

Coding and Reimbursement Mechanisms for Physician Services in Hospice and Palliative Care

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ABSTRACT

Many physicians misperceive that the current coding system used to bill third-party payers in the United States does not include codes related to hospice and palliative care. This article will help physicians and hospice and palliative care providers to: 1) understand how to code for physician services related to hospice and palliative care; 2) review the documentation required to support such services; 3) understand the differences between the reimbursement mechanisms to be used when the patient is enrolled in the Medicare Hospice Benefit, and the usual reimbursement mechanisms; and 4) understand some of the approaches for funding non-physician palliative care services for patients not enrolled in the Medicare Hospice Benefit.

INTRODUCTION

PALLIATIVE MEDICINE IS THE BRANCH OF MEDICINE focusing on the relief of suffering and the improvement of quality of life for patients and families who are living with life-threatening illness.¹ It is the medical component of the broad therapeutic interdisciplinary model known as palliative care.

Numerous prominent organizations and individuals, including organized medicine, have identified the need to improve physician skills in palliative medicine and strengthen the physician's role on the interdisciplinary team.²⁻⁸ To further that goal, the Institute for Ethics, American Medical Association, with funding from the Robert Wood Johnson Foundation, embarked on the Education for Physicians in End-of-life Care (EPEC) Project. This curriculum was developed to ensure that every practicing physician learns the core skills needed to provide competent and

confident symptom control and supportive care to patients and families whenever there is need.⁹

During the implementation phase of the EPEC Project, it became apparent that many physicians misperceived that the current coding system used to bill third-party payers for physician services did not include codes related to hospice and palliative care. There was also concern that the rate of reimbursement for these services was inadequate and/or less than the cost of care. As we were aware that some physicians were successfully using the existing coding and reimbursement systems, this paper was developed to help physicians and hospice and palliative care providers:

- understand how to code for physician services related to hospice and palliative care;
- review the documentation required to support such services;

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- understand the differences between the reimbursement mechanisms to be used when the patient is enrolled in the Medicare Hospice Benefit, and the usual reimbursement mechanisms; and
- understand some of the approaches for funding nonphysician palliative care services for patients not enrolled in the Medicare Hospice Benefit.

It was developed from the module on Physician Reimbursement originally written for inclusion within the EPEC curriculum.⁹

The first section of this paper discusses the approaches to coding for physician services used by many payers across the United States. Then we discuss the appropriate mechanisms for submitting claims for physician services, both for patients enrolled in the Medicare Hospice Benefit, and for those who may be covered by State Medicaid or other commercial insurance programs. Finally, we briefly discuss approaches to paying for nonphysician palliative care services when the patient is not enrolled in the Medicare Hospice Benefit.

CODING FOR PHYSICIAN SERVICES RELATED TO HOSPICE AND PALLIATIVE CARE SERVICES

Coding for the reimbursement of physicians for direct patient care services related to hospice or palliative care almost always uses the same coding technique whether the patient is enrolled in the Medicare Hospice Benefit, or receives those services through other funding mechanisms.

Physicians code for each service in two parts: a procedure/service code and a diagnosis code.

Procedure/service codes

For any patient encounter, the physician starts by selecting a procedure/service code from the Current Procedural Terminology (CPT™) codes published by the American Medical Association.¹⁰ For physicians involved in palliative care, the most frequently used codes are the evaluation and management (E/M) codes (99201–99499; see Table 1). There are groups of evaluation and management codes for each of the usual settings in which physicians provide services (e.g., ambulatory outpatient, acute inpatient hospital, extended care institutions, or in patients' homes). Within each group, there is a hierarchy of codes

from which to select, depending on the intensity of the service provided, from the least intensive to most complex. Documentation requirements for selecting a code based on complexity and intensity are complicated, and are currently contested. It is beyond the scope of this manuscript to review these guidelines.

