Coding Discussions about the Elephant in the Room

By Sharon Davies, RHIA, CCS-P

One thing is for certain, everyone's life will end someday. But who wants to broach this uncomfortable subject in a healthcare setting? The patient? The patient's family? The primary care provider? The hospitalists?

Medicare has recognized the value of this service, aptly called Advanced Care Planning (ACP), and began reimbursing for this difficult yet challenging provision in 2016. These counseling sessions open up conversations about treatment preferences and medical directives. ACP services can include early conversations before an illness progresses or at a later juncture in the patient's medical care to uphold their wishes. Discussion may include topics such as hospice care, designation of a healthcare proxy, durable power of attorney, living wills, Physician Orders for Life-Sustaining Treatment (POLST), and advanced directives.

A provider or non-physician practitioner (NPP) should make time for these lengthy discussions regarding a patient's preferences in late-stage life planning, and ensure reimbursement, by following the below guidelines:

1. **Follow the Definitions in the *2017 AMA CPT® Professional Edition*:** These include:

   CPT Code 99497—Advance care planning 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 care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

   CPT Code 99498—Each additional 30 minutes (List separately in addition to code for primary procedure)[1]

2. **Document the Time:** The time allocated specifically for this service must be documented in the patient's chart. Don't include the time that is noted on a charge capture screen or elsewhere; it must be in the patient's medical record on the date the service is provided.

   No time documented means no reimbursable service. The Current Procedural Terminology (CPT) time rule convention states: "A unit of time is attained when the midpoint is passed." Simple math dictates that 16 minutes would satisfy the CPT code 99497, which necessitates 30 minutes. Don't forget that this topic is often the "elephant in the room"—death may be a difficult subject to discuss and the provider needs to build a trusting and respectful relationship with the patient during this talk.

3. **Understand Face-to-Face Expectations:** Surprisingly, CPT states this does not have to be a face-to-face encounter with the patient. Time counts that is spent with the patient, family member, and/or surrogate. Additional time may be needed for further discussion due to disagreements caused by family dynamics. Always consult your own Medicare Administrative Contractors (MACs) for any specific documentation requirements they may have.

4. **Multiple Occurrences are Acceptable:** This service can be provided multiple times. For example, the spouse and patient discuss their preferences one day with their provider and then the next day, when the daughter flies in from Buffalo, NY they have another discussion with the provider regarding advance care planning for the parent. In the office setting it can be discussed at multiple visits. People can change their minds as their conditions and circumstances may change. To date, the Centers for Medicare and Medicaid Services has not established any frequency limits but has stated on their FAQ website that it would be "expected to see a documented change in the beneficiary's health status and/or wishes regarding his or her end of life care."[2] CPT likewise has not given any limits on the frequency for billing ACP services.

Providers should document the medical necessity for the ACP services by including the illness, high-risk procedure, or condition that has changed and prompted the need for advance care planning. This service is voluntary and beneficiaries need to accept ACP services as it will generate Part B cost sharing (co-payment and deductible) unless it is included as an optional element of the Annual Wellness Visit (AWV). Discussion regarding advance care planning made at the AWV does not generate additional costs to the patient if submitted with modifier 33 (preventive services) appended to the ACP code 99497-33.

When to Have the Conversation

Initiate the first conversation at a time when the patient may have no serious illnesses but faces challenges with chronic conditions such as COPD with a history of smoking. The AWV or a routine preventive exam presents an opportunity to start the conversation and to establish goals and decisions. It is also prudent to initiate an advance directive if one hasn't been made. A hospitalization with a serious illness may provide the opportunity for the provider to promote the conversation during the inpatient stay or for the primary care physician to discuss at a post-hospital discharge visit.

Advance care planning for patients with a health crisis can help ease family stress and confusion. When a patient's wishes are properly documented, they are more likely to be provided the treatments they have chosen as well as not provided the treatments they wanted to omit. It can be difficult for healthcare professionals to find the time to make ACP part of conversations with their patients, but it's critical to make certain their patients' healthcare wishes and expectations are upheld. Following the guidelines discussed above will ensure the provider(s) are reimbursed for the time spent having these important conversations.

Notes

[1] American Medical Association. *2017 AMA CPT® Professional Edition*. Chicago, IL: AMA, 2017.

[2] Centers for Medicare and Medicaid Services. "Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services." July 14, 2016.

Reference

Centers for Medicare and Medicaid Services. "Advance Care Planning." Medicare Learning Network. August 2016.

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