

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE PROVIDERS DID NOT  
ALWAYS COMPLY WITH FEDERAL  
REQUIREMENTS WHEN BILLING FOR  
ADVANCE CARE PLANNING**

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**November 2022  
A-06-20-04008**

# ***Office of Inspector General***

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## Report in Brief

Date: November 2022

Report No. A-06-20-04008

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Audit

Advance care planning (ACP) is a service consisting of a face-to-face discussion between Medicare physicians or other qualified health care professionals and patients to discuss their health care wishes if they become unable to make decisions about their care. Effective January 1, 2016, Medicare began paying for ACP services. Payments for ACP provided from 2016 through 2019 totaled more than \$340 million. Payments for services provided in an office setting represented 61 percent of all payments.

Our objective was to determine whether Medicare providers who received payments for ACP services in an office setting complied with Federal requirements.

### How OIG Did This Audit

Our audit covered 873,381 beneficiaries associated with claims for ACP services (CPT codes 99497 and 99498) in an office setting during calendar year 2019 (audit period) with a total paid amount of \$70.1 million. We selected for review a stratified random sample of 125 beneficiaries. We reviewed all 691 paid ACP services for the 125 beneficiaries selected for our sample.

## Medicare Providers Did Not Always Comply With Federal Requirements When Billing for Advance Care Planning

### What OIG Found

Medicare providers that billed for ACP services in an office setting did not always comply with Federal requirements. Specifically, of the 691 ACP services associated with our sample, Medicare providers complied with Federal requirements for 225 services totaling \$15,874. However, providers did not comply with Federal requirements for 466 services totaling \$33,332.

On the basis of our sample results, we estimated that Medicare providers in an office setting were paid approximately \$42.3 million for ACP services that did not comply with Federal requirements. These payments occurred because the providers did not understand the Federal requirements for billing ACP services.

We also identified questionable claims associated with 12 sampled beneficiaries for whom 15 or more ACP services were received. Although the billing of these ACP services did not reflect noncompliance with Medicare requirements, the billings do not align with guidance contained in CMS's Frequently Asked Questions.

### What OIG Recommends and CMS Comments

We recommend that CMS educate providers on documentation and time requirements for ACP services to comply with Federal requirements. Had the requirements been followed, Medicare could have saved an estimated \$42.3 million during our audit period. In addition, CMS should instruct the MACs to recoup \$33,332 for ACP services paid in error for claims in our sample. Also, CMS should instruct the MACs to notify appropriate providers so that they can exercise reasonable diligence in identifying, reporting, and returning any overpayments in accordance with the 60-day rule. Finally, CMS should establish Medicare requirements that address when it is appropriate to provide multiple ACP services for a single beneficiary and how these services should be documented when required to support the need for multiple ACP services.

CMS concurred with our first three recommendations. However, CMS did not concur with our fourth recommendation. After reviewing CMS's comments, we revised our fourth recommendation to address when multiple ACP services are appropriate, and the documentation required to support the need for these services. We maintain that our findings and recommendations, as revised, are valid.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

Advance care planning (ACP) is a service consisting of a face-to-face discussion between Medicare physicians or other qualified health care professionals (collectively called providers in this report) and patients to discuss their health care wishes if they become unable to make decisions about their care. Effective January 1, 2016, Medicare began paying for ACP services under the Medicare Physician Fee Schedule. ACP services may be provided in various places of service. Payments for ACP services provided from 2016 through 2019 totaled more than \$340 million. Payments for services provided in an office setting represented 61 percent of all ACP payments. In January 2018, the Comprehensive Error Rate Testing (CERT) program identified payments for ACP services that were improper due to insufficient documentation.<sup>1, 2, 3</sup> The Office of Inspector General (OIG) also identified payments that were improper due to insufficient documentation in survey work performed on paid 2018 ACP claims.<sup>4</sup> On the basis of this information, we conducted this audit of providers' compliance with Medicare requirements for ACP services provided in an office setting.