Coding Based on Time. When providing physician services in Hospice and Palliative Care, a little known and underappreciated provision of the current E/M coding guidelines often applies:

when more than 50% of a patient/physician interaction is comprised of counseling and/or information giving, then TIME becomes the factor that determines which E/M code to use.¹⁰

As palliative care consultations and direct patient services often incorporate extensive amounts of information giving and/or counseling as part of a physician/patient interaction, it is often the time it takes to complete these activities that determines which E/M code is appropriate. Each of the E/M codes is associated with an amount of time that correlates with the amount of work denoted by the code when more than 50% of the interaction is related to counseling and/or information giving (see Table 1).

Time is defined differently depending on the setting. In the hospital, the time used to determine which E/M code to choose is defined as the total time that the physician is present on the hospital unit. It includes time spent at the bedside rendering services to the patient. It includes the time in which the physician establishes and/or reviews the patient's chart, interviews and examines the patient, writes notes, and communicates with other professionals to coordinate care, and the patient's family. In the nonhospital setting, when time is used to determine which E/M code is appropriate, time is defined as the total time the physician spends face-to-face with the patient. The time spent on activities related to the visit, but not face-to-face with the patient, is not to be added into the calculation of time used to determine which E/M code to choose (it is already included in the total work connoted by the code).

In any setting, physicians who provide palliative care may also report codes for specific procedures or tests that they may perform (such as anesthetic injections, paracentesis, thoracentesis,

TABLE 1. SUMMARY OF SOME CPT EVALUATION/MANAGEMENT CODES

<i>Attending/Managing Physician</i>			
<i>New/Office</i>	<i>Established Office</i>	<i>Initial Hospital</i>	<i>Subsequent Hospital</i>
99201 10 min	99211 5 min	99221 30 min	99231 15 min
99202 20 min	99212 10 min	99222 50 min	99232 25 min
99203 30 min	99213 15 min	99223 70 min	99233 35 min
99204 45 min	99214 25 min		
99205 50 min	99215 40 min		
<i>Nursing Home-C</i>	<i>Nursing Home-F</i>	<i>Home—New</i>	<i>Home—Established</i>
99301 30 min	99311 15 min	99341 20 min	99347 15 min
99302 40 min	99312 25 min	99342 30 min	99348 25 min
99303 50 min	99313 35 min	99343 45 min	99349 40 min
	99344 60 min	99350 60 min	
		99345 75 min	
<i>Prolonged Service Face to Face—Office/Home</i>		<i>Prolonged Service Face to Face—Inpatient</i>	
99354 30 min		99356 30 min	
99355 each subsequent 30 min		99357 each subsequent 30 min	

Consultation

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician, or another appropriate source. A physician consultant may initiate diagnostic and/or therapeutic services. The request, and the need for consultation, must be documented in the medical record. The opinion, and any services ordered or performed, must also be documented. A “consultation” initiated by a patient and/or family, and not requested by a physician, should be reported using the codes for confirmatory consultation or office visits, as appropriate. *The follow-up codes should not be used if the consultant assumes responsibility for management of a portion, or all, of the patient’s condition(s).*

<i>Office/Home</i>	<i>Initial Hospital</i>	<i>Follow-up Hospital</i>	<i>Confirmatory</i>
99241 15 min	99251 20 min	99261 10 min	99271
99242 30 min	99252 40 min	99262 20 min	99272 Low Severity
99243 40 min	99253 55 min	99263 30 min	99273 Moderate Severity
99244 60 min	99254 80 min		99274 Moderate to High
99245 80 min	99255 110 min		99275 Moderate to High

etc.) For example, if the physician performed a paracentesis to relieve abdominal distension and discomfort during a home visit, the physician would report both an E/M code and a procedure code. The time required to provide procedures or tests is not counted in the calculation of whether or not the 50% criterion for counseling/information giving is used to establish the appropriate E/M code.

Documentation. The Health Care Financing Administration (HCFA) of the U.S. Department of Health has distributed extensive guidelines for the documentation that must support the use of each of the E/M codes. Documentation must indicate that more than 50% of the interaction was related to counseling or information giving if

time is used to determine which E/M code is appropriate.

