



## Summary of 2016 CMS Final Rule for Advance Care Planning

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On October 30, 2015, the Centers for Medicare & Medicaid Services (“CMS”) issued the 2016 final Medicare payment rules for physicians, hospitals and other providers. The rules include a provision that empowers patients, families and providers in the area of advance care planning. Specifically, the final rule solidified Current Procedural Terminology (“CPT”) codes 99497 and 99498, expanding the previously narrow window for reimbursement from only the initial enrollment of a Medicare beneficiary. Code 99497 covers the first 30 minutes of time with the patient, and code 99498 is used as an “add-on” code when a particular advance care planning session lasts beyond 30 minutes.

The CPT Editorial Panel, in creating the two new codes, described advance care planning (“ACP”) services as:

- 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 care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.
- 99498: 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 care professional; each additional 30 minutes (List separately in addition to code for primary procedure).

ACP, for the Medicare beneficiaries who choose to pursue it, will involve early conversations between patients and their practitioners, both before an illness progresses and during the course of treatment, to decide on the type of care that is appropriate for them.

Key impressions from the final rule:

- CMS will adopt the American Medical Association’s Relative Value Scale Update Committee’s recommended values for the services, with a work RVU, time and practice expense component. The actual values have yet to be identified, but are forecasted to be approximately \$90 for CPT code 99497 (the first 30 minutes) and \$75 for CPT “add-on” code 99498 (each subsequent 30 minute period).
- At least at the outset, CMS will not issue a National Coverage Determination in order to allow for implementation, experience and trend-watching before controlling rules are put into place. This means, initially, there will not be express limitations on the number of times the codes can be used to allow for continued talks over time with a patient. CMS says it plans to monitor utilization for trends before it considers caps.
- Practitioners are reminded that, unless the ACP services are provided as part of an annual wellness visit, the beneficiary will have typical Part B cost-sharing obligations and should be notified of that fact.
- The codes can be billed on the same day as other physician services and during other cap/bundle type payment episodes (e.g., TCM and CCM).

- The services can be provided through a team approach by both physicians and non-physician practitioners and other staff. If the physician is billing and non-physicians are providing the service, traditional “incident to” rules apply such that the billing physician must manage, participate and meaningfully contribute and provide direct supervision over the non-physician practitioners on the team.
- The CPT codes are payable in both facility and non-facility settings; although, rates will differ slightly if in a facility setting because of the practice expense component. CMS is working to allow for payment to facilities (e.g., payment to hospitals through the outpatient prospective payment system).

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