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Special Report

Top Ten Inpatient Palliative Medicine Billing and Coding Mistakes (and How to Fix Them This Week)

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Abstract

Palliative care (PC) has undergone incredible growth in the last 10 years, having gained subspecialty status and penetration into 85% of hospitals over 300 beds. The comprehensive services provided by multiple members of the PC team combined with low reimbursement for nonprocedural medical care challenges all PC teams to operate with financial sustainability. Accurately and compliantly documenting and coding services provided to patients can help to maximize PC programs' revenues and limit operating subsidies received from health care systems or hospice programs.

In this article we share common billing and coding mistakes made by our programs and colleagues while providing inpatient, consultative palliative care. Each mistake is explained and paired with a straightforward fix to enable compliant, efficient practice. This will allow clinicians to more accurately communicate to payers the complex care provided to inpatients by the PC team. This fuller picture of the complexity of care provided can increase reimbursements received by your PC program from payers. Understanding how to accurately document, code, and receive appropriate reimbursement will allow our field to continue to grow, broadening the reach of PC nationally to improve quality of life for all patients and families in need.

Introduction

For specialty palliative care, the last decade was marked by profound service growth across the United States.[1,2] Because of these efforts, over six million patients and caregivers have to-date experienced the benefits of these services in community-based and hospital settings.[3] Clinical teams now penetrate 62% of all hospitals, with teams available in 85% of those with 300 or more beds.[4] In parallel, remarkable reports of cost savings and decreased resource utilization from large palliative care programs in academic medical centers have secured its standing as a high-value, low-cost, patient-centered approach to care for those with serious illness at or near the end of life.[5,6]

As these successes in service growth continue to mature and flourish, the story of the forthcoming 10 years will be marked by palliative care's ability to establish its financial sustainability in a rapidly evolving reimbursement environment. Palliative care clinicians and leaders will be expected to remain in step with colleagues in other, larger specialties like cardiology, oncology, and surgery, ensuring that services are charged, billed, and reimbursed appropriately. This requires that all members of the palliative care team demonstrate proficiency in the issues, challenges, and nuances of specialty-specific billing and coding. This increase in understanding starts with identifying the common mistakes seen in palliative care and hospice billing and implementing practical and directed solutions. This collaborative approach additionally fosters a collective dialogue within the discipline to ensure that all services are consistently compliant, appropriately credited, and reflect the complexity of the clinical work. Though a thorough discussion of proper coding and billing requires an understanding that goes beyond this review article, we aim to touch upon a few key issues. This article is not a comprehensive overview of billing and coding practices, and we encourage you to speak with your local compliance and coding professionals, as state-specific Medicare and Medicaid rules may differ. The following tips come from mistakes we have made and errors we have encountered while working with hospice and palliative medicine colleagues nationally. We will focus on inpatient care in this article with a follow up review on the issues related to the outpatient setting.

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We present a ''Top 10'' of mistakes encountered, a brief description of common misunderstandings, and a ''bottom line'' fix for busy clinicians to take away.

Mistake 1: Confusing ICD-9/ICD-10 Codes and CPT® Codes

ICD-9/ICD-10 codes and CPT® codes confuse many clinicians, which can lead to ineffective conversations between them and administrators. CPT® codes describe what clinicians did (the service) and ICD codes are meant to explain why (sometimes described as medical necessity). CPT® codes are specific to the place of service and differ for visits done in the hospital, outpatient office, skilled nursing facility, and other care settings. The International Classification of Disease, 9th edition, are code numbers that correspond to diseases, signs and symptoms, and other conditions treated by clinicians. An updated version of these codes slated for incorporation into routine billing in the fall of 2015, termed ''ICD-10,'' adds additional precision by increasing specificity of the current codes using an expanded numerical listing. Both sets of ICD codes allow billers and coders to translate the qualitative information found in health care notes to numbers that can be sent to payers for reimbursement of services. To communicate to a payer that the team cared for a patient with dyspnea or cancer-associated pain, a provider would use ICD-9 code 786.0 or 338.3, respectively.

