CODING Alert

MSMS MICHIGAN STATE MEDICAL SOCIETY

MARCH 2017

Advance Care Planning

What is Advance Care Planning?

This is a face-to-face service between a physician or qualified health care professional and a patient, family member, or surrogate in counseling and discussing the advance directives, with or without completing relevant legal forms.

The advance care directive is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity. In the United States, it has a legal status in itself whereas in some countries it is legally persuasive without being a legal document.

Coding Specifics

Effective January 1, 2015, CPT codes 99497 and +99498 are used to report advance care planning (ACP). The patient need not be present as the discussion can also be between a physician or a qualified health professional and a family member or surrogate. When using 99497 and +99498, no active management of the problem or problems is undertaken during this time period reported. These codes are limited to the discussion of advance care planning only.

ACP may be billed with other Evaluation & Management (E/M) services on the same day, as well as during a Transitional Care Management (TCM) or Chronic Care Management (CCM) period and global surgical period. If ACP is done in conjunction with an annual wellness visit, the services is considered a preventive service and modifier 33 would be applied to the claim, and the deductible and coinsurance for the ACP is waived.

CPT exclusionary parenthetical note states critical care codes 99291 and 99292, the neonatal and pediatric critical care codes 99468-99476, and the initial and continuing intensive care services codes 99477-99480 should not be reported with advance care planning codes 99497 and +99498.

Codes 99497 and +99498 are time-based with 99497 reported for the first 30 minutes and add-on code 99498 reported for each additional 30 minutes.

Questions

For more information on reimbursement and coding issues, contact MSMS Reimbursement Advocate, Stacie J. Saylor, CPC, CPB, at (517) 336-5722 or ssaylor@msms.org.

Resources

- *CMS Frequently Asked Questions for ACP Services*
- *MQIC Advance Care Planning Guideline*

Health Plans that Reimburse Advance Care Planning

(January 2017)

- Blue Cross Blue Shield of Michigan
- Health Alliance Plan
- Health Plus
- Medicare
- Michigan Medicaid
- Priority Health

Frequently Asked Questions

Billing Advance Care Planning (ACP) services to the Physician Fee Schedule (PFS) under CPT codes 99497 and 99498 as of January 2016

CPT Code 99497

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

CPT Code 99498

Each additional 30 minutes (List separately in addition to code for primary procedure)

1. **CPT codes 99497 and 99498 are time-based codes (a base code and an add-on code). Are there minimum amounts of time required to bill these codes?**

   In the calendar year (CY) 2016 PFS final rule, we adopted the CPT codes and CPT provisions regarding the reporting of timed services. Practitioners should consult CPT provisions regarding minimum time required to report timed services. If the required minimum time is not spent with the beneficiary, family member(s) and/or surrogate to bill CPT codes 99497 or 99498, the practitioner may consider billing a different evaluation and management (E/M) service such as an office visit, provided the requirements for billing the other E/M service are met.

2. **Are there limits on how often I can bill CPT codes 99497 and 99498?**

   Per CPT, there are no limits on the number of times ACP can be reported for a given beneficiary in a given time period. Likewise, the Centers for Medicare & Medicaid Services has not established any frequency limits. When the service is billed multiple times for a given beneficiary, we would expect to see a documented change in the beneficiary's health status and/or wishes regarding his or her end-of-life care.

3. **In what settings can ACP services be provided and billed: Inpatient? Nursing home? Other?**

   There are no place of service limitations on the ACP codes. As we stated in the CY 2016 PFS final rule, ACP services may be appropriately furnished in a variety of settings depending on the needs and condition of the beneficiary. The codes are separately payable to the billing physician or practitioner in both facility and non-facility settings and are not limited to particular physician specialties.

4. **Who can perform ACP services?**

   As we said in the CY 2016 FPS final rule, the services described by CPT codes 99497 and 99498 are appropriately provided by physicians or using a team-based approach provided by physicians, non-physician practitioners (NPPs) and other staff under the order and medical management of the beneficiary's treating physician. The CPT code descriptors describe the services as furnished by physicians or other qualified health professionals, which for Medicare purposes is consistent with allowing these codes to be billed by the physicians and NPPs whose scope of practice and Medicare benefit category include the services described by the CPT codes and who are authorized to independently bill Medicare for those services. Therefore, only these practitioners may report CPT codes 99497 or 99498. The ACP services described by these codes are primarily the provenance of patients and physicians; accordingly we expect 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. The usual PFS payment rules regarding "incident to" services apply, so that when the services are furnished incident to the billing physician or practitioner all applicable state law and scope of practice requirements must be met and there must be a minimum of direct supervision in addition to other incident to rules.

