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# MEDICARE INITIAL PREVENTIVE

## Physical Exam and Annual Wellness Visits



*“Speak with patients and get records from prior physicians on new patients before scheduling a preventive service visit to ensure that a former physician has not billed for the appropriate code in the past 12 months.”*

As part of the Affordable Care Act, Medicare added preventive service codes several years ago. These codes are provided to encourage patients together with their providers to establish and then maintain a personalized prevention plan and increase usage of preventive services. Medicare part B covers at 100% those preventive services with a United States Preventive Services Task Force (USPSTF) grade A or B recommendation.

**Table 1 Medicare Part B Preventive Services**

Alcohol Misuse Screening and Counseling
Bone Density measurement
Cardiovascular Disease Screening tests
Colorectal Cancer Screening
Counseling to prevent tobacco use
Depression Screening
Diabetes Screening
Diabetes Self-Management Training
Glaucoma Screening
Hepatitis C Virus screening
HIV Screening
Influenza, Pneumococcal, and Hepatitis B Vaccinations
Intensive Behavioral Therapy (IBT) for Cardiovascular Disease risk reduction
IBT for Obesity
Medical Nutrition Therapy
Prostate Cancer Screening
Screening Mammography
Screening Pap test and Pelvic Exam
Sexually Transmitted Infections (STI) Screening and counseling to prevent STIs
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)
Lung cancer screening in special populations

These codes may be intimidating to use as Medicare requires certain elements documented and patients often misunderstand the purpose of the visits. They are appealing to patients, however, because Medicare waives any copay or deductible. Patients may confuse these visits with an annual physical exam, to which many are accustomed. In fact, no physical exam beyond basic vital signs is required by Medicare to bill for these visits. Family physicians are ideal providers of this service. These codes provide an opportunity to set aside an annual visit to address preventive care and get reimbursed for it!

**Table 2: Coding for Medicare Wellness Visits**

Name	Code	Limitations	Approximate payment
Initial Preventive Physical Exam (IPPE)	G0402	Once in a lifetime benefit, no later than 12 mo after effective date of first Medicare B coverage	\$166
Initial Annual Wellness Visit (AWV)	G0438	Once in a lifetime benefit, no longer in 12 mo window after covered under Medicare B and have not received AWV or IPPE in past 12 mo	\$172 (or typical for 99204)
Subsequent Annual Wellness Visit (AWV)	G0439	Have not received AWV in past 12 mo	\$111 (or typical for 99214)

The Initial Preventive Physical Exam (IPPE), aka “Welcome to Medicare” visit, is available only within the first 12 months a patient is covered by Medicare. The Annual Wellness Visit (AWV) is available annually thereafter, with separate codes for the initial and subsequent Annual Wellness visits.

**Table 3: Requirements for the Initial (Welcome to Medicare) Wellness Visit**

Administer Health Risk Assessment- a self-reported form that includes basic demographic and self-assessment information, Activities of Daily Living, and risks. This can be completed in advance of the visit, not to take more than 20 minutes.
Establish medical, surgical, and family history. Complete a medication list including over-the-counter drugs
Review risk factors for depression, screen for depression
Review functional ability and safety risks (fall risk, hearing impairment, home safety)
Assess height, weight, BMI, and blood pressure
List current providers and suppliers
Assess for cognitive impairment
Provide written screening schedule based on USPSTF (A or B) and ACIP recommendations
List of risk factors and medical conditions for which interventions are recommended or underway
Health advice and referral to education or preventive counseling services

**Table 4: Requirements for the Annual Wellness Visit**

For Subsequent Annual Wellness Visits:
Update the health risk assessment
Update the medical, surgical, and family history and Medication list
Assess weight and blood pressure
Update list of current providers and medical suppliers
Assess for cognitive impairment
Update written screening schedule based on USPSTF (A or B) and ACIP recommendations
Update list of risk factors and conditions for which interventions are recommended or underway
Provide personalized health advice and referrals to community resources as appropriate

Speak with patients and get records from prior physicians on new patients before scheduling a preventive service visit to ensure that a former physician has not billed for the appropriate code in the past 12 months. The AAFP and other national organizations recently called on the Centers for Medicare and Medicaid Services (CMS) to evaluate the propriety of various commercial entities providing these services outside of an ongoing care relationship. There is at this time no way to independently ensure that a patient has not had this service provided until a claim is denied.

**Table 5: Keys to successful utilization of these codes:**

Utilize a checklist or create a template in your EMR to be sure that all the required elements are properly documented.
Educate your office staff on the uniqueness of these visits so that they can answer patient questions and set up appropriate expectations when patients schedule the visit.
Develop an organized plan so that your staff will administer screening tools.
Educate patients in advance that this appointment will not address their acute or chronic medical problems.

A physician assistant, nurse practitioner, or other health professional working under the supervision of a physician can provide the AWV services. In fact, some practices have successfully implemented a two visit plan: a patient comes in initially to complete the Health Risk Assessment and be screened for depression, Activities of Daily Living (ADL), and cognitive impairment by a nurse or medical assistant. The patient returns for a second visit with the physician to review the data and develop the written plans as required. CMS does not require specific screening tools be used for such data as depression or cognitive impairment.

