NHPCO has contracted with physician-billing expert, Acevedo Consulting Inc., to develop a range of resources to help members navigate the recent and forthcoming changes in physician billing under the federal Medicare system. These resources will include several articles for NewsLine, including this first article that covers some basic but crucial aspects of Part A billing.

**Getting Paid for Hospice Physician Services:**
Covered Activities and Roles

By Christopher P. Acevedo, CHC, CPC

It is apparent from the multitude of questions that come through the various listserves that much trepidation and confusion still surrounds billing for physician services. This article covers some of the ‘nuts and bolts’ of billing Medicare for these services, along with steps your organization should take to help mitigate mishaps.

**Part B is Pretty Clear—But Part A is Another Matter**

In Chapter 11 of the Medicare Claims Processing Manual, CMS is quite clear about Part B billing for physician services: “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.” It is Medicare Part A billing that seems to garner confusion.

Before getting into a discussion of Part A billing, it is important to understand the two types of services that are rendered by physicians to hospice patients:

1. **Administrative Activities**
   These activities are covered by the Medicare Part A per diem rate. They consist of “participating in the establishment, review and updating of plans of care, supervising care and services, and establishing governing policies.” They are also “generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group.” In its current form, it appears as if a visit performed solely to comply with Medicare’s upcoming “face-to-face encounter” at 180 days and at every subsequent 60-day recertification would fall under this category.

2. **Patient Care Services**
   The hospice can bill Medicare for these services separately. They consist of medical services that relate to the treatment and management of the patient’s terminal illness and are rendered by a physician who is either employed by or has contracted with the hospice to provide the services.
You may be thinking, ‘Fine, but what about services provided by consulting physicians?’ When a consulting physician sees a hospice patient about his/her terminal diagnosis or illness, the hospice must bill Medicare, not the physician. However, as we discuss in more detail on page 4, the consulting physician must have an arrangement with the hospice “in place” before the hospice can bill for the services.

CMS states that payment for services rendered by physicians or nurse practitioners who (1) provide direct patient care services and (2) are hospice employees or under arrangement with the hospice, is made in the following manner:

- Hospices establish a charge and bill the Fiscal Intermediary (FI) for these services.
- The FI pays the hospice at the lesser of the actual charge or 100 percent of the Medicare physician fee schedule for physician services, or 85 percent of the fee schedule amount for nurse practitioner services. This payment is in addition to the daily hospice rates.
- Payment for physician and nurse practitioner services is counted with the payments made at the daily payment rates to determine whether the overall hospice cap amount has been exceeded.
- No payment is made for physician or nurse practitioner services furnished voluntarily. However, some physicians and nurse practitioners may seek payment for certain services while furnishing other services on a volunteer basis. Payment may be made for services not furnished voluntarily if the hospice is obligated to pay the physician or nurse practitioner for the services. A physician or nurse practitioner must treat Medicare patients on the same basis as other patients in the hospice; a physician or nurse practitioner may not designate all services rendered to non-Medicare patients as volunteer and at the same time bill the hospice for services rendered to Medicare patients.

And perhaps most importantly:

- No payment is made for nurse practitioner services that can be performed by a registered nurse, nor is payment made for nurse practitioner services that are performed outside of the attending physician role. Nurse practitioner services are generally encompassed in the per diem payment rate. The only payment that can be made for services of a nurse practitioner is made for services furnished in the role of an attending physician.

I will reiterate the last sentence 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.

Although there is no prohibition on providing both an administrative visit and a patient care visit during the same encounter, from a compliance perspective I would compartmentalize the functions and document accordingly. For example, if a physician was rendering a symptom management visit for progressive weakness or loss of function and was also rendering a visit to recertify the patient for hospice eligibility, I would encourage you to include the clinical documentation for the symptom visit in one area of the chart and the administrative documentation in either a separate portion of the clinical note or, preferably, as an altogether separate “tab” of the chart to avoid unwarranted scrutiny from a reviewer.
Physician Roles
It is also important to understand the roles of the various physicians who see hospice patients—as well as whose services your organization can (and should) be billing for (versus those that should be billed by the community physician).

There are actually only two roles that hospice providers should be clear about—that of the Attending of Record and the Consulting Physician. Currently, there is no requirement that the physician filling these roles be board certified in hospice and palliative medicine. It is important to note, however, that these roles may be filled by numerous physicians and this is where the process can get muddy.

Attending of Record
The Attending of Record (AOR) is specific to hospice and should never be confused with a facility attending. For example, a hospice patient may have Dr. Jones, a community doctor independent of the hospice, listed as his/her AOR and, upon admission to a community hospital, have a hospitalist managing the in-patient stay. The hospitalist does not become the patient’s AOR; the hospitalist is merely the facility attending. Remember, the AOR must be a doctor of medicine or osteopathy or an advanced registered nurse practitioner (ARNP), and should be identified by the patient at the time of the hospice benefit election as “having the most significant role in the determination and delivery of [his/her] medical care.”

AORs need not be employed or under contract with the hospice, but when they are, the hospice should be billing for their services. We must also remember that since the AOR is elected by the patient, it would be improper to arbitrarily change the AOR to an employed/contracted physician upon admission to your inpatient unit. Instead, your physicians (but, again, NOT your nurse practitioners) can simply provide coverage for the independent AOR since the patient care services performed by your physicians are billable and expressly permitted under the Hospice CoPs: “If the attending physician is unable to fulfill his or her duties, then the hospice physicians are responsible for fulfilling the attending physician’s duties in his or her absence.”