Billers then attach one or more ICD codes to a numerical procedural code (CPT®) that tells the insurer what the clinician did to treat their patient. This combines the ''what we did'' service information from the CPT® codes with the ''for what condition'' information from ICD codes to tell the complete story. CPT® codes exist for virtually every medical procedure, from a colonoscopy to a craniotomy to a midlevel inpatient follow-up note. Ultimately, we are paid in the fee-for-service world for each CPT® code we submit. Remembering that ICD codes are 'disease' codes and CPT® codes are for 'procedures' will help avoid confusion on the subject.

Fix 1

Remember that D in ICD is for disease and P in CPT® is for procedure.

Mistake 2: Ignoring the Tiny 'w' or 't' in Front of the RVU Codes

Relative value units (RVUs) seek to standardize the time, skill, training, and intensity of providing medical care.[7] To pay providers for care that varies substantially (compare a three-minute smoking cessation counseling to six-level spinal fusion), the American Medical Association (AMA) and a group of specialty physicians created a unit of measure to compare (and thereby compensate for) care provided. These relative values are reviewed annually by a committee of AMA members, the Relative Value Update Committee (RUC), though there exists a relative overabundance of procedurally based specialists (high tech) compared to those, like we in Hospice and Palliative Medicine (HPM), who perform more cognitively based care (high touch).

Total RVUs are the sum of work RVUs, a practice expense RVU, and a small malpractice RVU. Each of these components is then multiplied by a geographical adjustment that accounts for regional differences in costs (think Sioux Falls versus New York). The total RVUs are then multiplied by a dollar amount called the ''conversion factor,'' $35.8228 per RVU in 2014, to calculate the total payment for the service.[8] The work RVU captures the effort and expertise of clinicians who perform the care described by each CPT code. Total RVUs, which include the practice expense and malpractice RVUs, are always greater than what would be calculated only from work RVUs, sometimes by 50% or more.

Fix 2

For employed palliative care clinicians, notice whether the clinical revenue attributed to you includes only your work RVUs or whether it includes the total RVUs generated by your care; the higher total RVUs better reflect your financial impact on your organization.

Mistake 3: Taking at Face Value that You Collect Only 40% of Your Charges

Provider-specific billing reports often delineate the percentage of charges collected. Collecting only 40% of charges can make providers worry that they failed in some way. Most of the time, though, the percentage shared uses total dollars collected in the numerator and total hospital charges from its Charge Master in the denominator. The Charge Master is the master list of prices charged by the hospital. These prices are charged at 100% to the uninsured and are paid at a negotiated, discounted rate by insurers. Charge Master prices are quite a bit higher than what Medicare will pay, allowing discounts to be offered to private insurers that result in payments often significantly higher than public insurers. Traditional Medicare simply offers a fixed payment to participating providers based on the RVUs assigned to the CPT® code reported, independent of a hospital's published charges.

A 2004 examination of Charge Master prices for a two-view chest x-ray in California found charges ranging from $120 to $1,500.[9] Assuming Medicare was the insurer and paid $80 for the CPT code, providers at the lowest-priced hospital could claim credit for collecting 66% of charges, while those at the highest-priced hospital could only claim collecting a paltry 5.3%. On average, California hospitals in 2012 collected only 25% of their overall charges.[10] Asking for your program's collections data as a percentage of what Medicare pays, if only for your top 10 CPT® codes, will allow for benchmarking across institutions and can help programs to understand if they are leaving significant collectable revenue on the table.

If you are in the position of setting prices for your organization, though, setting the Charge Master prices at exactly the Medicare allowable can negatively impact revenue. Non-Medicare insurers, in some geographic markets, may negotiate fees well above 100% of the Medicare allowable for the area. All payers will pay the lower of your charge or their allowable amount, so real revenue can be lost by having a fee schedule or Charge Master with prices that are too low.

Fix 3

If you are being measured by your health system, ask for your collections as a percentage of the Medicare Fee Schedule and not as a percentage of your hospital's Charge

Master; if you are setting Charge Master prices for your organization, know the Medicare payment and exceed it.

