Advance Care Planning Billing Codes: Benefits and Barriers for Palliative Care Teams

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Disclosures

• Dr. Rodgers had nothing to disclose relevant to today’s presentation.

• He serves as the American Academy of Hospice and Palliative Medicine (AAHPM) representative to the American Medical Association Relative Value Scale Update Committee (AMA RUC). This is a **volunteer** position.
Objectives

• Describe the new Current Procedural Terminology (CPT) codes for Advance Care Planning services, including requirements for reporting;

• Summarize key benefits, barriers and considerations for palliative care teams to report advance care planning services separately through the new CPT codes;

• Develop a strategy for your providers and team to maximize the value of ACP code reporting
History – ACP Codes


• 2014: CPT creates new Advance Care Planning codes, forwards them to AMA Relative Value Scale Update Committee (RUC)

• 2014: RUC recommends RVU values for ACP codes; Medicare acknowledges ACP codes for CY2015, but does not begin payment

• 2016: Medicare begins making payment on January 1.
How did the ACP codes succeed?

• Broad support among the physician community

• Growing cultural attention to palliative care and EOL care

• Momentum for change in Medicare payment among diverse stakeholders

• Support from key patient and consumer groups
Medicare Reimbursement

• Starting January 1, 2016, Medicare began separate payment for ACP services, as follows:
  • 99497: 1.5 RVUs
  • 99498 (add on): 1.4 RVUs

• Code descriptors and values were adopted as recommended by the CPT Editorial Panel and Relative Value Scale Update Committee (RUC)
CPT Codes for ACP Services

- **99497**: “Advance Care Planning including the explanation and discussion of advance directives such as standard forms (including the completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family members and/or surrogate”.

- **99498** *(add-on)*: Each additional 30 minutes
CPT Codes for ACP Services

• **99497**: “Advance Care Planning including the *explanation and discussion* of advance directives such as standard forms (including the completion of such forms, when performed), by the *physician or other qualified health professional*; *first 30 minutes*, face-to-face with the *patient, family members and/or surrogate*”.

• **99498** (add-on): *Each additional 30 minutes*
What services are covered?

• Medicare provided *no specific requirements* for using ACP codes, beyond what is included in the code descriptors (though it may do so in future rulemaking)

• “Advance Care Planning” *may* include:
  – Discussion of goals and preferences for care
  – Complex medical decision-making regarding life-threatening or life-limiting illness
  – Explanation of relevant advance directives, including (but NOT requiring) completion of advance directives
  – Engaging patients, family members and/or surrogate decision makers, as clinical situation requires
Documentation Best Practices

• Document a brief summary of the voluntary conversation
  – Detail should reflect and justify length/complexity of the conversation
  – Document who was present, including the patient
  – Document either start/stop time, or total time in minutes

• Form completion may or may not occur
  – If forms are completed, document which forms were completed and maintain a copy in the record

• No diagnosis requirements, but...
  – If a serious illness is featured in documentation, it is should be reported on claim
Who can report the ACP codes?

- “Qualified” providers defined under Medicare Part B can report ACP codes for payment
  - Physicians (MD/DO), Nurse Practitioners and Physician Assistants
  - Other team members via applicable ‘incident to’ requirements

- All other providers (social work, psychology, chaplains) may not report codes independently
Where can the ACP codes be reported?

• ACP codes may be billed by qualified providers in any clinical setting:
  – Inpatient, observation, ED
  – Clinic
  – Home or ‘domicile’ (adult foster care, assisted living, etc.)
  – Skilled Nursing Facility
  – Long-term care
  – Hospice, if ‘qualified provider’ bills Medicare Part B

• May be used in ‘Hospital Outpatient’, FQHC and RHC settings, though some restrictions apply
ACP can be billed on the same day as:

- New or Established outpatient visits (99201-99215)
- Annual Wellness Visits (AWV)—once yearly
  - Use modifier 33 to waive patient deductible or coinsurance
- Hospital observation or inpatient visits (99217-99226), (99231-99236), (99238-99239)
- Consults (99241-99255)
- ED Visits (99281-99285)
- Nursing/Domiciliary Visits (99304-99310), (99324-99328), (99334-99337)
- Home visits (99341-45), (99347-99350)
- Transitional Care Management (TCM) (99495-99496)
ACP Codes cannot be billed with

- Most Critical Care Codes
- Care Plan Oversight Codes
- New Cognitive Impairment Evaluation Codes
How frequently can codes be reported?

• No limit to frequency, guided by medical necessity
  – AWV (no copay) is limited to once per year

• Documentation should support all services, especially high-frequency or prolonged time

• It is anticipated that when ACP is billed multiple times for the same patient, Medicare indicates they would expect to see a change in the health status and/or wishes for end of life care

• Will be subject to audit, like all services
ACP codes and “incident-to” billing

• Only applies to Part B (fee-for-service) Medicare patients
• Requires that general ‘incident-to’ provisions are met:
  1. Patient must be established patient under ongoing care of the billing physician
  2. The physical location of the conversation must take place in an an office, billed with Place of Service (POS) 11.
  3. The service (ACP) is one that a physician could provide, but has delegated to capable employee
  4. The delegated employee must be an employee of the physician group/practice
  5. A supervising physician must be available in person (direct supervision) to participate in the service as needed and address questions. The supervising physician must be the billing physician, but does not need to be the ordering physician.
What are Time Requirements to report ACP?