### OBJECTIVE

Our objective was to determine whether Medicare providers who received payments for ACP services provided in an office setting complied with Federal requirements.

### BACKGROUND

#### Medicare Program

The Medicare program, established by Title XVIII of the Social Security Act (the Act), provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Part B of the Medicare program provides supplementary insurance for

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<sup>1</sup> The Centers for Medicare & Medicaid Services implemented the CERT program to measure improper payments in the Medicare fee-for-service program.

<sup>2</sup> *Medicare Quarterly Provider Compliance Newsletter*, CERT Finding: Advance Care Planning. Available online at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN904144.pdf>. Accessed on Jan. 11, 2022.

<sup>3</sup> Documentation is insufficient when something is missing from the submitted medical records to support payment for the services billed. Many claims with insufficient documentation lacked clinical documentation to support that a face-to-face service that included the discussion of ACP was performed, clinical documentation of the time spent discussing ACP, or both.

<sup>4</sup> Claims with an office setting produced a 50-percent error rate, and all the errors were due to lack of documentation to support the amount of time the physician spent with the beneficiary to discuss ACP.

medical and other health services, including ACP. CMS contracts with Medicare administrative contractors (MACs) to process and pay Part B claims submitted by providers. CMS provides education and guidance to Medicare providers through various methods, including Quarterly Provider Updates, Change Requests, Medicare Learning Network Matters Articles, and on its website.

## **Advance Care Planning Services**

ACP is a service consisting of a face-to-face discussion between Medicare providers and patients to discuss the patients' health care wishes if they become unable to make decisions about their care. Medicare beneficiaries may request ACP services at no cost to them as part of the Annual Wellness Visit available to Medicare beneficiaries. However, when a beneficiary elects to receive ACP services separate from the Annual Wellness Visit, a provider should notify the beneficiary that Part B coinsurance will apply, as it does for other providers' services. Because the services are voluntary, Medicare beneficiaries may decline to receive ACP services.<sup>5</sup>

## **Federal Requirements and Other Guidance**

### *Federal Requirements*

Under section 1833(e) of the Act (42 U.S.C. § 1395(e)), the Department of Health and Human Services may deny payment to any provider of services or other person unless there is furnished such information as may be necessary to determine the amounts due to any provider or other person.

Providers' services are covered and paid by Medicare in accordance with section 1862(a)(1)(A) of the Act, which states that no payment may be made for any expenses incurred for items and services unless such items or services are reasonable and necessary for the diagnosis or treatment of illness or injury. Providers report Current Procedural Terminology (CPT) code(s)<sup>6</sup> when they provide services that are reasonable and necessary for the diagnosis or treatment of illnesses or injuries.<sup>7, 8</sup>

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<sup>5</sup> 80 Fed. Reg. 70886, 70956 (Nov. 16, 2015).

<sup>6</sup> **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT), copyright 2018 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this document should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

<sup>7</sup> 80 Fed. Reg. 70955 (Nov. 16, 2015).

<sup>8</sup> 45 CFR § 162.1002(c)(1).

CMS adopted CPT codes 99497 and 99498 for ACP services and CPT provisions regarding the reporting of timed services.<sup>9</sup> CPT code 99497 covers the first 30 minutes of ACP, which includes a face-to-face explanation and discussion of advance directives, such as standard forms, between the provider and the patient, family member(s) or a surrogate, or both. CPT code 99498 should be used for each additional 30 minutes and listed separately in addition to code 99497.

