Advance Care Planning – now reimbursable under Medicare

Beginning January 1, 2016, Medicare will pay healthcare providers for advance care planning (ACP) discussions with Medicare beneficiaries. Authorization for payment is set forth in the November 2015 Final Rule, published by the Centers for Medicare and Medicaid Services (CMS).

In order to be billable under Medicare, the ACP discussions must be face-to-face conversations with Medicare patients and/or their surrogates (the patient does not need be present) which cover the patient’s specific health conditions, their options for care and what care best fits their personal wishes, and the importance of sharing those wishes in the form of a written document.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Final CY 2016 work RVU</th>
<th>Approx. Amount</th>
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<tbody>
<tr>
<td>99497</td>
<td>Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.</td>
<td>1.50</td>
<td>$86 in doctor’s office/ $80 in hospital</td>
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<tr>
<td>99498</td>
<td>Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physicians or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure).</td>
<td>1.40</td>
<td>$75</td>
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Frequently Asked Questions

1. What qualifies as “advance care planning” for the purposes of these codes?

According to the current procedural terminology (CPT) description:

“Codes 99497 and 99498 are used to report the face-to-face services between a physician or other qualified health care professional and a patient, family member or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms.”

The CPT manual defines an advance directive as a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Relevant legal forms include, but are not limited to, a Health Care Proxy, Durable Power of Attorney for Health Care, a Living Will and/or completion of a Medical Order for Life Sustaining Treatment (MOLST).

California’s POLST form would qualify as a relevant legal form under this definition.
2. Which providers can bill these codes?
The provider billing the codes must be the patient’s “managing physician” or must be providing direct supervision to the qualified health professional conducting the ACP conversation. The codes may be billed by physicians or “non-physician practitioners” (NPPs) whose scope of practice includes the services described by the code and who is authorized to independently bill Medicare for such services. Providers must be in compliance with all applicable Medicare rules regarding authorization to bill (hold an active license, etc.)

3. Who can provide the ACP service billed under these codes?
Advance care planning as described by the CPT codes is primarily the provenance of patients and physicians. Accordingly, CMS “expects the billing physician or NPP to manage, participate and meaningfully contribute to the provision of the services, in addition to providing a minimum of direct supervision”. Standard Medicare “incident to” rules apply to these CPT codes. Thus, when these services are furnished incident to the services of the billing practitioner, including a minimum of direct supervision, these services may be billed. Per CMS, all usual “incident to” PFS payment rules apply, therefore all applicable state law and scope of practice requirements must be met.

4. Can the codes be used more than once?
YES. Both 99497 and 99498 may be billed on the same day. However, 99497 must always be billed for the first 30 minute period of the ACP discussion. If the conversation goes longer, 99498 (the add-on code) must be billed for each additional 30 minutes of the ACP discussion, with no limit. If an ACP discussion is initiated later in the same day, or on a separate day, 99497 is again used for the first 30 minutes and 99498 is used for each subsequent 30 minute period of those discussions.

5. Which patients qualify for this service?
Any Medicare beneficiary is entitled to this service. It is most important to have the ACP discussion with patients who have an end-stage chronic illness, who may not have previously considered their health care options and have critical health care decisions to make, those who have ACP planning needs that involve family members (such as patients with early dementia or mental health concerns), and individuals who lack decision making capacity (developmentally disabled adults) or authority (minor children) and must rely on guardians or parents for decision making.

6. Is there a cost to the patient for the ACP discussion?
MAYBE. Charges to the patient depend on the context of the visit. All Medicare beneficiaries are entitled to an annual wellness visit (AWV) which does not have cost-sharing liability for the beneficiary. If the ACP discussion is part of the AWV, there is no Part B coinsurance or deductible payment. The ACP discussion must always be noted to have been voluntarily conducted, “at the discretion of the beneficiary”, and must be billed separately with an appropriate modifier. If the ACP is conducted at a routine office visit or during another provision of healthcare services, appropriate beneficiary cost-sharing will apply. Clinicians are referred to their organization’s billing office for further detail on billing specifics.
7. Does the patient have to be present?
NO. While it is preferable that the patient be present and participating, the discussion can be between the physician or qualified health professional and the family member or surrogate.

8. Are telephonic or telehealth conversations billable under these codes?
NO. The service must be conducted face-to-face.

9. Are there specific documentation requirements?
NO. CMS did not issue any specific documentation requirements for use of these new codes. However, as with all CMS billing, these codes will be subject to audit. All documentation should support medical necessity for the ACP services, such as: patient has an end stage chronic illness; will be undergoing an emergent or high risk procedure; has had a condition change that prompts the need for ACP; is at increased risk for losing decision-making capacity, etc.

10. Can the ACP codes be used with other Evaluation and Management (E/M) codes?
YES. The time accounted to bill the ACP codes must only be counted for the ACP services. Time for the ACP discussion may not be used to meet the time-based criteria for an E/M service code. There are some prohibitions regarding using ACP codes on the same date of service as specific critical care E/M codes. Clinicians are referred to their billing offices for further detail on billing specifics.

11. Did CMS provide any case examples?
YES. CMS provided an example of a 68-year-old male with heart failure and diabetes. He is on multiple medications and visits his physician for the evaluation and management of these two diseases, including adjusting medications as appropriate. In addition to discussing short-term treatment options, the patient expresses interest in discussing long-term treatment options and planning, such as the possibility of a heart transplant if his heart failure worsens. The patient also wishes to discuss advance care planning, including his desire for care and treatment if he suffers a health event that adversely affects his decision-making capacity.

In this case the physician would bill a standard E/M code for the E/M services (disease and medication management) and one or both of the ACP codes depending upon the duration of the ACP service. If, in addition to the medical management, a half-hour was devoted to the discussion about long-term treatment options and wishes related to future care and treatment if an adverse event occurs, the physician would bill the appropriate E/M codes and 99497 would be billed for the 30 mins of the ACP discussion. Additional time spent on ACP discussion that day would be billed to the add-on code 99498. If on a later date, a follow-up one hour appointment was held for a more detailed ACP discussion, both 99497 for the first 30 minutes and 99498 for the second 30 minutes would be billed.

12. Will other payors, besides Medicare, use these codes and pay for these services?
UNKNOWN. These codes and payment rules apply only to services to Medicare beneficiaries. Medicare Advantage plan enrollees will have to check with their health plan carrier to determine if these codes will be payable. Frequently, other payors adopt Medicare billing and payment rules, but
providers should check with the health plan payor directly to determine applicability of these codes and payment rules.