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IN THIS ISSUE

■ Hospice savings:

Study data illustrate cost impact of Medicaid hospice benefit cuts Cover

■ Hospice Trends:

Can hospices gain respect they need to break into inpatient palliative care? 89

■ Billing opportunities:

Hiring a full-time physician improves medical component of hospice care and allows hospices to bill for physician's services 92

■ Unannounced company:

JCAHO has agencies preparing for unannounced inspection visits 95

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Report pegs savings generated by hospice at \$282 million annually

Study results used to fight state cuts in Medicaid hospice benefit

In an effort to persuade cash-strapped states not to reduce or eliminate their Medicaid hospice benefits, the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA, delivered a strong argument to state policy-makers: Cut hospice programs for the poor, and you'll end up spending almost \$300 million a year in additional hospital days, nursing home care, and drug costs.

A study released in June by Milliman USA of Washington, DC, suggests hospices save states a significant amount of money in addition to providing quality care. The report, *Value of Hospice Benefit to Medicaid Programs*, maintains that hospice care saves Medicaid approximately \$282 million annually, or approximately \$7,000 per hospice-eligible beneficiary.

It's no coincidence the report's release comes at a time when states — many facing budget deficits as the nation's economic recovery continues to stall — must make difficult budget decisions. Several states have considered eliminating the Medicaid hospice benefit in an attempt to reduce spending. Because hospice is an optional service, rather than a required one, it makes an easy target.

According to state hospice organizations, California, Ohio, and North Dakota were among the states considering cutting the Medicaid hospice benefit.

"The compassionate and comprehensive care provided through the Medicaid hospice benefit is justification enough to ensure that this important funding not be reduced or eliminated," says **J. Donald Schumacher**, PsyD, president and CEO of the NHPCO. "The realized cost savings that are illustrated in this new report only reinforce the value of a hospice benefit."

According to NHPCO director of communications **Jon Radulovic**, the study has been distributed to state hospice organizations as part of a tool kit that includes other education materials aimed at convincing

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state lawmakers to preserve, and perhaps even enhance, the hospice Medicaid benefit.

The Milliman USA study reinforces the message conveyed by other studies that have shown the cost benefit of hospice care. The Milliman study, however, has a different twist. While past studies suggest hospice care reduces costs, the latest study demonstrates how costs would increase in the absence of the Medicaid hospice benefit.

"It validates what we have been saying all along," says **Cherry Meier**, RN, MSN, Medicaid policy expert and specialist in long-term care with the NHPCO. "Only now we have the data to back up what we've been saying."

For now, states' efforts to balance their budgets at the expense of hospice seem to have ceased, says **Stephen Connor**, PhD, vice president for research, development, and finance at the NHPCO. But no one at the industry's largest trade association believes the matter has been resolved.

As long as states continue to struggle to pay for the most basic of services, hospice will continue to be at risk, adds Meier.

One of the states at risk is California. The state faces a \$38 billion deficit and started a new fiscal year in July without a budget. The California Hospice and Palliative Care Association (CHPCA) has been working to rebuff any initiative to cut hospice from Medi-Cal, the state's Medicaid program, since the organization learned a proposed budget did not include hospice.

"In May we were off the chopping block," says **Margaret Clausen**, executive director of the CHPCA, in Sacramento. "But we are not totally out of the woods. California still doesn't have a budget."

The CHPCA lobbied California officials prior to the release of the Milliman study and the distribution of the NHPCO tool kit. Yet, the tack they took was similar. Hospice officials successfully argued that hospice care saved state taxpayers \$12 million per year.

The hope is that hospices at the state and local level can use the data garnered from the Milliman USA study to persuade not only states, but other payers, including health plans, that hospice can lower their overall costs. While the study looks specifically at Medicaid, its message of cost savings is clear, says Meier.

The study, while not definitive, makes a persuasive argument when considered along with past studies that show hospice care is cost-effective, says Connor.

Milliman findings

According to the study, elimination of the hospice benefit in Medicaid would result in increased spending in the following areas:

- Without hospice, more patients would continue to receive end-of-life care in a hospital. (Additional cost: \$228 million.)
- Without hospice, Medicaid would continue to pay for expensive pharmaceutical treatments. (Additional cost: \$41 million.)
- Without hospice, states will pay about 5% more per day for hospice-eligible Medicaid patients in nursing homes, due to technicalities in federal rules. (Additional cost: \$13 million.)