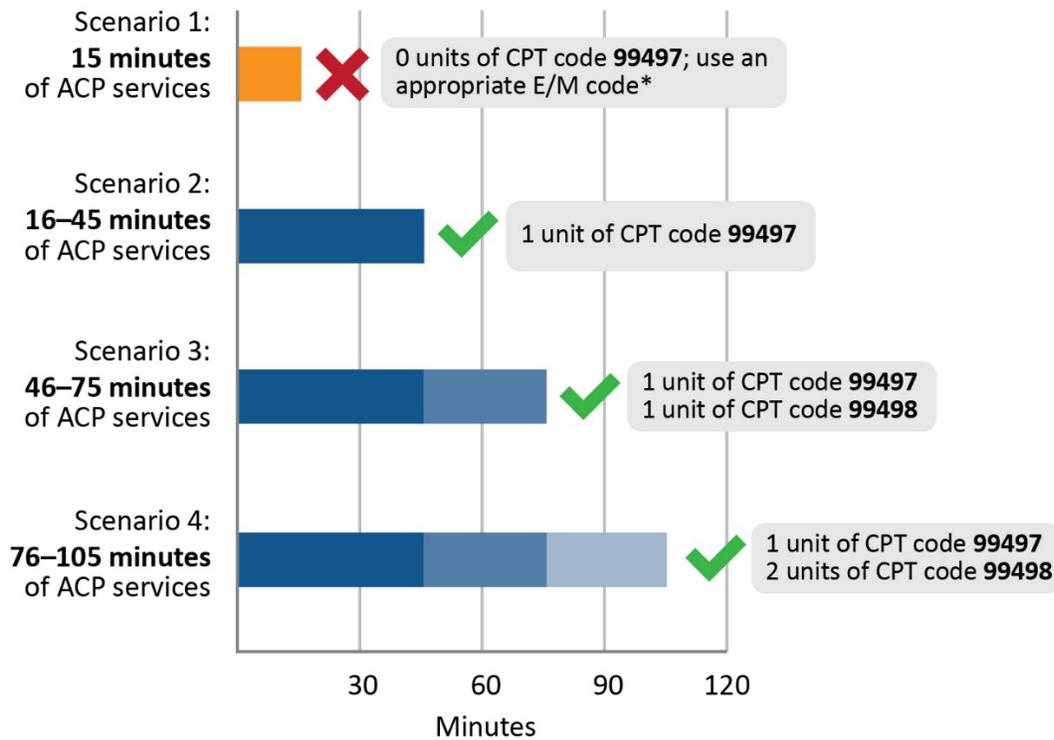
#### *Medicare Coverage for Advance Care Planning Services*

According to the *American Medical Association CPT 2018 Professional* (CPT codebook), a unit of time is billable when the midpoint of the allowable unit of time is passed. Thus, to bill code 99497, which is a code for 30 minutes, the provider must have at least 16 minutes of face-to-face time with the patient discussing ACP services. Any ACP discussion of 15 minutes or less should not be billed as ACP services. A provider may use the 99498-add-on code once the visit reaches 46 minutes. When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based services. See the Figure (next page) for an explanation on how to bill ACP services according to the amount of time spent providing ACP services.

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<sup>9</sup> 80 Fed. Reg. 70956 (Nov. 16, 2015).

**Figure: Advance Care Planning Minutes and Corresponding CPT Codes and Units**



\*E/M = evaluation and management.<sup>10</sup>

### Medicare Guidance on Advance Care Planning Services

According to CMS frequently asked questions (FAQs)<sup>11</sup> on what a provider must document to be paid for ACP services, examples of appropriate documentation would include an account of the discussion with the beneficiary (or family members and/or surrogate) regarding the voluntary nature of the encounter, documentation indicating the explanation of advance directives, who was present, and the time spent in the face-to-face encounter.<sup>12</sup> Providers should follow CPT provisions regarding the minimum time required to report timed services. If the required minimum time is not spent with the beneficiary, family member or surrogate, or

<sup>10</sup> Evaluation and management (E/M) coding is the use of CPT codes from the range 99202-99499 to represent services provided by a provider. As the name E/M indicates, these medical codes apply to visits and services that involve evaluating and managing patient health.

<sup>11</sup> CMS, Frequently Asked Questions about Billing the Physician Fee Schedule for Advanced Care Planning services, July 14, 2016. Available online at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-advance-care-planning.pdf>. Accessed on Jan. 6, 2022.

