



American Academy of Hospice and Palliative Medicine

## Hospice Medical Director Billing Guide

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**Update based on the 2011 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

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

Throughout this manual there will be references to “hospice medical directors.” This term is being used in the generic sense of a physician who is employed or contracted to provide core physician services for a hospice. Medicare makes a distinction between the hospice medical director, of whom there is usually only one per agency and a hospice or team physician, of whom there may be several in an agency. For billing purposes, there is no difference, so in this guide, all will be considered under the term “medical director”. The physician designee required by the current Conditions of Participation, will bill as a medical director when acting for the hospice and as a non-medical director when acting independently from the hospice.

The Medicare Hospice Benefit (MHB) pays certified hospice agencies on a per diem basis for almost all the services that the hospice provides its patients. This includes medications, supplies, durable medical equipment, and professional services from all team members except, under certain circumstances, 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 eligibility assessment or the required face-to-face encounter (FTFE). These will be reviewed in more detail later.

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 in billing and documentation requirements, 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

A medical director’s administrative activities consist of everything that they do for the agency that does not involve direct patient contact, plus any patient visits that are made solely for the purpose of determining eligibility or meeting regulatory requirements (the FTFE). A hospice medical director is expected to participate in interdisciplinary group (IDG) meetings, continuous quality improvement (CQI) meetings, various educational and marketing meetings, ethics committee meetings, as well as certifying terminal illness and providing clinical support for the staff. The medical director’s contracted pay (hourly or salary) covers all of these activities. The hospice does not bill Medicare or receive any additional reimbursement for these services. These expenses are covered by the hospice per diem.

### Technical Services

These services generally do not involve direct physician-patient contact, and do not require the professional expertise of a physician. Examples would be radiology and laboratory services provided in a physician’s office. Technical services related to the terminal illness are not included in administrative

reimbursement and are billable to the hospice agency. These costs are included in the hospice per diem and so the hospice cannot bill Medicare for reimbursement for this expense. For this reason, the hospice agency should be consulted and provide prior approval before these services are provided or billed.

### **Example: Technical Services**

A patient is receiving hospice services for end-stage COPD. During a clinic visit, the AOR physician decides to get an x-ray on the patient to rule out pneumonia as a cause of her progressive dyspnea. The test must be preauthorized by the hospice, and the technical fee for the x-ray should be billed to the hospice.

## **Professional Services**

These are the services performed by a physician directly with the patient. With the exception of visits made strictly for eligibility assessment and to meet the requirement for the FTFE, which, as previously indicated, are covered by a medical director's administrative pay, these visits are billed and reimbursed based on the appropriate Current Procedure Terminology (CPT) codes for the visit. A medical director will submit billing and documentation for these visits to the hospice agency and the agency will then directly bill Medicare A for the visits. Medicare A reimburses at 100% of the allowable rate and the agency then reimburses the medical director at the contracted reimbursement rate.

### ***If Medicare A reimburses at 100%, why shouldn't a Medical Director get paid 100%?***

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

- 1. 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. While CMS will not allow an agency require a specific number of visits, this type of compensation package usually includes a recommended average number of visits per week or month.
- 2. 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.
- 3. Compromise package between salary and percentage of reimbursement.*** This may be the best option if the medical director has significant administrative responsibilities that prevent them from doing enough visits to make the other two options viable.
- 4. Volunteer physician services.*** A physician may choose to volunteer all or only administrative services to a hospice. If volunteering all services, the hospice can not bill Medicare for physician patient visits. If not volunteering professional services then reimbursement for visits will be based on a contracted agreement.

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 ultimately collects a 100% reimbursement for physician services. However, the average clinic operates at a 40% (or higher) overhead, which means that a physician's actual take home pay is only 60% (or less) of the actual reimbursement for the visit. The 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.

## Chapter 2

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# Billing Implications of Physician-Patient-Hospice Relationships

*Physician status as a medical director and or hospice attending of record affects the way services should be billed.*

There are several types of physician-hospice-patient relationships; each has a different billing implication. If a physician has an agreement with a hospice agency to provide medical care and services to hospice patients then Medicare regards them as a “hospice medical director” when billing for any care provided to patients, that is related to the terminal condition. The one special exception is the volunteer medical director. If all services are volunteered, then the hospice can not bill for physician visits to patients.

