Welcome!

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• Q&A session at the end
  ▪ Use the Q&A button in the bar at the bottom of your Zoom window
  ▪ Type in your question
  ▪ We will address questions in the order they are received
Speakers

Allison Hirschorn
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ASCO Care Delivery Department
Advance Care Planning Services in an Oncology Setting

Allison Hirschorn
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Care Delivery Department

March 17th, 2022
Topics Covered

- Hematology/Oncology utilization of Advance Care Planning services.
- Practice Administration and Workflow.
- Advance Care Planning Coding and Reporting.
- Best practices for the administration of Advance Care Planning Services.
Hematology/Oncology Utilization of Advance Care Planning Services
Advance Care Planning Services

Background

Advance Care Planning 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 - Each additional 30 minutes

Refer to the latest version AMA CPT® Professional Edition for the full guidelines.

Published in the 2015 AMA CPT® Professional Edition.

Reimbursed under the Medicare Physician Fee Schedule in 2016.
ASCO’s Coverage and Reimbursement Steering Group: Are Advance Care Planning Services codes are regularly utilized by hematology/oncology physicians?
Advance Care Planning Utilization Study Analysis and Methods

Utilization was analyzed using Physician/Supplier Procedure Summary (2016-2019) and Medicare Provider Utilization and Payment Data: Physician and other Supplier PUF CY2018 (PUF) files.

Total ACP services submitted to Medicare and the total services denied were calculated for each year using the combination of: Hematology, Hematology/Oncology, and Medical Oncology (collectively Hematology/Oncology) specialties in addition to ALL specialties.

Pulled physician-level data for 6,335 hematology/oncology physicians who had billed Medicare for at least 500 office or hospital outpatient evaluation and management services in 2018.

Totals for codes 99497 and 99498 were calculated per physician, providing a distribution of volume.
### Results

<table>
<thead>
<tr>
<th>Year</th>
<th>Specialty</th>
<th>Submitted Services</th>
<th>Denied Services</th>
<th>Denied Pct. of Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>All Providers</td>
<td>708,183</td>
<td>88,410</td>
<td>12.5%</td>
</tr>
<tr>
<td>2017</td>
<td>All Providers</td>
<td>1,224,261</td>
<td>131,947</td>
<td>10.7%</td>
</tr>
<tr>
<td>2018</td>
<td>All Providers</td>
<td>1,597,490</td>
<td>155,574</td>
<td>9.7%</td>
</tr>
<tr>
<td>2019</td>
<td>All Providers</td>
<td>2,043,797</td>
<td>172,619</td>
<td>8.4%</td>
</tr>
<tr>
<td>2016</td>
<td>Hematology/Oncology</td>
<td>8,312</td>
<td>1,232</td>
<td>14.8%</td>
</tr>
<tr>
<td>2017</td>
<td>Hematology/Oncology</td>
<td>18,120</td>
<td>1,595</td>
<td>8.8%</td>
</tr>
<tr>
<td>2018</td>
<td>Hematology/Oncology</td>
<td>12,489</td>
<td>846</td>
<td>6.8%</td>
</tr>
<tr>
<td>2019</td>
<td>Hematology/Oncology</td>
<td>11,242</td>
<td>372</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

- Specialty utilization of ACP services has increased each year, from 708,183 submitted services in 2016 to 2,043,797 in 2019.
- Hematology/Oncology utilization increased from 2016 to 2017 but declined in volume for 2018 and 2019.
- Among 6,335 hematology/oncology physicians submitting at least 500 office or hospital outpatient evaluation and management visits only 145 billed Medicare at least 11 ACP services in either a facility or non-facility setting.
Conclusions

Advance Care Planning Services codes are **not** frequently reported to Medicare as separate services by Hematology/Oncology.

- Coding and reporting education
- Guidance on administrative processes

- Increase utilization
- Ensure appropriate reporting
Credible practices in administering, recording, and being reimbursed for advance care planning.

Available for download on Coding and Reimbursement section of ASCO Practice Central (practice.asco.org).
Practice Administration and Workflow
Components of Advance Care Planning
Practice Administration and Workflow

- Educating patients
- Initiation of services
- Performing services
- Staffing models
- Discussion guides
- Documentation of services
Educating Patients and Families

Remove the stigma of Advance Care Planning.

Encourages patient and healthcare team collaboration.

Ensures the patients receive care according to their preferences.
Verbal education + Written information = Patient and family education
Patients may review and complete on their own and/or with their families.

