

Coding Guidelines for Palliative Care and Hospice

by Linda Gledhill, MHA

Q. How should I code the diagnosis when a patient is receiving palliative care rather than treatment to cure a disease?

A. Diagnosis coding for palliative care visits consists of coding for the underlying disease, followed by encounter for palliative care, and the symptom being treated. For example: 162.9 Lung Cancer V66.7 Encounter for Palliative Care 286.66 Dyspnea (shortness of breath)

Q. The physician often spends most of the visit time counseling the patient. Can we charge for these counseling services?

A. Evaluation and Management (E&M) coding can be complicated. Many times, physicians do not complete all of the guidelines for an E&M visit, instead using the allotted time for counseling and coordinating care. In these cases, you can use the length of the patient encounter (time) to determine the appropriate visit level.

Q. How would a physician determine the level to charge if time was used as the basis for coding the visit?

A. E&M codes have approximate time values. If a physician must spend more than 50 percent of the time designated by these codes on counseling

and coordinating care, you can base the visit level on the length of the patient encounter (time). For example, a physician spends 40 minutes with an established patient to determine the palliative care the patient should receive. Thirty minutes of this time is spent counseling and coordinating care. This patient encounter can be coded using visit level 99215.

Q. Does the physician's time have to be spent with the patient or can the physician charge for services carried out in the office?

A. If the patient is seen in the physician's office, the time must be spent in face-to-face interaction. If the patient is seen in the hospital as an inpatient, the physician can include time spent counseling and coordinating care on the unit.

Q. If "time" is used to determine the level of the visit, what documentation is needed?

A. Documentation for visits based on time is critical and must include the total amount of time spent with the patient, as well as the time spent coordinating care (more than 50 percent), and the recommendations and treatment decisions.

Q. If the patient sees more than one physician on the same day, how do I avoid denied claims for billing more than one visit on the same day?

A. If a medical oncologist sees the patient for an E&M visit and refers the patient to a pulmonologist for evaluation of the shortness of breath, the pulmonologist should use the reason for the consult (dyspnea) as the primary diagnosis. ☐

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Hospice Care

If the physician has determined that the patient is terminally ill and has six months or less to live, the patient can choose hospice care. Hospice care is designed to enable a patient to be as comfortable as possible and does not involve curative treatment.

Q. How do hospice physicians bill for their visits?

A. Hospice care is billed to Medicare under Part A and is sent to the fiscal intermediary rather than the carrier. Here are the revenue codes used to bill for hospice care:

- 651 Routine home care
- 652 Continuous home care (24 hrs)
- 655 Inpatient respite care
- 656 General inpatient care

Q. How much does Medicare pay for hospice care?

A. Medicare pays 100 percent of the allowed charges for these codes; however, this benefit is capped at approximately \$20,000. (Payment rates vary depending on the area of the country.) The patient does not have a co-payment or deductible.

Q. If a patient exhausts this benefit, how do you bill for physician services?

A. Once the hospice benefit has been exhausted, you can bill any additional services to the Medicare carrier as you did prior to using the hospice benefit.

Q. Will commercial payers cover hospice services?

A. Many commercial carriers now have hospice benefits. These benefits may be similar to the Medicare benefit or they may be based on specific visit rates. Check with your private payers to determine specifics. ☐