

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

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.^{1,2} While five percent of Medicare beneficiaries die annually, Medicare payments in last year of life account for twenty five percent of all Medicare spending.³ Ten thousand Baby Boomers become Medicare eligible every day. The Institute of Healthcare Improvement⁴ and the Choosing Wisely⁵ 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

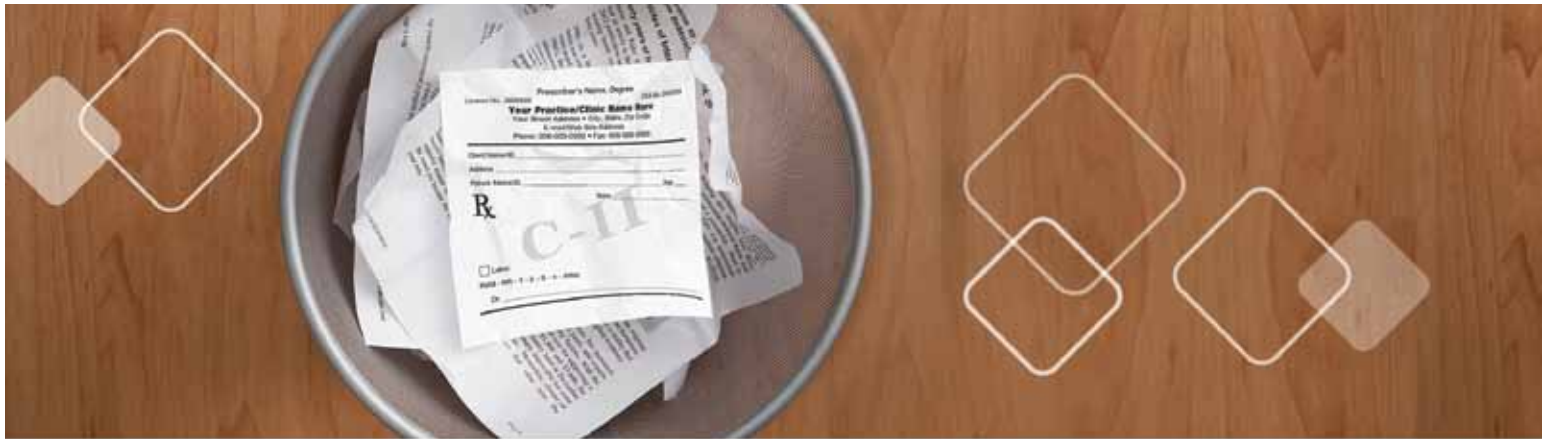
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Of people who indicate end-of-life care preferences, most choose care focused on alleviating pain and suffering. However, because the default mode is acute care and hospitalization in an emergency, advance care planning and medical orders like New 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*⁶ 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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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 discussion of the patient's goals for care 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 (NYSPL), 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

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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.

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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.

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Answer: *Yes*. The codes for Preventive Medicine Visits are 99381-99397. 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 the amount of time spent.

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- 4 www.ihl.org/Pages/default.aspx
- 5 www.choosingwisely.org/
- 6 www.nationalacademies.org/hmd/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx
- 7 [www.nationalacademies.org/hmd/~media/Files/Report%20Files/2014/EOL/Key%20Findings%20and%20Recommendations.pdf](http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2014/EOL/Key%20Findings%20and%20Recommendations.pdf)
- 8 Bomba, P.A., & Orem, K.G., (2015). Lessons learned from New York's community approach to advance care planning and MOLST. *Annals of Palliative Medicine*, 4(1), 10-21
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