ATTN: ALL PROVIDERS

End of Life Planning - Advanced Care Planning (ACP)

Advance Care Planning (ACP) is a process that enables individuals to make plans about their future health care. ACPs provide directives to healthcare professionals when a person is not in a position to either make and/or communicate their own healthcare choices. Advance directive means a written instrument, such as a living will or Durable Power of Attorney (DPOA) for health care, recognized under state law, and related to the provision of health care when the individual is incapacitated.

The Patient Self Determination Act of 1990 (PSDA) (42 USC Section 1395 (a)(1)(Q) and SSA 1866, Section 4206 (b)(1) of OBRA 90, 42 CFR 489.102) was passed by Congress in 1990 and became effective December 1, 1991 to require Medicare certified hospitals, skilled nursing homes, home health, hospice, and HMO to give patients information on state laws regarding advance directives such as living wills or DPOA. The PSDA was created to inform patients of their rights regarding decisions toward their own medical care; to ensure that these rights were communicated by the health care provider; and to provide a written summary of the patient's health care decision making rights on admission.

Providers have the responsibility to give patients information they need regarding decisions about medical interventions the patient wants when they are dying. On October 30, 2015, a final rule was issued authorizing **Medicare to pay providers** for consultation with patients on how they would like to be cared for as they are dying.
The Centers for Medicare and Medicaid Services (CMS) added CPT codes 99497-99498 to physician payment rules January 1, 2016 to discuss and document end-of-life choices; however these codes are not widely used by providers.

CPT Code	WRVU	2018 LA Medicare Area 99 F/S
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 care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	1.50	$ 78.75
99498- each additional 30 minutes (List separately in addition to code for primary procedure)	1.40	$ 73.76

Billing ACP codes includes discussion about the care the patient would want to receive if they become unable to speak for themselves 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 face-to-face with the patient, family members(s), and/or surrogate. (see sample forms at www.begintheconversation.org)

No specific diagnosis is required for the ACP codes to be billed. It would be appropriate to report a condition for which the provider is counseling a beneficiary, or a well exam diagnosis when furnished as part of the Medicare Annual Wellness Visit (AWV) (G0438 – G0439); sample form: https://www.acponline.org/system/files/documents/running_practice/payment_coding/medicare/hra.pdf)

There are no place-of-service (POS) limitations on the ACP codes. ACP services can be appropriately furnished in both facility and non-facility settings, and are not limited to particular provider specialties.

There are no limits on the number of times ACP can be reported for a given beneficiary in a given time period. However, when the service is billed multiple times by the same provider for a given beneficiary, CMS would expect to see a documented change in the beneficiary's health status and/or wishes regarding his or her end-of-life care.

Medicare **waives** both the coinsurance and the Medicare part B deductible for ACP (99497-99498) when it is provided on the same day as a covered Annual Wellness Visits (AWV) (G0438-G0439); furnished by the same provider as a covered AWV, and the APC code(s) are billed with modifier 33 (Preventive Services).
Sample forms:

https://www.aarp.org/caregiving/financial-legal/free-printable-advance-directives/

NOTE: The deductible and coinsurance **not waived** when ACP is provided without a covered AWV, i.e., if the AWV is billed with ACP and the AWV is denied, i.e., not covered, *for exceeding the once per year limit,* payment could still be made for the ACP service if it is indeed medically necessary; however in this instance the deductible and coinsurance **not waived**.

What is the next step to implement these codes in your office?

Know your patient population:

- Ask yourself: Would you be surprised if this patient died in the next year?
- Supplemented by objective criteria such as age, chronic conditions and recent hospitalizations, to identify patients with whom end-of-life issues should be discussed

Start the discussions with patients:

- Be direct, yet caring; truthful yet sustain spirit; use simple everyday language
- Aim to understand what outcomes the patients considers acceptable, and how changes in their health might change those values
- Involve substitute decision-makers such as family in the discussion, ensuring they understand the patients' wishes so they can make difficult calls regarding appropriate therapies when the time comes
- Explain the risks and benefits of life-sustaining therapies

Identify end of life goals:

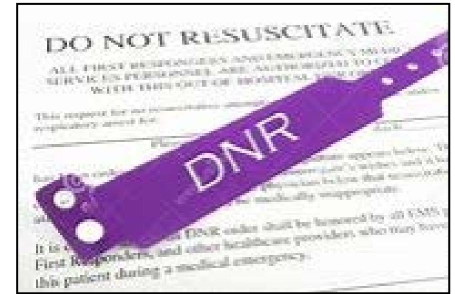
- Have patients establish any leeway they want granted to the substitute decision-makers in advance
- Explain the physician's role is to carry out the patients' wishes if it conflicts with that of substitute decision-makers

Develop a plan and discuss completing necessary forms as there are many types of Advance Directives.
The Begin the Conversation website (www.begintheconversation.org) offers state specific resources and forms, toolkits, and workbooks to assist providers and patients.

- Living wills or Durable Power of Attorney (DPOA)
    - A living will is a document designed to control certain future health care decisions only when a person becomes unable to make decisions and choices on their own. The person must also have a terminal illness (the patient cannot be cured) or permanent unconsciousness (often called a “persistent vegetative state”).
    - A durable power of attorney for health care is also called a health care power of attorney. It’s a legal document in which the patient names a person to be your proxy (agent) to make all your health care decisions if you become unable to do so.
- Advance Directive combined forms
    - A combination advance directive is a signed, witnessed (or notarized) document which contains specific written directions that are to be followed by a named agent. Since it is not possible to predict all circumstances that

may be faced in the future or to cover all possible interventions, specific directions may severely limit the discretion and flexibility that the agent needs and may restrict the agent's authority in a way the signer did not intend.

