Palliative Care Billing

Codes and Coverage

Today's Presenter

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Center for Clinical Systems Improvement

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

IPPE – Initial Preventative Physical Exam

AGENDA

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

Before we get started

- Pull out the PDCM Code review tool
- Pull out the MLN from CMS for Advance Care Planning
- Create a workflow for the decisions

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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.*

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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

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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 pertinent to serious illness status
    - Pain management, symptom management, constipation, sleep, ect.
2. Psychosocial status and needs pertinent to serious illness status
    - Financial concerns and preparation
    - Support system
    - Other SDOH needs identified during the SDOH Screening
3. Behavioral status and needs pertinent to serious illness status
    - Diagnosis, symptom management, medications, treatment
4. Establishing a plan of care based on values explored in the serious illness conversation
    - 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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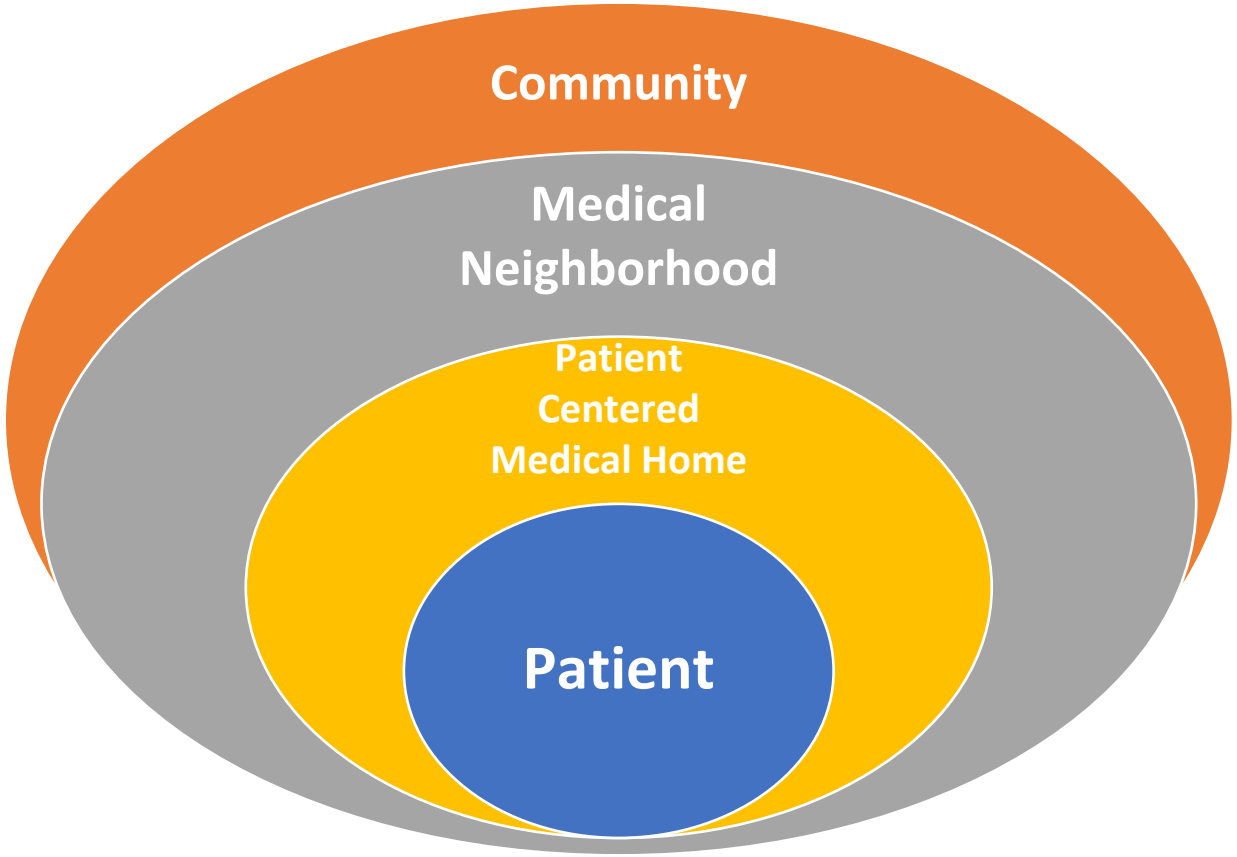
Periodic Monitoring Serious Illness and Palliative Care

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

Care Coordination

Team-Based Approach for Serious Illness

Discussion:
Who's on the team?



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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?**

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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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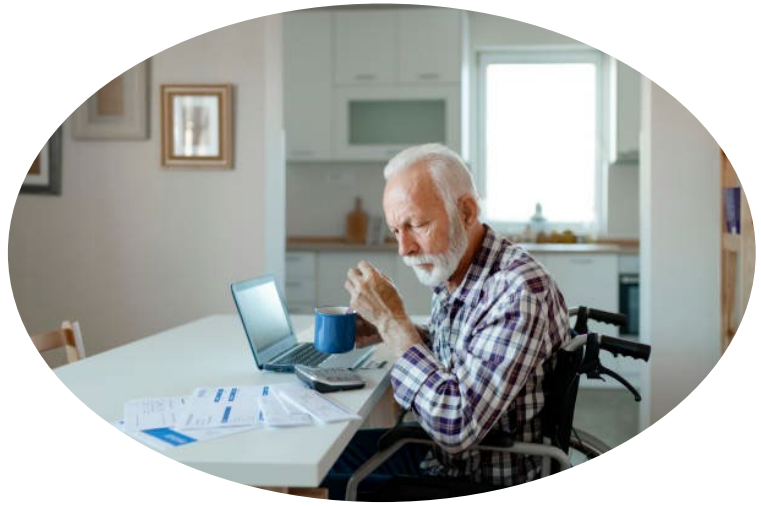
CMS Provider Codes: Advance Care Planning

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)



Note: A unit of time is billable when the midpoint of the allowable unit of time passes. See Table 2 for more information.

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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

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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.

Palliative Care
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).

Diagnosis

- Report the condition you discuss with the patient using an ICD-10-CM code. This code shows an administrative exam or an exam diagnosis when the ACP services are part of the AWV or IPPE. You don’t need to report a specific diagnosis to bill ACP.

Documentation Requirements

Documentation Requirements

You must document your ACP discussion with a patient, family member, caregiver, or surrogate. In your documentation, include:

- The voluntary nature of the visit
- The explanation of advance directives
- Who was present
- The time spent discussing ACP during the face-to-face encounter
- Any change in health status or health care wishes if the patient becomes unable to make their own decisions

Note: A unit of time is billable when the midpoint of the allowable unit of time passes. See Table 2 for more information.

Q & A

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Thank You

Contacts

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