ARTICLE ADDRESSES KEY ISSUES IN HOSPICES’ PHYSICIAN BILLING

The October *NHPCO Newsline* says that NHPCO has contracted with Acevedo Consulting, Inc. to develop resources that members may use to educate themselves on the coming changes in the Medicare billing system. The article in this issue, “Getting Paid for Hospice Physician Services,” is the first of those resources, and covers “some basic but crucial aspects of Part A billing.”

The article says that Part B billing is clear and straightforward, and cites the *Medicare Claims Processing Manual*, Chapter 11 (available at the link below) in support: “When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for professional services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an ‘independent attending physician,’ who is not an employee of the designated hospice nor receives compensation from the hospice for those services.”

Considering Part A, physicians render two types of services to hospice patients, administrative activities and patient care. Administrative activities are part of the per diem rate, and include developing plans of care, supervision of care and services, and the establishment of policies. According to the article, these activities are “generally performed” by the hospice medical director and/or a physician who is a member of the interdisciplinary team. NHPCO says that it “appears” that visits for recertification at day 180 subsequent 60 day intervals are in this category.

Patient care services are medical services necessary for the patient’s terminal illness, are given by a physician either employed or contracted by the hospice, and can be billed separately to Medicare. The article cites several important points regarding patient care services:

* The hospice bills Medicare, not a consulting physician, but the consulting physician and the hospice must have an arrangement in place before the hospice can bill for services.

* Services of physicians or nurse practitioners who provide direct patient care services and who are employed by or have arrangements with the hospice are billed to the Fiscal Intermediary.

* Payments to physicians and nurse practitioners are counted in the payments to determine if the cap is exceeded.

* No payments are made for patient services that physicians and nurse practitioners volunteer, although under certain circumstances they may be paid for certain services while they perform others on a volunteer basis.
* When physicians perform two services in different categories in the same visit (such as a treatment for managing symptoms and recertifying the patient for continued hospice care), the services should be documented in different areas of the chart.

Acevedo says that hospice should be clear about the Attending of Record and the Consulting Physician. “The Attending of Record (AOR) is specific to hospice and should never be confused with a facility attending.” The AOR must be an MD, DO, or advanced registered nurse practitioner (ARNP) who was chosen by the patient at hospice enrollment. A facility attending may be a hospitalist who cares for a patient during an inpatient stay, but is not the AOR. AORs need not be employed by or contracted with the hospice, but if they are, the hospice bills for their services.

Nurse practitioners cannot be paid for performing services that a registered nurse can perform, the article says. Nor can they be paid for services that are outside the role of an attending physician. The author reiterates this last statement “so that no one can walk away from this article with the wrong message: In order to bill for the services of a nurse practitioner, that specific nurse practitioner must have been elected by the patient to serve as his/her attending of record.” The services of a nurse practitioner are usually included in the per diem rate.

Acevedo suggests several tips and insights to help providers avoid “future mishaps,” particularly in light of the fact that the OIG will review physician billing:

* Make sure that the services of one physician do not duplicate that of another.
* “Thorough, concise documentation is your best ally…”
* CMS contractors have been instructed to use the following criteria to determine whether concurrent care is worthy: 1) “Does the patient’s condition ‘warrant the services of more than one physician on an attending (rather than consultative) basis?’” 2) “Are the services provided by each physician ‘reasonable and necessary?’”
* Substantiate and document the necessity for each visit.
* Document any follow-up directed by the physician.
* Most third-party insurers, including Medicare, are providing reimbursement for physician services. Interdisciplinary services are covered by the per diem.
* Physician billing should be covered by the hospice compliance program, and “someone should truly own the responsibility for these services.”
* Provide guide sheets to the physicians – the requirements “are not always easy to digest.”
* Do quality reviews and, if possible, conduct mock payer reviews and audits. (NHPCO Newsline, 10/2010; Medicare Claims Processing Manual, 146.123.140.205/manuals/downloads/clm104c11.pdf)

