AMERICAN HEALTH CONSULTANTS®

HOSPICE Management ADVISOR™

Integration • Outcomes • Managed Care • Medicare Compliance • Risk Management • QI • End-of-Life Care

INSIDE

■ **Mission and marketing:** Believe it or not, your mission statement says a lot about the direction of your marketing, so it's a good idea to update it frequently 16

■ **Proposed regulations:** CMS has proposed changes that could affect admissions and discharge 18

■ **Hospice care planning:** When a patient enters hospice care, it doesn't mean the physician is no longer involved; alert physicians can bill Medicare for some case management functions 20

■ **Obtaining long-term pledges:** Tips on conducting long-term fundraising efforts that support all services, not just your immediate needs 23

FEBRUARY 2003

VOL. 8, NO. 2 (pages 13-24)

The success of your hospice may depend on your marketing plan

Are you grasping for opportunities and lacking direction?

The word "marketing" is as broad a term as there is. Hospices apply a variety of marketing approaches — everything from cookie jars to television commercials — in illustration of that very point.

The problem is that many hospices' marketing plans are ineffective because they're based on hunches and theories that aren't supported by market data. Yet when those same hunches and theories are uttered out loud, they seem to make perfect sense.

If, in the past year or so, your marketing plan failed — even though its logic seemed sound — ask yourself (and your administrative team) if any of the following were true:

- **You didn't gather appropriate market data**, such as referrals by specialty, patient demographics, length of service by disease, or admissions by geography.
- **You gathered data, but didn't analyze them thoroughly or correctly.**
- **Your marketing plan lacked specific objectives.** The plan called for specific actions, but no expectations were tied to those actions.
- **Your marketing actions weren't tied to the original marketing plan.**
- **You didn't have a strategic mindset when coming up with a marketing plan.**

If any of the above statements apply to you, then you fell victim to some of the most common reasons why hospice marketing plans fail. If none of the statements apply to you but your marketing efforts still fell flat, chances are you fell into one or more of these categories without even knowing it.

The last point is worth focusing on. Having a strategic mindset drives the development of the marketing plan as well as its implementation. A devotion to strategic principles prompts organization leaders to move away from playing hunches and to rely on evidence instead.

"Someone with a strategic mindset has a plan and follows it," says **Dee Vandeventer**, president of Mathis Earnest & Vandeventer, a marketing and fundraising consulting firm in Cedar Falls, IA. "The plan's strategies are based on research and facts. Strategies are developed for the individual business or organization. They're not cookie-cutter strategies that could apply to anyone's business, but are customized to that specific business."

Base strategies on data

Too often, marketing strategies are based on seemingly good ideas without the benefit of facts to back up those ideas. "Data collection can tell you how to focus your marketing efforts," Vandeventer adds. "For example, if you want to reach legislators about legislation regarding end-of-life issues, research may indicate previous legislation related to those issues, how and which legislators voted on previous bills, and other pertinent information."

A hospice marketer may surmise that a hospice needs to focus on physician referrals in the outer reaches of its coverage area and then direct resources to market the hospice to primary care physicians in the rural towns in neighboring counties. The reasoning: The hospice is doing a good job of getting referrals from urban physicians. The percentage of referrals from urban doctors far outweighs the number of referrals from their country counterparts. It all makes perfect sense unless there were relevant data that weren't collected and analyzed.

For instance, suppose that while the hospice was indeed receiving far more referrals from city physicians than those in outlying areas, the number of urban physician referrals represented about 10% of the total physician population in their urban market area. Suppose further that of the remaining 90% of physicians who do not refer patients to their hospice, 30% did not even know the hospice existed, so they had been referring patients to a competing hospice program.

So, while the initial marketing strategy made sense in the beginning, a closer look suggests otherwise. Data would have pointed to the need to bolster referrals from in-town doctors. This example shows how data should be the driving force behind any marketing strategy, not ideas that may seem logical.

What data should a hospice collect? Any market-based strategy should begin with an inventory of one's customers. A hospice serves a surprisingly wide range of people. Because of this, customers can go overlooked, resulting in missed opportunities. Hospice customers include the following:

- patients;
- physicians (listed by specialty);
- hospitals;
- nursing homes;
- home health agencies;
- insurers (Medicare, Medicaid, and private health plans);
- employers;
- vendors.

Some categories may include subcategories that expand the list of customer types even further. For example, physicians should be broken down by specialty so a hospice can gauge which specialties require more effort to reach.

