

July 14, 2016

Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services

This document answers frequently asked questions about billing advance care planning (ACP) services to the Physician Fee Schedule (PFS) under CPT codes 99497 and 99498 beginning January 1, 2016.

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 care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

CPT Code 99498- each additional 30 minutes (List separately in addition to code for primary procedure)

1. CPT codes 99497 and 99498 are time-based codes (a base code and an add-on code). Are there minimum amounts of time required to bill these codes?

In the calendar year (CY) 2016 PFS final rule (80 Fed. Reg. 70956), we adopted the CPT codes and CPT provisions regarding the reporting of timed services. Practitioners should consult CPT provisions regarding minimum time required to report timed services. If the required minimum time is not spent with the beneficiary, family member(s) and/or surrogate to bill CPT codes 99497 or 99498, the practitioner may consider billing a different evaluation and management (E/M) service such as an office visit, provided the requirements for billing the other E/M service are met.

2. Are there limits on how often I can bill CPT codes 99497 and 99498?

Per CPT, there are no limits on the number of times ACP can be reported for a given beneficiary in a given time period. Likewise, the Centers for Medicare & Medicaid Services has not established any frequency limits. When the service is billed multiple times for a given beneficiary, we would expect to see a documented change in the beneficiary's health status and/or wishes regarding his or her end-of-life care.

3. In what settings can ACP services be provided and billed- Inpatient? Nursing home? Other?

There are no place of service limitations on the ACP codes. As we stated in the CY 2016 PFS final rule (80 Fed. Reg. 70956), ACP services may be appropriately furnished in a variety of settings depending on the needs and condition of the beneficiary. The codes are separately payable to the billing physician or practitioner in both facility and nonfacility settings and are not limited to particular physician specialties.

4. Who can perform ACP services?

As we said in the CY 2016 FPS final rule (80 Fed. Reg. 70956), the services described by CPT codes 99497 and 99498 are appropriately provided by physicians or using a team-based approach provided by physicians, nonphysician practitioners (NPPs) and other staff under the order and medical management of the beneficiary's treating physician. The CPT code descriptors describe the services as furnished by physicians or other qualified health professionals, which for Medicare purposes is consistent with allowing these codes to be billed by the physicians and NPPs 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. Therefore, only these practitioners may report CPT codes 99497 or 99498. The ACP services described by these codes are primarily the provenance of patients and physicians; accordingly we expect the billing physician or NPP to manage, participate and meaningfully contribute to the provision of the services in addition to providing a minimum of direct supervision. The usual PFS payment rules regarding "incident to" services apply, so that when the services are furnished incident to the billing physician or practitioner all applicable state law and scope of practice requirements must be met and there must be a minimum of direct supervision in addition to other incident to rules.

5. Can ACP services be furnished without beneficiary consent?

Since ACP services are voluntary, Medicare beneficiaries (or their legal proxies when applicable) should be given a clear opportunity to decline to receive ACP services. Beneficiaries, family members and/or surrogates may receive assistance for completing legal documents from others outside the scope of the Medicare program in addition to, or separately from, the physician or NPP.

6. What must be documented for the service?

Practitioners should consult their Medicare Administrative Contractors (MACs) regarding documentation requirements. Examples of appropriate documentation would include an account of the discussion with the beneficiary (or family members and/or surrogate) regarding the voluntary nature of the encounter; documentation indicating the explanation of advance directives (along with completion of those forms, when performed); who was present; and the time spent in the face-to-face encounter.

7. Does the beneficiary/practice have to complete an advance directive to bill the service?

No, the CPT code descriptors indicate "when performed," so completion of an advance directive is not a requirement for billing the service.

8. Can ACP be reported in addition to an E/M service (e.g., an office visit)?

CMS adopted the CPT codes and CPT provisions regarding the reporting of CPT 99497 and 99498 (see #1). This includes the CPT instructions that CPT codes 99497 and 99498 may be

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billed on the same day or a different day as most other E/M services, and during the same service period as transitional care management services or chronic care management services and within global surgical periods. CMS also adopted the CPT guidance prohibiting the reporting of CPT codes 99497 and 99498 on the same date of service as certain critical care services including neonatal and pediatric critical care.

9. What diagnosis must be used?

No specific diagnosis is required for the ACP codes to be billed. It would be appropriate to report a condition for which you are counseling the beneficiary, an ICD-10-CM code to reflect an administrative examination, or a well exam diagnosis when furnished as part of the Medicare Annual Wellness Visit (AWV) (see #11, 12).

10. Do deductible/coinsurance amounts apply to this code?

The usual Part B deductible and coinsurance apply except when ACP is furnished as an optional element of the AWV (see MLN Matters article MM9271/CR9271 for more information). Since ACP services are voluntary, when a beneficiary (or family members and/or surrogate) elects to receive ACP, we encourage practitioners to notify them that Part B cost sharing will apply as it does for other physicians' services (except when ACP is furnished as an optional element of the AWV).

11. Where can I find additional information?

These FAQs draw on the final rule policies for ACP delineated in the CY 2016 PFS final rule (80 Fed. Reg. 70955 through 70959, available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>). For additional information, we refer readers to that final rule and to the Medicare Learning Network Matters article MM9271/CR9271/R216BP and R3428CP (available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html>). CR9271 provides detailed billing instructions when ACP is furnished as an optional element of the AWV.