CALIFORNIA ACADEMY OF FAMILY PHYSICIANS

Advanced Care Planning (ACP) – One of Medicare's Newest Benefits

Use These Four Case Examples to Assure You Get Paid Appropriately

Beginning January 1, 2016, the Centers for Medicare and Medicaid Services (CMS) announced that they will pay providers for advance care planning (ACP) as a separate, stand-alone service when performed under one of two circumstances:

1. When ACP services are reasonable and necessary for the diagnosis or treatment of injury or illness.
2. When a patient voluntarily accepts ACP services as a separately payable part of an annual wellness visits (AWV).

Each scenario carries specific billing instructions (including the use of modifiers) to allow proper payment. Every family physician should become familiar with the billing requirements of this newly recognized service.

Before we address the billing aspect, let us review some basics about ACP. Both family physicians and other family medicine non-physician professionals should be familiar with the necessary documentation to support ACP services.

What is ACP?

ACP is a process to help patients with decision-making capacity and guide future health care decisions in the event that they become unable to participate directly in their care. The process involves four steps:

1. Think through the patient's relevant values and preferences.
2. Talk about the patient's values and preferences with their spokesperson, close family members and health care providers.
3. Document the patient's values and preferences with an advance directive (there are multiple types).
4. Review the documents periodically and update them as needed.

How is ACP different from an advance directive?

ACP is the *process* as outlined above. Advance directives are the written documents designed to allow competent patients the opportunity to guide future health care decisions in the event that they are unable to participate directly in medical decision making. Some examples of advance directive forms are:

- Health Care Proxy
- Durable Power of Attorney for Health Care
- Living Will
- Physician Orders for Life-Sustaining Treatment

What are the goals and expected outcomes of ACP?
The goals of ACP are numerous. These goals reflect: respect for the principles of patient autonomy, which is the right to self-determination in light of personal interests including goals, preferences and concerns for one's family; beneficence or promoting good; and non-maleficence or avoiding harm. In the event of decisional incapacity, the goals of ACP are to:

- Maximize the likelihood that medical care serves the patient's goals,
- Minimize the likelihood of over- or under-treatment,
- Reduce the likelihood of conflicts between a patient's spokesperson, family members and health care providers, and
- Minimize the burden of decision making on the spokesperson and/or family members.

As a health care provider who engages patients in ACP, you can expect to better understand your patients' views about who they want you to communicate with when they can no longer participate in health care decisions, their goals for medical treatment, their preferred approach to end-of-life care, their hopes (e.g., to live longer, to have quality relationships with loved ones) and their fears about medical interventions (e.g., permanent loss of cognitive functioning, loss of dignity). In addition, you can clarify misunderstandings. Patients, for example, often think that cardiopulmonary resuscitation is successful 80 percent of the time, that mechanical ventilation is a fancy word for nasal prongs and that coma patients still have the ability to enjoy life. Patients also often mistake a do not resuscitate (DNR) order for an advance directive.

You can also expect to better communicate with patients' family members or loved ones because there will be a shared understanding of the patient's values and wishes. Thus, you can expect to have fewer conflicts with family members when considering the approach to end-of-life care.

ACP may not initially lead to an advance directive. At a minimum, however, patients should become familiar with the concept and rationale for ACP. Some patients will want to mull things over, while others will want to discuss the topic with their close family or friends and perhaps other health care providers before personalizing their advance care plan.

When and where should ACP Take Place?

It is unknown when or where ACP should ***ideally*** occur. However, it is generally recommended to initiate in the outpatient setting, and then to review upon admission to and discharge from inpatient settings. Reviews are also recommended whenever there is a significant change in a patient's social or health status.

CAFP has compiled a list of questions or aids that patients can use for advance care planning follows at the end of this article.

Billing Examples

Medicare now accepts two new codes that pay for ACP services:

99497 – ACP includes: the explanation and discussion of standard forms such as advance care directives or Physician Orders for Life-Sustaining Treatment (POLST) forms by the physician or other qualified health professional (QHP) and the first 30 minutes of a face-to-face with the patient, family members and/or surrogate.

*Standard forms such as an advanced care directive or a POLST <u>does not</u> have to be completed at this time; the patient may elect to come back at a later time for further discussion and completion of the forms, or the patient may choose not to complete a form at any time.