CMS does not prohibit billing an Evaluation and Management (E/M) code for addressing an acute or chronic medical condition in addition to the Preventive visit code. However, the documentation for the E/M visit should completely justify the code when evaluated separate from the Preventive visit documentation and a modifier 25 should be used to designate the E/M visit as a separately identifiable service. In my experience, the E/M code is typically denied. Though inconvenient for the patient, a separate visit to address complaints and chronic conditions is the best approach from a billing perspective. Remember that you can increase the billing for additional services provided as appropriate, such as tobacco use counselling (G0436) or Screening Breast and Pelvic exam (G0101). Coming in January 2016, CMS will begin reimbursing for Advance Care Planning discussions regarding Living Will, Healthcare Surrogate, and resuscitation wishes (99497 up to 30 minutes/99498 additional 30 minutes).■

**Recommended Resources:**

Health Risk Assessments:  
[www.medicarehealthassess.org](http://www.medicarehealthassess.org), ask patients to print out summary and bring to office.  
[www.howsyourhealth.org](http://www.howsyourhealth.org)  
 Hughes, C. Medicare Annual Wellness Visits: Don't Forget

the Health Risk Assessment. Family Practice Management. Available at <http://www.aafp.org/fpm/2012/0300/p11.htm>. Includes printable Health Risk Assessment.

IPPE/AWV:

Hughes, C. What You Need to Know About the Medicare Preventive Services Expansion. Available at <http://www.aafp.org/fpm/2011/0100/p22.html>. Includes printable Medicare Preventive Physical Exam encounter form.

Cuenca, AE. Making Medicare Wellness Visits Work in Practice. Available at <http://www.aafp.org/fpm/2012/0900/p11.html>. Includes definitions and sample scripts to aid communication between patients and staff.

[http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV\\_chart\\_ICN905706.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf). Detailed requirements for Initial and Subsequent Annual Wellness Visits as well as Frequently Asked Questions and Resources.

### **About the Author**

Ariel Cole, MD, FAAFP, CMD, received her medical degree from the University of South Florida (USF) in Tampa, FL and completed her residency and fellowship training at Florida Hospital. As part of her role as Director of the Geriatric Fellowship, Dr. Cole supervises medical students, residents, and geriatric fellows in the care of elderly patients in the hospital, outpatient clinics, nursing homes, and home visits. She oversees a Comprehensive Geriatric Assessment Clinic within the Centre for Aging and Wellness where elderly patients and their caregivers meet with an interdisciplinary team to evaluate their medical, functional, and psychosocial status.

Dr. Cole is the Orlando campus Clerkship Director for Geriatrics at the Florida State University (FSU) College of Medicine. Dr. Cole is a member of American Academy of Family Physicians (AAFP), the American Geriatrics Society, and the American Medical Directors Association. She is Board Certified in Family Medicine and Geriatric Medicine and is a Certified Medical Director.

# OSTEOPOROSIS:

## A Preventable Disease of Aging



*“The prevention and treatment of osteoporosis is important to reduce fractures and help patients maintain their independence. Patient education of universal bone health and fall prevention recommendations is fundamental. A community support group can be instrumental in accomplishing this.”*

Osteoporosis is a disease of aging, but the prevention of osteoporosis starts in childhood and lasts a lifetime. Osteoporosis is characterized by reduced bone strength leading to an increased risk of fractures. Bone strength is determined by both bone mass (density) and bone quality. Bone mineral density (BMD) can be measured by Dual-energy X-ray absorptiometry (DXA) scan, while bone quality is estimated through risk factor assessment. Osteoporosis is the most common bone disease, but it is often unrecognized and untreated. One out of two women and up to one out of four men, over the age of 50, will break a bone due to osteoporosis. The National Bone Health Alliance (NBHA) campaign “2 million 2 many” is aimed at reducing the number of fragility fractures each year in the United States attributed to osteoporosis.

Primary and secondary fracture prevention improves patient outcomes and reduces healthcare cost. Every year, of nearly 300,000 hip fracture patients, ¼ end up in nursing homes and ½ never regain previous function. By 2025, osteoporotic fractures will likely cost \$25 billion dollars per year. Even after a fracture, only 23% of women over age 67 receive a BMD test or prescription for an anti-osteoporosis medication. Over 1/3 of patients with a hip fracture have had a prior fracture. Studies indicate that 50% of osteoporosis related fractures could be prevented with appropriate treatments.

The United States Preventive Services Task Force (USPSTF) and American Academy of Family Physician (AAFP) recommendations for osteoporosis DXA screening include all women age  $\geq 65$  and those at an equivocal risk as determined by World Health Organization (WHO) Fracture Risk Assessment Tool (FRAX) 10 year risk of any osteoporotic fracture  $\geq 9.3\%$ . The NBHA advocates Fracture Liaison Service Programs that coordinate post fragility fracture care to ensure osteoporosis assessment and treatment. The National Committee for Quality Assurance, Healthcare Effectiveness Data Information Set (NCQA HEDIS) has established a performance measure: Women ages 67-85 years who have had a fracture need a BMD test or a prescription for appropriate osteoporosis treatment within 6 months of the fracture.

The diagnosis of osteoporosis is established by measurement of bone mineral density (BMD) or by the occurrence of an adulthood hip or vertebral fracture in the absence of major trauma. The World Health Organization (WHO) criteria for osteoporosis is based on BMD as measured by DXA scan as a T score  $\leq -2.5$  at the spine, femoral neck or total hip. A vertebral fracture is consistent with a diagnosis of osteoporosis but most remain undiagnosed for years. Vertebral imaging can be performed using spine x-rays or lateral vertebral fracture assessment (VFA) on most DXA machines. It is important to evaluate patients diagnosed with osteoporosis for secondary causes which may be treatable. Initial laboratory tests to consider include: 25-hydroxyvitamin D, complete blood count, chemistry levels (calcium, renal function, phosphorus and magnesium), liver function tests, parathyroid hormone and thyroid testing.

