Cognitive Assessment and Care Planning Services

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Dementia Care Planning

- Difficult
- Takes time
- Involves family or caregiver
- Traditionally undervalued in fee for service models
- Ongoing process
  - Annually
  - Significant disease progression

Annals of Internal Medicine

ORIGINAL RESEARCH

The Underuse of Medicare's Prevention and Coordination Codes in Primary Care

A Cross-Sectional and Modeling Study

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Background: Efforts to better support primary care include the addition of primary care–focused billing codes to the Medicare Physician Fee Schedule (MPFS).

Objective: To examine potential and actual use by primary care physicians (PCPs) of the prevention and coordination codes that have been added to the MPFS.

Design: Cross-sectional and modeling study.

Setting: Nationally representative claims and survey data.

Participants: Medicare patients.

Measurements: Frequency of use and estimated Medicare revenue involving 34 billing codes representing prevention and coordination services for which PCPs could but do not necessarily bill.

Results: Eligibility among Medicare patients for each service ranged from 8.8% to 100%. Among eligible patients, the median use of billing codes was 2.3%, even though PCPs provided code-appropriate services to more patients, for example, to 5.0% to 60.6% of patients eligible for prevention services. If a PCP provided and billed all prevention and coordination services to half of all eligible patients, the PCP could add to the practice's annual revenue $124 435 (interquartile range [IQR], $30 654 to $226 813) for prevention services and $86 082 (IQR, $18 011 to $154 152) for coordination services.

Limitation: Service provision based on survey questions may not reflect all billing requirements; revenues do not incorporate the compliance, billing, and opportunity costs that may be incurred when using these codes.

Conclusion: Primary care physicians forego considerable amounts of revenue because they infrequently use billing codes for prevention and coordination services despite having eligible patients and providing code-appropriate services to some of those patients. Therefore, creating additional billing codes for distinct activities in the MPFS may not be an effective strategy for supporting primary care.

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For author, article, and disclosure information, see end of text.

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Table 1. Payment Amounts, Eligibility, Current Use of Code, and Receipt of Service as Input Data Used for Revenue Estimates*

Code	Medicare Payment in 2020 for Code, $†	Service Eligibility (Eligible for Code, Percentage of Medicare Beneficiaries), %	Among Medicare Beneficiaries Eligible for Service/Code	
			Billing Rate (Current Use of Billing Code, Percentage of Eligible), %	Service Provision (Received Service Regardless of Billing for Service, Percentage of Eligible), %‡
Prevention codes				
Smoking cessation counseling	15.52-29.59	8.8	10.1	60.6
Alcohol misuse screening	18.41	100	2.9	57.4
Alcohol misuse counseling	26.71	16.0	<1	25.9
Depression screening	18.41	100	7.9	27.1
Behavioral counseling for cardiovascular disease	26.71	74.0	1.4	46.7
Obesity counseling	26.71	34.6	<1	51.9
Shared decision making for lung cancer screening	29.95	9.3	1.5	5.0
Advance care planning	76.15-86.98	100	3.7	22
Wellness visit	117.29-172.87	100	35.8	-
Coordination codes				
Transitional care management	187.67-247.94	22.5	9.3	43.3
Chronic care management	37.89-92.39	65.8	2.3	-
Behavioral health integration	48.00-156.99	30.2	<1	-
Cognitive assessment with care planning services	265.26	10.5	1.5	-

* See Supplement Methods and Supplement Table 4 (available at Annals.org) for further details and sources.
† For some categories of prevention and coordination services, the full range of payment amounts are shown if there are multiple codes representing initial versus subsequent service delivery, different time requirements, or complexity. See Supplement Table 4 for an itemized list of payment codes.
‡ There is no estimate available for receipt of some services. In particular, the codes for wellness visits, chronic care management, behavioral health

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Services Analogous to E/M 2020 versus Now (12/29/2020 updated CMS files)

2021 E/M Changes

CPT	2020		2021	
	Work RVU	Non-Facility Payment Rate	Work RVU	Non-Facility Payment Rate
99495 - Trans care mgmt 14 day disch	2.36	$187.67	2.78	$207.96
99496 - Trans care mgmt 7 day disch	3.10	$247.94	3.79	$281.59
99483- Assmt & care pln pt cog imp	3.44	$265.26	3.80	$282.63

CPT 99483 Overview

- Alzheimer's disease & related dementias
- Requires an independent historian
- Outpatient (office, home, facility)
- Reimbursement
  - $282; RVU 3.8
- Comprehensive clinic visit (50 min)
- Results in written care plan

