Work Relative Value Units (wRVU) Table (2020) - Palliative Care and Hospice

Inpatient

Initial (min)	wRVU
99221 (30m)	1.92
99222 (50m)	2.61
99223 (70m)	3.86
Subsequent	
99231 (15m)	0.76
99232 (25m)	1.39
99233 (35m)	2.00

Office

New	wRVU
99201 (10m)	0.48
99202 (20m)	0.93
99203 (30m)	1.42
99204 (45m)	2.43
99205 (60m)	3.17
Estab	
99211 (5m)	0.18
99212 (10m)	0.48
99213 (15m)	0.97
99214 (25m)	1.50
99215 (40m)	2.11

Home

New	wRVU
99341 (20m)	1.01
99342 (30m)	1.52
99343 (45m)	2.53
99344 (60m)	3.38
99345 (75m)	4.09
Estab	
99347 (15m)	1.00
99348 (25m)	1.56
99349 (40m)	2.33
99350 (60m)	3.28

SNF

Initial	wRVU
99304 (25m)	1.64
99305 (35m)	2.35
99306 (45m)	3.06
Subsequent	
99307 (10m)	0.76
99308 (15m)	1.16
99309 (25m)	1.55
99310 (35m)	2.35
Annual	
99318 (30m)	1.71

ALF

New	wRVU
99324 (20m)	1.01
99325 (30m)	1.52
99326 (45m)	2.63
99327 (60m)	3.46
99328 (75m)	4.09
Estab	
99334 (15m)	1.07
99335 (25m)	1.72
99336 (40m)	2.46
99337 (60m)	3.58

Prolonged Service

Face-to-Face (add-on)

Outpt (face-to-face)	wRVU
99354 (30-74m extra)	2.33
99355 (76-105m)	1.77
Inpt (unit/floor)	
99356 (30-74m extra)	1.71
99357 (76-105m extra)	1.71

Non-F2F (Not for hospice)

Any setting	wRVU
99358 (31-75m)	2.10
99359 (76-105m)	1.00

Advance Care Planning

Any setting	wRVU
99497 (16-45m)	1.50
99498 (46-75m)	1.40

Care Management (Not for Hospice)

CM Initiation	wRVU	Complex CCM	wRVU
G0506	0.87	99487 (60m)	1.00
		99489 (90m+)	0.50
Chronic CM			
99490 (20m staff time in a month)	0.61	Principal CM	
		G2064 (30m MD/DO/QHP*)	1.45
G2058 (add/l 20m; max 2 per month)	0.54		
		G2065 (30m staff)	0.61

*QHP = Qualified Healthcare Provider

Notes:
Significant changes are planned for Office & Prolonged svcs CPT codes reported, time needed, documnt'n required, and wRVUs in January 2021.
Though Medicare will not, if your insurer pays consult codes (Outpt 99241-5; Inpt 99251-5), these codes have higher wRVUs than above.
All of these codes are billable for hospice patients except Non-F2F Prolonged Codes and Care Management Codes.
These are work RVUs only. Total RVUs include practice expense and malpractice expense RVUs as well.
RVU information comes from the Medicare Fee Schedule Lookup, shortened at https://go.cms.gov/1QdW07Z

Inpatient Billing – from 1995 Medicare Highmark Audit Tool

HISTORY

HPI: Status of chronic conditions:

☐ 1 condition ☐ 2 conditions ☐ 3 conditions

OR

HPI (history of present illness) elements:

☐ Location ☐ Severity ☐ Timing ☐ Modifying factors
☐ Quality ☐ Duration ☐ Context ☐ Associated signs and symptoms

ROS (review of systems):

☐ Constitutional (wt loss, etc) ☐ Ears,nose, mouth, throat ☐ GI ☐ GU ☐ Musculo ☐ Integumentary (skin, breast) ☐ Neuro ☐ Psych ☐ Endo ☐ Hem/lymph ☐ All/immuno
☐ Eyes ☐ Card/vasc ☐ Resp
☐ All others negative

PFSH (past medical, family, social history) areas:

☐ Past history (the patient's past experiences with illnesses, operation, injuries and treatments)
☐ Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)
☐ Social history (an age appropriate review of past and current activities)

