POLST
Pennsylvania orders for life-sustaining treatment paradigm

NOTES ON POLST
May 2016

POLST Stories

The POLST process was introduced in Pennsylvania almost 20 years ago and its use has slowly expanded over time. However, many clinicians and certainly the public are not aware of the value it provides in helping to assure patients' treatment choices for care at the end-of-life are respected. We encourage POLST users to share their stories so we can all have a better understanding of how it is used in Pennsylvania.

Dr. Leon Kraybill is the geriatric division chief at Lancaster General Hospital and medical director at Luther Acres, Masonic Village. He has been a long-time POLST champion, a member of the POLST Curriculum Committee and serves on the POLST stakeholder group convened by the Pennsylvania Medical Society to develop and propose POLST legislation. Recently for National Healthcare Decisions Day, Dr. Kraybill shared his family's personal story. We appreciate his willingness to share with readers of these notes.

> My father lay unresponsive on the emergency room cart. His normally smiling 94 year old face was blank. There was no response to my voice or touch. His pulse and blood pressure were worrisome. My physician brain instinctively realized that he was probably dying. As a son, my heart cried out against the end of life for this vibrant and compassionate man.
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> Earlier, he and my mother had navigated to services at their long-term care facility. He appeared to fall asleep, did not awake, and was transported to the emergency room. It is the phone call no child wishes to receive. I arrived to find my mother at bedside. Her face told me that she also recognized the seriousness of the situation.
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> As a geriatrician, I work every day with individuals with changing health. Discussions of disease, functional changes, clinical decline and end-of-life care are very common. I routinely encourage people to consider health options, make treatment choices, and share these through discussion and advance care planning documents.
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> But now it was my father in front of me. The man who had given life to me and six siblings. A man who had given his heart and soul to family and church. A man who had survived other serious illnesses. Of course I did not want him to die, but even more, I did not want him to endure a prolonged dying in a sterile medical environment if death was inevitable. I knew the many possible medical treatments – the harder part is deciding which things should be done.
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> I turned to my mother, starting my usual medical discussion of code blue, mechanical breathing and medical heroics. She listened briefly, then said, "Oh, we discussed that several weeks ago with our doctor, and completed a paper about those wishes. The paper is over there on the counter."

They had discussed and completed a POLST document (Pennsylvania Orders for Life-Sustaining Treatment). It is one of several documents used in the advance care planning discussion to document the wishes of an individual. The POLST form is used for people with significant illness, and allows specific medical orders about resuscitation, medical interventions, antibiotics and feeding tubes.

Based on this document, I quickly confirmed with my mother that they did not want a code blue, mechanical breathing or invasive life support. They would accept medications and comfort treatment. The document clearly established his wishes for the medical team. As a son, the document gave great comfort to our decisions, knowing we honored his values.

Based on his wishes, we chose supportive care, focused on comfort. If he had died, we as a family were at peace knowing that we followed his wishes. Remarkably, he slowly improved and returned to independent living. I'm delighted to still have him in my life, but I know his wishes if we face a future similar situation.

As a geriatrician, I repeatedly see the benefits of these discussions and documents. As a son, I have experienced the relief and comfort they can provide.

Advance care planning is an ongoing discussion about life priorities and goals, an evaluation of options, a choice about how we want to live, and a sharing of that through conversation and documents. Advance care planning was essential for my father. It is important for me at mid-life. It is appropriate for my young adult children. The priorities are different at various stages of life, but everyone after age 18 should consider and document the appropriate portions.

There are many Internet resources available to guide discussions and documentation of your wishes. My hospital, Lancaster General Health, has information, including a simplified advance directive form at www.lghealth.org/advancecareplanning/.

Other resources include:

- Your Life Your Wishes (ALLSPIRE), www.yourlifeyourwishes.com/
- Pennsylvania POLST (UPMC Aging Institute), http://www.upmc.com/services/aginginstitute/partnerships-and-collaborations/pages/polst.aspx

My father gave my family a great gift by having this discussion before his illness. Please give yourself and your loved ones the gift of having this discussion in the near future. It's one of the most important conversations you can have.

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Medical Director – Luther Acres, Masonic Village

POLST Not Completed

A medical practice in eastern Pennsylvania is now endeavoring to have a POLST conversation with all appropriate patients as an outcome of a patient death that occurred within the office. An advance directive had been completed by the patient and was on hand. The directive indicated the woman did not wish CPR. During an office visit, she ceased to breathe. She was pronounced dead by a physician in the practice, but upon arrival of EMS, CPR was initiated as per protocol. The goal of the physician practice is that such situations not occur again and that a POLST form will be in place to provide information to EMS and others and assure patients' wishes are respected.