Example in hospital. You are asked to provide a palliative care consultation to an 86-year-old former school teacher who has been admitted to the hospital for symptoms related to cirrhosis of the liver. The attending physician would like advice on managing her dyspnea. You spend an hour on the unit reviewing the chart, interviewing and examining the patient, and an additional 20 minutes writing your note and conferring with the attending physician. The majority (more than 50%) of your interaction with the patient was related to eliciting her values and goals of care, clarifying her understanding of her diagnosis and prognosis, giving information, and counseling.

You had some specific suggestions about the use of morphine to relieve her dyspnea.

For this initial consultation in the hospital that lasted 80 minutes, you would choose E/M code 99254. In your note documenting the consultation you would indicate:

- the name of the referring physician;
- the reason for the consultation;
- your recommendations for medical management of the patient's dyspnea;
- the fact that the majority (more than 50%) of the interaction was related to counseling and information giving;
- the total time spent to complete the consultation, including the time spent documenting and discussing the case with the referring physician (e.g., in this case 80 minutes); and
- a summary of the reasons why counseling and information giving was required, and a summary of the information you conveyed.

Example at home. The school teacher has been discharged home with home hospice care. Her daughter is her primary caregiver. Her care is covered under the Medicare Home Hospice Benefit. Her primary physician does not usually see patients at home. The patient has noted increasing abdominal girth associated with a "tightness" across her abdomen and increased dyspnea on exertion. Her attending physician asks you to see her at home. During the course of your history you provide supportive counseling related to how the patient and her daughter are coping with the illness. You elicit additional problems of constipation and occasional nausea. You perform a physical examination and determine that she has ascites. You discuss your findings with the patient and her daughter. She does not want to return to the hospital or her doctor's office for any procedures or tests. You call her primary physician in her presence and discuss your findings. You agree that a trial of increased captopril and senna seems warranted. You also agree that a therapeutic paracentesis is indicated. Because you brought the equipment with you in anticipation of the diagnosis, you withdraw a liter of fluid and she feels better. You call her hospice nurse to bring her up to date on the developments before you leave the house. You spent a total of 90 minutes in the house with the patient; 45 minutes of which was spent doing the paracentesis.

For this encounter, you would choose E/M code 99349 because the patient is known to you. You spent a total of 45 minutes in direct face-to-face time with the patient, including counseling and information giving, as well as coordination of care. Although you are a consultant to the primary physician, you use one of the home visit codes because this is a follow-up visit with an established patient, and the attending physician has asked you to manage this part of the patient's care. In addition to the E/M code, you would also report code 49080 for the paracentesis with the modifier-25. There is no time element associated with this code; materials to perform the procedure are included in the code. In your note documenting the encounter you would indicate:

- that you saw the patient at home;
- the reason for seeing the patient;
- your findings and recommendations for management;
- the fact that the majority (more than 50%) of the face-to-face interaction was related to counseling and information giving;
- a summary of the reasons why counseling and information giving was required, and a summary of the information you conveyed; and
- a summary of the procedure, including indications and outcome.

Similar approaches apply to coding for visits to patients living in Long Term Care facilities. It is beyond the scope of this manuscript to discuss the regional variations that guide the policies of fiscal intermediaries.

Diagnosis codes

In addition to the CPT code, physicians describe the reasons for their services by using one of the International Classification of Disease-Clinical Modification codes (ICD-9-CM) written by the National Center for Health Statistics (NCHS). These diagnosis codes are published by several organizations, including the American Medical Association.¹¹ The ICD-9-CM book contains not only disease codes but also many symptom codes. A few examples of ICD-9-CM codes commonly used in hospice and palliative care are presented in Table 2.