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Cognitive assessment and Care Planning Visit

- Who is eligible?
  - New or existing diagnosis
  - Signs or symptoms cognitive impairment
  - “Memory loss”
- Who can provide?
  - Practitioner able to report E/M services
  - Documentation supports moderate to high level of complexity
  - Usual “incident-to” rules

https://www.alz.org/professionals/health-systems-clinicians/care-planning

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Required elements code 99483

- Cognition-focused evaluation including history and physical exam
- Medical decision making of moderate or high complexity
- Functional assessment
  - ADL, IADL, decision making capacity
- Standardized instrument for staging dementia
  - FAST, clinical dementia rating
- Medication reconciliation
- Evaluation for neuropsychiatric symptoms
  - Depression standardized screening tool

Required elements code 99483 (cont)

- Evaluation of safety
  - Home, driving
- Caregiver
  - Identification of caregiver(s)
  - Caregiver knowledge
  - Caregiver needs
  - Social supports
  - Willingness of caregiver to take on caregiving tasks
- Advance Care Plan
  - Update, complete, revise
- Written Care plan
  - Initial plan to address any neuropsychiatric or neurocognitive symptoms
  - Functional limitations (driving)
  - Referral to community resources as needed

Alzheimer's Association tools

Domain	Suggested measures	Comments
Cognition	Mini-Cog	≤ 3 min, validated in primary care
	GPCOG	Patient/informant components
	Short MoCA	~ 5 min, needs testing in primary care
Function	Katz (ADL), Lawton-Brody (IADL)	Caregiver rated
Stage of cognitive impairment	Dementia Severity Rating Scale	Caregiver rated, correlates with Clinical Dementia Rating
Decision-making	3-level rating: able to make own decisions, not able, uncertain/needs more evaluation	Global clinician judgment
Neuropsychiatric symptoms	NPI-Q	10 items
Depression	BEHAVE 5+	6 high-impact items
	PHQ-2	Depression identification
Medication review and reconciliation	Med list + name of person overseeing home meds	Identify/reconsider high-risk meds; assess for reliable administration by self or other
Safety	Safety Assessment Guide	7 questions (patient/caregiver)
Caregiver identification and needs assessment	Caregiver Profile Checklist	Ability/willingness to care, needs for information, education, and support
	Single-Item Stress Thermometer	Rapid identification of stress
	PHQ-2	Depression
Advance care planning	End-of-Life Checklist	Screen for preferences and legal needs

