Advance Care Planning

The ABCs of Getting Paid

CODING Leader

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A Note from the Publisher

Dear Colleague:

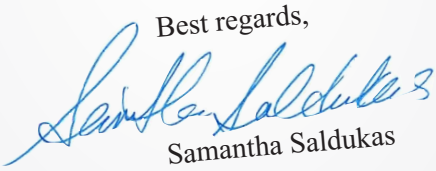
Helping your patients plan for when they can't make their own medical decisions is an important part of your practice. However, until recently, Medicare has not reimbursed claims for these services.

Since January of 2016, the Centers for Medicare and Medicaid Services (CMS) has reimbursed for Advance Care Planning (ACP) services. Making ACP reimbursement available is part of CMS' policy to promote better health outcomes and reduce hospital re-admissions. This works to your advantage – if you know how to correctly submit and support your claims.

Using this expert report, you can take the first steps to ensure you finally get paid for the ACP services your practice provides. Your office will be able to administer ACP, ethically boost your reimbursement, limit your patients' co-pays, and ensure the outcomes that you, your providers, your patients, and CMS all hope to achieve.

Thank you for your order, and we look forward to being able to assist you in the future with your coding, billing and/or compliance needs.

Best regards,



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P.S. – Check out our Website at www.codingleader.com to find additional expert advice on how to ethically increase your reimbursement, ensure compliance, and have a more successful practice.

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Rules You Need to Get Paid

Your practitioners have probably been educating their patients about end-of-life issues and the options available to them for years – all for free. But that ends here.

Previously, you couldn't be paid for ACP services because the Centers for Medicare and Medicaid Services' (CMS) guidelines bundled them into standard Evaluation and Management (E/M) services. However, effective January 2016, CMS approved ACP as a distinct service for which you can bill and Medicare will pay. But, in order to get paid, you must know how to properly document, code and file these claims correctly.

Advance Care Planning CPT Definition

*Codes **99497** [and] **+99498** are used to report the 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 relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life Sustaining Treatment (MOLST).*

*When using codes **99497** [and] **+99498**, no active management of the problem(s) is undertaken during the time period reported.*

What's Included in ACP?

An ACP conversation happens any time your providers help patients understand their medical options and plan for their futures. If your providers document these services correctly and the appropriate CPT codes are applied correctly, Medicare will reimburse you.

CPT describes **99497** and **+99498** as a "*face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate...*" Although CPT's definition states that the face-to-face service is with the "*patient, family member **OR** surrogate*" this isn't entirely correct. This issue is clarified in CMS' Change Request CR-9271 where it states, "*... ACP means the face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance*

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directives, with or without completing relevant legal forms." Accordingly, the patient must be present in order for Medicare to pay your ACP claim.

NOTE: You can find the actual CMS change request at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9271.pdf

IMPORTANT: The + in front of Advance Care Planning services code **99498** means that it is an "add-on" code and can only be reported with code **99497**.

CPT also states that *"no active management of the problem(s) is undertaken during the [ACP] time period reported."* This means that the ACP conversation time is ONLY about planning for future developments – not dealing with immediate illness-related issues.

> **EXAMPLE:** A 95-year-old patient with early-stage prostate cancer visits your office and spends 50 minutes with one of your doctors. Your provider spends 25 minutes reviewing the patient history, performing a detailed examination and making some moderately complex decisions about the patient's condition and medication.

Patient ACP Conversation Components

The National Hospice and Palliative Care Organization (NHPCO) suggests that when your providers sit down with patients and their families, the Advance Care Planning conversation should cover the following items:

- Educate patients and their families about the illness.
- Types of available life-sustaining treatments.
- Decisions about what types of treatment patients want if faced with a life-limiting illness.
- Sharing patients' values with loved ones. This includes discussing what patients want and making sure their voices are heard and accepted by family members.
- Decisions concerning who speaks for patients if they can't speak for themselves.
- What patients want to include in Advance Care Directive Documents (ACDDs).

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Then your doctor spends another 25 minutes educating the patient about his disease – which likely will progress slowly – and about expected outcomes. The patient also expresses a desire to avoid surgery, talks about end-of-life scenarios and discusses a Do Not Resuscitate (DNR) order.

