Palliative Care Certificate Program Faces Delay

BY PATRICE WENDLING

AUSTIN, TEX. — The release of the long-awaited Joint Commission–sponsored palliative care certificate program has been put on hold in order to complete a strategic planning process, Dr. Diane Meier said at the annual meeting of the American Academy of Hospice and Palliative Medicine.

The certificate program was expected in August 2008 after the Joint Commission announced it would release a new certificate for hospital palliative care programs. The commission convened an expert panel to establish quality standards and conducted market research showing strong interest in the program.

But that research was conducted before the economy began to tank, said Charles Mowll, executive vice president for business development, government, and external relations at the Joint Commission.

"Because of the change in the economic environment, we want to proceed carefully," he said in an interview. "Unfortunately, it's sometimes difficult to convert that enthusiasm to spending the resources and energy to pursue and obtain certification. The next steps for us are to refresh that market research and get a more contemporary view of the world and interest in the program. But it's a clear message that we have a significant collective investment in palliative care certification."

The fate of the program should be decided sometime this summer, he said.

In the meantime, the Center to Advance Palliative Care (CAPC) at the Mount Sinai School of Medicine in New York has agreed to advertise the program and raise funds to help offset costs to the Joint Commission to develop it, said Dr. Meier, director of CAPC and professor of geriatrics and internal medicine at Mount Sinai.

"Development of a quality assessment program to ensure high standards for the nation's 1,300 hospital palliative care programs is of the highest priority," she said in an interview.

► **Low-hanging fruit.** Cash-strapped states are eyeing the nursing home Medicaid Hospice Benefit as a way to shore up their budgets.

"There are a lot of hospices making a very large profit on stable long-term nursing home patients that are tarring the entire industry," Dr. Meier said. "The problem is that rather than identify and censor the bad actors, they [state and federal policy makers] just want to eliminate the benefit."

In late 2008, Florida proposed eliminating reimbursement for hospice in nursing homes, claiming that it would save the state $343 million. The effort was defeated after a statewide group, Florida Hospices and Palliative Care, hired its own research firm, arguing that the move would actually boost state health care costs by $3.7 million.

President Obama provided some breathing room by imposing a 1-year moratorium on hospice rate cuts through Sept. 30, 2009, as part of the economic stimulus plan. The National Hospice and Palliative Care Organization (NHPCO) is urging members to push for a permanent freeze.

"We're not expecting that this will completely go away," said audience member Judy Lund Person, NHPCO vice president of regulatory and state leadership. "There have been lots of discussions about whether it's double-dipping. … We don't believe that that's true, but it's an area where we have to be extraordinarily careful."

► **Part of the solution.** In other circles, hospice and palliative care are being viewed as part of the solution to the health care crisis. The National Priorities Partnership, convened by the National Quality Forum in 2008, named palliative and end-of-life care as one of six national priorities for transforming the nation's health care system.

Dr. Meier noted that another benchmarking group, HealthGrades, is getting increasing inquiries for help in starting palliative care programs, a sign that health care quality assessment organizations are seeing these programs as a way to get a handle on costs.

► **Coding conundrum.** Although the Centers for Medicare and Medicaid Services began recognizing hospice and palliative care as a new physician specialty as of 2009, a specific specialty code won't be assigned until this fall, said copresenter Lynn Hill Spragens, CEO and president of the consulting firm Spragens & Associates, Durham, N.C. A delay in implementation is not unusual, but in the meantime reimbursement denials continue.

Core causes of denials include a lack of professional preparation to do Part B billing, misinformed or underinformed billing specialists, and an increasing number of providers from different core specialties delivering palliative care services in the same hospital.

Many programs are staffed by specialists with primary credentialing in a specialty such as geriatrics or hospital medicine, who are also board certified in hospice and palliative medicine, Ms. Spragens said. Pending the assignment of the new CMS specialty code, when they receive referrals from physicians in their primary specialty, there is a high potential for bill denial, unless there is very careful documentation by the provider and the billing office.

Until the new specialty code is in place, she advises providers to use the 77 modifier to report a repeat procedure by another physician, include notation about palliative care on the bill, and follow up thoroughly with denials to identify acceptable documentation with payers. After the specialty code is assigned, providers will need to revise their credentialing information, she said.

Dr. Meier and Ms. Spragens reported no conflicts of interest. ■

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