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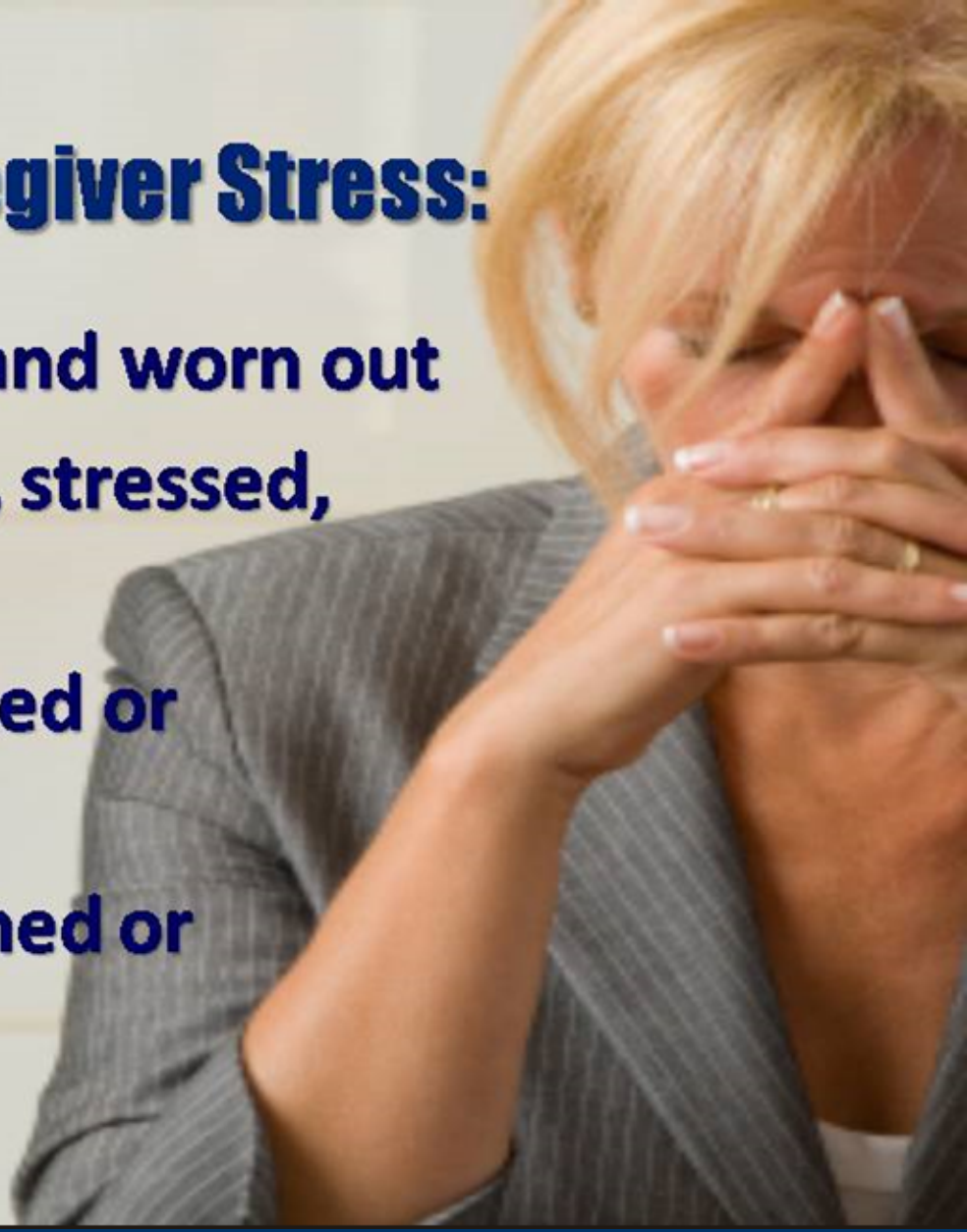
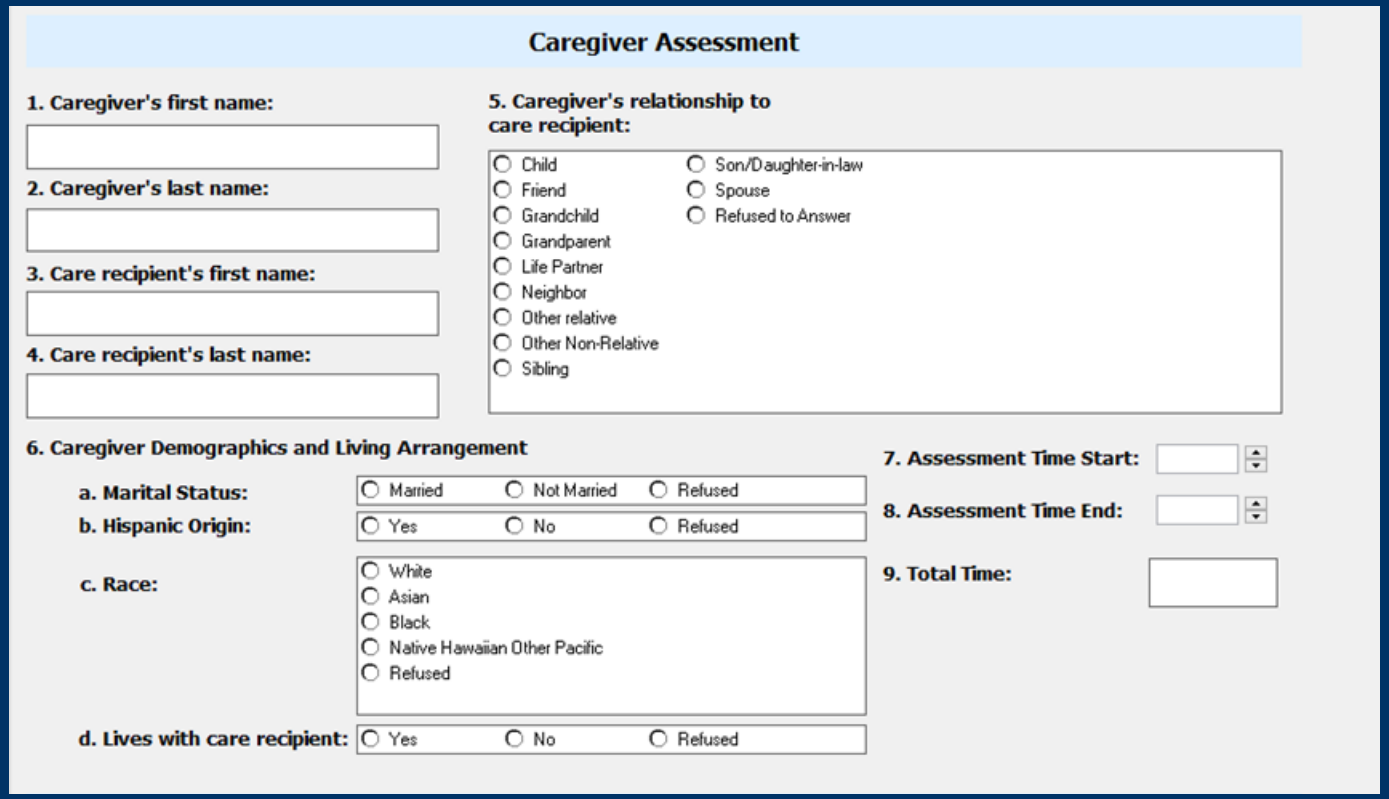
Warning Signs of Caregiver Stress:

- Physically – exhausted and worn out
- Emotionally – resentful, stressed, bitter
- Relationally – feeling used or unappreciated
- Financially – overwhelmed or depleted



Caregiver Assessment: Identification



Caregiver Assessment

1. Caregiver's first name:

2. Caregiver's last name:

3. Care recipient's first name:

4. Care recipient's last name:

5. Caregiver's relationship to care recipient:

- ○ Child
- ○ Friend
- ○ Grandchild
- ○ Grandparent
- ○ Life Partner
- ○ Neighbor
- ○ Other relative
- ○ Other Non-Relative
- ○ Sibling
- ○ Son/Daughter-in-law
- ○ Spouse
- ○ Refused to Answer

6. Caregiver Demographics and Living Arrangement

a. Marital Status: ○ Married ○ Not Married ○ Refused

b. Hispanic Origin: ○ Yes ○ No ○ Refused

c. Race:

- ○ White
- ○ Asian
- ○ Black
- ○ Native Hawaiian Other Pacific
- ○ Refused

d. Lives with care recipient: ○ Yes ○ No ○ Refused

7. Assessment Time Start:

8. Assessment Time End:

9. Total Time:

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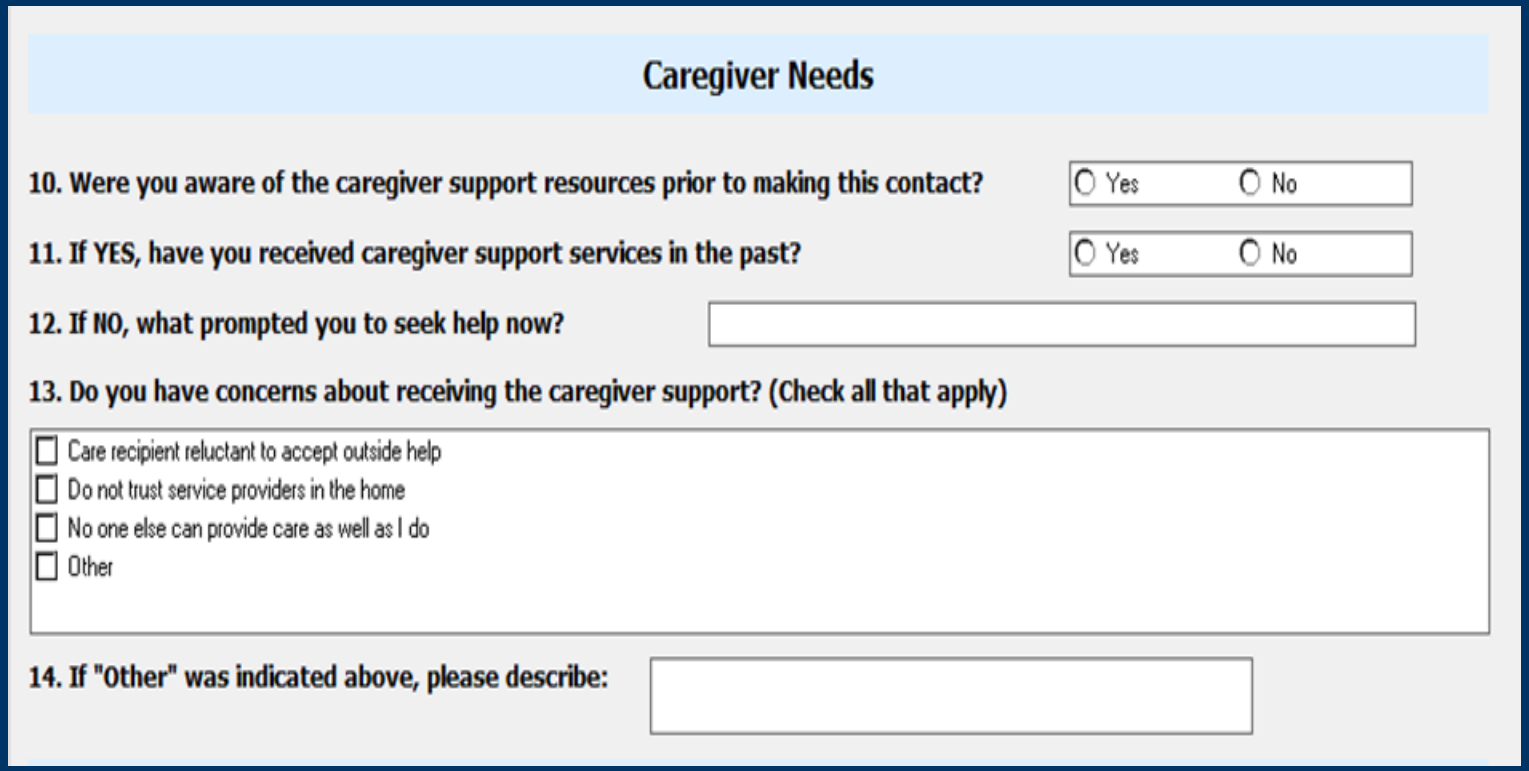
Caregiver Assessment: Needs