POLST Not Present

In the Pittsburgh region, a man of sound mind and with no family was admitted to a skilled nursing facility where a POLST discussion occurred. The patient's decision was for no resuscitation and treatment was to focus on comfort measures. He signed the POLST form. While in the facility he demonstrated increasing agitation and he was transferred to a local hospital without the POLST form where he was admitted for a psychiatric evaluation. While in the psych unit, the patient had a cardiac arrest and a code was called; he was placed on a ventilator and transferred to ICU. He was non-responsive. The Palliative Care Team that was consulted made a call to the nursing home to determine if there was any documentation of his treatment choices. Following this request, the POLST form was faxed to the hospital. It stated "allow natural death" and "comfort measures only". Following review, the ventilator was discontinued and the patient died.

POLST Exercise

Are you training others on POLST? The following is a brief exercise that facility trainers could consider for discussion during training sessions: [1]

Your patient is 86 years old with moderate to severe dementia, mild hypertension, and a history of osteoarthritis with hip and knee pain. The patient does not have decision-making capacity. You are introducing the patient's daughter to POLST. The daughter states, "I know that she would not want any of this, but I feel like I have to do this."

What can you say to the daughter? What questions can you ask her?

Key Areas for Discussion:

a. Is there an Advance Health Care Directive? If so, who is the decision-maker and what health care wishes if any were indicated?

b. Explore the daughter's statement and ask her, "If your Mom could talk to us right now, what would she say about all of this?

c. Explore family issues, values, culture, or discomfort with the mother's choices?

1. Above used with permission Materials used with permission from the Coalition for Compassionate Care of California, www.CoalitionCCC.org

Medicare Reimbursement for Advance Care Planning

As an outcome of the CMS decision to reimburse health care providers for ACP discussions, it is anticipated more discussions will occur. As part of POLST training, a Fact Sheet is being made available that describes the "who, what, when and where" of such discussions to help assure appropriate reimbursement. That fact sheet is found on the following pages.

Your Feedback

We are always interested in any comments on the use of POLST in PA. Please share your feedback with us. Also, if you are in need of POLST materials, please go the POLST website at: www.upmc.com/services/aginginstitute/partnerships-and-collaborations/pages/polst.aspx. You may also contact the POLST coordinator at the email address shown below.

Thank you,

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Medicare Reimbursement for Advance Care Planning

Fact Sheet

As of January 1, 2016, the Centers for Medicare and Medicaid Services (CMS) is reimbursing health-care providers for conversations with Medicare patients about advance care planning. The following are key points.

What is an advance care planning (ACP) discussion?

ACP is a discussion that a health care provider has with patients, and may include family members and surrogates, about an individual's preferences for care as they approach the end-of-life. The goal is to allow patients to retain control over the life-prolonging treatment they receive.

While ACP may be considered a benefit to beneficiaries, it is a service that is voluntary.

Who can bill and be reimbursed for an ACP discussion?

These codes can be billed by physicians and non-physician practitioners. This would include certified registered nurse practitioners (CRNP) and physician assistants (PA) whose scope of practice includes the services describes by the CPT codes and who are authorized to independently bill Medicare for those services.

The services can be provided using a team approach where ACP is provided by physicians, non-physician practitioners and other staff under the order and medical management of the beneficiary's treating physician. CMS expects the physician or CRNP to "manage, participate and meaningfully contribute to the provision of the services, in addition to providing a minimum of direct supervision".

What codes are required?

- **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 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).

Note: More than half of each interval must be used (>15 minutes) to bill for services and services can be paid on the same date or a different date as other E/M services.

The conversation does not need to be in the context of medical management. Any medical management can be billed separately as normally would be done. Then you may bill for additional time for the advance care planning discussion.

If not billing for medical management:

- Use 99497 if you exceed 15 minutes
- Use 99497 + 99498 if you exceed 45 minutes
- Use 99497 + 99498 + 99498 if you excel 75 minutes

What are the 2016 reimbursement rates?

Code	Philadelphia Area	Rest of Pennsylvania
99497	$90.56	$83.91
99498	$78.72	$73.33

Would a POLST conversation be eligible for payment?

The same conditions apply. If all described requirements are met, practitioners who engage in goals of care discussions and complete POLST forms may submit for reimbursement for that service.

What are allowable settings for reimbursable ACP discussions?

ACP services are appropriately furnished in a variety of settings, depending on the condition of the patient. Codes are payable in both facility and non-facility settings.

Discussions must be in-person, but does not need to be with the patient. It can occur with a surrogate or family members.

Is beneficiary cost-sharing allowed for ACP discussions?

As with most other physician services, beneficiaries are subject to cost sharing for advance care planning provided by their physician or health professional.

Can ACP be incorporated into the annual wellness visit (AWV)?

ACP Services can be a separately payable element of the AWV under HCPCS code GO438 or GO439 when parameters for billing these codes are met. No Part B co-insurance or deductible is permitted in this circumstance and ACP is to be reported with modifier -33.

Reference:
Federal Register / Vol. 80, No. 220 / Monday, November 16, 2015 / Rules and Regulations
https://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf