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INSIDE

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Culturally diverse care requires openness and understanding

Staff must be willing to set aside their own beliefs and learn others

As a four-month-old Pakistani girl lay dying in her crib at home, her young father slipped out of the house and left his wife to keep watch alone. The baby girl, born with a number of birth defects, would on this night succumb to her congenital diseases without her father by her side, her mother left alone to be consoled only by her own tears.

Most would find the father's absence at such a time to be highly inappropriate. How could a father not be with his child at the moment of death? How could he not be there to offer support to his wife and share his grief with her?

It would be easy to condemn the actions of the young father — if we critique his actions from a western perspective, that is. But if we examine his actions from another cultural perspective, his Muslim beliefs and his Pakistani heritage, we can develop a better understanding of his motives.

What hospice workers already knew was that this father did not leave the side of his dying baby for selfish reasons. Knowing the child was hours away from death, his responsibility as the spiritual leader of his Muslim family was not to be at the side of his child but to be in his masjid, praying for his child and acknowledging God's will during a confusing and difficult situation.

"It was a very difficult case because it involved a small child," says **Denise Greenberger**, LSW, manager of psychosocial and spiritual support for Hospice Atlanta (GA). "But they shared with me their spiritual beliefs and we talked about the Koran."

For Greenberger, a social worker, it would have been easy to assume the Pakistani family shared her own concepts about spirituality and the dying process. Such an assumption could have led to tragic circumstances. Rather than helping the family provide a peaceful death for the

child, Greenberger's actions might have served as an obstacle to healing for them.

Cultural diversity in hospice care is an implied mission. Hospices strive to relate to patients as they really are. The challenge is moving cultural diversity beyond its golden-idol appeal and implementing policies and practices that transform hospice into providing the individualized care that is one of the hallmarks of the industry's philosophy.

Still treat patient as an individual

While it seems a departure from recognizing the uniqueness of each culture, the starting point on the road to achieving diversity in hospice care is to recognize the uniqueness of individuals, says **Connie Borden**, RN, MSN, ANP, executive director of Hospice By The Bay in San Francisco.

"Regardless of race, we need to find out who the patient is as an individual," Borden says. "We need to ask about their beliefs, what they believe about the illness and where they are spiritually."

And just as every hospice worker needs to be aware of an individual's unique makeup, each worker also must be aware of his or her own inexperience in dealing with different cultures and realize how each worker's own culture and upbringing can affect patient care. Hospice workers still can unknowingly impose their own beliefs on their patients. For instance, inexperience with a specific culture can cause a hospice worker to allow culturally significant matters to go unrecognized because a nurse's own background may not prompt him or her to ask the right questions. To assist someone from another culture, hospice workers need to learn how to set aside their own beliefs and seek to understand the needs of their patients, says **Jane Bergquist**, RN, BSN, hospice program manager for Presbyterian Hospice and Palliative Care in Albuquerque, NM.

Presbyterian Hospice is like a lot of hospices around the country. As communities become more ethnically and culturally diverse, hospice workers are forced to learn how each group perceives the dying process. Once a predominantly Hispanic and white community, Albuquerque is home to a significant population of Native Americans from the Navajo and Pueblo Indian tribes, as well as Vietnamese people, Laotians, and African-Americans.

"We have never offered orientations about these cultures," Bergquist says. "Instead, we share what we learn in team meetings."

According to experts, hospices should take the following steps to ensure cultural diversity in their care:

- **Use local religious and cultural resources and contacts to help educate staff and to serve as resources when needed.**
- **Recruit paid staff and volunteers from a variety of cultural backgrounds, especially from among cultures a hospice serves.**
- **Provide inservice training for staff regarding these cultures.** The speakers need to cover the concepts this culture has about disease, pain management, dying, burial, and the grief process. (For example, hospice staff learned that for an East Indian, suffering is "God's will," so there is a more stoic attitude toward pain.)
- **Be sure translation services are available.** Rely on family as the last resort, because they may have trouble saying things about death and you may not be aware of how they are passing on your information. (For example, if you want a son to translate to his mother about her breast cancer, it may be totally inappropriate for him to do that in their culture.)

In many cultures, communication begins with the family, and hospice workers need to be aware of the family dynamics at work. In some cultures, for example, it is more appropriate to communicate through a family leader than directly with the patient.

"You have to be very sensitive to include the family in the discussion," says Bergquist. "In some cultures, it is not appropriate to talk about death."