Other examples of common subcategories are case managers and discharge planners of

Hospice Management Advisor™ (ISSN# 1087-0288) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. First-class postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospice Management Advisor™**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com) **Hours**: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

Subscription rates: One year (12 issues), $329. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $197 per year; 10 to 20 additional copies, $132 per year. For more than 20 copies, call customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $55 each. (GST registration number R128870672.)

Editor: **Eric Resultan**, (770) 329-9684, (eric_resultan@msn.com).
Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@ahcpub.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@ahcpub.com).
Managing Editor: **Robin Mason**, (404) 262-5517, (robin.mason@ahcpub.com).
Production Editor: **Brent Winter**.

THOMSON
AMERICAN HEALTH CONSULTANTS

Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

hospitals. Knowing the job titles of those who routinely refer patients to your hospice gives you the opportunity to market directly to people who hold specific job titles.

Get a complete picture

The idea is to collect as much data as possible so you can get a complete picture of each customer. For example, if you look at patients by age, sex, ethnic background, length of service, and disease, and you may find that your typical patient is a 65-year-old man with congestive heart failure whose stay is about two weeks. The data may suggest that opportunity lies in trying to diversify your patient base by actively marketing to specialties that are more likely to refer patients whose illness may result in longer stays, or in marketing to specific ethnic groups to ensure your mission to serve a diverse population is met.

The data you are looking for may be right under your nose. Start with a sampling of your own patient records, which will give you information such as patient demographics, the physicians who refer patients to your hospice, diseases patients present with, and the length of service. Depending on how much effort you put into your annual cost report, that document can also yield telling information.

Your market demographics will round out the data that need to be collected. While it is important to know who your current customers are — e.g., you currently receive 1,000 referrals a year from five primary care physicians, 20 oncologists, 15 cardiologists, and three hospitals — you get a more complete picture if you know there are 1,500 primary care physicians in your area, 500 oncologists, 300 cardiologists, and four hospitals.

State health organizations may also provide hospice data, says **Lisa Spoden**, president of Strategic Healthcare, a hospice consulting and marketing firm in Columbus, OH.

In addition, Vandeventer says you should look at information on these topics:

- trends for hospice management;
- new health concerns or breakthroughs;
- the competitive marketplace;
- characteristics of your key audiences;
- the level of understanding of the hospice concept within the medical community and the general public.

Try to compose as complete a picture of your market as possible. Think of it as a map; the more roads, streets, and highways that are plotted, the easier it is to navigate around the city. The more detailed your market map is, the more clearly your opportunities will appear.

Once you've collected enough data to get a three-dimensional view of your organization and your market, it's time to analyze the data. It is important to stress that the process of developing a marketing plan should not take place solely in the ivory towers of administration. Coming up with a successful marketing plan requires the input of department leaders, medical staff, nursing staff, administration, board of directors, and other stakeholders.

Re-examine the mission statement

One of the first tasks facing these stakeholders can be an uncomfortable one: re-examining the hospice's mission statement. The organization's focus may have changed over the years. Its current goals, which serve as the driving force behind the marketing plan, may no longer be in tune with the organization's stated mission.

There is no single right way to interpret the data you collect. However, hospice leaders should seek the input of department heads and staff during the data analysis process. The numbers may mean different things to people holding different responsibilities. For example, low referrals from one facility type may indicate to the administrator that more education in that area is needed, while the director of admissions, who may have better understanding of this specific customer type, determines that the admissions process hinders referrals. The recommendation that may arise from this observation could focus on streamlining the admissions process and promoting the changes to customers whose referrals lag behind the average.

"Create a team strategy when meeting with key members to develop the marketing plan," says Vandeventer. "Have every member participate. Don't let the president or CEO take over."

Once members of the marketing team have weighed in with their recommendations, the leaders can begin developing action strategies. An action strategy is a general plan that addresses a specific area.

For example, the marketing team may determine that the data suggest the need to increase referrals from local hospitals. That is the action strategy. It will likely be one of a number of action

strategies the marketing team comes up with.

Each action strategy should be accompanied by a detailed plan and should include specific goals by which the success of the strategy can be measured.

For instance, it isn't enough to simply set in motion a plan to increase referrals from a local hospital. Instead, a data-driven number of referrals over a set amount of time should be set as a goal. Also, the marketing team must establish a monitoring component for each action strategy and plan so adjustments to the plan can be made during the reporting period in case current plans are not working.