- Do Not Resuscitate (DNR)
  - In the hospital: A "Do Not Resuscitate" or DNR order means that if the patient stops breathing or their heart stops, nothing will be done to try to keep the patient alive. A DNR order allows natural death and is sometimes called an "Allow Natural Death" order.
  - Outside the hospital: Some states have an advance directive that's called a Do Not Attempt Resuscitation (DNAR) or special Do Not Resuscitate (DNR) order for use outside the hospital. The non-hospital DNR or DNAR is intended for Emergency Medical Service (EMS) teams, who answer 911 calls and are usually required to try to revive and prolong life in every way they can.



- Declaration of Mental Health Directive
  - Allows you to make decisions in advance about mental health treatment
- Organ donor card
  - Organ and tissue donation instructions can be included in your advance directive. Many states also provide organ donor cards or add notations to your driver's license.

Document the discussions and the resulting decisions

- Louisiana maintains a Living Will Declaration Registry.
  Patients can file an advance directive with the registry, then health care providers and loved ones may be able to find a copy of the patients directive in the event the patient is unable to provide one.
  Read more about the registry, including instructions on how to file an advance directive, at http://www.sos.la.gov/OurOffice/EndOfLifeRegistries/Pages/default.aspx.
- Louisiana Physician Orders for Scope of Treatment (LaPOST) form should be completed and signed by providers based on a patient's end of life preferences and medical indications. Forms are available via www.La-POST.org.

HIPAA PERMITS DISCLOSURE OF LaPOST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

LOUISIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT
(LaPOST)

FIRST follow these orders, **THEN** contact physician. This is a Physician Order Sheet based on the person's medical condition and wishes. Any Section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect. Please see www.La-POST.org for information regarding "what my cultural/religious heritage tells me about end of life care"

LAST NAME ____
FIRST/MIDDLE INITIAL ____
DATE OF BIRTH ____

PATIENT'S DIAGNOSIS OF LIFE LIMITING DISEASE AND IRREVERSIBLE CONDITION:

____

Check One — **A. CARDIOPULMONARY RESUSCITATION (CPR):** PERSON HAS NO PULSE AND IS NOT BREATHING
☐ CPR/Attempt Resuscitation (requires full treatment in section B)
☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)
When not in cardiopulmonary arrest, follow orders in **B, C, D** and **E.**

Check One — **B. MEDICAL INTERVENTIONS:** PERSON HAS PULSE OR IS BREATHING
☐ COMFORT MEASURES ONLY Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. *Patient prefers no transfer: EMS contact medical control to determine if transport indicated.*
☐ LIMITED ADDITIONAL INTERVENTIONS: Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubations, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care unit if possible.
☐ FULL TREATMENT: Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation. Transfer to hospital if indicated, Includes intensive care unit.
ADDITIONAL ORDERS: *(e.g. dialysis, etc.)*
____

Check One — **C. ANTIBIOTICS**
☐ No antibiotics. Use other measures to relieve symptoms.
☐ Use antibiotics if life can be prolonged.
☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal. (Benefit of treatment should outweigh burden of treatment)
ADDITIONAL ORDERS:
____

The administration of nutrition and hydration, whether orally or by invasive means, shall always occur except in the event another condition arises, which is life-limiting or irreversible in which the nutrition or hydration becomes a greater burden than benefit to Patient.

Check One in Each Column — **D. ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION:** **(Always offer food/fluids by mouth as tolerated)**
☐ No artificial nutrition by tube.
☐ Trial period of artificial nutrition by tube (Goal :____)
☐ Long-term artificial nutrition by tube. (If needed)
☐ IV fluids (Goal :____)
☐ No IV fluids
ADDITIONAL ORDERS:
____

Resources:

Advance Directives: Ensuring Compliance with CMS and TJC Presentation, 07/15/18

Just Ask: Discussing goals of care with patients in hospitals with serious illness, CMAJ, at
http://www.cmaj.ca/content/early/2013/07/15/cmaj.121274

CMS Advance Care Planning Fact Sheet: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

Commission on Law and Aging, Myths and Facts about Health Care Advance Directives:
www.americanbar.org/content/dam/aba/migrated/Commissions/myths_fact_hc_ad.authcheckdam.pdf

IHI, The Conversation Project: http://theconversationproject.org/
CMS, Frequently Asked Questions about Billing the Physician Fee Schedule for Advanced Care Planning Services:
www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

Begin the Conversation: http://www.begintheconversation.org/resources/?state=LA

GPO Access: www.gpoaccess.gov/cfr/index.html

Louisiana Advance Directive Planning for Important Healthcare Decisions:
http://www.caringinfo.org/files/public/ad/Louisiana.pdf

Louisiana End of Life Registry Programs: https://www.sos.la.gov/OurOffice/EndOfLifeRegistries/Pages/default.aspx

MEDTRON's Evaluation and Management (E&M) Information Packet:
https://www.medtronsoftware.com/User%20Guides/E&M_Resources/E&M_Information_Packet_General.pdf
(User ID and Password is required, contact Software Support)

Contact MEDTRON's Support Department for assistance or any questions via:
From **MED**PM or **MED**EHR Sign On screens, double click on 'support@medtronsoftware.com' to compose an email to the Software Support Dept.
-OR-
Phone: (985) 234-0599 (local)
(800) 978-0599 (toll free)
-OR-
Fax: (985) 234-0609