EXAM

Body areas:

☐ Head, including face ☐ Chest, including breasts and axillae ☐ Abdomen ☐ Neck
☐ Back, including spine ☐ Genitalia, groin, buttocks ☐ Each extremity

Organ systems:

☐ Constitutional (e.g., vitals, gen app) ☐ Eyes ☐ Ears,nose, mouth, throat ☐ Cardiovascular ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Skin ☐ Neuro ☐ Psych ☐ Hem/lymph/imm

E&M Initial Consult (HIGH):
- 4 point HPI
- 10 point ROS
- PMFSH (all 3)
- 8 system Exam
- 2 of 3 High-level MDM:
  - ≥4 points Dx
  - ≥4 points Data
  - High Risk

E&M Follow-up Visit(HIGH):
- Either 4 point HPI and 2 point ROS
- OR 8 system Exam
- 2 of 3 High-level MDM:
  - ≥4 points Dx
  - ≥4 points Data
  - High Risk

MEDICAL DECISION MAKING

Number of Diagnoses or Treatment Options

A	B	X	C	=	D
Problem(s) Status	**Number**		**Points**		**Result**
Self-limited or minor (stable, improved or worsening)	*Max = 2*		1		
Est. problem (to examiner); stable, improved			1		
Est. problem (to examiner); worsening			2		
New problem (to examiner); no additional workup planned	*Max = 1*		3		
New prob. (to examiner); add. workup planned			4		
			TOTAL		

Amount and/or Complexity of Data Reviewed

Reviewed Data	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	

Risk

Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic with identified risk factors) • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Time-based billing: "I spent _____ minutes in the care of this patient, >50% in counseling and care coordination."
Prolonged service: include "Time in / Time out"
ACP (99497 – 16-45min; +99498 – 46-75min)

Admits/Medicare Consult	Inpt Consult (Not M'care)	Follow-up
Level 1 – 30 min	Level 3 – 55 min	Level 1 – 15 min
Level 2 – 50 min	Level 4 – 80 min	Level 2 – 25 min
Level 3 – 70 min	Level 5 – 110 min	Level 3 – 35 min

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Special Report

Top 10 Tips for Using Advance Care Planning Codes in Palliative Medicine and Beyond

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Abstract

Although recommended for all persons with serious illness, advance care planning (ACP) has historically been a charitable clinical service. Inadequate or unreliable provisions for reimbursement, among other barriers, have spurred a gap between the evidence demonstrating the importance of timely ACP and recognition by payers for its delivery.[1] For the first time, healthcare is experiencing a dramatic shift in billing codes that support increased care management and care coordination. ACP, chronic care management, and transitional care management codes are examples of this newer recognition of the value of these types of services. ACP discussions are an integral component of comprehensive, high-quality palliative care delivery. The advent of reimbursement mechanisms to recognize these services has an enormous potential to impact palliative care program sustainability and growth. In this article, we highlight 10 tips to effectively using the new ACP codes reimbursable under Medicare. The importance of documentation, proper billing, and nuances regarding coding is addressed.

Keywords: advance care planning; billing and coding; community-based palliative care; inpatient palliative care; outpatient palliative care; revenue

Introduction

A CORE COMPONENT of high-quality palliative care (PC) delivery is facilitation of regular advance care planning (ACP) discussions. The National Hospice and PC Organization define ACP as ''making decisions about the care you would want to receive if you become unable to speak for yourself.'' ACP also includes sharing care options for patients diagnosed with a serious illness, permitting patients to share values and preferences for care with loved ones who will act as surrogates, and, sometimes, completing advance directive (AD) paperwork to put those wishes in writing.[2] Importantly, ACP constitutes a longitudinal and dynamic process that requires thoughtful, regular, and often time-intensive conversations between patients, their loved ones, and clinicians.

