Becoming a “Conversation Ready” Organization

Session 6: CMS Reimbursement

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Jean Acevedo, LHRM, CPC, CHC, CENTC, AAPC Fellow is a compliance consultant with a particular expertise in chart audits, compliance and education. Her firm assists providers in implementing effective compliance programs, including meeting HIPAA and other regulatory requirements. She has also been an expert witness in civil litigation, Federal fraud cases and serves as an Investigative Consultant for the DOJ and FBI on coding and compliance issues.
Kate Lally, MD, FACP, Chief of Palliative Care, Care New England Health System, also serves as Medical Director at Integra Accountable Care Organization and Hospice Medical Director of Care New England VNA Hospice. At Care New England, she developed a system-wide comprehensive, interdisciplinary palliative care program that has expanded from the hospital into the community. Dr. Lally spearheaded Care New England's role as a Pioneer Sponsor in the Institute for Healthcare Improvement's Conversation Ready initiative and helped integrate Conversation Ready principles into the health system's palliative care program. She has served on the faculty of the IHI since 2013, and as a result has developed and led a number of on-line and in-person educational initiatives for both national and international audiences. As a result of her work, she has received numerous awards including “Top Doc” in RI monthly, Providence Business News “40 under 40” and was named an “Inspiring Hospice and Palliative Medicine Leader Under 40” by the American Academy of Hospice and Palliative Medicine. She is a graduate of Yale School of Medicine and did her post-graduate training in Internal Medicine at the Hospital of the University of Pennsylvania. She currently serves as an Assistant Professor of Medicine (Clinical) at the Warren Alpert Medical School of Brown University.
Today’s Agenda

- Brief Review of Webinar Series
- *Conversations and CMS Reimbursement*
- Closing
Disclosures

- Angela Zambeaux is an employee of the Institute for Healthcare Improvement
- Kate Lally is a contractor with the Institute for Healthcare Improvement
- Jean Acevedo is principle at Acevedo Consulting Incorporated
- None has any additional disclosures
Webinar Series Objectives

At the conclusion of this webinar series, participants will be able to:

- Articulate the vision and mission of The Conversation Project and different ways to approach end-of-life care conversations.
- Describe strategies that have worked for pioneer organizations to engage patients and families in discussions to understand what matters most to them at the end-of-life.
- Explain ideas for reliably stewarding this information across the health care system, including strategies for working with electronic health records.
- Teach ways to engage communities that help to activate the public in having these conversations in advance of a potential medical crisis.
- Test methods to help staff engage in this work personally before exemplifying it for their patients.
- Describe changes to CMS reimbursement policies for advanced care planning conversations.
Schedule of Calls

Session 1 – The Conversation Project: Reaching people where they live, work, and pray  
**Date:** Tuesday, May 23, 2017, 2:00 PM-3:00 PM Eastern Time

Session 2 – Engage: Moving from passive to proactive  
**Date:** Tuesday, June 6, 2017, 2:00 PM-3:00 PM Eastern Time

Session 3 – Steward: Achieving the reliability of allergy information  
**Date:** Tuesday, June 20, 2017, 2:00 PM-3:00 PM Eastern Time

Session 4 – Respect: Meeting people where they are as illness advances  
**Date:** Tuesday, July 11, 2016, 2:00 PM-3:00 PM Eastern Time

Session 5 – The Exemplify Principle in Action/ Connecting In a Culturally Respectful Manner  
**Date:** Tuesday, July 25, 2017, 2:00 PM-3:00 PM Eastern Time

Session 6 – CMS Reimbursement  
**Date:** Tuesday, August 8, 2017, 2:00 PM-3:00 PM Eastern Time
When to Have “The Conversation”

- **Early**
  - Coming of Age – 18 & 21

- **Often**
  - Before a Medical Crisis – 30, 40, 50, 60, 70

- **Major Life Event**
  - College, Marriage, Children, Divorce, Medicare, Death in the Family

- **Major Trip**

- **Newly Diagnosed with a Serious Illness**
Conversation Ready Principles

1. **Engage** with our patients and families to understand what matters most to them at the end of life.
2. **Steward** this information as reliably as we do allergy information.
3. **Respect** people’s wishes for care at the end of life by partnering to develop shared goals of care.
4. **Exemplify** this work in our own lives so that we understand the benefits and challenges.
5. **Connect** in a manner that is culturally and individually respectful of each patient.
Am I taking away hope? Does this patient trust me?

