PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #48
CODING AND BILLING FOR PHYSICIAN SERVICES IN PALLIATIVE CARE

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Introduction Many primary care and specialist physicians (e.g. oncologists) are now becoming part or full-time palliative care "consultants". Issues of coding and reimbursement are no different for palliative care than for any other medical specialty. That is, physicians code for each patient encounter in two parts: 1) a procedure/service code, and 2) a diagnosis code.

Procedure/Service Codes are published in the Current Procedural Terminology book published by the American Medical Association. This is used universally in US health care; the Evaluation/Management (E/M) codes are used most frequently. A code is chosen based on location, complexity and effort. Time can be used as a measure of complexity and effort when counseling and information-giving comprise more than 50% of the encounter. For inpatient visits, time is defined as the total time on the unit related to the patient, including reviewing the chart, interviewing and examining the patient/family, reviewing studies, calling resources, and documenting the encounter. For out-of-the hospital patient encounters (e.g. clinic, home visit) time is defined as the face-to-face time with the patient.

Diagnosis codes are chosen from the International Classification of Diseases (ICD). The list is broader than pathophysiological entities—there are many symptom codes (e.g. fatigue 780.79 or vomiting 787.03). Those who do billing for physicians often make a list of frequently used codes for easy reference rather than looking them up each time.

Concurrent care and billing is permitted as long as there is a legitimate need, and the concurrent physician provides a service different from the other physician seeing the patient on the same day. Coding can describe the differences by using a different diagnosis code from other physicians. For example, if you provide a consultation for a patient with CHF and dyspnea. The primary physician will likely use the code for CHF; the palliative care physician can use the code for dyspnea (786.09).

Documentation must support the coding and billing. If time is used, explicitly indicate the total time spent and what was done: e.g. "*I spent a total of 90 minutes; 60 minutes were comprised of counseling and information giving around the diagnosis and prognosis with the patient and her husband. In summary, we agreed that…"* Make any recommendations or conclusions clearly legible and easy to find in the note.

Explicitly describe the issues and prognosis. Describe the physical, psychological, social, and spiritual dimensions that make this case so complex as to require your expert assistance. For example *"I have rarely seen such a challenging case of refractory pain, nausea and vomiting complicated by difficult family dimensions and existential distress. Specifically…."* **Do not hedge about prognosis.** "*There is evidence of multiple organ failure. In my best judgment, this patient will die in 24-48 hours and continues to require skilled RN and daily MD assessment because of the rapid changes."*

If the patient has elected the **Medicare Hospice Benefit**, the primary attending (if not associated with the hospice organization, i.e. as a hospice medical director) submits bills to Medicare under Part B. All other physicians (e.g. consultants) submit their bills to the hospice organization, who then submit the claims to Part A. These physicians are reimbursed directly from the hospice agency.

Reference

von Gunten CF, Ferris FD, Kirschner C, Emanuel L. Coding and reimbursement mechanisms for physician services in hospice and palliative care. *J Palliat Med*. 2000; 3(2):157-164.

Version History: This *Fast Fact* was originally edited by David E Weissman MD. 2nd Edition published August 2005; 3rd Edition May 2015. Revised in February 2008 to reflect changes in ICD-9-CM codes. Current version re-copy-edited April 2009; then again May 2015.

Fast Facts and Concepts are edited by Sean Marks MD (Medical College of Wisconsin) and associate editor Drew A Rosielle MD (University of Minnesota Medical School), with the generous support of a volunteer peer-