PUBLIC POLICY NOTES

* According to a NYT article, nursing home personnel say that DEA’s efforts to prevent prescription drug diversion is causing pain for their patients. Nursing homes usually do not have physicians on staff, and until recently, nurses could call a pharmacy for painkillers based on a phone order from a physician. Because the DEA is cracking down on phone orders in several states, the orders now have to be faxed from the physician, causing delays when the physician is not in the office. In some cases, patients must wait over a weekend for...
treatment. Some professionals think that the problem is that nursing homes do not provide adequate care for patients. A lawyer for CMS says, “If people are so sick that they desperately need pain medication, they should be seen by a doctor. The absence of doctors in nursing homes has been a problem for decades, and this doesn’t solve it at all.” (The New York Times, 10/2, www.nytimes.com/2010/10/03/us/03rules.html)

* A new DEA policy statement has been issued on the “nurse as agent” issue. The statement allows DEA registered prescribers who are authorized to prescribe under state law to directly communicate prescriptions for controlled substances (Schedules III-V) to pharmacists. An NHPCO NewsAlert says, “The DEA has now officially recognized that physicians … can delegate these tasks to nurses in other settings, such as long term care facilities, who are not employed by the authorized prescriber. In such circumstances the DEA recommends, but does not require, that prescribers enter into a written arrangement with the agent or agents to whom they delegate certain tasks, and the DEA notice includes a sample of such an agency agreement.” Prescription of Schedule II drugs has not changed – the prescriber must communicate directly with the pharmacist. (Federal Register, 10/6, www.gpo.gov/fdsys/pkg/FR-2010-10-06/pdf/2010-25136.pdf; NHPCO NewsAlert, 10/8)

**RESEARCH & RESOURCE NOTE**

* A recent article in the Mayo Clinic Proceedings explores the ethical and legal issues of withholding or withdrawing life-sustaining treatments and comfort measures. The article explores the differences between palliative sedation and physician-assisted suicide or euthanasia. The authors say that for “refractory and unacceptably severe suffering,” palliative sedation is appropriate. They add, “We hope that by increasing familiarity with the ethical basis for these practices we will encourage their appropriate application.” (Benzinga.com, 10/1; Mayo Clinic Proceedings, 2010, 85(10):949-954, dx.doi.org/10.4065/mcp.2010.0201)

* “The Intersection of Need and Opportunity: Assessing and Capitalizing on Opportunities to Expand Hospital-Based Palliative Care Services” includes five case studies on “how successful programs identify and address institutional needs to create opportunities for palliative care program growth.” The authors say that each project identified critical needs, developed their programs to meet those needs, took advantage of existing resources and expertise, collected “relevant data” to demonstrate their value, and benefited from expert mentoring. (Journal of Palliative Medicine, 2010, 13(10), dx.doi.org/10.1089/jpm.2010.0112)

**END-OF-LIFE NOTES**

* Hospital patients who want to go home to die can often safely do so if their family members offer support and they have hospice services. But some cases present ethical conflicts, such as when a patient competent to make decisions insists on going home, but there is no one to care for them or other potential for harm exists. Clinicians are concerned about unsafe discharges, which can leave the hospital open to legal action. However, one expert said that the hospital “is absolved of liability if it clearly and carefully documents that the patient chooses to leave ‘against medical advice.’” (Hospice Management Advisor, 10/1)
In Roanoke, all the students entering the Edward Via College of Osteopathic Medicine began their studies by discussing end-of-life care. The college’s leaders think “the way doctors address death” is so important that they’ve included it in the curriculum. Students are also required to do a rotation in geriatric medicine. Educational offerings in palliative care from other facilities in the area target nurses and physicians, and Carilon Roanoke Memorial Hospital has been approved for a palliative care fellowship program. *(The Roanoke Times, 10/3)*

Presenters at the recent Art of Dying Conference, sponsored by the New York Open Center and Tibet House, frequently made the point that “we are missing out on an precious opportunity for spiritual growth, when we avoid confronting and contemplating what we call death.” The article says, “Fearfully avoiding the reality of death increases suffering at the approach of this inevitable life passage. And, paradoxically, so does the belief that we are nothing but a body.” *(The Huffington Post, 10/6, www.huffingtonpost.com/alison-rose-levy/what-would-you-do-if-you-_b_752201.html)*