The first two areas of increased spending apply to Medicaid-only patients, the study points out. The third area of increased spending applies to patients with Medicaid-only coverage (Medicaid patients without Medicare coverage) and dual

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Editorial Questions

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

Source: Value of Hospice Benefit to Medicaid Programs, Milliman USA, Washington, DC.

coverage (Medicare and Medicaid).

According to the NHPCO, Medicaid recipients make up about 5% of hospice patients, and other hospice patients receive both Medicaid and Medicare. In 2001, hospices admitted approximately 775,000 patients; about 40,000 of these had Medicaid as their primary coverage.

The authors of the Milliman report analyzed hospital discharge data that suggested approximately 64,000 Medicaid beneficiaries die each year in hospitals, 45,000 of whom suffer from typical hospice diagnoses.

Avoided hospitalizations

To estimate the cost of a terminal hospitalization, the study authors used 2001 hospital discharge data from the hospital discharge databases of 19 states and identified all Medicaid-only beneficiaries who died during a hospital stay (about 38,000 beneficiaries). The researchers then identified hospice-eligible beneficiaries based on ICD-9 codes for terminal illnesses often associated with hospice care. These included cancer, congestive

heart failure, chronic obstructive pulmonary disease, end-stage renal and liver disease, HIV, and congenital anomalies.

From the data, the study authors identified about 70% of Medicaid beneficiaries who died during a hospital stay to be hospice-eligible. They used a per diem rate of \$900 and an average length of stay of 15 days to estimate the average cost of a terminal hospitalization.

Based on those assumptions, Medicaid spending on hospitalization for terminal illness would increase if hospice-eligible patients were not able to elect hospice benefits, the researchers concluded.

"We used the projected 40,000 Medicaid-only hospice deaths for 2003 to model the impact of the hospice program on shifting beneficiaries from dying in the hospital to dying in the home," the report said. "We assumed 10% of those receiving hospice would die in the hospital and 40% of those without hospice would die in the hospital. We added \$100 per day cost of hospice care using an average 48-day hospice enrollment. The extra cost to Medicaid without a hospice benefit is

Source: Value of Hospice Benefit to Medicaid Programs, Milliman USA, Washington, DC.

\$228,000,000 or \$5,700 extra cost per Medicaid-only hospice patient.” **(See table on p. 87.)**

To estimate the impact on drug costs for Medicaid-only beneficiaries who would be deprived of hospice care, the Milliman researchers used a large commercial insurer database with claims for about 2 million covered lives in 2001.

“Hospice provides all medications related to the terminal illness,” they wrote. “Consequently, we believe that, without hospice, Medicaid’s drug costs would increase” if hospice were not available.

The study authors identified people who died and had hospice-eligible ICD-9 codes for terminal

illness (almost 1,000 patients) and identified prescription drug claims for those patients, including oral, injectable, and parenteral drugs. After accounting for a 15% annual drug trend and a 20% price discount received by Medicaid programs, the researchers estimated that 2003 prescription drug costs would average over \$20 per day during each of the last three months of a terminally ill patient’s life.

“We estimate the avoided drug costs for the 40,000 Medicaid-only hospice deaths for 2003 to be about \$41 million or \$1,032 per Medicaid-only hospice patient,” the report said. **(See table above.)**

The third cost savings area is simply a matter

Source: Value of Hospice Benefit to Medicaid Programs, Milliman USA, Washington, DC.

of removing a discount commonly associated with hospice care provided in nursing homes. According to federal rules, when a Medicaid-only or dually eligible nursing facility beneficiary with a Medicaid hospice benefit enrolls in hospice, Medicaid pays hospice 95% of room-and-board allowable charges, rather than the 100% Medicaid typically pays directly to the nursing facility. Hospice, in turn, reimburses the nursing facility 95% percent of room and board. For nursing facility hospice-eligible patients without a Medicaid hospice benefit, Medicaid would pay 100% of the room-and-board charges to the nursing facility.