## Coding Modifiers

When billing Medicare for the care of patients who have elected their hospice benefit, there are two coding modifiers that can be used. These indicate the relation of the physician to the patient and the nature of the condition being treated, whether related or unrelated to the hospice diagnosis. The coding modifiers are:

- **GV:** This modifier is only used by the **non-medical director**, hospice attending of record (term to be explained subsequently in this chapter) when billing Medicare B for any care provide to the patient. It does not matter if the treatment is related or unrelated to the terminal condition. This code identifies the physician as a hospice attending of record that is not the patient’s hospice medical director and allows routine Medicare B billing.
- **GW:** Regardless of the provider, care that is not related to the terminal illness is billed as usual through Medicare B even though the patient is receiving hospice care. The billing code GW indicates that the condition being treated is not related to the hospice diagnosis. In the case of the hospice attending of record (who is not the medical director) GW will be used in conjunction with GV when appropriate. GW would also be used in the event that the hospice medical director (who is not the attending of record) provides care to the patient that was not related to the hospice diagnosis. This care would then be billed to Medicare B, and would not be billed through the hospice.

## Medical Director - Attending Physician

“Hospice attending of record” is a very important concept in billing for hospice patients. When a patient elects their MHB, they are asked to select the physician they want as their hospice attending physician. This is a patient/family decision but the hospice can make suggestions. For billing convenience, the attending of record (AOR) should be the physician who is primarily responsible for managing the patient’s terminal illness. The AOR may not—and sometimes should not—be the patient’s primary care physician. For example, if a patient is on service for cancer and they have an oncologist who is still actively involved in their care, the oncologist should be listed as the AOR. If a specialist is not involved,

then the primary care physician should be listed. In the common situation, where the patient does not have a physician or the patient's physician asks the hospice medical director to assume care, then the medical director should be listed as the AOR on the hospice election of benefit form. Medicare discourages hospice agencies from pressuring patients to elect the medical director as the AOR.

In the circumstance where the hospice medical director is also the patient's AOR, any direct patient care services which are related to the hospice diagnosis, must be billed through the hospice. Care for unrelated conditions will be billed as though the patient were not receiving hospice services, with the exception that the physician will use the coding modifier **GW**. This indicates that the condition being billed for is not related to the hospice condition. Billing for care that is unrelated to the hospice condition will generally be done through Medicare B and is not billed through the hospice.

### ***Examples: medical director - attending of record***

1. A patient, who is receiving hospice services for lung cancer, presents to the clinic for follow-up on long-standing diabetes. This is a condition which is unrelated to the cancer. The physician (who is also the hospice medical director) will bill Medicare B for services and indicate that this condition is not related to the hospice diagnosis by using the **GW** modifier on the billing form.
2. The same patient with lung cancer comes to the physician's clinic for follow-up on the treatment of pain from the cancer. Since this visit is related to the hospice condition, the physician (who is also the hospice medical director) will bill for the visit through the hospice agency, which will then bill Medicare A and reimburse the physician per their compensation agreement.
3. The physician – medical director sees a patient during a routine nursing facility visit. The primary purpose of the visit is to fulfill the nursing facility administrative requirements for physician visits. The physician may address topics related to the terminal illness, but the visit was not requested or approved by the hospice IDG and would not have happened except for the facility regulatory requirements. The physician should bill this visit as they normally would, if the patient were not receiving hospice care, through Medicare B. For billing purposes it is best if the hospice diagnosis is not used as a billing diagnosis. Instead, use ICD-9 codes for the symptoms related to the diagnosis, if needed or for another unrelated diagnosis, and use the coding modifier **GW**.
4. The IDG team is not sure whether a patient is eligible for care; the medical director makes a visit to assess eligibility. No other types of assessment or recommendations occur during the visit. This is not a billable visit; eligibility assessments are covered under a medical director's administrative pay.