While there is no guarantee that any marketing plan will ultimately succeed, hospices that implement sound market-based plans based on data are taking most of the guesswork out of the marketing planning process.

But there is one other way a plan can fail at this point: failure to integrate the plan with the organization's business plan. Hospices must make marketing a key component of the overall business. Failure to do so increases the possibility that the marketing plan becomes nothing more than an annual exercise that has no value.

But success is dependent on being committed to the development and implementation of the plan. With that in mind, Vandeventer offers the following plan characteristics to emulate:

- **Make sure the plan is well-written.** It should be simple and easy to understand, clear about responsibilities and desired results, practical about goals, and flexible with regard to changing conditions, and should take a comprehensive look at the organization's business and competitive climate.
- **Make sure it is well-planned.** There should be agreement on marketing objectives, strategies, time lines, and budget before the plan is prepared.
- **Make sure the team communicated well.** This requires open communication among all team members on all aspects of the marketing plan.
- **Make sure goals are established.** Before any planning, develop an outline that sets forth the plan's purpose, overview, goals/objectives, challenges. The outline also should detail the plan itself and strategies to achieve it, along with action items needed to implement those strategies. There also should be a budget and a time line for when the action items will begin.
- **Make sure the plan is evidence-based.** The plan should present an independent, objective point of view. ■

Mission statement is key to a good marketing plan

Goals should be tied to statement

You've decided to get serious about developing a market-based marketing plan. You've decided to adopt a strategic approach and are committed to collecting as much data as it takes to get a clear picture of your organization, your market, and your competitors.

But are you ready to make the changes that affect the very essence of your hospice? Are you prepared to put your mission statement under the microscope and at least examine the words that may have been around since your hospice was born?

If the answer is "no," then you're not as serious about your marketing plan as you thought you were. Times change and priorities change. The direction your hospice is going today may look nothing like what the authors of your current mission statement had in mind. If that is the case, why are you taking your hospice in a direction that contradicts your mission?

"I think hospices need to review their mission statement at least every other year," says **Lisa Spoden**, president of Strategic Healthcare, a hospice consulting and marketing firm in Columbus, OH.

A common misconception is that mission and marketing are unrelated. That couldn't be further from the truth. Just as the mission statement drives the way hospice workers relate to and care for patients, the mission also sets the tone for marketing. It can also be said that a marketing plan is an expression of the organization's mission.

"Hospices should look at their marketing plan as a living, breathing extension of their mission," says **Dee Vandeventer**, president of Mathis Earnest & Vandeventer, a marketing and fundraising firm in Cedar Falls, IA. Those that look at their marketing plan as an annual chore are less likely to actually update it, and consequently less likely to believe in and practice their mission and business plan.

"One of the first things that should be examined in the plan is the current mission statement," says Vandeventer. "Evaluate whether top management's direction for the organization is consistent with the current mission statement. If it isn't, one of the first strategies and action items should

be to revise the mission statement. The marketing plan must be consistent with the mission statement, because the plan should flow from those core values."

Times have changed for hospices. They have gone from mostly small volunteer organizations to a sector of the health care market that now reaps more than $3 billion in Medicare reimbursement. In the two decades since hospices began getting paid for their services, HMOs have become dominant players in private insurance, and end-of-life care has begun to emerge from the shadows.

If your hospice mission hasn't changed recently, there is a pretty good chance it is too narrow for today's marketplace. That is not to say that the marketing plan should drive the mission, but if you look at how a hospice conducts business, it likely that the authors of the original mission statement had these things in mind.

To use an example outside of health care, banks no longer define their mission as "banking." Rather, a bank's mission likely is based on the provision of "financial services," a much broader term that fits the wide variety of services banks have come to offer to compete not only with other banks, but with other financial institutions.

The same can be said about hospices. The term "palliative care" has become a buzzword in the health care industry — so much so that other providers, such as hospitals, have seized on it as an opportunity. To re-establish hospice's claim to palliative care, hospices and hospice trade organizations have included the term in their name and missions, reflecting the broadening scope of their organizations.

In the book *Health Care Marketing Plans: From Strategy to Action* (Aspen Publishers), authors **Steven G. Hillestad** and **Eric N. Berkowitz** emphasize the need to start the process of developing a marketing plan by defining the organization's mission. Their theory requires hospices to think outside the traditional definition of hospices.