When coding this example, the first 25 minutes of the encounter is a standard established patient E/M service, and you should code it as **99214** (*Office or other outpatient visit*). The second 25 minutes should be tracked separately as an ACP conversation, and you should report it as **99497** (*Advance care planning ... first 30 minutes*) as long as the provider appropriately documents the conversation, such as:

DOCUMENTATION:
"*Provided separate advance care planning services to patient for 25 minutes (from 3:25 p.m. to 3:50 p.m.) including discussion of DNR.*"

In the example above, you can see how illness management is part of the E/M service, and planning for the future is part of the ACP service. The DNR they discussed is considered an Advance Care Directive Document (ACDD). Remember that CPT indicates that ACP involves "*...counseling and discussing advance directives, with or without completing relevant legal forms*." Other examples of ACDDs include living wills, health care proxies, and durable powers of attorney for health care. Although ACP frequently involves discussing ACDDs, they are not required to bill for them.

If your practitioners do get involved in helping patients with ACDDs, they must understand the relevant state laws for your jurisdiction. Each state has separate regulations regarding ACDDs. Check with your state board of medicine or with the The National Hospice and Palliative Care Organization (NHPCO), which maintains a database of state advance care requirements on its Website at:
http://www.caringinfo.org/i4a/pages/index.cfm?pageis=3289

IMPORTANT: This report focuses on billing ACP to Medicare. There can be significant variation among private insurance carriers, so you should check with each of your private payers for their individual ACP requirements.

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Time-Based Code Tracking That Works

ACP codes **99497** and **+99498** are time-based, which means your providers must specifically document the time they spend offering these services. To record ACP services correctly, your providers must document the time the conversation started, when it stopped, and the total amount of time included. This is your only hope of supporting your ACP claims if Medicare initially denies them, and to ultimately getting paid.

For example, if your doctor merely documented, "*Conducted annual wellness visit, discussed ACP, patient signed DNR*," your chances of reversing a denial to ultimately get paid are rather poor. This documentation doesn't indicate the ACP conversation was separate from the annual wellness visit or how much time the provider spent discussing ACP services in addition to the wellness visit.

When using time-based ACP codes, there are several guidelines you and your providers must follow to be eligible for payment:

1. **Track Time:** Your practitioner must keep track of the actual minutes spent when providing ACP services, including the start and stop times, duration, and specifically what they discussed.

   EXAMPLE: A 72-year-old patient comes in for an annual wellness visit and tells your doctor, "*My friend has a Do Not Resuscitate (DNR) order in place even though he's not sick. Should I have one?*" Your provider completes the wellness visit and then spends an additional 32 minutes discussing a DNR document with the patient, which the patient decides to sign. The provider's ACP notes for this service should look something like this:

   DOCUMENTATION:
   "*In addition to the time spent conducting his annual wellness visit, I spent 32 minutes (starting at 1:10 p.m. and ending at 1:42 p.m.) reviewing several ACP options with the patient, who executed a DNR during our discussion.*"

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Documenting these services accurately is only half the battle, you must also code them correctly. Here is how you would accurately code the above example:

- **99397** - *Periodic comprehensive preventive medicine; established patient; 65 years or older.*

- **99497-33** - *Advance care planning including the explanation and discussion of advance directives … with completion of such forms …: first 30 minutes face-to-face with patient … .*

  NOTE: Modifier -33 (*Preventive service*) should be applied in this example to indicate it is a preventive care service as outlined by the Affordable Care Act and the patient should have no Medicare cost share.

- **Total Time:** CMS follows CPT time rules for ACP. This means that your provider must spend more than half of the code's defined time face-to-face with the patient. This means at least 16 minutes of the 30 minutes indicated in each code descriptor (**99497** and **+99498**). If your provider spends 46 minutes and properly documents, you can bill **99497** (*first 30 minutes*) and **+99498** (*each additional 30 minutes*).

  EXAMPLE: An 82-year-old male with mild dementia comes in accompanied by his son to discuss his future care. Your provider spends 25 minutes face-to-face with the patient and his son, performing a history, exam, and medical-decision-making related to the patient's medications. They also spend another 46 minutes discussing ACP. During this discussion, the patient states that he doesn't want a feeding tube, and that he's willing to go to a nursing home. Finally, the practitioner helps him complete an Advance Care Directive Document (ACDD) that conveys his wishes. Documentation might look like:

  DOCUMENTATION:

  "*In addition to the time spent evaluating and managing the patient's end-stage Parkinson's disease and mild dementia, we also spent 46 minutes (starting at 2:14 p.m. and ending at 3:00 p.m.) discussing the fact that he doesn't want a feeding tube, and that he is open to nursing home care. Finally, I helped him complete an Advance Directive Document that he ultimately signed.*"

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You should submit the following to bill for this example:

- **99214** – *Office visit, 25 minutes spent taking history, performing exam and making decisions about medication*.
- **99497** – *First 30 minutes* of ACP service.
- **+99498** – *Additional 16 minutes* of ACP service.

