Palliative Care: Non Traditional Physician Services

Session 3
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Agenda

- Advance Care Planning
- Virtual visits and Telehealth
- Principal Care Management
- Cognitive Assessment

Newer Physician Service Codes

- Transitional Care Management
  - 2013
- Chronic Care Management
  - 2015
  - Enhanced in 2017, 2019
- Principal Care Management added in 2020
- Virtual Visits
  - 2019
- Telephone “visits”
  - 2020
- Cognitive Assessment
  - 2021

Advance Care Planning

Advance Care Planning Defined*

Advance care planning includes:

- Getting information on the types of life-sustaining treatments that are available.
- Deciding what types of treatment you would or would not want should you be diagnosed with a life-limiting illness.
- Sharing your personal values with your loved ones.
- Completing advance directives to put into writing what types of treatment you would or would not want – and who you chose to speak for you - should you be unable to speak for yourself.

**NHPCO – Advance Care Planning, Caring Info*

Advance Care Planning (ACP) - the Codes

CPT® Code	Description
99497 Medicare allowable ~$85 OP ~$79 IP	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
+99498 Medicare allowable ~$75 OP ~$74 IP	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)

Codes 99497 and 99498 are time-based codes with code 99497 reported for the first 30 minutes and add-on code 99498 reported for each additional 30 minutes but only if a total of more than 45 minutes is spent.

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.
- 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 but excludes all critical care codes

ACP – Who May Qualify

1. Individuals with end-stage chronic illness, such as congestive heart failure, renal disease, or acquired immune deficiency syndrome (AIDS);
2. individuals who, because of the timing of their illness or injury, have not been considered appropriate for ACP, such as those facing emergent and high-risk surgery, or those who experience a sudden event, such as a transient ischemic attack (TIA), and are at risk of repeated episodes;
3. individuals who have ACP needs beyond the more familiar decisions to withhold or withdraw life-sustaining treatment, such as those with early dementia or mental illness;
4. individuals who lack decision-making capacity (developmental disabilities) or authority (minors) and must rely on guardians or parents to make substitute decisions and plan for the inevitable.

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, a change in the beneficiary's health status and/or wishes regarding his or her end-of-life care should be documented.
- There are no place of service limitations on the ACP codes.
- Only physicians and NPPs may report CPT codes 99497 or 99498.
- CPT codes 99497 and 99498 can only be reported for time spent with the beneficiary, family members, and/or surrogate. 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 Documentation

Examples of appropriate documentation would include:

- an account of the discussion with the beneficiary (or family members and/or surrogate) regarding the voluntary nature of the encounter;
- documentation indicating the explanation of advance directives (along with completion of those forms, when performed);
- who was present; and
- the time spent in the face-to-face encounter.

Billing for ACP Services

- Time spent in ACP cannot also be counted towards time spent in C/CC during the same encounter.
- CPT codes 99497 and 99498 **may** be billed on the same day or a different day as most other E&M services. Modifier-25* should be appended to the E&M code when billed with an ACP code.
- CPT codes 99497 and 99498 **may not** be billed on the same date of service as certain critical care services including neonatal and pediatric critical care.
- 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.
- In Palliative Care, the usual Part B deductible and coinsurance apply

**Modifier -25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service*

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
    - Must have more than an additional 16 minutes for each unit of 99498 reported
  - 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
  - Not directly by a clinical social worker, at least not for a Medicare beneficiary.
  - The service must be medically necessary.

ACP During the COVID-19 PHE

- Advance Care Planning codes are on the current list of payable Telehealth services.
- Bill with modifier -95 when provided via telehealth
- Telehealth requirement updated 4/30/20 to allow audio only
- No requirement to do so, but best practice…
  - Document method of service delivery
    - “Patient unable to use audio/video application, discussion held via audio only telephone with……”
    - “Advance care planning discussion via (FaceTime) (Skype) (Zoom) (other)….with…..”

Virtual Check-In
Telephone E/M Visits
Telehealth.

For now…

"Traditional" telehealth remains as-is, but now we have...

