

# Billing and Coding for Advance Care Planning (ACP) Conversations

## How to Document Services Correctly to Reflect your Productivity

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# 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/](http://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/>

### Optimizing Billing Practices

Last Reviewed: 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

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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:

**Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel.**

[Sudore RL](#)<sup>1</sup>, [Lum HD](#)<sup>2</sup>, [You JJ](#)<sup>3</sup>, [Hanson LC](#)<sup>4</sup>, [Meier DE](#)<sup>5</sup>, [Pantilat SZ](#)<sup>6</sup>, [Matlock DD](#)<sup>2</sup>, [Rietiens JAC](#)<sup>7</sup>, [Korfage LJ](#)<sup>7</sup>, [Ritchie CS](#)<sup>8</sup>, [Kutner JS](#)<sup>9</sup>, [Teno JM](#)<sup>10</sup>, [Thomas J](#)<sup>11</sup>, [McMahan RD](#)<sup>8</sup>, [Hewland DK](#)<sup>12</sup>. *J Pain Symptom Manage*. 2017 May;53(5):821-832.e1. doi: 10.1016/j.jpainsymman.2016.12.331. Epub 2017 Jan 3.

<sup>5</sup> Sudore, et al. Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. *Journal of Pain Symptom Management*, 10.1016/j.jpainsymman.2016.12.331; available at: <https://www.ncbi.nlm.nih.gov/pubmed/28062339>

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)

# Documentation Requirements

- 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

# Case: ACP and E&M 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 1<sup>st</sup> 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

CPT Code	Time
<b>99497</b>	<b><i>First 30 minutes</i></b> <i>(at least 16 minutes of time spent performing services described in the code)</i>
<b>99498</b>	<b><i>Additional 30 minutes</i></b> <i>(at least 16 minutes beyond the first 30 minutes; may be billed as many times as needed to cover the time spent)</i>

# Threshold Time to Bill

Time	CPT Code
<b>≤ 15 minutes</b>	<i>Included in E/M Code</i>
<b>16-45 minutes</b>	<i>99497</i>
<b>46-75 minutes</b>	<i>99497 + 99498</i>
<b>76- 105 minutes</b>	<i>99497 + 99498 x 2</i>
<b>106-135 minutes</b>	<i>99497 + 99498 x 3</i>

→ May report additional CPT codes 99498s to cover the time spent performing extended services

# RVU's

CPT Code	RVU
99497	1.5
99498	1.4

# 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 1<sup>st</sup> 30 minutes 99497 = 1.5 rvu
  - 99232 for subsequent level 2 = 1.39 rvu



# ACP vs Prolonged Services

## ACP

- Time-based code
- Can be provided in any site of service
- Documentation should support services delivered
  - Does **not require** another E/M service to be reported
- Can be reported after **16 minutes** service, **with or without** accompanying E/M
- RVU values are the **same in any site** of service

## Prolonged Services

- Time-based code
- Can be provided in any site of service
- Documentation should support services delivered
  - **Requires** another E/M service to be reported
- Can be reported after **31 minutes** of service **with** an accompanying E/M
- Outpatient RVU's higher than inpatient

# RVU Comparison: ACP vs Prolonged Services Billing

Time	ACP RVU	Prolonged Services RVU inpatient	Prolonged Services RVU outpatient
<15 min	0	0	0
16 – 30	1.5	0	0
31 – 45	1.5	1.77	2.33
46 - 75	2.9	1.77	2.33
76 – 105	4.3	3.48	4.04
106 – 135	5.7	5.19	5.75
136 – 165	7.1	6.9	7.46

# Inpatient Codes

Code	RVU
99221 Initial Hosp Level 1	1.92
99222 Initial Hosp Level 2	2.61
99223 Initial Hosp Level 3	3.86
99231 Subsequent Hosp Level 1	0.76
99232 Subsequent Hosp Level 2	1.39
99233 Subsequent Hosp Level 3	2.0
99497 ACP first 30 min	1.5
99498 ACP next 30 min	2.9

# Outpatient Codes

Code	RVU
99201 Outpatient Visit New Level 1	0.48
99202 Outpatient Visit New Level 2	0.93
99203 Outpatient Visit New Level 3	1.42
99204 Outpatient Visit New Level 4	2.43
99205 Outpatient Visit New Level 5	3.17
99211 Outpatient visit established level 1	0.18
99212 Outpatient visit established level 2	0.48
99213 Outpatient visit established level 3	0.97
99214 Outpatient visit established level 4	1.5
99215 Outpatient visit established level 5	2.11
99497 ACP first 30 min	1.5
99498 ACP next 30 min	2.9

# 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

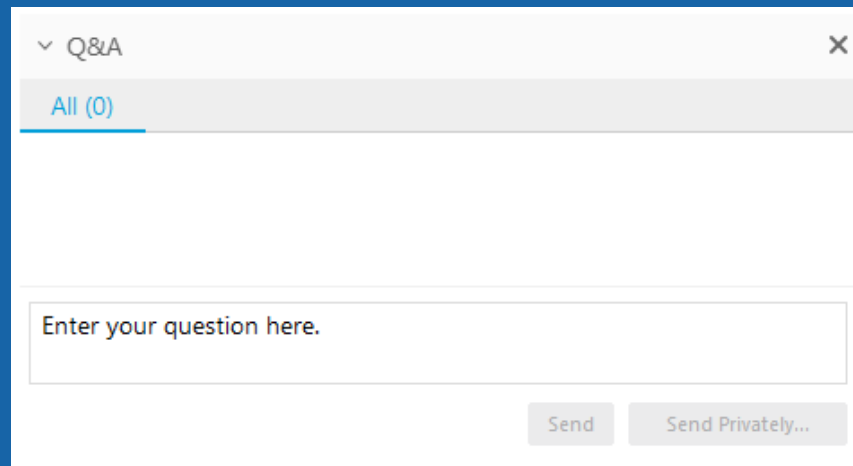


# References and CMS Resources

- *CAPC's Billing and Coding Tip Sheet/Toolkit:*  
<https://www.capc.org/toolkits/optimizing-billing-practices/>
- *Department of Health Centers for Medicare & Medicaid Services- Advance Care Planning*
- *Department of Health Centers for Medicare & Medicaid Services- FAQ Advance Care Planning*
- *Top 10 Tips for Using Advance Care Planning codes in Palliative Care and Beyond Jones, C., et al Journal of Palliative Medicine*  
<https://www.ncbi.nlm.nih.gov/pubmed/27682147>
- *Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. Sudore, et al. Journal of Pain Symptom Management*  
<https://www.ncbi.nlm.nih.gov/pubmed/28062339>

# Questions?

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



The image shows a screenshot of the WebEx Q&A interface. At the top, there is a header with a dropdown arrow and the text "Q&A" and a close button "X". Below the header is a tab labeled "All (0)". The main area is a large empty space. At the bottom, there is a text input field with the placeholder text "Enter your question here." and two buttons: "Send" and "Send Privately...".



**Tipping Point**  
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