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Palliative Care Billing

Codes and Coverage

Today's Presenter

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Disclosure

MI-CCSI, or the presenter, does not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

OBJECTIVES

At the conclusion of this presentation, the participant will be able to:

Identify the billing codes available when providing serious illness care

Terms and Acronyms for Billing and Coding

ACP – Advance Care Plan

CMS – Centers for Medicare & Medicaid Services

PDCM – Provider Delivered Care Management

SI – Serious Illness

SDoH – Social Determinants of Health

MWV – Medicare Wellness Visit

AGENDA

1	PDCM Codes
2	Track 2 CMS Codes - Advance Care Planning Codes

Palliative Care

2 Tracks for Serious Illness/Palliative Care Services

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Use of the PDCM Codes

Use of the CMS Codes

POLL
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Billing Codes for Palliative Care

Experience with Palliative Care

Identifying the Palliative Care Team

PDCM Codes for Palliative/Serious Illness

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PDCM Procedure Codes List

- G9001* - Coordinated Care Fee – Initial Assessment
- G9002* - Coordinated Care Fee – Maintenance or follow up (quantity billed >45 minutes)
- 98961* - Group Education 2–4 patients for 30 minutes (quantity billed)
- 98962* - Group Education 5–8 patients for 30 minutes (quantity billed)
- 98966* - Phone Services 5-10 minutes
- 98967* - Phone Services 11-20 minutes
- 98968* - Phone Services 21-30 minutes
- 99487* - Care Management Services 31-75 minutes per month (care coordination in medical neighborhood)
- 99489* - Care Management Services, every additional 30 minutes per month (care coordination in medical neighborhood)
- G9007* - Team Conference
- G9008* - Physician Coordinated Care Oversight Services (physician only service and can only be billed by the physician)
- S0257* - End of Life Counseling

** Priority Health Notation: PDCM codes applicable for the care manager are defined as QHPS: QHPs include RNs, certified NPs, PA-Cs, licensed Master social workers (LMSWs), psychologists (LLPs and PhDs.), certified diabetic educators (CDEs), Registered Dieticians, Masters'-trained nutritionists, clinical pharmacists and respiratory therapists.*

Palliative Care
Integration into PDCM Approach

1. Patient Identification – Identifying individuals with Serious Illness who would benefit from Care Management
   - Pre-screening (Review diagnosis codes, utilization reports (ER/Hospital, use of specialist)
   - Referral to Care Manager for SI conversation
2. Assessment and Care Planning – Conducting a comprehensive assessment and establishing a patient-centered plan of care
3. Monitoring – changes in the medical, social, and behavioral aspects that may impact the ACP
4. Closure/Transition – Patient condition or decision changes that warrant case closure to PDCM

Palliative Care
Using Data

Serious Illness List

		1	Bulbasaur
		2	Ivysaur
		3	Venusaur
		4	Charmander
		5	Charmeleon
		6	Charizard
		7	Squirtle
		8	Wartortle
		9	Blastoise
		10	Caterpie
		11	Metapod
		12	Butterfree
		13	Weedle
		14	Kakuna
		15	Beedrill
		16	Pidgey
		17	Pidgeotto
		18	Pidgeot
		19	Rattata
		20	Raticate
		21	Spearow
		22	Fearow
		23	Ekans
		24	Arbok
		25	Pikachu
		26	Raichu
		27	Sandshrew
		28	Sandslash
		29	Nidoran♀
		30	Nidorina
		31	Nidoqueen
		32	Nidoran♂
		33	Nidorino
		34	Nidoking
		35	Clefairy
		36	Clefable
		37	Vulpix
		38	Ninetales
		39	Jigglypuff
		40	Wigglytuff
		41	Zubat

		42	Golbat
		43	Oddish
		44	Gloom
		45	Vileplume
		46	Paras
		47	Parasect
		48	Venonat
		49	Venomoth
		50	Diglett
		51	Dugtrio
		52	Meowth
		53	Persian
		54	Psyduck
		55	Golduck
		56	Mankey
		57	Primeape
		58	Growlithe
		59	Arcanine
		60	Poliwag
		61	Poliwhirl
		62	Poliwrath
		63	Abra
		64	Kadabra
		65	Alakazam
		66	Machop
		67	Machoke
		68	Machamp
		69	Bellsprout
		70	Weepinbell
		71	Victreebel
		72	Tentacool
		73	Tentacruel
		74	Geodude
		75	Graveler
		76	Golem
		77	Ponyta
		78	Rapidash
		79	Slowpoke
		80	Slowbro
		81	Magnemite
		82	Magneton

