Billing and Coding for Advance Care Planning (ACP) Conversations
How to Document Services Correctly to Reflect your Productivity

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June 2019
Join us for upcoming CAPC events

→ Upcoming Webinars:
  – BRIEFING: Key Findings From the Latest CAPC Research on Attitudes and Perceptions of Palliative Care (OPEN TO ALL)
    Thursday, July 18 at 12:30pm ET
  – Creating Innovations to Address the Palliative Care Workforce Shortage
    Wednesday, July 31 at 12:30pm ET

→ Virtual Office Hours:
  – How to Contract with Payers
    Wednesday, June 12 at 12:30pm ET
  – Planning for Community Palliative Care: Getting Started
    Monday, June 17 at 12:30pm ET

Register at www.capc.org/providers/webinars-and-virtual-office-hours/
Billing Series: Upcoming CAPC events and Resources

➔ **Upcoming Webinar:**
  - Demystifying RVUs (Part of the CAPC Billing Series) with Andy Esch, MD, MBA and Phillip Rodgers, MD, FAAHPM
    Wed, August 28 at 12:30pm ET

➔ **Virtual Office Hours:**
  - Billing for Community Palliative Care with Anne Monroe, MHA
    Wed, June 19 at 2:00pm ET
  - Billing and RVUs in Hospital-Based Palliative Care with Julie Pipke, CPC
    Fri, June 21 at 12:30pm ET

➔ **Resources:**
  - Optimizing Billing Practices
    [https://www.capc.org/toolkits/optimizing-billing-practices/](https://www.capc.org/toolkits/optimizing-billing-practices/)

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**Optimizing Billing Practices**
Last Updated: March 4, 2019

Optimized billing and coding are critical to the financial stability of the palliative care program. Palliative care providers can bill for Part B Professional Services, and revenue from billing often covers a substantial portion of direct costs (staff time).

The degree to which you can cover costs billing fee-for-service (FFS) is impacted by:
- Quality of documentation and billing processes
- Mix of team members—who on the team can bill for services, and which staff are counted in your direct costs
- Place of service (care setting)
- Contracts with payers and payer mix
- Proportion of time spent on direct patient care vs. other activities (such as education) that may impact patient care but not be billable

Programs must seek specific interpretation and advice from their local billing staff and regional payer and CMS administrators.

**What’s in the Toolkit**

- Foundational Principles of Palliative Care Billing
- Evaluation and Management (E/M)
- Prolonged Services
- Advance Care Planning (ACP)
- Chronic Care Management and Complex Chronic Care Management
- Care Plan Oversight (CPO)
- Transitional Care Management (TCM)
- Billing for Palliative Care in the Intensive Care Unit (ICU) and the Emergency Department (ED)
Billing and Coding for Advance Care Planning (ACP) Conversations
How to Document Services Correctly to Reflect your Productivity

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Advance Care Planning (ACP) Defined:

- Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care.

- The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.

Reference:

Intent:

Maximize the return for the value provided
CPT Codes for ACP Services

- **99497**: “Advance Care Planning including the explanation and discussion of advance directives such as standard forms (including the completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family members and/or surrogate”.

- **99498 (add-on)**: Each additional 30 minutes

ACP Requirements

→ Medicare provided *no specific requirements* for using ACP codes, other than *it must be voluntary* face-to-face discussion regarding ACP with patient, proxy or surrogate

→ Advance Care Planning *may* include:
  – Discussion of goals and preferences for care
  – Complex medical decision-making regarding life-threatening or life-limiting illness
  – Explanation of relevant advance directives, including (but NOT requiring) completion of advance directives
  – Engaging patients, family members and/or surrogate decision makers, as clinical situation requires
ACP Guidelines: Who Can Provide Service

“Qualified” providers defined under Medicare Part B can report ACP codes for payment

- Physicians (MD/DO), Nurse Practitioners and Physician Assistants, Clinical Nurse Specialists
  - Other team members via applicable ‘incident to’ requirements

All other providers (social work, psychology, chaplains) may **not** report codes independently
ACP Guidelines: Who Can Provide Service – ‘Incident-to’ or ‘Shared Visits’ Billing

Can time spent in ACP conversations by non qualified providers be counted in ACP billing? Yes, but with quite a few provisions