Do I trust this person? Does she recognize how this will affect my life?

Let’s talk about your illness

What are my options?

Emotions and Cognition

Words
Ms. Smith is 68 year-old woman with hypertension, hyperlipidemia, and history of smoking. She was recently diagnosed with emphysema/COPD. She’s coming in for a routine follow-up for her hypertension with her daughter.

You wonder…

- Does she need “a conversation”?
- At this stage, what’s the purpose?
- How do I begin?
- How do I document and bill for this?
Starting a conversation
In the absence of serious illness

- Key is to **normalize** these conversations
- Try starting it after family history
- “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?”
Conversation (continued)

- If they already have an advance directive (AD)
  - "May I see it? What does it say?"

- If they do not have an AD
  - "Can I offer you some tools to start thinking about it?"
    - Conversation Project Starter Kit
    - State durable power of attorney form

- Regardless of AD
  - "It is important that your surrogate know what your wishes are"
  - "A lot can happen beyond what is written in your AD"
  - A conversation can be more useful and informative than a document

- "Would it be ok if we talk about this at your next visit?"
  - Consider delegating follow up to another member of your team
Mrs. Smith: Serious Illness

- Since that visit, Ms. Smith did well for a few years, and then at age 71 developed a COPD exacerbation, which turned into a pneumonia with significant shortness of breath. She was admitted to the hospital and required an ICU stay for BiPAP. There was a disagreement between her children about what her wishes were.

- You wonder…
  - At this stage, what’s the purpose of “a conversation”?
  - How can I begin a conversation, document, and bill for it?
Starting a Conversation
When there is a serious illness

- Talk about “what matters most”
  - “Can you tell me your understanding of what happened in the hospital?”
  - “What was that like for you?”
  - “How are you doing now?”
  - If surrogate decision making was needed, how was that?
  - Identify the values that guided decision making, i.e. “what mattered most”
    - Goals, hopes
    - Fears, worries
    - Tradeoffs

- Try using an RN or MSW to get at “what matters most”
- Ensure >50 % of time dedicated to patient, family talking*

Suggested Language

- **Align around hope, ask for permission**
  - “We’re all hoping things go well, but as you’ve experienced, that doesn’t always happen. Would it be ok to talk about a plan in case things don’t go the way we’d like?”

- **Ask if anyone else needs to be present**
  - “Are the right family members/friends here?”

- **Explain potential emergencies, reflect on experiences**
  - “I am worried that you might get sick again and that they might consider putting you on the breathing machine again”

- **Align around respect**
  - “If you get sick again, it’s important to me that we’re certain we’re respecting your wishes.”
  - “Your family wasn’t sure what your wishes were. Give them the gift of knowing what you want.”
Ms. Smith did well for a few years after your last conversation and then about 2 months ago her illness seemed to progress. She was no longer able to walk around the block and now can only go to and from the bathroom before getting so short of breath that she has to stop and rest.

She’s now 75 years old and starts the visit by telling you how tired she is. It becomes clear that she doesn’t want to have to go back to the hospital and she really prefers to stay at home.

You wonder…
- At this stage, what’s the purpose of a conversation?
- How can I begin a conversation?
- How can I introduce palliative care, and help the patient make a transition to hospice when the time is right for her?
- How do I document and bill for the conversation?
“You have been in and out of the hospital quite a bit, how has that been?”

“How do you feel about your quality of life?”

“Given everything that has happened, what are you hoping for?”

“Unfortunately, we don’t have any more treatments to help your lungs get better.”

“It seems to me what matters most to you is to stay out of the hospital, control your symptoms at home and make the most of each day, and I think hospice is the best way of doing that.”

“Would it be ok if I had one of the hospice nurses come to your home and speak with you about what they can offer?”
Pause

Questions? Comments?
The Conversation Project:
Reimbursement for this Important Work

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Disclaimer

The information enclosed was current at the time it was presented. Medicare and other payer policies change frequently. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations.

