



## **Providing Direct, Billable Physician Services to Hospice Patients**

*An Opportunity to Upgrade the Medical Component of Hospice Care*





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## Introduction

## Providing Direct, Billable Physician Services to Hospice Patients: *An Opportunity to Upgrade the Medical Component of Hospice Care*

Medicare regulations define an essential role for the hospice medical director, who is charged with overseeing clinical aspects of the hospice program, consulting with the team, certifying patients' terminal illnesses and directing the agency's overall patient care policies and quality of care. The medical director or hospice physician participates on the core hospice team and is responsible for the medical needs of hospice patients not met by their attending physicians.

Some certified hospices have tried to fulfill those requirements with a very part-time or even volunteer physician. Others employ one or more full-time physicians who contribute to program administration, marketing, professional relations and direct clinical activities including face-to-face encounters with hospice patients in hospitals, nursing homes or private residences whenever necessary to manage their care. The medical director's role in education and training can include CEU courses for community physicians, in-services for hospice staff and volunteers and student education through professional rotations, internships and residencies.

These markedly different approaches to the physician's role and profile in the hospice program may be explained in part, but only in part, by the size of the hospice. Smaller hospices with a census of less than 50 patients are less likely to employ a full-time or significantly part-time physician. Also at issue is the hospice's overall commitment to the medical component of care. Hospices that place a high priority on the medical director's role are more likely to employ a physician specialized in palliative care; readily accessible to staff, patients and attending physicians throughout the week; actively involved in clinical aspects of care, including patient visits; and proactive in building professional relations.

That commitment often is reflected in the agency's overall success.

Anecdotal evidence suggests that significant benefits can be derived from full-time physician participation in hospice care in terms of increased patient census, extended lengths of stay, enhanced relations with referring physicians and greater community acceptance. The overall result can be improved credibility for the program, along with improved quality of care. Physicians can contribute to cost effectiveness through appropriate, evidence-based decisions about palliative drugs and treatments. 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.

In fact, most face-to-face encounters between hospice physicians and patients can be used to appropriately generate bills to Medicare or other payers. Patients will enjoy the added reassurance that comes from personal contact with the doctor while the hospice team's effectiveness is enhanced by the participation, professional skills and perspectives of an involved medical director/hospice physician.

This report was developed to demonstrate to NHPCO members how they can add full-time physician involvement to their programs in a cost-effective manner. It profiles several successful hospices of different sizes that employ full-time physicians, the roles played by those physicians and their contributions to the hospice's success, including their ability to generate billing income. Medicare regulations and billing opportunities will be reviewed, along with recent research conducted by NHPCO and by the Center for Health Workforce Studies at the State University of New York, Albany.





# The Hospice Physician Community

Almost all of America's 3,200 hospice programs have a designated medical director, which is required for Medicare certification. The American Academy of Hospice and Palliative Medicine (AAHPM), Glenview, Ill., had approximately 1,500 physician members in 2002. A total of 1,200 physicians have passed the specialty certification examination prepared by the American Board of Hospice and Palliative Medicine (ABHPM). What else is known about this small but growing professional community?

Recently, NHPCO surveyed its 2,200 provider members about how they utilize hospice physicians.<sup>1</sup> The 2002 survey provides an essential snapshot and baseline for further study of this key resource in hospice care. There were 309 respondents (14 percent return rate), and they reflect national averages in such measures as rural vs. urban setting, length of stay, average daily census and budget size. Their responses portray an "average" hospice medical director who is a middle-aged white male with considerable medical experience and background in internal or family medicine.

As Table 1 shows, full-time or half-time (20 hours per week or more) physician staffing in hospice has become more common than previously realized.

Other important results from NHPCO's survey include a delineation of the actual roles and responsibilities of practicing hospice medical directors. The top five areas of responsibility for hospice physicians are:

- ◆ Acting as a medical resource for the interdisciplinary team;
- ◆ Participating in admission and re-certification decisions;
- ◆ Participating in interdisciplinary team meetings;
- ◆ Reviewing patient eligibility for hospice services; and
- ◆ Consulting with attending physicians regarding pain and symptom control.

In addition, significant involvement was seen in the following areas:

- ◆ Home visits for patient assessment and intervention (67 percent); and
- ◆ Availability to teach medical students, residents and fellows (49 percent).