		83	Farfetch'd
		84	Doduo
		85	Dodrio
		86	Seel
		87	Dewgong
		88	Grimer
		89	Muk
		90	Shellder
		91	Cloyster
		92	Gastly
		93	Haunter
		94	Gengar
		95	Onix
		96	Drowzee
		97	Hypno
		98	Krabby
		99	Kingler
		100	Voltorb
		101	Electrode
		102	Exeggcute
		103	Exeggutor
		104	Cubone
		105	Marowak
		106	Hitmonlee
		107	Hitmonchan
		108	Lickitung
		109	Koffing
		110	Weezing
		111	Rhyhorn
		112	Rhydon
		113	Chansey
		114	Tangela
		115	Kangaskhan
		116	Horsea
		117	Seadra
		118	Goldeen
		119	Seaking
		120	Staryu
		121	Starmie
		122	Mr. Mime
		123	Scyther

- The care manager has the office manager run a list to identify individuals that would benefit from a serious illness conversation.
- The list is completed, and the care manager reviews the list of patients with their providers.
- The providers carefully select patients and with that, agree to have the care manager outreach to these individuals to set up an office visit.
- The provider will complete an assessment and after that, if deemed appropriate, introduce the care manager to the patient to begin assessing the patient's values and wishes should the condition worsen.
- Has your team started to discuss which patients would benefit from a SI or Palliative Care discussion?
- What PDCM codes, if any, can be used for this activity?

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Patient Identification and Selection

- The PDCM begins reviewing the list and checking this with the patient schedule.
- The PDCM sees one of the patients identified by the provider is coming into the office this week for a post-discharge follow up visit.
- The PDCM notifies the provider.
- Together, they plan for the visit. The provider will review the diagnosis and prognosis with the patient, recommend the patient work with the PDCM, and if agreeable to the patient, and determined and appropriate, complete a warm hand-off to the care manager.

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Patient Identification Summary – Billable Codes

Determine Criteria	Review potential candidates with the treating provider
• Non-billable • PO/Team input and decision	• Non-billable • Verify diagnosis and prognosis have been discussed • Warm handoff

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Case Study: Patient Presents to the Clinic

- Winnie is following up in the clinic after an admission to the hospital for her heart failure.
- In the last 12 months she's been in ER 3x, admitted twice, and her disease trajectory is stage 4 heart failure. She is not a candidate for LVAD or a heart transplant.
- During the visit, Winnie's provider reviews her concerns for Winnie and inquires on Winnie's understanding of her prognosis.
- The provider shares treatment options are limited, and would like to know, should the heart failure worsen, how she, as Winnie's provider, can line up care that is most important to Winnie.
- **What PDCM code(s) could be used for this discussion with the provider?**

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Patient Enrollment

- The plan goes as anticipated, and the PDCM, **with permission** from the patient, shares the services available through PDCM services.
- The PDCM **inquires on the patient's interest**. The **patient agrees** to review the services and based on the conversation, the PDCM begins the first step of having a serious illness conversation by asking:

"Thank you for taking the time to speak with me today. On our next call/visit, I would like to discuss how our team could make sure you have the best care possible. To do this it would be good to talk about what is happening with your health and what things are important to you. Is that okay?"

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Case Study: Visit with Winnie

- Winnie is seen by the provider. They discuss the diagnosis and prognosis. The provider shares with Winnie the role of the PDCM, and does a warm hand-off to the PDCM.
- The PDCM, using the **Serious Illness guide**, identifies **Winnie's values**, begins an assessment, and starts creating a **care plan with Winnie**. This includes thoughts from Winnie regarding what her wishes are should her disease progress.
- **Which PDCM code(s) can be used for this visit?**

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Case Study: Patient Decision Possibilities

1. Winnie chooses no services and does not want to complete an ACP at this time.
    - **What now – what can be billed?**
2. The patient works with the Care Manager to create an ACP but is not interested in ongoing PDCM services at this time.
    - **What can be billed?**
3. The patient agrees to PDCM services. The Care Manager and Winnie review the ACP and schedule another appointment to finish the assessment. Enrollment into PDCM
    - **What can be billed?**

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G9001 Comprehensive Assessment

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Use for Managing Serious Illness and Palliative Care

Comprehensive assessment to support palliative care

1. Biomedical status and needs
    - Pain management, symptom management, constipation, sleep, ect.
2. Psychosocial status and needs
    - Financial concerns and preparation
    - Support system
    - Other SDOH needs identified during the SDOH Screening
3. Behavioral status and needs
    - Diagnosis, symptom management, medications, treatment
4. Establishing a plan of care
    - Provider, patient, and care management input and agreement