A major barrier to widespread facilitation of ACP by clinicians has been lack of recognition by payers through appropriate reimbursement. Efforts at increasing completion of AD in the community[3] and skilled nursing facility settings[4] have had limited success but have not led to widespread, sustained increases in AD completion. As would be expected, when ACP processes are supported by project or grant funding only and not routine reimbursement from payers, regular adoption of ACP is often not realized outside of research settings. As many begrudgingly remember, an attempt to include payment for ACP in 2009s Patient Protection and Affordable Care Act was derided as ''death panels''[5] and the provision was dropped from the final bill.[6]

After several years of continued requests by healthcare and patients' rights groups to pay providers for ACP discussions with their patients, the Centers for Medicare and Medicaid Services (CMS) reversed course. On October 30, 2015, CMS announced a ''proposal that supports patient- and family-centered care for seniors and other Medicare beneficiaries by enabling them to discuss ACP with their providers.''[7] Yet, payers did not provide robust guidance for how clinicians should implement these changes. In this article, we will present 10 tips to compliantly provide ACP services to Medicare patients and offer insight into billing for these services. While the information we provide is intended for an audience of PC practitioners, the information is applicable to providers of all specialties.

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Tip 1: Medicare has adopted CPT® codes 99497 and 99498 to reimburse for ACP and will utilize CPTs broad definition of ACP.

Medicare's definition of ACP was adopted from the American Medical Association's Current Procedural Terminology (CPT) publication.[8] ACP is defined within CPT as a ''face-to-face service between a physician or other qualified healthcare professional and a patient, family member, or surrogate in counseling and discussing AD, with or without completing relevant legal forms.'' An AD is ''a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.''[8]

CPT code 99497 pays for ''ACP, including the explanation and discussion of AD such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional, first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate'' and code 99498 reimburses for each additional 30 minutes. Code 99498 is an add-on code and so can only be used along with code 99497.[8]

It is important to understand that CPT guidelines state that certain time-based codes, ACP codes included, may be used when 1 minute more than the midpoint of the code time is reached. Since 99497 is a 30-minute code, it may be billed once 16 minutes of ACP services are provided.[8] See Table 1 for the ranges of service times when ACP code(s) may be billed. *As with other time-based codes, it is vitally important that the clinical documentation includes the amount of time, in minutes, spent in the ACP activity to ensure compliance.*

Tip 2: A successful ACP bill does not require completion of a formal AD, Healthcare Power of Attorney, or Physician/Medical Orders for Scope of Treatment (MOST) form.

Performed very commonly by PC practitioners, ACP includes counseling, discussion of ADs, discussions of the risks, benefits, and alternatives to various ACP tools (AD, living will, durable power of attorney, Physician Orders for Life-Sustaining Treatment, MOST), a patient's values and overall goals for treatment, palliative and disease-directed care options, ways to avoid hospital readmission including hospice discussions, care preferences should the patient suffer another adverse health event, and discussion of surrogate decision makers. While broad, this list is certainly not all-inclusive. While considered in preliminary iterations of ACP regulations, it is NOT required that formal paperwork such as an AD or HCPOA be completed for physicians to be reimbursed for ACP.

Table 1. Time Thresholds and Ranges for Medicare Reimbursement for Advance Care Planning Services

Time in ACP (minutes)	*ACP CPT® code(s)*
0–15	Not separately billable
16–45	99497
46–75	99497 and 99498
76–105	99497 and 99498 × 2
106–135	99497 and 99498 × 3

ACP, advance care planning; CPT®, current procedural terminology.

Table 2. Ten Tips for Compliant Use of ACP Codes for Medicare Patients

1. Medicare has adopted CPT® codes 99497 and 99498 to reimburse for ACP and will utilize CPTs broad definition of ACP.
2. A successful ACP bill does not require completion of a formal Advance Directive, Healthcare Power of Attorney, or Physician/Medical Orders for Scope of Treatment form.
3. ACP is reimbursable when performed by a physician or qualified health professional, defined as a nonphysician provider, including nurse practitioners, physician assistants, and clinical nurse specialists.
4. ACP discussions held by other members of the healthcare team are reimbursable if performed ''incident to'' the services of a billing practitioner, including a minimum of direct supervision.
5. ACP codes may be billed on the same day/during the same visit as an Evaluation and Management code, with the exception of critical care codes, or they may be billed as stand-alone codes.
6. ACP codes may be used in the inpatient, outpatient, skilled nursing facility, and home settings but not during telehealth or phone-based visits.
7. Patients should be informed that Part B cost sharing under Medicare is in effect and be given the opportunity to refuse ACP services.
8. While CMS has authorized payment for ACP using ACP codes 99497 and 99498, the ultimate decision to pay providers will be made at the Medicare Administrative Contractor level.
9. ACP codes may be billed as often as every day and may be billed for patients who have elected the Medicare Hospice Benefit.
10. ACP codes can be used in addition to transitional care management and chronic care management codes and within global surgical periods.