**Table 1**

Staffing*	Employed (Percent FTE)	Contracted (Percent FTE)	Volunteer (Percent FTE)	Cumulative (Row Percent)
Full-time	29%	6%	7%	42%
>20 hours per week	24%	26%	17%	67%
<20 hours per week	24%	10%	4%	38%
<b>Cumulative Column Percent</b>	77%	42%	28%	

\*Hospice agencies with multiple physicians indicated various levels of staffing for physicians/medical directors.

<sup>1</sup> "The Involvement of Physicians in Hospice and Palliative Care." Alexandria, Va.: National Hospice and Palliative Care Organization, March 2002.



## The Hospice Physician Community

It is not clear, however, how many home visits are being billed for allowable physician reimbursement. Overall, there is less emphasis on research and education than on duties mandated by the Medicare Hospice Benefit. Among other results from NHPCO's survey:

- ◆ 37 percent of identified physicians are ABHPM-certified;
- ◆ 88 percent are doctors of medicine and 12 percent are doctors of osteopathy; and
- ◆ In terms of primary medical specialty, 36 percent report internal medicine, 30 percent report family medicine and 17 percent report oncology.

Research at the New York Center for Health Workforce Studies at the State University of New York, Albany, sheds further light on medical practice in hospice and palliative care.<sup>2</sup> Authors Bonnie Primus Cohen and Edward Salsberg surveyed 2,423 physicians who were identified as medical directors of NHPCO-member hospices and/or physicians certified by ABHPM, with a 52 percent return rate. They found:

- ◆ Physicians committing 20 or more hours weekly to hospice and palliative care constituted 26 percent of the surveyed population but provided 70 percent of total palliative care hours;
- ◆ Physicians working nine hours or fewer per week in palliative care represented 53 percent of respondents but 14 percent of total palliative care hours; and
- ◆ Those who had been certified by ABHPM were more likely to work 20-plus hours per week.

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The survey also found evidence of widespread participation in EPEC (Education for Physicians on End-of-Life Care) training or other short courses in palliative care. Much smaller proportions (less than 10 percent) have completed fellowships, residency rotations or medical school electives in palliative care. The most common role performed within respondents' current palliative care practice was as the medical director of a hospice, followed by:

- ◆ Direct patient care
- ◆ Consultant to other health professionals
- ◆ Coordinating palliative care team
- ◆ Administrative duties
- ◆ Consultant to other physicians
- ◆ Attending policy and clinical committees
- ◆ Teaching
- ◆ Medical director of palliative care service
- ◆ Conducting home visits

The majority of those currently working less than 100 percent in palliative care said they would prefer to devote more hours to the field. Respondents also said they expect their palliative care practices to grow in the future, while the supply of physicians with training in palliative care is perceived to be insufficient. Those spending 20 hours or more per week were also more likely to be involved in palliative care teaching, research, direct patient care and consultation to other physicians. However, both physicians and hospitals viewed current palliative care reimbursement as inadequate to sustain physicians in practice.

<sup>2</sup> *The Supply, Demand and Use of Palliative Care Physicians in the United States: A Report Prepared for the Bureau of HIV/AIDS, Health Resources and Services Administration.* Rensselaer, N.Y.: Center for Health Workforce Studies, School of Public Health, University at Albany, September 2002.



## Reimbursement for Medical Services in Hospice

Certified hospices are paid by Medicare under a *per diem* payment system, which bundles the costs of virtually all of the services necessary to manage the patient's terminal illness into one of four all-inclusive daily rates for routine home care, general inpatient care, inpatient respite care or continuous nursing care in the home. Although most medications, supplies and professional services such as nursing, social work and therapies are covered under the all-inclusive daily rate, direct physician services (other than medical director administrative duties) are not included in the *per diem* and are reimbursed separately by Medicare.

Hospices also operate under an aggregate “cap” or overall, average per-patient limit on the total reimbursement they can receive for Medicare-covered patients. Attending physician billing is not counted under the cap unless the physician is employed by the hospice. For most hospices the cap is not a significant concern because short average lengths of stay mean that few programs ever come close to the cap. Medical services that are not related to the patient's identified terminal illness are also excluded from the hospice *per diem* or cap and are billed to Medicare separately under usual channels.

Reimbursement for physician services in hospice is summarized in Table 2 on page 12. Generally speaking, Medicare recognizes three broad categories of medical services: (1) professional, (2) administrative and (3) technical.

 **Professional Services** are actual, direct, hands-on procedures (including assessments and counseling) performed by a physician and described by an appropriate Current Procedure Terminology (CPT) physician billing code with an associated International Classification of Disease (ICD-9) diagnostic code.

