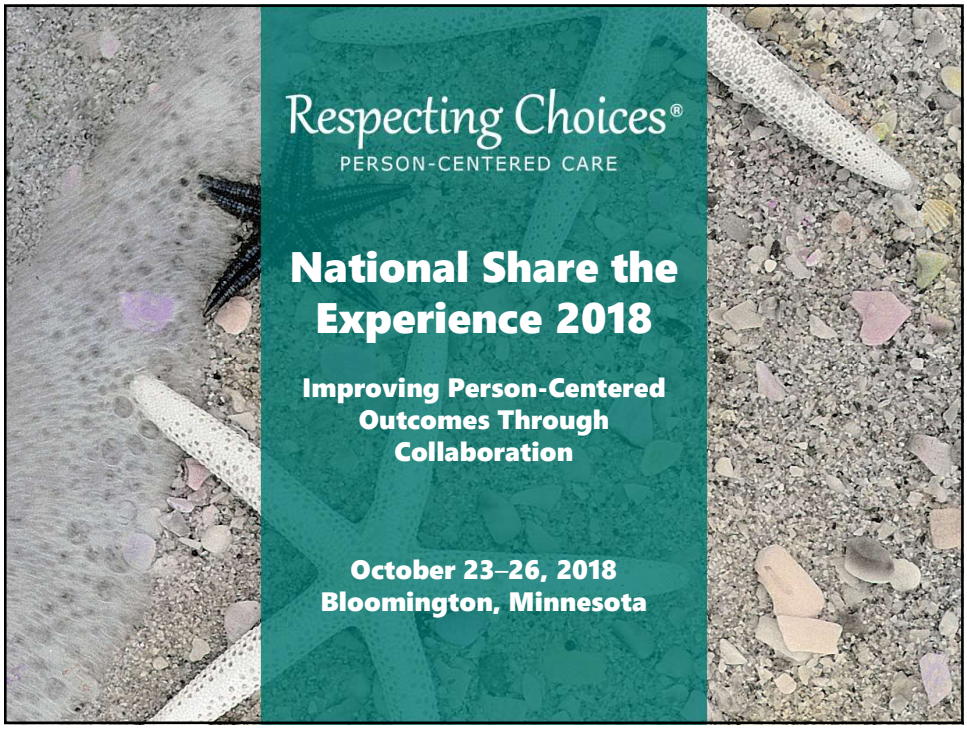

Update on Advance Care Planning Billing 2018: Using Lessons Learned

Phil Rodgers, MD FAAHPM, Associate Professor, Family Medicine and Internal Medicine, University of Michigan

October 24, 2018, 9:30-10:30 a.m.

Disclosures

- Dr. Rodgers represents the American Academy of Hospice and Palliative Medicine as an Advisor to the American Medical Association (AMA) Relative Value Scale Update Committee (RUC). This is an unpaid, volunteer position.
- Dr. Rodgers receives support from the Cambia Foundation Sojourns Scholars Program.

Optimization of ACP and SDM Reimbursement Opportunities

Wednesday October 24, 11:00 a.m. - 12:30 p.m.

- *To Bill or Not to Bill, That is the Question?! Using ACP Codes in Your Daily Practice*
  - Phil Rodgers, MD FAAHPM, Associate Professor, Family Medicine and Internal Medicine, University of Michigan; Sandra Schellinger, MSN, RN, NP-C, Senior Faculty and Consultant, Respecting Choices
  - Panelists: Kellie Durgan, BSN, RN, Manager, Advance Care Planning, Providence Health Care; Lynda Tang, DO, Vancouver Clinic, Department of Palliative Medicine; Kathryn Pence, PA-C, Vancouver Clinic, Internal Medicine; Cindy Adams, BSN, RN, CHPN, Regional Advance Care Planning Coordinator, Baptist Health

Thursday October 25, 9:30 a.m. Concurrent Session

- *The Currency of Advance Care Planning: From Practice to Payment*
  - Lynda Tang, DO, Chair, Department of Palliative Medicine, The Vancouver Clinic; Katie Pence, PA-C, Internist, The Vancouver Clinic
- *Collaboration Enables Advance Care Planning (ACP) Conversations, Sustains ACP Billing, and Keeps Patient & Physician at Center of Process*
  - Betsy Payn, MSN, RN, Executive Director, Looking Ahead Advance Healthcare Planning

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Learning Outcomes

1. Describe the fundamentals of Medicare ACP billing codes, including updates since 2016.
2. Understand the elements of ACP billing relevant to your specific practice setting.

History – ACP Codes

- 2013: Illinois State Medical Society submits new code proposal to the AMA Continuing Procedural Terminology (CPT) Editorial Panel.
- 2014: CPT creates new Advance Care Planning (ACP) codes, forwards them to AMA Relative Value Scale Update Committee (RUC).
- 2014: RUC recommends Relative Value Units (RVU) for ACP codes; Medicare acknowledges ACP codes for CY2015, but does not begin payment.
- 2016: January 1 Medicare begins making payment.

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 Update Committee (RUC).

Trends in ACP Code Reporting

	January – June 2016	January – June 2017
Number of Providers	13,803	23, 509
Number of Beneficiaries	222,997	453,288
% of Total Medicare Beneficiaries	0.40%	0.78%
Number of Claims	236,862	493,236
Average Length of Service	30.8	31.0
Total Submitted Charges	$34,791,949	$80,264,295
Total Medicare Payment	$15,931,970	$31,575,327
% Reimbursed	46%	37%

https://www.thectac.org/wp-content/uploads/2018/03/ACP-Billing-Code-Utilization-Overview.pdf

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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

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- **99498** (add-on): *Each additional 30 minutes*

**Although the AMA indicates the conversation may occur without the patient present, CMS maintains the face-to-face requirements for Medicare patients.*

What Services are Covered?

