Palliative Care Billing & Coding for the Interdisciplinary Team

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Objectives

1. Clarify the difference between complexity and time based billing
2. Differentiate when to use complexity vs time in coding
3. Explain z51.5 ICD-10 Palliative Care by Specialist diagnosis code
4. Describe when and how to bill for advance care planning
5. Understand prolonged service codes and how to use them

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Decision Making

1. Given the choice, complexity based billing should be your default.
   i.e., if you have not surpassed the threshold time, choose the bill based on complexity.

2. Always document your times even if you are billing based on complexity.
   *National Experts estimate 30% is left on the table when billing based on time alone

3. It is theoretically possible to perform more than one level 3 initial consult within the "standard" 70 minutes – **bill based on complexity.**

It is quite common for Palliative Care consults to exceed the "standard" time associated with a given CPT.

Location of Service

Inpatient – Full Admission

Skilled Nursing Center / Nursing Home

Unit Time: time starts upon arrival to the unit. Include time in conversation with the RN & SW, chart review, coordination with the attending, family meetings, charting, etc.

Observation / Emergency Center

Out-Patient Clinic

Home

Face Time: time starts upon arrival to the patient's room. Only services provided while patient facing are included.

Unit Time

Whether you will bill on complexity or time, you should <u>ALWAYS</u> record and document your times.

Unit time is any and all time on the patient's floor, spent in any activity related to the patient's care or medical condition. e.g., reviewing EMR, talking to nurse/social worker/attending, family meeting (even if down the hall), coordination of care, discussion with hospice, documentation, etc.

Total Time: sum of all time, does not have to be concurrent
Face to Face Time: sum of all time in patient's room
Time in: clock time you entered patient's room
Time out: clock time you exited patient's room

Total Time: 125 minutes
Face to Face Time: 35 minutes
Time in: 12:15
Time out: 12:50

If you completed any **Goals of Care or Advance Care Planning**, you need to document that time also.
"Completed family meeting and goals of care conversation with son, David the DPOAHC. Discussed withdrawal of endotracheal tube and conversion to comfort care. Spent 25 minutes in ACP."

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Type of visit

- **Hospital: initial or subsequent?** There is one initial with every admission (first visit), all visits after the initial are billed as subsequent visits. If patient is seen in Emergency Center and going to be admitted, bill as inpatient. If unsure, bill as inpatient.
- **Clinic, Emergency Center** (if not admitted), and **Observation:** Use office/clinic codes new or established. One **New Patient** visit every three years (within practice and specialty) – so the hospital consult that later is referred to the OP clinic is billed as an **Established Patient**.

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Complexity Requirements

INPATIENT HOSPITAL DOCUMENTATION REQUIREMENTS (1995 Guidelines)

INITIAL HOSPITAL CARE - Initial hospital visits require that all 3 areas (History, Exam & MDM**) must be met to reach the overall level of service

CPT Code	Time	History	Exam	Medical Decision Making
99221	30 Minutes	4+ HPI elements OR status of 3+ chronic illnesses, 2-9 ROS, at least 1 PFSH required	2-4 Body Areas and/or Organ Systems (at least one in detail OR 5-7 Body Areas and/or Organ Systems	Low
99222	50 Minutes	4+ HPI elements OR status of 3+ chronic illnesses, 10+ ROS, at least 3 PFSH required	8+ Organ Systems or a Complete Exam of a Single Organ System	Moderate
99223	70 Minutes	4+ HPI elements OR status of 3+ chronic illnesses, 10+ ROS, at least 3 PFSH required	8+ Organ Systems or a Complete Exam of a Single Organ System	High

SUBSEQUENT HOSPITAL CARE - Subsequent hospital visits require that 2 of 3 areas (History, Exam & MDM**) must be met to reach the overall level of service

