AMA

# Billing for end-of-life care talks grows, but barriers remain

JUL 8, 2019

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Advance-care planning (ACP) is the keystone of goal-concordant care, enabling patients to state their treatment preferences while they still have the mental capacity to do so. The Centers for Medicare & Medicaid Services has acknowledged this by accepting two Current Procedural Terminology (CPT®) reimbursement codes for these essential conversations.

A study indicates ACP billing is growing significantly, although most of the physicians who are likelier to engage in these conversations still don't use the codes, suggesting there are barriers to initiating these end-of-life talks, or documenting them, or both. A related commentary highlights tools for having more effective conversations.

The AMA *Code of Medical Ethics* provides guidance on end-of-life care, such as chapter 5, "Opinions on Caring for Patients at the End of Life," which covers topics such as advance care planning, advance directives and orders not to attempt resuscitation.

The study, published in *JAMA Internal Medicine*, was based on analysis of Medicare Physician/Supplier Part B claims for all fee-for-service beneficiaries 65 and older in 2016 and the first three quarters of 2017. It found billing rose from 1.9% of beneficiaries in 2016 to 2.2% in 2017, and claims rates were higher—3.3% in 2016 and 5.8% in 2017—among beneficiaries who died within the given year.

The study also found strong variation in the percentage of decedents with an ACP visit by state in 2016—from just 0.14% to 10.4%—and changes in claims rates by specialty, with the biggest gains coming in hospice and palliative care medicine, where the share of physicians using an ACP code at least once grew from 27.6% in 2016 to 35.9% in 2017.

"Despite an increase in ACP claims nationally, particularly among decedents each year, the overall ACP claims rate remains low," wrote Emmanuelle Belanger, PhD, of the Department of Health Services, Policy & Practice in the Brown University School of Public Health, and her colleagues.


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The authors noted that ACP billing may be a poor proxy for actual ACP practice and that payment rates may not be high enough. “Two-thirds of HPM specialists did not use the new CPT code in 2017 despite working with seriously ill patients and it being unlikely that they would have no ACP conversation in a given year.”

This last finding “may be due to lack of awareness of these CPT codes, uncertainty about appropriate code use or billing for these discussions is not part of standard workflow,” wrote the authors of an accompanying invited commentary.

“Regardless, the low rates of utilization of ACP codes is alarming and highlights the need to create strategies to integrate ACP discussions into standard practice and build ACP documentation and billing in clinical workflow,” wrote the authors, Ankita Mehta, MD, and Amy S. Kelley, MD, both of whom work in the Brookdale Department of Geriatrics and Palliative Medicine at the Icahn School of Medicine at Mount Sinai.

## Things to know and do

To be reimbursable, the commentary’s authors noted, ACP conversations must be held in person with patients or their surrogates and be documented in the electronic health record. CPT code 99497 is used for the first 30 minutes and pays about $86 for outpatient visits and $80 for inpatient visits.

CPT code 99498 is used thereafter and provides payment of $75 for each additional 30-minute period. Payment can be billed through Medicare Part B or as part of the patient’s annual visit, and no legal forms are required.

To learn more about another approach to this facet of care, explore the AMA STEPS Forward™ CME module, “End-of-Life Care: Facilitate Early Discussions with Patients,” which is enduring material and designated by the AMA for a maximum of 0.5 AMA PRA Category 1 Credit™.

This module is offered through the AMA Ed Hub™, an online platform that brings together all the high-quality CME, maintenance of certification, and educational content you need—in one place—with activities relevant to you, automated credit tracking and reporting for some states and specialty boards.

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