Consider the mission statements of two hospices: Hospice A defines its mission as providing care for dying patients and their families in their homes. On the other hand, Hospice B uses a broader statement that says the organization provides end-of-life care and palliative care services. If both hospices determined that they would provide services to Alzheimer's patients living in nursing homes, only Hospice B would be acting in accordance with its mission, while hospice A is limited by its mission to providing in-home hospice care.

Hillestad and Berkowitz advise health care institutions to ask the following questions to reach a consensus mission statement:

- What are the history and heritage of the organization?
- What are the historical relationships of the organization?
- What prior relationships, formal and informal, have been arranged, developed, and nurtured that have an impact on the organization?
- What is the corporate value structure of management, the board of trustees, and constituencies of the organization? (Is the corporation affiliated with a religious organization, for example?)
- What is the value structure of the people that the organization serves?
- What is the probable future of the external environment? (Demographic changes in the neighborhoods served is one example.)
- Will corporate resources support the mission?

Specify goals

Hospices can use a newly revised statement as a launching pad for goal setting. Goal-setting should be centered on profitability or growth. For example, a nonprofit hospice may want to focus its goals on growing the organization in new ways such as increasing admissions among nursing home residents. Whatever goals the hospice chooses, the number of goals connected with the mission statement should be limited. This is not the place for detailed plan objectives. The goal statement should be a broad expression of the organization's intended direction.

It is important to note that the creation of a new mission statement and accompanying goals is not an administration-only task. The development of these two critical items must involve the entire organization. Key personnel, including finance, nursing, medical directors, chaplains, and social workers, just to name a few, should all have a place at the table when creating a hospice's mission and goals.

Some examples of the goal statements a hospice might use include:

- Establish itself as the largest hospice in the tri-county area.
- Increase patient diversity by reaching out to minority groups to educate them about hospice care.
- Provide end-of-life care to all types of terminally ill patients regardless of residence.

• Expand services to include care of dying children.

The new mission statement and broad goals give a hospice a focused perspective in which it can review market data that it will soon begin collecting. The mission and goals draw the boundaries within which the marketing plan will be governed. The two statements will help marketing planners prioritize opportunities and even exclude some avenues because they do not fit in with the current mission and goals.

To help ensure health care organizations get their marketing plans off to a good start, Hillestad and Berkowitz offer the following questions as a checklist to ensure mission statements and goals are reviewed, revised, or created properly:

• Does the mission of your organization reflect a broad enough orientation and provide flexibility to make changes as required?

• Did all important constituencies have an opportunity to provide input or comment on the mission?

• Did your organization work through possible alternative operating scenarios to see how the mission might be applied? In other words, did the mission provide guidance as to what types of scenarios are acceptable and not acceptable?

• Does the mission provide a set of goals that are specific enough to give guidance to the organization, yet broad enough to provide flexibility? ■

Medicare changes range from benign to troublesome

More documentation may be required

Hospices could have to develop and follow new procedures for certifying terminal illnesses, admissions, and discharges, if proposed rule amendments are finalized by the Centers for Medicare & Medicaid Services (CMS).

The proposed rule, which appeared in the Nov. 22, 2002, *Federal Register*, would revise existing regulations that govern coverage and payment for hospice care under the Medicare program. The revisions are required by the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

"We are proposing to make conforming changes to the Medicare hospice regulations to reflect the statutory changes discussed above," CMS wrote in the *Federal Register*. "In addition, we are proposing to revise the regulation to reflect current policy on the documentation needed to support a certification of terminal illness, admission to Medicare hospice, and discharge from hospice. We are proposing to add one new requirement that would allow for discharges from hospice for cause under very limited circumstances."

The proposed changes represent a mixed bag of proposals ranging from benign to troublesome, says **Judi Lund Person**, MPH, vice president of state and regulatory affairs for the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA.

But CMS sees the changes as merely housekeeping moves that follow legislation and tighten gaps in current regulation.

"The general lack of hospice data and the unpredictable nature of hospice care have made it extremely difficult to predict the savings or costs associated with the changes contained in this proposed rule," CMS wrote. "However, we believe that the proposed changes would create very little, if any, new economic or regulatory burdens on hospice providers. These proposed changes are either statements of current policy or clarifications of policy that would benefit hospice providers."