- **Virtual check-ins** – A brief **phone call** to determine whether or not an in-person visit or other appropriate treatment is needed.
- **Telephone services -** A **phone call** to manage a patient's problem(s)/symptom(s).
  - Audio only telehealth
- **Telehealth visits:** A real-time interactive audio and video communication
  - Report with E&M codes

VIRTUAL VISITS

G2012 – Virtual Check-in Service

- G2012 - Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. [emphasis added]
- G2252 -….11-20 minutes
- Call/other communication must be initiated by the patient.
- New or Established patients during PHE
- Interaction only with the physician/QHP, not other clinical staff.
- Verbal consent by the patient initially and at least annually thereafter must be documented in the medical record.
- Requires permanent documentation of the encounter

Virtual Check-ins – Key Takeaways

- G2012/G2252: A brief phone call to determine next steps; does the patient need a visit?, etc.
- Does not include any actual patient management
- Virtual check-in services can be reported for new or established patients during the COVID-19 public health emergency

Virtual Check-in: New for 2021

- LCSWs, CPs, LPTs, OTRs, SLP can furnish the brief online assessment and management services as well as virtual check ins and remote evaluation services.
  - G2250: Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment
  - G2251: Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion

Telephone Services

PHE Approved – through Jan. 16, 2022

- The telephone E/M codes had been considered non-covered. Medicare now considers them covered and payable services and will be paid as 99212, 99213, 99214
- Physicians/NPPs use 99441, 99442, 99443:
  - Telephone evaluation and management service provided by a physician to a patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours…

Telephone Visits*

E&M visit via a telephone call by a Medicare provider who can bill an E&M code (physician, ARNP, CNS, PA, CRNA)

Telephone Evaluation and Management Services codes

- 99441: telephone evaluation and management service; 5-10 minutes
  - ~$46
- 99442: ….11-20 minutes
  - ~$76
- 99443: …21 or more minutes
  - ~$110

* Fees are National Medicare Allowable amounts

Telephone Call Takeaways

- Telephone Services
  - Must be managing a problem
  - For new or established patients during the PHE
  - Requires permanent documentation of the encounter
  - Clinical/office staff time is not calculated as part of the time for these services.
  - Do not report service time less than 5 minutes.
  - Do not bill if E/M provided within the previous 7 days nor leading to an E/M service within the next 24 hours…
  - Medicare deductible and co-insurance apply
  - Considered audio only telehealth during the PHE
    - Modifier 93 – for services rendered after Jan. 1, 2023

Telemedicine/Telehealth Services

Telehealth Rules and What You Need to Know Now

- These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits
  - Based on place of service (11 for example)
  - Append modifier 95
- Medicare coinsurance and deductible would generally apply to these services.
- Providers must continue to comply with state telehealth laws and regulations
  - Treating patients across state lines
  - Professional licensure
  - Scope of practice
  - Standards of care
  - Patient consent
  - Payment requirements for non-Medicare fee-for-service patients.

Clinical Scenario #1

- I’m a physician/ARNP. If I treat an established patient who is at home w/ audio-only phone, what code(s) can I report?
  - You would report the applicable telephone service based on the amount of time spent: 99441, 99442, 99443

Clinical Scenario #2

- As a palliative care nurse practitioner, I have a lot of Advanced Care Planning discussions. Now that I am unable to see most patients in person, how do I bill this service if the discussion is on the phone (audio only)? Via telehealth?
  - Advance Care Planning codes (99497-8) are on the list of approved telehealth services. When providing this discussion via telehealth, document as you would if the encounter had taken place in-person, and bill 99497 and, if appropriate, 99498.
  - If this is a telephone conversation with audio only with the patient and/or family, you would still report the ACP codes per CMS's 4/30/20 update.

Recap

All require Medical Necessity, Patient Consent & normal POS code

- **Virtual check-ins** – A brief **phone call** to determine whether or not an in-person visit or other appropriate treatment is needed. No actual patient management.
- **Telephone services -** A **phone call** to manage a patient's problem(s)/symptom(s). Time-based codes
  - Require modifier -95
- **Telehealth visits**: An E&M service provided via real-time interactive audio and video communication (some exceptions for audio only).

Principal Care Management

Care Management Services

- Non face-to-face service
- May be provided by the Physician, NPP or clinical staff*
  - Incident-to direct supervision criteria has been waived for CM when provided by clinical staff
  - 24/7 access for urgent clinical need is required
- Chronic Care Management - Only one physician/NPP can provide in a given month
- Principal Care Management – specialist(s) can provide for their disease-specific care

Development of Care Plan: G0506

- G0506: Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services, including assessment during the provision of a face-to-face service.
- When the provider billing and initiating CCM personally performs extensive assessment and care planning beyond the usual effort described by the E&M, AWV or IPPE code, can also bill G0506.
  - "Add on" code – no modifier required when billed with E/M code
- Can bill this once per patient (Per provider)
- Bill separately from the monthly PCM
  - Cannot count time spent in G0506 towards any other billed service
- Medicare allowable - ~$61 (national)

Principal Care Management 2020

- Principal Care Management (PCM)
  - "We have heard from a number of stakeholders, especially those in specialties that use the office/outpatient E/M code set to report the majority of their services, that there can be significant resources involved in care management for a single high risk disease or complex chronic condition that is not well accounted for in existing coding." CMS in final MPFS rule.
  - "We anticipate that in the majority of instances, PCM services will be billed when a single condition is of such complexity that it cannot be managed as effectively in the primary care setting and instead requires management by another, more specialized practitioner." CMS in final MPFS rule.

Care Management Services: PCM 2020

“We anticipate that many patients will have more than one complex chronic condition. If a clinician is providing PCM services for one complex chronic condition, management of the patient’s other conditions will continue to be managed by the primary care practitioner while the patient is receiving PCM services for a single complex condition. It is also possible that the patient could receive PCM services from more than one clinician if the patient experiences an exacerbation of more than one complex chronic condition simultaneously.”

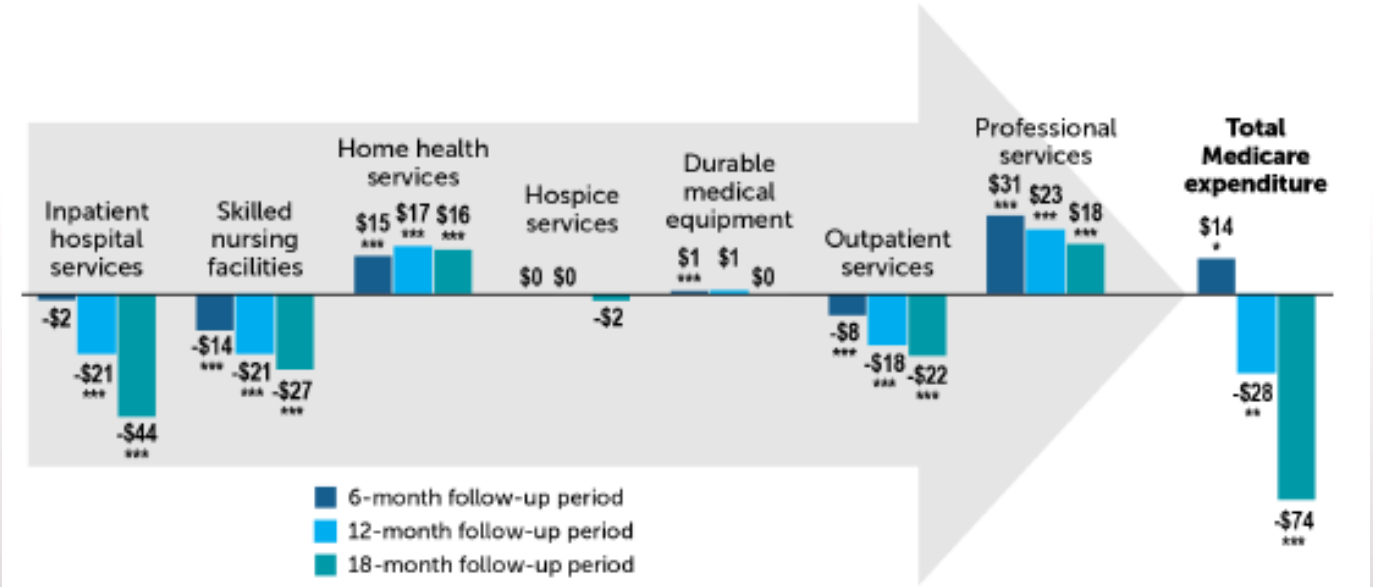
Principal Care Management 2020

- Principal Care Management (PCM) codes
  - **G2064** – PCM by physician or qualified health care professional; at least 30 minutes per calendar month.
  - **G2065** – PCM by clinical staff; at least 30 minutes per calendar month
  - Full descriptors are much like CCM

