CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 216	**Date: December 22, 2015**
	Change Request 9271

NOTE: This Transmittal is no longer sensitive and is being re-communicated on December 22, 2015. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

Transmittal 210, dated August 7, 2015, is being rescinded and replaced by Transmittal 216, dated December 22, 2015, to revise the language in the Background and Policy sections to reflect the finalization of the policy changes published in the CY 2016 Physician Fee Schedule final rule. All other information remains the same.

SUBJECT: Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to waive the deductible and coinsurance 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: January 4, 2016

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
R	15/Table of Contents
N	15/280/280.5.1 Advance Care Planning (ACP) Furnished as an Optional Element with an Annual Wellness Visit (AWV) Upon Agreement with the Patient

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

Pub. 100-02	Transmittal: 216	Date: December 22, 2015	Change Request: 9271

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SUBJECT: Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV)

EFFECTIVE DATE: January 1, 2016
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IMPLEMENTATION DATE: January 4, 2016

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) has made the CPT codes for Advance Care Planning (ACP) separately payable for Medicare. The change in policy will be implemented through the annual Medicare Physician Fee Schedule Database (MPFSDB) update.

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.

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.

In addition, for dates of service on or after January 1, 2016, the coinsurance and deductible do not apply for voluntary ACP performed on the same day and by the same provider as a covered AWV. Under that circumstance, both the ACP and AWV must also be billed together on the same claim. In order to have the deductible and coinsurance waived for ACP when performed with an AWV, the ACP code(s) must be billed with modifier 33 (Preventive services). Since payment for an AWV is limited to only once a year, the deductible and coinsurance for ACP billed with an AWV can only be waived once a year.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9271 - 02.1	For claims with dates of service on or after January 1, 2016, contractors shall waive the deductible and coinsurance for Advance Care Planning (code 99497 and add-on code 99498) if billed with modifier 33 on the same claim and with the same date of service as a covered AWV code (G0438 or G0439) when performed by the same provider.		X				X			NCCI/MUE
9271 - 02.1.1	CWF will allow ACP (99497 and add-on code 99498) to be received with the deductible and coinsurance waived. (**NOTE:** ACP must have modifier 33.)								X	
9271 - 02.2	For claims with dates of service on or after January 1, 2016, contractors shall waive the deductible and coinsurance for Advance Care Planning (code 99497 and add-on code 99498) if billed with modifier 33 on the same claim and with the same date of service as a covered AWV code (G0438 or G0439) when performed by the same provider. **NOTE:** This is for only: Type of Bill (TOB) 85x: Revenue codes 96X, 97X, and 98X CAH Method II Payment is based on the lesser of the actual charge or the facility-specific MPFS.					X				
9271 - 02.2.1	Contractors shall allow HCPCS codes 99497 and 99498 to be billed with Revenue codes 96x, 97x and 98x on type of bill 85X only.	X								
9271 - 02.3	If the ACP with modifier 33 is billed with an AWV and that AWV is denied, contractors shall allow the ACP but apply the deductible and coinsurance. (There must be a covered AWV in order to waive the deductible and coinsurance for the ACP.)	X	X			X	X			
9271 - 02.4	Since payment for an AWV is limited to only	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	once a year, the deductible and coinsurance for ACP billed with an AWV can only be waived once a year. Contractors shall waive the deductible and coinsurance for ACP billed with modifier 33 and a covered AWV only once a year.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9271 - 02.5	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	X			

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Tom Dorsey, 410-786-7434 or thomas.dorsey@cms.hhs.gov (Part B Claims Processing Contact) , Ryan Howe, 410-786-3355 or ryan.howe@cms.hhs.gov (Payment Policy contact) , Kathleen Kersell, 410-786-2033 or kathleen.kersell@cms.hhs.gov (Payment Policy contact) , Cindy Pitts, 410-786-2222 or cindy.pitts@cms.hhs.gov (Part A Claims Processing Contact)

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 Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

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(Rev. 216 Issued: 12-22-15)

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280.5.1 – Advance Care Planning (ACP) Furnished as an Optional Element with an Annual Wellness Visit (AWV) Upon Agreement with the Patient

(Rev. 216 Issued: 12-22-15, Effective: 01-01-16, Implementation: 01-04-16)

Beginning in CY 2016, CMS will treat an AWV and voluntary ACP that are furnished on the same day and by the same provider as a preventive service. Voluntary ACP services, upon agreement with the patient, will be an optional element of the AWV. (See section 1861(hhh)(2)(G) of the Act.) When ACP services are furnished as a part of an AWV, according to sections 1833(a)(1) and 1833(b)(10) of the Act, the coinsurance and deductible are waived.

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.

See Pub. 100-04, Medicare Claims Processing Manual, chapter 18, section 140.8 for claims processing and billing instructions.