## **Nonmedical Director and Attending Physician**

This applies when a physician is the hospice AOR for a patient who is receiving hospice services but the physician does not have any financial or other (volunteer) relationship with the hospice as a medical director. This also applies when the physician is a medical director for hospice A and their patient is receiving services from hospice B. Essentially, the physician cannot be acting as a hospice medical director with real or potential oversight responsibilities for the patient on service. In this circumstance, all professional services performed by the (nonmedical director) AOR are billed as though the patient were not receiving hospice services, with three exceptions.

- When billing for care related to the hospice diagnosis, the AOR physician must indicate that they are not employed by the hospice by using the coding modifier **GV**.

- When billing for care that is not related to the hospice diagnosis, the coding modifiers **GV** and **GW** will be used. The use of coding modifiers is reviewed in detail under the chapter on Specific Billing Issues.
- 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 per diem.

The above statements assume that the physician is the “hospice attending of record.” If a non-medical director, physician encounters problems when billing for a patient receiving hospice services, the first step is to verify that they are listed as the AOR with the hospice. A physician 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 (and should) be listed as the attending of record. Occasionally, errors are made and a covering physician, emergency room doctor, or hospitalist is named in the Medicare Election of Benefit as the AOR. With consent from the patient, the AOR can be changed by the hospice to a more appropriate choice.

When a physician, who is providing care to a hospice patient, is not named as the AOR, they can still bill Medicare as usual for visits and care unrelated to the terminal illness – using the coding modifier **GW**. However, for any care related to the terminal condition, they will need a contract with the hospice and must bill through the hospice using attending/managing CPT codes. In this circumstance, the physician is 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 non-attending physician) for more details.

**Example: Non medical director-attending of record, office visit**

A patient with end-stage chronic obstructive pulmonary disease has elected her Medicare Hospice Benefit. The physician listed as the AOR and is not a medical director for the hospice. The patient is seen for a follow-up visit because of her progressive dyspnea, related to her terminal diagnosis. The physician will bill Medicare B using the appropriate CPT code for the visit and use the coding modifier **GV**, indicating that they are not the hospice medical director. Since this condition is related to the hospice diagnosis, the modifier **GW** will not be used.

## Care Plan Oversight

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

- The physician must *not* be a medical director for the hospice that is providing the care
- The physician must document in the patient’s chart that they spent 30 minutes or more in a calendar month in CPO activities.
- The physician must have billed for a face-to-face contact with the patient in the 6 months prior to billing for CPO.
- Only one physician may bill CPO for a given time period and this must be the physician who signs the hospice plan of care.

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
- 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
- Communication including telephone calls for purposes of assessment or care decisions with health care professionals, family members, surrogate decision makers and/or key caregivers involved in the patient’s care.

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 the reimbursement for the visit.

If these requirements are met, a physician 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 reimbursed; the two reimbursable codes are listed below. Care Plan Oversight activities have designated CPT codes but Medicare requires that they be billed using the indicated HCPCS G codes.

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

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

### **Example**

During the course of one calendar month, a physician AOR can document 35 minutes of CPO activities which include talking with the patient’s nurse by phone, reviewing the care plan, and reviewing lab test results. The physician can bill Medicare B for CPO using code **G0182** with the modifier **GV**.

## **Nonmedical Director and Non-Attending Physician**

- **Consulting Physician:** This is not to be confused with the CPT consultant billing codes (which are no longer available). When a physician is asked to see a hospice patient for symptoms related to the hospice diagnosis, but that physician is neither the attending of record nor the medical director, they are considered a consulting physician. 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, the physician can then bill the agency for both professional and technical services. The hospice bills Medicare A for professional services, and the physician is reimbursed at the contracted rate. Technical services are paid by the hospice (from their per diem), but cannot be not separately billed to Medicare by the hospice.