 **Administrative Services** are those related to the workings of the hospice, its interdisciplinary team and the physician's role on that team, including certifications of terminal illness, care plan development, team conferences and supervisory, educational or management activities. While many of these services are mandated for hospices, they are not reimbursed separately but instead included in the hospice's daily rate. (In other words, the hospice *per diem* was structured to include a certain amount of physician administrative expense.)

 **Technical Services** refer to radiology, lab and other non-professional services that can involve the physician and might be directly reimbursed to the physician outside of a hospice context. But in hospice these are considered part of the *per diem* and should be billed to the hospice.

Table 2 (page 12) describes significant opportunities to bill Medicare for physicians' professional services in both hospice and palliative care. But some physicians and hospices may not be aware of or taking advantage of the legal reimbursement channels that exist for hospice employees and non-employees, for attendings and consultants and for care provided to hospice patients and non-hospice palliative care patients. Some might not even be aware of those opportunities.

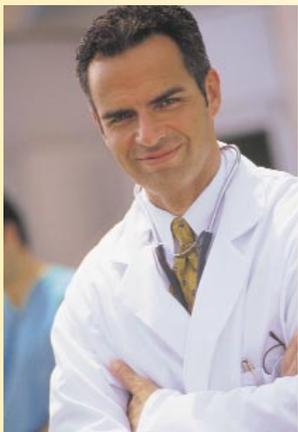
Specific rules apply and appropriate coding is required to specify diagnosis, concurrent billing and whether or not the physician is the attending and/or a hospice employee. Hospices should approach physician billing as a compliance issue, because they can be held accountable for the bills they submit on behalf of an employed or consulting physician. Therefore, they need to be sure that the



## Reimbursement for Medical Services in Hospice

physician is documenting correctly to support the bill. Rules and opportunities for billing may be different for other payers such as private insurers or HMOs and under state Medicaid programs.

Among the resources developed to clarify physician billing requirements in end-of-life care is a seminal paper produced for the EPEC project by Drs. Charles von Gunten and Frank Ferris, available from the Web site of the Center to Advance Palliative Care.<sup>3</sup> It is also recommended that hospice physicians work closely with their agency's billing staff on proper coding, utilizing the American Medical Association's CPT coding manual, while helping to educate referring physicians' office staff about how the regulations work. Agencies may find it helpful to work with a billing consultant familiar with physician billing for a chart audit of billing records, as well as making physician billing part of their routine compliance activities.



Many physicians and their hospice employers across the country are now taking advantage of the opportunities, working with their fiscal intermediaries to clarify the appropriateness and limits to Medicare hospice reimbursement for physician services. In fact, some of America's most innovative hospices, large and small, attribute much of their success to the role played by their full-time medical directors in direct clinical care and in end-of-life care leadership in their communities.

It is also important to acknowledge that hospice medical directors' actual roles vary widely depending on their communities and the structure and size

of their agencies, reflecting the enormous diversity of hospice programs nationwide. In some communities, volunteer medical directors are able, for personal reasons, to contribute many more hours to the hospice than others.

Different communities also have markedly different physician cultures, degrees of competition in hospice and medical care, patient population case mixes, demographics and other key variables. The degree to which primary physicians are open to suggestion or to hands-on involvement by the hospice medical director also varies. Hospices often are anxious to make sure community physicians don't feel that the hospice physician is trying to "steal" their patients. However, experienced hospice doctors suggest that this concern may be overstated and, in any case, actual objections can be overcome through education and collaboration.

Different hospice physicians also have markedly different skill sets, whether in counseling, pain and symptom management, education, marketing, public relations or administration, and their hospices are well-advised to take advantage of their particular strengths. At the same time, while effective doctor-to-doctor communication and favorable reputation in the community are essential traits, so, too, is expertise and confidence in palliative pain and symptom management. To a certain extent, the latter can be enhanced through available training opportunities. Successful hospices have made the commitment to employ physicians in full-time or significantly part-time roles and to take advantage of what they can contribute to the program's overall success.

<sup>3</sup> von Gunten C, Ferris F. "Procedure/Diagnosis Coding and Reimbursement Mechanisms for Physician Services in Palliative Care." EPEC Trainer's Guide, 1999. Accessed at: <http://www.capcmssm.org/content/130/index.html?topic=4>.



## Case Study #1

### Providing Direct, Billable Physician Services to Hospice Patients: *An Opportunity to Upgrade the Medical Component of Hospice Care*

#### *Hope Hospice and Palliative Care, Fort Myers, Florida*

**Average Daily Census:** 650 patients

**Medical Director:** Dr. Diane Smith, employed full-time since 1999

**Specialty:** Internal Medicine; ABHPM-certified

**Primary Responsibilities:** Community relations, speaking engagements, education for community physicians, quality improvement, supervision of staff physicians, rotations through team and inpatient coverage.

