

Advance Care Planning CPT codes 99497 and 99498

Key barriers for physician engagement in thoughtful MOLST discussions include, lack of time, lack of reimbursement for time and the need for advance care planning training to improve knowledge, attitudes and communication skills.

A key recommendation of the IOM Report Dying in America includes providing incentives for improved shared decision making and advance care planning that reduces the utilization of unnecessary medical services and those not consistent with a patient's goals for care.

In January 2016, the Center for Medicare Services (CMS) approved two new CPT Codes 99497 and 99498 to allow physicians and "other qualified health care professionals," to be reimbursed for having an advance care planning conversation with their Medicare patients. The decision affirms advance care planning as an integral component of the practice of medicine and overcomes a key barrier.

Other "qualified health care professionals" are non-physician practitioners who are enrolled in the Medicare program and eligible to receive Medicare payments provided to Medicare beneficiaries. Examples include nurse practitioners, physician assistants, and licensed clinical social workers. Opportunities exist to leverage existing payment stream with CPT codes 99497 and 99498 to encourage upstream shared, informed, decision making.

The ACP Section from Final Rule, AMA CPT Codes Manual affirms advance care planning involves learning about and considering the types of decisions that will need to be made at the time of an eventual life-ending situation and what the patient's preferences would be regarding those decisions.

CPT codes 99497 and 99498 are time-based codes used to report 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 legal forms. No active management of the problem(s) is undertaken during the time period reported.

The description of the procedure code 99497 includes the first 30 minutes (16-45 minutes) of a face-to-face meeting with the patient, family member(s), and/or surrogates during which time:

- the physician evaluates the patient and determines the patient's capacity to understand the risks, benefits, alternatives to specific treatment
- the physician elicits patient's values and goals for treatment

- the physician may explain and review advance directives and MOLST, if appropriate, with or without completion of forms;
- the patient is given an opportunity to review a blank advance directive & MOLST, if appropriate

The clinical example in the AMA CPT Codes Manual is a 68 year old male with heart failure and diabetes on multiple medications who is seen with his wife to discuss advance care planning.

CPT code 99498 is an extension of the work of 99497. This service is performed when the time required to perform 99497 is greater than 45 minutes. Each additional 30 minutes (for example, 16-45 additional minutes for a total of 46 – 75 minutes) is listed separately in addition to code for primary procedure. In other words, use 99498 in conjunction with 99497. Consistent with the 8-Step MOLST protocol, additional time may be needed to discuss:

- the patient's condition, prognosis, options and resolve conflicts due to the presence of a new, unexpected, or sudden illness
- a complicated family dynamic
- disagreement or controversy over advance directive or shared decision making for adult not able to make their own decision.

Individuals who may need additional time are patients appropriate for MOLST:

- Individuals with end-stage chronic illness (e.g. CHF, COPD, renal disease, HIV/AIDS)
- Individuals facing emergent and high-risk surgery, or those who experience a sudden event (e.g. TIA) and are at risk of repeated episodes
- Individuals with early dementia or mental illness
- Individuals who rely on guardians or parents to make decisions; for example, persons with developmental disabilities who lack capacity and minor patients

The clinical example in the AMA CPT Codes Manual is a 68 year old male with heart failure and diabetes on multiple medications, who was recently discharged from the intensive care unit, is seen with his wife to discuss advance care planning.

CPT codes 99497 and 99498 cannot be reported on the same day of service as critical care codes: 99291, 99292; neonatal/pediatric critical care: 99468 – 99476; and initial & continuing intensive care: 99477-99480.

ACP CPT Codes 99497 and 99498 Frequently Asked Questions

Who Can Receive and Where Can ACP Services Be Rendered?

CMS: All MC and MA beneficiaries can receive ACP services in all settings.

EBCBS: all members in all lines of business (LOBs) in all clinical settings.

Other Commercial: check with your carrier

Can ACP be Part of a Regular Office Visit?

Yes, if active management of the clinical problem(s) and ACP both occur on the same day. Active management and ACP cannot occur during the same time period reported. For ACP, additional CPT codes can be reported, if the service is provided; the provider must add modifier 25. Documentation of the content of the ACP discussion is critical, including amount of time spent for each service.

Can ACP be Part of the CMS Annual Wellness Visit (AWV)?

Yes, ACP is an optional element, at the beneficiary's discretion. The AWV provides an opportunity to access ACP services should the beneficiary elect to do so. The code for an initial AWV is G0438; for a subsequent visit, the code is G0439. Part B cost sharing does not apply when ACP is part of the AWV.

Can ACP be Part of Preventive Medicine Visits?

Yes. Codes for Preventive Medicine Visits are 99381-99397. For ACP, additional CPT codes can be reported if service is provided; the provider must add modifier 25. Documentation of the content of the ACP discussion is critical, including amount of time spent.

What are the cost sharing requirements for beneficiaries?

CMS: Part B cost sharing will apply, as it does for other physician services; the EXCEPTION is the Annual Wellness Visit.

EBCBS: PCP/Specialist Co-Pays apply

Other Commercial Carriers: Check with Provider Services

Can Telemedicine Be Used to Provide and Bill for Services?

CMS: **No** (But, is included in the 2017 CMS Physician Fee Schedule) In 2016, the service must be face-to-face with the patient, family member(s) or surrogate(s)

EBCBS: In accordance with NYS regulations, for new or renewing commercial policies, on or after 1/1/2016, we must cover services provided by telemedicine that would be covered if delivered Face-to-face.