CPT Code	Time	History	Exam	Medical Decision Making
99231	15 Minutes	1-3 HPI elements, No ROS, No PFSH required	1 Body Area / Organ System	Straightforward/Low
99232	25 Minutes	1-3 HPI elements, No ROS, No PFSH required	2-4 Body Areas and/or Organ Systems	Moderate
99233	35 Minutes	4+ HPI elements OR staus of 3+ chronic illnesses, 2-9 ROS, at least 1 PFSH required	2-4 Body Areas and/or Organ Systems (at least one in detail OR 5-7 Body Areas and/or Organ Systems	High

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Practice Example

You are asked to complete an initial consult on the CCU, you arrive to the unit at 0845, and you consult with the RN, and unit social worker, and you discuss the history and a new diagnosis of metastatic cancer with the attending (requesting) physician. You are with the patient and his family from 0900 - 0930. After your examination and discussion with the family, you review your plan and suggestions with the attending and complete your documentation on the unit. You leave the unit at 1000.

1. Location: inpatient full admission. Unit Time applies.
2. Type of visit: Initial
3. Total time: 75 minutes
4. Face to Face Time: 30 min

Code: 99223

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Why complexity coding is your friend

You are asked to see a patient for severe pain in the spine from tumors invading the bone and nerve roots. You take a good pain history/ROS, do a comprehensive exam, review the CT scan, get medication history from the oncology NP, and you recommend a PCA pump with IV morphine. You are getting slammed that day so with your note, your spend 45 min.

1. Location: inpatient full admission. Unit Time applies.
2. Type of visit: Initial
3. Total time: 45 minutes
4. Face to Face Time: 18 min

Code: Time – 99221 (Low Level Initial) – 1.92 work RVUs
Complexity – 99223 (High Level Initial) – 3.86 work RVUs

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Palliative Care Diagnosis

- **ICD10 Z51.5 (fka V66.7 in ICD-9)** is a billable ICD code used to specify a diagnosis of encounter for palliative care. A 'billable code' is detailed enough to be used to specify a medical diagnosis.

- **Should be included in every Palliative Care Note**
- Encompasses all Palliative Care, so not necessary to code for Z71.89 “Other Specified Counseling” This is redundant AND repetitive.

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Threshold Times

Hospital

Initial Consult		**Subsequent Visit**
99221: 30 min		99231: 15 min
99222: 50 min	or	99232: 25 min
99223: 70 min		99233: 35 min

Clinic/Observation

New Patient		**Established Patient**
99201: 10 min		99211: 5 min
99202: 20 min		99212: 10 min
99203: 30 min	or	99213: 15 min
99204: 45 min		99214: 25 min
99205: 60 min		99215: 40 min

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Hospital Initial (CPT 99221, 99222, 99223)

If your visit is less than 70 minutes, you should bill based on complexity. See guide for required elements!
If your visit is at least 70 minutes, **AND** if greater than 50% of your visit is spent in counseling and/or coordination of care, you can bill based on time.

- If your total time is at least (threshold time):

threshold time	Face to Face	You should bill:
70 minutes (1 hour & 10 min)	N/A	99223
100 minutes (1 hour & 40 min)	30 min	99223 & 99356
145 minutes (2 hours & 25 min)	75 min	99223, 99356 & 99357
175 minutes (2 hours & 55 min)	105 min	99223, 99356 & two 99357s

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Hospital Subsequent (CPT 99231, 99232, 99233)

If your visit is less than 35 minutes, you should bill based on complexity. See guide for required elements!
If your visit is at least 35 minutes, **AND** if greater than 50% of your visit is spent in counseling and/or coordination of care, you can bill based on time.

- If your total time is at least (threshold time):

threshold time	Face to Face	You should bill:
35 minutes	N/A	99233
65 minutes (1 hour & 5 min)	30 min	99233 & 99356
110 minutes (1 hours & 50 min)	75 min	99233, 99356 & 99357
140 minutes (2 hours & 20 min)	105 min	99233, 99356 & two 99357s

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Prolonged Services - Inpatient with Patient

99356 - Prolonged service in the **Inpatient** setting with patient, requiring unit/floor time beyond the usual service; **First hour** (select in addition to code for inpatient Evaluation and Management service)

