Current Trends in Palliative Care: A Briefing from the Palliative Care Leadership Centers™ (PCLC)

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November 15, 2017

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Today's Objectives

- Update the field on the most current and important operational trends the PCLCs are witnessing right now
- Address the concerns, challenges, and opportunities these trends present to programs across the country
- Participate in Q&A

Principals, Methods, Codes

BILLING

Billing principles

- Providers should bill for the clinical work provided
- Documentation must support coding and billing
  - If it's not documented – you didn't do it.
  - If it's not legible – it doesn't count.
  - If it's not signed – it's not acceptable.

Basic requirements for coding

- Who is the patient?
- Where is the patient?
- Who is asking you to the patient?
- Who is the provider?
- Why are you being asked to see the patient?
- What are your recommendations?

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Abbreviations

- CPT
  - Current Procedural Terminology
    - These are the codes that drive the reimbursement
    - In general, you can only bill for one service (CPT code) per day, but there are exceptions
    - There are thousands of codes, but most of us use only a handful

Abbreviations

- ICD-10
  - International Classification of Diseases
  - This was implemented in October of 2015
  - These are the codes that identify what diseases or symptoms you are managing
  - Literally, billions of codes
  - Again, most providers use a select set of these codes

Methods for determining the level of coding

- Intensity
  - Based on how ‘much’ you do:
    - How sick is the patient
    - How much medical information you reviewed
    - How many symptoms you are managing

Intensity

- Three components of evaluation and management (E&M) coding
  - History
  - Physical Exam
  - Medical Decision Making (MDM)
    - Risk (how sick the patient is)
    - Diagnostics (labs, x-rays, etc.)
    - Problems (disease/symptoms)

Intensity

- The MDM combined with the history and physical exam define what CPT codes are to be used.
- Your documentation of history and physical must meet the criteria for the specific E&M code

Examples

- New consults-inpatient
  - 99221 (99253), 99222 (99254), 99223 (99255)
- New consults-observation
  - 99213, 99214, 99215
- Follow up-inpatient
  - 99231, 99232, 99233
- Follow up-observation
  - 99224, 99225, 99226

Methods for determining the level of coding

- Time
  - Given certain requirements, how much time did you:
    - Spend with the patient
    - Spend reviewing the medical record
    - Spend discussing with other providers

Time

- An alternative to billing based on intensity, is to bill based on time spent
- Each CPT has a ‘time’ associated with it.
- Half of that attributed time needs to be spent with the patient counseling and coordinating care.

Examples

- 99233 has an allotted time of 35 minutes
- If half of that 35 minutes (17 ½ minutes) is spent counseling/coordinating care with the patient, and other 17 ½ minutes is spent reviewing the case/documenting/discussing with other professionals, then the code 99233 can be used.
- It does not require a physical exam, but does require documentation of what was discussed.

Extended time: inpatient

- If you spend at least an extra 30 minutes above and beyond the allotted time of a specific code, then you can add ***99356*** as a secondary code.
- For each additional 30 minutes that you spend after that, the code ***99357*** is used
- These are exceptions to the rule of only one CPT code per day

New CPT code

- Advanced care planning as of 1/1/2016
  - ***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***
    - *each additional 30 minutes*

New CPT code

- No limits on the number of times it can be used
- No place of service limitation
- It appears that only a physician or NP may use this code
- Often used in addition to primary code, but it seems it may be billed alone.
  - (CMS adopted the CPT codes and CPT provisions regarding the reporting of CPT 99497 and 99498 (see #1). This includes the CPT instructions that CPT codes 99497 and 99498 may be billed on the same day or a different day as most other E/M services, and during the same service period as transitional care management services or chronic care management services and within global surgical periods.)

