Billing for Advance Care Planning

In his recent book, *Being Mortal*, Atul Gwande calls the conversations about end-of-life decisions and advance directives, "the difficult conversations." They are difficult, requiring skill and time to be done well.

Fortunately, Medicare now recognizes the value of these conversations and effective January 1, 2016 will pay for Advance Care Planning (ACP).

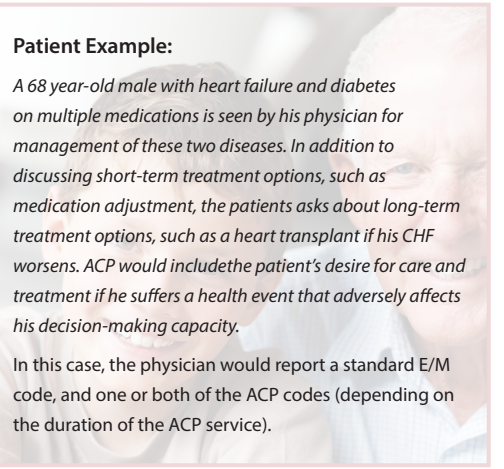
Effective January 1, 2016, Medicare will reimburse physicians for having an advance care planning (ACP) conversation with a patient.

Advance care planning involves multiple steps designed to help individuals:

a) learn about the health care options that are available for end-of-life care;

b) determine which types of care best fit their personal wishes;

c) share their wishes with family, friends, and their physicians.



Patient Example:

A 68 year-old male with heart failure and diabetes on multiple medications is seen by his physician for management of these two diseases. In addition to discussing short-term treatment options, such as medication adjustment, the patients asks about long-term treatment options, such as a heart transplant if his CHF worsens. ACP would includethe patient's desire for care and treatment if he suffers a health event that adversely affects his decision-making capacity.

In this case, the physician would report a standard E/M code, and one or both of the ACP codes (depending on the duration of the ACP service).

Additional information of note:

- Documentation should include reference to the specific time spent and issues discussed.
    - *99497*: "I spent 30 minutes discussing code status with Mrs. Jones and her family."
    - *99498*: "I spent an additional 30 minutes with the Jones Family reviewing and answering questions about the advance directive of Mrs. Jones."
- A provider is able to submit codes documenting repeat planning discussions (ie more than one session may be required and is allowed.)
- The planning may take place at any time.
- ACP can be separately billed, in addition to a wellness visit.
- The beneficiaries' usual cost-sharing fees apply (except when done in a wellness visit.)

ACP discussions are an important part of patient and family-centered care. Patients and families can now have the discussion when and where they want— before patients become ill, after they receive a diagnosis of a terminal illness, or while they are receiving hospice or palliative care.

Conversations will likely involve patient goals of care, discussions of ACP and help understanding advance directives, which are a helpful tool for patients, their family caregivers, and the professionals caring for them during the course of an illness.

ACP services are voluntary and patients should be given an opportunity to decline or receive them. This service must be administered face-to-face.

Eligible Providers*

ACP counseling is payable to any qualified health provider with the training necessary to provide this service. These include:

- RNs
- Certified NPs
- PA-Cs
- Licensed Masters Social Workers (LMSWs)
- Psychologists (LLPs and PhDs)
- Certified Diabetic Educators (CDEs)
- Registered Dietitians and Masters'- trained Nutritionists
- Clinical Pharmacists
- Respiratory Therapists

Required Documentation

These are the minimum documentation requirements for advance care planning discussions:

1. The person designated to make decisions for the patient, if the patient cannot speak for him/herself
2. The types of medical care preferred
3. The comfort level that is preferred
4. How the patient prefers to be treated by others
5. What the patient wishes others to know

Reimbursement for ACP*

There are two Medicare billing codes for ACP, one code [99497] for the first 30 minutes, and a second add-on code [99498] for additional 30 minute conversations. Physicians may also include this service as part of patient's annual check-up *(Payment under HCPCS code G0438 or G0439, ACP should be reported with modifier -33, and there will be no coinsurance or deductible).* These are time-based codes, therefore, an attestation should be included.

These codes are billable under Medicare Part B and some private insurances. They can be used by any physician or non-physician practitioner who bills Part B for their services.

HCPCS Code*	Descriptor	Rate
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; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	$85.91 $79.73
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 physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	$75.11 $74.77

- *ACP cannot be reported with critical care codes
- The planning can take place at any time. ACP can be the sole reason for a visit or can be billed in addition to another office visit on the same day e.g. 99214 and 99497.
- ACP can be separately billed, in addition to a wellness visit or other office visit.

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