Mistake 4: Coding Exclusively on Time

Many clinicians submit their bills exclusively using face-to-face time (so-called ''billing on time''), which is the hospital setting and includes floor time, but not in the outpatient setting. 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. Counseling is often thought of as ''giving information to the patient,'' such as discussing risks and benefits of treatment options. Eliciting a patient's history does not qualify as counseling, whereas offering information about feeding tubes or prognostication does.

Often billing on time is not the best approach. For example, ''high risk'' care and billing by complexity rather than time may be appropriate in the following situations commonly encountered in HPM: visits during which opioids are used to treat symptoms, management of a patient who has one or more chronic illnesses with severe exacerbation or progression of disease, decisions to de-escalate care due to poor prognosis, or managing side effects of medication or polypharmacy. When paired with the appropriate history, physical exam, and medical decision making elements, caring for these high-risk patients, 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.

Fix 4

Understand how to bill both by intensity and time. Generally the majority of billings should be based on intensity.

Mistake 5: Failing to Document the Medical Necessity for a Patient Visit

Palliative care teams perform several roles in the hospital setting ranging from helping patients and families with complex medical decision making to managing symptoms to supporting patients' and their families' emotional and spiritual needs. Failing to document the medical reason for a visit can cause an entire note to be considered nonbillable. In addition, offering emotional and spiritual support services alone during a visit is not considered a medical encounter and is unbillable.

Medicare, for example, requires a chief complaint be listed for each encounter. This is where you should capture the medical necessity of the visit, which may coincide with what the patient reports as the chief complaint or may be very different. Never use a simple statement like ''Discuss goals of care,'' but rather use language like ''Discuss complex medical decision making related to goals of care.'' Make sure that this chief complaint information aligns with the medical reason you are seeing the patient. If a patient was started on an opioid or antipsychotic, the follow-up visit chief complaint could read, ''Follow up to check for medication adverse effects and efficacy'' with the medication(s) referred to in the interval history. The chief complaint should set the overarching reason for the necessity of your visit, and is one of the most important aspects the auditors look for when examining a billable encounter.

Fix 5

Use the chief complaint section to document the medical necessity for your visit.

Table 1. Ten HPM Billing and Coding Fixes to Implement this Week

FIX 1:	Remember that D in ICD is for disease and P in CPT® is for procedure.
FIX 2:	For employed palliative care clinicians, notice whether the clinical revenue attributed to you includes only your work RVUs or whether it includes the total RVUs generated by your care; the higher total RVUs better reflect your financial impact on your organization.
FIX 3:	If you are being measured by your health system, ask for your collections as a percentage of the Medicare Fee Schedule and not as a percentage of your hospital's Charge Master; if you are setting Charge Master prices for your organization, know the Medicare payment and exceed it.
FIX 4:	Gain an understanding of E&M rules and on which types of patients E&M coding is more likely to capture the complexity of the service you provide, regardless of time spent.
FIX 5:	Use the chief complaint section to document the medical necessity for your visit.
FIX 6:	Document the medically appropriate key component of the visit personally performed to satisfy APP split-share documentation; we recommend that is the personally performed physical exam.
FIX 7:	Palliative care providers should report the ICD-9 code for the symptoms treated, allowing the referring provider to code for the underlying disease.
FIX 8:	Ensure your primary Medicare Specialty Code is updated to accurately reflect your current clinical practice; HPM is specialty code 17.
FIX 9:	Remember that a 4-point HPI, a 10-point review of systems, past medical, family, and social histories are ALL required for moderate and high-level new consults and admission/observation stays in the hospital. To use a simple football analogy, remember 4th and 10.
FIX 10:	Know that your level of personally documented information increases dramatically when working with unlicensed student providers; they can only provide review of systems and past medical, social, and family history.

