CPT Coding for Hospice in Long-Term Care

Ronald J. Crossno, MD, CMD, FAAFP

The ability to correctly code and document for purposes of physician reimbursement has become an increasingly essential part of long-term care (LTC) practice. As was pointed out by Stone and Tarnove in a recent article,1 “the complexity and nuances of these codes have cost physicians huge sums of money and actually have driven many excellent, caring physicians to stop providing services to our nation’s frail older residents.” As a result, that same article proceeded to explain the sometimes-circuitous pathway through this coding maze. The actual billing codes that are most often used are outlined in that article and are not duplicated here.

However, that article made only brief mention of the even more complicated billing rules for services provided for the LTC patient who is on hospice. This article is an attempt to shed light on this nebulous area of hospice-related reimbursement. First, an overview of hospice insurance benefits is presented followed by specific situations depending on the patient’s and/or provider’s status. Finally, some additional suggestions and hints are provided.

INSURANCE CONSIDERATIONS FOR HOSPICE PATIENTS

To understand physician reimbursement, one must first have some general knowledge of how hospice insurance benefits are administered. Because most terminally ill patients are 65 years of age or more, the vast majority of hospice coverage in the United States is reimbursed through Medicare. State Medicaid programs provide for only a small percentage of the total number of hospice patients, followed by charity care. Private insurance covers the relatively few hospice patients who are dependents or who have not yet lost their private insurance because of their inability to work with their medical condition. Therefore, the Hospice Medicare Benefit is presented in more detail, followed by explanations of the others.

Hospice Medicare Benefit

The Hospice Medicare Benefit2 came into being in 1983 and became a permanent part of Medicare in 1985. Despite this length of time in existence, there remains considerable lack of knowledge regarding this program by both healthcare professionals and the general public. The most recent revision of this legislation was on October 1, 2000.

Compared with standard Medicare, there are some important differences and peculiarities about the Hospice Medicare Benefit. To access this benefit, an eligible individual must elect or choose to change to the Hospice Medicare Benefit. The eligibility requirements, as spelled out by regulation,3 are actually very simple. These state that an individual must be (1) eligible for Part A of Medicare, and (2) certified as being terminally ill. There are no other qualifying criteria.

Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. Two physicians, one of whom is employed by the hospice, provide the initial written certification of the terminal illness. Thomas Scully, Administrator of the Department of Health and Human Services, has helped to clarify this further in a widely disseminated letter4 in which he states:

Medicare regulations use the terms “expectancy” and “if the terminal illness runs its normal course” in its definition to indicate that it is entirely possible for hospice services to be needed for more than a 6-month period. The Medicare program recognizes that terminal illnesses do not have entirely predictable courses. In further recognition of the difficulty in making exact predictions, physicians certifying Medicare patients for hospice are expected only to use their best “clinical judgment regarding the normal course of the individual’s illness.”

Once these eligibility criteria are met, the individual can then choose to elect hospice care. Doing so changes the individual’s Medicare coverage such that the terminal illness and any related conditions are now covered by the Hospice Medicare Benefit and not by Medicare Part A. The hospice is paid a per diem rate to provide care that is related to the terminal illness. This coverage is more comprehensive than the standard Medicare benefit, covering 100% of costs for these services.
- Medical and nursing care;
- Medical equipment;
- Medications and pharmaceuticals;
- Home health aide and homemaker services;
- Social work services;
- Physical, occupational, and speech therapy;
- Dietary counseling;
- Bereavement and other counseling services; and
- Case management.  

Please note that these services are covered only when they are related to the terminal illness and are deemed appropriate for a palliative plan of care. The regulations leave this determination of what is “deemed appropriate for a palliative plan of care” up to the philosophy of individual hospices, with a myriad of interpretations compounding the confusion regarding what could be covered. Some hospice organizations could choose to include such items as palliative radiation or chemotherapy. Many hospices would prefer to delay hospice admission until after such treatments have been completed.

The determination of whether a service is related or unrelated to the hospice diagnosis is ultimately made by the Medicare fiscal intermediary. However, for practical purposes, such determinations are commonly made by the hospice, because this is the entity at financial risk. Treatments for conditions unrelated to the terminal illness are still covered by the standard Medicare benefits. The per diem rate is tiered, with routine home care receiving one rate (which also applies for patients whose “home” is a LTC facility), and correspondingly higher rates for respite care, general inpatient care, or continuous home care.

