO
- the NP has seen and examined the patient

Medicare specifies that the NP is not functioning as a consultant providing care for a single problem but rather is providing multidisciplinary coordination of care.

Hospice patient services

When the hospice patient has chosen the NP as his/her attending physician, NP services can be reimbursed under Part A if employed or contracted with the hospice and under Part B if the NP providing attending physician services is independent of the hospice. An NP cannot certify the patient has a terminal illness and cannot recertify for continuing services. The NP can only be reimbursed as an attending physician, not as a consulting, under Medicare Part A. The billing instructions related to hospice billing for physicians apply for NP billing as an attending as well, with additional requirements as outlined above.

Billing Examples

1. Incident-to

A physician evaluates a patient and diagnoses diabetic neuropathic pain. The physician initiates treatment. The employed NP conducts follow up office visits to manage the pain, monitoring and treating the pain over months or years. The physician is present in the office at the time of the NP services and sees the patient intermittently. The visits may be billed under the physician's provider number and the practice will receive 100% of the physician's fee schedule.

2. Split/Shared billing

NP visits patient in the morning of the second hospital day and performs a detailed examination and medical decision-making of high complexity. Later that day, the physician visits the patient and checks pupillary reaction. The work is combined and the visit is billed as level 3 subsequent hospital care under the physician's provider number.

3. SNF initial visit

Patient admitted to facility on skilled NF benefit on Monday and has new fever on Tuesday. NP can visit and bill subsequent visit code, level 2 or 3 as documented, then later (within 30 days of admission date) the physician can visit and bill initial SNF initial service code.

4. NP as attending in hospice

Patient managed by NP in her practice, admitted to hospice and her collaborating physician certifies terminal status. NP then can bill for hospice visits, home, ALF or NH visits. Billing will depend on the arrangement her practice has with the hospice.

- If the NP is an employee or is contracted with the hospice, he/she will send the bill to the hospice, and be reimbursed according to the agreement the practice has with the hospice. The hospice will bill Medicare Part A.
- If not an employee of the hospice and the patient has designated the NP as the hospice attending physician, the NP may bill Medicare Part B for attending physician services and bill for CPO for the hospice patient.

5. NP consulting in palliative care

An internist admits a patient to the hospital for decompensated congestive heart failure. The family requests no intubation and no intensive care admission. The patient has no written advance directives and the internist is uncomfortable managing symptoms outside the ICU setting. The internist requests a palliative care consultation to determine goals of care and for advice regarding symptom management short of intubation. The NP may perform the consult and bill for consultative services if allowed by state regulations and hospital policies. The palliative care physician may **not** submit this consult under a split/shared billing.

Care Plan Oversight

Care plan oversight (CPO) is defined by the Medicare Benefit Policy Manual as “supervision of patients under care of home health agencies or hospices that require complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication with other health professionals not employed in the same practice who are involved in the patient’s care, integration of new information into the care plan, and/or adjustment of medical therapy.”

These services are covered for home health and hospice patients, but are not covered for patients of skilled nursing facilities (SNFs), nursing home facilities, or hospitals. They are billed using HCPCS code G0181 (home health) or G0182 (hospice) and are covered by Medicare when the following requirements are met.

Requirements for Billing CPO

1. The beneficiary must require complex or multi-disciplinary care modalities requiring ongoing physician involvement in the patient’s plan of care;
2. The care plan oversight (CPO) services should be furnished during the period in which the beneficiary was receiving Medicare-covered HHA or hospice services;
3. The physician who bills CPO must be the same physician who signed the home health or hospice plan of care;
4. The physician furnished at least 30 minutes of care plan oversight within the calendar month for which payment is claimed. Time spent by a physician’s nurse or the time spent consulting with one’s nurse is not countable toward the 30-minute threshold. Low-intensity services included as part of other evaluation and management services are not included as part of the 30 minutes required for coverage;
5. The work included in hospital discharge day management (codes 99238-99239) and discharge from observation (code 99217) is not countable toward the 30 minutes per month required for work on the same day as discharge but only for those services separately documented as occurring after the patient is physically discharged from the hospital;
6. The physician provided a covered physician E/M service that required a face-to-face encounter with the beneficiary within the six months immediately preceding the first care plan oversight service;
7. The care plan oversight billed by the physician was not routine post-operative care provided in the global surgical period of a surgical procedure billed by the physician;
8. If the beneficiary is receiving home health agency services, the physician did not have a significant financial or contractual interest in the home health agency. A physician who is an

employee of a hospice, including a volunteer medical director, should not bill CPO services. Payment for the services of a physician employed by the hospice is included in the payment to the hospice;

9. The physician who bills the care plan oversight services is the physician who furnished them;
10. Services provided incident to a physician's service do not qualify as CPO and do not count toward the 30-minute requirement;
11. The physician is not billing for the Medicare end-stage renal disease (ESRD) capitation payment for the same beneficiary during the same month; and
12. The physician billing for CPO must document in the patient's record the services furnished and the date and length of time associated with those services.

Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the home health agency or hospice during the month for which CPO were billed.

Documentation

When a physician bills for HCPS codes G0181 or G0182, he/she is stating that the criteria for billing have been met. The physician must maintain supporting documentation of the activities spent in providing CPT. Documentation supplied by home health agencies or hospices cannot be used in lieu of a physician's documentation. Only the physician who has signed the patient's plan of care (in hospice, the designated hospice attending physician) can be paid for HCPS codes G0181 and G0182.

Coding and Billing Guidelines for CPO

With the CPO bill, the physician must submit the six-character Medicare provider number for the home health agency (HHA) or hospice.

- For paper claims, the six-character Medicare provider number for the HHA/hospice must be entered in item 23 of the HCFA 1500.
- For electronic claims submitted using NSF format, the HHA/hospice provider number must be entered in Record EAO, field 49, positions 290 through 295.
- For electronic claims submitted in ANSI-837 format, the HHA/hospice provider number must be entered in 2-250NM109(MP). The physician is responsible for obtaining the Medicare provider number for the HHA or hospice.

The physician should supply his/her UPIN or NPI number to the HHA or hospice furnishing the service.

Claims submitted for CPO services submitted with an invalid HHA or hospice provider number will be denied.

- Claims submitted for CPO services in which the Medicare HHA or hospice number is missing will be denied with no appeal rights
 - Claims for CPO services will be denied when review of beneficiary claims history fails to identify a covered physician service requiring a face-to-face encounter by the same physician during the six months preceding the provision of the first CPO service
- Place of service (POS) should be coded for “office” (11) on the claim form.

Dates of service entered on the claim must be the first and last date during which documentation shows that care planning services were **actually provided** during the calendar month (**not** just the first and last day of the calendar month). Medical records for those dates must document that 30 minutes or more of time have been spent by the physician for countable care planning activities, as well as which services were furnished and the date and length of time associated with those services.

Patients are responsible for the 20% co-payment for CPT.

CPT Code Changes in 2006

Effective January 1, 2006, there are changes to three sets of CPT codes routinely used by Hospice and Palliative Medicine physicians: consultations, nursing facility services, and domiciliary/rest home services.

Reference: Current Procedural Terminology (CPT) 2006, Fourth Edition, revised 2005, American Medical Association

Consultations

Follow-up inpatient consultations (99261-99263): **discontinued**

- Subsequent hospital or nursing facility care codes should be billed for follow-up visits

Confirmatory consultations (99271-99275): **discontinued**

- Consultations requested by the patient/family may be billed using location-specific attending/managing codes

Nursing Facility Services

Comprehensive nursing facility assessments (99301-99303): **discontinued**

Subsequent nursing facility care (99311-99313): **discontinued**

- Nursing facility codes now differentiate between initial and subsequent care, paralleling the hospital admission codes. Both categories apply to new and established patients. The new codes for 2006 no longer have typical unit times established. This means that **no time-based billing can be used** with these codes. The annual nursing facility assessment has been given a unique code, 99318. This code should not be reported on the same date as nursing facility service codes 99304-99316.

Initial Nursing Facility Care

99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components

- a detailed or comprehensive history;
- a detailed or comprehensive examination; and
- medical decision making that is straightforward or of low complexity

Usually, the problem(s) requiring admission are of low severity

99305 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity

Usually, the problem(s) requiring admission are of moderate severity

99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity

Usually, the problem(s) requiring admission are of high severity

Subsequent Nursing Facility Care

99307 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three components

- a problem-focused interval history;
- a problem-focused examination;
- straightforward medical decision making

Usually, the patient is stable, recovering, or improving

99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three components

- an expanded problem-focused interval history;
- an expanded problem-focused examination;
- medical decision making of low complexity