<sup>12</sup> We did not question ACP services based on CMS FAQs but presented information from the FAQs here to provide more details on what CMS would expect from providers that bill for ACP services.

both, to bill CPT code 99497 or 99498, the provider may consider billing a different E/M service, such as an office visit, provided the requirements for billing the other E/M service are met.<sup>13, 14</sup>

CMS does not place limits on the number of times ACP services may be reported for a beneficiary. When the service is billed multiple times for a beneficiary, CMS would expect a documented change in the beneficiary's health status, end-of-life care wishes, or both.<sup>15</sup>

## **Medicare Requirements for Providers To Identify and Return Overpayments**

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.<sup>16</sup>

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.<sup>17</sup>

## **HOW WE CONDUCTED THIS AUDIT**

Our audit covered 873,381 beneficiaries associated with claims for ACP services (CPT codes 99497 and 99498) in an office setting during calendar year 2019 (audit period) with a total paid amount of \$70,059,745.

We selected for review a stratified random sample of 125 beneficiaries. From all beneficiaries who received fewer than 15 ACP services during our audit period, we randomly selected for

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<sup>13</sup> CMS, Frequently Asked Questions about Billing the Physician Fee Schedule for Advanced Care Planning services, July 14, 2016. Available online at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-advance-care-planning.pdf>. Question #1. Accessed on Jan. 6, 2022.

<sup>14</sup> The required minimum time is 16 minutes based on code 99497 being for a 30-minute service.

<sup>15</sup> CMS, Frequently Asked Questions about Billing the Physician Fee Schedule for Advanced Care Planning services, July 14, 2016. Available online at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-advance-care-planning.pdf>. Question #2. Accessed on Jan. 6, 2022.

<sup>16</sup> The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

<sup>17</sup> 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual*—Part 1, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. 7670.

review 100 beneficiaries, who received a total of 137 ACP services. We also selected for review the remaining 25 beneficiaries, who received 15 or more ACP services during our audit period, totaling 554 ACP services. We reviewed all 691 paid ACP services for the 125 beneficiaries selected for our sample.<sup>18</sup> We requested from providers the medical records to support the paid ACP services and reviewed them for documentation supporting the ACP face-to-face discussion with beneficiaries and the time providers spent talking to the beneficiaries about ACP.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

## **FINDINGS**

### **ADVANCE CARE PLANNING SERVICES DID NOT COMPLY WITH FEDERAL REQUIREMENTS**

#### **Federal Requirements**

Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act § 1833(e)). CPT codes 99497 and 99498 are time-based codes. The provider must have at least 16 minutes of face-to-face time with the patient discussing ACP services to bill code 99497 and at least 46 minutes discussing ACP services to bill code 99498. When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service.<sup>19, 20</sup>

#### **Providers Did Not Properly Document Advance Care Planning Services**

Of the 691 ACP services associated with our sample, Medicare providers complied with Federal requirements for 225 services totaling \$15,874. However, providers did not comply with Federal requirements for 466 services totaling \$33,332. Specifically, we found that:

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<sup>18</sup> The 691 services were performed by 108 providers.

<sup>19</sup> 80 Fed. Reg. 70956 (Nov. 16, 2015).

<sup>20</sup> *AMA CPT 2018 Professional*, page xvi.