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Case Study: Assessment

- Winnie comes into the office to complete the comprehensive assessment with the Care Manager.
- The Care Manager and Winnie continue the Serious Illness conversation, and together review the ACP document.
- Winnie is going to review the ACP with her daughters and ex-husband to make sure they understand her wishes and agrees to bring the completed document back into the practice at her next visit.
- **What can be billed?**

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Periodic Monitoring Serious Illness and Palliative Care

1. Follow up with the patient to include a review of the plan of care
    - Change in diagnosis/prognosis
    - Medication management
    - Symptom management
    - Review of psychosocial values and needs (support system)
    - Care transitions follow-up and monitoring (hospital/ER use)
    - Determine need for different level of care
    - Review of financial/social planning needs
    - Review of behavioral care (screening) and needs
2. Follow up – Care Coordination
    - Team members
    - Medical neighborhood
    - SDOH/Community services

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Case Study: Monitoring into PDCM

- The Care Manager telephones Winnie to see how she is doing overall and address any questions from their last visit.
- Winnie shares she is doing “o.k.” nothing new except having less energy and more difficulty caring out day to day activities. She did review the ACP with her daughter and ex-husband, and together filled out the ACP.
- She has the form completed and will bring it in next week at her scheduled visit.
- The Care Manager updates the provider to discuss next steps.
- **What can be billed?**

Palliative Care
Case Closure

1. Agreement with the provider
    - Review patient status and reason for case closure
    - If applicable agreement from the provider to coordinate care with others
2. Agreement and notification to the patient
    - Communicating the plan of care and transition
    - Communicating the contacts and information needed for ongoing management
3. Provider care coordination
    - Outreach to medical neighborhood
4. Care team care coordination
    - Coordination of care with medical neighborhood, SDOH/Community Services/Specialist/Hospice

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Case Study: Closure for PDCM Services

Winnie comes into the office with her completed ACP.

- Winnie is brought in by a wheelchair by her daughter, who asks to attend the visit with the provider with her mother. Winnie provides permission for this.

- The Care Manager and Winnie continue the Serious Illness conversation, and together review the ACP document. Winnie shares she is no longer able to do minimal activities, is no longer able to prepare meals or bath herself. Her daughter is quite distraught and doesn't know what to do. She works full-time and isn't able to take time off from work to attend to Winnie's needs.

- After a very challenging and difficult conversation with the provider, Winnie states, "I'm ready to meet my father in heaven. I just don't have the energy anymore to live life how I want to. " With additional conversation and clarifying Winnie's wishes, the decision is to enroll Winnie into Hospice care. The provider reviews this with the PDCM.

- The PDCM arranges the referral and provides a handoff to the nurse who will be in charge of Winnie's care with the Hospice agency. The Care Manager will provide the information to Winnie and her daughter, at the next check-in to make sure the services are in place, the Care Manager plans to close the case to her services.
- **What can be billed?**

Track 2 CMS Codes
Advance Care Planning Codes

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CMS Provider Codes: Advance Care Planning

CPT Codes & Descriptors CPT Codes Billing Code Descriptors

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

99498 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)

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CMS Provider Codes: 99497 & 99498

BILLING & PAYMENT

If you bill this service more than once, document the change in the patient's health status and/or wishes about their end-of-life care. There's no **limit** on the number of times you can report ACP for a patient.

You can offer ACP services in **facility and non-facility settings**.

When a patient gets ACP services outside the MWVs, we **encourage** you to tell the patient Part B cost sharing applies as it does for other physicians' services.

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Medicare Learning Network

Palliative Care

CMS Provider Codes: 99497 & 99498

CODING

Hospitals, physicians or non-physician practitioners (NPP) may bill ACP services if the practice scope and Medicare benefit category include the services described below.

CPT Codes & Descriptors

CPT Codes	Billing Code Descriptors
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
99498	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)

NOTE: There are no limits on the number of times you can report ACP for a given patient in a given time period.

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Waiving the ACP Coinsurance Part B Deductible

BILLING

Medicare waives the ACP coinsurance and the Part B deductible when the ACP is:

- Delivered on the same day as a covered MWV (HCPCS codes G0438 or G0439)
- Offered by the same provider as a covered MWV
- Billed with modifier –33 (Preventive Services)

If Medicare denies the MWV for exceeding the once-per-year limit, Medicare can still make the ACP payment as a separate Medicare Part B medically necessary service.

In that case, Medicare applies the deductible and coinsurance to the ACP service.

NOTE: Critical Access Hospitals (CAHs) may bill ACP services using type of bill 85X with revenue codes 96X, 97X, and 98X. Medicare bases the CAH Method II payment on the lesser of the actual charge or the facility-specific Medicare PFS.

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Who Can Bill for CMS?