## **Examples**

1. A patient who is receiving hospice services is referred to a palliative care physician for evaluation of poorly controlled symptoms related to their hospice diagnosis, which the hospice team has been unable to manage. The palliative care physician must bill for this service through the hospice agency based on a contract with the agency.
2. A hospice patient with metastatic cancer and painful boney metastases is referred to a radiation oncologist for consideration of palliative radiation therapy. The radiation oncologist is not the attending of record or the medical director and the condition is related to the terminal diagnosis. In order to be paid for providing professional or technical services to the hospice patient, the radiation oncologist will need a payment contract with the hospice agency and will bill through the hospice agency.

## Chapter 3

### Time Based Billing

*When the majority of the visit is spent teaching, counseling and/or coordinating care, the billing may be based on the time spent rather than the usual E&M complexity criteria.*

As with all the other members of the IDG, physician patient visits need to be approved by the IDG, and that approval should be documented in the patient chart. Planned physician visits should 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 physician rounding on hospice patients should not occur. One of the key factors for Medicare in determining reimbursement is the medical necessity of the visit. 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	Related to Terminal Dx	Service	Billed To	Codes
Medical Director	Attending of Record or not AOR but managing a medical problem	Yes	Professional Technical	Hospice	
		No	Professional Technical.	Medicare B <sup>1</sup>	Modifier GW
		Yes	CPO	Not billable	
Non-Medical Director	Attending of Record	Yes	Professional	Medicare B <sup>1</sup>	Modifier GV
		Yes	Technical	Hospice	
		Yes	CPO	Medicare B	Modifier GV
		No	Professional Technical	Medicare B <sup>1</sup>	Modifiers GV and GW
Non-Medical Director	Not Attending of Record	Yes	Professional Technical	Hospice	
Non-Medical Director	Not Attending of Record	No	Professional Technical	Medicare B <sup>1</sup>	Modifier GW

<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; this 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 on these activities, 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 components of history, exam, or decision-making complexity which are otherwise required for the given billing code.

### **Location**

When using time as the guide to billing, note that the definition of “time spent” is based on whether the patient is in an inpatient or outpatient setting.

- **Hospital or Skilled Nursing Facility:** time spent means the total time spent on the facility unit where the patient is located and includes chart review, patient history and physical (H&P), communication with other caregivers and family to coordinate care, and writing the visit note.
- **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 family members or caregivers prior to or after the patient visit.

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

Each of the billing codes has an associated “suggest time”. The suggested times should be considered as threshold values. When billing based on time, a given CPT code should not be used unless the time documented time associated with the visit meets or exceeds the suggested time associated with that code. Previously, these times were considered averages and it was recommended that the time be rounded up or down to the appropriate code, this use of the suggested times is no longer correct.

### **Example**

A physician sees a new patient at home and the visit lasts 70 minutes. The physician can document that he spent at least 50% of the time in teaching and counseling with the patient. The coding choices are **99344** (60 minutes) and **99345** (75 minutes). The correct choice would be to select the 99344 code since the documentation did not meet or exceed the 75 minutes required for the higher level code.

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

Billing based on time is an option for any visit for which the documentation can support that more than half of the time spent was in teaching or counseling. When these criteria cannot be met the only other option is to use the more common criteria based on documentation and problem complexity. When billing based on the complexity of E&M services, the documentation must support the level of service billed based on the following components of the 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 2009: Current Procedural Terminology* (AMA, 2011).

## Prolonged Service Codes

### Face-to-Face Visits

The prolonged service codes are to be used when the face-to-face) patient encounter lasts *at least* 30 minutes longer than the usual time for a given visit code. This applies to both the inpatient and outpatient setting. 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. When using prolonged service codes, while billing based on time, the highest code level in the family of codes must be used as the primary code.

### Example

A physician makes a new home visit and spends 70 minutes, half of which is spent in teaching and counseling. They can not bill using 99341 (20 minutes) and a prolonged service code 99354 (additional 30-74 minutes), Instead they should bill using the highest appropriate code in the new home visit family: 99344 (60 minutes). Prolonged services could not be used unless the documented time was 105 or more minutes – 30 or more minutes beyond the highest typical time for a new home visit which is a 99345 (75 minutes). As a reminder, in this case, the physician can not round the 70 minute visit up to the 99345 code because the 75 minutes are considered a threshold not an average.

