Learning Objectives

- Leverage tools/training to be comprehensive and efficient during the office visit.
- Identify the management goals and your role for patients with Alzheimer's and other dementias.
- Utilize the visit codes that best reflect your value/time/complex comprehensive care with patient and family.

The Dr. Robert Bree Collaborative
Dementia and Alzheimer's Disease: Building a Health Care System for All of Us

To align care delivery with existing evidence-based standard of care for diagnosis, treatment, supportive care, and advance care planning within primary care for patients with Alzheimer's disease or other dementias and their families and caregivers while decreasing variation in quality of treatment across the state of Washington.

http://www.breecollaborative.org/2018/02/26/dementia/

Our Report and Recommendations has six focus areas developed in partnership with the Dementia Action Collaborative:

1. Timely and Accurate Diagnosis with AWV or family /patient concern
2. Ongoing care and support
3. Advance care planning and palliative care
4. Need for increased support and/or higher levels of care
5. Preparing for potential hospitalization
6. Screening for delirium risk

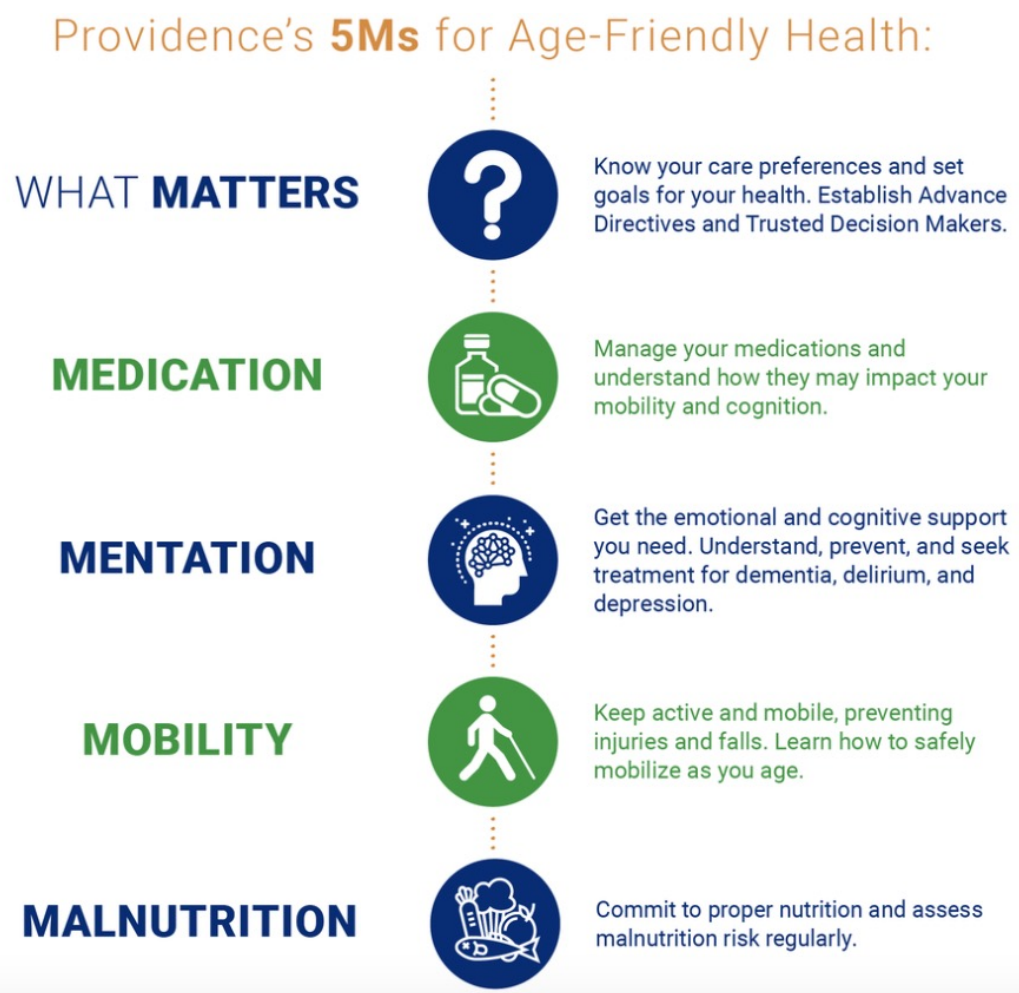
DR. ROBERT BREE COLLABORATIVE

An age-friendly health system (AFHS) will measurably improve the quality of care for older adults and optimize value for health systems across the continuum of care.

AFHS is a health care system in which:

- Older adults get the best care possible;
- Healthcare-related harms to older adults are dramatically reduced;
- Older adults and their families are satisfied with their care;
- Value is optimized for all

Age-friendly health systems will ensure reliable implementation of the "four M's":



The Problem: Time Lost is Independence Lost

7.2 million people 65+ are projected to have Alzheimer's dementia by **2025**

Source: https://www.alz.org/media/documents/alzheimers-facts-and-figures.pdf

Providence

Timely detection and comprehensive care

- Growing evidence regarding the importance of early detection and accurate diagnosis –

  -Cardiometabolic risk reduction/improving management of comorbid conditions/reducing polypharmacy/iatrogenic harm

  -Connecting with community resources, programs/services

  -Reducing preventable hospitalizations, inappropriate surgeries, delirium, PHCD/POCD and emergency room visits