A family meeting with hospice representatives is good way to learn how to approach patients and families from various cultures. It is important to remember that the key decision-maker may not be the same person as the primary caregiver.

Also be aware of language differences. A language barrier may be present because of a family's limited English. Realize that while people with a moderate comprehension of English may appear to understand discussions, family meetings may require an interpreter to communicate complex medical information. Also be aware of taboo words. For example, in some cultures the word "death" should not be used.

The only way to achieve this level of understanding is to ask questions, says Greenberger. Do not hesitate to ask about relevant cultural aspects. It is respectful to show an interest in other cultures.

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How perspectives on death vary by cultures

Traditions span a wide gamut

To learn more about cultural diversity and about the cultures in its own community, Presbyterian Hospice and Palliative Care in Albuquerque, NM, hosted a conference that brought in experts from various ethnic and religious groups to share their views on death and dying.

While no culture should be viewed through a narrow set of general characteristics, the conference offered some insight regarding how different cultures approach the dying process.

Jane Bergquist, RN, BSN, hospice program manager for Presbyterian Hospice and Palliative Care, noted the following important characteristics from cultures common among her hospice's patients:

• **Hispanics.**

— Not all Hispanics are from the same cultural background. Hispanics may be Mexican, Guatemalan, Puerto Rican, or Spanish, just to name a few Hispanic cultures. In New Mexico, for example, many Hispanics are descendants of Spanish immigrants dating back 200 years.

— Rituals, herbs, and traditional home remedies may be part of the treatment focus. Medical staff should be aware of these treatments so that interactions can be monitored, but should refrain from offering judgments.

— Hispanics tend to be very communally oriented. Expect the need to have the extended family involved in decision-making or present at time of death.

— They tend to be strongly Catholic.

— Cremations are considered acceptable.

• **Navajo Indians.**

— It is inappropriate to talk about death, because it can cause emotional harm. It is appropriate to discuss do-not-resuscitate orders using vague terms such as: "If you knew someone with a disease like you have, when do you think they should use a ventilator or stop using a ventilator?"

— Know that a decision is not made in isolation. Decisions are communal. Families will wait until all the appropriate family members are present to make decisions. "While this may slow down the process, it is crucial to their way of making decisions," Bergquist says.

— When a sick person chooses to participate in Navajo ceremonies, such as sweat lodges, or to go to the medicine man, it is not for a "cure." Rather, it is to help the person complete their spiritual work. Navajos believe they are on the earth to do a specific work and it needs to be done before death. These ceremonies are part of their search for their life's purpose.

— Burial occurs within 24 hours of death, if possible. Cremations are not considered appropriate, nor are organ donations. They believe the body should be returned to the earth as whole as it was when it came into this world.

• **Pueblo Indians.**

— Family plays a key role, and decision making is communal.

— It is not appropriate to discuss DNR or organ donations.

— Burial should occur within 24 hours, and cremation is usually not an option.

— Grief is explained by the elders and is handled through prescribed rituals. There is a "letting go" ceremony one year after the death of the loved one.

— A key component is for the family not to have tension after the loved one has died. No wills are necessary, because ownership of material goods is passed on verbally based on cultural norms. For example, property is passed through the mother to the daughters.

• **African-Americans.**

— The African-American community often misunderstands hospice, believing that medical professionals recommend hospice because they don't want to treat African-Americans. This community often has a generalized distrust of the medical profession as the result of a long history of racism and discrimination.

• **Chinese people.**

— They are strongly communal. Family members are crucial in passing on information to their loved one as well as in making decisions.

— Do not talk about death directly. Chinese people believe the best way to die is in one's sleep, not knowing you were going to die. ■

"We learned that in the traditional Chinese culture, one does not tell the person they may die or discuss a poor prognosis," Bergquist says. "The family will decide what to tell their elder. If the person is an American-born Chinese, this could be different, so again the family can help with the decision about what is said."

A hospice worker should start by admitting to the patient and family that he or she has little understanding of their culture. "Normally a family will appreciate your openness and see your questions as their opportunity to educate you," Greenberger adds. "It's one thing they can do that can help direct the care the patient will receive."

While families play a role in educating hospice workers, hospices have a responsibility to educate their own workers. A formal training program should be established based on the various ethnic, religious, and other cultural groups a hospice serves.