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

What Services are Covered?

- "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

1. Document a brief summary of the voluntary conversation:
   - Detail should vary based on length/complexity of the conversation, which would also justify time duration.
2. Document the time and who was present:
   - Either by start/stop time or total time in minutes.

Documentation Best Practices

3. Form completion may or may not occur:
   - If forms are completed, document which forms were completed and maintain a copy in the record.
4. No diagnosis requirements:
   - If a serious illness is a driver to the conversation, it is expected that such diagnosis will be reflected on the claim.

Who Can Use 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 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
- May be used in 'Hospital Outpatient' and FQHC & RHC settings, though some restrictions apply.

ACP Can be Billed on the Same Day as:

- ✓ New or Established patient visits (99201-99215)—*do **not** use modifier 25*
- ✓ Annual Wellness Visits (AWV)—once yearly for Original (FFS) Medicare
  - Use modifier 33 to waive patient deductible or coinsurance
- ✓ Hospital observation or inpatient visits (99217-99226), (99231 -99236), (99238-99239)
- ✓ Consults (99241-99255)

ACP Can be Billed on the Same Day as:

- ✓ ED Visits (99281-99285)
- ✓ Nursing/Domiciliary Visits (99304-99310), (99324 -99328), (99334-99337)
- ✓ Home visits (99341-45), (99347-99350)
- ✓ Preventive Med Visits (99381-99397)
- ✓ Transitional Care Management (TCM) (99495-99496)

ACP Code Reporting Restrictions

- ACP codes may not be reported on the same day by the same provider who also reports Critical Care codes (adult, pediatric, neonatal).
- Do not report 99497 and 99498 on the same date of services as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480, 99483.

What are the Time Requirements?

- 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 mins. of time spent performing services described in the code.
  - **99498** *(add'l 30 mins.)*: at least 16 mins. beyond the first 30 mins; may be billed as many times as needed to cover the time spent.

Time Thresholds for Reporting

- 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 use additional 99498s to cover the time spent performing ACP services

RVU Comparison: ACP vs. Prolonged Service

(reported with another E/M service)

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

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

How Frequently can Codes be Reported?

- No limit to frequency, guided by medical necessity.
  - AWV (no copay) is limited to once a 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.

Medicare 'Incident-to' Billing Rules

- Only applies to Traditional, Fee-For-Service Medicare (NOT Medicare Advantage, Medicaid or Commercial).
  - Other payer types may still follow incident-to policy, check with payer/contracts.

Medicare 'Incident-to' Billing Rules

- ✓ Personal provision of a service with the patient (patient must be **established patient** under ongoing care of a physician).
- ✓ The physical location of the service must take place in the office (billed with place of service 11), *excludes hospital-owned outpatient practices.*

Medicare 'Incident-to' Billing Rules

- ✓ The service (ACP) is one that a physician could provide, but has delegated to capable **employee** of the physician group/practice.
- ✓ 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.

Medicare Reimbursement Tidbits

- When billed in the HOPD by the facility, CPT code 99497 is considered "conditionally packaged" and therefore, when billed with another covered service billed under the Outpatient Perspective Payment System, 99497 (ACP) will not be paid separately.
  - If a hospital employee, such as a LCSW or credentialed chaplain, performed the service in the HOPD, ***the facility*** can bill for the service. Payment logic would follow the above algorithm.
  - Physicians can perform ACP in the hospital outpatient department, but must do so personally, no incident rules would apply.

Medicare Reimbursement Tidbits

- If hospital employed team members perform this service during an inpatient stay, 99497 can be reported on the facility bill and will roll into the DRG payment.
- Physicians (MD/DO) and Advanced Practitioners can provide this service personally, "place of service home" or any other approved location.
  - Medicare requires a patient to be home-bound for home care.

More Medicare Reimbursement Tidbits

- ACP may be billed in FQHCs and RHCs, but only one service will be paid per patient, per day.
- Deductible and co-insurance will apply for this service and can only be waived (*for Medicare*) during an Annual Wellness Visit or 'Welcome to Medicare' Physical.
  - If the patient has a supplement which absorbs copay/deductible, it will be covered 100%.
  - If Medicare Advantage plans follow Medicare guidelines (most do) – there is likely not going to be any deductible or copay, but always confirm with the plan.
  - Commercial payers may cover this service, check your contracts or with your plan liaison.

More Reimbursement Tidbits

- If non-Medicare patients have no defined coverage for ACP, you may consider billing an E/M code for time spent with the patient performing counseling and care coordination code:
  - Typically in the case of a serious illness
  - Time must be documented
  - Would generally need to be performed by a physician or NPP
    - NPP guidance subject to contract awareness

Having More than One Fee Schedule

- Do you have any "most favored nation clauses" in your commercial contracts?
  - Legal agreement outlining no customer should be treated worse than all other customers.
- Do state Medical Assistance laws have "usual and customary charge" language?
  - Applies to Medicaid participating providers and can require providers to charge the same to persons not eligible for MA benefits.
- Do you have a charity or foundation that would donate for self-pay or patients with no coverage?
  - Verify with legal counsel all state and applicable federal laws.

ACP via Telehealth

- Starting January 2018, CMS now allows **eligible** ACP services provided via telehealth to be reported with 99497 and 99498 per CPT rules:
  - Must be delivered in real time, with interactive telecommunications technology.
  - Patient must be physically in an 'originating site' (NOT patients home, nursing home, or ALF).
  - Patients must reside in an eligible community.
  - Contact your practice's billing office or consultant.

Questions

Contact:

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