NOTE: Because the example case above is NOT a preventive visit you would not add modifier **-33** (*Preventive service*) to either **99497** or **+99498**, and your patient should be responsible to pay a deductible and 20 percent cost share.

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Rules That Determine Payment

Provider rules can work in your favor, but you need to pay close attention to be sure you don't jeopardize your reimbursement or overlook a justifiable opportunity to submit a claim. Here are CMS' specific rules regarding who Medicare payers can reimburse for providing ACP services:

1. **Provider Type:** CMS states that only physicians and qualified health professionals can be reimbursed for providing ACP services. Medicare indicates that "*qualified health professionals*" include Nurse Practitioners (NP), Physician Assistants (PA), Clinical Nurse Specialists (CNS), and Certified Nurse Midwives (CNM). Non-Physician Practitioners (NPP) must meet all requirements for "incident-to" billing.

   NOTE: See page 21 for more information on "incident-to" requirements.

   IMPORTANT: To bill ACP, a provider must be someone who CAN bill E/M services. Psychologists (PhD, PsyD), Licensed Clinical Social Workers (LCSW), and Counselors may help patients through end-of-life issues, but they may not bill for ACP services because they are not allowed to bill E/M services. A psychiatrist, however, can bill for E/M visits and therefore may bill for ACP.

2. **Specialty:** A qualified health professional's specialty does not matter when reporting ACP services. The most common specialties likely include, but are not limited to, Internal Medicine, Family Medicine, Oncology and Palliative Care.

   EXAMPLE: A psychiatrist may help treat a patient with dementia and can bill for an ACP conversation with the patient and patient's family.

   IMPORTANT: Even in cases of dementia where the conversation is predominantly with the family, the patient must be present for the services to be eligible to be paid for ACP.

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3. **Medical Residents:** Residents can't report ACP on their own. On the other hand, if their teaching physician is present and able to assist while the resident performs the service, the teaching physician may bill for ACP as long as the services are documented appropriately.

4. **RHCs and FQHCs:** Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can bill for ACP at their daily flat rate. This is true even if ACP is the only service provided to the patient that day. Of course, if the patient receives other services in addition to ACP, the RHC/FQHC may only bill one flat rate for the whole encounter. The difference is that ACP now counts as one of the things RHCs and FQHCs can bill under the flat rate.

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10 Keys to Avoiding Denials

Just knowing who can provide ACP and when to report it isn't enough. You must have a handle on the required guidelines and how to accurately utilize them in order to make these services eligible for payment:

1. **Frequency of Services:** You **CAN** bill for these services per patient as many separate times as your practitioner provides them – as long as you code and document properly. Medicare places no frequency limits on ACP.

   When you bill for multiple ACP sessions, your practitioner must document specific activities or directive changes covered with the patient. Your provider can make a valid case for answering additional questions, sharing patient wishes with family members, helping a patient complete an advance care directive begun in an earlier sessions, or changing a patient's existing advance directive. Be sure your practitioner documents exactly what he accomplished in each ACP session to support billing.

   a. Multiple Days: You **CAN** report ACP more than once per month. A patient may speak to her doctor on Tuesday for 20 minutes about designating her daughter as her health care proxy. Then, she may return with her daughter on Thursday and speak to the doctor for an additional 40 minutes to actually complete the form. Both are separately billable.

   b. Same Day: You **CAN** report ACP more than once in the same day, as long as it occurs during separate encounters. Say a patient discusses ACP with her doctor for an hour in the morning, and then returns to discuss another ACP issue for an hour later the same day. When this happens, you can bill **99497** and **+99498** for both the morning and afternoon conversations.

      IMPORTANT: Even though you are eligible to bill for multiple ACP visits for one patient on the same day, it doesn't mean your claim won't get denied. If

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this happens, the only chance you have of getting paid is if you can support your claims with clear complete documentation from your practitioner. Otherwise, you'll be left providing these services for free.

2. **Multiple Providers:** More than one provider **CAN** bill for ACP services for one patient, CMS doesn't limit this.