Caregiver Needs

10. Were you aware of the caregiver support resources prior to making this contact? ○ Yes ○ No

11. If YES, have you received caregiver support services in the past? ○ Yes ○ No

12. If NO, what prompted you to seek help now?

13. Do you have concerns about receiving the caregiver support? (Check all that apply)

- ☐ Care recipient reluctant to accept outside help
- ☐ Do not trust service providers in the home
- ☐ No one else can provide care as well as I do
- ☐ Other

14. If "Other" was indicated above, please describe:

Caregiver Profile

15. Are you paid to provide care for [care recipient's name]? ○ Yes ○ No **(If Yes, stop here)**

16. Are you the only non-paid person providing care to [care recipient's name]? ○ Yes ○ No ○ Refused to Answer

17. How long have you provided care for the patient? [yr] year(s) [mon] month(s)

18. How often do you provide care to [care recipient's name]?

○ Weekly ○ Monthly ○ Less than once per month ○ Refused to Answer

19. Do you have children under the age of 18? ○ Yes ○ No ○ Refused to Answer

20. Are you also providing care to any other individuals? ○ Yes ○ No ○ Refused to Answer

21. Is there anyone you can call on in an emergency to fill in for you as a caregiver? ○ Yes ○ No ○ Refused to Answer

22. Distance to care recipient's home:

○ 0 - 10 miles ○ 11 - 40 miles ○ 41 - 100 miles ○ Over 100 miles ○ Refused to Answer

23. Do you have a chronic health condition or have you experienced a recent health crisis? (If No, go to question 25) ○ Yes ○ No