- **Code 99356 reports the first hour of prolonged services on a given date, but may be reported if at least 30 minutes are spent providing prolonged care.**
- **All payers accept 99356 to be billed in conjunction with inpatient CPTs 99221-99223, 99231-99233.**
- **Only one 99356 per day**

99357 - Prolonged service in the **Inpatient** setting with patient, requiring unit/floor time beyond the usual service; **Each additional 30 minutes** (select separately in addition to **99356**)

- **Code 99357 reports each additional 30 minutes for that date of service, but is only reported when the service extends 15 minutes or more into the next time period.**
- **99357 must be reported in conjunction with CPT 99356**
- **Can report as many as total time indicates**

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Practice Example

You are asked to complete an initial consult on the CCU, you arrive to the unit at 0815, and you consult with the RN, unit social worker, and you discuss plan and new diagnosis of metastatic cancer with the attending (requesting) physician. You are with the patient and his family from 0900 - 0950. After your examination and discussion with the family, you review your plan and suggestions with the attending and complete your documentation on the unit. You leave the unit at 1010.

1. Location: inpatient full admission. Unit Time applies.
2. Type of visit: Initial
3. Total time: 115 minutes
4. Face to Face Time: 50 min

Code: 99223 and 99356

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Prolonged Services - Outpatient

99354 - Prolonged service in the **Office** setting, requiring direct patient contact beyond the usual service; **First hour** (List separately in addition to code for inpatient Evaluation and Management service)

- **Code 99354 reports the first hour of prolonged services on a given date, but may be reported if at least 30 minutes are spent providing prolonged care.**
- **All payers accept 99354 to be billed in conjunction with inpatient CPTs 99201- 99205, 99211- 99215.**

99355 - Prolonged service in the **Office** setting, requiring direct patient contact beyond the usual service; **Each additional 30 minutes** (List separately in addition to code **99354**)

- **Code 99355 reports each additional 30 minutes for that date of service, but is only reported when the service extends 15 minutes or more into the next time period.**
- **99355 must be reported in conjunction with CPT 99354**

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Practice Examples

You complete an Outpatient consult in the clinic. The patient was seen by the PC inpatient team last week in the ICU. The patient arrives at 0900 for his appointment, and is roomed by the MA at 0905. You review the inpatient notes then enter the exam room at 0915. Your exam and discussion with the patient, his spouse and their daughter take 70 minutes, and you depart the room at 1025. You document the visit and send a note to the patient's PCP, you are ready for your next patient at 1045.

1. Location: outpatient. Unit Time does not apply.
2. Type of visit: Established
3. Total time: 70 minutes
4. Face to Face Time: 70 min

Code: 99215 and 99354

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Prolonged Services – Without Patient

99358 - Prolonged service in **Any** setting, requiring time beyond the usual service; **First hour** (List separately in addition to code for inpatient Evaluation and Management service)

- **Code 99358 reports the first hour of prolonged services on a given date, but may be reported if at least 30 minutes are spent providing prolonged care.**
- **to be billed in conjunction with inpatient CPTs 99221- 99223, 99231- 99233.**

99359 - Prolonged service in **Any** setting, requiring time beyond the usual service; **Each additional 30 min** (List separately in addition to **99358**)

- **Code 99359 reports each additional 30 minutes for that date of service, but is only reported when the service extends 15 minutes or more into the next time period.**
- **99359 must be reported in conjunction with CPT 99358**

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Prolonged Services – Without Patient

Prolonged Services outside the presence of the patient may be billed on a different day than is the E&M

Example 1**:** you receive a new consult, but there is no family present and the patient is not able to engage. You collect as much info as you can, but pend the consult and complete it the next day.

Day one: you document on a progress note what you did, with whom and include your times.
Day two: you document on a consult template and on the bottom when you document today's times, you also indicate a connection to yesterday's visit and total all the times together.

Example 2: after your follow-up visit with the patient and his spouse they tell you their son is the DPOA-HC and you attempt to call him at his home in Denver, and leave a message. He returns your call the next day and you spend 35 minutes on phone while you discuss his care, prognosis, code status, etc.

