

Discussing end-of-life decisions with your patients and their family members can be difficult and uncomfortable. As a patient's primary care provider, family physicians are ideally suited to facilitate this conversation.

Advance care planning (ACP) enables patients and families to have this important end-of-life conversation with their family physician. The patient can discuss their wishes and preferences about the type of treatment and care he or she wants to receive during the latter stages of life. The Centers for Medicare & Medicaid Services (CMS) defines ACP as the face-to-face time a physician or other qualified health care professional spends with a patient, family member, or surrogate to explain and discuss advance directives.

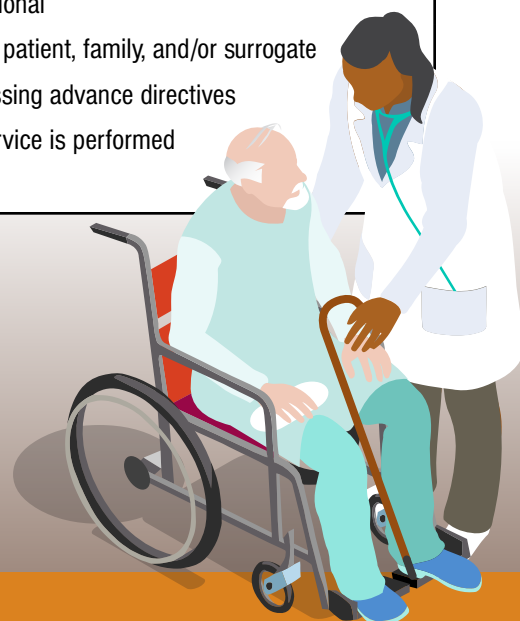
CODING FOR ADVANCE CARE PLANNING

Starting January 1, 2016, CMS began paying for ACP services for traditional Medicare beneficiaries. ACP is one of four care management codes highlighted by the American Academy of Family Physicians (AAFP) that can optimize payment now, while preparing for value-based care. ACP can satisfy a high-priority quality measure for reporting in the Medicare Access and CHIP Reauthorization Act (MACRA).

There are two current procedural terminology (CPT) codes used to report and file claims for ACP services: 99497 and 99498.

CPT CODES	REQUIREMENTS
99497	<ul style="list-style-type: none"> • Provided by the physician or other qualified health care professional • First 30 minutes of a face-to-face discussion with the patient, family, and/or surrogate • Discuss advance care planning, including explaining and discussing advance directives • Completion of advance directive forms at the time when the service is performed
99498	<ul style="list-style-type: none"> • Provided by the physician or other qualified health care professional • Each additional 30 minutes of a face-to-face discussion with the patient, family, and/or surrogate • Discuss advance care planning, including explaining and discussing advance directives • Completion of advance directive forms at the time when the service is performed • List code separately, in addition to code for primary procedure

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FOLLOWING PAGE



TOP 10 FACTS ABOUT ADVANCE CARE PLANNING

1. Medicare and some commercial payers pay for ACP.
 - Medicare average allowable for CPT code 99497 is \$82.90 and 99498 is \$72.50. Check with your local carriers to find out what their allowable is for each of these codes.
2. Physicians and other qualified health professionals (QHPs) can bill for ACP.
 - Medical assistants and registered nurses are not considered QHPs for the purposes of billing ACP. A QHP includes those qualified by education, training, licensure/regulation, and facility privileging who performs a professional service within his or her scope of practice, and independently reports the service. This includes physicians and other non-physician practitioners, such as advance practice nurses or physician assistants.
3. When ACP is provided on the same day as the Annual Wellness Visit (AWV), it is not subject to coinsurance and deductibles.
 - Physicians billing ACP on the same day as an AWV should attach modifier -33 to the ACP code. ACP may be provided in conjunction with other evaluation and management services, or as a stand-alone service on a different date of service, but it would be subject to coinsurance and deductibles.
4. Completion of an advance directive is not required to provide ACP.
 - Discussion and explanation of an advance directive is required in ACP.
5. There are specific documentation guidelines to bill ACP.
 - Documentation should include: counseling for and explanation of an advance directive; who was present during the encounter; and the time spent in the face-to-face encounter. For additional information, physicians may contact their Medicare administrative contractor (MAC).
6. Medicare considers ACP a 30-minute face-to-face encounter.
 - According to CPT guidelines, the time requirement for a service is met when the midway point is passed. For ACP, this would indicate that a physician should spend at least 16 minutes providing ACP. It is important to check with all payers regarding their policies on time thresholds.
7. There are no diagnosis restrictions for providing ACP.
 - When providing ACP in conjunction with an AWV, the well-exam diagnosis would be appropriate to use with ACP. If ACP is provided independent of an AWV, it would be appropriate to report a condition for which you are providing counseling to the patient. ACP is subject to coinsurance and deductibles when it is provided independent of an AWV.
8. There are no limits on the number of times or how often ACP is provided to a beneficiary.
 - If billed multiple times, CMS would expect to see documented changes in the beneficiary's health status and/or wishes regarding end-of-life care.
9. ACP is considered a face-to-face service.
 - ACP cannot be provided via telephone or telemedicine.
10. Providing ACP can satisfy a quality measure in the Merit-based Incentive Payment System (MIPS), one of the two payment tracks in MACRA.
 - ACP is considered a high-priority quality measure, called "Care Plan" (quality ID: 047).