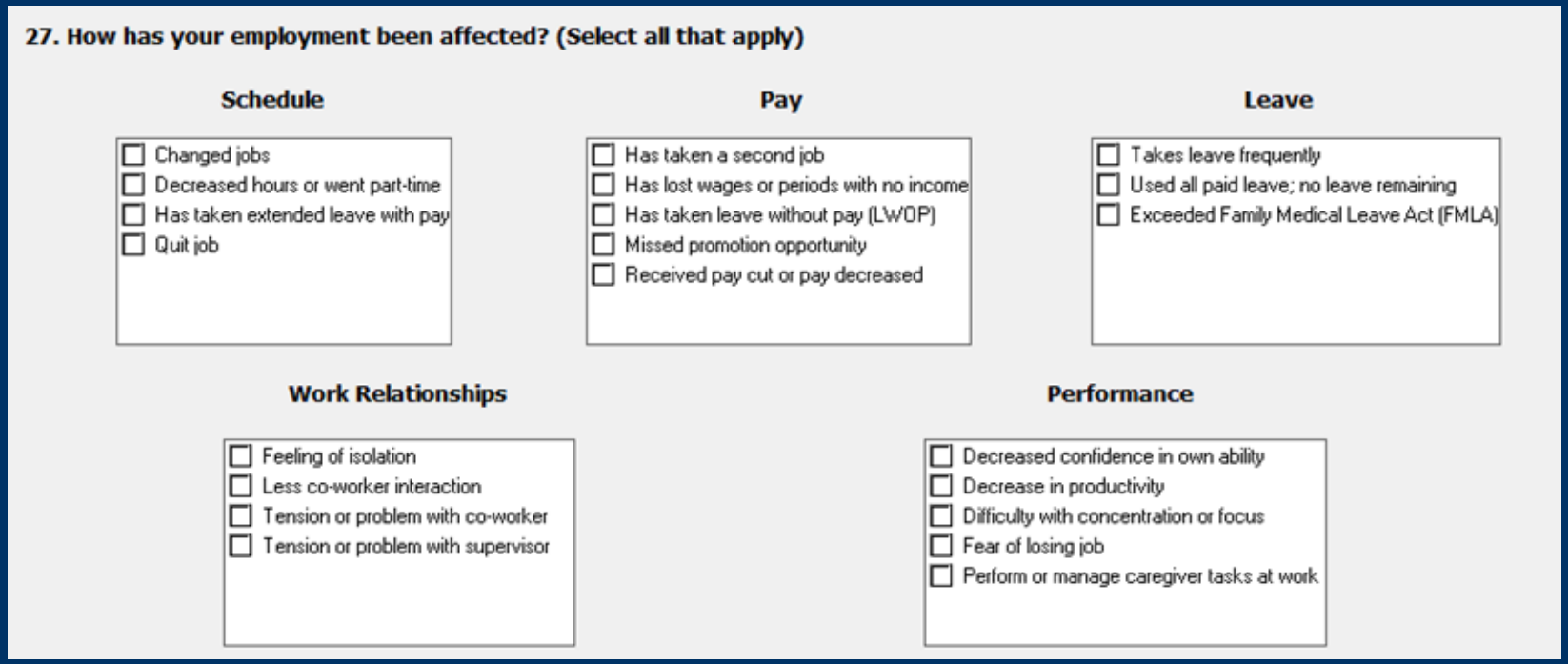
Caregiver's health condition/crisis:

24. Has this health condition affected your ability to care for [care recipient's name]? ○ Yes ○ No

25. Are you employed? ○ Full-time ○ Part-time ○ Not Employed ○ Refused to Answer

26. Have your caregiver responsibilities ever affected your employment? ○ Yes ○ No ○ Refused to Answer **(If No, go to question 28)**

Caregiver Assessment: Financial



27. How has your employment been affected? (Select all that apply)

Schedule

- ☐ Changed jobs
- ☐ Decreased hours or went part-time
- ☐ Has taken extended leave with pay
- ☐ Quit job

Pay

- ☐ Has taken a second job
- ☐ Has lost wages or periods with no income
- ☐ Has taken leave without pay (LWOP)
- ☐ Missed promotion opportunity
- ☐ Received pay cut or pay decreased

Leave

- ☐ Takes leave frequently
- ☐ Used all paid leave; no leave remaining
- ☐ Exceeded Family Medical Leave Act (FMLA)

Work Relationships

- ☐ Feeling of isolation
- ☐ Less co-worker interaction
- ☐ Tension or problem with co-worker
- ☐ Tension or problem with supervisor

Performance

- ☐ Decreased confidence in own ability
- ☐ Decrease in productivity
- ☐ Difficulty with concentration or focus
- ☐ Fear of losing job
- ☐ Perform or manage caregiver tasks at work

Caregiver Assessment: Skills/Training

Caregiver Skills and Training Assessment

28. Which of the following tasks do you assist the care recipient with? (Check all that apply)

- ☐ Personal care tasks (ADLs)
- ☐ Homemaker chores (IADLs)
- ☐ Transportation
- ☐ Managing finances
- ☐ Health care (doctor visits, medication monitoring)
- ☐ Supervision
- ☐ Emotional support
- ☐ Other:

30. If [care recipient's name] has a chronic disease or condition, how knowledgeable do you feel about this disease or condition?

