PAYMENT

Reimbursement Tips:

FQHC Reimbursement for Advance Care Planning (ACP)

Advance Care Planning (ACP) involves discussion between an FQHC core practitioner and their patient about future care decisions that may need to be made should the patient become unable to make decisions on their own.

Program Requirements

ACP is a voluntary, face-to-face service between the FQHC core practitioner and a patient, family member, or surrogate. The beneficiary's care wishes and preferences are included in this discussion as is an explanation of the use of advance directives. ACP may involve the completion of standard advance directive forms by the patient with the assistance of the provider.

ACP, while encouraged as part of high-quality care, is not required to be furnished to Medicare beneficiaries. CMS began reimbursing FQHCs for ACP services as a stand-alone qualifying visit billable under the Prospective Payment System in 2016. ACP is not separately reimbursable if provided during a Medicare Wellness Visit.

In March 2023, CMS revised their Advanced Care Planning Fact Sheet to clarify guidance on documentation, coding, and billing for ACP. This was a result of an OIG audit report that found that Medicare providers did not always comply with the time and documentation billing requirements for ACP.

Patient Eligibility & Consent

Individuals who are enrolled in Medicare Part B are eligible to receive ACP services. Patient consent for ACP must be documented in the medical record.

Other payers may provide ACP coverage for beneficiaries, and it is important for health centers to check with State programs and their payer contracts for terms and payment rates.

Timeframe & Services

CMS has not placed frequency limitations on stand-alone ACP visits. This is in contrast to an Annual Wellness Visit, during which ACP may be provided, which is limited to once every 12 months. The frequency of stand-alone ACP visits may vary depending upon changes in a patient's condition or wishes over time.

An explanation and discussion of advances directives is an element of ACP. An advance directive is a legal document that records a patient's medical treatment wishes and designates an individual to act upon those wishes if a patient is unable to do so themselves. Examples of advance directives include, but are not limited to: Living Will, Durable Power of Attorney (Health care), Health Care Proxy, Psychiatric advance directives, and Medical Orders for Life-Sustaining Treatment (MOLST).

Under **Medicare**, a new patient is someone who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service. Dental service would not count as dental is not covered by Medicare. This definition differs from the traditional CPT definition of a new patient. FQHCs are encouraged to educate staff on the variance and may choose to use a single definition.

Authorized Provider/Staff

ACP is a face-to-face service between an FQHC core practitioner and the patient, family member, or surrogate to discuss health care wishes if the patient becomes unable to make their own decisions. A surrogate is defined by Medicare as a healthcare agent, designated decision maker, family member or caregiver. The discussion can occur with or without completing relevant legal forms.

Other FQHC care team members may participate in ACP under the direct supervision of the treating and billing practitioner. The practitioner must have a face-to-face visit with the patient and participate and meaningfully contribute to furnishing ACP services. The auxiliary staff would typically be involved in providing the patient with standardized forms (i.e., advance directives) and assisting with the completion of those forms.

TREATING (BILLING) PROVIDER						UNDER DIRECT SUPERVISION
Physicians (MD or DO)	Non-Physician Practictioners					Auxiliary Staff
	NP	PA	CNM	CP	CSW	Examples: CNS+, RN, LCSW, MA, CHW
x	x	x	x	x	x	x

Physicians: Medical Doctor (MD) or Doctor of Osteopathy (DO)

Non-Physician Practitioners: Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife (CNM), Clinical Psychologist (CP), and Clinical Social Worker (CSW) as per training and State licensure and scope of practice parameters.

+Clinical Nurse Specialists (CNS) do not fit the Medicare definition of an FQHC practitioner. CNS services would be billed to Medicare as incident to the supervising provider. Medicare Fee-For-Service in a non-FQHC setting does allow CNSs to furnish services an independent practitioner.

© 2022 National Association of Community Health Centers. All rights reserved. | QualityCenter@nachc.org | June 2023

Documentation

CMS clarifies in the Advance Care Planning Fact Sheet that the practitioner's discussion with the patient, family member or surrogate must be documented. Documentation must include:

- Content and medical necessity of the ACP discussion (i.e., patient health status changes or care wishes if patient becomes unable to make his/her own health decisions)
- Voluntary aspect of the encounter
- Explanation and content of any advance directives
- Names and relationships of discussion participants
- Time spent discussing ACP during the encounter

Because ACP is a time-based service, the details of the documentation should vary based upon the length and complexity of the discussion. Any time spent assisting the patient with completion of advance directive forms should also be documented. Document which forms, if any, were completed, and maintain a copy in the patient's medical record.

PHE Exception. *During the COVID-19 PHE, Medicare will reimburse AWVs furnished via telehealth at the G2025 telehealth rate of $98.27. Note: IPPE is not on the Medicare list of approved telehealth services.*

Coding & Billing

Separately Reimbursable

CMS will reimburse an FQHC when ACP services are provided to a patient during a separate encounter from a Medicare Wellness Visit. ACP service CPT® 99497 is a qualifying visit for a new (PPS G0466) or established patient (PPS G0467). Any relevant diagnosis(es) should be documented, and the ICD code(s) included on the claim. As is true for any qualifying FQHC medical visit, the patient is responsible for any coinsurance associated with an ACP-only encounter.