- For 268 services associated with payments totaling \$18,912, the provider documented the ACP service but did not distinguish between time spent face-to-face with the beneficiary discussing ACP and time spent on concurrent services. For example, the patient notes for one beneficiary said that the patient has a living will in place and is to remain full code and that her husband will become the primary medical decision-maker should the patient become incapacitated.<sup>21</sup> The notes go on to say: “We have spent 35 minutes in obtaining interval history and performing clinical exam. We have reviewed her medications, allergies, and ROS.<sup>22</sup> We have reviewed her medications and she continues her current meds. Her recent eye exam was good and her xerophthalmia has been controlled. We have reviewed her advanced directives and performed medication reconciliation.”<sup>23</sup> According to the provider’s documentation, the entire visit lasted 35 minutes. The documentation does not specify what portion of the 35 minutes was spent discussing ACP.
- For 174 services associated with payments totaling \$12,672, providers did not document in the medical records that an ACP discussion occurred, nor did they distinguish between time spent face-to-face with the beneficiary discussing ACP and time spent on concurrent services.
- For 24 services associated with payments totaling \$1,748, we were unable to obtain any medical records from the provider.

Some providers told us that they did not comply with Federal requirements because they did not know that the time for ACP services had to be distinguished between time spent discussing ACP and time spent on concurrent services or because they were unaware there was a time requirement. Additionally, some providers stated that ACP services should not have been billed.

Table 1 shows a summary of the claims that did not comply with Federal requirements.

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<sup>21</sup> Full code means that if a person’s heart stops beating or the person stops breathing, or both, all resuscitation procedures will be provided to keep the person alive. This process can include chest compressions, intubation, and defibrillation and is referred to as “CPR.”

<sup>22</sup> ROS stands for “Review of Systems” and is an inventory of the body systems that is obtained through a series of questions used to identify signs or symptoms that the patient may be experiencing.

<sup>23</sup> Medication reconciliation is the process of ensuring that a patient’s medication list is as up-to-date as possible.

**Table 1: Summary of Claims That Did Not Comply With Federal Requirements**

<b>Requirements Not Met</b>	<b>Number of Services</b>	<b>Total Paid for Non-compliant Services</b>
Time Not Documented	268	\$18,912
ACP Discussion and Time Not Documented	174	12,672
Medical Records Not Submitted by the Provider	24	1,748
<b>Total Services With Errors</b>	<b>466</b>	<b>\$33,332</b>

On the basis of our sample results, we estimated that Medicare providers in an office setting were paid approximately \$42.3 million for ACP services that did not comply with Federal requirements from January 1 through December 31, 2019.<sup>24</sup>

**Providers Submitted Questionable Claims for Advance Care Planning Services**

Providers submitted questionable claims for ACP services associated with 12 sampled beneficiaries for whom 15 or more ACP services were received during our 12-month audit period. Although the billing of these ACP services did not reflect noncompliance with Medicare requirements, the billings do not align with CMS’s guidance contained in an FAQ. The FAQ states that when ACP services are billed multiple times for a beneficiary, CMS would expect a documented change in the beneficiary’s health status, end-of-life care wishes, or both. The providers’ medical records that we received did not mention a change in the beneficiaries’ health status or wishes for end-of-life care. For example, for one beneficiary in our sample, CPT code 99497 was billed on 22 dates of service by one provider during 2019. All of the appointments on these days were for followup or medication refills, and no documentation supporting that a change in the beneficiary’s health status or wishes for end-of-life care had changed between any of these 22 dates of service was included in the medical records submitted to us by the provider.

CMS did not have Medicare requirements that address when it is appropriate to provide ACP services multiple times to a single beneficiary and how these services should be documented. Without these requirements, Medicare may continue to make questionable payments.

**RECOMMENDATIONS**

We recommend the following:

- The Centers for Medicare & Medicaid Services should educate providers on documentation and time requirements for ACP services to comply with Federal

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<sup>24</sup> The estimated improper Medicare payment amount was \$42,266,931.

requirements. (That is, when another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service, and time and ACP discussion must be documented). Had the requirements been followed, Medicare could have saved an estimated \$42,266,931 during our audit period.

- The Centers for Medicare & Medicaid Services should instruct the MACs to recoup \$33,332 for ACP services paid in error for claims in our sample.
- The Centers for Medicare & Medicaid Services should instruct the MACs, based on the results of this audit, to notify appropriate providers (i.e., those for whom CMS determines that this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence in identifying, reporting, and returning any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation.
- The Centers for Medicare & Medicaid Services should establish Medicare requirements that address when it is appropriate to provide multiple ACP services for a single beneficiary and how these services should be documented when required to support the need for multiple services.