In order to have strong bones in the geriatric years, bone strength must be developed in childhood and maintained throughout life. Patient education regarding bone health is the backbone of osteoporosis prevention and treatment. The universal recommendations for bone health are independent of bone health status. Encourage a diet rich in calcium, incorporating supplements only as needed to meet the Recommended Daily Allowance (RDA) (Table 1). Calcium is best absorbed when consumed in amounts of 500-600mg or less. Calcium carbonate is better absorbed with stomach acid as produced when food is consumed. Acid suppressive medications such as proton pump inhibitors (PPI) interfere with the absorption

## Institute of Medicine: Dietary Reference Intakes for Calcium and Vitamin D -- 2011

YEARS	CALCIUM (mg/ d) Recommended Dietary Allowance	VITAMIN D (IU/d) Recommended Dietary Allowance
19-50 y M/F	1,000	600
51-70 y Males	1,000	600
51-70 y Females	1,200	600
>70 y M/F	1,200	800

**Table 1: Recommended Dietary Intake of Calcium and Vitamin D (see reference 4)**

of calcium carbonate. Aging also results in less stomach acid production. Calcium citrate does not require stomach acid for absorption and can be taken with or without food. It is difficult to consume adequate Vitamin D from foods and supplements are commonly needed to meet the RDA. Vitamin D is made in the skin from sunlight but sunscreen can block this process. Consuming approximately 8-10 dried plums per day has been shown to improve BMD in postmenopausal women. Universal recommendations also include abstaining from smoking and limiting alcohol to less than 3 drinks per day. Lifelong daily weight bearing exercise and muscle strengthening exercises are essential to bone health.

In addition to the universal bone health recommendations, consider pharmacologic therapy for:

- Postmenopausal women and men  $\geq 50$  years with a hip or vertebral fragility fracture
- T-score  $\leq -2.5$  at femoral neck, total hip, or spine
- T-score between  $-1.0$  and  $-2.5$  and a FRAX 10-year fracture risk score of  $\geq 3\%$  (hip) or  $20\%$  (major)

Oral bisphosphonates are the first line of treatment due to efficacy, cost and long-term safety data. Since oral alendronate is generic, many insurers require prior approval for other medications. Randomized controlled trials indicate bisphosphonates have robust fracture reduction: alendronate, risedronate, ibandronate and zoledronic acid have relative risk reduction (RRR) of spine fractures by 50%. Risk reduction of hip fractures is 40% with all bisphosphonates except ibandronate, which does not have hip fracture prevention data. Patients who are not able to tolerate oral bisphosphonates may be considered for intravenous bisphosphonate, zoledronic acid. Bisphosphonates are contraindicated if Glomerular Filtration Rate (GFR)  $\leq 30-35$ . The U.S. Food and Drug Administration (FDA) issued a warning in 2010 about an elevated risk for atypical femur fractures and osteonecrosis of the jaw (ONJ) in patients using bisphosphonates, especially for more than 3-5 years. Bisphosphonates are antiresorptive agents and primarily increase bone mass by decreasing osteoclastic activity. Short-term treatment (3-5 year) benefits far exceed the risks, while long-term treatment ( $>5$  years) benefits are smaller and risks are higher. Residual benefit of bisphosphonates may be retained for several years

after discontinuation. Two randomized extension trials failed to show a reduction in nonvertebral fractures. Both trials showed a reduction in vertebral fractures in patients with high fracture risk as defined as a femoral neck T score  $\leq -2.5$  or patients with a vertebral fracture and femoral neck T score  $\leq -2.0$ . Hence, after 3-5 years of bisphosphonate therapy, perform a comprehensive risk assessment including fracture history, BMD testing and vertebral imaging. Consider discontinuing bisphosphonate therapy or a "drug holiday" for patients who are not at high-risk for fracture.

Second line FDA approved osteoporosis therapies include calcitonin, denosumab, raloxifene and teriparatide. Calcitonin is not commonly used due to suggested risk of increased malignancy. Denosumab is monoclonal antibody, RANKL inhibitor. It has been shown to reduce the incidence of vertebral, nonvertebral and hip fractures. It can be used first line for patients with GFR  $<35$  ml/min. Recent FDA warnings note the increased risk of hypocalcemia, atypical femur fractures and ONJ. Raloxifene is an estrogen agonist that reduces vertebral but not nonvertebral or hip fractures. It reduces the risk of invasive breast cancer but has similar risk of deep vein thrombosis as estrogen. Teriparatide is the only anabolic therapy to stimulate new bone growth. It is administered as a daily subcutaneous injection. Duration is limited to 18-24 months due to increased risk of osteosarcoma in rats. Following treatment, bone growth needs to be maintained with another medication such as a bisphosphonate. Adherence with osteoporosis medications is estimated at only 45% and follow up is important.

Ongoing care of patients with osteoporosis includes interval office appointments for review of universal recommendations for calcium, vitamin D and exercise as well as medication management. Physical therapy is beneficial for patients with osteoporosis for both primary and secondary fracture prevention. Components of an exercise program should include weight bearing activities, resistance training, impact activities, posture training, balance and fall risk reduction. The interval for repeat DXA scans depends on the BMD result, but a minimum of 2 years is recommended.

In summary, the prevention and treatment of osteoporosis is important to reduce fractures and help patients maintain their independence. Patient education of universal bone health and fall prevention recommendations is fundamental. A community support group can be instrumental in accomplishing this. The National Osteoporosis Foundation, [www.nof.org](http://www.nof.org), has resources for establishing support groups, patient educational materials and clinician guidelines. Osteoporosis is an age-related disease, but recommendations for the prevention and treatment of osteoporosis can help maintain a healthy skeleton for a lifetime. ■

### About the Author

Robin Cornell Creamer, DO, FAAFP, is an Assistant Director for the Family Medicine Residency and Geriatric Medicine Fellowship at Florida Hospital. After teaching family medicine for 15 years, she returned to training and completed a fellowship in geriatrics at Florida Hospital. Following her passion of osteoporosis prevention, she leads a National Osteoporosis Foundation (NOF) Support Group-Central Florida Healthy Bones and has received NOF fracture liaison service certification.

