What is the Physician Fee Schedule?

The Centers for Medicare and Medicaid Services (CMS) pays for Medicare Part B physician services through the Physician Fee Schedule (PFS) that lists more than 7,000 covered services and their accompanying payment rates. Medicare Part B covers many outpatient services including office visits, preventive services, and diagnostic tests, and these services receive a unique current procedural terminology (CPT) code for billing purposes.

What's the Value in Voluntary Advance Care Planning?

Voluntary and informed patient and family decision-making forms the basis of high-quality, person-centered care. Without the proper opportunity to discuss their wishes with clinicians and other trusted advisors, patients may face treatment that is unwanted, uncoordinated, and unfit to meet their changing needs.

Current estimates suggest that the number of Americans over the age of 85 is expected to reach 18 million by 2050.¹ Many of these individuals will soon experience advanced illness, which occurs when one or more conditions become serious enough that general health and functioning begin to decline, treatment may no longer lead to preferred outcomes, and care oriented toward comfort may take precedence over attempts to cure – a process that extends to the end-of-life. These people will experience a range of spiritual, emotional, and physical needs that will become increasingly complex as they reach the end of life. Consultations about patient wishes and preferences can lead to improved health outcomes, increased patient/family satisfaction, and decreased caregiver burden.

The IOM Report Dying in America supports the implementation of advance care planning as an open, continuous dialogue between the provider, patient, and family/surrogate that can begin at any stage or state of health and should be reviewed through regular discussions. The Report also highlights the low rates of these discussions, gaps in patient-provider communication, and the need to “normalize” these conversations.

What’s the Current Funding Opportunity?

Each year, CMS releases its proposed physician fee schedule for the following calendar year and solicits feedback from the stakeholder community on the services provided in the schedule. In this year’s proposed 2016 Physician Fee Schedule, CMS announced the

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activation of two codes that would reimburse physicians or other qualified professionals for voluntary advance care planning discussions with patients and families about their care choices and treatment preferences. These consultations include the explanation, discussion, and completion of advance directives by the provider with the patient, family members, and/or surrogate. The two codes are as follows:

- 99497 for an initial thirty minute voluntary advance care planning consultation
- 99498 as an add-on code for additional thirty-minute time blocks needed

Last year, the CPT Editorial Panel announced the inclusion of these two codes in the proposed CY 2015 Physician Fee Schedule but did not reimburse for them and designated the codes as “inactive”. This year, the proposed rule for CY 2016 included these codes and designated them as “active” and applicable for reimbursement.

In its final rule, CMS has confirmed this proposal and will begin reimbursing for these consultations starting January 1st, 2016. You can view the final rule here:

**What’s the Reimbursement Rate?**

CMS proposes a payment of approximately $86 for the initial consultation (code 99497) and $75 for any 30-minute add-on conversation (code 99498). The relative value units (RVUs) for these codes are estimated at 1.5 and 1.4, respectively. RVUs are a measure of value used to calculate Medicare reimbursement for physician services.

Although these codes can now be reimbursed, this does not indicate a national Medicare coverage determination. Third party contractors can use their discretion to determine the utilization of these codes.

**What’s Next? How Can Providers Put This into Practice?**

A number of C-TAC members have successfully integrated advance care planning into care delivery. These programs focus on the following components:

- Early integration of advance care planning in care delivery and continuous renewal of patient wishes as care needs evolve and change;
- Ensuring that preferences for care are communicated, documented, available, and followed by clinicians at all points of care;
- Allowing for a comprehensive understanding of the individual through the progression of illness;
- Developing a close connection to family caregivers and physicians actively engaged in care delivery;
- Sharing of understandable information about illness and care options;
- Eliciting individual awareness of personal values, goals, tradeoffs and other important determinants of care preference;
• Facilitation of shared decision making between physicians and patients along with their families faced with advanced illness;
• Reconciliation of expectations and understanding between the patient, and those directly involved in care decisions;
• Standardized documentation and communication of care decisions to all participants in care delivery; and
• Regular review to stay current with changes in condition and preferences.

As a result of this intervention, program sites have reported high patient satisfaction rates and medical treatment that was consistent with patient wishes 97 or 99.5 percent of the time.2

Decision aids are also helpful tools that can be used to facilitate these consultations. Tools such as conversation starters and guides, informational resources, “values clarifiers”, lifesustaining treatment decision aids, and documentation aids are commonly used to address low health literacy and also enhance clinician training.

In order to ensure the successful implementation of these codes, C-TAC submitted a comment letter providing suggested recommendations on the frequency of the consultation, the definition of “qualified professional”, the evaluation of the consultation, and the location of the consultation.

What’s the Big Picture?

C-TAC applauds the Administration for the inclusion and reimbursement for these codes. Providing access to patient-provider consultations about personal goals, values, and treatment preferences is essential to ensuring that care delivery is high-quality and person-centered.

While the reimbursement of these codes is an important first step to ensuring that care delivery aligns with patient goals, values, and wishes, the work to achieve our vision is not done. We will continue to advocate for broader reform efforts that will help support the implementation of the advanced care model framework including comprehensive advance care planning, effective care management and coordination, and treatment and palliation delivered through a team-based, interdisciplinary approach.

To learn more about how our policy and advocacy work supports this kind of comprehensive reform, please see our federal policy agenda here

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2 The Advanced Care Project, a collaboration of various of health systems and plans nationwide, produced recommendations on best-practice care delivery models here