A peculiarity of this system involves how one can discontinue hospice care. An individual (or the individual’s legal representative) can revoke the Hospice Medicare Benefit at any time with complete and immediate resumption of prior Medicare coverage. The Interdisciplinary Group (IDG), comprised of the hospice physician, case-managing nurse, social worker, and counselor (most commonly a chaplain), can determine that discharge is recommended for such circumstances as the individual moving out of the service area or into a facility with which the hospice does not have (and is unable to obtain) a contract, or the individual is no longer hospice-eligible because the condition is no longer terminal. Please note, “the attending physician does not have the right to ‘discharge’ a patient from hospice.” Unlike certification for traditional LTC or for home health services, there is no requirement for a skilled need to be eligible for and to receive hospice services.

The Hospice Medicare Benefit is the first nationwide managed care program within the United States. The individual hospice is the entity responsible for “case management” and thereby are “at risk” if aggregate costs exceed the received reimbursements. The assumption of this risk is a major factor in what has led to the differing interpretations by various hospice entities as what might be included in a “palliative plan of care.”

Medicaid Hospice Benefits

Because Medicaid programs are state-administered and unique to each state, covering each state’s program is beyond the scope of this article. However, the majority of states model their programs on the federal Medicare prototype. Most of the coverage and rules for Medicare would generally apply to the state Medicaid programs. The individual hospices functioning within each state are very familiar with that state’s rules and regulations and should be a resource for further information.

Other Hospice Coverage

Many hospices provide care for otherwise unfunded individuals. The rules and coverage provided are determined by the individual hospice and can vary considerably. Likewise, most private insurers provide a hospice benefit, but these vary so widely that each policy must be individually examined to determine what is covered.

One more comment about insurance and hospice: because the Medicare Hospice Benefit covers 100% of services related to the terminal illness, there is no need for a separate Medicare supplement policy for hospice care. Of course, such a supplement could be desired for medical conditions not related to the terminal illness.

FACILITY-SPECIFIC BILLING CONCERNS

When a Medicare hospice beneficiary is cared for in a facility, for care related to the hospice diagnosis, the hospice must have a contract with that facility. Such contracts can be ongoing agreements or one-time contracts for an individual patient. The contract spells out the rate, if applicable, for reimbursement for that patient’s stay in the facility. For example, when Medicare hospice beneficiaries are hospitalized for conditions related to the terminal illness, then the hospice, not Medicare, is the payor for the hospital. This typically is paid on a per diem rate to the hospital and is not set by Diagnosis Related Groups (DRGs). The hospice’s IDG determines continued need for inpatient care, just as a third party managed care insurer might.

By regulation, a Medicare hospice beneficiary can not stay in a Medicare skilled nursing facility (SNF) bed for Medicare Part A reimbursement if the reason for the SNF stay is related to the terminal illness for which the patient is on hospice. If the condition is unrelated to the terminal illness, then hospice and skilled care can be concurrent, with both being reimbursed. For patients in non-Medicare-reimbursed nursing facility beds, the payor is not Medicare so that Hospice Medicare Benefits can continue. In some states, when Medicaid is the payor source for the LTC facility stay, then Medicaid pays the hospice, which must in turn reimburse the nursing facility. This can lead to delays in payment, with such delays acting as a disincentive for hospice referral in some facilities.

ANCILLARY SERVICES BILLING CONCERNS

Care Unrelated to the Hospice Diagnosis

For diagnostic imaging, laboratory or any other ancillary services (eg, physical therapy, occupational therapy, speech therapy, and so on) that are provided to or on the behalf of a
hospice Medicare beneficiary, any charges that are unrelated to the hospice diagnosis should be billed to and will be reimbursed through the patient’s regular Medicare benefit. Care must be taken not to bill using the diagnosis code for which the patient is on hospice, because this would indicate to the intermediary that the services rendered are related.