The interdisciplinary team meeting provides a perfect venue for cultural diversity training. Use the meeting, experts say, to tap into the experience and background of team members. For example, Greenberger, who is Jewish, often shares her faith with others to help team members determine how to approach patients and their families.

And just as spiritual matters are an important topic during team meetings, so should cultural matters be. Use team meetings to share experiences from the field with other team members, to discuss cases made difficult by cultural matters, and to bring in outside help to enlighten the entire team on a specific culture.

Hospice Atlanta regularly invites speakers to educate their staff. Among the speakers are rabbis, ministers, and staff members themselves.

"I always find it fascinating to learn and share with staff," Greenberger says. ■

Wanted: A hospice nurse, any hospice nurse

Solving nurse shortage requires innovation

It started in the late 1990's like a whisper: A nursing shortage was beginning to emerge. Across the board, from hospitals to home health, the need for nurses was outpacing the supply. Even more disturbing was the diminishing availability of skilled nurses.

Hospices, which rely heavily on skilled nurses to provide much of their care, have had to compete with other health care facilities in their markets, not to mention other hospices. From the onset of the shortage, hospices were at an economic disadvantage. Hospice could not compete with the higher salaries offered by hospitals and home health agencies. Even worse, hospitals and home health agencies in some markets have been offering signing bonuses to entice prospective nurses.

Then the whisper evolved into a scream. The nursing shortage was further exasperated by a red-hot economy that provided nurses with other options. The rise in health care-related companies, including Internet startups, provided new ways for nurses to apply their medical knowledge. Some even left nursing altogether for more lucrative jobs.

Hospice nursing was once considered a haven for nursing purists, a place where old-fashioned, hands-on nursing could be practiced unencumbered by bureaucracy. But even that has changed, says **Janet Neigh**, executive director of the Hospice Association of America in Washington, DC.

"It's a combination of competing with hospitals and home health, and all the documentation that is involved in hospice," she says. "With all the documentation that the government requires, [hospice] nurses feel that they can't practice nursing the way they were taught to."

How are hospices supposed to be able to recruit talented nurses and keep them? To make matters more complicated, not just any nurse will do. Hospices need nurses with experience, especially for home hospice nurses, who are asked to function independently and must make critical decisions during a home visit.

While there are inherent disadvantages that hospices will be unable to overcome, there are still recruiting tactics that can help hospices attract experienced nurses. Experts agree that the two areas hospices should highlight during their recruiting attempts are:

- high job satisfaction as a result of practicing hands-on medical care and the close relationship nurses develop with their patients and families;
- flexible working hours that will attract nurses who can't work traditional 40-hour weeks.

Job satisfaction is perhaps hospice's greatest selling point, says **Metta G. Johnson**, RN, BSN, OCN, ACRN, executive director and owner of

Haven House, an Atlanta-area hospice. She and other Atlanta-area hospices should know. Because Georgia does not require a certificate of need to start a hospice program, competition is strong in Atlanta and surrounding counties. Not only are Atlanta-area hospices competing for patients; they are also competing for nurses.

Knowing that competition for hospice nurses is fierce, Johnson says she broadens her pool of prospective nurses by not limiting her search to nurses with hospice experience. Instead, her search includes all experienced nurses from a variety of disciplines. "What I'm looking for are nurses who are mission-oriented and willing to learn if they don't have hospice nursing experience," says Johnson.

For prospective nurses outside of hospice, the message of greater job satisfaction may have greater impact. Hospices can use nurses' current job dissatisfaction to their advantage. According to Neigh, hospices should stress how hospice nurses can have a direct and immediate impact on patients and their families and emphasize the gratitude families have for hospice workers who helped them get through a difficult situation.

"The reward comes from the patient and family," Neigh says. "It can't only be about money. If a nurse takes a job just for the money, after a month they will still have to do the job."

Still, money is a strong motivating factor. To help neutralize the money factor, providing employment that enhances quality of life beyond professional job satisfaction can go a long way to persuading a nurse to join a hospice.

"I feel that an employer that is meeting an employee's personal and professional goals is the one with the most satisfied workers," says Johnson.

Offer flexible working hours

The best way to do that, say Neigh and Johnson, is to offer flexible hours and working arrangements. At Haven House, Johnson allows nurses to work as many hours as they like, whether it's 20 hours a week or 40 hours a week. This allows Haven House to employ talented nurses, who, for example, cannot work a full-time job because they want to be home with their children after school. Hospice can offer that nurse an opportunity to pursue her professional interests while still being able to fulfill family obligations.

