

Palliative Care in the ED: How Do We Bill Appropriately?

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Billing and coding can be confusing; think of any provider picking from the seemingly endless “pedestrian struck” codes. Perhaps this holds truer for specialties like emergency medicine where chart review and coding are often completed by a third party agency. Billing may not be the most interesting

aspect of our jobs or why we decided to pursue medicine, but it is essential to being reimbursed for the services we render. This article is targeted at educating how to bill for palliative care services you may already be providing and what exactly constitutes palliative care in the emergency department.

Palliative care is a broad term and under current CMS guidelines any specialty may bill for palliative care services. There are two general routes on billing for palliative care in the emergency department. The first is integrating palliative care into critical care and the other involves advanced care planning discussions with non-critical care patients.

Critical Care Billing Route

Critical care time may be billed on any patient requiring high complexity decisions that are aimed at preventing vital organ failure or life threatening deterioration. Most patients who meet criteria for critical care billing would benefit from incorporating palliative care. In this setting, palliative care is implemented with a discussion regarding patient care preferences and overall goals. Time devoted to this discussion is then added to the overall critical care time.

Two components of palliative care that can be easily integrated with critical care patients include:

1. Patient preferences regarding treatment options
2. Decisions on how a patient would like distressing symptoms managed

With either example a discussion can be carried out directly with the patient or under certain circumstances with their family.

A direct discussion with a patient can be attempted and accomplished with any patient who is competent and aware of their condition. A family discussion may be attempted if the patient cannot participate either due to instability or lack of capacity. If a provider does speak with family instead of the patient they must document: 1) Why the patient cannot participate; 2) Need for the discussion (patient instability and some form of organ failure).

In either situation the conversation should cover medically necessary treatment decisions and how the patient would like distressing symptoms managed. Examples of treatment decisions include: preferences on cardiopulmonary resuscitation, mechanical ventilation, initiation of vasoactive medications, dialysis, invasive procedures (enteral feeding tube / tracheostomy/chest thoracotomy), and artificial hydration and nutrition. Examples of distressing symptoms include pain management strategies, treatment of dyspnea, and delirium.

When you discuss these types of goals with a patient you are providing a palliative care service and the time spent during discussion may be added to your critical care billing time. To bill for this service add together: 1) Time spent preparing for the discussion; 2) Total actual discussion time. After tabulating this time you may add it directly to your existing critical care billing time.

Example: You perform 60 minutes of critical care time resuscitating a patient. After resuscitation you have a discussion with family regarding patient care preferences lasting 15 minutes.

Total critical care time = 75 minutes.

Advanced Care Planning Billing Route

Advanced care planning (ACP) is another route that we as emergency department providers can integrate and bill for palliative care. Advanced care planning refers to having a direct discussion with a patient, family member, or surrogate regarding advanced directives. This discussion may be billed independently of an E/M code and does not require the completion of any official advanced directive documentation.



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PALLIATIVE CARE An emergency department provider can have an advanced care planning discussion with essentially any patient. The requirement is that this planning must involve an advance directive type discussion which records the wishes of a patient pertaining to his or her medical treatment. The purpose of the discussion is to develop a plan for future care if the patient lacks decisional capacity.

There are not specific CMS requirements as to what must be discussed during an ACP session, however some recommended aspects include:

- Identifying who the discussion was with
 - Patient, family, or other health care surrogate
- Describing the existence of any current legal documentation regarding health care decisions
 - POLST, MOLST, durable power of attorney, health care proxy, living will, etc.
- Medical care preferences
 - Patient priorities, goals, and values
- Advance directive choices and designation of a health care decision maker

Similar to discussing treatment choices and options within critical care if you perform an ACP discussion you are providing a palliative care service and the time spent during discussion is billable. The appropriate code is the “first 30 minutes” ACP code which is 99497 and reimburses at 1.5 RVUs. One important note in with billing for ACP is that you must spend 16 minutes face-to-face with patient or family.

Example: You care for a CHF exacerbation patient who is complex and requires admission. While in the emergency department you also enter into an ACP conversation with the patient.

Billing= Level 5 E/M code + ACP code.

Appropriate Documentation for All Palliative Care Services

An important aspect of integrating palliative care is the requirement of proper documentation. For both the critical care and ACP methods there are certain documentation requirements which must be met. This includes:

1. Start time of discussions
2. End time of discussions
3. Total ACP or critical care time
4. Summary of what was discussed

*For critical care you must also list time preparing for discussions (which can be added to total time)

Finally, one additional caveat is that the ACP code can be billed with an E/M code however you cannot bill for ACP and critical care time together. Although documenting these requirements may seem daunting; a small macro in your local EMR can make it as quick as clicking on a few boxes.

Palliative Care is of great benefit to patients and families facing serious or life limiting illness. It allows for the individual or family members to be an active participant in the medical care being provided. It ensures that the treatments and care are consistent with their values. Please consider implementing more of these practices for your patients and when you do, now you know how to bill for it! ●

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www.aaem.org/get-involved/committees/interest-groups/palliative-care