CMS, Centers for Medicare and Medicaid Services.

Based on general billing and coding requirements, *the authors recommend at a minimum clinical documentation, including identification of the supervising physician (if appropriate), the location of service, the content of the conversation, the recipient of ACP, patient/family member/surrogate's acknowledgment and acceptance of ACP services, and the total time spent in ACP discussions.*[9]

Tip 3: ACP is reimbursable when performed by a physician or qualified health professional, defined as a nonphysician provider (NPP), including nurse practitioners, physician assistants, and clinical nurse specialists (CNSs).

CMS specifically states that ACP is ''primarily the provenance of patients and physicians'' and expects the billing physician or NPP to ''manage, participate and meaningfully contribute to the provision of the services.''[10] While CMS acknowledges the team-based approach of PC and ACP, it specifically asserts that ACP codes may only be billed by ''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.''[10] In the opinion of the authors, this sentence specifically eliminates Licensed Clinical Social

Workers (LCSW) as independent ACP providers for Medicare patients because LCSW services are limited in scope to the ''diagnosis and treatment of mental illnesses.''[11] LCSW provision of ACP may be reimbursable when provided in accordance with Tip 4 below. CNS visits are reimbursable only if the CNS is ''legally authorized and qualified to furnish the services in the State where they are performed.''[11]

Tip 4: ACP discussions held by other members of the healthcare team are reimbursable if performed ''incident to'' the services of a billing practitioner, including a minimum of direct supervision.

ACP codes are payable when medically necessary ACP discussions are held by a physician or NPP. Medicare also offers to pay for ACP using ''incident to'' payment rules. ''Incident to'' services are ''furnished incident to physician professional services in the physician's office. .. or in a patient's home.''[12] ''Incident to'' services require a physician or NPP to have ''personally performed an initial service and remain actively involved in the course of treatment'' and require the physician/NPP providing direct supervision to be ''present in the office suite to render assistance, if necessary.'' If the service is provided in the home, the physician/NPP must be present in the home throughout.[12]

''Incident to'' services must be provided in an office or home setting (hospital or SNF settings generally do not apply) and the clinical staff providing the ''incident to'' services must be directly supervised by the physician/NPP and represents a ''direct financial expense to you.'' The supervising physician/NPP must ''order the services, maintain contact with the nurse or other employee, and retain professional responsibility for the service'' to qualify as an ''incident to'' service. If the physician/NPP is a member of a practice group, any physician/NPP member of the group may be present in the office or home setting to provide the direct supervision.[12]

If ACP services are provided by a member of the healthcare team acting within the scope of practice and meets criteria for ''incident to'' billing under direct supervision, the service is billed under the supervising physician/NPP National Provider Identifier number, as if they personally provided the service.[12]

Tip 5: ACP codes may be billed on the same day/during the same visit as an Evaluation and Management (E&M) code, with the exception of critical care codes, or they may be billed as stand-alone codes.

This is a generous provision and crucial for PC providers to understand. CPT guidelines note that the purpose of an ACP visit is a discussion around a patient's wishes. As such, no active management of the underlying medical problems is expected during the time when ACP discussions are occurring.[8,10,13] Since patients frequently require active management of their medical conditions on the same day that ACP discussions occur, CPT and CMS recognize that both an E&M code and an ACP code may be billed and paid on the same day. The authors' opinion is that an E&M service coded using complexity and a clearly identified ACP discussion coded using time would best show the separateness of the services provided and support the use of multiple billing codes.