  -Identifying goals around **what matters**, end-of-life care and improving advance care planning

- Approximately **$8 trillion** could be saved in medical and long-term care costs if mechanisms for early detection of AD are employed.[1]
- Cost savings can be realized from:
  - Diagnosis during MCI phase, rather than progressive dementia phase
  - Lower medical and long-term care costs for individuals who have diagnosed and well-managed MCI and dementia, compared with individuals with unmanaged MCI and dementia

Alzheimer's Association. 2019 Alzheimer's Disease Facts and Figures. *Alzheimers Dement*. 2019;15(3):32.

Hospitalization Rates in Dementia

- Each year **40%** of community-dwelling People with dementia (PwD) will visit ED and **30%** will be hospitalized at least once.

- Hospital care is **3 times as costly** compared to older people w/o dementia

- Acute hospitalization in PwD is associated with increased **risk of delirium, falls, cognitive and functional decline, 30 day readmission, longer LOS, long-term care admission and death**

- Shepherd *et al, BMC Medicine* 2019

The Office Visit

- Patient and caregivers should bring in all meds at each visit
- Med reconciliation should occur at each visit
  - Printed copy of adjusted meds AVS
- AD drugs dosed early and effectively
  - Discontinuations based on drug side effects
    - GI, cardiac, sleep (dreams & nightmares)
  - As disease progresses, discontinuation based on benefit vs. risk
- Simplify care at every opportunity/deprescribe

Mitigating the impact of Alzheimer's Disease

Hallmarks of disease remain memory loss and inability to problem solve

- Environment needs to change
- Caregiver needs to learn, receive support and change
- Pt with dementia has more challenges over time

- Pt and their families can still improve their odds
  - Lower cholesterol and homocysteine levels
  - Lower high blood pressure
  - Control diabetes
  - Exercise regularly
  - Engage in social and intellectually stimulating activities, care partner self-care, education, support.
  - Optimize hearing, diet, sleep, mood

Simplification of the treatment program

- Each therapy needs a justification
- Redundancies and duplication can be eliminated
- Pharmacies can blister pack a week (or a month) worth of medications for easy identification and improved compliance
- Reductions in drug passes may be single biggest opportunity to reduce errors, reduce caregiver burden, save money and limit transitions of care