Mistake 6: Writing "Seen and examined. Agree with above" When Working with an Advance Practice Provider to Document a Split-Share Visit

Split-share billing[11] can occur when a physician provider works together with an advance practice provider (APP) from the same group practice in the care of an inpatient. Split-share billing is limited to services provided in the inpatient hospital, outpatient hospital, and emergency department; it is not allowed in nursing homes or any other locations of service or in hospice care. Often, the APP will see the patient first, document the encounter, and the physician will follow later, visiting the patient either alone or with the APP that same day. Under Medicare's split-share rules, the encounter is billed using the physician's provider number, enabling payment at 100% of the allowable rate (APPs seeing patients alone in the inpatient setting receive payment at 85% of the physician's rate). Incident-to billing, a shared physician/APP billing structure, is only permitted in the outpatient setting, so must be avoided in the inpatient setting.

Unlike the minimal documentation required to attest a resident's or fellow's note, split-share with an APP requires some additional documentation. The physician is required to have performed ''a substantive portion'' of the encounter typically shown by documenting all of one of the three major sections of the note: history, physical exam, or medical decision making. In split-share billing, the APP and the physician must each document and sign their own note supporting that each saw the patient and what component(s) of the visit each personally performed. We encourage physicians to document the least onerous section, the relevant physical exam they personally performed, to meet this substantive portion requirement. As an example, when caring for a patient with lung cancer with a pleural effusion, the physician auscultates the heart and lungs and documents her findings to satisfy split-share requirements, then comments on the APP assessment and plan of care to provide good medical care.

Fix 6

Document the medically appropriate key component of the visit personally performed to satisfy split-share documentation; we recommend that component be the physical exam.

Mistake 7: Billing for the Patient's Underlying Disease When Seeing a Patient on the Same Day as the Referring Specialist

Palliative care providers, while offering an ''extra layer of support,'' often 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 an oncologist and a palliative care consultant both treat a patient with lung cancer and both report only ICD-9 code 162.3 (malignant neoplasm of upper lobe), one provider will likely not get paid. 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. In this case, the oncologist would code 162.3 and the palliative care consultant would code 786.0, dyspnea.

Table 2. Twenty Useful ICD-9 Codes for Palliative Care Providers

112.0	Candidiasis of mouth
338.1	Acute pain
338.3	Neoplasm-related pain
527.7	Disturbance of salivary secretion
564.00	Constipation, unspecified
698.9	Unspecified pruritic disorder
780.0	Alteration of consciousness
780.09	Delirium, acute
780.52	Insomnia, unspecified
780.7	Malaise and fatigue
780.96	Generalized pain
783.0	Anorexia
786.0	Dyspnea and respiratory abnormalities
787.02	Nausea, alone
787.20	Dysphagia, unspecified
787.91	Diarrhea, NOS
789.0	Abdominal pain
799.3	Debility
799.4	Cachexia
v66.7	Encounter for Palliative Care(never list as first code, but should be listed on all claims)

NOS, not otherwise specified.

Fix 7

Palliative care providers should report the ICD-9 code for the symptoms treated, allowing the referring provider to code for the underlying disease.

Mistake 8: Believing that Medicare Will Know You are Providing a Separate Service from Your Colleague Based on the Content of Your Note

Medicare distinguishes physicians both by group practice and specialty. Two clinicians from the same group who are in the same specialty cannot both bill Medicare for services, even if ICD diagnoses are different, on the same day. It is considered duplication of service. This is particularly relevant to HPM clinicians, since all have a relationship with one of 10 primary boards, even if specialty certification in Hospice and Palliative Medicine was obtained. An academic HPM provider certified by the American Board of Internal Medicine (ABIM) and specialty boarded in HPM can conceivably see 10 patients cared for by ABIM boarded hospitalists from the same group in a day. If two physicians from the same group and of the same specialty submit bills for the same date of service, the bill submitted first is paid and others are rejected (sometimes called ''first to the trough eats''). Since most hospitalist groups have a well-oiled billing and coding system in place, the HPM provider often ends up with the unreimbursed encounter.