Agency's medical component includes an associate medical director, six full-time hospice physicians and one part-time physician, with full-time physicians on staff since 1992.

In Florida, with its large retirement population, Hope Hospice and Palliative Care has grown to be one of the country's largest hospices. The agency employs nine salaried staff physicians and is now hiring a tenth. The full-time physicians rotate every other week through assignments with one of the hospice's five home-based teams, its two inpatient/residential facilities or the team that makes referral and palliative care consultation visits to hospitals, as well as on-call coverage.

The agency's policy calls for a physician to see every hospice patient, if possible, at least once as a member of the interdisciplinary team, ideally within two weeks of admission. Other priorities for medical home visits are patients with difficult symptom management problems and those coming up for recertification with questionable prognoses. Patients in the inpatient centers are seen by a hospice physician every day. Patients in nursing homes, who may have had limited exposure to a doctor, particularly benefit from face-to-face contacts with hospice physicians, reports Hope Hospice's CEO, Samira Beckwith.

"There has always been a direct role for physicians in hospice," Beckwith says. "For us it's a priority to have physicians involved, first of all, for the benefit of our

patients. For them to receive attention from our physicians gives them an added sense of security. It's part of being able to provide more comprehensive hospice care and to improve physician relations." Because physicians' visits are billable, increasing physician involvement has not increased net expense to the agency, including salaries, malpractice insurance rates, which the hospice pays, and administrative expense. "Not to have a physician or medical component as available to patients as the other components of hospice, we believe, is wrong," Beckwith adds.

The hospice has also developed a set of pain and symptom management protocols, which spell out standardized medical responses to some 20 common symptoms. Referring physicians are given the option to sign the protocols (some 90 percent do) and the hospice team then follows the symptom management steps contained in the protocol without having to call the doctor for new medical orders. "Our policy is that we never change non-protocol medications without calling the physician," says medical director Dr. Diane Smith. Attending physicians are encouraged to visit their hospice patients at home or in facilities and are able to specify the level of hospice physician involvement they are comfortable with. As a result they have come to embrace Hope Hospice's medical services.

"We emphasize that we are a group practice. We get together frequently for meetings and regularly review the protocols," Smith reports. Team physicians receive from their teams a list of patients who need to be seen, along with a set of portable charts, and then work out their own visit schedules. Often they start directly from home, with visits bunched geographically, and some days they may not go into the office at all.

The agency has general expectations for productivity, but these are not strictly enforced. "We are more interested in quality than quantity," Smith says. "We want the doctors to feel free enough to do what needs to be done with patients and families." One final advantage of this approach, she adds, is quality of life for the doctors, who get to make their own schedules and spend quality time with patients. "If you're a physician interested in patient care, I can't imagine another setting where you could really care about people and give good patient care like you can here."



## Case Study #2

### Providing Direct, Billable Physician Services to Hospice Patients: *An Opportunity to Upgrade the Medical Component of Hospice Care*

*Hernando Pasco Hospice, Hudson, Florida*

Average Daily Census: 600

Medical Director: Dr. David McGrew, on a contract basis since 1985

Specialty: Family medicine; ABHPM-certified

Primary Responsibilities: Patient visits and management of independent hospice medical group.

An equally intensive physician component that is structured in a very different way can be found at Hernando Pasco Hospice, where the agency contracts for medical services with a freestanding hospice and palliative care medical group led by Dr. David McGrew. The medical group includes seven physicians, three nurse practitioners and a physician's assistant and provides similar medical services to two other hospices in the region.

"The doctors don't have offices but they are out seeing our patients and using those visits to cover their salaries," notes the hospice's CEO, Rodney Taylor. "We get a lot of visits out of them (approximately 1,200 per month), and an awful lot of support for our staff." The contract doctors, who are assigned to a specific hospice team, provide their own on-call coverage five days a week and are available by pager to answer staff's clinical questions day and night.

This approach grew out of McGrew's longstanding relationship with Hernando Pasco Hospice, starting as a very part-time contract medical director in 1985. As his involvement in hospice grew, he began to make home visits and eventually closed his non-hospice medical practice to devote himself entirely to end-of-life care. Two years ago he formed the hospice medical group.

