Inpatient Palliative Care Billing: 3 Case Studies

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Join us for upcoming CAPC events

- **Upcoming Webinars:**
  - **Caring for Vulnerable Populations with Serious Illness** with Will Kennedy, DO

    Tuesday, April 30 at 1:30pm ET
  - **Bridging Gaps in the Continuum of Care through Local Partnerships** with Stephanie Broussard, LCSW, ACHP-SW and Robert Link

    Tuesday, May 14 at 12:30pm ET

- **Virtual Office Hours:**
  - **Marketing to Increase Referrals** with Andy Esch, MD, MBA and Lisa Morgan

    Thursday, April 11 at 2:00pm ET
  - **How to Contract with Payers** with Tom Gualtieri-Reed, MBA and Kris Smith, MD

    Friday, April 12 at 12:30pm ET

Register at www.capc.org/providers/webinars-and-virtual-office-hours/

Billing Series: Upcoming CAPC events and Resources

- **Upcoming Webinar:**
  - **Billing and Coding for Advance Care Planning: How to Document Services Correctly to Reflect Your Productivity** with Andy Esch, MD, MBA and Kristina Newport, MD

    Tuesday, June 11 at 12:30pm ET

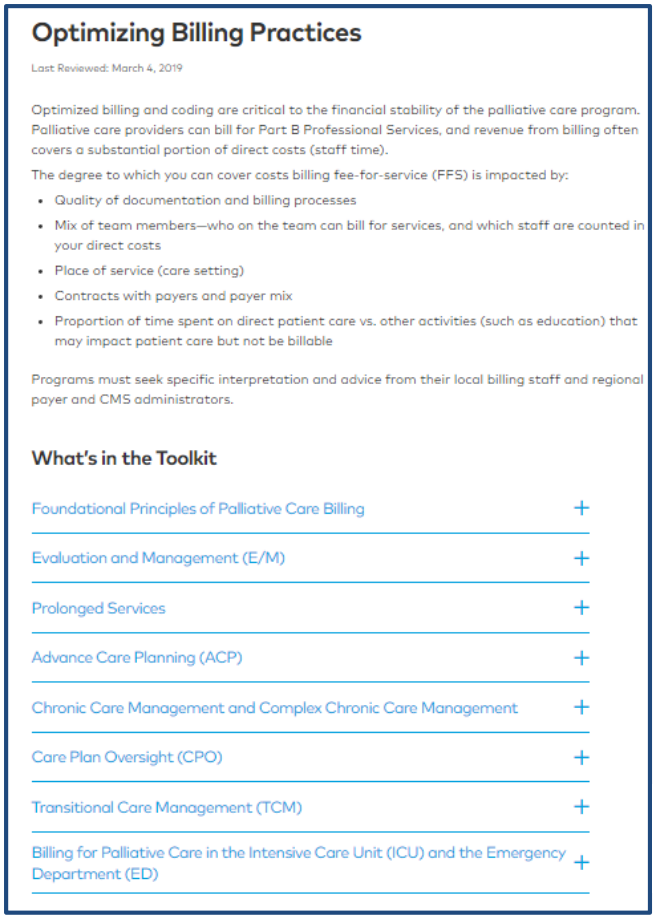
- **Virtual Office Hours:**
  - **Billing for Community Palliative Care** with Anne Monroe, MHA

    Friday, April 12 at 2:00pm ET
  - **Billing and RVUs in Hospital-Based Palliative Care** with Julie Pipke, CPC

    Friday, April 19 at 12:30pm ET

- **Resources:**
  - **Optimizing Billing Practices**

    https://www.capc.org/toolkits/optimizing-billing-practices/



Optimizing Billing Practices

Last Reviewed: March 4, 2019

Optimized billing and coding are critical to the financial stability of the palliative care program. Palliative care providers can bill for Part B Professional Services, and revenue from billing often covers a substantial portion of direct costs (staff time).

The degree to which you can cover costs billing fee-for-service (FFS) is impacted by:

- Quality of documentation and billing processes
- Mix of team members—who on the team can bill for services, and which staff are counted in your direct costs
- Place of service (care setting)
- Contracts with payers and payer mix
- Proportion of time spent on direct patient care vs. other activities (such as education) that may impact patient care but not be billable

Programs must seek specific interpretation and advice from their local billing staff and regional payer and CMS administrators.