   EXAMPLE: An elderly patient has an aortic weakening that is a suspected aneurysm, hyperammonemia caused by decreased liver function and esophageal varices. He and his daughter (his primary caregiver) have separate ACP conversations in the same week with his cardiologist, hepatologist and gastroenterologist. As long as each of the three physicians properly document their time, they eligible to bill for the ACP services they provided for the same patient.

3. **Location:** You **CAN** bill ACP services in both facility and non-facility settings; Medicare will pay for both. Medicare will also pay hospitals as long as the practitioner provides the service in an outpatient department. Make sure that documentation clearly shows that 16 minutes or more of ACP is separate from the provider's time spent in any inpatient care service.

   NOTE: You **CAN** also bill ACP on the same date of service as inpatient care.

4. **Transitional Care Management:** You **CAN** bill ACP in the same month in which you bill for Transitional Care Management (TCM) codes (**99495-99496**).

   EXAMPLE: One of your practitioners has a 73-year-old male patient with stage 4 lung cancer. The patient is discharged from the hospital after a brief stay. Your office calls the patient within 2 business days to say, "*Now that you've been discharged from the hospital, let's make a follow-up appointment.*" The patient comes in the following week to see your doctor, who reviews their diagnosis, treatment options, and a variety of resources to meet the patient's needs.

   During this follow-up appointment, your physician also spends 30 minutes talking to the patient about his end-of-life care wishes. During this conversation,

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your doctor helps the patient complete an Advance Care Directive Document (ACDD) in compliance with your state law.

DOCUMENTATION:
"*In addition to the time spent in transitional care management, I spent 30 minutes (starting at 3:17 p.m. and ending at 3:47 p.m.) with the patient discussing advance care planning. Patient completed an advance directive during this 30 minutes; directive scanned into patient's medical record.*"

You can submit both TCM and ACP services on the same date as follows:

- **99495** – *Transitional Care Management services*
- **99497** – *Advance Care Planning, 30 minutes in duration*.

NOTE: Do not add modifier **-33** (*Preventive service)* to **99497** because this is not a preventive visit.

IMPORTANT: In order to qualify to be paid for TCM you must provide specified services by very specific deadlines. You can be denied payment for being even one day late. To learn more about how to comply with the complexities of TCM services see the "Transitional Care Management" section of Coding Leader's Resources page on the following page: http://codingleader.com/pages/resources.

5. **Incident-to:** You **CAN** bill ACP under incident-to guidelines, which allow a Non-Physician Practitioner (NPP) to bill for services under a supervising physician's national provider identifier (NPI). This means you can bill the NPP's services at 100 percent of the physician's Medicare Physician Fee Schedule (MPFS) rate, instead of only 85 percent if billed using the NPP's NPI. Keep in mind, however, that your NPP must meet Medicare rules regarding incident-to services, and must also comply with applicable state laws and scope-of-practice requirements. Therefore, your NPP must follow a physician-established plan of care, and your physician must be somewhere in the office and immediately available during the ACP service.

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NOTE: You can utilize the online tools listed below to find your state-specific laws and scopes of practice:

- Nurse Practitioners: http://www.bartonassociates.com/nurse-practitioners/nurse-practitioner-scope-of-practice-laws/
- Physician Assistants: http://www.bartonassociates.com/nurse-practitioners/physician-assistant-scope-of-practice-laws/

EXAMPLE: Your Nurse Practitioner (NP) sees a Parkinson's patient who has been evaluated by a physician in your practice during a previous appointment. The patient has an established plan of care with your physician. Based on this, your NP can discuss ACP issues with the patient that can billed under the physician's NPI based on incident-to guidelines - as long as the documentation supports the claim.

NOTE: For more information on accurately billing incident-to services, see "*NPP Services: Get Paid More Today*," a 2016 Coding Leader online training session http://codingleader.com/products/npp-services-16.

6. **Critical Care:** You **CANNOT** bill for ACP services provided at the same time as critical care services including codes: **99291, +99292** (*Critical care, evaluation and management*), **99468-99476** (*Inpatient neonatal and pediatric critical care*), and **99477-99480** (*Initial and Continuing Intensive Care Services*). Family discussions and decision making are considered inherent parts of critical care and are not separately reimbursable.

7. **Preventive Services (99381-99397) :**

   a. "Welcome to Medicare:" You **CANNOT** bill for ACP services provided during the Medicare Initial Preventive Physical Exam (IPPE), commonly called the "Welcome to Medicare" visit. End-of-life planning is part of the IPPE for new Medicare members.