Troubling for the hospice industry is the resurrection of issues raised by Operation Restore Trust, a 1994 joint investigation between the then-named Health Care Financing Administration and the Office of the Inspector General that sought to weed out abuses in the Medicare system. Hospices were singled out as abusers of the Medicare program because many admitted patients who lived longer than six months, despite terminal illness certifications.

The hospice industry has since successfully argued that the characterization was unfair and led many physicians to delay terminal illness certification, causing patients to be admitted to hospice too late to reap the full measure of the Hospice Medicare Benefit. CMS also has issued directives explaining that the six-month diagnosis should be based upon a "physician's clinical judgment" and should not be interpreted as a deadline for the patient to either die or be discharged.

The NHPCO is concerned that revisiting Operation Restore Trust nearly 10 years after it

was initiated will negate the gains the industry has enjoyed as a result of greater awareness of palliative and end-of-life care.

"We want to make sure the gains we've made in the past few years are not lost," Person says. The references to Operation Restore Trust "are odd because you would think if CMS still had problems [with hospice], they would have been addressed by Benefits Improvement Act of 2000."

In the 1990's, Operation Restore Trust accused hospices of admitting patients who were ineligible for the Hospice Medicare Benefit. CMS' latest take on the issue says hospices as a whole fail to provide the proper documentation that supports admission to hospice.

'A mere signed certification is not sufficient'

"Operation Restore Trust found that certification and recertification occurred without the documentation that would support the terminal illness prognosis," CMS wrote in the Nov. 22, 2002, *Federal Register*. "Accordingly, in 1995, we issued program memoranda requiring clinical findings and other documentation that support the medical prognosis. This documentation must accompany a certification and be filed in the patient's medical record. We recognize that medical prognostications of life expectancy are not always exact, but the amendment regarding the physician's clinical judgment does not negate the fact that there must be a basis for a certification. A hospice needs to be certain that the physician's clinical judgment can be supported by clinical findings and other documentation that provide a basis for the certification of six months or less if the illness runs its normal course. A mere signed certification, absent a medically sound basis that supports the clinical judgment, is not sufficient for application of the hospice benefit under Medicare."

Using Operation Restore Trust as evidence, CMS makes the case that certifications are being made for patients who are chronically ill but who are without complications or other circumstances that indicate a life expectancy of six months or less. As a result, CMS is proposing the following changes:

- Regulations will be reworded to state that certification for the hospice benefit will be based upon the physician's or medical director's clinical judgment regarding the normal course of the individual's illness.
- Regulations will add language that requires specific clinical findings and other documentation supporting the medical prognosis to accompany the written certification and be filed in the medical record.

While the NHPCO doesn't take issue with the need to document clinical findings that lead to terminal illness certification, it has told CMS the language suggests that physicians and hospice medical directors must perform additional, perhaps unnecessary tests, says Person. The NHPCO is hoping CMS adds the word "or" so that the regulation would read: ". . . requires specific clinical findings and/or other documentation supporting the medical prognosis . . ."

The hospice trade industry group is also concerned with proposed changes to regulations governing admission to hospice. Specifically, CMS wants to mandate consultations between the attending physician and hospice medical director.

CMS wants to establish admissions guidance

"Also in response to concerns raised by Operation Restore Trust, we are proposing to establish general guidance on hospice admission procedures," CMS wrote. "Currently, there is no guidance in manuals or regulations regarding admission procedures. We are proposing to add a new [section], 'Admission to hospice care,' which would establish specific requirements to be met before a hospice provider admits a patient to its care.

"We realize that many hospice patients are referred to hospice from various 'nonmedical' sources. This is entirely appropriate; however, it is the responsibility of the medical director, in concert with the attending physician, to assess the patient's medical condition and determine if the patient can be certified as terminally ill."

Those new requirements in the proposed "Admission to hospice care" section would do the following:

- allow admission of a patient only on the recommendation of the medical director in consultation with the patient's attending physician, if any;
- require that the hospice medical director consider at least the following information when making a decision to certify that a patient is terminally ill: diagnosis of the patient's terminal condition; any related diagnoses or comorbidities; and current clinically relevant findings supporting all diagnoses.

The problem with these two proposals is that they mark a departure from the normal interaction between attending physicians and medical directors. Many hospices have complained that requiring attending physicians to consult with medical directors could pose a barrier to hospice admission, says Person.

In addition, the proposal seems to negate the hospice interdisciplinary team's role in the admissions process. Also, NHPCO points out that the proposed regulation gives no guidance on how consultations are supposed to take place. "We question whether meeting this will prove to be cumbersome," Person says.

