

Documentation, Coding and  
Billing for Palliative Care  
Services



**Documentation, Coding and  
Billing for Palliative Care Services**

*National Hospice and Palliative Care Organization  
Creating the future of Palliative Care  
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*Presented by:  
Acevedo Consulting Incorporated  
Jean Acevedo, LHRM, CPC, CHC, CENTC*

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## **+ AGENDA**

- **Medical Necessity**
- **E&M Documentation Guidelines**
  - C/CC
  - Key Components
- **Consultations**
- **Hospital visits**

## + Medical Necessity

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Medicare law requires that in order for expenses incurred for items or services to be covered, they must be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

CMS Glossary for Beneficiaries defines medical necessity as: "Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor. "

## + Medical Necessity

*(Pub 100-4, Medicare Claims Processing Manual, Ch. 12, §30.6)*

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**"Medical necessity is the overarching criterion for payment, in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of service than is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service billed."**

## + What Hospice Physician Services Are NOT/Are Billable?

### ■ Are NOT:

- Administrative Activities
- Medical director
  - General supervisory services
- Physician member of IDG (team physician)
 

CFR 418.304 (a)
- Visits to Hospice patients performed by a Nurse Practitioner (NP), if the specific NP has not been formally elected as the Hospice Attending.

## + Patient Care Services

- Hospice can bill Medicare for these services separately:
  - Medical services that relate to the treatment and management of the patient's terminal illness and are rendered by a physician who is either employed by or has contracted with the hospice to provide the services.
  - Semantics mean something
    - Plan of Treatment
      - Billable medical service
    - Plan of Care
      - Part of the hospice benefit, paid in the per diem

## + Duplicative vs. Concurrent Care (Particularly for Palliative Care)

### ■ Concurrent Care

- *“reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient’s treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services,”*
- 1) Does the patient’s condition” warrant the services of more than one physician on an attending (rather than consultative) basis?”, and
- 2) are the services provided by each physician/NPP “reasonable and necessary?”

## + Duplicative vs. Concurrent Care

### ■ Duplicative Care

- Medicare Benefit Policy Manual: Chapter 15, Section 30 E.
  - clearly warns Medicare contractors to “*assure that the services of one physician do not duplicate those provided by another.*”

## **+ HPI & Impression/Plan: The Most Important?**

- HPI
  - Description of the illness/problem from its onset or since the last time patient seen...
  
- Impression/Plan
  - Not only indicates what today's findings and thought processes, but substantiates future intervention!

**E&M DOCUMENTATION**

## + 7 Components Define E&M Services:

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>■ Key elements in selection of level           <ul style="list-style-type: none"> <li>■ History</li> <li>■ Examination</li> <li>■ Medical decision making</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>■ Ancillary elements in selection of level           <ul style="list-style-type: none"> <li>■ Counseling</li> <li>■ Coordination of care</li> <li>■ Nature of presenting problem (medical necessity)</li> <li>■ Time</li> </ul> </li> </ul> |
|---|--|

## +Using time to assign the level of E&M service.

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>■ If a visit consists <b><u>predominantly</u></b> of counseling or coordination of care, time is the key element to assign the appropriate level of E&amp;M service.</li> </ul> | <ul style="list-style-type: none"> <li>■ The total length of time of the encounter should be documented and the record should describe the counseling and/or activities to coordinate care.</li> </ul> |
|--|--|

**+ C/CC**

- The physician need not complete a history & exam to select the level of service. The time spent in C/CC and medical decision-making will determine the level of service billed.
- Code selection based on total time of face-to-face or (in the inpatient setting) floor time, not just the counseling time.
- Medical record must be documented in sufficient detail to justify the selection of the specific code.

**+ C/CC****■ Office/outpatient setting**

- Face-to-face time refers to patient time with the physician only.
- Counseling by other staff does not count.
- Time spent after the patient has left the office does not count.
- Duration of c/cc may be estimated but must be recorded
- Total duration of the visit also documented.
- Do not round up!



## + C/CC

### ■ Inpatient Setting

- C/CC must be provided at the bedside or on the patient's hospital floor/unit.
- Time spent in C/CC after the physician has left the floor or begun to care for another patient does not count
- Duration of c/cc may be estimated but must be recorded
- Total duration of the visit also documented.
- Do not round up!

