Institute for Healthcare Improvement

conversation ready

End-of-Life Care Conversations: Medicare Reimbursement FAQs

The changes in Medicare reimbursement policy that went into effect January 2016 provide an opportunity for more clinicians and patients to engage in conversations about preferences for care at the end of life. However, many people are confused about where to start. Whether you are uncertain about the new rules for CMS reimbursements or about starting those conversations with patients, this document will help you understand this new landscape for end-of-life care conversations.

Before getting started, check to see if a local coverage determination has been made, and check with your local billing expert to ensure your practice is compliant with their recommendations. Make sure that the new reimbursement codes have been added to your system's billing apparatus. These codes may not be available until your facility approves them for use.

1. Do these new codes need to be used in the context of an illness?

No. In fact, any medical management must be billed separately.

2. What are the new advance care planning (ACP) codes from CMS that became active in 2016?

99497 – ACP, including 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 professional

99498 – Each additional 30 minutes (list separately in addition to code for primary procedure)

3. How much time must be spent to use the new codes?

More than half of each interval must be used. For example:

- Use 99497 if you meet or exceed 16 minutes.
- Use 99497 + 99498 if you meet or exceed 46 minutes.

4. Does the conversation have to be in-person to use the new codes? Does it have to be with the patient?

The conversation has to be in-person (you cannot use the code for telehealth), but it doesn't have to be with the patient. It can be with a surrogate or family members.

5. What are the documentation requirements?

- Total time in minutes
- Patient/surrogate/family "given opportunity to decline"
- Details of content (e.g. Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up)

6. What costs might patients incur from these codes?

When a provider discusses advance care planning with a patient at his/her Annual Wellness Visit, there is no cost to the patient. However, if the provider has an ACP conversation at other times, Part B cost sharing applies and the patient may be responsible for copay/coinsurance.

7. How much do payers reimburse for these codes?

99497 = 1.5 RVUs
99498 = 1.4 RVUs

8. Are there limits to the number of times that the new codes can be used?

There are no limits to the number of times the codes can be used. ACP can be readdressed as needed with a change in condition. Each time they are used, 99497 should be used for the first 30 minutes and 99498 should be used for each additional 30 minutes.

9. Which health care providers can be reimbursed for having ACP discussions with patients under the new rule? Can physicians charge for the codes if another staff member engages the patient in the ACP discussion?

Physicians (MDs and DOs), nurse practitioners (NPs), and physician assistants (PAs) (i.e. those who are authorized to independently bill Medicare for Current Procedural Terminology (CPT) services) are the only providers who can use these codes.

"Incident to" rules apply in the outpatient setting. This means that a provider can use these codes if they perform an initial service and a non-billing team member (e.g., registered nurse, social worker) helps deliver part of the service, with ongoing direct supervision and involvement of the billing provider. Example: The physician starts an ACP conversation, then says, "I'd like to introduce you to our nurse who will talk with you about choosing a surrogate medical decision maker and discuss with you how you might have a conversation with that person," then debriefs afterwards with the patient. Work with your local billing expert regarding "incident to" rules.

10. How can physicians bill for these conversations for non-Medicare patients?

If the patient has private insurance, find out if ACP conversations are covered. Otherwise, you can use "counseling and coordination of care" codes, but only in the context of a serious illness.