Several points should be noted. An ACP code may be billed in the absence of an E&M code so it is not considered an add-on code. When billing an additional procedure code (that is not designated in CPT as an ''add-on'' code), modifier –25 should be added to the E&M code. In these instances, documentation must support that the E&M service was a significant and separately identifiable service above and beyond that of the ACP represented by code 99497. In addition, CPT and CMS specifically exclude a practitioner from reporting an ACP code on the same day that provider billed a critical care code,[8,10] presumably because the higher relative value units assigned to critical care codes include ACP services.

Tip 6: ACP codes may be used in the inpatient, outpatient, skilled nursing facility, and home settings but not during telehealth or phone-based visits.

ACP codes are not limited to any particular setting. They may be used when discussing ACP with patients or the surrogates in virtually any setting PC is practiced. They will be most commonly used in the inpatient and outpatient settings although can be used in the home, assisted living, and nursing home settings as well. The ACP service must be face-to-face with the patient, their family, or their legal surrogate so ACP codes are not permitted to be used during a telehealth or phone-only visit.[10]

Tip 7: Patients should be informed that Part B cost sharing under Medicare is in effect and be given the opportunity to refuse ACP services.

Likely in deference to the political firestorm that erupted when reimbursing providers for ACP services was to be included in the ACA, Medicare has made clear that ACP services are voluntary. *CMS encourages practitioners to notify the patient that Medicare Part B cost sharing is in effect for ACP discussions and ensure that patients have the opportunity to decline ACP services.*[10] Patients with traditional Medicare Part B coverage without a supplemental insurance plan covering Medicare's standard 20% coinsurance would pay around $18 for the first 16–45 minutes of physician-led ACP discussions. The beneficiary would pay about $15 for up to 30 additional minutes and slightly less for discussions performed by APPs.[13] While not typically provided by PC providers, ACP performed as an optional element of the Annual Wellness Visit is exempt from cost sharing if clinicians append modifier 33 (Preventative Services).[14]

Tip 8: While CMS has authorized payment for ACP using ACP codes 99497 and 99498, the ultimate decision to pay providers will be made at the Medicare Administrative Contractor (MAC) level.

The Center for Medicare and Medicaid Services (CMS) does not actually pay providers for services itself but contracts with 13 large entities, called MAC, who follow Medicare's regulations and administer the benefit, including paying providers for their work. While CMS authorized Part B payment for ACP beginning January 1, 2016, currently there is no National Coverage Determination policy, and each MAC will be responsible for the Local Coverage Determination policy for implementation of payments. Both traditional Medicare and Medicare Advantage plans follow CMS regulations, although the timing of implementation is up to the local MAC. We recommend asking your local billing

specialist or contacting your state's Part B MAC to ensure that they have begun paying for CPT codes 99497 and 99498 before billing the MAC for ACP services.[10]

Tip 9: ACP codes may be billed as often as every day and may be billed for patients who have elected the Medicare Hospice Benefit.

Respecting that patients' clinical situations can change frequently, CMS has elected not to set any maximum frequency at which ACP codes may be billed but will be monitoring the use of these codes. Neither have they set a lifetime limit for patients to be billed for these codes although judicious use of ACP codes is warranted. If a medically necessary, face-to-face discussion regarding a patient's short- or long-term treatment options and planning occurs for at least 16 minutes, the ACP code(s) may be billed. If the patient's condition makes another discussion appropriate the next day, ACP code(s) may be billed again.[10]

CMS clarified that ACP services performed with patients who have elected the Medicare Hospice Benefit (MHB) are reimbursable. Although the MHB is reimbursed by Medicare Part A, CMS stated that ''there is nothing that restricts a Part A hospice claim from including line items and being reimbursed for ACP services performed by attending physicians that work for, or under arrangement with, the hospice.'' In the context of the MHB, an attending physician may be either the physician or nurse practitioner the patient has chosen as their hospice attending of record.[15] Of note, CMS has stated that ACP codes can be submitted only by the hospice attending physician of record (AOR). If the AOR is an independent attending, the claim would be submitted to Medicare Part B and cost sharing will apply. If the AOR has a financial relationship with the patient's hospice, the AOR bills the hospice, which bills Medicare Part A and no cost sharing applies.[16]

Tip 10: ACP codes can be used in addition to Transitional Care Management (TCM) and Chronic Care Management (CCM) codes and within global surgical periods.