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# THE OLDER ADULT DRIVER



*“Driving ability includes important qualities also important for successful ambulation, such as visual, cognitive, and motor function. A history of falls has been associated with an increased risk of motor vehicle crash.”*

With the rapid increase in the population of older adults across the United States, it is estimated that 25% of drivers will be over age 65 by the year 2030.<sup>1</sup> Driving is essential for independence, social contact, and access to nutrition, health care, and other services, but may be difficult for older adults to maintain with normal aging changes and potential comorbid medical conditions. Primary prevention of loss of driving ability, secondary detection and treatment of impaired driving skills, and tertiary management of lost driving capacity are essential if driving capacity and safety are to be maintained.

The prevention, detection and treatment of impaired driving ability is challenging for many health care providers. According to a 2014 survey of Florida health care and social service providers, main barriers to addressing driving concerns in older adults included a lack of tools to assess driving, no time to assess driving, lack of educational resources for older drivers, low awareness of alternative transportation options, and concern about the negative impact on older adults' quality of life.<sup>2</sup> So how can we help older adults drive safely for as long as possible and, when necessary, devise satisfactory alternative means of transportation?



## **Tools to Assess Driving**

Driving ability includes important qualities also important for successful ambulation, such as visual, cognitive, and motor function. A history of falls has been associated with an increased risk of motor vehicle crash.<sup>3</sup> Screening for obvious red flags such as medical conditions known to affect crash risk, potentially driving-impairing medications, and recent driving incidents or behaviors is the first step in assessing driving. Persons on three or more medications or a new medication should have a medication review performed, particularly for anticholinergics, antidepressants, antiepileptics, antihistamines, antihypertensives, antipsychotics, antispasmodics, anxiolytics, hypnotics, opioids and other pain medications. The American Geriatrics Society (AGS) in collaboration with the National Highway Traffic Safety Administration (NHTSA) is revising and updating the Guide to Assessing and Counseling Older Drivers, due for online release in the last quarter of 2015, which will include comprehensive descriptions of medical conditions and categories of medications potentially affecting older adult driving ability, as well as assessment strategies. Until



then, information regarding the risk of well-known cardiovascular, endocrine, neurological, musculoskeletal, orthopedic and visual conditions affecting driving ability can be accessed at NHTSA's website on Older Drivers, <http://www.nhtsa.gov/Driving+Safety/Older+Drivers>.

Driving-related functional skills including visual acuity (Snellen chart), visual fields (by confrontation), and motor skills not compensated by power vehicle modifications (turning the neck to each shoulder, grip and shoulder range of motion as if moving a steering wheel, Get Up and Go test) should be assessed. The Montreal Cognitive Assessment (MoCA [[www.mocatest.org](http://www.mocatest.org)]) is a cognitive screening test which is free, widely available in multiple languages, and a score of 18 or below has been found to correlate with crash risk.<sup>4</sup> Because these functions are the foundations of more complex abilities, if an older adult has a significant problem with any basic cognitive skills, it is likely to affect driving.

Optimizing impaired functional skills is the next step, such as discontinuing driving-impairing medications or improving arthritis. Consider referral to an occupational therapist (OT) or physical therapist (PT) for impairments in functional ability, and medical subspecialty referral may also be needed for visual, neurologic and cardiac conditions (e.g. cataracts, stroke, unstable angina). Older adult drivers with persistent deficits may benefit from referral to a driving rehabilitation specialist (DRS) for further clinical driving evaluations and driving mobility equipment evaluations and intervention to develop or restore driving skills and abilities.

Clinicians should re-evaluate older adults to determine if they have made changes and monitor those who stop driving for signs of depression and social isolation. Clinicians may suggest that older adults and caregivers choose to perform self-assessment of their own driving skills or their vehicle fit and safety through assessments such as the SAFER Driving Survey developed at the University of Michigan (<http://um-saferdriving.org>), the Fitness to Drive Screening Measure developed by the University of Florida (<http://fitnesstodrive.php.ufl.edu/>), or CarFit community events (<http://www.car-fit.org/>).

### No Time to Assess Driving

For medical providers, the time needed to assess older driving abilities may be covered by preventive care codes once a year (99386-99387, 99486-99497), time-based counseling codes (99401-99404), specific procedure codes depending on the tests used for assessment, or under the usual office/outpatient visit codes (99212-5) using a modifier -25 to indicate that multiple E/M services have occurred on the same day. For OT and PT evaluations, time is covered when the reason for referral cites the diagnosis underlying the functional impairment (e.g. arthritis, stroke) and not under a nonspecific referral statement such as "driving evaluation." Formal DRS referrals are covered as part of vocational rehabilitation or a specific condition at the time of the event (e.g. stroke) but rarely afterwards.

### Resources for Older Adult Driver Education and Alternative Transportation

Florida's Safe Mobility for Life Coalition's mission is to improve the safety, access and mobility of Florida's aging road users. Their activities and website are operated through a partnership between the Florida Department of Transportation (FDOT) and the Pepper Institute on Aging and Public Policy at Florida State University (FSU). The website, [www.flams.org](http://www.flams.org), has a wealth of resources and links

to useful information regarding alternative transportation in any county in Florida, how to find a driving rehabilitation specialist, self-assessment and education resources, and for information regarding the state licensing process (Figure 1). A print version of resources call Florida's Guide for Aging Drivers is available for free on request and also in Spanish, as well as other useful materials.

**Figure 1. Safe Mobility for Life website, [www.flams.org](http://www.flams.org)**



### Transitioning from Driving

At regular intervals discuss the ongoing maintenance of driving ability, safe driving behaviors, and potential driving restrictions as with any health maintenance intervention. If it is necessary to begin transitioning from driving, counsel older adults and their caregivers on potential driving cessation, and/or alternative transportation options as needed. Recommendations should emphasize concern for the older adult's safety and the safety of others as the primary reason for giving up driving. However, many patients are upset or angry upon receiving such a recommendation, and if cognitively impaired, some will lack the insight necessary to understand the consequences. It may help to reinforce the recommendation by asking the older adult to repeat back the reasons for driving retirement, to provide a prescription on which "Do Not Drive" is written, and to help the patient create a plan for alternative transportation.