The Milliman researchers used the hospice

cost report to estimate that the national total room-and-board revenue paid for Medicaid beneficiaries receiving hospice care in nursing facilities is about \$255 million in 2003. (See Table IV, p. 88, bottom.)

"We estimate that, without the hospice benefit, Medicaid spending would increase by about \$13 million," the report said.

"There is a silver lining to all this," says Clausen. "The threat of having the Medicaid hospice benefit cut has mobilized hospice providers. In the past we had to go out and sell hospice with anecdotal stories. We have never had data, and now we are forced to get it." ■

Hospice Trends

Interest in palliative care creates growth opportunity

Inpatient consults a tough market

By **Larry Beresford**

The growth of palliative care and the development of palliative medicine consultation services are major end-of-life trends with huge implications for America's hospice industry. Proponents say palliative care consultations offer hospice agencies a vehicle for sharing their expertise in pain and symptom management or life-transition counseling and end-of-life care planning in new contexts with seriously ill, hospitalized patients who are not yet ready or eligible for hospice care.

A hospice palliative care consultation service can be developed as a new program or product line or even as a clinic or a physician practice incorporated by the hospice agency, which bills Medicare and other payers for reimbursable physician consultation visits provided by its employed medical director and interdisciplinary team. Potentially, this service could encourage earlier consideration of hospice care by patients, leading to earlier and more appropriate hospice referrals, reducing the incidence of very-short-stay hospice patients, while helping the hospital better manage its most difficult, costly patients.

But some observers question whether it is realistic for most community hospices to send a palliative care consultation team into the high-technology, highly politicized acute care environment and expect them to prosper — let alone to be taken seriously by hospital staff and physicians. Hospice professionals obviously possess end-of-life skills needed by seriously ill patients, but do they have all of the tools and knowledge — and confidence — they will need to function within the acute care setting? Do they have an activist medical director and other team members who can command credibility, speak the language, and understand the culture of the hospital? Or will they be viewed as fish out of water, enmeshed in cultural clashes that condemn the new service to failure?

On the other hand, it's clearly not impossible, because a number of leading hospices are already offering inpatient palliative care consultations under varied auspices and models of collaboration with hospitals. These services generally have not yet succeeded in generating a profit on billing income alone, although they are justified on the basis of collateral benefits.

The National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA, has proposed a new benefit called hospice palliative care consultation, which would provide Medicare coverage at customary physician billing rates for a new range of consulting services provided by the certified hospice's interdisciplinary team to patients not enrolled in hospice care. A more limited version of this proposal, covering a one-time hospice "educational visit" by the hospice medical director, made it into the Medicare legislative package recently passed by the U.S. House of Representatives.

Meanwhile, the conferences, publications, and other resources of the Center to Advance Palliative Care (CAPC) — including a sponsored workshop at the upcoming NHPCO Management and Leadership Conference Sept. 6 in Phoenix and a December 2001 monograph titled *Hospital-Hospice Partnerships in Palliative Care: Creating a Continuum of Service* — have continued to promote a collaborative model of inpatient palliative care development by hospitals and hospices.

But the question remains: Is palliative care a viable direction, service, and new product line for the majority of America's hospices? Can they attract the consultation referrals they will need to make this product line succeed? If so, how can they maximize their chances of success in expanding access to appropriate end-of-life services and thus reach more patients with end-of-life needs earlier in the disease progression? The answers to these questions will help to shape the future of America's 3,200 hospices.

New things to learn

Hospice nurses possess considerable skill and experience in end-of-life care, but when they enter the inpatient realm, they may encounter treatment modalities and other issues that are unfamiliar, especially given the rapid pace of change in hospital medicine, observes **J. Andrew Billings**, MD, a one-time hospice medical director who now heads the palliative care service at Massachusetts General Hospital in Boston.

"I have seen this issue with people on my own staff. There are things they need to learn to provide good care for patients in the hospital, even if they already have a solid background in hospice and palliative care," he says.

"We already have experience from hospice's involvement in nursing homes and the lessons that were learned there. For instance, it is not easy to become part of another institution and its culture. Also, it is important not to come in acting as if you know all of the answers. You don't want to seem arrogant. You need to be willing to listen and learn," Billings says.