Concurrent care. Many physicians, particularly internists, are concerned about reimbursement for

TABLE 2. ICD-9 CODES COMMONLY USED IN PALLIATIVE CARE*

Anorexia	783.0	Ianition	263.9	Pain: nonspecified	780.9
Agitation	307.9	Mental Status Change	780.9	Pain: abdomen	789.0
Anxiety	300.0	Nausea	787.02	Pain: arm	729.5
Confusion	298.9	Nausea & Vomiting	787.01	Pain: back	724.5
Coma	780.01	Vomiting	787.03	Pain: bone	733.90
Cough	786.2	Weakness	780.7	Pain: chest	786.50
Debility	799.3	Weight loss	783.2	Pain: foot	729.50
Dementia	298.9	SOB	786.09	Pain: hip	719.45
Dyspnea	286.6	Unconscious	780.09	Pain: leg	719.45
Depression	311			Pain: Muscle	729.1
Delirium	780.09			Pain: sacroiliac	724.60
Diarrhea	558.9			Pain: throat	789.1
Fatigue	558.9			Pain: neck	723.1
Fever	780.6				
Headache	784.0				
Hemorrhage	459.0				

*Refer to the full tabular list of ICD-9-CM codes to ensure coding at the highest degree of accuracy (11).

concurrent care (i.e., if they see a patient on the same day as another internal medicine specialist or subspecialist, they worry that only one of them will have their services reimbursed). In October of 1995, HCFA published new rules that permit concurrent care by two or more physicians on the same day, even if they are of the same specialty. However, to describe the legitimate differences in evaluation and management services that multiple physicians may provide to a single patient, physicians need (as appropriate) to use different ICD-9-CM diagnosis codes for the hospice and palliative care services they are providing.

Example. For the 84-year-old woman with cirrhosis described above, if both her general internist and the palliative care specialist had used the ICD-9 code for cirrhosis when they saw her in the hospital, only one submission for reimbursement would likely be accepted, and the other denied. However, if you, as the palliative care consultant, are consulted for advice related to management of shortness of breath, you would use the ICD-9-CM diagnosis code for dyspnea (286.6), estimating that the internist is most likely to use the code for cirrhosis. Using different diagnosis codes, both claims are likely to be accepted. For the visit at home, you could use either code as appropriate, as you are the only physician providing direct care on that day. You would also report the code for ascites (789.5) as the diagnosis necessitating the paracentesis.

The Medicare Hospice Benefit. The Federal Medicare Hospice Benefit (the Benefit) was established in 1982 to pay for hospice services at home for

Medicare beneficiaries. Provision was also made for brief periods of inpatient services. A patient is eligible to elect the Benefit if the patient is confirmed by two physicians to have a prognosis of less than or equal to 6 months if the disease follows its usual course. The patient must acknowledge the terminal nature of the illness and sign election forms that indicate that care will be directed toward comfort, not cure of the disease.

When a patient elects the Medicare Hospice Benefit, the care related to his or her terminal illness/diagnosis becomes the direct responsibility of the hospice agency that the patient selects. The Benefit pays for all intermittent nursing, social work, chaplain, nurse aide, physical/occupational therapy, durable medical equipment, medication, and therapy related to the terminal illness. To cover their costs, the agency providing these hospice services receives a *per diem* payment from Medicare. This rate is set by the federal government and is not influenced by the particular treatments or services that the patient receives.

When it was established, the Medicare Hospice Benefit was one of the first examples of capitated medical care. Subsequently, many commercial payers have adopted similar approaches to covering their own home hospice care.

If a patient who has elected the Medicare Hospice Benefit needs medical care that is not related to the terminal illness/diagnosis, then that care can be provided and reimbursed through standard Medicare funding mechanisms. It is the responsibility of the hospice physician medical director to determine whether the care is related or not to the terminal illness/diagnosis. For example, if a patient is cared for under the Medicare

Hospice Benefit for a diagnosis of colon cancer and sustains a broken leg as a passenger in an automobile accident, care for the broken leg can be billed to standard Medicare.

