Advanced Care Planning
Agenda

• Overview of advance care planning
• How and when to bill
• Types of advance directives
• Advance care planning and hospice
• Helpful hints for having the conversation
• Other physician billing highlights they relate to hospice
• Tools and resources
Disclaimer

Although every reasonable effort has been made to assure the accuracy of the information within this presentation, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The official Medicare Program provisions are contained in the relevant laws, regulations and rulings.
Effective January 1, 2016, the Centers for Medicare and Medicaid Services (CMS) will reimburse physicians and other qualified health care professionals if they choose to have advance care planning, or end-of-life care, discussions with their Medicare patients.
Why Have This Conversation?

- 60% said making sure family is not burdened by tough decisions is extremely important
- 56% had not communicated end of life (EOL) wishes
- 80% would want to talk to a doctor about EOL care if they were seriously ill
- 93% never had an EOL conversation with their doctor
- 82% said it is important to put their wishes in writing
- 23% had their wishes in writing
- 70% preferred to die at home
- 70% die in a hospital, nursing home or long term care facility

California Health Care Foundation Study - 2012
Advance Care Planning Defined
(According to the AMA CPT Changes 2016)

• An advance directive is a document that appoints an agent and/or records the wishes of a patient pertaining to his or her medical treatment at a future time should he or she lack decisional capacity at that time.

• Codes 99497, 99498 are used to report the face to face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms.
Advance Care Planning (ACP)

• ACP is a face-to-face service for
  o Counseling on end-of-life decisions AND
  o Discussing advance directives, with or without completing relevant legal forms

• An advance directive is a document that
  o Appoints an agent and/or
  o Records the wishes of a patient pertaining to his or her medical treatment at a future time should he/she lack decisional capacity at that time
ACP Codes are Time-Based

- Codes 99497 and 99498 are time-based codes
- 99497 is reported for the first 30 minutes
- Add on code 99498 is reported for each additional 30 minutes, but only if a total of more than 45 minutes is reached

(According to the AMA CPT Changes 2016)
Medicare Coverage for ACP

Medicare pays for ACP as either:

• A separate Part B service when the service is reasonable and necessary for the diagnosis or treatment of illness or injury
• An optional element of a beneficiary’s Annual Wellness Visit (AWV)
  o Use Modifier 33
  o No Part B coinsurance or deductible is due
Billing for ACP: Code 99497

- For 1st 30 minutes face-to-face with patient, family and/or surrogate
  - 2018 Medicare Allowable average reimbursement:
    - $87.67 (non-facility)
    - $82.07 (facility)
  - Includes 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
Billing for ACP: Code 99498

• For each additional 30 minutes face-to-face with patient, family and/or surrogate
• Can only be used if a total of more than 45 minutes is reached
  o 2018 Medicare Allowable average reimbursement:
    ▪ $87.67 (non-facility)
    ▪ $82.07 (facility)
  o Continues the ACP discussion
  o Must be listed separately in addition to code for primary procedure

Who can Provide ACP?

- Physicians and Non-Physician providers (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

- Hospitals

- Not limited to any particular physician specialty

ACP – The In’s and Out’s

• To report the code:
  o The patient need not be present
  o The discussion can be between a physician or qualified health care professional and a family member or a surrogate

• It is appropriate to report the condition for which the beneficiary is being counseled
ACP – The In’s and Out’s

• Completion of relevant legal forms is not required at the time of the discussion

• Because the purpose of the visit is discussion, no active management of the problem is undertaken during this time period
Can ACP Be Billed with Other Services?

