Patricia Bomba, MD, FACP
Vice President and Medical Director, Geriatrics, Excellus BlueCross BlueShield
Dr. Bomba is a member of the Medical Society of the State of New York Ethics Committee and the committee that wrote Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. She will serve on the new National Academy of Medicine Roundtable on Quality of Care for People with Serious Illness. This article is the first in a series on current efforts to improve advance care planning nationally and in New York.

BACKGROUND
New York is ranked #1 in hospital deaths among seniors, the worst in the country. While five percent of Medicare beneficiaries die annually, Medicare payments in last year of life account for twenty five percent of all Medicare spending. Ten thousand Baby Boomers become Medicare eligible every day. The Institute of Healthcare Improvement and the Choosing Wisely campaign estimate thirty percent of health care is unnecessary or harmful; this estimate does not consider unwanted treatments, including life-sustaining treatment.

Most people near the end of life lack the capacity to make their own decisions about the treatment they wish to receive and avoid. Most patients will receive post-acute and long term care from physicians who do not know them. Advance care planning is essential to ensure that patients receive care that reflects their values, beliefs, goals for care and preferences for treatment they wish to receive and/or avoid.

Advance Care Planning is a communication process that involves learning about and considering the types of decisions that will need to be made at the time of an eventual life-ending situation or incapacity to make complex medical decisions and what the patient’s preferences would be regarding those decisions.

Discussions between the patient’s physician and other qualified health care professionals and the patient along with family members, health care agent or surrogates ahead of time, regarding these decisions and preferences, and preparation of an advance directive and medical orders when appropriate, increases the likelihood a patient will receive the care he or she prefers at the end of life.

Of people who indicate end-of-life care preferences, most choose care focused on alleviating pain and suffering. However, because the default mode is acute care and hospitalization in an emergency, advance care planning and medical orders like New York’s Medical Orders for Life-Sustaining Treatment (MOLST) are needed to ensure that these preferences are honored.

Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life was released in September 2014. The report found patients want time with their doctors to talk about end-of-life issues, and clinicians should receive the training for such discussions so they can provide quality end-of-life care consistent with their patients’ values and preferences.

In addition, frequent clinician–patient conversations about end-of-life values, beliefs, goals for care, and preferences are necessary to avoid unwanted treatment, particularly life-sustaining treatment. Clinicians need to initiate conversations about end-of-life care choices and work to ensure that shared

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Have We Improved Quality Of Care For People Near The End Of Life?

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(Continued on page 14)
Quality Of Care
(Continued from page 13)

medical decision making is well informed, based on adequate information and understanding.

Providing financial incentives for improved shared decision making and advance care planning that reduces the utilization of unnecessary medical services and those not consistent with a patient’s goals for care is among the key recommendations of Dying in America.

Effective January 1, 2016, two new CPT codes, 99497 and 99498, were approved by the Center for Medicare and Medicaid Services (CMS) to reimburse health care professionals for providing advance care planning services to Medicare and Medicaid members.

TIME FOR A STATUS UPDATE
To assess progress since the release of the Dying in America report in September 2014, and to inform the work of a new Roundtable on Quality of Care for People with Serious Illness, the National Academy of Medicine is conducting a nationwide survey to track improvements over the past 18 months, discover barriers that have prevented progress, and better understand current areas of need.

Your feedback will help the new roundtable shape its work over the next three years. Please tell the National Academy about your experiences, and encourage your friends and colleagues to take the survey as well.

For more information about the roundtable, contact Laurie Graig at lgraig@nas.edu.

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In this series, sponsored by the National Academy of Medicine, hear about various aspects of end of life care from the perspective of experts in the field. Topics include palliative care, interdisciplinary teamwork, clinician-patient communication and advance care planning, and policies and payment systems for care near the end of life.

Individuals can take control of the quality of their life at the end of life. They should choose how they want to live at the end of their life, who they trust to make decisions if they lose the ability to do so, and have a conversation with their loved ones. Doctors should help initiate discussions with their patients about such decisions.

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NEW YORK’S COMMUNITY APPROACH TO ADVANCE CARE PLANNING, A KEY PILLAR OF PALLIATIVE CARE

A recent article Lessons Learned from Dying in America: Improving Care at the End of Life reviews the lessons learned from the development and implementation of New York’s community approach to advance care planning (ACP) as a wellness initiative and the key components of two complementary programs: Community Conversations on Compassionate Care (CCCC) and Medical Orders for Life-Sustaining Treatment (MOLST).

CCCC is an advance care planning program designed to motivate all adults 18 years of age and older, as well as emancipated minors, to start advance care planning discussions that clarify personal values and beliefs; choose the right health care agent who will act as their spokesperson; and complete a health care proxy. CCCC combines storytelling and “Five Easy Steps” that focus on the individual’s behavioral readiness to complete a health care proxy. CCCC encourages completion of a health care proxy when healthy, as well as review and update the advance directive routinely along the health-illness continuum from wellness until end of life.

MOLST is a clinical process that emphasizes decision-making by patients and shared medical decision-making between health care professionals and patients who are seriously ill or frail, for whom their physician would not be surprised if they died within the next year. The result is a set of medical orders that reflect the patient’s preference for life-sustaining treatment they wish to receive or avoid. Under current New York State Public Health Law (NYSPHL), only licensed physicians can sign a medical order to withhold and/or withdraw life-sustaining treatment, including cardiorespiratory resuscitation.