The Federal Medicare Program is divided into two distinct parts—Part A and Part B. The purpose of Medicare Part A is to cover institutional and nonphysician services. It is funded by the payroll deductions and required contributions from employers for all employed Americans. The purpose of Medicare Part B is to fund physician services from payments made by Medicare beneficiaries. As will be discussed below, physician services for hospice and palliative care may be reimbursed through either Medicare Part A or Part B, depending on what service was provided, by whom, and whether the patient has elected the Hospice Medicare Benefit.

REIMBURSEMENT FOR PHYSICIAN SERVICES TO PATIENTS WHO HAVE ELECTED THE MEDICARE HOSPICE BENEFIT

Administrative/supervisory activities

As a part of the Medicare Hospice Benefit, the services of the hospice physician medical director that relate to the administrative and general supervisory activities of the hospice agency are included in the *per diem* payment that the agency receives. These activities include the physician medical director's participation in "establishing, reviewing, and updating plans of care, supervising care and services, and establishing governing policies for the agency" (Medicare Regulations Section 406). Therefore, the hospice physician medical director should expect that the time he or she spends on administrative/supervisory activities will be paid for by the Hospice agency (this does not include time the physician medical director spends on direct patient care).

Physician services for direct patient care

Physician services for direct patient care are not included in the *per diem* payment provided to the hospice agency by the Medicare Hospice Benefit. Any physician who provides direct patient care, whether he or she is the hospice medical director, or another physician caring for the patient, needs to apply for reimbursement of these services separately. The precise reimbursement

mechanism depends on whether the physician is the patient's attending physician or a consultant, and whether the physician is associated with the Hospice agency, either as an employee or a volunteer.

Attending Physicians not Associated with the Hospice. At the time when a patient elects the Medicare Hospice Benefit, he or she must indicate who the attending physician will be.

An attending physician who is not directly associated with the hospice codes for direct patient care services using the CPT and ICD-9-CM codes in the manner described above, and submits these claims directly to Medicare Part B through the fiscal intermediary responsible for processing his or her Medicare claims.

Physicians who submit paper claims must indicate on the HCFA 1500 claim form that he or she is the patient's attending physician, and is not associated with the hospice agency. If this statement is not present, the claims are likely to be denied.

For physicians who submit claims electronically (EMC), an HC modifier must be appended to the CPT code. This may trigger the fiscal intermediary to telephone the physician's office for further information. When the intermediary calls, they need to know that "This is a hospice patient. Dr. X is the patient's attending physician and is not employed by or associated with the hospice agency."

Attending Physicians Associated with the Hospice.

An attending physician who is associated with the hospice agency (e.g., as the hospice's medical director, as a salaried physician, or even as a non-salaried volunteer), codes for direct patient care services using the CPT and ICD-9-CM codes in the manner described above. However, he or she submits these claims to the hospice agency, not to his or her fiscal intermediary for Medicare Part B. The hospice agency submits these claims to Medicare Part A for reimbursement as part of their claims for the patient's care. Claims for direct patient care by employed or volunteer physicians are currently reimbursed to the hospice agency at 100% fee paid for physician services under Medicare Part B. The Hospice agency can then negotiate how they will reimburse the physician, either as part of a negotiated package of salary and benefits, or through a fee-for-service arrangement.

Example. If you were working for the hospice program caring for the 84-year-old woman with congestive heart failure who you saw at home, you would submit your codes to the hospice who would, in turn, submit them to Medicare. Depending upon your reimbursement arrangement with the hospice agency, they would pass the reimbursement on to you, or count it toward your salary and benefits.

Consulting Physicians. A consulting physician (see the definition in Table 2) who is asked by the attending physician to see a patient who has elected the Medicare Hospice Benefit, codes for consulting services using the CPT and ICD-9-CM codes in the manner described above. The consultant submits those codes to the hospice agency, not to the fiscal intermediary for Medicare Part B. Just like for attending physicians associated with the hospice, the hospice agency then submits the claims for reimbursement under Medicare Part A. The hospice then reimburses the consultant directly based on preexisting contractual arrangements. For this billing to occur there must be a contract between the hospice agency and the consultant.