5. **Can ACP services be furnished without beneficiary consent?**

   Since ACP services are voluntary, Medicare beneficiaries (or their legal proxies when applicable) should be given a clear opportunity to decline to receive ACP services. Beneficiaries, family members and/or surrogates may receive assistance for completing legal documents from others outside the scope of the Medicare program in addition to, or separately from, the physician or NPP.

6. What must be documented for the service?

Practitioners should consult their Medicare Administrative Contractors (MACs) regarding documentation requirements. Examples of appropriate documentation would include an account of the discussion with the beneficiary (or family members and/or surrogate) regarding the voluntary nature of the encounter; documentation indicating the explanation of advance directives (along with completion of those forms, when performed); who was present; and the time spent in the face-to-face encounter.

7. Does the beneficiary/practice have to complete an advance directive to bill the service?

No, the CPT code descriptors indicate "when performed," so completion of an advance directive is not a requirement for billing the service.

8. Can ACP be reported in addition to an E/M service (e.g., an office visit)?

CMS adopted the CPT codes and CPT provisions regarding the reporting of CPT 99497 and 99498 (see #1). This includes the CPT instructions that CPT codes 99497 and 99498 may be billed on the same day or a different day as most other E/M services, and during the same service period as transitional care management services or chronic care management services and within global surgical periods. CMS also adopted the CPT guidance prohibiting the reporting of CPT codes 99497 and 99498 on the same date of service as certain critical care services including neonatal and pediatric critical care.

9. What diagnosis must be used?

No specific diagnosis is required for the ACP codes to be billed. It would be appropriate to report a condition for which you are counseling the beneficiary, an ICD-10-CM code to reflect an administrative examination, or a well exam diagnosis when furnished as part of the Medicare Annual Wellness Visit (AWV) (see #11).

10. Do deductible/coinsurance amounts apply to this code?

The usual Part B deductible and coinsurance apply except when ACP is furnished as an optional element of the AWV (see MLN Matters article MM9271/CR9271 for more information). Since ACP services are voluntary, when a beneficiary (or family members and/or surrogate) elects to receive ACP, we encourage practitioners to notify them that Part B cost sharing will apply as it does for other physicians' services (except when ACP is furnished as an optional element of the AWV).

11. Where can I find additional information?

These FAQs draw on the final rule policies for ACP delineated in the CY 2016 PFS final rule (80 Fed. Reg. 70955 through 70959, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html). For additional information, we refer readers to that final rule and to the Medicare Learning Network Matters article MM9271/CR9271/R216BP and R3428CP (available at ttps://www.cms.gov/Outreachand-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html). CR9271 provides detailed billing instructions when ACP is furnished as an optional element of the AWV.

Visit CMS.gov for this and more information.

MSMS
MICHIGAN STATE MEDICAL SOCIETY

120 West Saginaw St., East Lansing, MI 48823 » P: 517 / 337.1351 » E: msms@msms.org

Michigan Quality Improvement Consortium
Clinical Practice Guideline Update Alert

Guideline: Advance Care Planning

Released: January 2016

Updated recommendations include:

Eligible Population
- Patients whose death in the next twelve months would not be surprising
- Patient with New or Established Diagnosis of a Serious Illness
- Consider patients aged 18 and over, in any stage of health

Advance Care Planning Process
- Evidence-based training in advance care planning is recommended for any person facilitating ACP conversations*

Assist patient in Advance Care Planning
- Encourage the patient to complete an Advance Directive (including Healthcare Power of Attorney and Patient Advocate Role Acceptance)
- Incorporate the patient's goals preferences and choices into the Treatment Preferences portion of the Advance Directive

Documentation and Implementation
- Place a copy of the Advance Directive documenting the designation of a surrogate/decision maker, patient's values and beliefs and goals for end of life care, and POLST, in the health record and in retrievable electronic format when available
- Incorporate the Advance Directive into the person's plan of care
- Make the Advance Directive and POLST accessible throughout the health system, to emergency departments, EMS companies, nursing homes, and share with family

*Respecting Choices
Making Choices Michigan
Five Wishes

This alert provides a brief summary of updated recommendations. Refer to the complete guideline for all recommendations and level of evidence.