It is imperative that physicians who act primarily as HPM providers denote themselves as such with Medicare. HPM fought for years to receive specialty recognition and this recognition allows a separate specialty code from Medicare. Physicians who practice predominantly HPM must ensure they are classified with Medicare under specialty code 17 (Physician/Hospice and Palliative Care) as their primary specialty to ensure that bills are not rejected as duplication of service when HPM consultants see patients cared for by those in the same professional group with whom they share a board certification.

Fix 8

Ensure your primary Medicare Specialty Code is updated to accurately reflect your current clinical practice; HPM is specialty code 17.

Mistake 9: Omitting Documentation of the Family History because "My Patient Is Elderly and It Is Not Relevant"

The medical note serves two purposes: it allows us to communicate the care we provided to our patient with others in the health care system and gives insurers a chance to measure the complexity of a nonprocedural encounter. Both the AMA and Medicare have decided what elements are required to be reviewed and documented for the history to be considered comprehensive. Failure to ask patients about all required elements, especially during a new admission or consultation, will decrease the level of your effort from 'comprehensive' to 'detailed.' Missing an element Medicare considers essential to comprehensive care decreases reimbursement by nearly half.

In the history section of a comprehensive initial encounter, Medicare requires documentation of a 4-point history of present illness (HPI), a 10-point review of systems, and one item each in past medical history, social history, and family history. Omitting any of these items, even if you do not feel it is clinically relevant, will significantly impact Medicare's interpretation of the effort devoted to your patient's care.

Fix 9

Remember that a 4-point HPI, a 10-point review of systems, past medical, family, and social histories are ALL required for moderate and high-level new consults and admission/observation stays in the hospital. To use a simple football analogy, remember 4th and 10.

Mistake 10: Cosigning Documentation Written by a Medical Student

Palliative care is typically a team sport. While we celebrate interdisciplinary learning, insurers are less enthusiastic about the documentation of learners.

Teaching physicians are able to link their documentation only to documentation written by licensed providers. Nurse practitioners are licensed, and split-share documentation, discussed in #6 above, applies in the inpatient setting. Fellows, medical residents, and medical interns are also licensed and, if the attending physician is physically present during the critical or key portions of the service and links compliantly, the entirety of their note can contribute to billable E&M documentation.[11] It is crucial to recognize that student members of the team can contribute only review of systems and past medical, social, and family history and that for these history elements to ''count'' toward physician billing, the physician must document his or her review of this information and update any changes. Any other E&M documentation must come from a licensed provider.

Fix 10

Know that your level of personally documented information increases dramatically when working with unlicensed student providers; they can only provide review of systems and past medical, social, and family history.

Conclusions

The incredible strides in palliative care growth and acceptance made over the last 20 years reflect the enormous effort of committed clinicians, administrators, leaders, and influencers in sharing the philosophy of an ''extra layer of support'' to our referring clinician colleagues, patients, caregivers, and payers. Demonstrating the value of our services to others through honest, accurate, and comprehensive billing is not only a clinician's professional responsibility, but is an obligation, as it will drive and ensure palliative care program sustainability and growth. Increasingly, as reimbursement mechanisms across medicine evolve to reflect fee-for-value, demonstrating the components of care delivered will remain a top priority. Unfortunately, clinicians are provided only a few options to increase revenue and decrease programs' health system subsidies: offer less-comprehensive or less-intensive care to permit increased volumes; cut team members' salaries and benefits; or carefully, thoughtfully, and accurately document clinical encounters to capture appropriate reimbursement. Clearly, the first two options are neither desirable nor tenable; reflecting an appropriate degree of clinical effort is imperative to financial health of palliative care organizations.

Our hope is that providers are already avoiding the mistakes discussed in this article. We know, though, that opportunities exist for all of us to better understand the business of medicine. Accurate, compliant billing and coding in palliative care is one small piece of a fuller understanding of our business. It can, however, help programs to increase the value brought to their health care systems so that our field can continue to expand the number of patients we serve.

In the end, the field must ensure that ''doing the right thing,'' our clinical mission, is valued by external stakeholders appropriately because of billing and charging that occurs ''in the right way.'' Only with diligent attention given to our financial practices and open dialogue regarding improving these practices can we continue to ensure the financial health of our growing discipline.

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