# Nevada POLST Quick Reference Guide - 2017

## Background

POLST is an acronym that stands for Provider Orders for Life-Sustaining Treatment. POLST helps give seriously ill patients more control over the medical treatment they receive. The POLST is intended for those their Provider would not be surprised should the patient die within a year. That would include the frail elderly, those near the end of a life-limiting illness or terminal condition. The POLST form guides discussions between patients, their families, their health care providers (physician, APRN or PA), and their healthcare team about treatment wishes in instances of serious illness. POLST transforms those wishes into medical orders, which are actionable and to be respected across the continuum of healthcare and home care settings. Research shows that POLST helps to ensure that patients receive the treatments that they want, and do not receive treatments that they do not want.

## POLST is voluntary for patients, but must be honored by healthcare providers

Filling out a POLST form is completely voluntary for patients; however, health care providers are required to explain to POLST profile patients (the frail elderly or those near the *end* of a life-limiting illness) what the POLST is, its features and benefits and how it differs from an Advance Directive.

Nevada law requires that the medical orders of a valid, completed POLST form be honored by healthcare professionals, and provides immunity from civil or criminal liability to those who comply in good faith with a patient's POLST requests.

## POLST and Advance Directives

The POLST form complements an Advance Directive and is not intended to replace that document. An Advance Directive is still necessary to appoint a legal healthcare decision-maker (Durable Power of Attorney for Health Care – DPOA-HC), and is recommended for all adults, regardless of their health status. If a patient lacks decisional capacity, their DPOA-HC may complete a POLST for the patient.

## Completing and signing the POLST form

A POLST form can be completed and signed by a physician, APRN or PA who has a treating relationship with the patient. This includes a primary care provider, but could also include consulting physicians, hospitalists, physicians caring for the patient in a nursing home, and Emergency Department physicians. Knowledge of the patient's medical condition, prognosis, and capacity to make decisions is required, as well as a willingness to have an informed, collaborative discussion with the patient and/or their decision-maker.

## Billing for completing a POLST form

By documenting the potential for a patient to encounter serious illness and complications as a result of their underlying disease, a provider (physician, APRN or PA) may bill for the time that is required to counsel and complete a POLST form. At least half of the time spent in the appointment must be devoted to counseling. Documentation must be explicit. For example: "One half of a 25 minute appointment was spent counseling regarding potential complications of heart failure including cardiac arrest and respiratory failure, and subsequent completion of POLST form."

According to CMS, "these codes will be separately payable to the billing physician or practitioner in both facility and non-facility settings and are not limited to particular physician specialties". ACP may be added as a voluntary, separately payable element of the AWV [Annual Wellness

Visit]. CMS instructs that "when ACP is furnished as an optional element of AWV as part of the same visit with the same date of service, CPT codes 99497 and 99498 should be reported and will be payable in full in addition to payment that is made for the AWV under HCPCS code G0438 or G0439, when the parameters for billing those CPT codes are separately met, including requirements for the duration of the ACP services. Under these circumstances, ACP should be reported with modifier -33 and there will be no Part B coinsurance or deductible, consistent with the AWV". These codes may not be used for telehealth services; the above described services must be face-to-face by the provider.

- 30 min counseling with an established patient = 99497
- 30 min add-on code providing addition reimbursement

## POLST for patients lacking capacity

A healthcare professional can complete the POLST form based on the legal decision-maker's understanding of their loved one's wishes. The legal decision-maker can then sign the POLST form on behalf of the patient. For information regarding who a legal decision-maker may be, see the back of the POLST form under "Completing a POLST"

## Modifying a POLST form

The POLST can be modified or revoked by a patient, verbally or in writing, at any time. Changes by others are limited as follow:

- A legal Representative (DPOA-HC, guardian or parent of a minor) may change, void or over-ride any POLST completed for the patient if the patient lacks decisional capacity.
- A legal Surrogate may *only* change, revoke or over-ride a POLST that they themselves completed for the patient, if the patient lacks decisional capacity.

Such changes should be based on new information or changes in the patient's condition, and should be consistent with the patient's goals of care.