Day one: you document on a progress note and you bill a 99233 as is supported by your documentation.
Day two: you document on progress note the connection to follow-up from yesterday, and you list your times plus the salient details of your phone conversation. You bill a 99358

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Prolonged Services

Prolonged time must be face to face to bill 99354/99355 or 99356/99357
If the prolonged time is not face to face, bill 99358/99359

You should include **FOUR TIMES**: Sum of **Total Time**,
Sum of **Time with Patient**,
Start and **Stop** times of the face to face.

Example:
A total of 120 minutes was spent on this case, of which greater than 50% was spent in counseling and/or coordination of care.
Start Time with Patient: 0900; Stop time: 1030; 90 minutes with patient.

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Practice Examples

You complete an initial consult on the ICU, you arrive to the unit at 0815, and you consult with the RN/unit social worker, and you discuss the plan and new diagnosis of metastatic cancer with the attending (requesting) physician. You are with the patient and his family from 0900 – 0915, but because the family doesn't want to discuss issues in front of the patient who is intubated, you move to the family room down the hall. After your examination and discussion with the family, you review your plan and suggestions with the attending and complete your documentation on the unit.
You leave the unit at 1030.

1. Location: inpatient full admission. Unit Time applies.
2. Type of visit: Initial
3. Total time: 135 minutes
4. Face to Face Time: 15 min

Code: 99223 and 99358

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Practice Examples

Your partner completed a subsequent visit on a PC patient this morning. Her documentation includes a full exam and is complete. She documented a total of 45 minutes of unit time, 15 of which was face to face. You are called in the afternoon by the nurse as the patient's family is now at bedside and they "have a ton of questions". You return to the patient's unit at 1515 and review the note from this morning, you enter the room at 1530 and spend 39 minutes in the room with patient and family. You leave the unit at 1630 after completing your documentation.

1. Location: inpatient full admission. Unit Time applies.
2. Type of visit: Subsequent
3. Total time: 120 minutes
4. Face to Face Time: 54 min

Partner Coded: 99233 You Code: 99356 & 99358

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Advance Care Planning

The AMA's CPT manual defines the service:

The two codes **(99497 and 99498)** are used to report the face-to-face service between a physician or other qualified healthcare professional (QHCP) and a **patient, family member, or surrogate** in counseling and discussing advance directives, with or without completing relevant legal forms.

Advance Care Planning

CPT code 99497 [Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed) by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate] ; and

An add-on **CPT code 99498**, [Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; each additional 30 minutes (List separately in addition to code for primary procedure)].

Advance Care Planning

For Palliative Care purposes, these codes can be billed in addition to:

Hospital Visits: initial consult (99221-99223), subsequent visit (99231-99233)
SNF Visits: initial consult (99304-99306), subsequent visit (99307-99310)
Office/EC/Obs: new patient (99201-99205), established patient (99210-99215)
also
Home Visits: new patient (99341-99345), established patient (99347-99350)
ALF/AFH Visits: new patient (99324-99328), established patient (99334-99347)

These codes **CANNOT be billed in addition to Critical Care** or Intensive Care

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Advance Care Planning

For Palliative Care purposes, these codes can also be billed in addition to:

Prolonged Visits:
Hospital/SNF: 99356-99357 or 99358-99359
Office/Home/ALF (EC & Obs): 99354-99355 or 99358-99359

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Advance Care Planning

Documentation required (our system):

- Indicate with whom discussion was held - must be with person designated to make decisions if the patient cannot speak for him or herself, or person legally able to make decisions if no designation was made.
- Identify the types of medical care preferred
- Identify the comfort level that is preferred

Documentation recommended:

- Identify how the patient prefers to be treated by others
- Identify what the patient wishes others to know
- Indication of whether or not an advance directive or POLST (physician orders for life-sustaining treatment) document has been completed