Rabbi Barry M. Kinzbrunner, MD, of Vitas Innovative Hospice Care, recently spoke at the annual Clinical Team Conference and Pediatric Intensive. Kinzbrunner said that the challenge that physicians face in trying to “mesh” spiritual concerns with objective science may result in a “significant disconnect” with patients. He cited a recent study that differentiated spirituality from religion which suggested that “religious patients often were described as experiencing distress related to what they perceived as punishment from God.” Kinzbrunner says that the message from the study is that “physicians have to be spiritual, as well, to make this work; if there is no spirituality by the [physician], then it’s very hard for the patient to express [spiritual/religious concerns].” *(Medical Ethics Advisor, 10/1)*

**HOSPICE & PALLIATIVE CARE NOTES**

The Pediatric Palliative Care Program at St. Cloud Hospital helps parents deal with the “emotional roller coaster” of taking care of a child not expected to live to adulthood. Sue and Jeff Blomstrom’s first child had chromosomal abnormalities, and were “just kind of inundated with doctors and health care professionals and all of this stuff, and we were just kind of completely lost,” Sue said. The hospice nurse who cared for their daughter gave them the idea of starting an annual fund raiser for the palliative care program in their daughter’s memory. *(St. Cloud Times, 10/5, www.sctimes.com/apps/pbcs.dll/article?AID=2010110050041)*

An interviewer with *Voice of San Diego* recently talked with Dr. Charles Van Gunten, provost of The Institute for Palliative Medicine at San Diego Hospice. In his discussion of the hospice movement and its challenges, and what he has learned from his dying patients, Van Gunten said, “We find overwhelmingly that when there is pain that is difficult to control, it's not because we don’t have the right drugs. It's because it may be in the emotional or spiritual dimension.” He added, “It is routine to find meaning in these weeks and months [of hospice care], for patients to say, “This is the most meaningful time of my entire life, I wouldn't miss it for the entire world,’ and regret the sense of fear and trepidation they had.” *(Voice of San Diego, 10/8, www.voiceofsandiego.org/people/article_b89deeb6-d32c-11df-97a2-001cc4c03286.html)*

The palliative care team at Oklahoma City’s Integris Baptist Medical Center works closely with the hospitals case managers because of the similarity between case management and
Palliative care. Palliative care coordinator Anita Bell says, “Hospital case managers are constantly challenged to decrease the utilization of hospital resources and length of stay while maintaining quality care. Studies have shown that palliative care can decrease the cost of hospitalization and improve a patient's quality of life by advocating for care in the most appropriate setting.” She adds that case managers are often the first to identify when a patient might benefit from palliative care. (Hospital Case Management, 10/1)

* Eighty-five-year-old Gloria Lucas planned her last days in complete detail, down to writing her own obituary with only the date of death left blank. Lucas, who had ovarian cancer, was treated by Dr. Natalie Gould, an oncologist at the Carilon Clinic. When Lucas’ cancer returned, Gould mapped out the options on paper, including hospice. Lucas said, “I always thought, when people was on hospice, they was about gone. But she told me, ‘Don’t you think like that.’ I made the decision that day.” Gould said that a mentor trained her to “have the conversation early and often,” and at each “new turn” in the treatment of a disease, she gives the option of hospice. (The Roanoke Times, 10/3, www.roanoke.com/262554)

**PAIN NOTE**

* In Phoenix, the Beatitudes Campus Health Care Center created a Campaign Against Pain to help residents with chronic pain, and short-stay patients who have acute pain. The program of education, consultation, work groups and administrative commitment resulted in a “drastic reduction in pain in the facility over five quarters.” The abstract says that “the facility met and exceeded the goals of the project and the Advancing Excellence in America’s Nursing Home Campaign.” (Journal of Hospice & Palliative Nursing, 2010,12(3):148-155, dx.doi.org/10.1097/NJH.0b013e3181d94f1b)

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