Reference

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

Investment, Infrastructure, Skill Sets

COMMUNITY-BASED PALLIATIVE CARE

Community-Based Palliative Care

- New opportunities for investment in community-based palliative care
- Infrastructure supporting community-based palliative care
- Skill sets required for community-based palliative care

Investing in community-based palliative care

Recent changes in payment models led by CMS which emphasize quality of care (vs. quantity) are leading to more compelling business model for palliative care, especially community-based palliative care

Incentives to invest

- **Readmission Reduction Program:** decreased DRG payments for readmissions within 30 days for specific conditions or procedure
- **Value-Based Purchasing Program:** payments based on quality metrics, including 30-day mortality rates and patient experience /satisfaction
- **ACO Models of Care:** with explicit rewards for decreasing overutilization of the costliest health care service

Evidence for efficacy

Payers and health systems willing to invest in community-based palliative care due to data showing these programs can:

- ➔ **Prevent hospitalizations** through symptom management and care coordination
- ➔ **Decrease inpatient and 30 day mortality**
- ➔ **Decrease costs of care**
- ➔ **Improve patient satisfaction**

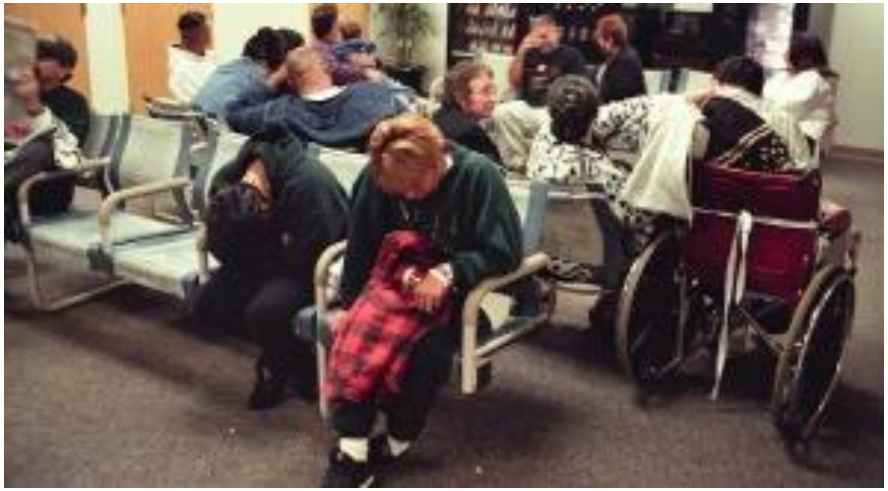
Temel, JS et al. (2010) Early palliative care… *N Engl J Med.* v363 n 8: 733-742.
Ramano, AM et al. (2017) Early palliative care… *Oncologist* v22 n 3: 318-323.
Morss, SD et al. (2015) Measuring what matters… *JPSM*. v49 n 4: 773-781.
Cassel, JB et al. (2010) Hospital Mortality Rates… *JPSM.* v40 n6: 914-925.
Kozar, RA et al. (2013) Are all deaths recorded equally? … *J Trauma Acute Care Surg.* v76 n 3: 634-641.

Return on investment?

Development of CBPC programs may require substantial investment.

Programs ***must be*** prepared to show that they are providing benefit commensurate with this investment, by tracking metrics such as:

- ➔ Hospital and ICU admissions / readmissions,
- ➔ Inpatient mortality
- ➔ Costs of care



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New settings, new challenges

- **Office-based**
- **Home based**
- **Telemedicine**
- **SNF**

??????????