"You need to come up with creative scheduling," says Neigh. "Try to come up with a more flexible schedule that allows nurses to have a better quality of life and reduce burnout."

Noncompetitive salaries and the potential to make more elsewhere are still factors hospices must contend with even after a nurse is hired. And while the job provides precious moments with patients and their families, it can also prove to be an emotional burden, with few outlets to allow nurses to unload their grief and frustration.

Hospices' ability to keep nurses happy will depend on how well hospices recognize nurses' contributions to the success of the organization. Yet, while ceremonies and rituals that pat nurses on the back have some impact, it is more important to recognize how nurses are affected by caring for the dying day in and day out, says Johnson.

"Being a hospice nurse is not dinner party conversation," says Johnson. "After you tell someone you are a hospice nurse, they say how wonderful that is and how they admire you for doing what you do. But they don't want to hear any further, they don't want to hear about the 19-year-old man you are taking care of." They especially don't want to hear about how emotionally trying it can be, adds Johnson. So, hospice nurses are left with few outlets to express their emotions at the end of the day. "Allow them time to express their feelings," says Johnson.

Hospice requires support group attendance

For example, the Hospice of Northern Virginia requires its workers to attend a support group twice a month. The support group is facilitated by an outside psychologist, and management personnel are not allowed to attend in order to promote frank conversation without fear of reprisal.

Yet, some hospices find it impossible to require their busy nurses to attend support groups. Rather than making attendance a requirement, they place a priority on providing a formal outlet to allow nurses to express their emotions.

Other venues in which nurses can share their feelings include:

- **Interdisciplinary team meetings.** A great deal is discussed during team meetings, from the patient's progress to spiritual matters. The team meeting also can serve as a platform for nurses and others to share their feelings, especially following a difficult case. This allows a nurse to share his or her feelings with peers who can empathize with the emotions a troubled nurse is going through.

• **Patient memorial services.** Most hospices hold these services on a monthly basis to allow staff to recall patients who have died that month. The event gives staff a chance to share their feelings about their patients with colleagues and sometimes with the family of the deceased as well.

The effort to retain workers by supporting them starts from the time they are hired. At the Hospice of Central Virginia, new nurses have an orientation program that not only introduces them to the organization but also provides coping skills to help them deal with the emotional rigors of caring for the dying.

"They aren't sent into the field until they are comfortable," says **Cheryl Rodgers**, RN, BSN, staff development-quality assurance coordinator. "The nurse stays in the orientation program for as long as the nurse needs it. It also gives me a chance to determine whether being a hospice nurse is the right job for the person."

The orientation program includes the following topics.

• **Organizational philosophy.** Recently hired workers are schooled on the hospice philosophy and mission.

• **Hospice basics.** For nurses who have never worked in hospice, there is a need to become familiar with ideas such as the interdisciplinary team, palliative care, spiritual care, advanced directives, and other tenets of hospice that are critical to getting nurses oriented.

• **Communication.** New nurses are taught how to listen to patients and take clues from patient interaction.

• **Death and dying.** New hires are asked to explore their own feelings about death and dying, perhaps by revisiting their own loss of a loved one.

• **Stress management.** The hospice emphasizes the importance of communication, not only for the sake of patient care but also for the mental well-being of its nurses. New nurses are taught the importance of using resources available through the interdisciplinary team, such as other team members who can provide additional support to the patient and alleviate the stress of having to support the patient on their own.

Neigh also suggests that hospices regularly survey their staff to gauge which aspects of the job they like the most and which ones they dislike or find frustrating. The results of the survey will provide important information on the areas in which a hospice needs to provide more support to its staff.

For example, if staff indicate that keeping up with documentation is a problem, then the hospice could find ways to improve the documentation process or provide more staff education on it.

In the end, says Neigh, hospices battling to hire experienced nurses will realize that money isn't the only answer to attracting nurses to hospice work. "It's a beginning," she says. "But you have to believe in what you are doing." ■

OIG 2001 work plan includes focus on hospice

Plans of care and payments targeted

The U.S. Office of Inspector General (OIG) intends to scrutinize hospice plans of care, payments to nursing homes, and use of continuous home care, drawing some concern from the National Hospice and Palliative Care Organization (NHPCO) but no cries of unfair scrutiny.

