DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM10000 **Related Change Request (CR) #: CR 10000**

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Related CR Transmittal #: R3739CP **Implementation Date: June 19, 2017**

Billing for Advance Care Planning (ACP) Claims

Provider Types Affected

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs) for Advance Care Planning (ACP) services provided as an optional element of the Annual Wellness Visit (AWV) to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 10000 provides billing instructions for ACP when furnished as an optional element of an AWV. Make sure that your billing staffs are aware of the billing instructions.

Background

The Centers for Medicare & Medicaid Services (CMS) has made the 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 a physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) for ACP separately payable for Medicare OPPS claims when the service meets the criteria for separate payment under OPPS. The change in policy will be implemented through the annual Medicare Physician Fee Schedule Database (MPFSDB) update.

ACP with Other Services

Effective January 1, 2016, payment for the service described by **CPT code 99497** is conditionally packaged under the OPPS and is consequently assigned to a conditionally packaged payment status indicator of ‘‘Q1.’’ When this service is furnished with another service paid under the OPPS, payment is packaged.

ACP Service Only

When ACP is the only service furnished, payment is made separately.

ACP Service with Add-on Code

CPT code 99498 (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; each additional 30 minutes (List separately in addition to code for primary procedure)) **is an add-on code** and therefore, payment for the service described by this code is unconditionally packaged (assigned status indicator ‘‘N’’) in the OPPS in accordance with 42 CFR 419.2(b)(18).

ACP Service with AWV

CMS is also including voluntary ACP as an optional element of the AWV. ACP services furnished on the same day and by the same provider as an AWV are considered a preventive service. Therefore, the deductible and coinsurance are not applied to the codes used to report ACP services when performed as part of an AWV. Additionally, when ACP services are furnished on the same day and by the same provider as an AWV, they are reimbursed under the MPFSDB rates.

Voluntary ACP means the face-to-face service between a physician (or other qualified health care professional) and the patient 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.

Voluntary ACP, upon agreement with the patient, is an optional element of the AWV. When ACP services are provided as a part of an AWV, practitioners should report CPT code 99497 (plus add-on code 99498 for each additional 30 minutes, if applicable) for the ACP services in addition to either of the AWV codes G0438 and code G0439. When voluntary ACP services are furnished as a part of an AWV, the coinsurance and deductible do not apply for ACP. The deductible and coinsurance does apply when ACP is not furnished as part of a covered AWV.

Note: The deductible and coinsurance for ACP will only be waived when billed on the same day and on the same claim as an AWV (code G0438 or G0439) and must also be furnished by the same provider. Waiver of the deductible and coinsurance for ACP is limited to once per year. Payment for an AWV is limited to once per year. If the AWV billed with ACP is denied for exceeding the once per year limit, the deductible and coinsurance will be applied to the ACP.

Summary of Changes

Beginning in CY 2016, CPT code 99497 used to describe ACP is conditionally packaged under the OPPS when it is not part of the AWV, and is consequently assigned to a conditionally packaged payment status indicator of ‘‘Q1.’’

When this service is furnished with another service paid under the OPPS, payment is packaged.

When it is the only service furnished, payment is made separately. CPT code 99498 is unconditionally packaged (assigned status indicator ‘‘N’’) when it is not part of the AWV.

Beginning in CY 2016, CPT codes 99497 and 99498 used to describe ACP will be separately payable under the MPFS for OPPS claims when billed as part of the AWV on the same date of service by the same provider.

Additional Information

The official instruction issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3739CP.pdf**.

You may also want to review MLN Matters Article **MM9271** (Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV)).

If you have any questions, please contact your MAC at their toll-free number. That number is available at **https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/**.

Document History

Date	Description
March 20, 2017	Initial article release