### **CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, CMS concurred with our first three recommendations. In regard to our first three recommendations, CMS stated that it will (1) continue to educate providers on the needs for appropriate documentation for advance care planning services; (2) instruct Medicare Administrative Contractors to recover identified overpayments consistent with relevant law and the agency's policies and procedures; and (3) instruct its Medicare Administrative Contractors to notify identified providers of potential overpayments and track any returned overpayments made in accordance with this recommendation and the 60-day rule. However, CMS did not concur with our fourth recommendation related to establishing an allowable frequency for ACP services.

After reviewing CMS's comments, we revised our fourth recommendation to respond to CMS's assertion that it would be inappropriate to establish an allowable frequency for ACP services. Therefore, we revised the recommendation to address when multiple ACP services are appropriate, and the documentation required to support the need for these services. We maintain that our findings and recommendations, as revised, are valid.

A summary of CMS's comments and our response follow. CMS's comments are included in their entirety as Appendix D.

## **CMS Comments**

Regarding our fourth recommendation, CMS stated that it would be inappropriate for it to establish an allowable frequency for ACP services because these services are furnished at the patient's request and when the patient experiences a change in health status or wishes about end-of-life care, or both. Therefore, CMS said, there is no limit on the number of times that ACP services may be reported for a given patient. CMS said that if ACP services are billed more than once, it encourages physicians to document the specific reasons why any subsequent ACP services are needed.

## **Office of Inspector General Response**

While we understand that CMS encourages physicians to document the specific reasons why any subsequent ACP services are needed and that it stated in an FAQ that when ACP services are billed multiple times it would expect a documented change in the beneficiary's health status, end-of-life care wishes, or both, we noted several instances during our audit in which a provider billed for ACP services 15 or more times for a single beneficiary. In addition, the providers' medical records that we received did not mention a change in the beneficiaries' health status, nor did the providers' records specify a reason why any subsequent ACP services were needed. There was also nothing in the providers' records to indicate that the beneficiaries' wishes for end-of-life care had changed. Without a requirement regarding when it is appropriate to provide multiple ACP services for a single beneficiary and the documentation required to support the need for multiple ACP services, Medicare may continue to make questionable payments.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered Medicare Part B payments for ACP services provided from January 1 through December 31, 2019. Our sampling frame consisted of 873,381 beneficiaries who received ACP services in an office setting. Payments for these services totaled \$70,059,745. We selected a stratified random sample of 125 beneficiaries. From the 873,356 beneficiaries who received fewer than 15 ACP services during our audit period, we randomly selected for review 100 beneficiaries. We also selected for review all of the 25 remaining beneficiaries in our sampling frame who received 15 or more ACP services during our audit period. We reviewed all 691 paid ACP services for the 125 beneficiaries during our audit period, totaling \$49,206.

We did not audit CMS's overall internal control structure. Rather, we reviewed only those internal controls related to our audit objective. Specifically, we reviewed the CMS communication to providers on billing for ACP services. We also consulted CMS officials to verify that we understood requirements related to billing for ACP services.

We conducted our audit from June 2020 through June 2022.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- obtained an understanding of the Medicare requirements related to ACP services;
- obtained from CMS's Integrated Data Repository the paid Medicare Part B claims for ACP services performed in an office setting during our audit period;
- created a sampling frame of 873,381 beneficiaries who received ACP services in an office setting and selected a stratified random sample of 125 beneficiaries (Appendix B);
- obtained from Medicare providers medical records to support paid ACP services and reviewed them to determine whether ACP services complied with Medicare requirements;
- contacted providers to discuss ACP services determined to be noncompliant with Medicare requirements;
- estimated overpayments to Medicare providers for ACP services that did not comply with Medicare requirements; and

- met with CMS officials to discuss the results of this audit.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

The sampling frame consisted of 873,381 beneficiaries with ACP claim payments totaling \$70,059,745 for ACP services rendered in an office setting during our audit period (January 1 through December 31, 2019). The sampling frame included non-railroad claim lines for ACP services for which a payment of \$20 or more was made from the Medicare Trust Fund.