Some hospice and palliative care services have targeted the intensive care unit (ICU) as a setting where end-of-life perspectives and consultations could be especially helpful (see *HMA*, March 2003, p. 31), but Billings warns that the ICU setting, in particular, requires an intimate understanding of contemporary medical techniques and technologies. Without obvious ICU experience

and expertise, it will be hard for the palliative care team to garner much credibility.

The questions that are raised about hospice's ability to provide a successful palliative care service in the hospital may reflect more familiarity with the "old" Medicare-model hospice than with the degree of diversification now being practiced by some leading-edge hospices, notes **Gretchen Brown**, president of Hospice of the Bluegrass in Lexington, KY. "We are living proof that it is possible for a hospice to successfully operate palliative care services," says Brown. Hospice of the Bluegrass operates palliative care services at Lexington's three acute-care hospitals.

On the other hand, Brown wonders whether most American hospices really want to diversify and make the programmatic changes necessary to succeed in palliative care. Step one is to invest in a competent, respected, full-time medical director (see *HMA*, July 2003, p. 81).

Hospice-run palliative care teams also should be familiar with the palliative applications of chemotherapy and high-tech treatments when those are appropriate and desired for the patient. Is the hospice willing to tackle the difficult cases and the ambivalence many patients and families experience before they are ready to consider hospice enrollment? "Do you have the ability and willingness to look forward and take risks — to consider the upside, downside, and unintended consequences of an initiative such as this?" Brown asks.

Find a champion on the inside

"If you are serious about it, then you need to identify your champion inside," she says. "How are you going to get the data you need — which belong to the hospital?" Without the results of a comprehensive needs assessment, the hospital might not appreciate the level of unmet need in the institution, and the hospice won't know where to target its efforts at patients in need, Brown says.

"If some doctors are already referring to your hospice for pain consults, that's a clue that you have friends inside," she notes. "On the other hand, it would be a mistake to go in and just say, 'Here we are.' That won't work."

It's not a sound business strategy to craft a new product like palliative care without significant involvement by the intended customer in planning and needs assessment, Brown says. You need to make sure the customer buys into the product.

Hospice of the Bluegrass' hospital palliative care teams are jointly staffed, with team members assigned and funded by both the hospice and each hospital, building on considerable groundwork in terms of joint needs assessments, planning, medical advisory committee involvement, and other relationship-building efforts.

Hospice of the Bluegrass is the sole hospice provider in many of the communities it serves, thanks to a state certificate of need and a long and constructive relationship with local medical communities. The hospice's medical director, **Terry Gutsell**, MD, who is well-known and respected within that community, also did a one-year palliative medicine fellowship at the Cleveland Clinic before taking his current position.

Know thyself

"The fact that hospice's role in palliative care within the walls of the hospital is open to question illustrates the problem: a lack of openness by some hospitals to collaborate in responding to the shortcomings of inpatient end-of-life care documented by the SUPPORT study," observes **Bill Finn**, president of Hospice Buffalo (NY) and the Center for Hospice and Palliative Care in Cheektowaga, NY. As the next wave of managed care focuses on disease management approaches to coordinating the care of complex, expensive patients, palliative care for patients nearing the end of life would seem to be an obvious opportunity for improving coordination and continuity of care, he says.

The Buffalo hospice operates a palliative consultation service at Buffalo General Hospital and its affiliated hospitals, building on historical relationships with its medical director, Robert Milch, MD. Finn says palliative care is an appropriate way to expand access for a hospice that can see above the horizon.

"The good hospice already knows what's going on inside the hospital, has relationships with its community's hospital providers, and understands its own strengths and weaknesses," he says.

For hospices interested in exploring palliative care development, the first commandment is to "know thyself," Finn says. "Next, benchmark. Take a look at the best programs you can find and see which ones fit your program and mission." There are a range of options open to hospices in working with hospitals, and they need to be explored.

"The calling is there; it's really a matter of doing good due diligence," Finn notes. "Also,

bear in mind that very few programs are generating net revenues on these services. On the other hand, we're not talking about a huge commitment of money. Starting small is not a bad idea."

Hospices need to be persistent in developing the labor-intensive relationships that lead to collaborative palliative care services, Milch adds. "You demonstrate the validity of the service you're offering by providing a good product. Then people will come to your door. That's how hospice grew in the first place."