McGrew continues to act as Hernando Pasco Hospice's medical director, while devoting much of his time to running the medical group. The other

doctors spend most of their time on direct patient visits, planning their schedules from home in consultation with hospice team leaders. Hospice patients are seen by a physician within two to four days of admission and then at intervals of 10 to 30 days, depending on acuity. Patients in the hospice residences are seen by a doctor one to three times per week. Patients' attending physicians retain their role and receive regular updates, including faxed or e-mailed progress notes, from the hospice physician providing primary care to their patients.

The contract physicians also staff team meetings and provide education and consultation to the teams, but aren't involved in marketing. "The way we structure the contract, the hospice decides what it wants the physicians to do that's non-reimbursable. We add up the hours and bill the hospice a flat rate per hour. The balance of the physicians' income comes from patient care and billable visits," McGrew says. The hospice bills Medicare Part A and pays the receivables to the medical group, after deducting a small percentage for billing and overhead. Individual physicians are then paid a percentage of their charges by the group.

"We have an electronic medical record that keeps us connected and in constant communication with the team. Every day I can see which patients got a visit yesterday. The computer also provides itineraries and schedules recall visits based on need," McGrew says. He views this innovative arrangement as a logical extension of the opportunity for hospices to employ contract medical directors. "In the hospices where we work, the majority of the primary physicians are quite happy to transfer care over to a hospice physician to see their patients and in fact would be uncomfortable being asked to order the morphine doses needed by hospice patients," he relates.

"Another advantage of this model is that a single physician could provide services to multiple smaller hospices. The advantage to the hospices is that they would have a physician practicing hospice and palliative medicine on a full-time basis available to their patients," McGrew says. "The fact that the doctor is providing similar services to other hospices' patients shouldn't make a difference."



## Case Study #3

***Pike's Peak Hospice, Colorado Springs, Colorado***

***Average Daily Census:*** 225 patients

***Medical Director:*** Dr. Jonathan Weston, full-time since 2000

***Specialty:*** Hospitalist; ABHPM-certified

***Primary Responsibilities:*** Clinical visits, physician relations and consultations with attending physicians for patients with unrelieved suffering.

*Agency's medical component includes one other nearly full-time physician who sees patients in the 40-bed inpatient hospice facility and three part-time physicians to cover on-call and team meetings, for a total of 2 FTEs, with plans to add more.*

**D**r. Jonathan Weston was hired as medical director by Pikes Peak Hospice in 2000 in response to a management consultant's recommendation. "Before me, the hospice had a part-time medical director and several other very part-time doctors. I started full-time two years ago and our census has grown from 90 patients to 225 today," he says. Median length of stay has also gone up, from 37 to 47 days. "When I first started, the physicians' time was about 20 percent clinical and 80 percent administrative." Now those proportions have reversed.

"I was hired to be an evangelist to the medical community. I would not have been hired if I hadn't practiced in this community for 20 years. We have two competing hospital systems and I set up the hospitalist program at each system. I have also taught our organization how to speak the language of physicians. I've been able to inculcate a medical culture into the culture of hospice, which had been predominantly nursing. Now doctors say to me: Your nurses know how to speak the language of doctors," Weston says.

"Physicians had a lot of reasons for not referring patients to hospice. One of the big ones was that if they refer to hospice and there's no accessible medical director, then those 2 a.m. phone calls for additional morphine go to the primary physician," who has to be awakened. Weston offers to sign the death certificate, which also makes their jobs easier. "Doctors love me to be involved, as long as I keep them informed with regular progress notes," he says.

Pikes Peak Hospice's obvious success with full-time medical direction inspired several other Colorado hospices to follow a similar path. Hospice of Larimer County in Fort Collins, with a current patient census of 100, used to employ two very part-time medical directors. In June of 2002, it hired its first full-time medical director and uses the doctor for medical rounds, daily visits to its five-bed inpatient center, pain and palliative care consults, quality assurance, physician education and visits to patients at home. The medical director also works closely with the hospice's in-house pharmacy staff, interacts with long-term care facility medical directors and calls private insurers to discuss coverage.

Despite these numerous administrative responsibilities, the agency targeted that the physician's billing would cover one-third of his salary in the first year and eventually half. "We also expected that his presence would lead to better care decisions, and it has already contributed to increased census," says CEO Brian Hoag.