Usually, the patient is responding inadequately to therapy or has developed a minor complication

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three components

- a detailed interval history;
- a detailed examination;
- medical decision making of moderate complexity

Usually, the patient has developed a significant complication or a significant new problem

99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three components

- a comprehensive interval history;
- a comprehensive examination;
- medical decision making of high complexity

The patient may be unstable or may have developed a significant new problem requiring immediate physician attention

99318 Evaluation and management of a patient involving an annual nursing facility assessment, which requires these three key components

- a detailed interval history;
- a comprehensive examination; and
- medical decision making that is of low to moderate complexity

Usually, the patient is stable, recovering, or improving

Domiciliary, Rest Home, or Custodial Care Services (Assisted Living)

New patient (99321-99323): **discontinued**

Established patient (99331-99333): **discontinued**

- The domiciliary, rest home, and custodial care codes now have typical times of service included. **Time-based billing can now be used** with these codes. Additionally, higher level codes have been added to document more complex physician management services

New Patient

99324 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components

- a problem-focused history;
- a problem-focused examination; and
- straightforward medical decision making

Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver

99325 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components

- an expanded problem-focused history;
- an expanded problem-focused examination; and
- medical decision making of low complexity

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver

99326 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components

- a detailed history;
- a detailed examination; and
- medical decision making of moderate complexity

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver

99327 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity

Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver

99328 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components

- a comprehensive history;

- a comprehensive examination; and
- medical decision making of high complexity

Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver

Established Patient

99334 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components

- a problem-focused interval history;
- a problem-focused interval examination;
- straightforward medical decision making

Usually, the presenting problem(s) are self-limiting or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver

99335 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components

- an expanded problem-focused interval history;
- an expanded problem-focused examination;
- medical decision making of low complexity

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver

99336 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components

- a detailed interval history;
- a detailed examination;
- medical decision making of moderate complexity

Usually, the presenting problem(s) are of moderate to high complexity. Physicians typically spend 40 minutes with the patient and/or family or caregiver

99337 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components

- a comprehensive interval history;
- a comprehensive examination;
- medical decision making of moderate to high complexity

Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver

| 2005 CPT Discontinued | 2006 CPT Replacement | 2006 CPT Description of Service |
|----------------------------------|---------------------------------|--|
| 99261 | 99231 | Hospital care-subsequent |
| | or, 99307 | Nursing facility care-subsequent |
| 99262 | 99232 | Hospital care-subsequent |
| | or, 99308 | Nursing facility care-subsequent |
| 99263 | 99233 | Hospital care-subsequent |
| | or, 99309 | Nursing facility care-subsequent |
| | or, 99310 | Nursing facility care-subsequent |
| 99271 | none | Confirmatory consultation |
| 99272 | none | Confirmatory consultation |
| 99273 | none | Confirmatory consultation |
| 99274 | none | Confirmatory consultation |
| 99275 | none | Confirmatory consultation |
| 99301 | 99304 | Nursing facility care-initial |
| 99302 | 99305 | Nursing facility care-initial |
| 99303 | 99306 | Nursing facility care-initial |
| 99311 | 99307 | Nursing facility care-subsequent |
| 99312 | 99308 | Nursing facility care-subsequent |
| 99313 | 99309 | Nursing facility care-subsequent |
| | or, 99310 | Nursing facility care-subsequent |
| n/a | 99318 | Annual nursing facility assessment |
| 99321 | 99324 | Domiciliary/rest home-new |
| 99322 | 99325 | Domiciliary/rest home-new |
| 99323 | 99326 | Domiciliary/rest home-new |
| | or, 99327 | Domiciliary/rest home-new |
| | or, 99328 | Domiciliary/rest home-new |
| 99331 | 99334 | Domiciliary/rest home-established |
| 99332 | 99335 | Domiciliary/rest home-established |
| 99333 | 99336 | Domiciliary/rest home-established |
| | or, 99337 | Domiciliary/rest home-established |

Appendix I: CPT Coding Tool

The tables of the following pages provide a brief description of the documentation requirements for individual CPT codes. Begin by choosing the code set based on the location of service and whether this was the initial facility admission, a new patient visit, or subsequent care of an established patient. Within each code set, the documentation requirements for each level of complexity are described.