99498 – Each additional 30 minutes. List separately in addition to above code for primary procedure.

Remember these two specifics when billing Medicare:

- Face-to-face visits must be between the physician or QHP and the patient (others may be present).
- Ensure you use the 50 percent time rule when billing ACP services (e.g., you must spend at least 16 minutes before you can bill for the 30 minutes service).

Medicare further instructs that the service can be billed:

- On the same day as an E/M service.
- During a period covered by Transitional Care Management (TCM), Chronic Care Management (CCM) or during a global surgery period.

The service may not be billed on the same day as any of the following services:

- Critical Care (CPT 99291 – 99292)
- Inpatient Neonatal and Pediatric Critical Care (CPT 99468 – 99476)
- Initial and Continuing Intensive Care of Neonate (CPT 99477 – 99480)

When billing ACP on the same date as another service, a modifier must be applied to one of the services. The service the modifier is placed on depends upon the condition under which the service is being performed for the Medicare patient.

1. When reasonable and necessary for the diagnosis or treatment of injury or illness:
    a. Modifier -25 is appended to the E/M service
    b. No modifier on ACP
    c. Medicare deductible and coinsurance applies
2. As a voluntary, separately payable part of an annual wellness visit (AWV):
    a. Modifier -33 (preventive service) is appended to the code for ACP
    b. No deductible or coinsurance applies

Below are five case examples of how a physician might provide and bill for ACP.

Case #1

Mrs. Noitall comes into the office for a three-month follow-up visit for her chronic conditions of hypertension, type II diabetes, hyperlipidemia and hyperthyroidism. She is compliant with her medication regimen as well as her diet and exercise routine and is doing well overall. During her visit, Mrs. Noitall mentions that she heard a presentation about POLST and other advance directives at the local senior center and would like to discuss her options for ACP. She and the physician plan for her chronic illnesses and also plan for her care and treatment in the event that she suffers from a health episode that adversely affects her decision-making capacity. She is given the opportunity to view a blank advance care directive and a blank POLST form. Mrs. Noitall then decides to take the forms home and discuss her wishes further with her family.

Billing			
CPT/Modifier	**Description**	**POS**	**CA Area 99 Payment**
99214-25	Office Visit, established patient	11	$124.03
99497	Advance Care Planning	11	$ 95.49

Case #2

Mr. Smitten comes into the office for his AWV. This is his subsequent visit, since he received his first AWV approximately 14 months ago. All the elements of a subsequent AWV were completed, including an update to his medical history, family medical history, current medication list and an update to his list of other medical

providers. An assessment of Mr. Smitten's cognitive functioning was performed and he was screened for depression. His preventive screening schedule was updated at this time. The physician then inquires as to whether Mr. Smitten has spoken with his wife and other family members about the ACP items decided at the time of his last AWV. Mr. Smitten indicates that he did, and he and Mrs. Smitten decided it was an appropriate time for him to complete an advance directive. The physician brought Mrs. Smitten into the room and provided Mr. and Mrs. Smitten with the advanced directive form produced by the California Hospital Association. The physician discussed the meaning of the form and answered a number of Mr. and Mrs. Smitten's questions about the various parts of the form. Mr. Smitten signed the form and a copy was scanned into the practice EMR system. Practice staff gave Mr. Smitten a copy of the form to take home. The physician spent a total of 50 minutes on ACP.

Billing			
CPT/Modifier	**Description**	**POS**	**CA Area 99 Payment**
G0439	Subsequent AWV	11	$197.94
99497-33	Advance Care Planning,1st 30 min	11	$ 95.49
99498-33	ACP, additional 30 min.	11	$ 81.57

Case #3

Mr. Lungford is seen in the hospital a day prior to his planned discharge. He was hospitalized for a severe exacerbation of his chronic obstructive pulmonary disease (COPD) and stabilization of his hypertension. He tells the physician that a hospital employee asked him to sign a POLST, but he was not sure what it was and wanted to talk with his doctor about it first. The physician explained the basic concept of ACP and emphasized to the patient that he (the physician) wanted to follow the patient's wishes, but to do that, he needed to know what those wishes were. They discussed the patient's values and overall goals for treatment. They also talked about palliative care options, ways to avoid hospital readmission and the patient's desire for care if he suffered a health event that adversely affected his decision making capacity. The patient asked to see the POLST form again, which the nursing staff provided. A copy of the form was placed on file at the hospital, sent to the physician's office for placement in the patient's file, and was given to the patient to take home.