## Case Study #4

### Providing Direct, Billable Physician Services to Hospice Patients: *An Opportunity to Upgrade the Medical Component of Hospice Care*

*Hospice of Siouxland, Sioux City, Iowa*

*Average Daily Census: 180 patients*

*Medical Director: Dr. Paul Fee, full-time at 20 paid hours per week since 1999*

*Specialty: Family practice for 35 years in Sioux City; ABHPM-certified*

*Primary Responsibilities: Medical consultation with staff on difficult symptom management issues; leadership in physician relations; agency leadership for strategic planning and palliative care development.*

*Agency's medical component includes an associate medical director.*

In 1999 Linda Todd, director of Hospice of Siouxland, Sioux City, Iowa, convinced her parent health system to bring volunteer medical director Dr. Paul Fee on staff, paid at 20 hours per week. He retired from his other medical practice and probably devotes more than 20 hours a week to the hospice. Meanwhile, the agency's average daily census has doubled, from 89 patients in 1999 to 180 today.

"I think a tremendous amount of that growth is Paul's expanded role, along with other end-of-life promotion and awareness," Todd says. Fee makes about six billable visits per month to patients, but his biggest contribution to the hospice's bottom line is increased census and his medical leadership with physicians in the tightly knit community of 100,000 people.

"I was at the point where the program was financially struggling. I realized that we needed physician leadership to move the program forward, but I had to sell the idea to our health system's administration," Todd relates. "Today we have a viable hospice program that is self-supporting, which I believe is directly related to the medical director. I believed that in my heart when we started, but still, I was scared to death. It was a lot of money to commit, but we had to take the risk."

Now Fee is called for pain and symptom management questions by small hospices in outlying rural communities and even to visit their patients. Hospice of Siouxland is starting to look at how to provide such physician support on a more formal basis, Todd says. "We're open to be a resource to small hospices and to provide consultation on program growth. But I think they'd be better off if they could build coalitions of smaller hospices." Five or six rural hospices, each with an average census of ten patients, by coming together could potentially achieve a big enough program to support a full- or significantly part-time medical director.



## Case Study #5

*Hospice of the Red River Valley, Fargo, North Dakota*

*Average Daily Census: 100 patients*

*Medical Director: Dr. John Thomas, "generous half-time" position since November 2002*

*Specialty: Family practice, emergency medicine, health care consulting*

*Primary Responsibilities: Medical relations, education, back-up for volunteer regional medical directors, home visits and, in time, palliative care consultations.*

*Agency's medical component includes eight regional medical directors staffing teams in five offices.*

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The doctor carries a pager and is available to the team 24 hours a day. "We also hope he will make it possible for us to be more liberal with our admissions policies and will act as a trouble-shooter for the occasional difficult dynamics between our nurses and physicians." With the opportunity to devote so much time to hospice, Fuglie hopes that Thomas eventually will become the state's leading expert in palliative care.

"We don't expect that a paid medical director position will ever pay for itself with direct billing. We do expect it to pay for itself in census growth, and the billable visits are extra," she says. The foundation that funded the organizational capacity study has also agreed to pay half of Thomas's salary for the first year.

The largest hospice in North Dakota, Hospice of the Red River Valley (HRRV), covers a large rural area across two states with five offices. Two years ago, in response to a local foundation's offer of grants to expand organizational capacity, the hospice engaged consultants from the Summit Business Group to review its mission and operations. Their recommendations included revisiting prospects for a freestanding unit, expanding access for patients receiving aggressive palliative treatments and hiring a paid medical director.

The hospice opted to retain its regional medical directors but in November 2002 hired its first paid medical director, Dr. John Thomas. Unlike some hospice physicians, Thomas does not have an extensive background in palliative medicine, although he is quickly learning and mentoring with hospice staff and the regional medical directors, says the hospice's director, Susan Fuglie. What Thomas brings, she explains, are strong administrative experience, explicit management skills and an appreciation for the highly political local medical culture, with two major health systems competing head to head across the hospice's extensive service area.





## Categories of Medical Care in Hospice

The following are the basic categories of roles played by physicians in hospice and palliative care:

