What Matters in Advance Care Planning: Strategies and Reimbursement

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12PM – 1PM

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Today’s Presenters

Deborah M. Silberstein, RN, ScM  
**Program Manager, Palliative Care at MaineHealth**  
Deb’s 30-year career spans work in the hospital setting, occupational health nursing and quality improvement. Deb has a personal and professional interest in palliative care and now supports MaineHealth’s Palliative Care and End of Life care program.

Isabella Stumpf, DO  
**Division Director of Palliative Medicine, Maine Medical Center**  
Dr. Stumpf is board certified in Hospice and Palliative Medicine and graduated from UNE’s College of Osteopathic Medicine. She completed her internal medicine residency and pulmonary and critical care fellowship at Maine Medical Center.

Angela Poland, RN, CM  
**Care Manager, Lincoln Medical Partners**  
Angela works with patients and healthcare teams to facilitate the completion of advance care plans, and when appropriate, POLST forms. She recently helped develop a comprehensive advance care planning process for Lincoln Medical Partners practices.
What Matters: Advance Care Planning – Strategies and Reimbursement

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Our goals today…

• Provide an overview of Advance Care Planning
  - Why it is important
  - How it is completed

• Provide an example of how Advance Care Planning has been integrated into the primary care office setting

• Describe the new CMS rules that provide for Medicare reimbursement for Advance Care Planning
With thanks to:

• Carol L. Cherry, RN, BSN, Billing Compliance Specialist, Audit & Compliance Services; MaineHealth

• Susan Whittaker, CPC, Susan Whittaker, Coding Compliance Manager, Maine Medical Partners

• Karen Wynne, CCS-P, CHA, Sr. Coding Specialist, Maine Medical Partners
Why is Advance Care Planning important?

Gap between what patients want and what they get

- 86% Medicare beneficiaries want to spend final days at home\(^1\)
- 25-39% die in an acute care hospital\(^2\)
- Many experience care transitions and very short hospice stays\(^3\)
- 50% of people are unable to participate in decisions around care and the default is to provide aggressive treatment
- Only 10% of deaths will be immediate
- Loved ones and providers who do not know the patient’s wishes and find the process burdensome

References: \(^1\)Barnato 2007; \(^2\)Teno JAMA 2013; Silveira NEJM 2010; \(^3\)Teno JM JAMA 2013

Advance Care Planning gives peace of mind to patients and families
What patients get often harms them and their families

Aggressive care for patients with advanced illness is often harmful:

**For patients:**
- Lower quality of life
- Greater physical and psychological distress\(^1\)

**For caregivers:**
- More major depression
- Lower satisfaction\(^2\)

**References:**
\(^1\)Wright, AA JAMA 2008; Mack JCO 2010; \(^2\)Wright, AA JAMA 2008; Teno JM JAMA 2004
Conversations are too little, too late, and not great

Multiple studies show patients with serious medical illnesses do not discuss EOL preferences, or first discuss them only in the last days to month of life\(^1\)

Among patients with advanced cancer:

- First EOL discussion occurred median 33 days before death\(^2\)
- 55\% of initial EOL discussions occurred in the hospital
- Only 25\% of these discussions were conducted by the patient’s oncologist\(^2\)

Many conversations fail to address key elements of quality discussions, especially prognosis and functional Outcome

References: \(^1\)Wright 2008, Dow 2010, Halpern 2011; \(^2\) Mack AIM 2012
How to bridge the gap between what patients want and what they get?

Ask patients about their values and priorities.

Do Advance Care Planning
Bridging the divide

Health Care Providers
- Medical Knowledge

Patients & Families
- Knowledge of Values & Goals

CONVERSATION

Medical Treatments Aligned With Values & Goals
Advance Care Planning (ACP) is…

• Planning for an unexpected life changing event or serious illness…

• …that leaves one unable to communicate or make choices for themselves…

• …and doctors believe it is very unlikely that the person will ever recover.
An Advance Directive (AD) is...

• **An advocacy tool**
  
  ...for helping patients clearly communicate to loved ones and health care providers how they would like to live to their end of life.

• **A counseling tool**
  
  .....for supporting and guiding loved ones and health care providers in making decisions in stressful situations.
Steps of Advance Care Planning

1. Understanding ACP and choosing a health care decision maker (agent) who understands and accepts the role and responsibilities.

2. Thinking about personal values, goals and treatment choice in the event of a serious illness.

3. Sharing decisions for health care with their agent, other family members, healthcare team and health care organizations.

4. Documenting so that the ACP can be retrievable

5. Revisiting the conversation
The conversation

For Healthy Adult

- Normalize the conversation
  » “Can you tell me about the supports in your life?”
  » “Who should speak for you if you cannot speak for yourself?”
  » “Have you ever thought about your end-of-life wishes
- Or… “about the kind of care you’d want if you got really sick someday?”

