

# FAQs: Advance Care Planning Under Medicare

As of January 1, 2016, Medicare began reimbursing 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).

CPT Code	Description
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 (APRN in Hawaii); first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.
99498	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).

## Frequently Asked Questions

### 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 Provider Orders for Life-Sustaining Treatment (POLST). Hawaii’s POLST form would qualify as a relevant legal form under this definition.

### Are there any limitations on the place of service for the ACP codes?

NO. ACP services may be appropriately furnished in a variety of settings depending on the needs and condition of the beneficiary, including inpatient, nursing home and physician offices. The codes are separately payable to the billing physician or practitioner in both facility and nonfacility settings.

### Which providers can bill these codes?

Use of the codes is not limited to particular physician specialties. 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.)

### **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.

### **Are there minimum amounts of time required to bill these codes?**

Codes 99497 and 99498 are time-based codes and CMS adopted the CPT codes and CPT provisions regarding the reporting of timed services.

Code 99497 can be billed for the first 30 minutes of the ACP conversation. For an ACP conversation of less than 16 minutes, CMS suggests considering billing a different evaluation and management (E/M) service such as an office visit. (The quality of ACP performed in brief encounters may be questionable, therefore, brief visits for the purpose of ACP are probably best reported as part of a routine E/M service.)

To bill 99497 AND the add-on code 99498, the ACP conversation must last 46 minutes or longer (i.e., at least 16 minutes beyond the initial 30 minutes of the primary service).

### **Can the codes be used more than once?**

YES. Per CPT, there are no limits on the number of times or how frequently ACP can be reported for a given beneficiary in a given time period. However, when the service is billed multiple times for a single beneficiary, CMS expects to see documentation which supports the need for multiple conversations – such as a change in health status and/or wishes regarding care.

### **Is code 99497 always billed first?**

Yes. Code 99497 must always be billed for the first 30 minute period of the ACP discussion. If the conversation lasts longer, 99498 (the add-on code) may be billed for each additional 30 minutes of the ACP discussion, with no limit. If an ACP discussion is initiated with the same patient 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.

**Which patients qualify for this service?**

Any Medicare beneficiary is entitled to this service. According to CMS, 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.

**Must a specific diagnosis be used?**

NO. No specific diagnosis is required for the ACP codes to be billed. CMS has stated that it would be appropriate to report a condition for which the provider is 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).

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

ACP services are voluntary. Therefore, Medicare beneficiaries (or their legal proxies when applicable) should be given a clear opportunity to decline to receive ACP services.

**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. Since ACP services are voluntary, when a beneficiary (or family members and/or surrogate) elects to receive ACP outside the AWV, CMS encourages practitioners to notify patients that Part B cost sharing will apply as it does for other physicians' services. Clinicians are referred to their organization's billing office for further detail on billing specifics.

**Does the patient have to be present?**

NO. While it is preferable that the patient be present and participating, the ACP discussion can be between the physician or qualified health professional and the family member or legally authorized representative or agent.

**Are telephonic or telehealth conversations billable under these codes?**

NO, not currently. The service must be conducted face-to-face. However, CMS is proposing to add the advance care planning codes to the list of services eligible to be furnished via telehealth under the Medicare Physician Fee Schedule for Calendar Year (CY) 2017.

**Are there documentation requirements?**

Practitioners are advised to consult their Medicare Administrative Contractors (MACs) regarding documentation requirements. While CMS has not issued specific requirements, it has suggested the following as examples of appropriate documentation: 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.

### **Can the ACP codes be used with other Evaluation and Management (E/M) codes?**

YES. 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. 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. 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. Clinicians are referred to their billing offices for further detail on billing specifics.

### **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.

### **Will other payors, besides Medicare, use these codes and pay for these services?**

UNKNOWN. Frequently, other payors adopt Medicare billing and payment rules, but they are not required to do so. Providers of patients enrolled in a Medicare Advantage plan or other payer will have to check directly with their health plan carrier to determine if these codes will be payable. HMSA has adopted the Medicare codes and will recognize them in their P4Q program. These codes will be recognized for people with HMSA as a primary or secondary payer.

*August 2016 - Adapted with permission from the Coalition for Compassionate Care of California*