Integrated end-of-life care

Even if NHPCO succeeds in obtaining legislative support for hospice palliative care consultations, the ultimate success of these services depends on integrating them into a broader continuum of end-of-life care. If the hospice is able to admit patients directly onto the Medicare hospice benefit while they are still in the hospital; if it can respond to referrals and consultation requests within hours instead of days; if it can establish a visible presence in the hospital through a dedicated hospice inpatient unit, these advances will help to fix the hospice in the minds of other health care professionals as *the* solution to difficult end-of-life cases.

If the hospice can involve the hospital in a collaborative team approach, then both sides will be invested in the program's success. It's important to build the hospice medical director's profile in the medical community — by serving on physician committees, for instance — and to establish close working relationships with hospitalists practicing in the community's hospitals.

Hospice remains the gold standard and most intensive form of palliative care, but the experiments now going on with palliative care consultation services remind us that patients have many end-of-life care needs before they are eligible or able to consent to hospice care. The more the hospice can be involved in finding solutions to those other needs, the more assured will be the place for its full hospice benefit services within the integrated continuum of end-of-life care.

[Editor's note: Health care journalist Larry Beresford of Oakland, CA, was primary author of the CAPC monograph, Hospital-Hospice Partnerships in Palliative Care: Creating a Continuum of Services. Contact him at (510) 536-3048 or at larryberesford@hotmail.com.] ■

Full-time medical director offers fringe benefits

Salaried MDs upgrade care

While virtually every hospice has a medical director, a surprising number of hospices are employing full-time medical directors, suggesting that hospices are placing a greater emphasis on the role of their top physicians.

According to the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA, full-time medical directors do not drain the budget. Instead, an in-house physician brings value-added services to patients, attending physicians, and the community. In addition, hospices can charge Medicare Part A for the billable services provided by the hospice medical director.

"Physicians can contribute to cost-effectiveness through appropriate, evidence-based decisions about palliative drugs and treatments," wrote health care journalist **Larry Beresford** in an NHPCO monograph titled *Providing Direct, Billable Physician Services to Hospice Patients*. "Hospices can also generate physician billing income from hospice patient visits, as well as from palliative care consultations for non-hospice patients, which can be used to offset the cost of the physician's salary."

The purpose of the report, which was released in June, is to provide guidance on how to add a full-time medical director and use the position effectively.

The motivation to bring in a salaried medical director should not be the revenue from direct, billable physician services, but from the greater connection an in-house physician will bring to the larger physician community and the increased accessibility to medical expertise, says **Stephen Connor**, PhD, vice president for research, development, and finance at the NHPCO.

Employing a full-time medical director allows a hospice to expand the medical director's role and responsibilities beyond those of a volunteer physician. According to the monograph, the top five areas of hospice medical director responsibility are:

- acting as a medical resource for the interdisciplinary team;
- participating in admission and recertification decisions;
- participating in interdisciplinary team meetings;

- reviewing patient eligibility for hospice services;

- consulting with attending physicians regarding pain and symptom control.

In addition, a majority of hospices reported that hospice physicians provided home visits, and nearly half said they were available to teach medical students, residents, and fellows about palliative care.

In general, services delivered by physicians, whether employed or not, fall under the following categories:

- **Professional services.** This describes services provided directly to the patient by the physician.

- **Administrative services.** This refers to tasks related to the workings of the hospice, such as certifications of terminal illness, care plan development, team conferences, and supervising and management activities.

- **Technical services.** This refers to services that may involve the physician, such as lab and other non-professional services.

Employment status determines how the physician bills for services. For example, an employed hospice physician bills the facility, which, in turn, bills the payer. A physician who is not employed by a hospice, such as a patient's attending physician, bills the payer directly. In the case of Medicare, services of employed physicians are billed by the hospice to Medicare Part A, while non-employed physicians bill Medicare Part B.

The salaried doctor

Employed hospice physicians, including volunteer physicians, provide a number of billing opportunities for hospices, including evaluation and management services. Hospices are bound by very specific billing rules outlined in the American Medical Association *Current Procedural Terminology* (CPT) manual. In addition, an appropriate ICD-9 code must accompany the billing code found in the CPT.

