



Facts & Tips for Healthcare Providers **Advance Care Planning Services for Reimbursement**

Effective January 1, 2016, CMS will pay for Advance Care Planning (ACP) services as outlined below.

- ❖ **Reimbursable Services** – Two CPT codes are active and separately reimbursable:
 - CPT code 99497 – Used for first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate for ACP, including explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician and non-physician practitioners*.
 - Add-on CPT code 99498 – Used for each additional 30 minutes (List in addition to code for primary procedure)
- ❖ **Providers Eligible for Reimbursement**
 - These codes can be billed under Medicare Part B by physicians and non-physician practitioners (NPPs - Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist, and Nurse Midwife)* including palliative care providers.
 - Hospice physicians billing to Part A will not be paid separately for these codes.
- ❖ **Payment Rates** – Reimbursement amounts will vary based on local rates, but general rates are:
 - 99497: First 30 minutes – \$85.99 in Non-Facility; \$79.54 in Facility
 - 99498: Each additional 30 minutes – \$74.88 in Non-Facility; \$74.52 in Facility
- ❖ **Beneficiary Cost-Sharing**
 - There is no beneficiary cost sharing when ACP occurs during the Annual Wellness Visit (AWV), as it is considered preventative. It should be reported with modifier 33.
 - Patients will have to pay the deductible and copay for ACP services that occur outside the AWV. CMS encourages practitioners to notify beneficiaries of this.
- ❖ **When & Where ACP Services Can Be Provided**
 - These codes may be billed on the same day or a different day as other Evaluation & Management (E/M) services.
 - The services can be provided during the same service period as Transitional Care Management (TCM) and Chronic Care Management (CCM) services.
 - 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 codes cannot be reported on the same date of service as certain critical care services, including neonatal and pediatric critical care.
 - These services can be provided using a team-based approach where ACP is provided by physicians, non-physician practitioners and other staff under the order and medical management of the beneficiary's treating physician. "Incident to" rules apply when these services are furnished incident to the services of the billing practitioner, including a minimum of direct supervision. CMS expects the physician or NPP to "manage, participate and meaningfully contribute to the provision of the services, in addition to providing a minimum of direct supervision."
- ❖ **ACP Services Implementation**
 - **Content** - Advance care planning services can include "discussion about future care decisions that may need to be made, how the beneficiary can let others know about care preferences, and explanation of advance directives which may (or may not) involve the completion of standard forms." This can include a discussion of short-term treatment options as well as long-term goals of care.

Note: Full details of the rule, "Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016," are available at <https://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf>.

❖ Tips for Having the Conversation

• **Triggers for Having the Discussion:**

- Welcome to Medicare visit for patients who have turned 65 since you last saw them
- Annual visit of anyone 65 or older, though service is not limited to those over age 65
- Diagnosis of a serious illness or exacerbation of a chronic illness (e.g. hospitalization, ED visit, etc.)
- When patient makes a comment about end-of-life planning such as “I don’t want to die like my aunt / brother / friend,” or they explicitly request such a conversation.

• **Things to Keep in Mind:**

- **This conversation will look very different for relatively healthy patients vs. seriously ill patients.**
- Patients have goals and priorities besides living longer; learning about them helps you to provide better care.
- Starting the conversation is the hardest part. Don’t wait for the “perfect time” because there isn’t one.
- Make sure the setting is appropriate and that other significant people are present. Explain why you’re raising the topic of health goals now (e.g. may relate to illness prognosis, the fact that you always discuss this, etc.).
- Anxiety is normal for both patient and clinician during these discussions. Don’t be afraid of silence. Don’t rush.
- Start with general questions about the patient’s goals for future health care treatment before moving into the specifics of their prognosis, or how they would manage uncertainty of different treatments.
- Don’t talk more than half of the time. Avoid medical jargon. Stop frequently to check a patient’s understanding.
- If dealing with a specific illness, discuss clear strategies for future treatment.
- Emphasize that you are there for the patient and will remain actively involved in their care.
- Stress that this is an ongoing conversation.

• **Questions to Consider, as Appropriate:**

- What is your understanding of where you are with your illness? [or, Do you have any serious health concerns?]
- What are your biggest fears and worries about your future health? Does your family have concerns?
- Who would you want to communicate for you and make health care decisions if you were unable to do so?
- Are there any situations you’ve heard about, or seen on TV, where you’ve said to yourself, “I hope that never happens to me,” or “I would never want to live like *that*.” If so, what are they? Why do you feel this way?
- For the situation(s) you just identified, what do you think should be the goals for your care? For example, should the goal be to prolong your life, to improve/maintain your function, to provide comfort care, etc.
- Are there any life-sustaining treatments that you *would* or *would not* want to receive? [Provide examples.] What are they and why do you feel this way about them?
- In the event that you are dying, where would you want (or not want) to receive your care?
- How much of this have you talked about with your family or loved ones?

❖ ACP Documentation - Documentation must follow standard E/M documentation guidelines to support the CPT code billed. CMS will monitor utilization of the new CPT codes to ensure that they are used appropriately. Consider documenting the following elements of the discussion:

- I spent ____ minutes in face-to-face counseling re: Advance Care Planning including the discussion of the patient’s goals of care and preferences, future treatment options and decisions, and an explanation of advance directives.
- In addition to the patient, _____ was present.
- Patient/Family was educated about the patient’s overall prognosis and disease trajectory.
- Goals of care discussion included _____. (*Reduce unnecessary hospitalizations, Maintain quality of life, Have symptoms well managed, Continue all efforts to prolong life.*)
- Patient and family had an opportunity to ask questions.
- A copy of _____ was provided. (*Isn’t It Time We Talk?, Advance directive forms*)
- Patient has completed Advance Directives and they are on file.
- Patient’s Healthcare Power of Attorney is name, contact information.
- A follow-up appointment has been made to discuss _____.