Medication Safety

- Simplification
  - 3 or 4 x a day reduced to 1 or 2 x a day
  - Elimination of PRN drugs
  - Switch from daily to weekly or from weekly to monthly
  - Consider using an infusion center (and its cost) for once a year rather than monthly or quarterly treatments
    - Osteoporosis
    - Anemia

Goals of Care

- Simplify treatment strategies
- Provide a rationale for each treatment
- **Limit transitions**
  - Home to hospital
  - Hospital to nursing home
  - Assisted living to skilled care
- Provide an environment where a person can function with minimal frustration/failure and maximal use of retained abilities/preserved strengths

FACTSHEET

ALZHEIMER'S IMPACT MOVEMENT
alzheimer's association

MAY 2021 alzimpact.org

Improving HOPE for Alzheimer's Act

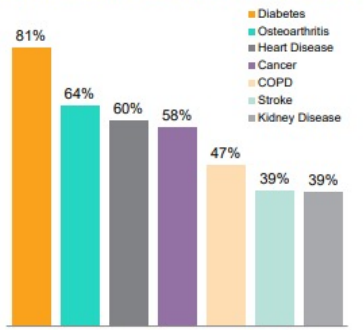
What is CPT® billing code 99483?

- The bipartisan HOPE for Alzheimer's Act from the 114th Congress would have created a care planning benefit for Medicare beneficiaries with Alzheimer's and other dementias.
- By 2016, more than two-thirds of Congress supported the bill. There were 310 cosponsors in the House of Representatives and 57 in the Senate.
- Since January 1, 2017, the Centers for Medicare and Medicaid Services (CMS) — through CPT® billing code 99483 — allows clinicians to be reimbursed for providing a comprehensive set of care planning services to cognitively impaired individuals and their caregivers.

Why is this care planning benefit necessary?

- More than 95% of people with Alzheimer's and other dementias have one or more other chronic conditions. Alzheimer's complicates the management of these other conditions — and as a consequence, increases costs.
- For example, a senior with diabetes and Alzheimer's costs Medicare 81% more than a senior who has diabetes but not Alzheimer's.
- Individuals receiving dementia-specific care planning have fewer hospitalizations, fewer emergency room visits, and better medication management.

Higher Medicare Costs Due to Alzheimer's



What about the individual's quality of life?

- Care planning allows diagnosed individuals and their caregivers to receive counseling and to learn about medical and non-medical treatments, clinical trials, and support services available in the community — all of which result in higher quality of life.
- Participating in planning early in the disease process also allows individuals with Alzheimer's to create advance directives regarding their care and finances as well as address driving and safety issues so that their wishes can be carried out when they are no longer cognitively able to make such decisions.

How many people have received the care planning benefit?

- In 2017 — the first year the benefit was available — 18,669 fee-for-service (FFS) Medicare beneficiaries received the care planning benefit.
- In seven states (Alaska, Montana, New Hampshire, North Dakota, Rhode Island, South Dakota, and Vermont) and the District of Columbia, not a single FFS Medicare beneficiary received the benefit.
- Even after accounting for individuals in Medicare Advantage plans, fewer than 1% of those with Alzheimer's and other dementias received the care planning benefit in 2017.

Why has the benefit been so underutilized?

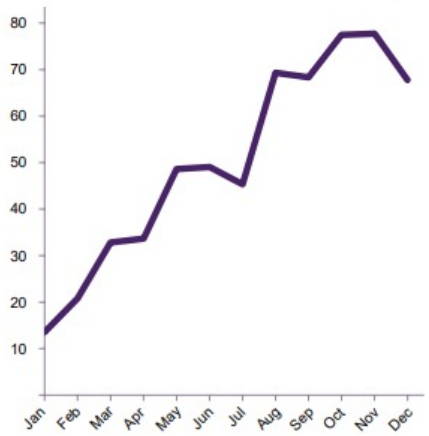
- The low rate of usage of the Medicare care planning benefit in the first year shows that patients and providers are generally not aware of the existence of the benefit.
- However, as more people become aware of the benefit, utilization of it increases. In 2017, use of the service increased steadily throughout the year. The rate of use of the care planning benefit was 3.3 times greater in the fourth quarter of 2017 than in the first quarter.