General billing guidelines for the hospice-employed physician are as follows:

- The physician bills hospice for medical services.
- Hospice verifies dates and services prior to billing Medicare Part A.
- Hospice is paid 100% of the allowable fee schedule.
- Hospice pays physicians per contractual agreement.

- Hospice obtains a physician billing number from Medicare.

- The payment for physician services is not part of the per diem payment, but it does count against aggregate cap.

Office visits and consultations are some of the more common professional services performed by physicians. At first glance, the codes associated with those services seem straightforward. But office visits and consultations are some of the most highly scrutinized codes because of the potential for fraud and abuse. Hospices should compare the reported code to the patient chart to ensure the proper level is assigned to the office visit or consultation.

A consult can be requested by an attending physician who seeks an opinion for a specific problem. Consults can take place in either an inpatient or outpatient setting. In order to bill for a consult, a written or verbal request must be made by an attending physician. The request must be documented in the patient record. Upon completion of the consultation, the consulting physician must document his or her findings in the patient record and submit a written report to the physician who requested the consult.

The level of the service equates to the level of payment, which depends in large part on the depth of the examination and the complexity of medical decision-making. The CPT manual has highly detailed guidelines for how to determine which of the three levels should be billed. Once the level is determined and the appropriate CPT code and ICD-9 code are chosen, the hospice bills for the salaried physician's consultation services.

The non-employed physician

Billing for hospice-related services by a physician not employed by the hospice is generally set aside for the patient's attending physician. An attending physician providing care to a hospice patient should be billed under Medicare Part B using CPT and ICD-9 codes.

The most common hospice-related service provided by an attending physician is care plan oversight (CPO). The problem is that there are a number of codes that can be used to describe this service.

The correct CPO codes for Medicare are listed in HCPCS as follows (commercial payers may require CPT codes):

- 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.

Code 99361 (medical conference) seems an accurate and appropriate code to report a meeting with home health workers or hospice interdisciplinary team members, but Medicare considers 99361 to be inclusive evaluation and management services.

In the same vein, 99371-99373, telephone conferences for the purpose of coordinating care, seems 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, CPO codes encompass the services described in 99361 and 99371-99373. More important, they may be reimbursable. The organization provides its referring physicians with reimbursement advice to help them get paid for their home health and hospice-related services.

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; and documenting the services provided in the patient chart.

CPO 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 includes:

- travel time and time spent preparing and processing claims;
- 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 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 home health agency or hospice (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).

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 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.

Also, physician time spent calling in prescriptions to a pharmacy or retrieving a chart are not considered eligible and cannot be counted toward time spent performing CPO. **(For a list of Medicare rules on physician billing for CPO, see box, at right.)**

Attending physicians or hospice-employed physicians may encounter medical conditions unrelated to the terminal diagnosis. This is the one instance where the hospice physician may bill Part B rather than billing the hospice. The

Medicare guidelines on physician billing

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.
- CPO 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 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 CPO within the calendar month for which payment is claimed, and no other physician can be paid for CPO within that calendar month.
- The physician or non-physician 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 care plan oversight 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 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 (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. ■

attending physician also should bill Part B.

Some codes refer to services that have technical and professional components, such as laboratory and radiation treatment services. The technical component of medical services is considered part of the hospice per diem and must be billed directly to the hospice by the physician who performed the service. ■

Joint Commission seeks continual compliance

Unannounced surveys keep facilities on their toes

It's not unlike preparing for an exam in school. You know the exam is approaching, and you do a little studying ahead of time, but you usually wait until the last minute to really push yourself to focus on getting ready for the exam.

In the home health world, the exam for many agencies is the triennial accreditation survey. While you still need to make sure you comply with the standards of both the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations and the New York City-based Community Health Accreditation Program (CHAP), Joint Commission-accredited organizations will have to undergo some cultural changes in the way they prepare for a survey.

Not only is the Joint Commission asking you to identify your own deficiencies in a self-assessment process called Periodic Performance Review, but starting in 2006, you won't know when the surveyors are coming. Organizations that are scheduled for surveys in 2004 and 2005 can volunteer to participate in the unannounced survey program as the Joint Commission tests the process.