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b. Annual Wellness Visit (AWV): Medicare considers ACP as a separately payable service from AWV. When your provider discusses ACP issues during a patient's AWV, you **CAN** bill for them. You must append modifier **-33** (*Preventive Services*) to the ACP code to indicate that you didn't charge the patient a coinsurance or deductible (as required under Medicare's AWV guidelines).

8. **ACP with a Diagnosed Disease:** Some patients and their families have specific concerns about the course of a diagnosed illness and how they should plan for available life-sustaining treatments. For example, patients diagnosed with Parkinson's disease have to plan for when they may become unable to eat. Planning ahead and documenting their wishes is essential to ensure patients receive the care they desire. When a patient with a diagnosed disease receives ACP the same day as an office visit or other E/M service for the disease the rules are slightly different:

   a. You are not required to use any modifiers with the ACP codes.

   b. The patient has to pay the Medicare cost share and deductible amounts for this visit.

9. **ACP without a Diagnosed Disease:** Patients with no diagnosed illness may also be concerned about things like intubation, ventilators, resuscitation after cardiac arrest, etc., and how to document their wishes. Once again, you CAN bill ACP for these patients. For example, a healthy 95-year-old patient is concerned after seeing both a friend and a family member survive cardiac arrest in a near-vegetative state. This patient doesn't want the same end-of-life experience, and he talks with his doctor about signing an Advance Care Directive Document (ACDD) that includes a Do Not Resuscitate (DNR) order.

10. **Evaluation and Management (E/M):** According to CPT, codes **99497** and **+99498** may be reported separately if these services are performed on the same day as the following E/M services:

    - **99201-99215** - *Office or Other Outpatient Services*

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- **99217-99220, 99224-99226** - *Hospital Observation Services*
- **99221-99223**, **99231-99239** - *Hospital Inpatient Services*
- **99241-99245**, **99251-99255** - *Consultations*
- **99281-99285** - *Emergency Department Services*
- **99304-99310**, **99315, 99316**, **99318** *Nursing Facility Services*
- **99324-99328**, **99334-99337** - *Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services*
- **99341-99345**, **99347-99350** - *Home Services*

NOTE: CPT also includes codes **99381-99397** (*Preventive Services*) and **99495-99496** (*Transitional Care Management*) as E/M services that can be billed at the same time as ACP. Both are covered earlier in this section.

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Billing Expectations and Results

The most recent information suggests that the average Medicare reimbursement for the first 30 minutes of ACP (**99497**) is $85.93. The average payer reimbursement for each additional 30 minutes of ACP (**+99498**) is $74.83.

Remember that you can bill multiple ACP claims for one patient, based on your provider's documentation.

EXAMPLE: A female patient is terminally ill, and the doctor meets with her and her family several times to explain her illness' likely progression. During one of these meetings, the patient asks for assistance to complete a formal Advance Care Directive Document (ACDD). Before signing the final document, the patient indicates that she wants to take it home and consider it further. She meets with her doctor during two additional appointments about the document before signing it. The doctor documents each of the ACP sessions as described earlier accurately, allowing you to bill for each visit separately.

Keep in mind that although Medicare reimburses for ACP, not all private payers will. Check with all your payers to verify their policies.

For many of your patients and their care givers, providing ACP will have a huge impact, and as long as your practitioners are familiar with your state ACDD requirements, your office probably has all it needs to provide the service and be paid for it right now.

Don't get left out of getting rightfully paid for Advance Care Planning services your office may already be providing. With a little planning and cooperation between your team you can add additional revenue to your bottom line for very little additional work.

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Online Resources

American Bar Association

- **State Downloadable ACP Forms:** http://www.americanbar.org/groups/law_aging/resources/health_care_decision_making/Stateforms.html

American Society on Aging

- **Starting ACP Conversations:** http://www.asaging.org/blog/6-online-resources-start-advance-care-planning-conversations

Aging With Dignity

- **5 Wishes:** https://www.agingwithdignity.org/five-wishes

Barton Associates -State Laws and Scope of Practice

- **Physician Assistants:** http://www.bartonassociates.com/nurse-practitioners/physician-assistant-scope-of-practice-laws/
- **Nurse Practitioners:** http://www.bartonassociates.com/nurse-practitioners/nurse-practitioner-scope-of-practice-laws/

Centers for Disease Control and Prevention (CDC)

- **ACP Brief:** https://www.cdc.gov/aging/pdf/advanced-care-planning-critical-issue-brief.pdf