Example. If you were a consultant to the attending physician for the care of the 84-year-old teacher with congestive heart failure, you would submit your codes to the hospice agency. In order for the hospice to submit the charges, they would need to have a contract with you for the provision of services to its patients. That contract would likely spell out the required arrangements for documentation, the ordering of tests and additional medications, and the submission of billing codes.

REIMBURSEMENT FOR PHYSICIAN HOSPICE AND PALLIATIVE CARE SERVICES TO PATIENTS WHO HAVE NOT ELECTED THE MEDICARE HOSPICE BENEFIT

Hospice under Medicaid/other state coverage

Hospice care for patients who have Medicaid or Public Aid coverage is administered under rules governed by individual states, not through the federal government. However, many states have adopted the HCFA/Medicare guidelines for

the care of hospice patients. The coding guidelines for the reimbursement of physician services are the same as those outlined above. As rules may vary from state to state, it is important that physicians and hospice agencies become familiar with the rules and regulations for reimbursing physician services in the individual state(s) in which they are practicing.

Private insurance

Most commercial payers (i.e., health plans, insurance companies) require physicians to code for direct patient services using the CPT and ICD-9-CM codes in the manner described above. Physicians then submit their claims directly to the commercial payer for reimbursement regardless of whether or not a patient is covered by a hospice benefit. As individual private payers may develop their own regulations regarding coding and reimbursement mechanisms, physicians and hospice agencies are encouraged to know the rules of each payer before submitting claims, to minimize reimbursement delays.

Palliative care services for Medicare patients who have not elected the Medicare Hospice Benefit

Physicians may see patients for the purpose of delivering palliative care services who are covered under Medicare but have not elected the Medicare Hospice Benefit. Physicians use the same coding procedures as outlined above and then submit their claims directly to their Medicare fiscal intermediary in the usual manner.

NONPHYSICIAN PALLIATIVE CARE SERVICES

Under the Medicare Hospice Benefit, the *per diem* payment to the hospice covers all services provided by nonphysician health-care professionals to the patient and his or her family, related to the terminal illness. However, patients who are not eligible or appropriate for enrollment under the Medicare Hospice Benefit may have legitimate needs for interdisciplinary palliative care services.

The challenge facing health-care providers is to find a way to pay for the nonphysician component of such services. Many health-care professionals such as nurse practitioners, clinical nurse

specialists, social workers, and chaplains can access fee-for-service reimbursement mechanisms either through Medicare or private insurance. More commonly, when a patient is hospitalized, the services of other health professions are included as part of the services reimbursed by private insurers. Frequently these options have not been used to their full potential.

When funding is not readily available, health-care providers may need to seek creative solutions, including philanthropy, to fund these services. As patient and family needs for palliative care are frequently significant, even when they are not eligible for the Medicare Hospice Benefit, it behooves providers to help collect reliable costing data, and then advocate for change in current commercial and government funding mechanisms.

CONCLUSION

Physician services to hospice and palliative care patients can be described using existing coding procedures and submitted for reimbursement. When these procedures are used, reimbursement at acceptable rates can be expected. For administrative and supervisory activities related to patients enrolled in the Medicare Hospice Benefit, hospice physicians should expect reimbursement from the hospice agency from the *per diem* provided to the agency for each hospice patient.

For the direct care of patients enrolled in the Medicare Hospice Benefit, attending physicians not associated with the hospice agency submit their claims directly to Medicare Part B. In contrast, attending physicians who are associated with the hospice agency, or serve as consultants, submit their claims to the hospice agency for submission to Medicare Part A. They can expect to receive reimbursement for their services from the hospice agency, not the Medicare fiscal intermediary. This latter process of reimbursement for direct patient care by physicians is a marked departure from standard approaches to reimbursement under Medicare. Similar reimbursement mechanisms exist for patients insured through state Medicaid/Public Aid and commercial agencies.

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