Billing			
CPT/Modifier	**Description**	**POS**	**CA Area 99 Payment**
99232-25	Subsequent Hospital Care	21	$ 79.63
99497	Advance Care Planning	21	$ 87.20

Case #4

Mrs. Wiggin is currently in the rehab unit following a lengthy hospitalization for severe cellulitis and sepsis, during which time she suffered from several seizures and an eventual cerebrovascular accident. She is now in the Skilled Nursing Facility, receiving both occupational and physical therapy while she rehabs in preparation for her return home. Her family physician sees her to follow up on her diabetes, which is currently under "fair" control, and several other chronic conditions. At the time of this nursing facility visit, the physician suggests that the patient consider her wishes for future health care treatment. Mr. Wiggin is currently visiting his wife and he joins the discussion. They talk about the patient's goals for future treatment, including palliative care if appropriate. They discuss the role of a designated agent as a substitute decision maker if the patient loses decisional capacity. The physician assures the patient that she will follow the patient's wishes, but she needs to know what those wishes are. The patient and her husband agree to consider an advance directive and would like to further discuss their options when they next see the physician. The physician spends 75 minutes with the patient and her husband discussing ACP.

Billing			
CPT/Modifier	**Description**	**POS**	**CA Area 99 Payment**
99308-25	Subsequent Nursing Facility Care	31	$ 78.10
99497	ACP – 1st 30 min.	31	$ 87.20
99498	ACP – add'l 30 min.	31	$ 81.57

The California Hospital Association has developed a helpful guide to complete advance directive and POLST forms. We've included the guide at the end of this article.

Note that the ACP service described in the examples above would not necessarily have to occur on the same day as another service. ACP can be billed as a stand-alone service. For providers billing under the Medicare prospective payment system for federally qualified health centers (FQHCs), ACP is a stand-alone billable visit. If furnished on the same day as another billable visit, only one visit will be paid.

You can raise ACP as one of many health prevention activities you offer. Emphasize that these discussions are aimed at avoiding harms (over- and under-treatment) and promoting benefits (treatments tailored to the patient's goals). You should reassure the patient that raising this issue does not mean that there is something unspoken to worry about. You may tell the patient that this topic is difficult for many patients and that you will understand if he or she does not want to come to any conclusions during the discussion. You should also emphasize to patients that any decision is not written in stone and can be amended as events unfold.

With Medicare's coverage of the service, there is an opportunity for additional revenue for your practice for a service that you may well have been providing previously for no additional payment. Now is the time to begin to implement ACP as a routine service for your patients. Begin by identifying those patients in your practice who would benefit the most from this discussion – those who are at higher risk for decisional incapacity.

Questions for Advance Care Planning

When having a discussion about advance care planning, here are some questions that are recommended:

1. Who should speak on your behalf if you become so sick you cannot speak for yourself?

2. Are there circumstances you have heard about through the news or TV where you have said to yourself, "I hope that never happens to me" or "I would never want to live like that?" If so, what are they and why do you feel this way about them?

3. For each of the circumstances that you just identified, what do you think should be the goals for your care? For example, should the goal of care be to prolong your life, improve or maintain your function and/or quality of life, provide comfort care or something else?

4. For other situations in which you would not be able to communicate your preferences, such as (those provided by the clinician based on your current and past health), what do you think should be the goals for your care? For example, should the goal of care be to prolong your life, improve or maintain your function and/or quality of life, provide comfort care or something else?

5. Are there any life-sustaining treatments that you know you would want to receive regardless of the circumstances or would not want to receive under any circumstances? If so, what are they and why do you feel this way about them?

6. Some people have more concerns about the way they will die or dying than about death itself. Do you have any fears or concerns about this?

7. In the event that you are dying, where do you want to receive your health care?

8. Should your current preferences be strictly applied to future situations or serve as a general guide to your spokesperson or family member(s)?

These suggested questions can also be developed into a pre-visit worksheet for you to utilize when considering what is involved with advance care planning.