"We're not sure, but we don't think there should be any cause for concern," says **Angela Thimis**, spokeswoman for the Alexandria, VA-based NHPCO.

The OIG issued its Work Plan for Fiscal Year 2001 in October, outlining areas in which the department intends to focus its fraud and abuse investigations. The 103-page document covers all segments of health care. The hospice section, which was just more than a page long, represented a fraction of the OIG's plan.

The Work Plan provides valuable guidance for identifying high-risk compliance areas. Providers and suppliers should review and address relevant Work Plan projects in their ongoing internal compliance efforts.

The three areas of the hospice industry to be scrutinized by the OIG are:

• **Plans of Care.**

It seems the OIG is concerned with variances between the plans of care and the actual care provided to patients, despite the fact that similar investigations in nursing homes showed that services were generally provided in accordance with the plans of care.

"This study will examine the variance among hospice plans of care and the extent to which services are provided to hospice patients in accordance with the plans of care," the OIG Work Plan

states. "Although hospice patients are required to have plans of care, there are no requirements or minimum standards that the plans must meet. In previous OIG work on nursing home populations, we found that plans of care varied and that services were generally provided in accordance with the plans of care."

The OIG offered a hint in 1999 that this area would be one on which it would focus when its Compliance Program Guidance for Hospices, issued on Sept. 30, 1999, identified it as a potential risk area.

The NHPCO's only concern is how the OIG will determine appropriate care and substandard care, says Thimis. Because hospice care is so individualized, two patients who have the same terminal diagnosis can have very distinct care plans.

• **Payments to Nursing Homes.**

Hospice payments to nursing homes have been the subject of OIG scrutiny for many years and have been addressed in OIG fraud alerts, reports, and the Hospice Compliance Program Guidance. Prior studies found that payment levels for patients in nursing facilities may be excessive. The OIG will evaluate the financial implications of Medicare hospice payments made on behalf of beneficiaries residing in nursing facilities.

"Our previous work found that current payment levels for patients in nursing facilities may be excessive," the Work Plan states. "Otherwise, we feel this is a reasonable area for the OIG to study."

According to the OIG, when a patient is entitled to both Medicare and Medicaid, the nursing home no longer bills the state Medicaid program for the patient's long-term care. Instead, the nursing home bills and receives payment from the hospice, and the hospice is reimbursed by Medicaid. Medicaid payments for room and board are in addition to Medicare's daily fixed rate paid to the hospice. Private-pay patients continue to pay the nursing facility directly, while Medicare pays the hospice.

• **Continuous Home Care.**

An OIG study will review how fiscal intermediaries ensure that hospices provided the services for which they submitted claims. Hospices are reimbursed based on four levels of care, three of which are fixed at a per diem rate. However, payment for the continuous home care level is based on the number of hours of care, with a minimum of eight hours on a particular day. The OIG will review this level of service because of its complexity, expense, and vulnerability to misuse.

Because of the potential for claims denial, few hospices offer this service, says Thimis. "We're finding too little use of continuous home care," she adds. The NHPCO is hopeful that OIG will provide clarification and guidance so hospices can provide this service and be confident that they will be reimbursed for it. ■

MDs can be confused about pain care payment

Teach docs how to get paid

With the growing concern over the quality of pain management, physicians are trying to catch up on the latest in palliative care, but many are still confused about how to get reimbursed for their pain management services.

Hospices can help promote better pain management and cultivate referrals not only by helping physicians become better educated about pain management but also by providing practical advice about getting reimbursed.

Pain management has garnered increased attention recently. End-of-life care advocates have long criticized physicians for not providing proper palliative care to their patients. This sentiment has been underscored by recent lawsuits for inadequate pain management, including a case involving an 85-year-old cancer patient.

Just as many physicians lack understanding about palliative care, many are equally befuddled about getting reimbursed for pain management treatments, such as the use of opioid drugs or drugs with an off-label pain management benefit.

Basic pain management drugs come in two forms: nonsteroidal anti-inflammatory drugs, such as ibuprofen and aspirin, and opioids, such as morphine, fentanyl, or codeine.

In most cases, pain drugs are given orally. Other than the cost of the drugs themselves, drugs that are self-administered are not covered by Medicare, but drugs that are administered in the physician's office via injection or infusion pump have a variety of reimbursement codes associated with them, says **Laurie Lamar**, RHIA, CCS, CTR, CSS-P, reimbursement specialist with the American Society of Clinical Oncology in Alexandria, VA. The remainder are administered

intramuscularly, subcutaneously, intravenously, intraspinally, or intraventricularly.