What's in the Toolkit

Foundational Principles of Palliative Care Billing +

Evaluation and Management (E/M) +

Prolonged Services +

Advance Care Planning (ACP) +

Chronic Care Management and Complex Chronic Care Management +

Care Plan Oversight (CPO) +

Transitional Care Management (TCM) +

Billing for Palliative Care in the Intensive Care Unit (ICU) and the Emergency Department (ED) +

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Gaps

- Gap 1 – Billing revenue is not sufficient to fund palliative care programs
- Gap 2 – Due to the complexity of billing and coding regulations, many palliative care teams miss opportunities to capture revenue for services performed
- Gap 3 – Lack of understanding of billing and coding e.g. billing on time vs. complexity, use of modifiers

Desired Outcomes

- Help palliative care teams understand a few foundational principals of billing and coding
- Help palliative care teams understand the relationship between RVUs and revenue
- Help palliative care teams use billing and coding to tell the story of what they do each day

Fundamentals

- Make sure you are billing for what you do
- Work at it
  - Meet with your biller and coders regularly
  - Train billing staff on how to write notes / Use note templates
  - Study it (links below)
    - CMS resources
    - CAPC resources
    - AAHPM

Billing Resources

➔ "New" billing revenue opportunities

	Codes	Links for Billing Resources
Prolonged Services (Inpatient)	• **F2F: 99354 – 99357** • **Non F2F: 99358 – 99359**	• CMS Resources • CAPC Resources
Advance Care Planning	**99497-99498**	• CMS Resources • CAPC Resources
Care Management Codes		
Chronic Care Management/Complex Chronic Care Management (CCM/CCCM)	**99490, 99487, 99489**	• CMS Resources • CAPC Resources
Care Plan Oversite (CPO)	**G0181 and G0182**	• CMS Resources • CAPC Resources
Transitional Care Management (TCM)	**99495 and 99496**	• CMS Resources • CAPC Resources

Billing and Productivity: Efficiency vs. Effectiveness

- **Efficiency** is about doing things right
  - Optimal billing and coding practices
  - Short concise team meetings
  - **Maximizing billing opportunities**
  - **Minimize non-billable time spent**
- **Effectiveness** is about doing the right things
  - **Making sure that patient and caregiver are getting what they need**
  - Making sure that referring clinicians are getting what they need
  - Making sure your program is aligned strategically with administration and leadership

Palliative Care Team Goals

- Be efficient to the extent that it does not have a negative impact on effectiveness

Dilemma

- A lot of palliative care EFFECTIVENESS (value/impact) is not reflected in $, volume measures or RVUs
- Comparative metrics are just emerging
- As hard as many team members work, there are variations in efficiency and effectiveness of teams

- **The burden is on Palliative Care Teams to define alternative measures of EFFECTIVENESS & deliver on them…while also being good stewards of resources and maximizing EFFICIENCY ($)**

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PALLIATIVE CARE CASE STUDIES

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Case 1: Mrs. X

- Mrs. X is a 93 year old female admitted to hospital with dementia and aspiration pneumonia. You assist with her dyspnea, discuss goals of care bedside with the family for 20 minutes, and coordinate care with the pulmonologist and hospitalists. Your total time spent is 35 minutes.

Mrs. X

- What ICD 10 code would you bill as first code?
- Would you bill on time or complexity?

What codes would you bill?

- Palliative care providers regularly see patients on the same day as other medical providers
- If multiple medical providers, regardless of specialty, treat a patient on the same date for the same diagnosis, there is a risk of rejection of one provider's bill for duplication of services
- If a pulmonologist and a palliative care consultant both treat a patient with aspiration pneumonia and both report only ICD-10 code J69.0 (Pneumonitis due to inhalation of food and vomit), one provider will likely not get paid.

What codes would you bill?

- To avoid impacting a referring provider's reimbursements, palliative care providers should bill for the symptom treated and allow the referring physician to bill for the underlying disease

Commonly Used ICD-10 Codes

Symptom	ICD-10	Symptom	ICD-10
Agitation	R45.1	Pain: abdomen	R10.9
Anorexia	R63.0	Pain: arm	M79.603
Anxiety	F41.9	Pain: back	M54.9
Coma	R40.20	Pain: bone	M89.9
Confusion	F29	Pain: chest	R07.89
Cough	R05	Pain: foot	M79.673
Debility	R53.81	Pain: hip	M25.559
Diarrhea	R19.7	Pain: leg	M79.603
Dyspnea	R06.00	Pain: muscle	M79.1
Encounter for palliative care	Z51.5	Pain: neck	M54.2
Failure to Thrive	R62.7	Pain: non-specified	R52
Fatigue	R53.83	Pain: sacroiliac	M53.3
Fever	R50.9	Pain: throat	R070
Headache	R51	SOB	R06.00
Hemorrhage	R58	Unconscious	R40.1
Inanition	E46	Vomiting	R11.10
MS Change	R41.82	Weakness	R53.1
Nausea	R11.0	Weight loss	R63.4
Nausea & Vomiting	R11.2		

Coding

- Safest choices would be Dyspnea (R06.00) and Palliative Encounter (Z51.5)
  - ACP coding would not apply (discussed goals of care not ACP per se)
  - Do not meet thresholds for Prolonged F2F
  - Does not meet Critical Care Criteria
- Allows for Pulmonology to bill for J69.0
- Communicate with other providers

Would you bill on time or complexity?