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THIS PRESENTATION CONTAINS ABBREVIATED CODE DEFINITIONS, IS NOT A SUBSTITUTE FOR YOUR CODE BOOKS, AND DOES NOT INCLUDE ALL CHANGES YOU MAY NEED TO KNOW. TO CODE AND BILL ACCURATELY.
## Advance Care Planning (ACP)

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99497</td>
<td>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 care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate (Medicare allowable ~$83 OP ~$78 IP)</td>
</tr>
<tr>
<td>+99498</td>
<td>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 care professional; each additional 30 minutes (List separately in addition to code for primary procedure) (Medicare allowable ~$72 OP ~$742 IP)</td>
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“A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes have elapsed.”*
ACP – CPT® code Rationale

- Codes 99497 and 99498 have been added for advance care planning, which involves counseling and discussing advance directives.
- An advance directive is a document that appoints an agent and/or records the wishes of a patient pertaining to his or her medical treatment at a future time should he or she lack decisional capacity at that time.
- To report the code(s), the patient need not be present as the discussion can also be between a physician or qualified healthcare professional and a family member or surrogate. Because the purpose of the visit is the discussion, no active management of the problem(s) is undertaken during this time period.
ACP – CPT® code Rationale

- Completion of relevant legal forms is not required at the time of the discussion.
- As stated in the CPT® guidelines, certain E&M services performed on the same day may be reported separately.
  - CPT lists visit codes in all places of services that ACP may be reported with,
  - but excludes all critical care codes
ACP and Medical Necessity

“CPT code 99497 (and CPT code 99498 when applicable) would be reported when the described service is reasonable and necessary for the diagnosis or treatment CMS-1631-FC 241 of illness or injury.”

“For example, this could occur in conjunction with the management or treatment of a patient’s current condition, such as a 68 year old male with heart failure and diabetes on multiple medications seen by his physician for the E/M of these two diseases, including adjusting medications as appropriate. In addition to discussing the patient’s short-term treatment options, the patient may express interest in discussing long-term treatment options and planning, such as the possibility of a heart transplant if his congestive heart failure worsens and advance care planning including the patient’s desire for care and treatment if he suffers a health event that adversely affects his decision-making capacity.”
ACP and Medical Necessity

“In this case the physician would report a standard E/M code for the E/M service and one or both of the ACP codes depending upon the duration of the ACP service. However the ACP service as described in this example would not necessarily have to occur on the same day as the E/M service.

Since the services are by definition voluntary, Medicare beneficiaries may decline to receive them. When a beneficiary elects to receive ACP services, we encourage practitioners to notify the beneficiary that Part B cost sharing will apply as it does for other physicians’ services except when ACP is furnished as part of the AWV.

We plan to monitor utilization of the new CPT codes over time to ensure that they are used appropriately.”
Who can provide ACP?

“\[emphasis added\]

We note that the CPT code descriptors describe the services as furnished by physicians or other qualified health professionals, which for Medicare purposes is consistent with allowing these codes to be billed by the physicians and NPPs whose scope of practice and Medicare benefit category include the services described by the CPT codes and who are authorized to independently bill Medicare for those services.

Therefore only these practitioners may report CPT codes 99497 or 99498.

Not limited to any particular physician specialty.
Who can provide ACP?

- We note that as a physicians’ service, “incident to” rules apply when these services are furnished incident to the services of the billing practitioner, including a minimum of direct supervision. We agree with commenters that advance care planning as described by the proposed CPT codes is primarily the provenance of patients and physicians. Accordingly *we expect the billing physician or NPP to manage, participate and meaningfully contribute to the provision of the services, in addition to providing a minimum of direct supervision*. We also note that the usual PFS payment rules regarding “incident to” services apply, so that *all applicable state law and scope of practice requirements must be met* in order to bill ACP services. [emphasis added]
Who can provide ACP?

“…we believe the services described by CPT codes 99497 and 99498 are appropriately provided by physicians or using a team-based approach where ACP is provided by physicians, non-physician practitioners and other staff under the order and medical management of the beneficiary’s treating physician.

We also note that the CPT code descriptors describe the services as furnished by physicians or other qualified health professionals, which for Medicare purposes, is consistent with allowing these codes to be billed by the physicians and NPPs whose scope of practice and Medicare benefit category include the services described by the CPT codes and who are authorized to independently bill Medicare for those services.

Therefore only these practitioners may report CPT codes 99497 or 99498, and “incident to” rules apply when these services are provided incident to the services of the billing practitioner under a minimum of direct supervision.
Who can provide ACP?