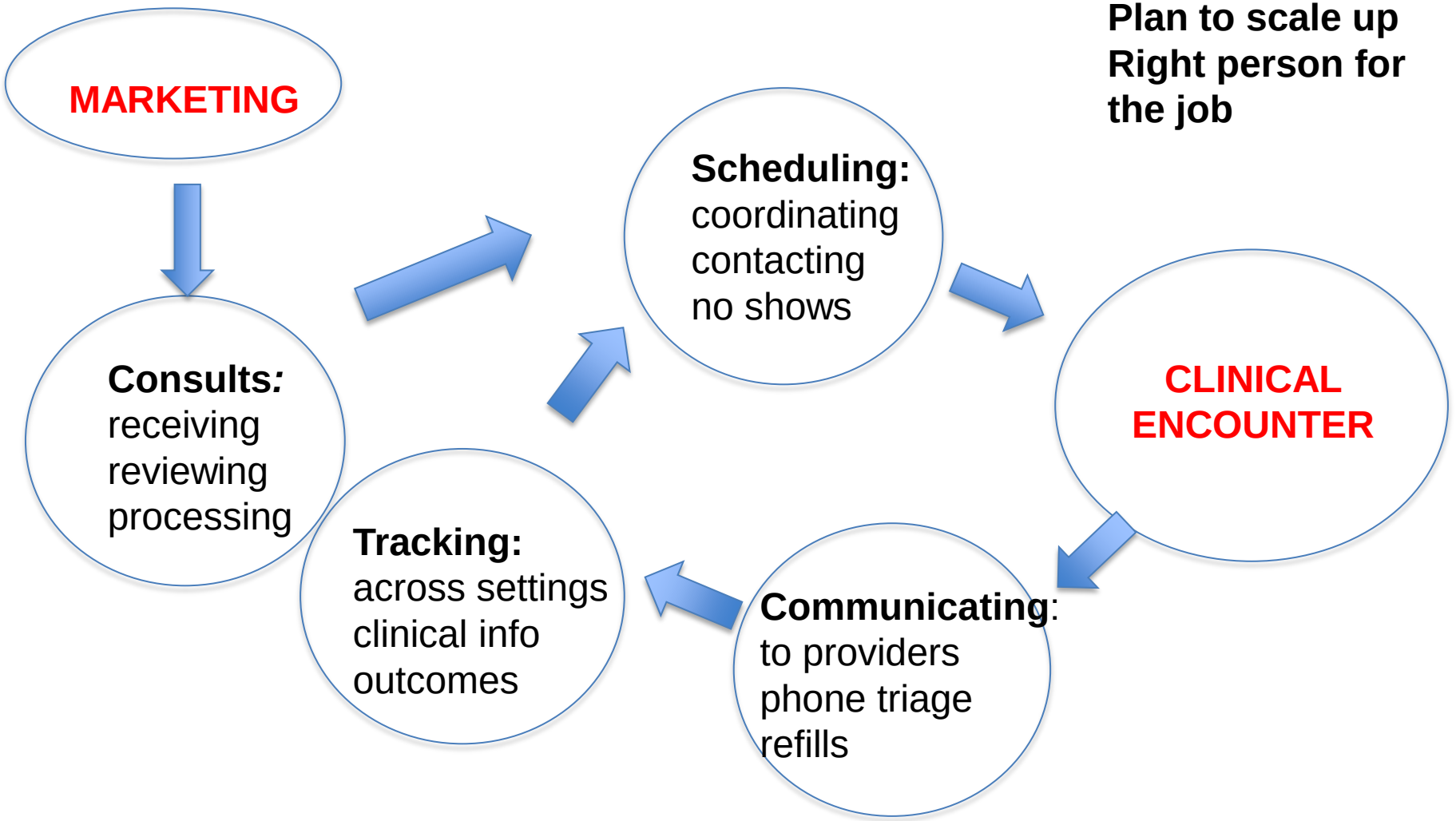
Infrastructure

- ✓ You need nurses, physicians, NPs, social workers, chaplains
- ✓ You need outreach and marketing

BUT

- ✓ Programs live or die by their ***infrastructure***.

Infrastructure



Plan to scale up
Right person for the job

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Symptom management

- Chronic pain vs. acute pain
- Chronic psychiatric problems
- Symptoms arising from treatments
- Safe prescribing (opioid abuse, polypharmacy, CKD, liver disease)

Are your providers adequately trained in this setting?

Are they excited about working in this setting?

Thank you.

Learn more about the Palliative Care Leadership Centers™, including how to apply, at pclc.capc.org

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