### SAMPLE UNIT

The sample unit was a beneficiary.

### SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample based on the number of ACP services each beneficiary received. One stratum included all beneficiaries who received 15 or more ACP services during our audit period.

Stratum	ACP Services per Beneficiary	Number of Beneficiaries	Frame Dollar Amount	Sample Size
1	1	842,181	\$65,075,066	70
2	2 to 14	31,175	4,945,602	30
3	15 or more	25	39,077	25
	<b>Total</b>	<b>873,381</b>	<b>\$70,059,745</b>	<b>125</b>

### SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

### METHOD OF SELECTING SAMPLE UNITS

We sorted each stratum by descending order of the number of ACP services and then by ascending HIC number. Then we consecutively numbered the items in each stratum of the sampling frame. We generated random numbers for each stratum and then selected the corresponding frame items for review.

### ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of unallowable Medicare payments for ACP services. We calculated a point estimate and a two-sided 90-percent confidence interval for this estimate.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Sample Results**

<b>Stratum</b>	<b>ACP Services Per Beneficiary</b>	<b>Number of Beneficiaries</b>	<b>Frame Dollar Amount</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Value of Unallowable ACP Services</b>
1	1	842,181	\$65,075,066	70	\$5,489	\$3,290
2	2 to 14	31,175	4,945,602	30	4,640	2,560
3	15 or more	25	39,077	25	39,077	27,482
	<b>Total</b>	<b>873,381</b>	<b>\$70,059,745</b>	<b>125</b>	<b>\$49,206</b>	<b>\$33,332</b>

**Estimated Value of Unallowable ACP Services in the Sampling Frame  
(Limits Calculated for a 90-Percent Confidence Interval)**

<b>Point estimate</b>	\$42,266,931
<b>Lower limit</b>	35,692,512
<b>Upper limit</b>	48,841,351

## APPENDIX D: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington, DC 20201

**DATE:** September 14, 2022

**TO:** Amy J. Frontz  
Deputy Inspector General for Audit Services  
Office of Inspector General

**FROM:** Chiquita Brooks-LaSure *Chiquita LaS*  
Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Medicare Providers Did Not Always Comply With Federal Requirements When Billing for Advance Care Planning (A-06-20-04008)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

Advance care planning services are voluntary services between a Medicare provider and a patient, family member(s), and/or surrogate to discuss the patient's health care wishes if they become unable to make decisions about their care. The services may be included as part of a patient's annual wellness visit or conducted separately as a medically necessary service under Medicare Part B.

CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes. CMS recognizes the importance of providing people with Medicare access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments.

CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments. For example, CMS uses automated system edits within the claims processing system, investigations of potential fraud, and prepayment and post payment reviews. CMS has also educated health care providers on Medicare billing through various channels including the Medicare Learning Network (MLN), weekly electronic newsletters, and quarterly compliance newsletters. For example, in October 2020, CMS published an MLN Fact Sheet, which includes details on coverage criteria and practitioner requirements for advance care planning.<sup>1</sup>

The OIG's recommendations and CMS' responses are below.

### **OIG Recommendation**

The Centers for Medicare & Medicaid Services should educate providers on documentation and time requirements for ACP services to comply with Federal requirements. (That is, when another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service, and time and ACP discussion must be documented). Had the requirements been followed, Medicare could have saved an estimated \$42,266,931 during our audit period.