- “We agree with commenters that advance care planning as described by the new CPT codes is primarily the provenance of patients and physicians. Accordingly we expect the billing physician or NPP, in addition to providing a minimum of direct supervision, to manage, participate and meaningfully contribute to the provision of the services. Also, we note that PFS payment rules apply when ACP is furnished incident to other physicians’ services, including where applicable, that state law and scope of practice must be met.

- “Since the ACP services are by definition voluntary, we believe Medicare beneficiaries should be given a clear opportunity to decline to receive them.

- “We note that beneficiaries may receive assistance for completing legal documents from other non-clinical assisters outside the scope of the Medicare program. Nothing in this final rule with comment period prohibits beneficiaries from seeking independent counseling from other individuals outside the Medicare program – either in addition to, or separately from, their physician or NPP.”
ACP with an Annual Wellness Visit

- CMS is also including voluntary ACP as an optional element of the AWV.
- ACP services furnished on the same day and by the same provider as an AWV are considered a preventive service.
  - Therefore, the deductible and coinsurance are not applied to the codes used to report ACP services when performed as part of an AWV.
  - Additionally, when ACP services are furnished on the same day and by the same provider as an AWV, they are reimbursed under the MPFSDB rates.
ACP with an Annual Wellness Visit

- When ACP services are provided as a part of an AWV, practitioners should report CPT code 99497 for the ACP services in addition to either of the AWV codes G0438 and code G0439
  - Plus add-on code 99498 for each additional 30 minutes, if applicable.
  - A minimum of 46 minutes documented as being spent in ACP
- When voluntary ACP services are furnished as a part of an AWV, the coinsurance and deductible do not apply for ACP.
  - Append modifier -33 to the ACP code(s)
- The deductible and coinsurance do apply when ACP is not furnished as part of a covered AWV.
Diagnosis Coding and ACP

- No specific diagnosis is required for the ACP codes to be billed.
- It would be appropriate to report a condition for which you are counseling the beneficiary,
- Or a well exam diagnosis when furnished as part of the Medicare Annual Wellness Visit
ACP Services Guidelines

- There are no limits on the number of times ACP can be reported for a given beneficiary in a given time period.
  - When the service is billed multiple times for a given beneficiary, Medicare/other payers would expect to see a documented change in the beneficiary’s health status and/or wishes regarding his or her end-of-life care.

- There are no place of service limitations on the ACP codes.

- Only physicians and NPPs may report CPT codes 99497 or 99498.

- If the beneficiary is not present, you should document that the beneficiary is impaired and unable to participate effectively and that ACP was instead conducted face-to-face with family or other legal surrogate(s).

- ACP services are voluntary, Medicare beneficiaries (or their legal proxies when applicable) should be given a clear opportunity to decline to receive ACP services.

- The beneficiary should be notified that Part B cost sharing will apply as it does for other physicians’ services.
ACP Services Guidelines

- Submit the code representing the amount of time actually spent performing the service.
- Document the specific time in the patient’s medical records.
  - Minimum of 16 minutes for 99497
  - Minimum of 46 minutes for 99497 + 99498
- Documentation of time spent may be start and stop times or total time spent performing the service
- Be clear there was a face-to-face encounter with the patient, family member or other caregiver/surrogate.
ACP with E&M Code Billing: Examples

**Complexity:** The (physician) (nurse practitioner) performs an established patient office visit based on the E&M components of detailed history, detailed exam, & moderate complexity of MDM and 30 minutes in ACP – Bill codes 99214 -25 & 99497

**Time-Based:** The nurse practitioner spends >50% of 75 minutes (new home visit) in C/CC face-to-face with the patient and an additional 10 minutes in ACP – Bill only 99345
ACP in Summary

- Two CPT time-based codes
  - 99497 for the 1st 30 minutes
    - 16 or more minutes face-to-face
  - 99498 for each additional 30 minutes
  - Only Face-to-face service time counts
  - May be reported in addition to other visit codes as ACP does not include any treatment or medical management

- May be provided by a physician or other qualified health care professional
  - Nurse practitioner, physician assistant, clinical nurse specialist
  - If provided by auxiliary office staff, all incident-to requirements must be met
  - The service must be medically necessary.
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