



CMS Posts CY2016 Physician Fee Schedule Final Rule

November 2, 2015

Summary at a Glance:

On Friday, October 30, CMS posted the [CY2016 Physician Fee Schedule Final Rule](#) (PDF).

Under the final rule, CMS establishes Medicare coverage for two Current Procedural Terminology (CPT) codes for advance care planning, effective for use for services provided on or after January 1, 2016. These codes are billable under Medicare Part B. They can be used by any physician or non-physician practitioner who is entitled to bill Part B independently, provided the services are within their scope of practice where they are licensed. Like other Part B services, beneficiary cost sharing requirements will apply to ACP services, unless they are provided in conjunction with the Annual Wellness Visit. Most hospice physicians who do not bill Part B for physician services will not use these codes and hospices will not be using these codes for Part A hospice physician services, but physicians providing palliative care consulting services and billing under Part B may bill these codes.

NHPCO applauds CMS for their recognition of the importance of advance care planning and for implementing these new codes for 2016.

1. Description of CPT codes

- **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
- **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)

2. Process for finalizing the Advance Care Planning (ACP) codes

CMS reports that they received approximately 725 public comments on the proposed rule regarding payment for advance care planning (ACP) services, including a [comment letter from NHPCO](#) (PDF). CMS states that “the majority of commenters expressed support for the proposal, providing recommendations on valuation, the types of professionals who should be able to furnish or bill for the services and the appropriate setting of care, intersection with existing codes, the establishment of standards or specialized training, and beneficiary cost sharing and education.”

3. Payment for ACP services

CPT code 99497: 1st 30 minutes	
Non-facility payment	\$85.99
Facility payment	\$79.54

CPT code 99498: each additional 30 minutes	
Non-facility payment	\$74.88
Facility payment	\$74.52

Note that these are national rates prior to the application of geographic adjustment, so local rates will differ. These rates also do not take into the consideration the two percent reduction to Medicare’s share of the payment due to sequestration.

4. National Coverage Determination

Many commenters expressed concern about the lack of a National Coverage Determination (NCD) for these new ACP codes, and that the Medicare A/B MACs could implement additional requirements or restrictions on ACP services. CMS stated that they “believe it may be advantageous to allow time for implementation and experience with ACP services, including identification of any variation in utilization, prior to considering a controlling national coverage policy through the National Coverage Determination process.” By including ACP services as an optional element of the Annual Wellness Visit (AWV) (for both the first visit and subsequent visits), this rule creates an annual opportunity for beneficiaries to access ACP services should they elect to do so.

5. Use of ACP codes and E/M services

CMS reports that “CPT codes 99497 and 99498 may be billed on the same day or a different day as other Evaluation and Management (E/M) services, and during the same service period as Transitional Care Management (TCM) or Chronic Care Management (CCM) services and within global surgical periods.” CMS also adopted guidance “prohibiting the reporting of CPT codes 99497 and 99498 on the same date of service as certain critical care services including neonatal and pediatric critical care.”

6. Who can provide ACP services?

CMS received many comments on the need for a team-based approach, made up of physician and non-physician practitioners, for ACP discussions. In the final rule, CMS states that “the CPT code descriptors describe the services as furnished by physicians or other qualified health professionals, which for Medicare purposes is consistent with allowing these codes to be billed by the physicians and NPPs whose scope of practice and Medicare benefit category include the services described by the CPT codes and who are authorized to independently bill Medicare for those services.”

Other qualified health professionals include:

- Nurse practitioner
- Physician assistant
- Clinical nurse specialist
- Nurse midwife

CMS also commented that the “physicians’ service, “incident to” rules apply when these services are furnished incident to the services of the billing practitioner, including a minimum of direct supervision.” The “incident to” rules will be explored in future regulatory alerts, but CMS reports that they “expect the billing physician or NPP to manage, participate and meaningfully contribute to the provision of the services, in addition to providing a minimum of direct supervision.”

For Medicare, “Direct Supervision” requires that the physician be present in the office suite and immediately available to furnish assistance and direction, but not physically present in the room when a service is provided. It should be noted that all applicable state law and scope of practice requirements must be met in order to bill ACP services.

7. Where can advance care planning services be done?

CMS noted that they agree with commenters that ACP services are appropriately furnished in a variety of settings, depending on the condition of the patient. These codes will be separately payable to the billing physician or practitioner in both facility and non-facility settings and are not limited to particular physician specialties. When ACP services are provided to patients in hospital outpatient department settings, the service is only separately payable if it is the only service provided to the patient that day.

8. Annual Wellness Visit

In the final rule, CMS is allowing ACP as a voluntary, separately payable element of the Medicare patient's Annual Wellness Visit (AWV), at the beneficiary's discretion. When ACP is furnished as an optional element of the AWV as a part of the same visit with the same date of service, the CPT codes 99497 and 99498 "should be reported and will be payable in full in addition to the payment that is made for the AWV." ACP services provided in conjunction with the AWV should be reported with modifier -33. There will be no Part B coinsurance or deductible since it is connected to the AWV, which requires no cost sharing.

CMS states that the "current regulations for the AWV allow the AWV to be furnished under a team approach by physicians or other health professionals under the physician's direct supervision."

9. Can ACP be delivered in the RHC or FQHC setting?

CMS reports that "beginning on January 1, 2016, ACP will be a stand-alone billable visit in a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC), when furnished by a RHC or FQHC practitioner and all other program requirements are met. If furnished on the same day as another billable visit, only one visit will be paid. Coinsurance will be applied for ACP when furnished in a FQHC and coinsurance and deductibles will be applied for ACP when furnished in an RHC. Coinsurance and deductibles will be waived when ACP is furnished as part of an AWV."

CMS expects to provide additional information on RHC and FQHC billing of ACP services at a later date.

10. Should extra training be required?

CMS received many comments on whether additional training should be required before a physician or other health professional can provide ACP services. They responded that they did not think it was appropriate at this time to require additional training as part of the additional payment standards. They also noted that ACP services are to be delivered in person and are not added to the list of Medicare telehealth services.

11. ACP voluntary/beneficiary choice

ACP services are, by definition, voluntary, and Medicare beneficiaries should be given a clear opportunity to decline to receive them. In addition, CMS notes that beneficiaries may receive assistance in completing the legal documents for ACP from others outside the scope of the Medicare program, either in addition to, or separately from the beneficiary's physician or other health professional.

12. Beneficiary cost sharing

Except in the case of the ACP being provided as a part of the AWV, beneficiaries will be required to pay the Part B cost sharing – either deductible or coinsurance. CMS recommends that practitioners

inform beneficiaries that the ACP services will be subject to cost sharing as a part of the ACP process.

13. Summary

CPT codes 99497 and 99498 PFS are officially moved to “active” status on January 1, 2016. In addition, ACP discussions are added, as an optional element, at the beneficiary’s discretion, during the Annual Wellness Visit (AWV).

Regulatory Language for the Annual Wellness Visit

Annual Wellness Visit

§410.15 Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage.

(a) * * * First annual wellness visit providing personalized prevention plan services * * *

(x) At the discretion of the beneficiary, furnish advance care planning services to include discussion about future care decisions that may need to be made, how the beneficiary can let others know about care preferences, and explanation of advance directives which may involve the completion of standard forms.

(xi) Any other element determined appropriate through the national coverage determination process.

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NHPCO members with questions should email regulatory@nhpco.org.

NHPCO • 1731 King Street • Alexandria, VA 22314
703/837-1500 • 703/837-1233 (fax) • www.nhpco.org