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). As many of these codes additional codes (99355 or 99357) as necessary can be used to cover the time spent, even if the time spent on a given day was not in a continuous block.

Duration of Services (beyond the “typical time for the appropriate CPT code)	Code(s) Used
Less than 30 minutes	Use only the appropriate CPT code for the visit
30 to 74 minutes (code time + from 30 to 74 additional minutes)	Outpatient: visit CPT code + 99354 x1 Inpatient: visit CPT code + 99356 x 1
75-104 minutes (code time + from 75 to 104 additional minutes)	Outpatient: visit CPT code +99354 x1 + 99355 Inpatient: visit CPT code +99356 x 1+ 99357
More than 104 minutes (code time + 104 or more additional minutes)	Use additional 99355 or 99357 codes as needed for each additional 30 minutes. The final code used must include at least 30 minutes

There is currently a discrepancy between the AMA CPT Billing guide and Medicare’s policy for reimbursement for inpatient prolonged service. The CPT guide replaces the phrase “direct face-to-face

patient contact” with “unit/floor time” a significant change that could result in better reimbursement for the actual time spent in providing comprehensive patient care in an inpatient setting, unfortunately, Medicare is still using the phrase “direct face-to-face patient contact” in their definition for inpatient prolonged service. (MLN Matters article MM5972 April 2008). Medicare writes the checks, so until we hear otherwise, bill based on direct face-to-face time for prolonged service.

### **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. A physician spends 1 hour and 40 minutes doing a follow-up home visit on a patient for whom they are managing several symptoms. The visit qualifies for billing based on time spent. The physician will bill using **99350** (established home 60 minutes), and because the prolonged service was 30 minutes or more beyond the typical time of 60 minutes, the **99354** code (prolonged service home/office 30 -74 minutes). The physician 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. A patient is admitted to GIP care due to a pain crisis. The 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, the physician is called back to the unit because the patient is having a reaction to the medication. An additional 30 minutes of face-to-face time is spent with the patient. That afternoon the physician returns to check on the patient and spends 30 minutes with her reviewing the plan for the hospital stay and symptom management. The billing for this patient is based on the total time spent during the day, as follows:
  - admission, 90 minutes (assuming the billing for the admission is based on time rather than E&M complexity);
  - first follow-up, 30 minutes;
  - second follow-up, 30 minutes.
  - The total time was 150 minutes. The coding is **99223** (initial hospital 70 minutes), plus **99356** (prolonged service 30–74 minutes)—this covers the first 144 minutes—the final 6 minutes can not be billed using **99357** (prolonged service additional 30 minutes) because prolonged service of less than 15 minutes beyond the first hour (this is the reason the initial prolonged service code is for 30 to 74 minutes rather than 30 to 60 minutes) or less than 15 minutes beyond the final 30 minutes is not reported separately.
3. A new patient is seen in their home and the physician spends 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 the physician also review their assessment and recommendations with his son, who has come to the home; this is done and the conversation with the son lasts 40 minutes. The physician 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, its general content and its duration need to be documented in the note to support this billing and this additional time needs to be spent in the presence of the patient.

## ***Documenting Time Spent***

When billing based on time spent, the documentation should clearly state the beginning, ending and total time of the encounter; 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. In addition, the rest of the note must contain sufficient documentation to support the time documented.

### ***Example***

A documentation entry might read as follows: “64 minutes (10:30 am to 11:34 am) of face-to-face time with the patient, >50% of the time was spent in reviewing the hospice philosophy of care, reviewing patient goals of care and instructing the patient on proper medication usage.”

## **New vs. Established; Initial vs. Subsequent Codes**

### ***New vs. Established Patient Visits (Outpatient)***

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) the billing physician or any member of their group/practice of the same specialty within the past three years. If the patient does not meet these criteria, then the visit must be billed using established visit codes even if the patient is new to the specific physician.