## CPR/Full Treatment requirement

Cardiopulmonary resuscitation (CPR) is defined to include chest compressions and Advanced Cardiac Life Support procedures, including intubation. If CPR is desired, then the full array of CPR procedures should be expected to be implemented. This should be clarified for the patient. If CPR is successful initially and the heart is revived, then it is highly likely that the patient will end up on a ventilator. A patient not willing to accept Full Treatment/ventilator treatment should not have CPR performed. The patient can choose Full Treatment as a "Trial Period" not to be kept on life support if not expected to recover; then, if not recovering, ventilator treatment could be withdrawn in accordance with his/her wishes.

## No CPR and Full Treatment compatibility rationale

"No CPR" represents a treatment decision that applies only to the specific situation of a complete cardiac arrest, where the patient is unconscious, has stopped breathing and has no heartbeat. CPR only applies when a patient has died. "Full Treatment," in comparison, describes treatment that is rendered, if indicated, when patient is still alive and has a heartbeat. "Full Treatment" would be given when in respiratory arrest, where breathing has failed but the patient still has a heartbeat. The prognosis for cardiac arrest is significantly different than the prognosis for respiratory arrest, and it is essential to delineate these differences. "No CPR" and "Full Treatment" is a legitimate combination of Section A and B choices on the POLST form.

## Selective Treatment

This medical intervention is the most complex category of treatment choices to understand. Patients choosing this treatment category generally are asking not to be treated with invasive medical procedures such as mechanical ventilators and major surgery, such as open-heart surgery. However, ICU care is not strictly prohibited. For instance, a patient who has chosen "Selective Treatment" could conceivably be treated in the ICU with intravenous vasopressors if transiently hypotensive, or with bi-level positive airway pressure (BiPAP) or similar respiratory interventions short of intubation, if such treatment is consistent with the patient's goals of care. Similarly, surgery is not prohibited. Consider the case of acute cholecystitis – cholecystectomy may be an option if it can be performed with relative ease and low risk.

Based on empiric experience, the common thread as to what is considered "Selective Treatment" is based upon the risk of the proposed treatment and the predicted course.
*Patients who choose "Selective Treatment" are often communicating that they do not want treatment that will result in prolonged, difficult, uncertain recovery*.

## Comfort-Focused Treatment

This is an appropriate selection when patients wish to avoid treatments for acute, potentially treatable illnesses (i.e., pneumonia ) in favor of treatments focused on relieving discomfort and providing comfort. In addition to pain medication, comfort measures may include other treatment. For example, in the case of a hip fracture, an operation is often performed in order to relieve pain. Without an operation, the patient with a fractured hip would likely have to endure prolonged and inadequately managed pain. Spiritual and psychosocial issues are also important to address.

## Artificially Administered Nutrition

Feeding tubes and enteral nutrition are best discussed with patients using the terminology of "medically prescribed nutrition" or "artificial nutrition." This terminology emphasizes that enteral feeding is a medical treatment that has potential benefits and potential risks.

Medically prescribed nutrition has been shown to be beneficial in some very well defined situations, including head and neck cancers, and also in neurologic syndromes that disproportionately cause dysphagia. There are other situations where medically prescribed nutrition shows no benefit. These include advanced dementia patients, or terminally ill patients who are expected to die within days. There are definite risks associated with enteral feedings in these situations, including aspiration and fluid overload. Artificial nutrition does not generally add comfort to a terminally ill patient.

Studies that are available suggest that most dying patients do not experience hunger pains. In the last days to weeks of life, many patients may force themselves to eat just to please family members. Their bodies and intestinal system cannot accept usual amounts of food and water. Artificial nutrition or fluids given by feeding tubes or intravenous lines often cause discomfort in dying patients, including nausea or abdominal pain. In the last days and hours of life, as the body is shutting down, food and fluids are not absorbed or metabolized. Administering fluids by tube or IV at this time may increase swelling and lung congestion, and cause additional discomfort to the patient.

**PLEASE REFER TO THE BACK OF THE POLST FORM FOR ADDITIONAL INFORMATION**

**This information was adapted with permission from the POLST Quick Reference Guide for Physicians offered by the California Coalition for Compassionate Care.**