Thus, only licensed physicians can sign a MOLST form as well as review and renew MOLST orders. MOLST is approved for use and must be followed by all providers in all clinical multiple settings including the community. MOLST is the only medical order form approved under NYSPHL that EMS can follow both DNR and DNI orders in the community. MOLST is New York’s nationally-endorsed Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program; see POLST.org. (www.POLST.org)

Development, implementation, outcomes, lessons learned and sustainability of the CCCC and MOLST programs highlight the success of a healthcare and community collaborative initiative focused on improving care at the end of life. Community data support the value of implementing the CCCC and New York’s MOLST throughout the state.

NEW CPT CODES FOR ADVANCE CARE PLANNING AND MOLST

Effective January 1, 2016, two new CPT codes, 99497 and 99498, were approved by the Center for Medicare and Medicaid Services (CMS) to reimburse health care professionals for providing advance care planning services to Medicare and Medicaid members. This approval affirms advance care planning is an integral component of the practice of medicine and overcomes a key barrier.

CPT codes 99497 and 99498 are used to report face-to-face service between a physician or other qualified health care professional and a patient, family member or surrogate in counseling and discussing advance directives, with or without completing legal forms. These are time-based codes and no active management of the medical problem(s) is undertaken during the time period reported.

Other qualified health professionals are Non-Physician Practitioners who are enrolled in the Medicare program and are eligible to receive Medicare payments provided to Medicare beneficiaries, for example, nurse practitioners, physician assistants, and licensed clinical social workers.

CPT code 99497 is used for the explanation and discussion of advance directives, with or without completion of forms. It includes the first 30 minutes of face-to-face time with the patient, family member(s), and/or surrogate. As with other procedure codes, it must pass the mid-point; thus the visit must be at least
16 up to and including 45 minutes before an additional code may be billed.

The 99497 procedure code is used when the physician or other qualified health care professional sees a 68 year old male with heart failure and diabetes on multiple medications with his wife to discuss advance care planning. During the visit, the physician or the qualified health care professional:

- Performs a cognitive evaluation to determine patient’s capacity to understand risks, benefits, alternatives to advance care planning choices
- Reviews advance care planning tools (advance directives and MOLST)
- Gives patient an opportunity to review a blank advance directive & MOLST, if appropriate
- Discusses patient’s values and goals for treatment
- As appropriate to patient’s condition (health status and prognosis), discusses palliative care options, ways to avoid hospital readmission, the patient’s desire for care if he suffers a health event if capacity is lost (including a discussion of the role of the health care agent if capacity is lost) and answers the patient’s and family member(s), health care agent or surrogate’s questions
- Completes and signs the forms or takes home to review and sign at a future appointment

The 99498 procedure code is billed when an extended period of time is needed for a longer visit. This is appropriate when additional time is needed for discussion of the patient's condition, prognosis, options and resolve conflicts due to the presence of a new, unexpected, or sudden illness; a complicated family dynamic; disagreement or controversy over advance directive or shared decision making for an adult who is not able to make their own decision.

For example, a 68-year-old male with heart failure and diabetes on multiple medications, who was recently discharged from the intensive care unit, is seen with his wife to discuss advance care planning. He has had multiple unplanned hospitalizations and is becoming increasingly frail. Each additional 30 minutes is billed. Use 99498 in conjunction with 99497; list each code separately. In this case, 16-45 additional minutes is billed for a total of 46 – 75 minutes. Do not report 99497 and 99498 on the same day of service as critical care codes: 99291, 99292; neonatal/pediatric critical care: 99468 – 99476; or initial & continuing intensive care: 99477-99480.

Individuals who need more assistance with advance care planning include persons with end-stage chronic illness (e.g. CHF, COPD, renal disease, HIV/AIDS), as well as individuals facing emergent and high-risk surgery, or those who experience a sudden event (e.g. TIA) and are at risk of repeated episodes. Vulnerable individuals with early dementia or mental illness and those who rely on guardians or parents to make decisions such as persons with developmental disabilities who lack capacity and minor patients will require more help.

**FREQUENTLY ASKED QUESTIONS**

**Question:** Who can receive and where can ACP services be rendered?

**Answer:** All Medicare and Medicaid beneficiaries can receive these services. All Excellus BlueCross BlueShield members in all lines of business (LOBs) in all clinical settings can receive these services. For all other commercial insurers, check with your carrier.

**Question:** Can ACP be part of a Regular Office Visit?

**Answer:** Yes, if active management of the clinical problem(s) and advance care planning both occur on the same day. The active management and advance care planning cannot occur during the same time period reported. For advance care planning, additional CPT codes can be reported, if the service is provided. Add modifier 25. Documentation of the content of the ACP discussion is critical, including amount of time spent for each service.

**Question:** Can ACP be part of the CMS Annual Wellness Visit (AWV)?

**Answer:** Yes, advance care planning is an optional element, at the beneficiary’s discretion. The AWV provides the beneficiary the opportunity to access advance care planning services should they elect to do so. Part B cost sharing does not apply when advance care planning is part of the AWV.

**Question:** Can ACP be part of Preventive Medicine Visits?

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**Question:** Can telemedicine be used to provide and bill for advance care planning services?

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For more information, listen to the “New CPT Codes for Advance Care Planning and MOLST Discussions” webinar. 9

**COMING SOON**

As part of MSSNY’s Advocacy Matters series, MSSNY will host a webinar on MOLST and eMOLST on Tuesday, May 10, from 12:30pm to 1:30pm.

Future articles in the series will focus on 1) New York’s eMOLST; 2) advance care planning tools and resources to help physicians with shared medical decision making and practice transformation; 3) additional topics as recommended by MSSNY members to assist with practice transformation for advance care planning and MOLST.

**ENDNOTES**

1 In Sickness and in Health, Where States are No.1 Wall Street Journal, June 9, 2014
4  www.ihi.org/Pages/default.aspx
5  www.choosingwisely.org/
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Quality Of Care

(Continued from page 13)

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