## + Examples

1. Seventy minutes was spent in caring for this patient. Over half the time was spent in counseling, answering questions and coordination of care. The available medical chart was reviewed.
2. I discussed hospice care philosophy with patient's wife who was present at the bedside. She is made aware that hospice care is not curative but palliative in nature providing comfort care and supportive care. I had this discussion with the patient present.
4. The patient's medications were reviewed and treatment care plan was formulated. Blood transfusion was discussed. We also discussed pros/cons, risks/benefits of blood transfusions. The patient and his wife are aware that there could be blood transfusion reaction, anaphylactic shock, death or the transmission of viral disease (hepatitis C/HIV). We will type and cross and transfuse the patient for 4 units of packed red blood cells slowly. His condition will be monitored throughout the process. As the nurse is having difficulty starting an IV site, we may have to have a PICC line placed. We will also begin some lactulose therapy to assist in regulating the patient's bowels. Please see orders.
6. The patient's treatment care plan was discussed with hospice inpatient nurse.

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Palmetto's Perspective

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## Counseling/Coordination of Care FAQ

What is minimally acceptable documentation of time for counseling/coordination of care E/M services?

- A. "The majority of time spent during this visit was for counseling."
- B. "35 minutes."
- C. "Total time – 40 minutes, coordination of care – 25 minutes."
- D. "Patient seen from 9:15 to 10:00, more than 50% was for counseling."

**Answer: C and D (documentation must include a description of the coordination of care or counseling provided)**

Palmetto GBA April 2010

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**The 3 Key Components  
(Coding based on complexity)**

## #1: Documentation of History

### ■ Based on 4 types

- Problem Focused
- Expanded Problem Focused
- Detailed
- Comprehensive

### ■ History elements

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

## + Chief Complaint

- Concise statement describing symptoms, problems, condition, physician recommended return, or other factor that is the reason for the encounter.
- Chief complaint must be explicitly stated or easily inferred from documentation:
  - "Severe abdominal pain for past 8 hours" (explicit)
  - "Less agitation since adding Ativan" (inference is that visit is to f/up on medication change)

## + History of Present Illness

- History of Present Illness elements:
  - Location – body area (abdomen)
  - Quality – sharp, burning, deep
  - Severity – intensity of illness (9 on a scale of 1-10)
  - Duration – how long symptoms last (past 8 hours)
  - Timing – relation to events (constant)
  - Modifying factors – precipitating or alleviating factors (relieved by pain med)
  - Associated signs (objective evidence) or symptoms (subjective evidence) (e.g., nausea)

## + Review of Systems

- |                                       |                         |
|---------------------------------------|-------------------------|
| ■ Constitutional symptoms; e.g. fever | ■ Musculoskeletal       |
| ■ Eyes                                | ■ Integumentary         |
| ■ Ears, Nose, Mouth, Throat           | ■ Neurological          |
| ■ Cardiovascular                      | ■ Psychiatric           |
| ■ Respiratory                         | ■ Endocrine             |
| ■ Gastrointestinal                    | ■ Hematologic/Lymphatic |
| ■ Genitourinary                       | ■ Allergic/Immunologic  |

## **+ Review of Systems (ROS), cont.**

- Complete ROS addresses system related to problem plus all add'l body systems.
  - At least ten organ systems must be reviewed.
  - Those systems with positive or pertinent negative responses must be individually documented.
  - For the remaining systems, a notation indicating "all other systems are negative" is permissible.
  - In the absence of such a notation, at least ten systems must be individually documented

## **+ Past, Family and/or Social History consists of:**

- Past history (the patient's past experiences with illnesses, operations, injuries and treatments);
- Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
- Social history (an age appropriate review of past and current activities).

## + When History is Unobtainable

- Times when you cannot obtain a history from patient, due to patient's condition, and there may be no one else present with knowledge of patient's history.
- This situation does *not* automatically qualify as a comprehensive history.
- Sample documentation for a nonresponsive patient:  
*"No further past/family/social history or review of systems obtainable; no family present, chart scoured."*

## + Selecting \*Level of History

HPI	ROS	PFSH	Level
Brief (1-3 elements)	n/a	n/a	<b>Problem Focused</b>
Brief (1-3 elements)	Problem Pertinent (system directly related to problem identified in HPI)	N/A	<b>Expanded Problem Focused</b>
Extended (4 or more elements)	Extended (system directly related to problem identified in HPI & a limited # of add'l systems - 2-9 total)	Pertinent (at least 1 specific item from any of the 3 areas)	<b>Detailed</b>
Extended (4 or more elements)	Complete (system directly related to problem identified in HPI + all add'l systems or a minimum of 10 systems)	Complete (2 or all 3 of the PFSH depending on E/M category)	<b>Comprehensive</b>

\*To qualify for a given level of history, **all 3 elements** in the history table must be met.

