Primary Care

CONNECTED CARE PARTNERS

COMMON PRACTICE

Addressing Patients' Greatest Concerns

Palliative care focuses on the relief of pain, stress and other symptoms of serious illness. Palliative care can begin at any stage of an illness, any age and alongside treatment.

Specialty palliative care consultation is available in the acute care setting at the NMMC-Tupelo and for cancer patients at the NMMC Cancer Center; however, palliative care makes the most impact in the primary care setting. Any provider should aim to provide symptom relief and have conversations that explore a patient's priorities as they relate to his/her illness, commonly referred to as advance care planning.

Medicare now reimburses time spent discussing advance care planning. Below is information on the use of ACP codes and examples of how to address this at various stages of illness.

Click for more information on palliative care and links to advance care planning.

End-of-Life Care Conversations: Medicare Reimbursement FAQs

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

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

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)

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.

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.

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?)

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. We have a financial obligation to inform patients when they will have a financial responsibility to a service we provide and bill for.

How much do payers reimburse for these codes?

99497 = 1.5 RVUs
99498 = 1.4 RVUs

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. When the service is billed multiple times for a patient, we would expect to see a documented change in the patient's health status and/or wishes regarding end of life care.

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.

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. When using counseling and coordination of care; while these discussions may take place with family members, a face to face with the patient must also occur on the same date of service. Please note, this only applies when using counseling and coordination of care.

	No Serious Illness	**Serious Illness**	**Advanced Serious Illness**
Sample Case Progression	Ms. Smith is a 68-year-old woman with hypertension, hyperlipidemia and history of smoking. She was recently diagnosed with emphysema/COPD. She's coming in for a routine follow-up for her hypertension with her daughter.	At age 71 Ms. Smith developed a COPD exacerbation, which turned into a pneumonia with significant shortness of breath. She was admitted to the hospital. She was sick enough to require BIPAP and was in the ICU. Eventually, she recovered and was discharged home. She is now in your office for routine follow-up.	Now 75 years old, Ms. Smith has had a couple of admissions for less severe COPD exacerbations. She was eventually placed on home oxygen, and then about 2 months ago her illness seemed to progress. You talk more and it becomes clear that she doesn't want to have to go back to the hospital if it isn't necessary. She really prefers to stay at home.
Conversation Goals	Build trusting and respectful relationships.	Continue to build trusting, respectful relationships. Continue to learn more	Rely on the trusting, respectful relationships

	Learn about the patient as a person. Establish a surrogate decision maker. Promote patient-surrogate-family conversations.	about the patient as a person. Ensure a good understanding of diagnosis, prognosis and treatment options. Anticipate emergencies and make a plan when appropriate. Promote patient-surrogate-family conversations.	that were built. Keep the focus on the patient as a person. Ensure a good understanding of diagnosis, prognosis and treatment options before introducing hospice. Continue to hope for the best, but prepare for when things don't go well.
Sample Case Progression	Normalize the conversation. Try starting it after family history: *"Have you ever thought who would speak for you if you couldn't speak for yourself? Is it ok if we talk about that?"* If he/she already has an advance directive (AD): *"May I see it? What does it say?"* If he/she does not have an AD: *"Can I offer you some tools to start thinking about it?"*	Talk about "what matters most": *"Can you tell me your understanding of what happened in the hospital?"* *"What was that like for you?" "How are you doing now?"* *"If surrogate decision making was needed, how was that?"* Identify the values that guided decision making, i.e., "what mattered most."	*"You have been in and out of the hospital quite a bit. How has that been?"* *"How do you feel about your quality of life?"* *"Given everything that has happened, what are you hoping for?"* *"Unfortunately, we don't have any more treatments to help your lungs get better."* *"It seems to me what matters most to you is to [stay out of the hospital, control your symptoms at home, and make the most of each day OR stay out of the hospital but continue to receive treatment] and*

			I think [hospice OR home care] is the best way of doing that."

Want more information? Visit ihi.org/CMSpaymentihi.org/CMSpayment

The information contained in this document is based on our best understanding of the new reimbursement codes. It is your responsibility to check with your local billing expert before using the new codes. Please review our full disclaimer of warranties and liability here.

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