What Does a Care Planning Visit Consist Of?

- Evaluating cognition
- Assessing function/decision-making capacity
- Reviewing/reconciling prescription medications
- Measuring behavioral symptoms
- Evaluating safety (including driving ability)
- Identifying and assessing a primary caregiver
- Developing advance care directives
- Creating a care plan, including referral to community resources

First Year Code Usage

(Per 1,000,000 FFS Medicare Beneficiaries)



What does the Improving HOPE for Alzheimer's Act do?

- In 2020, Congress passed and the President signed into law legislation that included the Improving HOPE for Alzheimer's Act.
- The new law seeks to address the low usage of the care planning benefit by requiring the Department of Health and Human Services (HHS) to:
  - Educate clinicians on care planning services available under Medicare and on the care planning billing code.
  - Report on the barriers to individuals receiving care planning services and how the rate of usage can be increased.

About CPT 99483

Effective January 1, 2018, CPT code 99483 is used to report cognitive assessment and comprehensive care planning services provided face to face to individuals who exhibit symptoms of cognitive impairment.

Project ECHO®
Alzheimer's Association®
United States

CPT 99483: Cognitive Assessment and Care Plan Services Required Service Elements

Cognition-focused evaluation, including a pertinent history and examination of the patient
Medical decision making of moderate or high complexity (defined by the E/M guidelines)
Functional assessment (for example, ADLs and IADLs), including decision-making capacity
Use of standardized instruments for staging of dementia (FAST is often used)
Medication reconciliation and review for high-risk medications
Evaluation for neuropsychiatric and behavioral symptoms, including depression and including use of standardized screening instrument(s) (PHQ-9)
Evaluation of safety (e.g., home), including motor vehicle operation
Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on caregiving tasks
Development, updating or revision, or review, of an Advance Care Plan
Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation programs, adult day programs and support groups); shared with the patient and/or caregiver with initial education and support. (Easy to do with Epic's After Visit Summary)

Alzheimer's Association Toolkit for CPT 99483

Service Element	Suggested Tools
Cognition-focused evaluation, including a pertinent history and examination of the patient	• Mini-Cog • Short MoCA • Key Elements of Cognition Evaluation
Functional assessment, including decision-making capacity	• Katz Index of Independence in Activities of Daily Living • Lawton-Brody Instrumental Activities of Daily Living Scale • Decision Making Capacity Assessment
Use of standardized instruments to stage dementia	• Questionnaire in Older Adults with Dementia • Dementia Severity Rating Scale (DSRS)
Medication reconciliation and review for high-risk medications, if applicable	• Medication List for Review
Evaluation for neuropsychiatric and behavioral symptoms, including depression and including use of standardized instruments	• NPI-Q • BEHAV5+ • PHQ-2
Evaluation of safety (for example, home safety), including motor vehicle operation, if applicable	• Safety Assessment Guide and Checklist
Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on caregiving tasks	• Caregiver Profile Checklist • Stress Thermometer
Advance care planning and addressing palliative care needs, if applicable and consistent with beneficiary preference	• End of Life Checklist

CPT 99483: Who Can Bill Under This Code

- Physicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified nurse midwives

Every 180 days as appropriate

CPT 99483: Reimbursement

- Reimbursement rates can vary slightly based on the setting in which the service is provided and geographic location.
- Time Based – 50 min
- RVU 3.80
- Estimated revenue $265

References

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- https://www.cms.gov/cognitive
- https://www.cms.gov/files/document/cognitive-assessment-provider-letter.pdf
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- https://www.capc.org/documents/download/921
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- https://www.youtube.com/watch?v=NmDjhRVax8E