NOTE: effective 1/1/22 these HCPCS codes are replaced with CPT® codes 99424-99427

CCM Impact on Medicare Spending

Figure ES.2. Estimated PBPM impact of CCM on total expenditures and by expenditure category: 6-, 12-, and 18-month follow-up periods



"Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report" Mathematic Policy Research report to CMS, Nov. 2, 2017

Resources

- Connected Care: The Chronic Care Management Resource
  - https://go.cms.gov/ccm
- *Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report*" Mathematic Policy Research report to CMS, Nov. 2, 2017
- CMS's Chronic Conditions Data Warehouse
  - https://www2.ccwdata.org/web/guest/home/k.pdf

Cognitive Assessment and Care Plan Services

CPT® 99483

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CPT® 99483

- Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (eg, home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.

CMS on CPT® 99483

- If your patient shows signs of cognitive impairment during a routine visit, Medicare covers a separate visit to more thoroughly assess your patient's cognitive function and develop a care plan – use CPT code 99483 to bill for this service.
- Effective January 1, 2021, Medicare increased payment for these services to $282 (may be geographically adjusted) when provided in an office setting, added these services to the definition of primary care services in the Medicare Shared Savings Program, and permanently covered these services via telehealth. Use CPT code 99483 to bill for both in-person and telehealth services

CMS on CPT® 99483

How do I get started?

- Detecting cognitive impairment is a required element of Medicare's Annual Wellness Visit (AWV). You can also detect cognitive impairment as part of a routine visit through direct observation or by considering information from the patient, family, friends, caregivers, and others. You may also use a brief cognitive test and evaluate health disparities, chronic conditions, and other factors that contribute to increased risk of cognitive impairment.
- If you detect cognitive impairment at an AWV or other routine visit, you may perform a more detailed cognitive assessment and develop a care plan during a separate visit. This additional evaluation may be helpful to diagnose a person with dementia, such as Alzheimer's disease, and to identify treatable causes or co-occurring conditions such as depression or anxiety.

CMS on CPT® 99483

Who can perform this service?

Any provider who can perform an E/M service

- Physicians (MD and DO)
- Nurse practitioners
- Clinical nurse specialists
- Physician assistants

Where can I provider this service?

At any of these locations:

- Office or outpatient setting
- Private residence
- Care facility
- Rest home
- Via telehealth

CMS on CPT® 99483

What's included in this service?

- The cognitive assessment includes a detailed history and patient exam. There must be an independent historian for assessments and corresponding care plans provided under CPT code 99483.
  - An independent historian can be a parent, spouse, guardian, or other individual who provides patient history when a patient isn't able to provide complete or reliable medical history.
- Typically, you would spend 50 minutes face-to-face with the patient and independent historian to perform the following elements during the cognitive assessment: (next slide)

CMS on CPT® 99483

Included services…

- Examine the patient with a focus on observing cognition
- Record and review the patient's history, reports, and records
- Conduct a functional assessment of Basic and Instrumental Activities of Daily Living, including decision-making capacity
- Use standardized instruments for staging of dementia like the Functional Assessment Staging Test (FAST) and Clinical Dementia Rating (CDR)
- Reconcile and review for high-risk medications, if applicable

Included services…

- Use standardized screening instruments to evaluate for neuropsychiatric and behavioral symptoms, including depression and anxiety
- Conduct a safety evaluation for home and motor vehicle operation
- Identify social supports including how much caregivers know and are willing to provide care
- Address Advance Care Planning and any palliative care needs

Questions?

Note:

Coverage, payment and other aspects of this and other services related to the telehealth continue to evolve, so stay tuned!

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