Keep in mind that a caregiver who depends on the older adult for transportation may find it difficult to support a recommendation for driving cessation. At no time should a "co-pilot" be recommended to unsafe drivers, as this merely places both persons at risk, unless it is strictly for the purpose of navigation. A follow-up letter documenting the recommendation for driving cessation and the transportation plan should be sent to the older adult, and—if the older adult consents—to involved caregivers. A copy should also be kept in the chart for documentation.

For older adults who lack capacity and insight, an appointed guardian or caregiver will need to help the older adult comply with the recommendation to stop driving. Many strategies have been employed to circumvent persistent attempts to drive, such as placing reminder signage on doors or inside the windshield on the driver's side, informing the older adult of cancelled insurance, providing

alternative personal photo identification, attempting to collect and remove all sets of keys, grinding down ignition keys, disabling the vehicle by removal of parts or fluids, and removing the vehicle. The older adult often regards gifting the vehicle to a family member as a face-saving strategy. A guardian may forfeit the patient's license and car on the patient's behalf if absolutely necessary as a last resort.

The only special provision for older adult drivers under Florida law is that the renewal period is shortened from eight to six years beginning at age 80, and proof of vision status must be supplied by examination occurring within the preceding year at the time of renewal. Under Florida law, any physician, agency, family member, or the general public, or agency who knows of any licensed driver's mental or physical disability to drive is authorized to report this information to the Department of Highway Safety and Motor Vehicles (DHSMV). Anyone reporting the driver must include their own contact information and sign the report. The contact information is not shared with anyone, including the driver being reported, it is only used in case the report information on the report needs to be clarified. These reports are kept strictly confidential and no civil or criminal action may be brought against the person who submits the information.

Florida has a Medical Advisory Board that advises the DHSMV on medical criteria and vision standards, reviews medical/vision reports and makes recommendations regarding a person's ability to drive safely. After the DHSMV receives a report regarding an unsafe driver, they will notify the reported driver that they need to take action. Depending on the reported findings, the driver may be required to take a re-examination (vision, written, or driving test) or submit a medical report from their doctor for review by the Medical Advisory Board. The board then considers all available facts including the driver's medical condition(s), driving record, and crash history when making their final recommendation.<sup>5</sup> The challenge is in balancing the safety of older adults against their transportation needs and the safety of society. ■

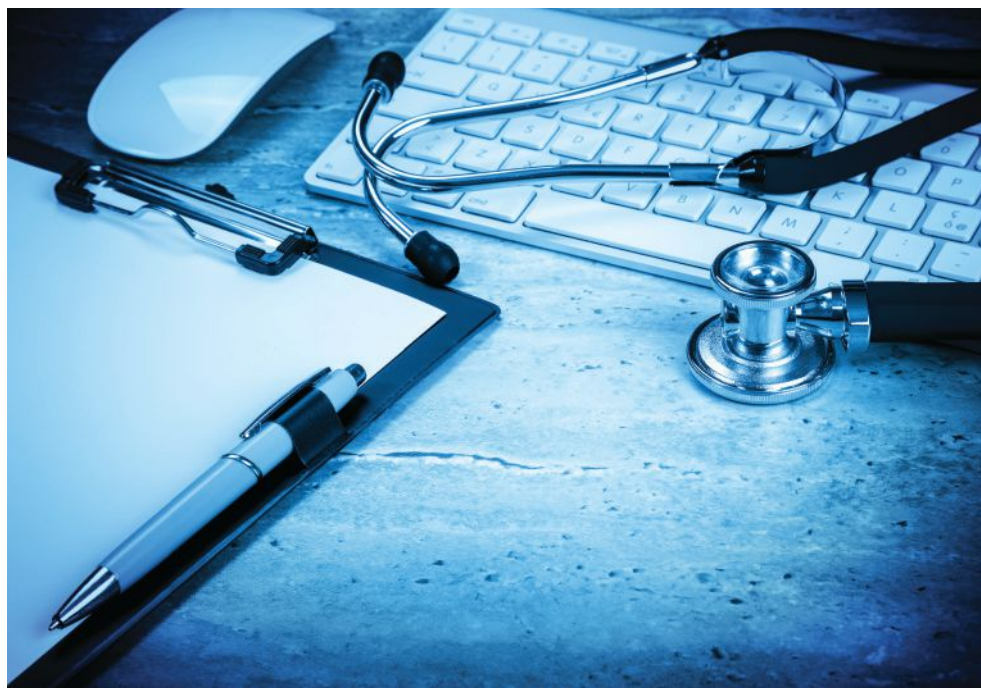
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## About the Author

Alice Pomidor, MD, MPH, AGSF, is a member of Florida's Safe Mobility for Life Coalition (SMFL), whose mission is to improve the safety, access and mobility of Florida's aging road users by developing a comprehensive strategic plan to reduce injuries and crashes among this vulnerable population. She is project co-manager for the SMFL's statewide survey of medical and social service professionals, to determine their current practices and needs regarding older drivers. Dr. Pomidor is also Chair of the American Geriatrics Society (AGS) Public Education Committee and Professor, Department of Geriatrics, Florida State University College of Medicine. She is Chair of the editorial board for a collaborative project between the AGS and the National Highway Traffic Safety Administration (NHTSA) to educate healthcare providers and the public about older driver safety. AGS and NHTSA are working together to revise and streamline web-based educational content based on the former AMA Physician's Guide to Assessing and Counseling Older Drivers, with the goal of increasing the number of participating interprofessional health care providers. She speaks frequently on the subject of driving and most recently co-authored a chapter on "Driving and the Older Adult" in Reichel's *Care of the Elderly*, 7th edition, 2015.