Discussion template for ACP visits.
Advance Care Planning Discussion Guides

Respecting Choices ®: https://respectingchoices.org/

Five Wishes ®: https://fivewishes.org/

The Conversation Project ®: https://theconversationproject.org/

ACP Decisions: https://acpdecisions.org/

Discussion Guide Contents Examples

- Understanding of current health situation
- Concerns about treatments
- Healthcare proxy
- Spirituality and end of life planning
- Forms
Initiating Advance Care Planning Services

Determine the process for ordering and initiating the service.

Options range from the managing oncologist recommending advance care planning to identifying specific triggers.
Advance Care Planning
Triggers

“Advance care planning (ACP) should be initiated early and be readdressed often for patients with cancer.”

Implementation of Advance Care Planning in Oncology: A Review of the Literature
Christine M. Bestvina and Blase N. Polite
Journal of Oncology Practice 2017 13:10, 657-662
## Advance Care Planning Triggers

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patients without an advance directive.</td>
<td>Not limited to advanced cancer or palliative care.</td>
</tr>
<tr>
<td>Initiation or change in treatment.</td>
<td>Patient education session prior to chemo, surgery, radiation.</td>
</tr>
<tr>
<td>Progression of disease or change in performance status.</td>
<td>Change in status may warrant a review or update to plan.</td>
</tr>
<tr>
<td>Hospitalization.</td>
<td>May result in discussion about palliative or hospice care.</td>
</tr>
<tr>
<td>Acute exacerbation of disease.</td>
<td>Medical orders for very sick and frail.</td>
</tr>
<tr>
<td>Initiation of palliative care.</td>
<td>Development or revision of plan.</td>
</tr>
</tbody>
</table>
Performing Advance Care Planning Services

Visits may include:

- Education about the patient’s disease, prognosis, and care plan.
- Review of patient’s support system, including family, friends, and organizations.
- Discussion of the patient’s goals of care, end-of-life wishes, and events that may trigger a review of advance directives and communicated goals.
- Completion of advance directives. Some states may require use of a notary public to witness signature of advance directive forms.
Advance Care Planning
Patient Discussions

Stanford University: Serious Illness Care Program
Serious Illness Conversation Guide

Setup ➔ Assess ➔ Prognosis ➔ Explore ➔ Close

Stanford University: Serious Illness Care Program

Resources
Serious Illness Conversation Guide

Discussion Prompts

I’d like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want. Is that okay?

What is your understanding now of where you are with your illness?

How much information about what is likely ahead with your illness would you like from me?

I want to share with you my understanding of where things are with your illness.

Uncertain: It can be difficult to predict what will happen with your illness. I hope you will continue to live well for a long time, but I’m worried that you could get sick quickly, and I think it is important to prepare for that possibility.

Time: I wish we were not in this situation, but I’m worried that time may be as short as ___ (express as a range, e.g., days to weeks, weeks to months, months to a year).

Function: I hope that this is not the case, but I’m worried that this may be as strong as you will feel, and things are likely to get more difficult.

What are your most important goals if your health situation worsens?

What are your biggest fears and worries about the future with your health?

What gives you strength as you think about the future with your illness?

What abilities are so critical to your life that you can’t imagine living without them?

If you become sicker, how much are you willing to go through for the possibility of gaining more time?

How much do your loved ones know about your priorities and wishes?

I’ve heard you say ____. Keeping that in mind, and what we know about your illness, I recommend that we ____. This will help us make sure that your treatment plans reflect what’s important to you.

How does this plan seem to you? We will do everything we can to help you through this.

Handoff: To colleague: “I talked with the patient about ____. I learned ____, I think they would benefit from talking with you about ____.”
Physicians

Team-based approach provided by physicians, non-physician practitioners, and other staff under the order and medical management of the patient’s treating physician.
Practice Staffing Model Options

Oncologist

Palliative care physician

Advance practice provider

Clinical social workers

Patient navigators
Advance Care Planning
Staff Training and Education

Prepared to answer questions about advance care planning.

Help patients formulate views and articulate their preferences for care.

Referrals to additional resources for further information and guidance if appropriate/needed.

Explain how as to how advance directives are used as collaborative tools to help guide treatment decisions when they have decision-making capacity.

American Medical Association
Advance Care Planning: Code of Medical Ethics Opinion 5.1
Keys to Staff Success

Training for clinical staff and physicians.

Development of standard processes and protocols.

Effective communication among the care team.
Advance Care Planning Services Documentation

- Accurate record of visit and what was discussed.
- Supports effective communication among the care team.
- Validates the reporting of the Advance Care Planning CPT® code(s).
Documentation of Advance Care Planning Services

Who was included (patient, family, health care team, and others).