For IV and intraspinal administration, an infusion pump is used (E0779-E0791, infusion supplies). An implantable infusion pump (E0782-E0785) is covered when it is used to administer opioid drugs (e.g., morphine) intrathecally or epidurally (64999) for treatment of severe chronic intractable pain of malignant or nonmalignant origin in patients who have a life expectancy of at least 3 months and who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

- The patient's history must indicate that he/she would not respond adequately to non-invasive methods or pain control, such as systemic opioids (including attempts to eliminate physical and behavioral abnormalities which may cause an exaggerated reaction to pain).
- A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary intrathecal/epidural catheter to substantiate adequately acceptable pain relief and degree of side effects (including effects on the activities of daily living) and patient acceptance.

Reimbursement for patient use of an infusion pump is dependent upon whether the physician's office owns the pump. If it does, the practice can bill its durable medical equipment regional carrier using its provider number. If it rents the pump from a vendor, the vendor is responsible for billing Medicare.

Outside of billing for pump rental, oncologists have other reimbursement opportunities. The insertion of a catheter and implantation of a pump used for pain management is covered by Medicare. Catheter and pump implantation codes include:

- 62350 — implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term pain management via an external pump or implantable/infusion pump without laminectomy;
- 62351 — with laminectomy;
- 62355 - removal of previously implanted intrathecal; or epidural catheter;
- 62360 - implantation or replacement of device intrathecal or epidural drug infusion, subcutaneous reservoir;
- 62361 - non-programmable pump;
- 62362 - programmable pump, including preparation of pump, with or without programming.

Physicians can also use codes 96520, refilling and maintenance of portable pump, and 96530, refilling and maintenance of implantable pump or reservoir, but they should not be used to report port flushing.

In the rare instance that a physician administers pain management drugs in the office or if drugs are administered in a hospital or outpatient facility, the physician can also bill for related procedures, such as injections.

CPT changes clarify pain management

"There has been much confusion when reporting pain management procedures. So much so that the American Medical Association [AMA] made massive changes to CPT 2000 in hopes of clarifying the coding of injection, drainage, and aspiration procedures performed in pain management," says **Laurie Castillo**, MA, CPC, CPC-H, president of the American Association of Procedural Coders' Northern Virginia Chapter and consultant with Physician Coding & Compliance Consulting, both in Manassas, VA. **(See chart detailing these changes, p. 9.)**

Choosing the appropriate drug is also a challenge for many physicians. Medicare regulations mention common drugs that can be used with infusion pumps for intractable pain, such as morphine. But the array of pain management drugs is much wider than that, says **Terry Gutgsell**, MD, medical director of the Hospice of the Bluegrass in Lexington, KY. Gutgsell often advises physicians in palliative care.

Drugs that have primary uses outside palliative care include methadone (used to treat heroine addiction), J1230; ketamine (anesthesia); and pamidrinate (bone resorption in metastatic breast cancer), J2430. While these drugs are effective, physicians have the burden of proving medical necessity, he says. This is especially important for expensive drugs like pamidrinate, which can cost $600 to $1,200 for a single injection. Gutgsell says physicians need to prove necessity by providing data published in journals. When physicians seek advice from pain management experts, Gutgsell says physicians should ask for published data to support the recommendation.

In addition, Lamar recommends following Medicare regulations for off-label use of drugs and biologicals. Off-label use of drugs is covered when all of the following criteria are met:

- The drug meets the definition of drugs and biologicals.
- The drug is the type that cannot be self-administered.

Changes in CPT Procedure Codes

NEW 2000		DELETED OLD 1999
	Injection of diagnostic or therapeutic substances, epidural or subarachnoid	
62310	Injection, Single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; **Cervical or Thoracic**	62274, 62275, 62288, 62298
62311	**Lumbar, sacral (caudal)**	62274, 62278, 62288, 62289
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; **Cervical or Thoracic**	62276, 62279
62319	**Lumbar, sacral (caudal)**	62276, 62277, 62279
	Injection of anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve	
64470	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; **Cervical or Thoracic**	64440-64443
+64472	Cervical or thoracic each additional level *(list separately in addition to code for primary procedure)*	64440-64443
64475	Lumbar or sacral, single level	64440-64443
+64476	Lumbar or sacral, each additional level *(list separately in addition to code for primary procedure)*	64440-64443
64479	Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level	64440-64443
+64480	Cervical or thoracic each additional level *(list separately in addition to code for primary procedure)*	64440-64443
64483	Lumbar or sacral, single level	64440-64443
+64484	Lumbar or sacral, each additional level *(list separately in addition to code for primary procedure)*	64440-64443
64622	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level	Revised
+64623	Lumbar or sacral, each additional level *(list separately in addition to code for primary procedure)*	Revised
64626	Cervical or thoracic, single level	
+64627	Cervical or thoracic, each additional level *(list separately in addition to code for primary procedure)*	
	Examples of neurolytic agents are chemical, thermal, electrical or radiofrequency.	