**Care Related to the Hospice Diagnosis**

For chemotherapeutic treatments, radiation therapy, diagnostic imaging, laboratory or any other ancillary services (eg, physical therapy, occupational therapy, speech therapy, and so on) that are provided to or on the behalf of a hospice Medicare beneficiary, those charges that are related to the hospice diagnosis must be billed through the hospice, and the service provider must have a contract with that hospice to be paid. Such contracts can be either ongoing agreements or a one-time contract for an individual patient. The hospice core team makes the determination as to whether such services are in accord with the patient's palliative plan of care and whether they are therefore reimbursable. This means that such services can be best managed through a preauthorization procedure, like with many other managed care plans. The hospice has no contractual obligation to pay for such services that are not authorized, but in reality many hospices negotiate retroactive payment on a case-by-case basis. If the hospice determines that such services are not a part of the patient's palliative care plan, even though they are in some way related to the hospice diagnosis, then the service provider can bill the patient directly. Such bills could, for obvious reasons, cause consternation and frustration and are often not collected. Bills sent to the Medicare intermediary in such situations will be justifiably denied.

**PHYSICIAN-SPECIFIC BILLING CONCERNS**

By regulation, there are certain intricacies that are dependent on how the physician is associated with the patient and the hospice that determine to which entity the physician actually submits a claim. When the hospice submits its claim to Medicare, it must list a physician as the hospice attending. When physician orders are received that establish the plan of care for the hospice patient, the hospice attending physician is identified. Although this could or could not be the physician who provides the bulk of the care for the patient, it is generally easiest from a billing standpoint if it is. The hospice attending need not be a primary care physician. The hospice can, on a physician's order, change the hospice attending of record.

The Medicare fiscal intermediaries have become increasingly sophisticated in determining whether the diagnosis code used for the hospice’s billing purposes is the same or different from that used by other providers. The intermediaries almost entirely rely on electronic means of checking, because the hospice's intermediary could be different from that used by the other providers, including physicians. Therefore, when the diagnosis code for the hospice’s billing exactly matches that used for others’ billings, such care is automatically assumed to be related. If the codes do not match (even for similar diagnoses, eg, “cardiomyopathy” and “heart failure”) or if it is not listed first in a series of diagnoses, then they can be electronically determined to be unrelated even though on secondary review they actually are related. It is helpful for the physician’s billing office to know the exact code that the hospice is using for billing and to list this first when billing for related services. If the diagnosis code is incorrect, ask the hospice to make a correction.

For his or her professional billing purposes, it is vital that the physician knows who is listed as the hospice attending whenever the patient is seen. Determinations of how to bill are also made based on whether the attending physician is contracted with the hospice supervising the patient’s care. The remainder of this article examines each combination and variation of these instances.

**Administrative and Supervisory Activities**

Just like a LTC facility medical director is directly and separately reimbursed for those duties having to do with administrative and supervisory activities, physicians serving as hospice medical directors are similarly reimbursed by the hospice. The costs associated with such administrative duties are included in the per diem paid to the hospice. The hospice medical director is then reimbursed for such duties as determined by his or her contract. However, direct patient care reimbursements are not included in the per diem that the hospice receives from Medicare. Such costs can be passed through (see subsequently).

**Care Unrelated to the Hospice Diagnosis—All Physicians**

When a hospice Medicare beneficiary receives services from any provider for a condition not related to the terminal illness for which the patient is on hospice, then the physician/provider should bill Medicare Part B like for any other Medicare patient. Some intermediaries could require a clarification on the billing statement verifying that the services were provided to a hospice patient for a condition unrelated to the hospice diagnosis. Each fiscal intermediary has different procedures for this, and billing offices are encouraged to ask their own intermediary for specifics.

**Care Related to the Hospice Diagnosis—Physician Not Associated With the Hospice**

When the attending (per the hospice’s billing records) physician is not contracted with or otherwise financially associated with the hospice, then that physician should directly bill Medicare Part B. This is done just like for a nonhospice patient with one important addition. If filing the claim on paper, the claim must indicate that the patient is on hospice and the physician is the patient’s attending but is not employed by or associated with the hospice. If filing electronically, a CPT modifier is appended to the code to indicate this. This can trigger the fiscal intermediary to call the physician’s billing office for further information. The intermediary should be told that this is a hospice patient and that the physician is the patient’s attending but is not employed by or associated with the hospice. The specifics of how this should be done will vary by fiscal intermediary.
Nonattending Physician—Associated With Attending

When patient services are provided by a nonhospice physician who is an associate of the attending physician of hospice record, this physician should bill under the attending physician’s name as outlined in the previous section.