### ***Initial vs. Subsequent Patient Visits (Inpatient)***

When billing for inpatient services, an initial patient visit is generally billed for the first visit made by a given physician to the patient. The patient may be either new or established to physician. There are no longer “consult codes” so consulting physicians will bill using initial or subsequent codes as appropriate based on the complexity (or time) of the visit. Some first visits by a consultant may not contain sufficient documentation to meet criteria for an initial visit, such a visit may be billed using a subsequent code even if it is the physician’s initial visit with the patient during the inpatient episode of care.

### ***Example***

A patient is admitted to the hospital for problems related to their cancer. A request is made to the palliative care team to assist with pain management. Although an initial code was used by the admitting physician, the palliative care physician may also use an initial code for the first visit if complexity or time spent meets the criteria for an initial code. Additional visits by either the admitting or palliative care physician will be billed using subsequent codes.

## Chapter 4

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### Billing Based on Visit Location

*There is a lot of confusion regarding the new vs. established and initial vs. subsequent visit codes – especially with the loss of the consult codes.*

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

A physician who is seeing an outpatient for the first time, will use the new office or other outpatient (**99201–99205**) or new home (**99341–99345**) codes. If the physician is seeing a known (to the physician, clinic or group) patient, they will use attending/managing physician established codes for home (**99347–99350**) or office or other outpatient (**99211–99215**) visits. If the physician is the non-medical director, AOR then these visits regardless of the diagnosis used will be billed as usual using the coding modifier GV, if the diagnosis is not related to the hospice diagnosis then the modifier GW will also be used. If the physician is not the AOR then any visit related to the hospice diagnosis will be billed through the hospice and any unrelated visit will be billed as usual using the coding modifier GW.

<b>New Home</b>	99341 (20 minutes)
	99342 (30 minutes)
	99343 (45 minutes)
	99344 (60 minutes)
	99345 (75 minutes)

<b>New Office</b>	99201 (10 minutes)
	99202 (20 minutes)
	99203 (30 minutes)
	99204 (45 minutes)
	99205 (60 minutes)

<b>Established Home</b>	99347 (15 minutes)
	99348 (25 minutes)
	99349 (40 minutes)
	99350 (60 minutes)

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

#### **Hospital Visits**

The first visit, by the admitting and any consulting physicians, during a given inpatient episode of inpatient care should be billed using an initial hospital code. On occasions, a consultant's initial visit will not meet the E&M criteria for an initial visit, in that circumstance, if not billing based on time, use of a

subsequent hospital code is acceptable. Remember that the initial codes are only used once during a hospitalization, by a given physician/group. Time with the patient on the hospital floor or unit can be counted when billing based on time. Either code group can be used with a new or an established patient.

<b>Initial Hospital</b>	99221 (30 minutes)
	99222 (50 minutes)
	99223 (70 minutes)

<b>Subsequent Hospital</b>	99321 (15 minutes)
	99322 (25 minutes)
	99323 (35 minutes)

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

For billing purposes, a nursing facility is considered any one of the following: skilled nursing facilities (SNFs), intermediate care facilities (ICFs), or long-term care facilities (LTCFs). These are locations where a patient is receiving convalescent, rehabilitative or long-term care. They are to be distinguished from domiciliary locations such as assisted living facilities which provide room and board sometimes other personal services, but these do not include a significant medical component of care.

The coding groups for nursing facilities are initial, subsequent, and annual. The initial and subsequent nursing facility codes can be used for either new or established patients. The initial codes (99304-99306) are used for the first visit, by the admitting and any consulting physicians, during a given episode of inpatient care. On occasions, a consultant's initial visit will not meet the E&M criteria for an initial visit, in that circumstance, if not billing based on time, use of a subsequent hospital code is acceptable. Remember that the initial codes are only used once during a given SNF stay by a given physician/group. These codes cannot be used by advance practice nurses. The annual nursing facility assessment has its own code.

<b>Initial Nursing Facility</b>	99304 (25 minutes)
	99305 (35 minutes)
	99306 (45 minutes)

<b>Subsequent Nursing Facility</b>	99307 (10 minutes)
	99308 (15 minutes)
	99309 (25 minutes)
	99310 (35 minutes)

<b>Annual Nursing Facility</b>	99318 (30 minutes)
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### ***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 state to state.