- Requires that general ‘incident-to’ provisions are met:
  - Patient must be established patient under ongoing care of the billing physician
  - The physical location of the conversation must take place in an an office, billed with Place of Service (POS) 11.
    - Nursing and social work is considered part of the provision of care in a hospital
    - Outpatient clinic cannot be “owned” by the hospital
- The service (ACP) is one that a physician could provide, but has delegated to a capable employee
- The delegated employee must be an employee of the physician group/practice
- A supervising physician must be available in person (direct supervision) to participate in the service as needed and address questions. The supervising physician must be the billing physician, but does not need to be the ordering physician.
ACP Guidelines: Where ACP Can Be Performed

➔ There are no place of service limitations on the ACP codes.
➔ ACP codes may be billed by qualified providers in any clinical setting:
  – Inpatient, observation, ED
  – Clinic
  – Home or ‘domicile’ (adult foster care, assisted living, etc.)
  – Skilled Nursing Facility
  – Long-term care
  – Hospice (must bill Medicare Part B)
Practitioners should always consult their Medicare Administrative Contractors (MACs) regarding documentation requirements.

- **Document a brief summary of the voluntary conversation**
  - Detail should reflect and justify length/complexity of the conversation
    - Document who was present, including the patient
  - Document either start/stop time, or total time in minutes
  - Document specific start and end times in addition to total time

- **Form completion may or may not occur**
  - If forms are completed, document which forms were completed and maintain a copy in the record

- **No diagnosis requirements**
  - If a serious illness is featured in documentation, it should be reported on claim
What *should* be included in the ACP visit note?

- Involved (and supervising) clinicians
- Involved patient, family, surrogates
  - And their consent for discussions
- Location of service
- Visit content:
  - Documents completed, if any
  - Decisions made, if any
  - Time spent in ACP discussion
What *might* be included in the ACP visit note? (not exhaustive)

Documentation of discussion about:

- Risks, benefits, and alternatives to various ACP tools
  - (AD, living will, durable power of attorney, Physician Orders for Life-Sustaining Treatment)
- Values and overall goals for treatment
- “Code Status”: CPR/life sustaining measures, DNR orders
- Prognosis
- Palliative and disease-directed care options
- Options for avoiding or limiting aggressive care
- Recommendations of the treating physician
- Hospice
- Care preferences in the setting of future adverse events
- Choosing and utilizing surrogate decision makers
- Ability to change mind
A Sample template
(must review locally!)

Date & Location (Automatically stamped on visit)
Met with_
Discussed prognosis, expected outcome with or without ongoing aggressive treatments and the options for de-escalation of care. Assessed patient specific goals and addressed the best way to achieve them. (Can be made into a drop down list and choose all that apply)
Diagnosis(es)_
Prognosis_
Code Status_
Advance Directive Documentation_
Disposition_
Next Steps_

Advance Care Planning/Goals of Care discussion was performed during the course of treatment to decide on type of care right for this patient from _ to _
Patient/surrogates consented to discussion.
Total Time Spent Face to Face addressing advance care planning in the presence of the Patient: _ minutes
Total Time Spent Face to Face addressing advance care planning in the presence of the Surrogate decision maker: _ minutes
ACP Codes and E/M Billing

→ ACP codes do not need an accompanying E/M code to be billed

However;

→ You may report ACP separately, when performed on the same day as other, specified evaluation and management services
  – Add modifier 25

→ ACP codes _may_ be billed on the same day or a different day as most other E/M services

→ _Can_ be billed with transitional care management or chronic care management codes

→ If providing both E/M and ACP services on the same day, choose E/M code based on complexity, and ACP code(s) based on face-to-face time

→ Note: it is possible to bill both the E/M and ACP services based on time, but this may increase audit risk and _is thus not recommended_. Consult your billing professional or MAC for further guidance.
ACP Codes *Cannot* Be Billed With:

- Critical Care Codes
- Care Plan Oversight Codes
- Cognitive Impairment Evaluation Codes
43 year old male with head and neck cancer, subsequent clinic visit includes pain, depression and nausea management and completion of POLST with referral to hospice.