• Certain E/M (Evaluation and Management) services performed on the same day may be reported separately.
• ACP can be billed on the same day as Chronic Care Management OR Transitional Care Management.
• ACP cannot be billed on the same date of service as certain critical care services, including neonatal and pediatric critical care.
ACP Requires Documentation

• This documentation should include:
  • The patient’s name
  • The date of the conversation
  • The length of the conversation
  • The topics discussed
  • An overview of any materials or resources given to the patient
  • The outcome of the conversation
Facilitating the Conversation

When meeting with the patient and family or health care representative

- Begin the conversation by determining how much is known about the patient's condition
- Ask if there are any questions
Facilitating the Conversation

• Help the conversation progress by employing the following suggestions:
  o Be attentive and empathetic to the emotional state of the patient and family
  o As much as possible, proceed at their pace
  o Talk about what *can* be done first while emphasizing that there is always something that can be done, although it may not be curative

• Make sure the "big picture" is understood before going on to specific issues
Advance Care Planning Documents

- In Arkansas, there are three types of advance care planning documents available:
  - Arkansas Physician Orders for Scope of Life-Sustaining Treatment, or ArPOLST
  - Arkansas Declaration (Living Will)
  - Healthcare Power of Attorney
Advance Care Planning Documents

- POST/POLST (state-specific)
- Living Will
- Healthcare Power of Attorney
ACP and Hospice

• When discussing disease process and the patient’s options for care, hospice may be a natural part of the ACP conversation
• If the coverage criteria are met, ACP may be billed prior to hospice election
• However, not all advance care planning discussions and/or decisions are required to be made before hospice election
ACP and Hospice

- ACP may also be billed while the patient is on hospice if discussions are needed at that time.
- A qualified provider may also bill ACP while a patient is receiving the general inpatient level of care, if necessary.
Introducing Hospice

• Hospice can be
  • A natural part of a discussion during a visit following a recent hospitalization
  • A seamless part of caring for a patient dealing with a chronic illness that is approaching the end stage or including, but not limited to:
    o COPD
    o CHF
    o Alzheimer’s Disease
    o ALS
Introducing Hospice

• Having the hospice discussion early results in more patients receiving the hospice benefit when they are entitled to receive it

• Example:

  “Your mother may qualify for more supportive services. I partner with an organization that focuses on taking care of patients like your mother who are living with advanced stages of illness. I would like for you to meet them to learn more about the benefits to which you are entitled so you can know your options down the road.”
Other Physician Billing Highlights Relating to Hospice

The attending physician is defined as the physician chosen by the patient to be primarily responsible for the patient’s hospice plan of care

- The attending physician, not employed by the hospice, providing professional services to a patient receiving hospice can bill regular Medicare Part B, like normal, including the GV modifier
- The attending physician may also bill for Physician Care Plan Oversight to Medicare Part B if the coverage requirements are met using CPT Code G0182
Consulting Physician Services

The physician is not the attending but, is providing a medically reasonable and necessary service to a hospice patient

- Consulting physician services require a contract with the hospice
- The consulting physician bills hospice and then, hospice bills Medicare Part A for the physician’s professional services that are included in the Plan of Care
- The hospice pays the consulting physician according to the terms of the contract
Not Related to the Terminal Prognosis

• When patients elect hospice, they waive their rights to directly access Medicare services that are related to the hospice illness and related condition.
• Patients do not waive their right to services that are not related to the terminal prognosis.
• Physicians providing services that are not related to the terminal prognosis to hospice patients bill using modifier GW.
Resources and Tools

• Advance Care Planning Billing Brochure
• Arkansas POLST Provider Fact Sheet
• Arkansas POLST Form and Directions
• Heart of Hospice Consultation
• Webinar: POLST Arkansas Physician Orders for Life Sustaining Treatments
Hospice Medical Director, Hospice Physician and Hospice Nurse Practitioner Billing

• Hospice Medical Director and Hospice Physicians bill their administrative time on the administrative time sheet monthly.

• Hospice Medical Directors, Hospice Physicians and Nurse Practitioners bill any non E&M visits using the new physician documentation note. See draft visit note. This is available in the system.
Resources and Tools

- **Advance Care Planning: Medicare Learning Network:**

- **Advance Care Planning: Implementation for Practices**

- **Advance Care Planning FAQs: CMS**
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf
Resources and Tools


Together, we can transform end-of-life care in our community.
HEART of HOSPICE

For referrals 1.844.HOH.0411
www.heartofhospice.net