Institute for Healthcare Improvement

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End-of-Life Care Conversations: Medicare Reimbursement FAQs

The changes in Medicare reimbursement policy that went into effect January 2016 provide an opportunity for more clinicians and patients to engage in conversations about preferences for care at the end of life. However, many people are confused about where to start. Whether you are uncertain about the new rules for CMS reimbursements or about starting those conversations with patients, this document will help you understand this new landscape for end-of-life care conversations.

Before getting started, check to see if a local coverage determination has been made, and check with your local billing expert to ensure your practice is compliant with their recommendations. Make sure that the new reimbursement codes have been added to your system's billing apparatus. These codes may not be available until your facility approves them for use.

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

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

2. 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)

3. 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.

4. 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.

5. 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)

6. 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.

7. How much do payers reimburse for these codes?

99497 = 1.5 RVUs
99498 = 1.4 RVUs

8. 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.

9. 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.

"Incident to" rules apply in the outpatient setting. This means that a provider can use these codes if they perform an initial service and a non-billing team member (e.g., registered nurse, social worker) helps deliver part of the service, with ongoing direct supervision and involvement of the billing provider. Example: The physician starts an ACP conversation, then says, "I'd like to introduce you to our nurse who will talk with you about choosing a surrogate medical decision maker and discuss with you how you might have a conversation with that person," then debriefs afterwards with the patient. Work with your local billing expert regarding "incident to" rules.

10. 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.

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Having the Conversation at Three Life Stages: A Guide for Providers

	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 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 • Learn about the patient as a person • Establish a surrogate decision maker • Promote patient-surrogate-family conversations	• Continue to build trusting, respectful relationships • Continue to learn more 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	• Rely on the trusting, respectful relationships 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
Examples of What to Say	• 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 they already have an advance directive (AD): *"May I see it? What does it say?"* • If they do 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."*

Billing Details	New Codes from CMS • Use 99497 if you meet or exceed 16 minutes	• Use 99497 + 99498 if you meet or exceed 46 minutes
	Documentation Requirements • Total time in minutes • Patient/surrogate/family "given opportunity to decline" • Details of content • Attending MDs and DOs, as well as NPs and PAs (i.e., those who are authorized to independently bill Medicare for CPT services), are the only providers who can use these codes.	• If medical management billing is based on medical decision making, then you can bill as you normally would in that scenario. On top of that, you should also bill based on time spent for ACP. • If instead you are billing for the medical management based on time, you should be sure you do not double count the time spent on the advance care planning conversation.

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