- ○ Very
- ○ Somewhat
- ○ Not at all

Care recipient's disease/condition:

31. Do you need information, education and/or training about the following? (Check all that apply)

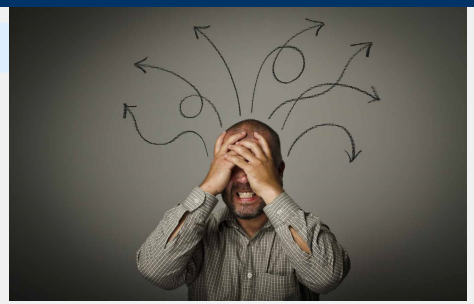
- ☐ How to care for yourself while caring for others
- ☐ How to provide care to an aging individual
- ☐ More information about care recipient's disease/condition
- ☐ How to get other family members to help
- ☐ Home safety and/or home modifications, or equiptment
- ☐ Legal and financial issues, power of attorney, living will
- ☐ Long-term care options (insurance and/or other benefits)
- ☐ In-home services
- ☐ Short-term respite care in facility
- ☐ Choosing a long-term facility
- ☐ Support groups
- ☐ Individual counseling options
- ☐ On-line information and supports
- ☐ Hands on skills training for personal care tasks (bathing, grooming, toileting)

32. Other, please describe:

- ***Caregiver stress*** is a major factor that leads to nursing home placement. Therefore, it must be addressed if you want to keep people in their homes. *-Dr Popeo*

#116 Geriatric Psychiatry - Dementia Pearls - The Curbsiders %

Caregiver Assessment: Stress



Caregiver Stress Interview

33. Do you find caring for the patient to be stressful? ○ Yes ○ No ○ Refused to Answer

34. Would you rate your stress level as: ○ Low ○ Moderate ○ High ○ Refused to Answer

Check the response that best describes how you feel:

35. I feel a sense of satisfaction helping [care recipient's name]	○ Strongly disagree	○ Disagree	○ Neither Agree nor Disagre	○ Agree	○ Strongly agree	○ Refused to Answer
36. I am confident about providing care to [care recipient's name]	○ Strongly disagree	○ Disagree	○ Neither Agree nor Disagre	○ Agree	○ Strongly agree	○ Refused to Answer
37. Caring for [care recipient's name] while trying to meet other responsibilities for my family or work is causing increased stress.	○ Strongly disagree	○ Disagree	○ Neither Agree nor Disagre	○ Agree	○ Strongly agree	
38. I feel a sense of obligation to provide care.	○ Strongly disagree	○ Disagree	○ Neither Agree nor Disagre	○ Agree	○ Strongly agree	○ Refused to Answer
39. My health has suffered because of my involvement with providing care.	○ Strongly disagree	○ Disagree	○ Neither Agree nor Disagre	○ Agree	○ Strongly agree	○ Refused to Answer
40. My finances are strained because I provide care.	○ Strongly disagree	○ Disagree	○ Neither Agree nor Disagre	○ Agree	○ Strongly agree	○ Refused to Answer
41. I could do a better job of caring for [care recipient's name].	○ Strongly disagree	○ Disagree	○ Neither Agree nor Disagre	○ Agree	○ Strongly agree	○ Refused to Answer

42. What do you do to cope with the stress related to the challenges of caregiving? Describe:

43. Is this working to help relieve stress? ○ Yes ○ No ○ Not at all

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Caregiver Priority Status (check all that apply)

- ☐ Providing care to a person with Alzheimer's disease or related dementia
- ☐ Grandparents or older relative caregivers who are 55+, who are providing care for children with severe disabilities

Optional targeting categories (check all that apply)

- ☐ Caregiver recently hospitalized
- ☐ Care recipient recently hospitalized
- ☐ Caregiving is likely to continue indefinitely
- ☐ Care recipient is at risk for institutionalization
- ☐ Caregiver has chronic health condition or has had a recent health crisis
- ☐ Care recipient requires assistance with three or more ADLs
- ☐ Caregiver's income is a or below federal poverty level
- ☐ Caregiver is caring for more than one person
- ☐ Other (describe)

Cognitive Care Plan

- Written Care plan
  - Initial plan to address symptoms
  - Neuropsychiatric
  - Neurocognitive symptoms
  - Functional limitations IADL/ADL
    - Driving
    - Finances
  - Referral to community resources as needed

Example of Care Plan

- Written Cognitive Care Plan

  “This written care plan was developed with the patient, caregiver or family in the office during the cognitive assessment procedure and was shared with them as initial education with ongoing support.”