<sup>1</sup> CMS, MLN Fact Sheet, Advance Care Planning, October 2020. Accessed at: <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/advancecareplanning.pdf>

### **CMS Response**

CMS concurs with this recommendation. CMS educates health care providers on Medicare billing through various channels including the Medicare Learning Network (MLN), weekly electronic newsletters, and quarterly compliance newsletters. In July 2016, CMS published a Frequently Asked Questions (FAQs) document about billing for advance care planning services.<sup>2</sup> Subsequently, in October 2020, CMS published an MLN Fact Sheet, which includes details on coverage criteria and practitioner requirements for advance care planning.<sup>3</sup> In the FAQs on advance care planning services, CMS provides examples of appropriate documentation including an account of the discussion with the patient (or family members and/or surrogate) regarding the voluntary nature of the encounter; documentation indicating the explanation of advance directives (along with completion of those forms, when performed); who was present; and the time spent in the face-to-face encounter. CMS will continue to educate providers on the needs for appropriate documentation of advance care planning services.

### **OIG Recommendation**

The Centers for Medicare & Medicaid Services should instruct the MACs to recoup \$33,332 for ACP services paid in error for claims in our sample.

### **CMS Response**

CMS concurs with this recommendation. CMS will instruct its Medicare Administrative Contractors to recover the identified overpayments consistent with relevant law and the agency's policies and procedures.

### **OIG Recommendation**

The Centers for Medicare & Medicaid Services should instruct the MACs, based on the results of this audit, to notify appropriate providers (i.e., those for whom CMS determines that this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence in identifying, reporting, and returning any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation.

### **CMS Response**

CMS concurs with this recommendation. CMS will analyze OIG's data to identify appropriate providers to notify of potential overpayments. CMS will then instruct its Medicare Administrative Contractors to notify the identified providers of OIG's audit and the potential overpayment and track any returned overpayments made in accordance with this recommendation and the 60-day rule.

### **OIG Recommendation**

The Centers for Medicare & Medicaid Services should establish Medicare requirements that address the allowable frequency of ACP services and any additional documentation requirements that would apply to multiple ACP services for a single beneficiary

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<sup>2</sup> CMS, Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services, July 14, 2016. Accessed at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-advance-care-planning.pdf>.

<sup>3</sup> CMS, MLN Fact Sheet, Advance Care Planning, October 2020. Accessed at: <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/advancecareplanning.pdf>.

### **CMS Response**

CMS non-concurs with this recommendation. CMS recognizes the importance for people with Medicare to be able to access voluntary advance care planning services as they prepare for important medical decisions. It would be inappropriate for CMS to establish an allowable frequency for advance care planning services because these services are furnished at the patient's request and when the patient experiences a change in health status and/or wishes about their end-of-life care. Therefore, there is no limit on the number of times that advance care planning services can be reported for a given patient. CMS encourages practitioners to notify the patient that Part B cost sharing will apply as it does for other physicians' services when a patient elects to receive advance care planning services (except when advance care planning is furnished as part of the annual wellness visit). If advance care planning services are billed more than once, CMS encourages physicians to document the specific reasons as to why any subsequent advance care planning services are needed. CMS issued FAQs<sup>4</sup> on advance care planning services that provide examples of appropriate documentation including an account of the discussion with the patient (or family members and/or surrogate) regarding the voluntary nature of the encounter; documentation indicating the explanation of advance directives (along with completion of those forms, when performed); who was present; and the time spent in the face-to-face encounter. CMS will continue to educate providers on the needs for appropriate documentation of advance care planning services, including as described in the MLN Fact Sheet.<sup>5</sup> CMS recognizes the importance of continuing to provide Medicare beneficiaries with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments. For example, CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, provider outreach and education, investigations of potential fraud, and prepayment and post payment reviews.

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<sup>4</sup> CMS, Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services, July 14, 2016. Accessed at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-advance-care-planning.pdf>.

<sup>5</sup> CMS, MLN Fact Sheet, Advance Care Planning, October 2020. Accessed at: <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/advancecareplanning.pdf>.