## Documentation of Exam

Problem Focused	A limited exam of the affected body area or organ system <b>(1+ BA/OS)</b>
Expanded problem focused*	A limited exam of the affected body area or organ system and any other symptomatic/related area(s)/system(s) <b>(2-7 BA/OS)</b>
Detailed*	An extended exam of the affected body area(s) or organ system(s) and any other symptomatic or related area(s)/system(s) <b>(2-7 BA/OS)</b>
Comprehensive	Gen'l multi-system <b>(8+ OS)</b> or complete single organ system exam.

\*criteria varies by contractor

### † #2: Documentation of Exam (1995 DG)

- **Comprehensive: Gen'l multi-system (8+ OS) or complete single system organ system exam.**

#### Body Areas:

- Head, including face
- Neck
- Chest, incl. breasts & axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, incl. spine
- Each extremity

#### Organ Systems:

- Constitutional
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

## + EPF v. Detailed Exam - Example

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- **Expanded Problem Focused exam** “a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).” 2-7 BA/OS

Constitutional: VSS

Heart: RRR

Lungs: Clear

- **Detailed exam** “an extended examination of the affected body area(s) and other symptomatic or related organ system(s)” 2-7 BA/OS

Constitutional: VSS. Well developed, well nourished white female in no acute distress.

Heart: RRR, S1 S2. No murmurs, rubs or gallops.

Lungs: Clear to P&A. Normal expiratory effort w/decreased breath sounds noted. No rales or rhonchi.

## + #3: Medical Decision making (2:3 variables required)

1. The number of possible diagnoses/number of management options that must be considered
2. Amount/complexity of medical records, diagnostic tests, &/or other information obtained, reviewed and analyzed
3. Risk of significant complications, morbidity &/or mortality, as well as comorbidities associated w/the patient's presenting problem(s), the diagnostic procedure(s), &/or possible management options
  - Each variable can be one of four levels: from minimal/none to extensive/high.



## + # DX/Mgmt Options

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Number of Diagnosis/Management Options	#	X Points	= total
Self limited or minor (stable, improved, or worsening) – Maximum of 2 points in this category.		1	
Established problem (to examining MD); stable or improved.		1	
Established problem(to examining MD); worsening.		2	
New problem(to examining MD); <u>no</u> additional work up planned - Maximum of 1 point in this category.		3	
New problem (to examining MD); additional work up planned (e.g., admit/transfer).		4	
<b>4+ new problems addressed</b>		4	
<b>Total</b>			

### Legend for #Dx and Amt of Data:

Straightforward = 1 pt

Low = 2 pts

Moderate = 3 pts

High = 4 pts

## + Amount/Complexity of Data

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Amount and/or Complexity of Data Reviewed	Points
Review and/or order clinical lab tests(regardless of # ordered).	1
Review and/or order tests in the radiology section of CPT (nuclear medicine and all imaging except echocardiography and cardiac cath).	1
Review and/or order of tests in the medicine section of CPT, (EEG, EKG, echocardiography, cardiac cath, non-invasive studies, pulmonary function studies).	1
Discussion of tests results with performing physician.	1
Decision to obtain old records and/or obtain history from someone other than the patient.	1
Independent review of image, tracing, or specimen (not simply review of report).	2
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion with other health provider.	2
<b>Total</b>	

### Legend for #Dx and Amt of Data:

Straightforward = 1 pt

Low = 2 pts

Moderate = 3 pts

High = 4 pts

# + Table of Risk

TABLE OF THE RISK OF COMPLICATIONS, MORBIDITY AND MORTALITY

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

One criteria must be met or exceeded.

# + Determining MDM

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Putting these elements together...

Medical Decision Making	Straight-forward	Low	Moderate	High
Number of Diagnoses or Management Options	< 1	2	3	4 or more
Amount and Complexity of Data	< 1	2	3	4 or more
Overall Risk	Minimal	Low	Moderate	High

Which equates to...