January 2016

Michigan Quality Improvement Consortium Guideline

Advance Care Planning

The purpose of this guideline is to assist the practitioner in engaging the patient in a discussion of goals, preferences, and priorities regarding the patient's care at different stages of life. The guideline recommends tools and interventions to address Advance Care Planning across the patient population.

Eligible Population	Key Components	Recommendation
Patients whose death in the next twelve months would not be surprising Patient with New or Established Diagnosis of a Serious **Illness** Consider patients aged 18 and over, in any stage of health	Advance Care Planning Process	**Relevant topics include:** ◆ The value of making one's goals preferences and choices for care and treatment known both verbally and in writing ◆ The importance of early conversations with family in a non-crisis situation ◆ The value of identification of a surrogate decision-maker, with consent ◆ The value of cultural sensitivity ◆ For appropriate patients, the value of having a Physician's Orders for Life-Sustaining Treatment (POLST)[1] ◆ Discussion should include family members, the surrogate decision-maker, and others who are close to the patient ◆ Any individual can start the conversation (patient, family, physicians, nurses, behavioral health providers, social workers, clergy, trained facilitator, etc.) ◆ Evidence-based training in advance care planning is recommended for any person facilitating ACP conversations[2] ◆ At the later stages, the facilitator should have experience with/knowledge of the patient's specific condition (e.g. CHF, cancer)
	Assist patient in Advance Care Planning	**Use an Advance Care Planning tool[2] to:** ◆ Help the patient identify a surrogate who would make decisions on their behalf if they did not have decision-making capacity ◆ Encourage the patient to complete an Advance Directive[3] (including Healthcare Power of Attorney and Patient Advocate Role Acceptance) ◆ Incorporate the patient's goals preferences and choices into the Treatment Preferences portion of the Advance Directive ◆ Encourage the patient to discuss their preferences and care plan with the surrogate, family member, spiritual counselor and others
	Revision of Advance Care Plan	◆ Review the patient's goals and preferences for end-of-life care and advance directives at least annually ◆ With a significant change in prognosis, work with the patient to update his/her advance directives, giving consideration to specific potential scenarios ◆ If patient has limited life expectancy, consider using the POLST[1] tool to address the patient's specific requests for end-of-life care
	Documentation and Implementation	◆ Place a copy of the Advance Directive documenting the designation of a surrogate/decision maker, patient's values and beliefs and goals for end of life care, and POLST[1], in the health record and in retrievable electronic format when available ◆ Incorporate the Advance Directive into the person's plan of care ◆ Make the Advance Directive and POLST[1] accessible throughout the health system, to emergency departments, EMS companies, nursing homes, and share with family

[1] Physician's Orders for Life-Sustaining Treatment (POLST)

[2] Respecting Choices Making Choices Michigan Five Wishes

[3] In Michigan, the only legally recognized advance directives are Durable Power of Attorney for Health Care (DPOA) and Do Not Resuscitate (DNR). Living wills are not legally recognized by the State of Michigan.

Levels of evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the Institute of Medicine Dying in America, Improving Quality and Honoring Individual Preferences Near the End of Life Key Findings and Recommendations (**http://iom.nationalacademies.org/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx**); The American Medical Association: E-2.225 Optimal Use of Orders Not To Intervene and Advance Directives (**http://www.ama-assn.org//ama/pub/physician-resources/medical-ethics/about-ethics-group/ethics-resource-center/end-of-life-care/ama-policy-end-of-life-care.page**); NCCN Clinical Practice Guidelines in Oncology: Palliative Care, Version 2.2011 (**http://www.nccn.org/professionals/physician_gls/f_guidelines.asp#palliative**); Physician Orders for Life-Sustaining Treatment Paradigm; and The National Committee for Quality Assurance: 2010 Special Needs Plan (**http://www.ncqa.org/Programs/OtherPrograms/SpecialNeedsPlans.aspx**); Institute for Clinical Systems Improvement, Palliative Care for Adults health care guideline, Updated November 2013 (**https://www.icsi.org/_asset/k056ab/PalliativeCare.pdf**); Advance Care Planning Decisions (**http://www.acpdecisions.org/**). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Approved by MQIC Medical Directors January 2012, 2014, 2016