Not Separately Reimbursable

ACP may also be provided during a Medicare Wellness Visit (hyperlink to Medicare Wellness Visits Reimbursement Tips) although the ACP is not separately reimbursable when provided during this visit type. Medicare Wellness Visits include the Initial Preventive Physician Exam (IPPE: HCPCS G0402) and Annual Wellness Visits (AWV: HCPCS G0438/G0439).

A health center that furnishes an IPPE and AWV would include and bill all services using PPS G0468. When ACP is part of an Annual Wellness Visit, then the well exam diagnosis should be included on the claim. The patient is not responsible for any coinsurance when ACP is part of the Medicare Wellness Visit.

ACP may also be separately reported when performed during the same service period as a care management service (PPS G0511 or G0512). Time counted towards ACP cannot be counted toward any other billed code. The patient is responsible for coinsurance for each of the visits when an ACP is provided during the same period as a care management service.

ACP is a time-based service. CMS reinforced in its Advance Care Planning MLN Fact Sheet that the coding rules for minimum time requirements to report must adhere to CPT rules. Those rules make clear that a unit of time is reached when the mid-point is passed. For example, 30 minutes is attained when at least 16 minutes have passed. This means that service time of less than 16 minutes would not meet the criteria for a 30-minute time requirement and should not be billed. Similarly, an allowed additional 30 minutes of service would not begin until 46 minutes of services above the first initial 30 minutes is reached. The code table below illustrates the emphasis CMS places on the time requirements for ACP as part of their response to the OIG audit.

Time spent assisting the patient with the completion of advance directive forms may be counted as part of the ACP service.

© 2022 National Association of Community Health Centers. All rights reserved.

Reimbursement Tips: FQHC Reimbursement for Advance Care Planning (ACP

Advance Care Planning: Separate Visit

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*CMS/Medicare 2023 Fee*
CPT® 99497	Advance care planning, including the explanation and discussion of advance directives, by the physician or other qualified healthcare professional, first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate. Total ACP service time range is 16-45 minutes. *	G0466, new FQHC patient Or G0467, established FQHC patient	$251.13 $187.19
CPT® +99498 **(reported with 99497)**	Each additional 30 minutes. Total additional ACP service time range is 46-75 minutes.		(No additional payment to FQHC)
The extension of the COVID-19 PHE flexibility allows FQHCs to furnish ACP services, through December 31, 2024, using audio and visual telehealth telecommunications technology.		G2025	$98.27

Health centers submit a claim with their charges for all services and Medicare will reimburse the lesser of the charges or the fully adjusted PPS rate.

Coinsurance applies to the AWV but not to the ACP services.

Rates here are based on the 2023 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI.

Advance Care Planning: Same Visit as Medicare Wellness Visit*

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*CMS/Medicare 2023 Fee*
G0439	Annual Wellness Visit (AWV), subsequent visit	G0468	$251.13
CPT® 99497	Advance care planning, including the explanation and discussion of advance directives, by the physician or other qualified healthcare professional, first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.	G0467	(No additional payment to FQHC under PPS)
The extension of the COVID-19 PHE flexibility allows FQHCs to furnish ACP and AWV services, through December 31, 2024, using audio and visual telehealth telecommunications technology.		G2025	$98.27

Rates here are based on the 2023 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI.

Health centers submit a claim with their charges for all services and Medicare will reimburse the lesser of the charges or the fully adjusted PPS rate.

**This scenario is provided as an example only and health centers should follow coding guidelines specific to each encounter.*

Add-on codes, identified with the + symbol in the CPT manual, offer providers in a fee-for-service setting (i.e., non-FQHC) a mechanism for reporting and receiving reimbursement for professional service time spent with a patient above the time allocated in the primary care management service code when service is furnished by the same provider. FQHCs do not receive additional Medicare PPS payment for additional time spent with patients. CMS views the higher FQHC reimbursement associated with the encounter rate as adequate compensation for the service time spent with the patient. However, it is important for FQHCs to capture the add-on codes in order to accurately capture the cost of providing these services.

FQHC may submit a Medicare claim for a billable CMS PPS “G” code visit and a care management service on a single claim. Payment for the PPS “G” code will be the lesser of its charges or the fully adjusted PPS rate for the billable visit plus 80% of the charges for G0511 or G0512. The date of service (DOS) used on the claim may be the date when the requirements to bill for the service have been met for that month or any date before the last day of the month.

© 2022 National Association of Community Health Centers. All rights reserved. | QualityCenter@nachc.org | June 2023

References

- AMA CPT 2023 Professional Edition.
- CMS Billing and Coding: Advance Care Planning. Local Coverage Determination A58664. Accessed at https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=58664
- CMS FQHC MLN. Accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/fqhcfactsheet.pdf
- CMS FQHC PPS Codes. Accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf
- CMS Medicare Physician Fee Schedule; Final Rule CY 2023. Accessed at https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other
- CMS MLN Advance Care Planning Fact Sheet. Accessed at. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf
- Medicare Chapter 9 FQHC Claims Processing Manual. Accessed at. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf
- Medicare Chapter 13 FQHC Benefit Policy Manual. Accessed at. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf
- OIG Report: Medicare Providers Did Not Always Comply with Federal Requirements When Billing for Advance Care Planning. Accessed at https://oig.hhs.gov/oas/reports/region6/62004008.pdf

© 2022 National Association of Community Health Centers. All rights reserved. | QualityCenter@nachc.org | June 2023