For Patients with Serious Illness

- Ask about understanding of illness
- Ask about information preference
- Provide prognosis
- Explore goals/values
- Address trade-offs and wishes for functional outcome
- Explore family involvement and understanding
Triggers for Advance Care Planning

• All adults 18 years of age and older
  – Life changing events

• Disease specific (such as CHF, COPD, Dementia)

• Related to prognosis (surprise question)

• Acute change in condition

• Multiple medical conditions/admissions

• Functional decline

• Patient/family request
5 good times to update an Advance Directive

1. **Decade**  
   With each new decade of life or every 10 years

2. **Death**  
   If a patient’s close friend or loved one dies

3. **Divorce**  
   If the patient goes through a divorce

4. **Diagnosis**  
   If the patient is diagnosed with a new or serious health condition

5. **Decline**  
   If the patient’s health is in decline due to an existing illness
• Part 1 - Choose someone to make health care decisions-Power of Attorney for Health Care (Health Care Agent/Proxy)

• Part 2 - Choose certain treatments

• Part 3 - Name your primary care clinician

• Part 4 - State decision about donating organs, body or tissues after death

• Part 5 - Choose someone to make or state your wishes about funeral and burial decisions

• Part 6 - Sign AD, 2 witnesses, notary, distribution

• Part 7 - Do Not Resuscitate (DNR) form
Case studies

• 18 year old – life changing event

• Person with chronic condition – Mr. T.
  - At time of diagnosis
    » Review ACP or start process if does not have one
  - As the chronic condition progresses
    » Repeated review of the ACP
  - As the person’s prognosis indicates that they are possibly entering into their last year of life
    » Update ACP
    » Complete the POLST
## What is the difference between POLST and Advanced Directives

<table>
<thead>
<tr>
<th>POLST</th>
<th>Advance Directives</th>
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<tbody>
<tr>
<td>For the seriously ill</td>
<td>All adults</td>
</tr>
<tr>
<td>Current care</td>
<td>Future care</td>
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<tr>
<td>Health Care Professionals</td>
<td>Patients</td>
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<td>Can engage in discussion if patient lacks capacity</td>
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</table>

**Population**: 
- POLST: For the seriously ill
- Advance Directives: All adults

**Timeframe**: 
- POLST: Current care
- Advance Directives: Future care

**Who Completes the Form**: 
- POLST: Health Care Professionals
- Advance Directives: Patients

**Resulting Form**: 
- POLST: Medical Orders (POLST)
- Advance Directives: Advance Directives

**Health Care Agent or Surrogate Role**: 
- POLST: Can engage in discussion if patient lacks capacity
- Advance Directives: Cannot complete

**Portability**: 
- POLST: Provider responsibility
- Advance Directives: Patient/family responsibility

**Periodic Review**: 
- POLST: Provider responsibility
- Advance Directives: Patient/family responsibility
Lincoln Medical Partners Advance Care Planning Process Map

1. Hospital referral for Advance Care Planning
2. Office Visit
3. PCP discusses Advance Care Planning with Patient
4. Patient would like to fill out Advance Care Planning form (POLST/Advance Directive)
   - Y: Nurse completes Advance Care Planning form with patient during visit
     - Y: Patient returns to complete Advance Care Planning form with nurse
       - Paperwork submitted to physician for signature
     - N: Patient is given original form / GREEN copy of POLST form and instructed to keep document on refrigerator
       - Paperwork submitted to Medical Records to be scanned into Meditech and Epic
   - N: Form taken with pt. for review
     - Pt. name is added to list for follow up contact
     - RN verifies documentation is in pt. chart
New Advance Care Planning CPT billing codes

- **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. Approximant reimbursement: $86 Office, $80 Hospital (1.5 RVUs)

- **99498** (Add on Code) – each additional 30 minutes. Approximant reimbursement: $75 (1.4 RVUs)
Using the new codes

Who can use these codes:

- Physician
- Other qualified health professional

“Incident to” rules apply in the outpatient setting

- Provider performs an initial service, a team member helps deliver part of the service, with ongoing direct supervision and involvement of the provider.

CMS expects the physician to manage, participate and meaningfully contribute to the provisions of the service.

*Remember to work closely with your local billing compliance expert.
Documenting the conversation

- Patient/surrogate/family “given the opportunity to decline”
- Who was involved?
- Start and end time (total time?) (Required for coding/reimbursement purposes)
- What was discussed?
- Understanding of the illness by patient or guardian
- Spiritual factors
- Reflections on family/personal losses
- Why are they making the decision they are making?
- Was any advance directive offered/filled out?
- Follow-up

Is there a patient cost? Maybe

Depends on content of visit.

- Evaluation and Management Service (E/M):
  - ACP service may be billed on the same day as a stand-alone service.
  - Do not combine the time for each service. Clearly document the time dedicated to each service.
  - Copay required

- Annual Wellness Visit (Preventative Service)
  - Copay waived when provided during an AWV (Preventative Service), bill separately with modifier 33
  - Can only be waived once a year with the AWV.

Reference: CMS Manual Pub 100-2 Medicare Benefit Policy Manual; Chapter 15, sec. 280.5.1; Change Request 9271; December 22, 2015
New Advance Care Planning billing codes

Rural Health Clinics (RHC) and Federally Qualified Health Center (FQHC)

- The ACP is a stand-alone billable visit.
- If furnished on the same day as another billable visit at the RHC or FQHC, only one visit will be paid.
- All other RHC or FQHC program requirements must be met.
System factors

• How will you maintain this documentation in your electronic medical record?

• How will you assure that the documentation is easily available when and where needed in the future?

• Is the documentation done in a way that the next provider will know where to begin the next conversation?

• How do you manage the information to be sure that you have the most up-to-date information?

• How reliable are your processes?
Two important points

1. CMS has not defined all of the requirements of this codes
   - For CY 2016 CMS has not imposed a National Coverage Determination, nor has it set frequency limits
   - We could see a Local Coverage Determination by of local carrier NGS anytime

2. Please consult with and collaborate closely with your local billing compliance expert when using these codes
Questions and Answers
Resources

• For Patient Advance Care Planning Resources:
  - MaineHealth Learning Resource Center;
    http://www.mainehealthlearningcenter.org/topics/advanced-care-direc-tive/

• For information about CMS Payment rules go the Advance Care Planning section at:

• For Institute for Healthcare Improvement ACP resources go to:
  http://www.ihi.org/resources/Pages/AudioandVideo/WIHI MedicareReimbursedements.aspx
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