

ACP

- Per Proposed Rule, local coverage decisions being made by Medicare Contractor. Not whether to cover, rather to assure that services provided are reasonable ... e.g., frequency and circumstances for which code is being billed.
 - If the code is to be used frequently/repeatedly a clear explanation should be included in the documentation of why it was necessary, e.g., time to digest options and discuss with family; change in status.
- Both ACP codes are time-based but only include face-to-face time. Total time for the base code (99497) is 45 minutes (5 pre; 30 intra; 10 post) which provides no time for non-face-to-face time which is often necessary, e.g. for ...
 - Conversations with patient’s family that are unable to attend face-to-face meeting with the patient when patient requests their input, or when patient has impaired decision-making capacity
 - Time for billing provider to clarify prognosis, treatment options, etc. by review of medical records and/or encounters (telephonic or email) with other professionals involved in the care of the patient to allow for honest prognostication.
 - I can even see genuine circumstances where it might ONLY be a non-face-to-face encounter (e.g., dementia patient and designated decision maker lives elsewhere) though I suspect it would require its own code because of the varied practice expense.

CPT Code	Description	Work RVUs	Non-Facility PE RVUs	Malpractice RVUs	Total Non-Facility RVUs	Global	Calculated National Payment
99497	Advanced Care Plan 30 min	1.50	0.80	0.10	2.40	XXX	\$86.66
99498	Advance care plan addl 30 min	1.40	0.58	0.10	2.08	YYY	\$75.11

- The language of the CPT code indicates service provided by “physician or other qualified health care professional (QHCP),” (i.e. those that can bill). What role should other professionals have in providing and or assist with providing this service?
 - I doubt there would be any inclination at this point to allow this to be billed by other than physician/QHCP alone, nor do I personally think there should be at this point, however, I can see a role for appropriately trained IDT members to assist incident to (with *general supervision*)
- How do we know that physicians and QHCPs understand the elements of what should be included when providing ACP?
 - We have to remember this is a first step, and if there are too many obstacles these codes won’t get used (i.e., services won’t be provided). There will be opportunities to refine the current CPT

codes, add other ACP CPT codes to the family and also to revalue them as there is experience using them but his effort at least gets the process going.

- That said ... in (at least partial response to) the National Right to Life Committee March 2015 report, “The bias against life-preserving treatment in ACP (attached)” and following introduction of the King bill to block any payment for ACP I think it could be helpful to suggest that at a minimum there should be guidance/emphasis that patient preferences should reflect the individual’s/surrogate decision maker’s preferences, NOT the physician’s and that preferences should be elicited only after the individual is sufficiently informed about their situation and options.
- There is always emphasis on use of ACP for patients that are “seriously ill” and the examples are typically cancer or other severe single-organ diseases (e.g., CHF, ESRD, COPD). The same is true in general Re hospice and palliative care services. Education of professionals is needed so that also included as appropriate for these discussions (i.e., frail older adults and dementia (earlier than hospice criteria) in the “seriously ill” group.
- In addition to medical aspects (e.g., current disease state/progression, available treatments, cardiopulmonary resuscitation/other life sustaining measures, life expectancy (considering patient age and co-morbidities) ... ACP discussions need also to include preferences Re more global preferences of what’s important to the individual, e.g., what matters most to them, location of death, goals before death.