- ❧ **Attending Physician:** Also known as the primary physician; identified by the patient at the time he or she elects to receive hospice care as the doctor with the most significant role in determining that individual's care. The attending physician consents to hospice care, certifies the patient's terminal prognosis and signs the hospice plan of care and subsequent medical orders. The attending is often described as the titular head of the hospice interdisciplinary team for his or her patients enrolled in hospice care. In reality, attendings rarely visit hospice patients in their homes or other care settings, while most hospice patients eventually become too sick to visit the doctor's office. As a result, the attending's involvement in hospice care is conducted largely by telephone, mail and/or e-mail contact with the hospice team. Nonetheless, the attending physician's primary role and history with the patient are essential to the success of hospice care. Mechanisms of reimbursement for the attending physicians of hospice patients (described in Table 2 on page 12) are determined by whether or not the physician has a direct employment relationship with the hospice.
- ❧ **Hospice Medical Director:** A hospice-employed or contracted physician who assumes overall responsibility for the medical component of the hospice's patient care program. The medical director has a signed and formal relationship with the hospice as a salaried employee, contract employee or volunteer. Job responsibilities of hospice medical directors typically include staff, professional and community education, supervision of clinical staff including other physicians and fellows, standards development, quality improvement, professional relations and marketing to physicians, program development and involvement in agency management issues. Medicare-mandated responsibilities include certification and re-certification of terminal prognosis, attendance at team meetings and medical consultations with the hospice team and attending physicians.
- ❧ **Hospice Team Physician:** Often hospices refer to any physician in their employ as medical director. In reality, hospices typically designate a primary medical director; other physicians on staff are more accurately described as *hospice* or *team physicians*. They may perform administrative functions as assigned by the medical director as well as hospice teamwork and direct clinical services including patient visits.
- ❧ **Consulting Physician:** Medicare hospice regulations also recognize a role for a consulting physician, who is called upon by the attending or the hospice team for his or her specialized knowledge and expertise. Consulting physicians for hospice patients work under a signed letter of agreement with the hospice agency and send their bills to the hospice, not to Medicare. Just as the attending physician of record for some hospice patients may be an employee of the hospice, so, too, can consulting physicians.
- ❧ **Palliative Care Consultant:** Increasingly, hospices, hospitals and other health care organizations are establishing palliative care programs, especially designed for patients who are not yet hospice-appropriate or ready to consider a hospice referral but still have significant palliative care needs related to a serious or life-threatening illness. Most often, palliative care programs are structured as interdisciplinary consulting services, typically comprised of a physician, a nurse and perhaps other professionals such as a social worker, chaplain or pharmacist. Palliative care consultations generally are provided at the request of the attending physician or other health professional for a time-limited involvement to address specific concerns related to symptom management, life-transition management or other palliative needs. Often palliative care physician consultations are reimbursable (particularly the physician's direct services).



## Table 2

### Reimbursement for Professional Services of Physicians in Hospice <sup>4</sup>

#### Attending Physician of Hospice Patient

*If NOT employed by hospice:*

- ◆ Bills Medicare Part B using existing CPT and ICD-9 codes
- ◆ Paid 80% of allowable fee schedule
- ◆ Not included in hospice *per diem* or cap
- ◆ If a physician other than hospice patient's named attending bills Medicare Part B, the bill likely will be denied unless the care is unrelated to the patient's terminal illness (in which case the physician should so indicate on the bill)

*If employed by the hospice (even as a volunteer):*

- ◆ Bills the hospice for medical services
- ◆ Hospice needs to verify dates and services before billing Medicare Part A
- ◆ Hospice is paid 100% of allowable fee schedule
- ◆ Hospice pays physician per contractual agreement
- ◆ Hospice needs to obtain a physician billing number from Medicare
- ◆ Not included in hospice *per diem* but does count against aggregate cap

#### Consulting Physician

*Whether employed by hospice or not:*

- ◆ Bills hospice
- ◆ Hospice bills Medicare Part A, which pays 100% of allowable fee schedule
- ◆ Consultation is requested for specific problem by attending or team members
- ◆ Request and need for consultation must be documented
- ◆ Must have signed letter of agreement with hospice
- ◆ Not included in hospice *per diem* but does count against cap

#### Care Plan Oversight

- ◆ Attending physician qualifies for reimbursement when spending more than 30 minutes per calendar month on phone calls, chart reviews and coordination of care for a hospice (or home health care) patient
- ◆ Does not apply if patient resides in nursing home
- ◆ Only the designated attending for a hospice patient may bill for care plan oversight
- ◆ Generally, hospice-employed physician cannot bill separately for care plan oversight
- ◆ Billed to Medicare Part B, using HCPCS code G0182, which pays 80% (currently about \$135 per month)
- ◆ Physician must have had face-to-face encounter with patient in previous six months

#### Care Unrelated to Terminal Diagnosis

- ◆ May be billed to Medicare Part B by attending and/or hospice physician
- ◆ Bill should specify that care is unrelated to hospice patient's terminal diagnosis

#### Technical Component of Medical Services

- ◆ Technical component of medical services such as lab tests or radiology is considered part of hospice *per diem* and must be billed directly to the hospice by the physician under a written agreement

