FACT SHEET
Advance Care Planning Services for Reimbursement
CY2016 Physician Fee Schedule Final Rule

Advance Care Planning Services
CMS has authorized payment for Advance Care Planning (ACP) services effective January 1, 2016. Full details are outlined in the advance copy of the 1358-page final rule, “Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016,” which will publish in the Federal Register on November 16. Provisions of the ACP aspects of the rule are:

- **Reimbursable Services** – Two CPT codes will be active and separately reimbursable:
  1. 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 professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate
  2. Add-on CPT code 99498 – Used for each additional 30 minutes (List separately in addition to code for primary procedure)

- **Payment Rates** – Reimbursement amounts will vary based on local rates, but general rates are:
  - 99497: 1st 30 minutes – $85.99 in Non-Facility; $79.54 in Facility
  - 99498: Each additional 30 minutes – $74.88 in Non-Facility; $74.52 in Facility

- **Beneficiary Cost-Sharing** – Patients will have to pay the deductible and copay for ACP services. However, if the conversation occurs during the Annual Wellness Visit (AWV) then it is considered a preventive service and cost sharing is waived. ACP services provided in conjunction with the AWV should be reported with modifier -33. CMS encourages practitioners to notify the beneficiary that Part B cost sharing will apply as it does for other physician services.

- **When & Where ACP Services Can Be Provided** – These codes may be billed on the same day or a different day as other Evaluation & Management (E/M) services. Additionally, the services can be provided during the same service period as Transitional Care Management (TCM) and Chronic Care Management (CCM) services. ACP codes cannot be reported on the same date of service as certain critical care services, including neonatal and pediatric critical care. These codes will be separately payable to the billing physician or practitioner in both facility and non-facility settings and are not limited to particular physician specialties.

- **Providers Eligible for Reimbursement** – These codes can be billed by the physicians and non-physician practitioners (NPPs-Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist, and Nurse Midwife) 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. The codes are billable under Medicare Part B and can be billed by palliative care providers. Hospice physicians billing to Part A will not be paid separately for these codes.
These services can be provided using a team-based approach where ACP is provided by physicians, non-physician practitioners and other staff under the order and medical management of the beneficiary’s treating physician. “Incident to” rules apply when these services are furnished incident to the services of the billing practitioner, including a minimum of direct supervision. CMS expects the physician or NPP to “manage, participate and meaningfully contribute to the provision of the services, in addition to providing a minimum of direct supervision.”

❖ **ACP Services Implementation & Documentation**
- **Content** - Advance care planning services can include “discussion about future care decisions that may need to be made, how the beneficiary can let others know about care preferences, and explanation of advance directives which may involve the completion of standard forms.” This can include a discussion of short-term treatment options as well as long term goals of care.
- **Documentation** - Documentation must follow standard E/M documentation guidelines to support the CPT code billed. CMS will monitor utilization of the new CPT codes to ensure that they are used appropriately.
- **Training** - CMS is not outlining any special training requirements for providers furnishing ACP services at this time. However, they will “continue to consider whether additional standards, special training or quality measures may be appropriate in the future as a condition of Medicare payment” for these advance care planning services.

**Helpful Recommendations to Physicians and NPPs**
The Carolinas Center offers the following information for consideration as ACP services are implemented:

❖ **Triggers for having the conversation**
- Welcome to Medicare visit for patients who have turned 65 since you last saw them
- Annual visit of anyone 65 or older
- Exacerbation of a chronic Illness

❖ **Tips for starting the conversation:**
- As your office visit winds down, say: “Before you go, I'd like to ask if you have completed your advance directives: living will and health care power of attorney.” If your patient has advance directives, this will be a good time to congratulate them and ask if they would like for you to have copies. If they do not, say something that you are comfortable saying, without apology or equivocation, about a matter that is important.
- Acknowledge that it can be an uncomfortable conversation for many people to have because we don’t like to think about or talk about death. But completing advance health care directives is in the same realm as completing your Last Will and Testament – just a smart thing to do!
- Speak from your own experience of having completed advance directives or helping your family members with this -- that it doesn’t take long, is free, can give them a voice in their future health care, and is a gift to their family who won’t struggle with having to guess what their wishes are. (Local hospices and hospitals have staff who are equipped and willing to help people complete their advance directives.)