Consulting Physician
When it comes to consulting physicians (CP), they must have an arrangement with your organization “in place” prior to rendering services in order for you to bill for those services. It is also imperative that you ask your compliance officer a few questions:

- Do we receive any documentation to back up charges from consulting physicians?
- Do these physicians understand physician coding and documentation any better than our own physicians?
- Is another physician in the consulting physician’s practice actually the one seeing our patients?
- Are the patients being seen by a non-physician practitioner? (I hope not!)
- Are they being paid according to the contract?

Of Note
Oftentimes, primary care physicians will assume they are a patient’s attending of record, when the patient may have designated an oncologist instead.

When this occurs, and the primary care physician sees the patient concerning the terminal illness, he/she must have an arrangement with the hospice in place as a “consulting physician,” and the hospice must be the one to bill for the primary care physician’s services.
Let me give you an example of why asking these questions can be so important:

On a recent trip to a hospice (that will remain nameless), Jean in our office was reviewing the documentation of a physician who had been contracted to provide attending services for patients residing in three nursing facilities. As the review started—and aside from the almost ever-present legibility issues (even your ‘docs’ should be chuckling)—she noted what could be clearly deciphered as “ARNP” after the signature. Well, if you have been truly reading this article (and not just skimming it), you will recall that only the services of a nurse practitioner who has been elected as the AOR are billable. When this was brought to the attention of the hospice CFO, he was understandably distraught, given his contract was clearly with the physician and not with the ARNP. After discussion with the contracted physician, it was clear that the physician had no idea this restriction existed. Luckily the contract was in its infancy and the physician was amenable to the requirement that only he could see the hospice patients in the nursing facility.

Avoiding Future Mishaps
In light of the OIG Work Plan for 2010 (and the OIG’s plans to review billing for physician services), it is crucial that your physicians understand and clearly define their role in delivering care to your patients.

As your organization continues to expand the number of physician services it offers, ensuring that your physician care services are not viewed by payers as duplicative care will be imperative to your program’s success. The Medicare Policy Manual\(^2\) clearly warns Medicare contractors to “assure that the services of one physician do not duplicate those provided by another.” Thorough, concise documentation is your best ally in substantiating the services you are rendering as medically necessary and non-duplicative in nature. It also helps to coordinate the care with your physician colleagues, so that they have a clear understanding of your role.

Medicare specifically addresses concurrent care, stating that: “Reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient’s treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services.” Note that this requires each physician rendering concurrent care to play an active role in the patient’s treatment.

CMS has instructed its contractors to apply the following criteria in determining the worthiness of concurrent care:

- Does the patient’s condition “warrant the services of more than one physician on an attending (rather than consultative) basis”?
- Are the services provided by each physician “reasonable and necessary”?

It is imperative that your documentation support your services as a necessary, concurrent, but not duplicative component of the patient’s care.

Once you have established the general necessity for your services, the focus turns to substantiating the necessity for “today’s” visit. This is another area that takes coordination and
communication between the physicians, since contractors have been instructed to “assure that the services of one physician do not duplicate those provided by another.”

In a hospital setting or inpatient unit, it is fairly easy to substantiate your physician’s role; for patients seen in a nursing facility or at home, however, you must be sure to paint a clear picture of the services you are providing. Remember, these patients are more than likely still receiving care from the community AOR.

It is also important that the physician-directed follow-up be documented. Most of your physicians came from the private practice world, so what did their assessment and plan end with? Probably “follow up or return to clinic in X number of days”! For some reason, this doesn’t seem to happen with consistency in the hospice and palliative care world. To make matters worse, at times planned follow-up will be documented for 60 days, but a visit will be provided to the patient in 14 days with no documented explanation as to why this visit is required. I am by no means saying that these visits are not necessary; however, the documentation must support the accelerated visit—just as it would if the patient came to the physician’s private practice.

We must also remember that the majority of third-party insurers (e.g., Medicare, United Healthcare) are only providing reimbursement for a “physician” service delivered to the patient, since the hospice per diem provides the payment for interdisciplinary care.

As with any service line, you must be sure to incorporate physician billing into your compliance program to help ensure you avoid under/overpayments—and someone should truly own the responsibility for these services. You need to be able to turn to an individual and ask the following questions:

- Are we assessing physician documentation?
- Are we assessing contract physician documentation?
- Since we are billing for these services, are they being documented appropriately?
- Are we up to date on annual code changes and changes to coding rules?
- Are we in compliance today?

You should identify any internal experts you may have as well as try and identify physician champions of compliance as they will be your best allies when addressing concerns with the physician team. Education is the key! Not just for the providers though; you should include the appropriate billing staff and leadership as they need to know what the risks are. As always, thorough and concise documentation is paramount, and, if possible, you should provide your physicians with cheat sheets as the documentation requirements are not always easy to digest (even for your best clinical team members)! It is important to incorporate quality reviews and, possibly, mock payer reviews/audits.

Without doubt, the current environment makes billing for physician services more challenging than ever before. On the one hand, we are facing shrinking reimbursement and increased regulatory requirements, while on the other, we are seeing the volume of physician services continue to expand, thereby increasing our risk and exposure. It is imperative that your leadership and staff have a clear understanding of both the risks and rewards.
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References