ACP may be appropriate throughout a patient's disease trajectory. Medicare has opted not to limit significantly the times when ACP codes may be reimbursed. Other than prohibiting the same provider to bill for ACP and critical care services on the same day, ACP codes may be submitted whenever ACP discussions are held assuming documentation supports all the previously noted requirements. The use of TCM or CCM codes or that a patient is within a global surgical period does not limit a provider discussing ACP from being reimbursed separately for that service.[10]

Scenarios

Scenario 1: Mr. M is a 66-year-old man with New York Heart Association Class III heart failure. His functional status is limited at times by dyspnea on exertion. He visits his cardiologist who adjusts his diuretic dose and frequency. After notifying the patient about Medicare cost sharing and giving him a chance to refuse to participate, they spend 35 minutes discussing future care options, including milrinone infusion, left ventricular assist device, and heart transplant. The patient wishes for all aggressive measures and a summary of the discussion is documented in the patient's record. The patient takes an AD form home but does not complete it. The cardiologist may submit for reimbursement for both 99214 and 99497, 30 minutes of ACP discussion. Completion of documents is not required for reimbursement of ACP codes.

Scenario 2: The same patient has a decompensation of his heart failure and is admitted to the intensive care unit (ICU) a year later. PC is consulted to help with dyspnea and medical decision making. After the PC, NP evaluated the patient and recommended IV hydromorphone for his dyspnea due to coexisting renal failure, she participated in a 47-minute-long discussion with the patient's wife and the intensivist. The PC NP should submit an E&M bill for dyspnea treatment, preferably coded using complexity. ACP discussions with his family are reimbursable separately. Code 99497 will be reimbursed for the first 30 minutes of ACP discussions and code 99498 is appropriate since at least one minute beyond the midpoint of the second 30-minute code was reached. Since the intensivist billed critical care code 99291, he is not eligible to be reimbursed separately for ACP discussions on that day.

Scenario 3: Mr. M survives his hospitalization and regains most of his functional status. He returns home to live with his wife. The patient visits his primary care physician's office for a routine blood pressure check and asks to see the doctor. The physician's schedule is already overbooked. Mr. M wants to clarify his code status, as his brother recently died on the ventilator after six weeks in the ICU. The doctor documents his request for the office social worker to discuss code status, which she does for 35 minutes, and the patient ultimately wishes all resuscitative efforts be made although elects to avoid a tracheostomy or gastrostomy tube. Documentation of the visit was made. Since the physician developed the plan of care, met direct supervision requirements, and the LCSW was acting within her scope of practice, code 99497 should be submitted under the physician's provider number and will be reimbursed as an ''incident to'' service.

Scenario 4: Mr. M suffers a significant myocardial infarction and develops overwhelming sepsis from a foley catheter while in the hospital. He requires mechanical ventilation, pressors, and an intraaortic balloon pump to maintain his blood pressure. His blood cultures are persistently positive and there is evidence of seeding of hardware in the patient's back, placed during a lumbar fusion years ago. He is not a surgical candidate and his persistent bacteremia precludes advanced heart failure therapies. His blood pressure wanes. ACP discussions are held for 30 minutes by the cardiology team and for 80 minutes by the PC team. His family decides to withdraw life-sustaining treatment. The cardiology provider bills code 99497 and the PC team bills 99497 and 2 units of 99498 today and all may be reimbursed on the same day. CMS has indicated no minimum time in the future that ACP must be performed.

Conclusion

ACP is a routine procedure performed by PC clinicians and an intrinsic component of patient-centered, serious illness care. The implementation of new billing codes for ACP should both increase the frequency with which ACP occurs while also appropriately recognizing the important efforts that clinicians already expend. We believe that billing for

ACP should become a routine process in PC, after a few important caveats presented are considered. Ultimately, we believe that ACP processes, appropriately recognized and incentivized, will lead to greater proliferation of this crucial preparatory step for all patients with serious illness.

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