P = problem-focused
E = extended problem-focused
D = detailed
C = comprehensive
S = straightforward decision-making
L = low complexity
M = moderate complexity
H = high complexity

Office or Other Outpatient – New Patient

(Requires 3/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|-------|-------------------------|----------------------|----------------------------|----------------------|
| 99201 | P | P | S | 10 |
| 99202 | E | E | S | 20 |
| 99203 | D | D | L | 30 |
| 99204 | C | C | M | 45 |
| 99205 | C | C | H | 60 |

Click on column headings for more information

Office or Other Outpatient – Established Patient

(Requires 2/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|-------|---------------------------------------|----------------------|----------------------------|----------------------|
| 99211 | May not require presence of physician | | | 5 |
| 99212 | P | P | S | 10 |
| 99213 | E | E | L | 15 |
| 99214 | D | D | M | 25 |
| 99215 | C | C | H | 40 |

Click on column headings for more information

Hospital Observation – Initial Visit or Discharge

(Requires 3/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|-------|-------------------------|----------------------|----------------------------|----------------------|
| 99218 | D/C | D/C | S/L | n/a |
| 99219 | C | C | M | n/a |
| 99220 | C | C | H | n/a |
| 99217 | Discharge Services | | | n/a |

Click on column headings for more information

Initial Inpatient Care

(Requires 3/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|-------|-------------------------|----------------------|----------------------------|----------------------|
| 99221 | D/C | D/C | S/L | 30 |
| 99222 | C | C | M | 50 |
| 99223 | C | C | H | 70 |

Click on column headings for more information

Subsequent Inpatient Care

(Requires 2/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|-------|-------------------------|----------------------|----------------------------|----------------------|
| 99231 | P | P | S/L | 15 |
| 99232 | E | E | M | 25 |
| 99233 | D | D | H | 35 |

Click on column headings for more information

Same Day Inpatient/Observation

Admit and Discharge

(Requires 3/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|-------|-------------------------|----------------------|----------------------------|----------------------|
| 99234 | D/C | D/C | S/L | n/a |
| 99235 | C | C | M | n/a |
| 99236 | C | C | H | n/a |

Click on column headings for more information

| Inpatient Discharge Services | | | | |
|---|--------------------------------|-----------------------------|-----------------------------------|-----------------------------|
| Level | <u>History</u> | <u>Exam</u> | <u>Complexity</u> | <u>Time</u> |
| 99238 | n/a | n/a | n/a | <30 min |
| 99239 | n/a | n/a | n/a | >30 min |
| Click on column headings for more information | | | | |

| Office or Outpatient Consultation | | | | |
|---|--------------------------------|-----------------------------|-----------------------------------|-----------------------------|
| (Requires 3/3 <u>Key Components</u>) | | | | |
| Level | <u>History</u> | <u>Exam</u> | <u>Complexity</u> | <u>Time</u> |
| 99241 | P | P | S | 15 |
| 99242 | E | E | S | 30 |
| 99243 | D | D | L | 40 |
| 99244 | C | C | M | 60 |
| 99245 | C | C | H | 80 |
| Click on column headings for more information | | | | |

Initial Inpatient Consultation

(Requires 3/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|---|-------------------------|----------------------|----------------------------|----------------------|
| 99251 | P | P | S | 20 |
| 99252 | E | E | S | 40 |
| 99253 | D | D | L | 55 |
| 99254 | C | C | M | 80 |
| 99255 | C | C | H | 110 |
| Click on column headings for more information | | | | |

Initial Nursing Facility Care

(Requires 3/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|---|-------------------------|----------------------|----------------------------|----------------------|
| 99304 | D | D | S/L | n/a |
| 99305 | C | C | M | n/a |
| 99306 | C | C | H | n/a |
| Click on column headings for more information | | | | |

Subsequent Nursing Facility Care

(Requires 2/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|-------|-------------------------|----------------------|----------------------------|----------------------|
| 99307 | P | P | S | n/a |
| 99308 | E | E | L | n/a |
| 99309 | D | D | M | n/a |
| 99310 | C | C | H | n/a |

Click on column headings for more information

Nursing Facility Discharge Services

| Level | History | Exam | Complexity | Time |
|-------|-------------------------|----------------------|----------------------------|----------------------|
| 99315 | n/a | n/a | n/a | <30 min |
| 99316 | n/a | n/a | n/a | >30 min |

Click on column headings for more information

Annual Nursing Facility Assessment

(Requires 3/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|-------|-------------------------|----------------------|----------------------------|----------------------|
| 99218 | D | D | L/M | n/a |

