

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3739	Date: March 17, 2017
	Change Request 10000

SUBJECT: Billing for Advance Care Planning (ACP) Claims

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide billing instructions for Advance Care Planning when furnished as an optional element of an Annual Wellness Visit.

EFFECTIVE DATE: January 1, 2016

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: June 19, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	4/200.11/Billing Advance Care Planning

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

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SUBJECT: Billing for Advance Care Planning (ACP) Claims

EFFECTIVE DATE: January 1, 2016

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I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) has made the CPT code 99497 for Advance Care Planning (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.

Effective January 1, 2016 payment for the service described by 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) 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; when it is the only service furnished, payment is made separately. 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).

In addition, CMS is also including voluntary Advance Care Planning as an optional element of the Annual Wellness Visit (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 Medicare Physician Fee Schedule Database (MPFSDB) rates.

Voluntary advance care planning 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 would 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 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.

B. Policy: Beginning in calendar year (CY) 2016, CPT codes 99497 and 99498 used to describe Advance Care Planning will be separately payable under the Medicare Physician Fee Schedule for OPPS claims when billed as part of the AWW on the same date of service by the same provider.

Beginning in calendar year (CY) 2016, CPT code 99497 used to describe Advance Care Planning is conditionally packaged under the OPPS when it is not part of the AWW 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 AWW.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
10000.1	A/B MACs (Part A) should be aware of the policy regarding Advance Care Planning (ACP) claims.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
10000.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, fred.rooke@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital

(Including Inpatient Hospital Part B and OPPS)

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(Rev.3739, Issued: 03-17-17, Effective: 01-01-16, Implementation: 06-19-17)

200.11 – Billing Advance Care Planning (ACP)

200.11 – Billing Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV)

(Rev. 3739, Issued: 03-17-17, Effective: 01-01-16, Implementation: 06-19-17)

Effective January 1, 2016 payment for the service described by 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) is conditionally packaged under the OPSS and is consequently assigned to a conditionally packaged payment status indicator of ‘Q1.’ When this service is furnished with another service paid under the OPSS, payment is packaged; when it is the only service furnished, payment is made separately. 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 OPSS in accordance with 42 CFR 419.2(b)(18).

In addition, for services furnished on or after January 1, 2016, Advance Care Planning (ACP) is treated as a preventive service when furnished with an AWV. The Medicare coinsurance and Part B deductible are waived for ACP when furnished as an optional element of an AWV.

The codes for the optional ACP services furnished as part of an AWV are 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 professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate;) and an add-on code 99498 (each additional 30 minutes (List separately in addition to code for primary procedure)). When ACP services are provided as a part of an AWV, practitioners would report CPT code 99497 (and add-on CPT code 99498 when applicable) for the ACP services in addition to either of the AWV codes (G0438 or G0439).

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.

Also see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 280.5.1 for more information