Neuropsychiatric Care Plan

- Anger
- Apathy
- Bathing
- Driving
- Eating
- Hiding
- Money
- Suspicion
- Wandering/elopement

- **Treating Dementia-Related Behaviors**
  AGS Choosing Wisely #2: "Don't use antipsychotics as the first choice to treat behavioral and psychological symptoms of dementia."
- First line treatment for dementia-related behaviors (e.g. agitation) is non-pharmacologic treatment, e.g. via the DICE approach (Kales HC et al. *JAGS.* 2014).
- **Describe:** Caregivers describe the distressing behaviors (e.g. environment, patient-centered issues, context)
- **Investigate:** Team-members look into possible causes of the behavior (e.g. pain, medications, sleep, sensory impairment, psychiatric issues)
- **Create:** The multi-disciplinary team and patient/family collaborates to create a plan (e.g. treating pain, changing the environment, or improving communication/provide reassurance)
- **Evaluate:** The team evaluates iteratively if the plan has been effective.
- Patients with Alzheimer's Disease, prescribed **antipsychotics**, have a long-term increased risk of mortality (DART-AD trial, Ballard et al. *Lancet Neurol.* 2009). The number needed to harm with antipsychotics in patients with dementia is 26 for haloperidol, 27 for risperidone, 40 for olanzapine and 50 for quetiapine (Maust et al. *JAMA psychiatry. 2015*).
- **Citalopram** may have a role in reducing the dementia-related behavior of agitation along with caregiver distress, but its cognitive and QTc prolonging effects may limit its use (Porsteinsson et al. *JAMA.* 2014). Max dose is citalopram 20 mg daily in the elderly.

Generic Neuropsychiatric Care Plan

- Dementia Behavior treatment
  Pharmacologic treatment of behavioral disturbances and dementia of limited efficacy and only use after non-pharmacological agents have been implemented. Pain, constipation, urinary retention, nausea, dyspnea, will be treated first if present. In the underlying metabolic disorder will also be treated. We will continue ongoing care of underlying infection, cardiovascular disorders or other underlying chronic illness as indicated. Recommend avoiding overstimulation and recommend social interaction with family or caregivers. Patient will be offered a music therapy trial. Frequent reassurance or redirection as necessary with a gentle approach and patient's ability to make decisions where possible should be supported. Please don't argue with the patient, but continue to provide basic needs and a safe environment and if unsuccessful after due diligence contact the physician for further orders.

  If the behavior is unresponsive and documented attempts at non-pharmacological therapy and the benefits of treatment outweigh the risks or concerns for patient caregiver safety then a risk-benefit discussion will be performed with caregivers or surrogate.

Example of Care Plan: Anger

Patients who have illnesses and dementia can become angry and may lash out to you as you're trying to assist to help them. Anger can manifest itself by slamming objects around, hitting people, refusal of cares, throwing food, yelling or making accusations. These behaviors can be upsetting for you and may cause problems in the household. Despite your best efforts to help and assist your loved one you may feel this hostility is aimed at you and be afraid that they will hurt themselves or someone else when they become angry and out of control.

Anger and violent behavior is usually catastrophic reaction and should be handled as you would any other catastrophic reaction with a calm response. Do not respond to the anger and attempt to remove the patient from the situation or the upsetting stimulus. Look for the event that precipitated reactions to so you can minimize the recurrence in the future. Do not interpret anger in the same way you would if it came from a person without dementia. The anger is probably the result of a misunderstanding of what is happening and forgetfulness is helpful because a person may quickly forget that episode. Distraction is effective strategy and you can offer a object, snack or activity that the person really enjoys.

Example of Care Plan cont.

- Caregiver Empowerment:
  - Seek out opportunities for support: support groups are available and call office for individualized conversations and support resources. Take time for things YOU enjoy: take care of yourself, spend time with your loved ones, take a break by going for a drive, weekend away or a few hours a week
  - Opt for help: I encourage you to reach to seek help from family, friends, neighbors, and our office
  - Prioritize your needs: Take a break, I said it twice so this is important!
  - Change your perspective remember this is hard!
  - Stay positive

Example of Care Plan cont.

- Referral to community resources
  - Rehabilitation
  - Adult day program
  - Support group
  - Social services
  - Legal services
  - Financial services
  - Meals on Wheels
  - Transportation
  - Personal assistance services

Example of Care Plan cont.

Education resources

- Family Caregiver Alliance (FCA) has supported and sustained the important work of families and friends nationwide who care for adult loved ones with chronic, disabling health conditions. https://www.caregiver.org/
- Vascular Dementia: A Complete Guide: https://www.kindlycare.com/vascular-dementia/
- Lewy Body Dementia Association https://www.lbda.org/
- UCLA caregiver videos: https://www.uclahealth.org/dementia/caregiver-education-videos
- Care consults available through the Alzheimer's Association https://secureform.mediprocity.com/forms/13854/4990/PGNL/form.html
- Center of Excellence on Dementia Caregiving:

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Questions

- For further questions, contact Dr Melissa Gaines at 269-9220 or Melissa.gaines@coxhealth.com

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