What was discussed.

Time spent face-to-face with the patient (separate from other services).

Presence of an advance directive, health care proxy, or medical orders.

Code status, types of medical care preferred, preferred comfort level, and other wishes of the patient.

Need for further sessions (either immediately or in the future).

Referrals to other services based on patient needs (social work, palliative care, hospice care, etc.).
Care Delivery, Quality, and Payment Models

**ASCO/COA Oncology Medical Home Standards**
Advance care planning discussion and complete a goals of care discussion

**Oncology Care Model**
Documentation of care plan.

**Patient Centered Oncology Payment Model**
Requires a dedicated advance care planning session by a trained professional.

**Medicare’s Quality Payment Program**
Implementation is considered a reportable improvement activity.
Advance Care Planning Coding and Reporting
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99497</td>
<td>Advance care planning; first 30 minutes (primary code)</td>
</tr>
<tr>
<td>99498</td>
<td>Advance care planning; each additional 30 minutes (add on code)</td>
</tr>
</tbody>
</table>

ACP codes may be reported for services of 16 minutes above (midpoint).

CMS limits the number of times 99498 may be reported per date of service to 3 (90 minutes).
Advance care planning services may be reported in addition to:

Office and outpatient E/M services (99202-99215)

Inpatient and observation E/M Services (99221-99223; 99231-99239, 99217-99220, 99224-99226)

Chronic care management and complex chronic care management services (99490, 99439, 99491, 99437)

Principal care management services (99424-99427)

Transitional care management services (99495 and 99496)
Who can report Advance Care Planning Services?

- Clinical Nurse Specialists
- Physician Assistants
- Nurse Practitioners
- Physician

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Coding Scenario 1

A physician or qualified healthcare provider has a **16-minute**, face-to-face discussion with a patient to determine if they have advance directives on file such as a living will or assigned health care power of attorney.

Report CPT® code 99497 when at least **16 minutes have passed**, which exceeds the **15-minute midpoint** required to bill the code.
Coding Scenario 2

An advance practice provider spends 60 minutes with the patient and their family to discuss hospice care. The advance directive paperwork on file is reviewed with the patient and family members to ensure it is correct and up to date.

First 30 minutes: CPT ® code 99497
Additional 30 minutes: CPT ® code 99498
Total time: 60 minutes
Coding Scenario 3

A provider has a low complexity E/M visit with an established patient to address pain (CPT® code 99203). Then, a 30-minute advance care planning service is conducted with the patient’s family to discuss goals of care, future treatment options, and code status. The advance care planning discussion is documented along with total time spent on the service.

CPT code 99497 is reported for the 30-minute advance care planning service in addition to CPT code 99203. Do not count any time spent for ACP towards the total time of the office E/M service.

- Established patient E/M service: CPT code 99203
- Advance Care Planning, 30 minutes: 99497
Reporting Advance Care Planning to Medicare

Reported as part of a Medicare Wellness Visit (MWV)*
Deductible and coinsurance are waived

Report independently from a Medicare Wellness Visit (MWV)
Deductible and coinsurance apply

*HCPCS codes G0438 or G0439 plus modifier -33
Best Practices for the Administration of Advance Care Planning Services
Best Practices for Advance Care Planning Services

**Practice Administration**
- Develop or adopt written discussion guides.
- Establish practice-wide standards.
- Train staff.

**Patient Procedures**
- Acquire patient consent.
- Education of patient/family/caregivers.

**Coding and Reporting**
- Document time and discussion.
- Utilize CPT codes 99497 and 99498.
Resources
Resources

American Society of Clinical Oncology
Advance Care Planning Practice Administration and Reimbursement Guide

Centers for Medicare and Medicaid Services
MLN Fact Sheet: Advance Care Planning

US Department of Health and Human Services
Advance Care Planning Among Medicare FFS Beneficiaries and Practitioners: Final Report
Questions?

Use the Q&A button in the bar at the bottom of your Zoom window.
Questions and Answers

Questions about Advance Care Planning services (or any other billing and coding question) can be sent to ASCO staff at practice@asco.org.
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  ▪ Gynecologic oncology
  ▪ Oncology Care Model
• Must have at least 1 ASCO member at your practice
• Contact us at practicenet@asco.org
Next Call

- Thursday, April 21
  - Topic TBA
- 3rd Thursday of each month, 4:00pm Eastern Time

https://practice.asco.org/calendar