Discharge planning

The proposed regulations also try to address concerns hospices have had for years regarding the discharge of patients due to cause — for instance, patients, their families, or caregivers become abusive and represent a threat to the hospice worker who must enter the home. Current regulations allow hospices to discharge patients only when the patient is no longer terminally ill.

Under the proposed changes, hospice may discharge a patient if:

1. the patient moves out of the hospice's service area or transfers to another hospice;

2. the hospice determines that the patient is no longer terminally ill; or

3. the hospice determines, under a policy set by the hospice for the purpose of addressing ``discharge for cause'' that also meets the requirements discussed in the remainder of the new paragraph (a), that the patient's behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.

"It's helpful to have a discussion about discharging patients," says Lund. "We don't expect that our reasons for discharging patients will be any more lenient than other health care providers'."

Other changes being proposed include changes to the hospice benefit period and how physician certifications are obtained. Those changes include:

- The hospice benefit period will be two 90-day periods, followed by an unlimited number of 60-day periods.
- A hospice must obtain written certification before it submits a claim for payment.
- If the hospice cannot obtain the written certification within two calendar days, it must obtain an oral certification within two calendar days, and the written certification before it submits a claim for payment would be required for each benefit period rather than just for the initial 90-day period. ■

Doctor role doesn't end when hospice care begins

Do's and don'ts of oversight codes

When a patient is referred to hospice, that doesn't mean the physician no longer has a say in treatment, nor does it mean there are no more billing opportunities. There are several case management-related services that are billable by a physician whose patient is being cared for in a home health or hospice setting, including G0181 and G0182 for care plan oversight.

Physicians often take an active role in monitoring their patients' progress following a referral to home health or hospice. They may take part in interdisciplinary team meetings, hold telephone conversations with other health care professionals, and recertify patients for continued care under home health.

All these services may represent a significant portion of a physician's time and may be deserving of payment. The problem is that there are a number of case management codes to choose from, most of which are not covered under Medicare or are no longer being used, says **Cindy C. Parman**, CPC, CPC-H, RCC, president of Coding Strategies, Inc., a coding consulting firm in Dallas, GA.

Coding Strategies provides its clients, which include physicians, with reimbursement advice to help physicians get paid for their home health and hospice-related services.

At first blush, code 99361 (medical conference) seems an accurate and appropriate code to report a meeting with home health workers or hospice interdisciplinary team members. In CPT 2003, the code is described as a "medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care."

Code 99361 is not a separately payable item and is always considered part of evaluation and

management services, the document advises.

Similarly, 99371-99373, telephone conferences for the purpose of coordinating care, seem appropriate. According to the CPT, 99371-99373 describes a telephone call by a physician to a patient or health care professional for medical management or coordinating medical management. But Medicare policy excludes payment of these codes.

While it seems that the codes that best describe the case management efforts of physicians lead to no reimbursement, care plan oversight codes encompass the services described in 99361 and 99371-99373. More importantly, they may be reimbursable.

It is important to note that the Center for Medicare & Medicaid Services (CMS) does not recognize codes 99374-99375 (physician supervision). Rather than using 99374-99375 for home health and 99377 (physician supervision) for hospice, the correct care plan oversight codes are listed in HCPCS:

• **G0181** — Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revisions of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communications (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.

• **G0182** — Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revisions of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communications (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.

While Medicare requires G codes and commercial payers likely require CPT codes, the way to determine time spent performing care plan oversight (CPO) is the same. Using Medicare as an example, practices must painstakingly document each minute the physician spends performing CPO services in a 30-day period. Because these codes state "30 minutes or more," they are generally reported only once each month, typically at the end of each month where CPO services were provided, says Parman.

The definitions for both home health and hospice CPO point to seven services that can be used to tally CPO: review of charts, reports, treatment plans, and other test results; telephone calls (excluding time spent on hold) to hospice or home health representatives; team conferences; discussions with pharmacist about pharmaceutical therapies; medical decision-making; coordination of services; documenting the services provided in the patient chart.

CPO services must be provided by physician

Care plan oversight provided by a nurse, nurse practitioner, physician assistant, clinical nurse specialist, or other staff is not separately reimbursable and cannot be counted toward the total CPO time for the month. CPO codes are reserved for services provided directly by the physician. Telephone calls to the patient or family made by someone other than the physician are not eligible for reimbursement. Aside from the previously mentioned non-countable services, Medicare's list of non-covered CPO services include:

• travel time and time spent preparing claims and for claims processing;

• initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter;

• low-intensity services included as part of the evaluation and management services;

• informal consults with health professionals not involved in the patient's care.

