Cognition in Primary Care

Version: 2/13/2024

Advance Directives for Dementia

"Imagine if your loved one could look on themselves now, what might they say they would want?"

1. Dementia Directive

Available for download from: **Dementia-directive.org**

Best time to offer a Dementia Directive is:

- *Before* any signs of cognitive impairment occur.
- Consider: for everyone over age 65

- What it is: Brief descriptions of mild, moderate, and severe dementia.
- Below each stage, ability to choose a goals of care option for that stage.

2. Durable Power for Health Care (DPOA-HC)

- All patients *who have early signs of cognitive impairment* – need DPOA-HC as soon as possible – because their legal-default person might not be able to serve as DPOA ten years from now, which might be past when patient has capacity to assign a backup.

3. POLST/ MOLST form

- High value as a communication tool. More than just guidance for medics who arrive at the home. POLST/ MOLST serves as clear documentation (to take to ER or SNF) if a decision is made say for comfort-focused care, or whether or not to resuscitate/ intubate if patient has a cardiac/ respiratory arrest.

- "I worry that due to dementia, if you were to survive a cardiac or respiratory arrest you would be at a very high risk of being in a much worse state than you are now."

How to Bill for Advance Care Planning at an AWV

Medicare now pays for Advance Care Planning (ACP.) It's easy. Here's how.

The RVU for this is large (1.5) It **doubles** the usual (1.5) RVU for an Annual Wellness Visit.

This ACP billing code is great to use as part of a Medicare Annual Wellness Visit (AWV.)

When part of an AWV, the increased billing to Medicare is no-added-cost to the patient. (There is no cost sharing, no co-pay, no deductible for the patient.)

This ACP code can also be added to a regular E+M visit. The patient will generally have additional out of pocket costs in that case.

Note: There is no limit to the number of times in a patient's lifetime this code can be billed.
Note: If added to a **not-Medicare** Preventive Visit, the ACP code **may or may not** be covered.

What documentation is needed in your note?

1. You should say how long you spent discussing advance care planning (for billing this code, time spent must be >15 minutes) (i.e. 16 minutes or more)

2. Add a very brief statement about what you learned about the patient's preferences. Consider making your own Epic .dotphrase. Here is a perfectly acceptable example:

   *Advance Care Planning: Patient would like DPOA to be <spouse>. Patient preference if cardiac arrest then: <full code> <DNR>. Forms on file are: ***. Dementia directive discussed. I spent *** minutes (> 15 to bill) face to face with the patient discussing preferences for future care. Patient agreed to having this service.*

Here's how to add this billing code to an Annual Wellness Visit:

1. Enter the usual visit code (such as Medicare Annual Wellness Visit, Subsequent) then add "**Additional E/M Code.**"

2. The additional E/M code to add for ACP planning is: **ADVANCE CARE PLANNING [99497]**

3. Then add a "**Modifier**" to the code: Use code **33** if adding to an AWV (code 33 is the code when adding a modifier as a "preventive" service.)