Centers for Medicare and Medicaid Services (CMS)

- **ACP FAQs (3/22/16):** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf
- **Fee Schedule (2016):** https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-2.ht
- **MLN Matters MM9271:** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9271.pdf
- **Transitional Care Management**: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

The Kaiser Family Foundation

- **Medicare's Role in End-of-Life Care:** http://kff.org/medicare/fact-sheet/10-faqs-medicares-role-in-end-of-life-care/

National Hospice and Palliative Care Organization (NHPCO)

- **What Are Advance Directives?** http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3285
- **Reimbursement for Advance Care Planning:** http://www.nhpco.org/press-room/press-releases/reimbursement-advance-care-planning

NIH National Institute on Aging

- **Advance Care Planning:** https://www.nia.nih.gov/health/publication/advance-care-planning

Caring Info

- **State's Advance Directives Listings:** http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289

US Department of Veterans Affairs

- **Advance Care Planning:** http://www.va.gov/geriatrics/guide/longtermcare/advance_Care_Planning.asp

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Definitions – Fast and Easy

Advance Care Planning (ACP)

ACP is the most recent planning and care management code to become payable by CMS. You can use CPT codes **99497** and **+99498** starting on January 1, 2016 to report face-to-face planning services regarding a patient's medical instructions. You use code **99497** to report "*advance care planning, including explanation and discussion of advance directives ... by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.*" You also use code **+99498** to report "*each additional 30 minutes of advance care planning.*"

Advance Care Directive Documents (ACDD)

An advance directive is a document by which a person makes provisions for health care decisions in the event that, in the future, he/she becomes unable to make those decisions. There are two main types of advance directive — the "Living Will" and the "Durable Power of Attorney for Health Care."

Annual Wellness Visit (AWV)

AWV is available to all Medicare participants who have had Part B for longer than 12 months. The AWV enables patients to develop or update a personalized prevention help plan to prevent disease and disability based on current health and risk factors. The provider will ask the patient to fill out a questionnaire, called a "Health Risk Assessment," as part of this visit. Answering these questions can help the patient and provider develop a personalized prevention plan to help the patient stay healthy and get the most out of visits to the provider. ACP can be offered along with the AWV and can be separately reimbursed if properly documented. AWV is covered once every 12 months – and 11 full months must have passed since the last AWV.

Centers for Medicare and Medicaid Services (CMS)

CMS is the federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state

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governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. CMS has a variety of other responsibilities, including certifying long-term care facilities and overseeing HealthCare.gov. CMS is a primary source for information about coding, billing, appropriate use of modifiers and a host of other related issues. You can access the CMS web site here: https://www.cms.gov.

CPT Time Rules

CMS follows CPT (Current Procedural Terminology) time rules for ACP. That means a practitioner has to spend more than half the code's defined time face-to-face with the patient. So for ACP services, your provider must document spending at least 16 minutes of the 30 minutes indicated in each code descriptor (**99497** and **+99498**). If a provider properly documents 46 minutes of ACP with a patient, you can bill **99497** (*first 30 minutes*) and **+99498** (*each additional 30 minutes*).

Incident-to Guidelines

Incident-to guidelines allow a Non-Physician Practitioner (NPP) to bill for services under a supervising physician's national provider identifier (NPI). This means you can bill the NPP's services at 100 percent of the physician's Medicare Physician Fee Schedule (MPFS) rate, instead of only 85 percent if billed using the NPP's NPI. Keep in mind, however, that your NPP must meet Medicare rules regarding incident-to services, and must also comply with applicable state law and scope-of-practice requirements. Therefore, your NPP must follow a physician-established plan of care, and your physician must be somewhere in the office and immediately available during the service provided.

Transitional Care Management (TCM)

TCM services take place during a patient's transition from a hospital to a community setting. TCM services are meant to address any issues requiring moderate or high complexity medical decision making during the transition to reduce the likelihood or re-hospitalization and improve the patient's chances of a better healthcare outcome.

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Welcome to Medicare Visit (WMV)

The Welcome to Medicare introductory visit is designed for patients who have had Part B for less than 12 month. This visit includes a review of patient's medical and social history related to health along with education and counseling about preventive services, including certain screenings, shots, and referrals for other care, if needed. This visit only occurs once and is different from the Annual Wellness Visits (AWVs) that will follow it in subsequent years. You CANNOT bill for ACP as part of the WMV, since end-of-life planning is considered an inherent part of the visit.

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