Total visit requires 50 minutes, ~25 for symptoms:

→ Document all elements for E&M billing of complex symptom visit
→ Document content & time of ACP conversation and completion of documents
→ Bill: Subsequent level 4 99214 + ACP 1st 30 min 99497 = 3.00 rvu
  – (If used 99214 alone based on time or complexity = 1.50 rvu)
Threshold Time to Bill

When ACP services (as described in the code) are performed for a length of time equal to ‘one minute past the midway point’ of the code interval

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99497</td>
<td><strong>First 30 minutes</strong> (at least 16 minutes of time spent performing services described in the code)</td>
</tr>
<tr>
<td>99498</td>
<td><strong>Additional 30 minutes</strong> (at least 16 minutes beyond the first 30 minutes; may be billed as many times as needed to cover the time spent)</td>
</tr>
</tbody>
</table>
Threshold Time to Bill

<table>
<thead>
<tr>
<th>Time</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 15 minutes</td>
<td><em>Included in E/M Code</em></td>
</tr>
<tr>
<td>16-45 minutes</td>
<td>99497</td>
</tr>
<tr>
<td>46-75 minutes</td>
<td>99497 + 99498</td>
</tr>
<tr>
<td>76-105 minutes</td>
<td>99497 + 99498 x 2</td>
</tr>
<tr>
<td>106-135 minutes</td>
<td>99497 + 99498 x 3</td>
</tr>
</tbody>
</table>

May report additional CPT codes 99498s to cover the time spent performing extended services
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99497</td>
<td>1.5</td>
</tr>
<tr>
<td>99498</td>
<td>1.4</td>
</tr>
</tbody>
</table>
BILLING FOR ACP VS PROLONGED SERVICES?
Case: ACP vs E&M time based

80 year old female with acute CVA and coma, initial hospital visit requires 75 minutes, mostly counseling.

→ Document content & time of meeting and bill *time based* services as below since content was much more than simply ACP

→ Initial hospital care Level 3 99223 = 3.86 rvu
  – Versus ACP codes 99497 +99498 = 2.9 rvu
Case: ACP vs E&M time based

82 year old male with newly diagnosed bladder cancer, already knew his wishes, you facilitate POLST requiring 20 minute follow-up visit:

- Document ACP time and content
- Bill ACP 1st 30 minutes 99497 = 1.5 rvu
  - 99232 for subsequent level 2 = 1.39 rvu
### ACP vs Prolonged Services

<table>
<thead>
<tr>
<th>ACP</th>
<th>Prolonged Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>➔ Time-based code</td>
<td>➔ Time-based code</td>
</tr>
<tr>
<td>➔ Can be provided in any site of service</td>
<td>➔ Can be provided in any site of service</td>
</tr>
<tr>
<td>➔ Documentation should support services delivered</td>
<td>➔ Documentation should support services delivered</td>
</tr>
<tr>
<td>✔️ Does not require another E/M service to be reported</td>
<td>✔️ Requires another E/M service to be reported</td>
</tr>
<tr>
<td>➔ Can be reported after <strong>16 minutes</strong> service, with or without accompanying E/M</td>
<td>➔ Can be reported after <strong>31 minutes</strong> of service with an accompanying E/M</td>
</tr>
<tr>
<td>➔ RVU values are the <strong>same in any site</strong> of service</td>
<td>➔ Outpatient RVU’s higher than inpatient</td>
</tr>
</tbody>
</table>
# RVU Comparison: ACP vs Prolonged Services Billing