<sup>4</sup>The above table of billing information is summarized from the following sources: von Gunten C, Ferris F. "Procedure/Diagnosis Coding and Reimbursement Mechanisms for Physician Services in Palliative Care." *EPEC Trainer's Guide, 1999*; "Physician Billing Guidelines for Medicare Hospice Services." unpublished document prepared by the National Hospice Work Group, San Diego, Calif., 2002; *UNIPAC 1: The Hospice/Palliative Medical Approach to Palliative Care*. Glenview, Ill.: American Academy of Hospice and Palliative Medicine; von Gunten C. "Billing for the Professional Services of Physicians." Teleconference, December 12, 2002, Center to Advance Palliative Care, New York, N.Y.



## Table 2

### **Nurse Practitioner**

- ◆ In some states nurse practitioners are permitted to bill Medicare, either directly or under a physician's supervision. Rules for nurse practitioner billing vary from state to state and recently underwent change. Outstanding regulatory questions remain about what happens to such billing once the patient enrolls in hospice care. However, it is known that such billing can only be done if the attending physician is not an employee of the hospice, and hospices themselves are not allowed to bill Medicare for nurse practitioner services.

### **Palliative Care Consultation**

- ◆ May be billed by physicians not employed by the hospice, under existing physician reimbursement channels using CPT procedure/service codes and ICD-9 diagnosis codes. Concurrent billing, even by a consultant with the same medical specialty as the attending physician, is permitted based on medical necessity, with procedure and diagnosis codes that describe a substantially different symptom or service than the primary physician is addressing. Actual reimbursement reflects payer's fee schedule, co-payments and payer mix.

### **Hospice Operating a Medicare Part B Physician Clinic:**

- ◆ In January 2003, CMS clarified that a hospice may become a Medicare Part B provider — a physician clinic — in order to bill for non-hospice palliative care. The services of physicians, physician assistants, and nurse practitioners may be billed under this arrangement. The

patients would be Medicare beneficiaries who are not enrolled in the Medicare Hospice program and who are receiving palliative care. If physicians are employees of the hospice, they must reassign their benefit payments to the hospice (operating as a clinic) and the clinic does the billing.

In preparing the application to become a Medicare Part B provider, the hospice should do the following:

1. Check with the state government to see what the state requirements are for becoming a physician clinic under Medicare Part B. There may be state licensing requirements or other regulations governing physician clinics. Also check to see whether nurse practitioners can bill separately in the state where services are provided.
2. Complete the application found online at [www.cms.gov](http://www.cms.gov) in the Medicare Provider/Supplier Enrollment area and indicate the hospice's provider status as physician clinic.
3. The 855-B form is the appropriate form for enrollment.

Once the application has been submitted, the process of enrollment should include enrolling all physician and nurse practitioner employees individually so that they can reassign their Medicare benefit payments to the clinic. Physician assistants may not bill separately, so their services will automatically be billed to the clinic.



## Resources

### RESOURCES

**The National Hospice and Palliative Care Organization** is the oldest and largest non-profit membership organization representing hospice and palliative care programs and professionals in the United States. The organization is committed to improving end of life care and expanding access to hospice care with the goal of profoundly enhancing quality of life for people dying in America and their loved ones.

1700 Diagonal Rd., Suite 625, Alexandria, VA 22314, 703/837-1500,  
[www.nhpco.org](http://www.nhpco.org)

**The American Board of Hospice and Palliative Medicine** offers yearly examinations for physicians to become subspecialty-certified in hospice and palliative medicine, as well as education to prepare for the exam. 9200 Daleview Ct., Silver Spring, MD 20501, 301/439-8001, Dale Lupu, President/CEO, [www.abhpm.org](http://www.abhpm.org)

**The American Academy of Hospice and Palliative Medicine** offers extensive resources and networking opportunities for physicians, including national conferences and its "UNIPAC" modular self-study curriculum. The Academy is planning to publish a series of detailed models of the physician's role in hospice and palliative care starting in 2003.

4700 W. Lake Ave., Glenview, IL 60025, 847/375-4712, Dick Muir, Executive Director, [www.aahpm.org](http://www.aahpm.org)

**The Center to Advance Palliative Care**, a national program office of the Robert Wood Johnson Foundation based at the Mount Sinai School of Medicine in New York City, provides extensive education and training materials on palliative care development, including the physician's role.

1255 - 5th Ave., Suite C-2, New York, NY 10029, 212/201-2670,  
[www.capcmssm.org](http://www.capcmssm.org)





## Acknowledgements

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