4 tips to boost advance care planning revenue at your practice

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Patient encounters

Take advantage of new resources to help your providers earn revenue for advance care planning (ACP) — the end-of-life counseling service for which Medicare started paying last year.

ACP services could be a missed opportunity for your practice. In the first half of 2016, just 13,803 providers billed the two ACP 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) and **99498** (… ; each additional 30 minutes [List separately in addition to code for primary procedure]). Medicare pays a national average of $78 for 99497 and $73 for 99498.

Those providers received nearly $16 million in payments after deductibles and coinsurance for the services provided to 222,977 Medicare beneficiaries, according to CMS' data. (*For more analysis, see benchmark, page 5.)*

Some providers use the codes regularly and successfully. As a house call physician service that sees many elderly homebound patients, Visiting Physician Services/VNA Health Group (VPS) of Eatontown, N.J., has many opportunities to initiate ACP discussions, says Sarah Leonard, M.D., one of its physicians. They'd been performing equivalent services all along, but since Medicare started accepting charges, "we have seen a slight uptick in the number of discussions our clinicians are having with their patients," she says.

Vendors have created resources to help you do ACP. For example, many schools, such as the California State University, have developed continuing medical education programs on ACP for practicing providers, says M. Jane Markley, founder of M. Jane Markley Consulting in Derwood, Md. She believes those schools were motivated by the Medicare decision. So have independent contractors: Five Wishes, a non-profit that does patient-centered end-of-life planning education, now also has an ACP framework to help health care systems and practices do the work and bill Medicare, Markley says (*PBN 4/25/16*).

4 tips for getting started with ACP

Don't limit yourself to the old and very sick. "I'm a firm believer that when a patient comes in for any appointment, along with smoking history and height and weight, doctors should ask: Do you have an advance directive?" says Markley. "'We don't ask because you're sick or old — we do this for everybody.' It should be a natural part of health care in America and it's not."

Revisit ACP when the patient has life changes. VPS doctors bring up the subject at initial visits, but also on other occasions when broaching the subject seems natural — for example, "when a patient returns home after a hospitalization and/or when there is a significant change in the status of an acute or chronic condition," says Leonard.

Let doctors follow their instincts. While it would be problematic to bill ACP for a conversation in which, say, end-of-life forms were not discussed at all, the CMS and CPT guidelines for the code are sufficiently general that a conscientious provider with reasonable knowledge of the situation, laws and options likely will perform the service properly (*PBN 11/9/15*).

VPS' electronic health record has its own ACP template, which makes sure the providers hit some conversational targets that may be useful for documentation and billing challenges (*PBN 3/14/16*). But "our conversations are generally guided by clinical intuition and experience," says Leonard. "While we don't use a script, our ACP conversations generally include a discussion of the patient's diagnoses and prognosis, time for the patient to ask questions and process information, and the opportunity to discuss his/her wishes for end-of-life care. This may include reviewing options and completing an advance directive."

Have forms ready — and be prepared to file them for the patient. A large percentage of VPS' ACP discussions result in the completion of a New Jersey provider order for life-sustaining treatment (POLST) form, says Leonard. They not only accept the forms from patients but also "keep copies of completed POLSTs and other types of advance directives as scanned documents in our EHR. Clinicians frequently use the NJ POLST as well as our EHR as tools to ensure that a patient's end-of-life wishes are well documented." — *Roy Edroso (redroso@decisionhealth.com)*

Resources:

California State University Advance Care Planning CME: https://csupalliativecare.org/programs/advance-care-planning/

Five Wishes for Organizations: www.agingwithdignity.org/five-wishes/organizations

BACK TO TOP