- Non-Physician Practitioner Covered Recipient
- Health care providers who practice either in collaboration with or under the supervision of a physician, including physician assistants, nurse practitioners, and clinical nurse specialists, are referred to as non-physician practitioners (NPPs).

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Q & A

Care Coordination

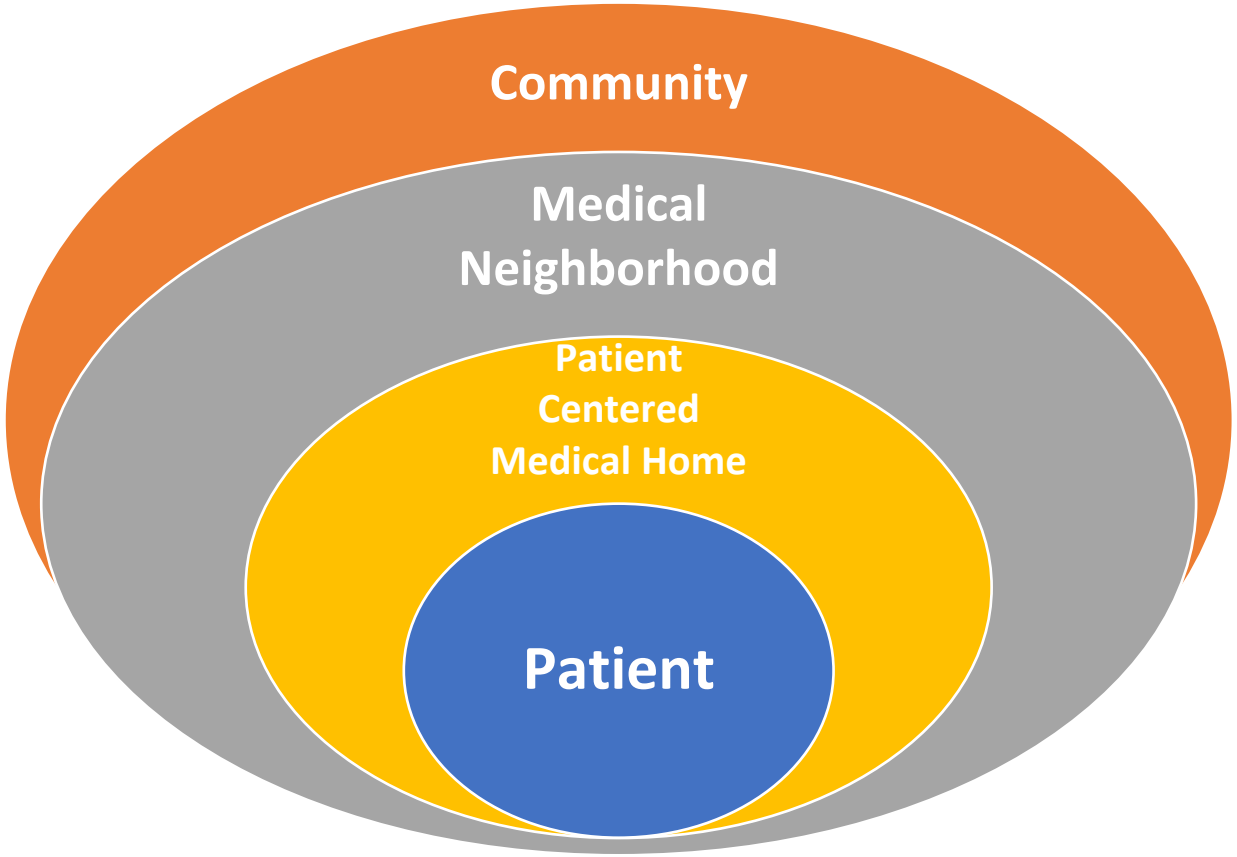
Serious Illness

Objective: **Identify care coordination needs for the patient with serious illness**

Care Coordination

Team-Based Approach for Serious Illness

Discussion:
Who's on the team?



Consider:
Who will be the lead with the patient
Coordinate patient equipment, supplies
Keep providers apprised and coordinated

Activity

Care Coordination Considerations

Roles	Provider	Care Manager	Medical Assistant	Triage Nurse	Specialist Cardiac, etc	Specialist palliative	
	Communicate with patient on status	Coordinate supplies, equipment					

Breakout

Transitioning to care coordination

Key Actions – What needs to happen on you teams

- Defining roles and responsibilities – PCMH, Medical neighborhood, SDOH
- Determining who will be the care coordinator of all team members

Where do your teams go from here to:

1. Address any gaps in care needs
2. Establish agreement and means of communications
3. Ensuring patients do not fall through the cracks,
4. What else

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Thank You

Contacts

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