Nonattending Physician—Covering for But Not Associated With Attending

What patient services are provided by a physician with a loose coverage relationship with the attending, but who is not financially associated with either the attending physician or the hospice, then the bill should be submitted to the attending who should in turn bill Medicare as outlined previously under “Attending Physician—Not Associated With the Hospice.”

Nonattending Physician Providing Consultation, Second Opinion, or Procedures

When the physician providing services is not associated with the attending and is providing consultation services, second opinion services, or performing diagnostic or therapeutic procedures, that physician should bill the hospice. This includes the physician component of imaging studies. Prior authorization could be required by the hospice. If the services are not consistent with the palliative plan of care established by the hospice IDG, payment could be denied. The physician should have a contract with the hospice to receive this payment.

Care Related to the Hospice Diagnosis—Physician Is Employed by/Associated With the Hospice

For services provided by a hospice physician, the hospice could bill the Medicare intermediary for reimbursement. Some hospices choose not to do this because of the expense involved with such billing. Most hospices do bill the Medicare intermediary for reimbursement. However, the hospice does have an obligation to reimburse the physician for these services as detailed in whatever contract or agreement the two entities have together.

Care Provided by the Hospice Physician

When a physician who is associated with or employed by the hospice provides services that are related to the hospice diagnosis, that physician should bill the hospice in accord with his or her contract. Whether the physician is the patient’s attending or not makes any difference. The hospice can pass these charges through to Medicare and be reimbursed in addition to the standard per diem rate as described in the preceding paragraph.

Care Provided by the Hospice Physician’s Associate

When the hospice physician’s associate provides services that are related to the hospice diagnosis, that physician should bill hospice.

Care Provided by the Physician Covering for But Not Associated With the Hospice Physician

When services that are related to the hospice diagnosis are provided by a physician covering for but not associated with the hospice physician, that physician should bill the hospice physician who should in turn bill hospice.

Care Provided by the Physician Who Is Not the Attending But Provides Care (ie, a Consultant)

By regulation, physicians providing services, but who are not the hospice attending physician of record, can only receive payment for services rendered that are related to the hospice diagnosis by billing the hospice. Because they can only bill the hospice if they have a contract or agreement with the hospice, the only recourse to receive payment in such a situation is to obtain a contract or agreement with the hospice. Such agreements can be ongoing contracts or a one-time agreement for an individual patient. With such an agreement, this category is merely a variation of item “Care Provided by the Hospice Physician.”

Physicians in this category can include specialty physicians who directly provide direct services to the patient (eg, cardiologists, pulmonologists, intensivists, hospitalists, oncologists, and so on), but this also includes other physicians who provide indirect services (eg, radiologists or pathologists). To reiterate, without a contract or agreement with the hospice, services related to the hospice diagnosis could not legally be reimbursed by the hospice, and the Medicare fiscal intermediary will deny such claims if received directly. Therefore, it is strongly recommended that physicians providing such services consider contracting with local hospices to ensure reimbursement for related services.

Even with such a contract or agreement, such services should concur with the hospice’s palliative plan of care for the hospice to determine whether to make payment. Therefore, it is important that ongoing communication, including possibly obtaining preauthorization for procedures, is necessary. For example, placement of a feeding gastrostomy could not significantly alter prognosis sufficiently to render an end-stage dementia patient ineligible for hospice (ie, prognosis likely greater than 6 months). However, some hospices might decide that such a procedure is inconsistent with their philosophy of care and would therefore not be reimbursable through their agency. In such an instance, the patient then becomes the one responsible for any bills related to the procedure, and the patient’s guardian might choose to revoke the patient’s hospice benefit to avoid such a financial risk.

Care by such physicians for diagnoses unrelated to the hospice diagnosis should be directly billed to the Medicare fiscal intermediary as described in the section entitled “All Physicians.”