<table>
<thead>
<tr>
<th>Time</th>
<th>ACP RVU</th>
<th>Prolonged Services RVU inpatient</th>
<th>Prolonged Services RVU outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;15 min</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16 – 30</td>
<td>1.5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>31 – 45</td>
<td>1.5</td>
<td>1.77</td>
<td>2.33</td>
</tr>
<tr>
<td>46 – 75</td>
<td>2.9</td>
<td>1.77</td>
<td>2.33</td>
</tr>
<tr>
<td>76 – 105</td>
<td>4.3</td>
<td>3.48</td>
<td>4.04</td>
</tr>
<tr>
<td>106 – 135</td>
<td>5.7</td>
<td>5.19</td>
<td>5.75</td>
</tr>
<tr>
<td>136 – 165</td>
<td>7.1</td>
<td>6.9</td>
<td>7.46</td>
</tr>
</tbody>
</table>
Inpatient Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221 Initial Hosp Level 1</td>
<td>1.92</td>
</tr>
<tr>
<td>99222 Initial Hosp Level 2</td>
<td>2.61</td>
</tr>
<tr>
<td>99223 Initial Hosp Level 3</td>
<td>3.86</td>
</tr>
<tr>
<td>99231 Subsequent Hosp Level 1</td>
<td>0.76</td>
</tr>
<tr>
<td>99232 Subsequent Hosp Level 2</td>
<td>1.39</td>
</tr>
<tr>
<td>99233 Subsequent Hosp Level 3</td>
<td>2.0</td>
</tr>
<tr>
<td>99497 ACP first 30 min</td>
<td>1.5</td>
</tr>
<tr>
<td>99498 ACP next 30 min</td>
<td>2.9</td>
</tr>
</tbody>
</table>
# Outpatient Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 Outpatient Visit New Level 1</td>
<td>0.48</td>
</tr>
<tr>
<td>99202 Outpatient Visit New Level 2</td>
<td>0.93</td>
</tr>
<tr>
<td>99203 Outpatient Visit New Level 3</td>
<td>1.42</td>
</tr>
<tr>
<td>99204 Outpatient Visit New Level 4</td>
<td>2.43</td>
</tr>
<tr>
<td>99205 Outpatient Visit New Level 5</td>
<td>3.17</td>
</tr>
<tr>
<td>99211 Outpatient visit established level 1</td>
<td>0.18</td>
</tr>
<tr>
<td>99212 Outpatient visit established level 2</td>
<td>0.48</td>
</tr>
<tr>
<td>99213 Outpatient visit established level 3</td>
<td>0.97</td>
</tr>
<tr>
<td>99214 Outpatient visit established level 4</td>
<td>1.5</td>
</tr>
<tr>
<td>99215 Outpatient visit established level 5</td>
<td>2.11</td>
</tr>
<tr>
<td>99497 ACP first 30 min</td>
<td>1.5</td>
</tr>
<tr>
<td>99498 ACP next 30 min</td>
<td>2.9</td>
</tr>
</tbody>
</table>
ACP CPT Code Benefits

- **Capture revenue** for visits more targeted to advance care planning, goals of care, and family meetings
- **Added revenue** from consults/visits with significant advance care planning work
- **Streamline documentation** (ACP narrative vs. E/M documentation)
- In the right settings, may be able to include the work of **interdisciplinary team members** through ‘incident-to’ billing
- Potential for dedicated “**ACP note**” that can be easily found and/or counted
- More **accurately describe** services delivered and quantify value through billing data
Implementing ACP Code Use

➔ Consult your Medicare Administrative Contractors (MACs) and/or local coding experts and auditors regarding documentation requirements in your area
➔ Collaborate regularly with local billing professionals
➔ Provide billing clinicians education on when and how to optimize ACP code use (type of visits, time thresholds, ACP vs. prolonged services)
➔ Create feedback to processes to optimize billing in real time
➔ Use templates to meet documentation requirements, while minimizing clinician burden
FAQ’s

1. Does the patient have to complete an advance directive in order to bill ACP codes? No.

2. Should I use ACP codes for all of my visits since I always talk about goals? Probably not, but...

3. Should I use ACP codes everyday for the same patient? Probably not, but...

4. Will my patient have to pay a copay? Maybe

5. Can I bill ACP for a telehealth visit? No

6. Can I bill ACP for patients who have elected Hospice Medicare Benefit? Yes

7. Do I also need to choose diagnosis codes when I use ACP CPT codes? Yes.
Take-Aways

➔ ACP codes are *one* tool to maximize return for the value you provide in any care setting

➔ Use for discussions with patients or surrogates about the pt condition, care and future decisions held by medical clinician (or use “incident to”)

➔ Know & Agree upon how to document required items with your billers

➔ Recognize ACP codes are not always the best way to capture the most value for your visit
References and CMS Resources

- Department of Health Centers for Medicare & Medicaid Services - Advance Care Planning
- Department of Health Centers for Medicare & Medicaid Services - FAQ Advance Care Planning
Questions?

Please type your question into the questions pane on your WebEx control panel.