"Of all health care organizations, home care agencies have a tremendous amount of experience with unannounced surveys because all Medicare or state surveys have always been unannounced," says **Maryanne L. Popovich**, RN, MPH, executive director of the home care accreditation division. In fact, she says, the most

frequently asked question about unannounced surveys is, "What if I'm not here?"

For agency managers concerned about their absence when the surveyor arrives, Popovich points out that the new survey process implemented by the Joint Commission during the past year, Shared Visions — New Pathways, focuses much more on the actual care provided to patients rather than lists of policies and procedures.

"Because we are committed to better communication with our organizations, we will provide a short, concise list of documents that we will need, so an agency manager needs to make sure the responsibility for those documents is designated to a couple of people so at least one is available when the surveyor arrives," she says.

"One thing surveyors will want to evaluate is how performance improvement activities and leadership actions impact patient care," says Popovich. For this reason, you should make sure there is always someone who knows how to access patient records for the surveyor, she adds.

Another major change in the Joint Commission survey process is scheduled for implementation for home care organizations slated for survey in and after July 2005. "In October of 2003, these home care organizations will receive their Periodic Performance Review tool that is to be used as a self-assessment of their compliance with Joint Commission standards at the 18-month point between triennial surveys," says Popovich.

An organization has 90 days to complete the Periodic Performance Review and submit it to the Joint Commission. Organizations use the tool by accessing a secure, password-protected web site. The tool basically is the same one used by surveyors that lists standards, rationales for standards, and elements of performance. If the organization determines that it is not in compliance, there is a button that can be clicked to submit a brief plan of action to correct the deficiency.

Once the organization submits the Periodic Performance Review, Joint Commission staff members review the tool and then arrange a conference call to discuss the self-assessment within one month. Deficiencies that are identified during the Periodic Performance Review do not affect

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the organization's survey results as long as the deficiency is corrected by the time of the survey.

Home health agencies accredited by CHAP have always had to complete and submit a self-assessment prior to their survey, says **Terry A. Duncombe**, RN, MSHA, president and chief executive officer of the organization. "Our home health agencies use it as a tool to assess their readiness for the survey and to develop a work plan," she adds.

Although home care pilot tests of the Periodic Performance Review still are ongoing, hospital organizations with home health or hospice organizations were involved the first tests.

"The opportunity to assess the organization in a penalty-free environment is very appealing," says **Angie King**, RN, CPHQ, quality management director for Tift Regional Medical Center in Tifton, GA, and one of the participants in the first pilot test for the new accreditation process.

"You either meet the standards or you don't, and the self-assessment gives you an opportunity to develop the policies or implement a program that will bring you into compliance with the standards," she says.

The best news is that you are not penalized for any deficiencies you identify during the self-assessment phase, she points out. "Once you've identified your own deficiencies, you submit a plan to correct them." Then you have 18 months to implement those corrections, King says.

Although the tool is designed so only one person within the organization can submit information, it is set up so multiple people can access the tool to contribute information. This makes it easy for the coordinator of the review to assign different parts of the self-assessment to the appropriate departments.

Because the initial pilot test did not address all standards, King did not need all departments, such as Tift Regional's hospice, to provide information, but that will not be the case when the organization undergoes its actual self-assessment.

"I will coordinate the process, but I will have each department provide information on issues from their area," says King.

All departments will be able to use the web site to see what policies or measurement and monitoring information they must provide, she adds. Then, they can enter it directly on the tool for the coordinator to review and prepare for submission, she explains.

"Most home care organizations already have some sort of ongoing self-assessment program,

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but even if they don't, completing the Periodic Performance Review should not be a huge burden," says Popovich. "There is more time involved in the transmission of the document, the conference call, and preparation of action plans if needed, but the benefit of making sure that you are compliant well ahead of your survey will outweigh any extra work," she says.

"The greatest benefit is that you won't be performing your self-assessment in a vacuum," points out Popovich. "During the pilot tests, Joint Commission staff members discovered that some organizations judged themselves noncompliant in some standards when they really had just misunderstood the intent and did not have to correct anything. In fact, the organizations were much harder on themselves than our surveyors were." ■

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