<b>New Assisted Living</b>	99324 (20 minutes)
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99325 (30 minutes)  
99326 (45 minutes)  
99327 (60 minutes)  
99328 (75 minutes)

**Established Assisted Living**      99334 (15 minutes)  
99335 (25 minutes)  
99336 (40 minutes)  
99337 (60 minutes)

### ***Hospice Inpatient Facilities***

There are no specific codes available for use when billing for patient visits in a dedicated hospice facility. For GIP patients most are using hospital codes. A more conservative approach would be to bill using SNF codes.

There are two types of patients to consider:

1. Billing for hospice patients who are on a residential status in the facility
2. Billing for hospice patients who are on GIP status in the facility.

In the absence of direct guidance from CMS, the following are recommended:

**Residential:** a number of facilities are currently billing these as ‘home visit’ on the basis that this is now the patient’s home. This is not correct. The home codes (99341-99350) are used for visits to a patient in a “private residence”. In an informal survey, a majority of IPU’s, were using the domiciliary codes (99324-99337) and absent further guidance from CMS this seems reasonable.

**General Inpatient:** In an informal survey of several agencies around the country, nearly all were using hospital inpatient codes to bill for GIP patients who are in a dedicated hospice facility. The more conservative option would be to bill using SNF codes.

## Chapter 5

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### Specific Billing Issues

*The newest and most important of these is the face-to-face encounter.*

#### Consultations

Consultation codes, while still listed in the CPT manual, are not reimbursed by CMS so should not be used. When performing consult services bill using the code most appropriate to the location and nature of the visit as reviewed above.

#### 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. The key to a GIP admission is that there must be a documented skilled care need that can not be provided in the home. Billing for physician visits to GIP patients is generally based on the nature of the GIP facility – nursing facility vs. hospital. Hospice inpatient units do not have unique billing codes and the use of hospital or SNF billing codes are recommended.

#### Face to Face Encounters

As of January 2001 CMS now requires that all patients have a, physician or hospice employed nurse practitioner, face to face encounter (FTFE) prior to recertification, when they are entering their third and each subsequent certification period. The regulatory components of the FTFE are beyond the scope of this manual but there are significant billing issues to be considered.

The FTFE is a “regulatory” as opposed to a clinical visit, and therefore falls under the medical director’s administrative responsibilities. This type of visit, like a visit for eligibility assessment, is not separately billable. However, if the visit combined the FTFE with a component of care that was **medically reasonable and necessary** the physician or nurse practitioner (NP) should use the appropriate billing code, based on what occurred during the clinical portion of the visit. It is recommended that the documentation of the clinical portion of the visit be separate from the documentation of meeting the FTFE requirement. A hospice employed NP can only bill the clinical portion of the visit if they are designated as the hospice attending of record, which is true for all NP hospice billing. If the visit does not include a component that can be justified in the documentation as medically reasonable and necessary, beyond the FTFE requirement, then the visit is non-billable.

#### 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,



The key is that the visit was not made for the sole purpose of performing the procedure and other billable activities occurred during the visit that would not be construed as usual pre and post procedure activities.

***Procedure Codes Commonly Used***

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

## Chapter 6

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### Documentation

*Documentation must not only support the billing codes that are used but must also meet the specific requirements for the type of visit which is being billed.*

Physicians 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.

#### General Documentation Guidelines

By way of final review, visit documentation should meet the following minimal standards:

- Medical necessity: there must be a documented reason for the visit beyond routine rounding on the patient
- Time: particularly if billing based on time, document the beginning and end of the visit, the total time spent and the amount or percentage of time spent in teaching, counseling and coordinating care. To be safe, document where the time was spent to meet the criteria for time based billing based on location. This is particularly true if billing with prolonged service codes.
- What was done: If billing based on time or using prolonged service codes, the note must justify the time spent.
- Legibility: an illegible note will likely not be able to justify the level of code that was used.

## References

1. American Medical Association. *CPT 2011*. Chicago, IL: American Medical Association; 2011.
2. MLN Matters number: MM5972 release date April 11, 2008
3. CMS Claims Processing Manual, Chapter 11 Hospice Claims