## HOME HEALTH CARE REFERRALS AND DME



*“In order to fulfill the documentation requirements for many of these services we must include information regarding our functional assessment of our patients in our medical records.”*

Home health care nursing and therapy services, along with the ability to prescribe durable medical equipment (DME) are valuable tools that we can use in the care of our older patients. Unfortunately, incorrect prescribing of these items has led to abuse and excess health care costs. This has resulted in an increasing burden of documentation required from the prescribing physician. A clear understanding of the rules can lessen much of the pain of required documentation. As the primary health care provider for patients, we should be able to direct these services correctly so that they remain available.

### **Home Health Care Services**

Care in the home, with special attention to functional needs, is an essential focus in providing good geriatric care. Understanding what is and what is not covered is the first step in providing patient centered care using home health care services.

Home healthcare services covered by Medicare:

- Intermittent skilled nursing services;
- Physical therapy;
- Speech-language pathology services;
- Occupational therapy;
- Home health aide;
- Medical social services;
- Medical supplies; and
- Durable medical equipment.

Home services that are not covered by Medicare:

- 24-hour-a-day care at home;
- Meals delivered to the home;
- Homemaker services; and
- Personal care.

Skilled nursing services can include: services and care that can only be performed safely and effectively by a licensed nurse. Injections, teaching patients to self-inject, tube feedings, catheter changes, observation and assessment of a patient's condition, management and evaluation of a patient's care plan, and wound care are examples of skilled nursing care that Medicare may cover. Physical therapy includes gait training and exercises to regain movement and strength to a body area. Speech-language pathology services include exercises to regain and strengthen speech and language skills. Occupational therapy helps the patient regain the ability to do usual daily activities by themselves, such as eating and putting on clothes. Medicare will pay for therapy services to maintain the patient's condition and prevent them from getting worse as long as these services require the skill or supervision of a licensed therapist, regardless of the potential to improve. If a patient only needs occupational therapy and has not needed other home health care services then they do not qualify for the Medicare home health benefit for isolated occupational therapy. On the other hand if they previously required other home health care services and now only require and are benefitting from occupational therapy, then these services will be covered. A home health aide will be covered if the patient requires other skilled services. A home health aide provides personal care services including help with bathing, using the toilet, and dressing. The patient would not qualify for the Medicare home care benefit if only personal care is needed. Medicare pays in full for services ordered by a physician to help the patient with social and emotional concerns related to the illness. This might include counseling or help finding resources in their community. Medicare pays in full for certain medical supplies provided by the Medicare-certified home health agency, such as wound dressings and catheters needed for the patient's care. Finally, Medicare pays 80 percent of its approved amount for certain pieces of durable medical equipment, such as a wheelchair or walker. The patient is responsible for a 20% coinsurance payment.<sup>1</sup>

A face-to-face visit is now part of the Medicare requirement for home care. This face-to-face visit must have occurred either within 90 days of the needed service or within 30 days if a new need has occurred since the last office encounter. The physician, a nurse practitioner or clinical nurse specialist who is working in collaboration with the physician or a physician assistant under the supervision of the physician may do the face-to-face visit.

Essential points of documentation must include:

- The date of the face-to-face encounter;
- How the patient's clinical condition as seen during that encounter supports the patient's homebound status; and
- The need for skilled services.

According to Medicare, homebound is defined as: the individual has a condition due to an illness or injury that restricts the ability to leave his or her home except with the assistance of another individual or the aide of a supportive device (such as crutches, a cane, a wheelchair or a walker) or if the individual has a condition due to an illness or injury such that leaving his or her home is medically contraindicated.

*“A face-to-face visit is now part of the Medicare requirement for home care. This face-to-face visit must have occurred either within 90 days of the needed service or within 30 days if a new need has occurred since the last office encounter. The physician, a nurse practitioner or clinical nurse specialist who is working in collaboration with the physician or a physician assistant under the supervision of the physician may do the face-to-face visit.”*

Home health care agencies will often provide a face-to-face form but it is acceptable and probably preferable from the physician's standpoint for the documentation to be generated from a physician's electronic medical record at the time of the visit. In our office we use a “ambulatory face-to-face visit” template that has various services to select along with the current diagnosis and attestation choices for homebound status.<sup>2</sup>

### **Durable Medical Equipment**

Medicare covers medically necessary durable medical equipment for use in helping patients meet their mobility related activities of daily living (MRADL) – eating, dressing, bathing, transferring/ambulating and toileting) in their home. An assisted living facility is considered a patient's home but a hospital or skilled nursing facility is not. Examples of some of the most common types of durable medical equipment are: canes, walkers, manual wheelchairs and power mobility devices.<sup>3</sup>

Physician orders for durable medical equipment under Medicare requires that physicians must document that a physician, nurse practitioner (NP), physician assistant (PA) or clinical nurse specialist (CNS) has had a face-to-face encounter with the patient. The encounter must occur within the six months before the order is written for the DME. The date of the written order must not be prior to the date of the face-to-face encounter, and the face-to-face encounter must document that the beneficiary was evaluated and/or treated for a condition that supports the DME item(s) ordered. The Centers for Medicare and Medicaid Services (CMS) believes this new requirement will reduce the risk of fraud, waste, and abuse since these visits help ensure a patient's condition warrants the DME item. During the face-to-face encounter, the physician or other qualified healthcare professional must evaluate the patient, conduct a needs assessment, and/or treat the patient for the medical condition that supports the need for each covered DME item. Documentation in the medical record must include the identity of the practitioner who provided the face-to-face assessment. A written order is required for covered DME items.