The physician's time spent discussing, with his or her nurse, conversations the nurse had with the hospice does not count toward this 30-minute requirement. However, the time spent by the physician working on the care plan after the nurse has conveyed the pertinent information to the physician is countable toward the 30 minutes. Only one physician per month will be paid for CPO for a patient. Other physicians working with the physician who signed the plan of care are not permitted to bill for these services.

The work included in hospital discharge day management (99238-99239) and discharge from observation (99217) is not countable toward the 30 minutes per month required for billing of care

Care plan oversight rules for physicians

Dos and don'ts from CMS

Medicare has established the following rules to guide physicians in billing for care plan oversight (CPO):

- The beneficiary must require complex or multidisciplinary care modalities requiring ongoing physician involvement in the patient's plan of care.
- Care plan oversight must be billed during the period in which the beneficiary is receiving home health or hospice services.
- The beneficiary must be receiving Medicare-covered home health or hospice services during the period in which the care plan oversight 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 CPO (see details of countable services 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 or nonphysician practitioner must have provided a covered physician service that required a face-to-face encounter (codes 99201-99263, 99281-99357) with the beneficiary within the six months immediately preceding the provision of the first CPO service (a face-to-face encounter does not include EKG, lab services, or surgery).
- The CPO billed must not be routine post-operative 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.
- The care plan oversight 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 (s)he bills the Medicare monthly capitation payment (90918-90925) (ESRD benefit) for the same beneficiary
- The physician billing for CPO must document in the patient's record which services were furnished and the date and length of time associated with those services. ■

plan oversight. Physicians may bill for work on the same day as discharge, but only for those services separately documented as occurring after the patient is actually physically discharged from the hospital.

Physician time spent calling in prescriptions to a pharmacy, retrieving a chart, or traveling is not considered eligible and cannot be counted toward time spent performing CPO. **(For a list of rules guiding physicians in billing for care plan oversight, see story, above.)**

Practices also can bill for certifying and recertifying patients for home health services. Oncology physicians, for instance, who refer patients to home care should bill Medicare for certifying and recertifying services provided to a home health agency. The codes are meant to encourage greater physician involvement in their patients' care.

Use G0179 (MD recertification, home health agency patient) to recertify a patient who has received home health services for at least 60 days, or one certification period. Code G0180 is for physician certification services for Medicare-covered services provided by a participating home health agency (patient not present), including review of initial or subsequent reports of patient status, review of patient responses to OASIS assessment instrument, contact with the home health agency to ascertain the initial implementation plan of care, and documentation in the patient's office record, per certification period. It applies to patients who have not received Medicare-covered home health services for at least 60 days.

The national reimbursement average for G0180 is $73, and the national reimbursement average for G0180 is $53.These amounts will vary by region. ■

Turn one-time gifts into long-term pledges

Planned fundraising campaigns add support

Your budget is shrinking. Reimbursement is dropping. Expenses are rising. How can you meet the growing need for funds?

Fundraising campaigns are one way, but hospices typically don't run capital campaigns for one-time needs, says **Charles R. Hillary**, president of Hillary Lyons Associates, a fundraising consulting firm in Dimondale, MI. "Home health and hospice agencies need to focus on long-term fundraising efforts that are designed to support all services of the agency, not just one immediate need," he suggests.

Hillary recommends that hospice organizations take a look at how they can convert their periodic memorial gift-givers into ongoing contributors. "People who make memorial contributions based on their good feelings about your agency and how you treated their family member are an excellent way to build a donor base," he says.

The funds can be significant for hospices that take the time and effort to build a fundraising program, says **Anne E. Koepsell**, MHA, executive director or the Hospice of Spokane (WA). "Between the years 1985 and 1997, we usually received around $300,000 in donations," she says. Following her efforts to establish a formal program for fundraising, her agency has seen donations rise to $544,000 in 2000 and $937,000 in 2001. "Part of the money we raised in 2001 are funds designated for use to build a hospice house, but the undesignated funds are at least $600,000," she says. Undesignated funds are used to underwrite programs such as bereavement classes, new services, and staff salaries, she explains.

Koepsell's agency is not affiliated with a hospital, so it was easy for her to gain approval to actively solicit funds.

