



## **To Bill or Not to Bill, that is the Question?! Using ACP Billing Codes in Your Daily Practice**

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## 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

*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

## Learning Outcomes

1. Describe a general overview of Medicare ACP billing codes, including updates since 2016.
2. Understand the details of ACP billing codes and what is and is not allowed by Medicare or other payers in different locations and patient situations.
3. Define strategies to create a system to report and bill for ACP services in an organization.

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

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

## 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.
  - AWW (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.

# ACP Billing Case Scenarios

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## Medicare Annual Wellness Visit

- John is 67 and in relatively good health. Since his retirement, he looks forward to golfing, traveling, and spending time with his grandkids.
- During his Medicare Annual Wellness visit, Dr. Samms noted that John does not have an advance directive on file.

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## Medicare Annual Wellness Visit

John is willing to explore:

- The value of having an advance care planning conversation,
- How to identify and prepare his health care agent if he were unable to make decisions, and
- The importance of documenting his goals, values, and preferences in an advance directive.

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## Medicare Annual Wellness Visit

- Dr. Samms spent 20 minutes in advance care planning conversation with John, documented the details of their discussion including:
  - His experiences in caring for his mother through the end of her life
  - His intent to name his wife as his Durable Power of Attorney
  - His intent to complete an advance directive
  - Resources available to assist in AD completion

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**Dr. Samms spent 20 minutes of the 50 minute visit in advance care planning conversation with John. How should Dr. Samms report ACP CPT codes?**

Medicare Annual Wellness Visit (AWV)  
CPT code only

AWV CPT Code and 99497

99497 only

AWV CPT Code and 99497 add modifier  
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None of the above. An Advance directive  
was not completed and 30 minutes was  
not spent in ACP conversation

## Follow-Up Office Visit

- Unfortunately, John has been having difficulty managing his high blood pressure, developed atrial fibrillation, and experienced a stroke on the golf course.
- After the hospitalization, Dr. Samms reviewed John's advance directive during a clinic follow-up visit.

## Follow-Up Office Visit

- Dr. Samms explored John's goals and preferences if he had another stroke, was no longer able to know who he was or who he was with, and needed to rely on others for all of his care.

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## Follow-Up Office Visit

- John shared more detail of his experience caring for his mother after she had a stroke. She lived in a nursing home for several years, unable to speak and care for herself.
- She was confused most of the time and dependent on others to anticipate all of her needs.

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## Follow-Up Office Visit

- John stated he would not want to continue with life-saving treatments if he were in a similar condition.
- Dr. Samms advised John to update his advance directive with his additional preferences, and updated the medical record to reflect their discussion.
- Dr. Samms spent 17 minutes of the 46-minute follow-up visit in advance care planning services.

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### Does this follow up office visit meet the requirements for reporting ACP CPT codes?

Yes, Dr. Samms should report 99497 in addition to his Evaluation and Management (E/M) visit code.

No, Dr. Samms should report his E/M visit code only because the ACP conversation did not address John's Code status.

Yes, Dr. Samms should report 99497 and add modifier 25 to his E/M visit code.

Yes, Dr. Samms should report his E/M visit code, 99497 & 99498 because the visit lasted 46 minutes

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## 'Incident To' Billing

- Janice is 78 and sees James Nelson, NP-C to manage her COPD and heart failure. At her 3-month clinic visits, James manages her shortness of breath and fluid overload by making frequent changes to her medications.
- Janice's husband died last year and her children live out of town. She doesn't have anyone identified to make health care decisions if she is unable to do so herself.

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## 'Incident To' Billing

- Upon James' encouragement, Janice was willing to set up an appointment to discuss her advance care planning needs.
- James made a referral to Nancy, a clinic nurse, who is trained and certified to assist Janice with an advance care planning visit. They have an appointment set up the following week at a satellite clinic of the same physician-owned group that employs both James and Nancy.

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## 'Incident To' Billing

- During the 50-minute ACP visit, Janice shared what she learned while caring for her husband who died of heart failure.
- Her husband was confused and no longer knew who he was or who he was with. She did not want to suffer with a prolonged illness, needing 24-hour care.

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## 'Incident To' Billing

- Janice would like to receive hospice care if she was expected to be at the end of her life.
- She worries about being in pain and short of breath. She is not concerned about being too sleepy from pain medications as long as she is comfortable. She identified her daughter as her healthcare agent.

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## 'Incident To' Billing

After the ACP visit, Nancy....

- Assisted Janice to complete a new advance directive (AD).
- Documented a summary of the visit in her note in the medical record, and updated the supervising physician in the clinic for the day.

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## 'Incident To' Billing

After the ACP visit:

- The supervising physician for the day reported ACP CPT 99497 & 99498.
- Nancy notified James, NP-C of the completed documentation and updated AD in the medical record.

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**This ACP conversation qualifies for 'Incident to' billing based upon following statements EXCEPT:**

The referring Health Professional initiated and established care, and a medical plan.

The referring health professional was immediately available to provide direct supervision and address ACP questions as needed

The ACP service was delegated to a capable non-physician employee of the physician group.

The only time counted for the 'incident to' is that of Nancy, RN, ACP Facilitator.

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## **Inpatient Palliative Care Consult and Follow-Up Clinic Visit**

- Janice was recently hospitalized for pneumonia where she needed ventilator support in the intensive care unit. She had difficulty weaning off of the ventilator.
- Janice and her family participated in a Palliative Care consult. They explored her goals, options for future treatments for airway management, and whether Janice would want to be re-hospitalized.

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## Inpatient Palliative Care Consult and Follow-Up Clinic Visit

- The POLST form was reviewed with Janice but she was hesitant to complete without talking with James Nelson, NP-C.
- The Palliative Care clinician sent their consult note summarizing the ACP conversation to James.

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## Inpatient Palliative Care Consult and Follow-Up Clinic Visit

- During her follow-up clinic visit, Janice and James, NP-C, explored her understanding of the COPD progression, options for managing future complications of her lung condition, and her code status.
- As a result they completed a POLST form based upon Janice's goals and preferences.

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**The Palliative Care provider should not report ACP CPT codes because the Intensivist billed professional fees using critical care codes on the same day.**

True

False

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**In this situation, the palliative care provider and primary care provider should not both report ACP codes because the use of these codes are limited to once a month regardless of care setting.**

True

False

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## Panel Discussion: Lessons Learned

### 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, Department of Palliative Medicine

**Cindy Adams**, BSN, RN, Regional Advance Care Planning Coordinator, Baptist Health

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## Questions

### Contact:

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