The CMS Program Integrity Manual delineates the minimum information that the order must contain:

- Beneficiary's name;
- Item of DME ordered;

- Prescribing practitioner's National Provider Identifier (NPI);
- Signature of the ordering practitioner; and
- Date of the order.<sup>4</sup>

### Power Mobility Device (PMD)

The physician or treating practitioner must conduct a face-to-face examination of the beneficiary before writing a PMD prescription. The PMD prescription must meet the following requirements:

- The PMD prescription must be in writing and signed and dated by the physician or treating practitioner who performed the face-to-face examination, and must be received by the supplier within 45 days after the face-to-face examination.
- The PMD prescription must include the beneficiary's name, the date of the face-to-face examination, the diagnosis and conditions that the PMD is expected to modify, a description of the item, the length of need, the physician or treating practitioner's signature, and the date the prescription was written.

The following exceptions apply to the face-to-face examination requirement:

- A beneficiary discharged from a hospital does not require a separate face-to-face examination if the physician or treating practitioner that performed the face-to-face examination during the hospital stay issues the PMD prescription and supporting documentation to the supplier within 45 days after the date of discharge.
- The face-to-face examination is not required when only accessories for PMDs are being ordered.

In addition to the prescription for the PMD, the physician or treating practitioner must provide the supplier with supporting documentation, which will include relevant parts of the beneficiary's medical record that clearly support the medical necessity for the PMD in the beneficiary's home.

- Relevant information may include the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans.
- The selected records should be sufficient to:
  - o delineate the history of events that led to the request for the PMD,
  - o identify the mobility deficits to be corrected by the PMD,
  - o document that other treatments do not obviate the need for the PMD,
  - o establish that the beneficiary lives in an environment that supports the use of the PMD, and establish that the beneficiary or caregiver is capable of operating the PMD.

In most cases, the information recorded at the face-to-face examination will be sufficient to support medical necessity; however, prior documentation may be necessary when the information recorded at the face-to-face examination refers to previous notes in the medical record.<sup>5</sup>

### Final thoughts

In order to fulfill the documentation requirements for many of these services we must include information regarding our functional assessment of our patients in our medical records. Some items that I like to include in my assessment (and EMR template) are:

History:

- Signs/symptoms that limit ambulation
- Diagnoses that are responsible for these signs/symptoms
- Medications or other treatment(s) for these signs/symptoms.
- Progression of ambulation difficulty over time
- Other diagnoses that may relate to ambulatory problems
- How far the patient can ambulate without stopping and with what assistive device, such as a cane or walker
- Place of ambulation
- History of falls, including frequency, circumstances leading to falls, what ambulatory assistance (cane, walker, wheelchair) is currently used and why it is not sufficient;
- What has changed in the patient's condition?
- Description of the home setting, including the ability to perform ADLs in the home, as well as the ability to utilize the PMD in the home.

Physical findings:

- Weight and height
- Musculoskeletal examination
  - o Arm and leg strength and range of motion
- Neurological examination
  - o Gait assessment
  - o Balance and coordination
  - o If the patient is capable of walking, documented observation of ambulation (with use of cane or walker as appropriate)<sup>6</sup> ■

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# DIFFICULT DECISIONS: NEGOTIATING GUIDELINE RECOMMENDATIONS AND QUALITY MEASURES IN OLDER PERSONS WITH FRAILTY OR LIMITED LIFE EXPECTANCY

Family physicians are deluged by clinical guidelines and quality measures from multiple sources. Patients are deluged by direct-to-consumer advertising, prompting them to “ask your doctor” about the next great medicine or device for their problems. Electronic health records and insurance companies are constantly reminding us to order that A1C level or that your patient’s blood pressure is “not in control.” For your oldest, frailest, and sickest patients your clinical experience and intuition tells you that there is a good chance the patient may be thrown under the bus for some of these “quality” goals.

The main problem is that most guidelines and quality measures are not patient-centered – they are disease (or condition) centered. Take three of the most common measures used by insurance companies or Medicare today – blood pressure, hemoglobin A1C, and lipid levels. Ask a patient, “Why do you take hydrochlorothiazide?” Frequently the patient, especially if older, will likely answer, “Because the doctor told me to.” The patient, the doctor and the third party payer think the goal of treatment is lowering blood pressure. Is it any wonder that many (or most) patients have trouble adhering to treatment recommendations when the “goal” is so unimportant to daily life?

The second problem with guidelines is that they are directed to a single condition and rarely include older persons in the studies that lead to the guidelines. A study of the nine most commonly used guidelines showed that there was limited attention to older patients, the quality of evidence in older patients was poor and rarely included quality of life measures, patient preferences or discussions of the burden of treatment. None discussed trade-offs in goals of therapy.<sup>1</sup>

Real goals of care are things that people care about – being active, going to church, being with family members, reading, exercising, maintaining cognition, not becoming dependent on their children, not going to a nursing home, not dying too soon or dying badly. The question is are the guidelines that drive care, the quality measures used to assess care, related to real goals? I assert that they can be, but a link must be made through a discussion of a care plan with the patient for the goal to become “real.”

The family physician can take the steps listed in **Table 1** to help us move from the disease-centered approach to the patient-centered view of quality.

## Table 1 Steps to Balancing Patient-Centered Care with Guidelines

- Elicit patient-centered goals
- Understand the concept of time to benefit and time to harm
- Develop a care plan for reaching those goals
- Educate patients and their families on the concept of “trade-offs” in medicine
- Advocate for “customized standardization” in medicine

## Elicit patient-centered goals

Understanding the patient’s goals is fundamental to care for older persons with advanced frailty or limited life expectancy. In such persons, treatment is often more burdensome and the patient is likely to experience adverse effects. In addition, such persons have multiple chronic conditions so treatment is far more complex and single condition guidelines may not apply. Patient goals can be elicited by asking the questions in **Table 2**.