• The drug meets all the general requirements for coverage of items as incident to a physician's services.

• The drug is reasonable and necessary for the diagnosis or treatment of the illness or injury for which it is administered according to accepted standards of medical practice.

• The drug is not excluded as a drug used for immunization.

• The drug has not been determined by the FDA to be less than effective.

Unfortunately, cancer often results in a terminal diagnosis. For many cancer patients, hospice is an appropriate setting for their care, including pain management. But the treating physician maintains oversight of the patient, working with hospice professionals and medical directors. The physician who manages patient pain in the hospice setting can bill for care plan oversight services (99377-93778) each month.

For example, if a physician adjusts pain medication for his or her patient and communicates the

changes to hospice staff, the physician can bill 99377 if the oversight service lasts less than 30 minutes or 99378 if the service is more than 30 minutes.

The oversight service does not have to be continuous, Lamar says. The billed time can be accumulated over a one-month period and does not have to be face-face time as long as the physician has had at least one face-to-face contact within six months of the time the service is billed. ■

HCFA issues new codes for plan oversight billing

Requirements still the same

In the November issue of *Hospice Management Advisor*, Medicare coding experts advised how hospices should train referring physicians on how to use care plan oversight (CPO) codes listed in the CPT 2000. In December, however, the Health Care Financing Administration released new guidelines for CPO billing.

The changes set for 2001 have to do with little-used care plan oversight codes, currently 99374 and 99375 for home health and 99377 and 99378 for hospice.

HCFA has released two new codes to replace those found in CPT 2000. Physicians will have to bill CPO in 2001 using the HCPCS code, G0181 and G0182, new temporary codes for procedures and professional services. G0181 will apply to home health patients and G0182 will apply to hospice patients.

While the codes have changed, the requirements related to using them have not, says **Nancy Cothern**, business manager at Baptist Cancer Institute in Jacksonville, FL.

For example, Palmetto Government Benefits Administrator, a Medicare payer, offers the following directives to its Medicare providers:

• The beneficiary must require complex or multidisciplinary care modalities requiring ongoing physician involvement in the patient's plan of care.

• The beneficiary must be receiving Medicare-covered home health agency, hospice, or nursing facility services during the period in which the CPO services are furnished.

• The physician who bills CPO must be the same physician who signed the home health or hospice plan of care.

• The physician must furnish at least 30 minutes of care plan oversight (see details of services that may be included below) within the calendar month for which payment is claimed and no other physician has been paid for care plan oversight within that calendar month.

• The physician must have provided a covered physician service that required a face-to-face encounter with the beneficiary within the six months immediately preceding the provision of the first care plan oversight service (a face-to-face encounter does not include EKG, lab services, or surgery).

• The care plan oversight billed must not be routine postoperative care provided in the global surgical period of a surgical procedure billed by the physician.

• For beneficiaries receiving Medicare-covered home health services, the physician must not have a significant financial or contractual interest in the home health agency.

• For beneficiaries receiving Medicare-covered hospice services, the physician must not be the medical director or an employee of the hospice or providing services under arrangements with the hospice.

• CPO services must be personally furnished by the physician who bills them.

• Services provided incident to a physician's service do not qualify as CPO and do not count toward the 30-minute requirement.

• The physician may not bill CPO during the same calendar month in which he or she bills the Medicare monthly capitation payment for the same beneficiary.

• The physician billing for Care Plan Oversight must document in the patient's record which services were furnished and the date and length of time associated with those services.

In addition to the numerous rules associated

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with CPO codes, tracking the length of each phone call used to oversee patient care can prove to be a tedious task. Nevertheless, physicians must document the length of time to choose the appropriate time-based code.