• When Advance Care Planning services (as described in the code) are performed for a length of time equal to ‘one minute past the midway point’ of the code interval

  • **99497 (first 30 mins):** at least 16 minutes of time spent performing services described in the code

  • **99498 (add’l 30 mins):** at least 16 minutes beyond the first 30 minutes; may be billed as many times as needed to cover the time spent
Time Thresholds for Reporting ACP codes

- Up to 15 minutes: included in E/M code
- 16-45 minutes: 99497
- 46-75 minutes: 99497 + 99498
- 76-105 minutes: 99497 + 99498 x 2
- 106 – 135 minutes: 99497 + 99498 x 3, etc
- May report additional 99498s to cover the time spent performing extended services
What about Prolonged Services codes?

- Provides reimbursement for prolonged face-to-face service with patient in hospital, outpatient, home or facility settings
  - ‘Base codes’ for first 60 minutes (can report at 31 minutes)
  - ‘Add on codes’ for each add’l 30 minutes (can report at 76 minutes)
- Requires a ‘companion’ E/M code (inpatient, office, home, facility)
- Can be used to describe extended palliative care encounters, including advance care planning services
ACP Codes
• Time-based code
• Can be provided in any site of service
• Documentation should support services delivered
• Does not require another E/M service to be reported
• Can be reported after 15 minutes of service, with or without accompanying E/M
• RVU values are the same in any site of service

Prolonged Services Codes
• Time-based code
• Can be provided in any site of service
• Documentation should support services delivered
• Requires another E/M service to be reported
• Can be reported after 30 minutes of service, in addition to accompanying E/M
• RVU values are now higher in the office setting
## RVU Comparison: ACP vs. Prolonged Service
*(reported with another E/M service)*

<table>
<thead>
<tr>
<th>Time (minutes)</th>
<th>ACP Codes</th>
<th>Prolonged Service</th>
<th>Prolonged Service (office)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 15</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16 – 30</td>
<td>1.5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>31 – 45</td>
<td>1.5</td>
<td>1.77</td>
<td>2.33</td>
</tr>
<tr>
<td>46 – 75</td>
<td>2.9</td>
<td>1.77</td>
<td>2.33</td>
</tr>
<tr>
<td>76 – 105</td>
<td>4.3</td>
<td>3.48</td>
<td>4.04</td>
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<tr>
<td>106 – 135</td>
<td>5.7</td>
<td>5.19</td>
<td>5.75</td>
</tr>
<tr>
<td>136 – 165</td>
<td>7.1</td>
<td>6.9</td>
<td>7.46</td>
</tr>
<tr>
<td>166 – 195</td>
<td>8.5</td>
<td>8.61</td>
<td>9.17</td>
</tr>
</tbody>
</table>

*For 2017, RVUs for office-based prolonged service will increase from 1.77 to 2.33*
Benefits for Palliative Care Teams

• Capture revenue for visits more targeted to advance care planning, goals of care, family meetings
• Streamline documentation (ACP narrative vs. E/M documentation)
• More accurately describe services delivered through billing data
• Added revenue from consults/visits with significant advance care planning work
• In the right settings, may be able to include the work of interdisciplinary clinicians through ‘incident-to’ billing
Barriers

- Developing systems and supports to identify when and how to optimize ACP code use (type of visits, time thresholds, ACP vs. prolonged services)
- Providing billing clinicians with training and resources to optimize billing in real time
- Meeting documentation requirements, while minimizing clinician burden
- Educating billing professionals on code requirements
Possible threats to ACP code reimbursement

• Per CMS rulemaking, payment for ACP codes is dictated by each Medicare Administrative Contractor (MAC)—this could result in nonpayment.

• Legislation introduced in the US House of Representatives (HR410), by Steve King (R-IA), would eliminate Medicare payment for ACP services.
Summary

• Advance care planning (ACP) codes offer palliative care teams a new source of reimbursement for services they deliver every day
• Codes are primarily time based, and can be reported in all settings, with or without an accompanying E/M service
• Documentation should reflect the length and intensity of service
• In some circumstances, prolonged services codes may be preferable IF another E/M service is also provided
• If ‘incident-to’ requirements are met, time spent by interdisciplinary clinicians may be reported via ACP codes
Resources

• CMS/Medicare Learning Network: [http://go.cms.gov/2bWsju7](http://go.cms.gov/2bWsju7)
• CMS FAQs about ACP Services: [http://go.cms.gov/2icWena](http://go.cms.gov/2icWena)