- Many clinicians submit their bills exclusively using face-to-face time (so-called “billing on time”)
- This often makes sense, since complex medical decision making and goal setting can be very time consuming.
- Time-based billing is appropriate when a clinical encounter supports documentation that:
  - (1) notes that more than 50% of time was spent in counseling and/or care coordination
  - (2) lists the minutes of total time spent, and
  - (3) describes specifically what was counseled or with whom care was coordinated.

Would you bill on time or complexity?

- When paired with the appropriate history, physical exam, and medical decision making elements, caring for high complexity patients (multiple comorbidities, use of opioids etc..), even if done quickly, can justify a high-level CPT® code and increased reimbursement
- As an example, the highest-level subsequent hospital visit (CPT® 99233) requires that the visit last at least 35 minutes to code based on time, and that greater than 50% of the time is spent in counseling and coordination of care
- Alternately, the CPT® 99233 based on using key components (billing by intensity or comprehension) requires two of the following: Detailed Interval History (four or more elements of History of Present Illness, two Review of Systems); Detailed Exam (an extended exam of two or more body areas or organ systems); and High Complexity of Medical Decision Making, which could be done in a 15-minute timeframe

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4347885/

Billing Time vs. Complexity

- I'd bill on time here
- Not that complex
- Greater than 50% was spent counseling

(20 min of 35 total)

Case 2: Ms. Y

Ms. Y is a 45 year old female with stage IV breast cancer referred by the surgical oncologist for neuropathic pain, nausea, and establishing goals of care. She is seen for 50 minutes on the inpatient oncology floor of the hospital as a new patient for her symptoms and counseling that was face to face but less than 50% of the time spent in her care. Your documentation reflects a comprehensive history, comprehensive exam and medical decision making of moderate complexity.

- What ICD 10 codes would you use
- Would you bill by complexity or time?

Billing and Coding Explanation

Diagnosis/Symptoms–ICD-10 codes:

- **Symptoms**
  - M79.2 neuropathy
  - R11 nausea
- **Diagnosis**
  - C50.111 Malignant neoplasm of central portion of right female breast
- **Modifier**
  - Z51.5 Encounter for Palliative Care
- *CPT: Time or **Complexity**
  - Initial Inpatient Visit = 99222
- POS (You won't code this) – Inpatient hospital = 21

Z51.5

Palliative care services should be identified with ICD-10 code

Z51.5 Encounter for palliative care

- This code signifies a palliative care encounter by a specialist
- Specialist can be a physician, nurse practitioner, clinical nurse specialist, physician assistant or social worker
- It is essential to use this code to signify palliative care visits
- List Z51.5 after the ICD-10 codes for symptoms and diagnoses

Z51.5

Z codes can be used in any healthcare setting, inpatient or outpatient

- Z codes indicate a reason for an encounter
  - They give more information about certain characteristics of a patient
- Z51.5 Encounter for Palliative Care
  - Identifies the patient as being seen for palliative care
  - This is important to capture national data on palliative care visits
- ***Z51.5 Code Cannot be Principal/First-Listed Diagnosis***

Please refer to ICD-10 CM Official Guidelines for Coding and Reporting (2018) in CAPC's Billing and Coding Toolkit

RVUs BILLING AND REVENUE

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RVUs

- RVU stands for **relative value unit**. It is a value assigned by CMS to each CPT/HCPCS code, and represents the cost for providing a service
- An RVU is made up of three components: physician work, practice expense, and malpractice overhead.
  - **Physician work RVUs (wRVU) is the main measure for clinician productivity**

- *Medicare payments are composed of these RVU values multiplied by factors of conversion and geographical adjustment.*

RVUs

- For each service, Medicare determines RVUs for three types of resources:
  1. **Physician work RVUs (wRVU) account for the time, technical skill and effort, mental effort and judgment, and stress to provide a service**
     - **This will be the focus of our discussion as it is the what clinicians are measured with**
  2. Practice expense RVUs account for the non-physician clinical and nonclinical labor of the practice, as well as expenses for building space, equipment, and office supplies
  3. Professional liability insurance RVUs account for the cost of malpractice insurance premiums

  Total RVUs = 1 + 2 + 3

Principles & Drivers of wRVU Targets: Why Administration is Interested in Your wRVUs

- Equity and consistency – "we do it for everyone else"
- Need for comparative metrics to evaluate resource requests
- **Direct correlation to revenue (higher RVU is higher reimbursement)**
- They are a proxy for "accountability" and "productivity"

Case 3: Mr. Z.