"If you don't track your calls, you won't get paid," says Cothern.

She recommends oncology practices implement a log system to routinely track the length of time a physician spends on the phone reviewing home health or hospice patient care.

In addition to new CPO codes, oncology physicians who refer their patients to home care will have an additional opportunity to bill Medicare for home care-related work. HCFA also established a new code set for certifying and recertifying home health plans of care.

The new payment was added to encourage greater physician involvement, HCFA officials say. Code G0179 will be used to recertify a patient who has received home health services for at least 60 days, or one certification period. Code G0180 applies to patients who have not received Medicare-covered home health services for at least 60 days. Oncologists will earn about $61 for each certification and $53 for each recertification. The two amounts are based on national averages, amounts adjusted by region, and other factors that will not be available until the final physician fee schedule is released. ■

News From the End of Life

NHPCO offers three new products

The National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA, has released three new products to help hospices answer the challenges of caring for the dying. The three products include:

- **2000 Hospice Standards of Practice.**

This reference manual addresses the current climate of regulatory scrutiny and accreditation and helps prepare hospices to encounter any surveys or regulatory scrutiny.

This latest edition includes extensively revised and updated sections on bereavement care and clinical care, as well as appendices on hospice inpatient facilities and nursing facility hospice care.

Previous editions were released in 1993 and 1987. The NHPCO's Standards and Accreditation Committee has revised the manual, which incorporates input from Health Care Financing Administration; the American Academy of Hospice and Palliative Medicine; the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); Community Health Accreditation Program (CHAP); National Council of Hospice Professionals; and a number of hospice programs of varying type, size, ownership, and location.

The input of these groups led to dramatic changes in the final Standards. The Standards were also field-tested by 11 hospice programs around the country.

The Standards are organized into 10 chapters according to topic areas, including bereavement care, interdisciplinary team, management of

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information, performance improvement and outcomes measures, hospice inpatient facility, and nursing facility hospice care.

The publication includes a specific Self-Assessment Tool and a useful crosswalk, which cross-references the standards of NHPCO, Medicare conditions of participation, JCAHO, CHAP, and the Accreditation Commission for Home Care.

NHPCO members will receive the manual for free, with additional copies available to members for $59.95. Copies are available to nonmembers for $118.95.

• **The Compliance Program Toolkit.**

The Compliance Program Toolkit was written for hospices that want to develop an effective compliance program or enhance an existing compliance program. The Toolkit provides the information, tools, and resources needed to develop, implement, maintain, and evaluate a compliance program that meets the recommendations outlined by the Office of the Inspector General's (OIG) Compliance Program Guidance for Hospices.

The Toolkit provides a step-by-step guide for developing the written compliance plan; resources and tools for implementing, maintaining, and evaluating the compliance program; a focus on the 28 hospice risk areas identified by the OIG; background information on compliance programs that hospice managers and compliance officers need; and copies of federal documents and resources with which hospice managers and compliance officers need to be familiar.

The Toolkit sells for $119 for NHPCO members and $189 for non-members.

Section One addresses the underlying principles of pediatric palliative care and provides models for care delivery and education. Section Two addresses communication, ethics, decision making, and palliative care for newborns. Section Three focuses on the management of pain and other symptoms. Section Four covers psychosocial, spiritual, and bereavement care of children with life-threatening conditions, as well as how to work with schools and communities.

Also, a free copy of the Children's International Project on Hospice-Palliative Services Compendium will be mailed to all NHPCO provider members. Additional copies are available to members for $79.95 and nonmembers for $129.95. Copies also will be distributed to hospitals in the U.S. that treat children with life-limiting conditions and many interested international organizations. ▼

Congress authorizes family caregiver program

In November, Congress passed the National Family Caregiver Support Program, the first federal legislation to target the needs of America's family caregivers. The act provides $125 million in the first year of the five-year program.

The legislation, which was a part of the reauthorization of the Older Americans Act, calls for the establishment of services that would help family caregivers. Program services are expected to include counseling and respite care, as well as more traditional information and referral services.

"It's great to see this legislation passed. It is the first real federal recognition of the needs of America's family caregivers," says **Suzanne Mintz**, president and co-founder of the National Family Caregivers Association. "I'm particularly pleased because caregiver advisory services are part of the program. Caregivers need help in making decisions, especially during times of crisis. Getting information and referrals is valuable, but having someone to talk to about decisions is what really makes a difference." ■