<b>Straight-forward</b>	<b>99341</b>
<b>Low</b>	<b>99221, 99231</b>
<b>Moderate</b>	<b>99222, 99232, 99344</b>
<b>High</b>	<b>99223, 99233, 99345</b>

## Consultations

### + Intent

- The intent of a consultation service is that a physician or qualified nonphysician practitioner (NPP) or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge.

## †The 3 Rs: Request, Recommendations, Report

- A request for a consultation from an appropriate source and the need for consultation (*i.e., the reason for a consultation service*) shall be documented by the consultant in the patient's medical record and included in the requesting physician or qualified NPP's plan of care in the patient's medical record; and
- After the consultation is provided, the consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician.

## ‡Consultation: 99244/99254 Documentation Required (all of the below)

1. Comprehensive History
  - Chief complaint
  - HPI (4 or more elements; e.g. location, severity, quality, timing, context, modifying factors, etc.)
  - ROS – 10 or more systems
  - Past/Family/Social History
2. Comprehensive Exam (8 or more organ systems)
3. Medical Decision Making of Moderate Complexity (at least 2 of the following)
  - Moderate # of diagnoses or management options
  - Moderate amount or complexity of data (to be) reviewed
  - Moderate degree of risk

## ☞ Consultation: 99245/99255 Documentation Required (all of the below)

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1. **Comprehensive History**
  - Chief complaint
  - HPI (4 or more elements; e.g. location, severity, quality, timing, context, modifying factors, etc.)
  - ROS – 10 or more systems
  - Past/Family/Social History
2. **Comprehensive Exam (8 or more body areas/organ systems)**
3. **Medical Decision Making of Moderate Complexity (at least 2 of the following)**
  - Extensive # of diagnoses or management options
  - Extensive amount or complexity of data (to be) reviewed
  - High degree of risk

## + Initial Hospital Care

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### INPATIENT HOSPITAL SERVICES (1995 Guidelines)

#### Initial Hospital Care

(Documentation must support all 3 key elements<sup>1</sup>)

Code	History	Physical Exam <sup>3</sup>	Decision Complexity <sup>1</sup>	Counseling/Coordination of Care - Visit Time <sup>2</sup>
99221 Detailed Hx & Exam (problem(s) are of low severity)	CC; HPI (4+); ROS (2-9); PFSH (1:3)	Extended exam 2-7 Body areas/Organ systems	Straightforward or low	30 minutes
99222 Comprehensive Hx & Exam (problem(s) are of mod. severity)	CC; HPI (4+); ROS (10); PFSH (3)	Gen'l Multisystem 8+ Organ Systems	Moderate	50 minutes
99223 Comprehensive Hx & Exam (Problem(s) are of high severity)	CC; HPI (4+); ROS (10); PFSH (3)	Gen'l Multisystem 8+ Organ Systems	High	70 minutes

# + Subsequent Hospital Visits

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## Subsequent Hospital Care

(Documentation must support 2 of the 3 key elements)

Code	History	Physical Exam <sup>3</sup>	Decision Complexity <sup>1</sup>	Counseling/Coordination of Care – Visit Time <sup>2</sup>
99231 Problem Focused Hx. & Exam (patient is stable, recovering or improving)	CC; HPI (1-3)	Limited exam of 1+ Body Areas/Organ Systems	Straightforward or low	15 minutes
99232 Expanded Problem Focused Interval History/EPF exam (Patient is responding inadequately to treatment or has developed a minor complication)	CC; HPI (1-3); ROS (1)	Limited exam of 2-7 Body Areas/Organ Systems	Moderate	25 minutes
99233 Detailed Interval Hx. Detailed Exam (patient is unstable or has developed a significant new problem)	CC; HPI (4+); ROS (2-9);	Extended exam of 2-7 Body Areas/Organ Systems	High	35 minutes

Questions?

Jean Acevedo, LHRM, CPC, CHC, CENTC  
Acevedo Consulting Incorporated  
2605 W. Atlantic Ave., #D-102  
Delray Beach, FL 33445  
561.278.9328

[info@acevedoconsulting.com](mailto:info@acevedoconsulting.com)  
[www.AcevedoConsultingInc.com](http://www.AcevedoConsultingInc.com)