- Mr. Z has Lung Cancer with hemoptysis, respiratory failure, and COPD. He was admitted to the ICU and put on mechanical ventilation. He has been intubated for 2 weeks and weaning attempts have been unsuccessful. ICU team is considering feeding tube placement, and tracheostomy but his prognosis is poor, and he is agitated. Palliative care team is asked to consult. PC team does a comprehensive history and physical exam and addresses his pain, delirium, secretions in the initial visit and then meets with family in the patients room for an additional 60 min to discuss prognosis and goals of care.

- How would you bill and code this case?

Billing and Coding for Mr. Z

- Option 1
  - Initial inpatient hospital visit Comprehensive History and Physical 99223

Billing and Coding for Mr. Z

- Option 2
  - Initial inpatient hospital visit – comprehensive. Code 99223
  - Prolonged Face to Face meeting – Code 99356

Billing and Coding for Mr. Z

- Option 3
  - Initial inpatient hospital visit – comprehensive. Code 99223
  - ACP discussions first 30 min – Code 99497
  - ACP discussion additional 30 min – Code 99498

Billing and Coding for Mr. Z

- Option 4
  - Bill Critical Care Codes for 90 min of care
    - 99291 for first 74 min
    - 99292 for each additional 30 min beyond the first 74

Comparative RVUs

Code	RVU	Revenue (approx.)
99223	3.86	$206
99356	1.71	$93
99497	1.50	$80
99498	1.40	$75
99291	4.50	$205
99292	2.25	$103

Use the **CMS physician fee schedule look-up tool** to check the exact reimbursement for your location.

Billing and Coding for Mr. Z: Which is the right answer?

- Option 1
  - Initial inpatient hospital visit Comprehensive History and Physical 99223
- Option 2
  - Initial inpatient hospital visit – comprehensive. Code 99223
  - Prolonged Face to Face meeting – Code 99356
- Option 3
  - Initial inpatient hospital visit – comprehensive. Code 99223
  - ACP discussions first 30 min – Code 99497
  - ACP discussion additional 30 min – Code 99498
- Option 4
  - Bill Critical Care Codes for 90 min of care
    - 99291 for first 74 min
    - 99292 for each additional 30 min beyond the first 74

Answer

- I do not know, BUT there are RVU implications, and RVUs approximate productivity and directly influence revenue

	Codes	wRVUs	Total wRVUs	Revenue
Option 1 Comprehensive	99223	3.86	**3.86**	**$206**
Option 2 Prolonged Visit	99223 + 99356	3.86+1.71	**5.57**	206+93 **= $299**
Option 3 ACP	99223 + 99497 + 99498	3.86 +1.50+1.40	**6.76**	206+80+75 **= $361**
Option 4 Critical Care	99291 + 99292	4.5+2.25	**6.75**	205 + 103 **= $308**

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Many teams only bill for the initial visit and do not take advantage of prolonged, ACP and Critical care services. Meaning only 3.86 RVU. **Did they do less work?**

Same Visit, Different RVUs

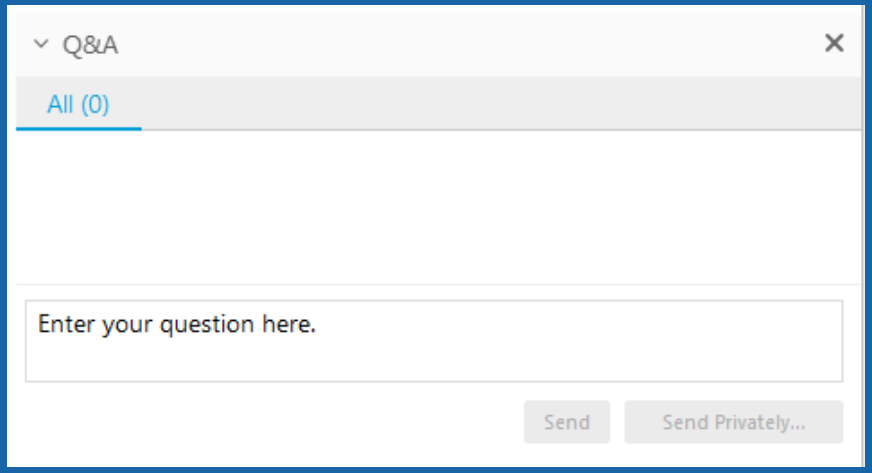
- Billing is influenced by many factors
  - Local culture
  - Regional MAC preferences
- We are not encouraging one way of billing a case like this, just pointing out that HOW your **billing and coding will impact** any measures of productivity using RVUs and **YOUR BOTTOM LINE**

Putting It All Together

- Billing is a skill – you need to work at it
- Learn the foundational principals first
- Work with you billers and coders
- Your billing should tell the story of your day – just like your notes
- Understand how RVUs relate to revenue and your perceived productivity

Questions?

Please type your question into the questions pane on your WebEx control panel.



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