Click on column headings for more information

Domiciliary/Rest Home Initial Service

(Requires 3/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|-------|-------------------------|----------------------|----------------------------|----------------------|
| 99324 | P | P | S | 20 |
| 99325 | E | E | L | 30 |
| 99326 | D | D | M | 45 |
| 99327 | C | C | M | 60 |
| 99328 | C | C | H | 75 |

Click on column headings for more information

Domiciliary/Rest Home Subsequent Service

(Requires 2/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|-------|-------------------------|----------------------|----------------------------|----------------------|
| 99334 | P | P | S | 15 |
| 99335 | E | E | L | 25 |
| 99336 | D | D | M | 40 |
| 99337 | C | C | M/H | 60 |

Click on column headings for more information

Home New Service

(Requires 3/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|--------------|--------------------------------|-----------------------------|-----------------------------------|-----------------------------|
| 99341 | P | P | S | 20 |
| 99342 | E | E | L | 30 |
| 99343 | D | D | M | 45 |
| 99344 | C | C | M | 60 |
| 99345 | C | C | H | 75 |

Click on column headings for more information

Home Established Service

(Requires 2/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|--------------|--------------------------------|-----------------------------|-----------------------------------|-----------------------------|
| 99334 | P | P | S | 15 |
| 99335 | E | E | L | 25 |
| 99336 | D | D | M | 40 |
| 99337 | C | C | M/H | 60 |

Click on column headings for more information

Domiciliary/Rest Home Initial Service

(Requires 3/3 [Key Components](#))

| Level | History | Exam | Complexity | Time |
|-------|-------------------------|----------------------|----------------------------|----------------------|
| 99324 | P | P | S | 20 |
| 99325 | E | E | L | 30 |
| 99326 | D | D | M | 45 |
| 99327 | C | C | M | 60 |
| 99328 | C | C | H | 75 |

Click on column headings for more information

Prolonged Services

| | | | |
|-------|----------|----------------------|----------------------------|
| 99354 | Direct | Outpatient or Office | 30 – 74 minutes |
| 99355 | | | Each additional 30 minutes |
| 99356 | | Inpatient | 30 – 74 minutes |
| 99357 | | | Each additional 30 minutes |
| 99358 | Indirect | All other settings | 30 – 74 minutes |
| 99359 | | | Each additional 30 minutes |

| Case Management Services | | |
|---------------------------------|------------------------|---------------------|
| 99361 | Team Conference | 30 minutes |
| 99362 | | 60 minutes |
| 99371 | Telephone Calls | Brief |
| 99372 | | Intermediate |
| 99373 | | Complex |

| Care Plan Oversight | | |
|----------------------------|-------------------------|-----------------------|
| 99374 | Home Health Care | 15-29 minutes |
| 99375 | | >30 minutes |
| 99377 | Hospice | 15-29 minutes |
| 99378 | | >30 minutes |
| 99379 | Nursing Facility | 15-29 minutes |
| 99380 | | >30 minutes |

Appendix II: Table of Risk

| <i>Level of Risk</i> | Presenting Problem(s) | Diagnostic Procedure(s) Ordered | Management Options Selected |
|----------------------|---|--|--|
| <i>Minimal</i> | <ul style="list-style-type: none"> • One self-limited or minor problem, eg, cold, insect bite, tinea corporis | <ul style="list-style-type: none"> • Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, eg, echocardiography • KOH prep | <ul style="list-style-type: none"> • Rest • Gargles • Elastic bandages • Superficial dressings |
| <i>Low</i> | <ul style="list-style-type: none"> • Two or more self-limited or minor problems • One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain | <ul style="list-style-type: none"> • Physiologic tests not under stress, eg, pulmonary function tests • Non-cardiovascular imaging studies with contrast, eg, barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies | <ul style="list-style-type: none"> • Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives |
| <i>Moderate</i> | <ul style="list-style-type: none"> • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, eg, lump in breast • Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis • Acute complicated injury, eg, head injury with brief loss of consciousness | <ul style="list-style-type: none"> • Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization • Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis | <ul style="list-style-type: none"> • Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation |
| <i>High</i> | <ul style="list-style-type: none"> • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss | <ul style="list-style-type: none"> • Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic Endoscopies with identified risk factors • Discography | <ul style="list-style-type: none"> • Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis |

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