Advance Care Planning

Providers of ACP: While CMS recognizes the role of other providers in the provision of ACP services (such as social workers, chaplains, and others), CMS notes that CPT code descriptors describe **services furnished by physician or other qualified professionals**, which for Medicare purposes is consistent with allowing these codes to be billed by the physicians and non-physician practitioners (NPPs) whose scope of practice and Medicare benefit category include the services described by the CPT codes and who are authorized to independently bill Medicare for those services. Therefore only these practitioners may report these CPT codes. As a physician service, CMS notes that **"incident to" rules apply** when these services are furnished incident to the services of the billing practitioner, which includes a minimum of direct supervision. CMS expects the billing physician or NPP to manage, participate and meaningfully contribute to the provision of the services. CMS also notes that the usual PFS payment rules regarding "incident to" services apply, so that all applicable state law and scope of practice requirements must be met in order to bill ACP services. CMS does not believe it would be appropriate to create an exception to allow these services to be furnished incident to a physician or NPP's professional services under less than direct supervision.

Practice Examples

You complete an initial consult on the CCU, you arrive to the unit at 1155, and you consult with the RN, unit social worker, and you discuss plan and new diagnosis of stage IV metastatic cancer with the attending physician. You are with the patient and his family from 1230 - 1245, but the patient tires quickly, so you move to the family room down the hall, where you spend another 50 minutes with the family. You discuss patient's and family's goals and wishes, you detail the course of treatment and outline options for the spouse who is the DPOA-HC. She explains that the patient does not wish to undergo chemo as was offered by the oncologist and he would like to transition home with hospice. After your examination and discussion with the family, you review your plan and suggestions with the attending, you confirm with the patient and he signs a POLST that was completed during the family meeting, then you complete your documentation on the unit. You leave the unit at 1350.

1. Location: inpatient full admission. Unit Time applies.
2. Type of visit: Initial
3. Total time: 115 minutes
4. Face to Face Time: 15 min

Code: 99223, 99497, and 99358

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Usually best to code ACP before Prolonged Service

- You need > 15 minutes minimum of ACP.
- Then decide if you have enough (at least 30 minutes) to add a prolonged service.
  - Did I spend at least 30 minutes face to face with the patient? Code 99356
  - Did I not spend at least 30 minutes face to face with the patient? Code 99358
- If you do both, yes you can and should bill for both.

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ACP FAQs

- Does the patient need to be present? No, can be with surrogate in the same site
- Does patient need to give consent? No
- Can you provide telephonically? No, requires face-to-face visit
- Can more than one provider bill on the same day? Yes
- Is there a limit to the number of encounters by physician or APRN/PA specialty? No
- Is there a limit to the number of add-on codes billed? No
- Can ACP codes be billed together with routine office visit, hospital visit and nursing home visit E/M charges? Yes
- Can RNs, social workers and chaplains bill for their time doing ACP? Not usually
- Are there documentation requirements? No
- Can the services be billed when delivered via qualifying Telehealth? Yes

Borrowed from Phil Rodgers, MD, MBA, HMDC, FAAHPM

Can our Social Worker bill?

- Short answer, it depends!
- Inpatient [POS 21]
  - Typically not, services are considered bundled with the DRG
  - Same in Skilled Nursing Facility
  - Same for Hospital Out-Patient Services (onsite clinic or infusion center) [POS 22]
- Out Patient: YES!! but use caution on same day as provider if they share a TIN
  - Clinic [POS 11] – yes. Also remember Incident-to billing of ACP here!!
  - Home - Yes

Typical Behavioral Health Codes for SW

CPT Code	SHORT DESCRIPTION	Medicare 2018	WORK RVU	Time Needed
90832	Psychotherapy w/ pt 30 minutes	$63.79	1.5	16-37 min
90834	Psychotherapy w/ pt 45 minutes	$84.78	2	38-52 min
90837	Psychotherapy w/ pt 60 minutes	$127.11	3	53 min or longer
90846	Family Psychotherapy w/o pt 50 min	$102.54	2.4	27 min or longer
90847	Family Psychotherapy w/pt 50 min	$106.49	2.5	27 min or longer
90839	Psychotherapy crisis initial 60 min	$132.87	3.13	31-75 min
90840	Psychotherapy crisis ea addl 30 min	$63.43	1.5	add on after 76 min
90785	Interactive Complexity	$10.13	NA	NA

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