CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1795	**Date: February 10, 2017**
	Change Request 9862

SUBJECT: Advance Care Planning (ACP) Implementation for Outpatient Prospective Payment System (OPPS) Claims

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement system changes necessary to process Advance Care Planning services for OPPS claims.

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 3, 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/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1795	Date: February 10, 2017	Change Request: 9862

SUBJECT: Advance Care Planning (ACP) Implementation for Outpatient Prospective Payment System (OPPS) Claims

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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 AWV.

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 AWV 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 AWV.

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	
9862.1	For OPPS claims with a bill type 13x with dates of service on or after January 1, 2016, contractors shall make payment for Advance Care Planning (code 99497 and add-on code 99498) (ACP) using the MPFS rate found on the HCPCS file when the Status Indicator "A" is returned on the line by the Integrated/Outpatient Code Editor. When any other Status indicator is returned (i.e., "N" or “V”), do not make payment using the MPFS rate from HCPCS file.					X				IOCE
9862.2	For OPPS claims with a bill type 13x with dates of service on or after January 1, 2016, contractors shall waive the deductible and coinsurance for ACP (code 99497 and add-on code 99498) if billed 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. The Status Indicator "A" is returned on the line by the I/OCE only in this scenario and payment is made for both 99497 and 99498 using the MPFS rate found on the HCPCS file. 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. Contractors shall waive the deductible and coinsurance for ACP billed with a covered AWV only once a year (see supporting information Section A).					X				IOCE
9862.3	For OPPS claims with a bill type 13x with dates of service on or after January 1, 2016, if the ACP 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.) 99497 will be paid with the APC with Status Indicator "V", if payable and is reported with no other OPPS payable services, and					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	99498 be packaged with Status Indicator "N". If 99497 is reported with other OPPS payable services, it is packaged with Status Indicator "N".									
9862.4	Contractors shall adjust ACP claims processed incorrectly from January 1, 2016 forward when ACP was an optional element of the Annual Wellness Visit (AWV). Contractors shall complete these adjustments within 180 days from the implementation into production.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9862.5	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				

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:
4	CR 9271, Transmittal 3428, PUB 100-04 Medicare Claims Processing Manual, issued December 22, 2015, and Transmittal 216, PUB 100-02 Medicare Benefit Policy Manual,

X-Ref Requirement Number	Recommendations or other supporting information:
	issued December 22, 2015 and reason codes U5273, U5274 & U5275

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

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, fred.rooke@cms.hhs.gov (for claims processing questions) , Marina Kushnirova, marina.kushnirova@cms.hhs.gov (for policy questions)

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