## Table 2 Goals of Care Questions

- What is most important in your life?
- What experiences have you had with serious illness or death?
- Can you imagine health experiences that are worse than death?
- Is it important to you to:
- Try to live as long as possible, even with pain or disability?
- Try treatments for a period of time, but stop if you are suffering?
- Focus on quality of life and comfort, even if your life is shorter?
- Have you changed your mind about what matters most in life over time?

(Adapted from Prepare for Your Care)  
{[www.prepareforyourcare.org](http://www.prepareforyourcare.org)} and ACP Decisions  
{[www.acpdecisions.org](http://www.acpdecisions.org)})

### **Understand the concept of time to benefit and time to harm**

Patients often have basic misunderstandings of the way that preventive interventions modify risk. Many treatments for chronic conditions – hypertension, diabetes, COPD – are geared to risk reduction. The time it takes from starting a treatment to seeing a benefit is usually about 3 to 5 years. Even though the blood pressure may be controlled within weeks of starting an antihypertensive medication, the reduction in cardiovascular events will not be seen until years later. Similarly, when a risk-reducing medication is stopped, the harm will not be seen for years, though the evidence about actual timing is not as robust. Treatment geared to symptom reduction ideally has a very short time to benefit – pain medication, rescue inhalers are good examples, but they may also have short time to harm intervals.

### **Develop a care plan for reaching those goals**

Older patients with multiple chronic conditions will usually have a mixture of short-term goals (e.g., having less knee pain so that she can do daily walks with her dog) and long-term goals (e.g., not letting her dementia get so bad that she has to live out her life in a nursing home). One of the most difficult situations is when the treatment oriented to a long-term goal (e.g., not having a stroke and then having to move out of his home) may conflict with achieving a short-term goal (e.g., the blood pressure treatment is keeping his blood pressure so low that he is too tired to walk to the senior center for socialization). Most older people, and especially those with frailty and limited-life expectancy, will choose a short-term goal oriented to quality of life, over a long-term goal of extending life. As the family physician, you may have to advocate for such a choice to the specialists the patient may be seeing. Cardiologists will want to lower cardiovascular risk by lowering the blood pressure or maintaining the statin. But if the patient's quality of life is adversely affected by unsteadiness of gait or muscle weakness, the patient's goals should be the deciding factor.

Recommended preventive interventions are also best addressed by understanding the patient's goals, the time until benefit, and the patient's life expectancy.<sup>2</sup> Interestingly, the patient's functional abilities determine life expectancy to a greater degree than diseases do. The combination of multiple chronic conditions with functional deficits is the strongest determining factor in life expectancy. A healthy 75-year-old woman has a life expectancy of 17 years, while a healthy 75-year-old man has a life expectancy of 14 years. On the other hand, a frail 75-year-old woman has a life expectancy of 7 years and a frail 75-year-old man 4 years. Even a healthy 75-year-old may have difficulty undergoing the prep for a colonoscopy and the relative benefit over screening using occult blood testing is not high. Hence, the short-term goal of remaining active may turn the decision towards a less invasive and more dangerous intervention. An excellent resource for cancer screening decisions is the app *ePrognosis: Cancer Screening* (available for the iPhone or Android).

### **Educate patients and their families on the concept of “trade-offs” in medicine**

Every medical intervention, and even not doing anything, involves risk. Elderly patients are particularly prone to problems due to exposure to multiple medications and changes in physiology from aging that make adverse reactions more likely. Many adverse reactions

(like fatigue) are misinterpreted as “just getting old.” All patients will be faced with multiple questions when a medical intervention is recommended – how will this affect my view of myself, how will I afford it, how will I get to the doctor's office for monitoring, will I have side effects, will it work? Perhaps one of the most difficult, and rarely discussed tradeoff is seen in the treatment of chronic medical conditions in the patient with dementia. Unfortunately, “successful” treatment of chronic conditions like diabetes and hypertension will result in the greater chance of reaching an advanced stage of dementia. Though one can describe what advanced dementia looks like to patients, unless one has cared for someone with advanced dementia it is hard to imagine. Angelo Volandes has done some incredible work using videos to educate patients and their families about medical interventions.<sup>3</sup> Not surprisingly, people's attitudes towards aggressive interventions change when they see pictures of what it really looks like.

### **Advocate for “customized standardization” in medicine**

Donald Berwick, founder of the Institute for Healthcare Improvement and former Director of the Centers for Medicare and Medicaid Services (CMS), has advocated for more standardization in medical care. He is also passionately patient-centered and realizes that at individual customization to the patient's goals is key to good health care outcomes. We are beginning to see such changes in the area of guidelines and quality measures. The American Geriatrics Society (AGS) guidelines on diabetes clearly emphasize patient goals, quality of life and trade-offs in treatment decisions.<sup>4</sup> Recently, the AGS released guidelines devoted to patients with multimorbidity.<sup>5</sup> The Choosing Wisely campaign also has a number of new recommendations targeted to patient-centered goals.<sup>6</sup> Finally, an excellent resource is, “The Best CVD Calculator” which uses the three most common cardiovascular disease risk calculators, melded with patient-centered treatment decision models, to allow patients and their doctors arrive at value-driven customization of care.<sup>7</sup>

Family physicians are in the ideal position to properly apply guidelines and quality measures to frail older adults and those with limited life expectancy. Our strong connection to patients and our commitment to patient, rather than disease-centered, care enables us to help patients make the best decisions based on their goals and preferences. We also need to advocate though the American Academy of Family Physicians (AAFP), Florida Academy of Family Physicians (FAFP) and other groups to ensure that all measures are evidence-based, free from proprietary influence, and incorporate patient values into the metric. ■

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