Midlevel Providers

There are no provisions in the Hospice Medicare statutes or regulations that allow reimbursement for nurse practitioner or physician assistant services that are related to the terminal condition. Therefore, when a physician or physician group employs midlevels, there are no means to be reimbursed for
TABLE 1. Physician Billing Decision Grid

<table>
<thead>
<tr>
<th>Care By</th>
<th>Care Related to Hospice Diagnosis</th>
<th>Care Unrelated to Hospice Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending physician (not associated with hospice)</td>
<td>Bill Medicare</td>
<td>Bill Medicare</td>
</tr>
<tr>
<td>Attending physician’s associate (not associated with hospice)</td>
<td>Bill Medicare under attending physician’s name</td>
<td>Bill Medicare</td>
</tr>
<tr>
<td>Attending physician’s on-call coverage (not associated together) (not associated with hospice)</td>
<td>Bill attending, who in turn bills Medicare</td>
<td>Bill Medicare</td>
</tr>
<tr>
<td>Nonattending physician providing consultation, second opinion, diagnostic or therapeutic procedures</td>
<td>Bill hospice after receiving preauthorization</td>
<td>Bill Medicare</td>
</tr>
<tr>
<td>Physician employed by or associated with hospice (whether attending or not)</td>
<td>Bill hospice</td>
<td>Bill Medicare</td>
</tr>
</tbody>
</table>

their services related to the hospice diagnosis. Although such midlevel providers could be employed by a LTC facility or by the hospice, there is still no mechanism for additional reimbursement to these entities outside of their employer’s usual income stream.

For conditions unrelated to the terminal condition, all standard rules for reimbursement still apply, like for any Medicare beneficiary.

**Care Plan Oversight**

For physicians not employed by or associated with the hospice, Care Plan Oversight services can be billed (code G0182) directly to the Medicare beneficiary for patients receiving services at home and for whom the physician has had a face-to-face encounter in the preceding 6 months and provides 30 minutes or more of qualifying supervisory activities within a calendar month. This code can be billed monthly for each calendar month that 30 minutes or more of qualifying supervisory activities occur. Note that unlike care plan oversight for home health services, there is no separate billing code for the time spent doing certification. Therefore, time spent completing certification forms, hospice eligibility determination, and the like can be counted toward the 30-minute minimal time requirement. This applies only for home hospice patients and is not applicable to patients in a LTC facility. Further information on Care Plan Oversight services is available elsewhere and is outside the scope of this article.7

**SUGGESTIONS FOR BILLING**

It always behooves the physician treating a patient receiving hospice services to be aware of several important facts. First is just recognizing that the patient is actually a Medicare beneficiary on hospice. Next is what the hospice diagnosis is, including the actual diagnosis code. Finally, the name of the physician who is designated as the assigned hospice physician must be known. With this information, Table 1 provides an easy way to determine how to bill.

When questions arise regarding any of this, the involved hospice should be able to help provide answers. Also, each hospice must have a medical director who supervises the palliative plan of care for each patient. This medical director would be expected to be knowledgeable regarding such questions, although medical directors do vary from very expert full-time practitioners to part-time physicians who might not be as well informed.

**SUMMARY**

Any reimbursement issues involving federal payor sources are always complex. Then add the additional regulations involving hospice, and the process becomes even murkier. Unfortunately, these difficulties act as barriers that prevent individuals at the ends of their lives from receiving the end-of-life care to which all Medicare beneficiaries are entitled. To once more quote Thomas Scully, Administrator of CMS,

> The Center for Medicare & Medicaid Services believes hospice care is an essential Medicare benefit that can bring physical and emotional care to the terminally ill individual and his or her family when life nears its end. However, we are concerned that some individuals who may want hospice care, and could benefit from it, may not be learning about it or may be learning about it late in the course of their illness. Therefore, we are requesting that members of the physician community, as well as other health care professionals think more about hospice as they care for terminally ill patients.4

By reviewing these issues, this article hopes to have provided physicians seeing hospice patients with a resource to overcome at least this one barrier to hospice referral.

**REFERENCES**

2. 42 CFR 418 (December 16, 1983).