"Hospital-affiliated hospice and home health agencies may have to get permission to conduct their own fundraising activities, but it can be done," Hillary says. He suggests that agency managers offer to get staff and themselves involved in the hospital's fundraising effort and offer community service activities such as seminars on health-related issues or bereavement issues as a way to help the hospital foundation's community efforts. "The more educated donors and your own hospital fundraisers are about your services, the more likely you can participate in raising or helping distribute funds received," he says.

"We are not allowed to solicit our own funds, and whatever donations we do receive from patients or the community go directly to the hospital foundation," says **Judy Hannah**, RN, director of home health care and hospice for Hamilton Medical Center in Dalton, GA. "All our employees do participate in the hospital's fundraising campaign through payroll deduction, and we often do request financial assistance for some of our patients through the foundation," she says.

"Almost all of our requests are for hospice patients who need financial assistance to pay for medications, add a room air conditioner during the summer months, or pay essential bills such as rent or telephone," says Hannah. Although most home health patients don't require the same type of assistance, it is available if needed, she adds.

Hannah points out that if funds are designated for use in hospice or home health, they must be used in those areas. "We have one hospice benefactor who donated a substantial amount of money and designated it for the hospice's use," she says. The funds were used to refurbish and refurnish the hospice agency's offices to make them more efficient, she adds.

If you can solicit your own funds, be sure to think long-term, says Hillary. Design your program to ask first for donations from two groups that are already believers in your good service, he says. "Solicit funds from employees and from people who have already contributed," he says.

Not only are these two groups readily available, but also it is important to show that your employees support your efforts before you go to community donors, he adds.

COMING IN FUTURE MONTHS

- Building community awareness programs that work
- How to make the Internet work for you and your clients
- More proven strategies in hospice marketing
- The latest advances in pain management

The most successful long-term fundraising programs are based on a system of committees composed of community volunteers, Hillary says. "We set up committees such as annual support, planned giving, and major gifts. The leaders of these committees as well as key community leaders make up the volunteer governing board," he says. Each committee chair is responsible for recruiting committee volunteers and developing a plan for soliciting donors, he explains. Employees volunteer to serve on the employee giving committee and set their own goals and objectives, he adds.

Be sure to recognize your donors with letters, preferably handwritten, never e-mailed, Hillary says. "I also recommend telephone calls and will often suggest a board meeting at which half of the time is spent calling donors to say thank you," he says. While technology has made mailing, receiving, and tracking pledges much easier, it's important to remember that fundraising is an effort that requires a personal touch, he adds. Also, don't forget public displays such as a wall of honor that displays donors' names in a lobby or area that others will see, he suggests.

Setting up a fundraising program doesn't require the use of a consultant, but Koepsell chose to hire a consultant when she realized that her staff did not have the expertise or experience to keep everyone focused on the task during the formation of the committees and kick-off of the program.

If you choose to use a consultant, look for one who offers assistance in the specific type of program in which you are interested, suggests Hillary. "Some consultants specialize in long-term fundraising, capital campaigns, or planned giving," he says. One good source of information is the Association of Healthcare Philanthropy in Falls Church, VA. and colleagues in other agencies that have conducted campaigns, he suggests.

While long-term fundraising foundations or programs don't have the specific amount of money to raise or a brick-and-mortar project to describe to potential donors, it still is important to be specific about how the money is used, says Hillary. "In all of your reports, describe how much you raised and how the funds were used," he says. If you add a music therapy program, a special camp for children who have lost a parent, new equipment, or extra staff, that enables you to provide a service for which you previously had to rely upon outside contractors, so describe how this benefits your patients, he explains.

You also need to watch how much you spend to raise funds, adds Hillary. In the first two years of a fundraising program, plan to break even at best, he says. But in the third through fifth years, plan on spending less than 20 to 25 cents to raise each dollar, he suggests.

Koepsell's agency spent a little more than 13 cents per dollar raised in 2001. "We do have a total of two full-time equivalents allocated to support the fundraising effort," she explains. The staff people coordinate the volunteer meetings, handle paperwork such as minutes, receive and track donations, and generate reports for the governing board.

You can keep fundraising costs down by selectively recruiting some volunteers, Koepsell points out. "We have a printer on one of our committees, and he printed our brochures at a very low cost," she says. "We encourage 'in kind' donations from our donors because it is an easy way for them to donate, and it keeps our costs down," she adds ■