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Why providers are slow to adopt new Medicare codes

By Chris Hayhurst | November 9, 2017

Over the past few years, Medicare has moved to cover two new services -- advanced care planning and chronic care management -- that have been hailed by patient advocates as innovative and necessary.

But recent analysis of claims on the athenahealth network finds that few practices are actually billing for either service.

"That surprised us," says Josh Gray, vice president of research at athenahealth. "There's real money here just sitting on the table, but almost no one seems interested in cashing in."

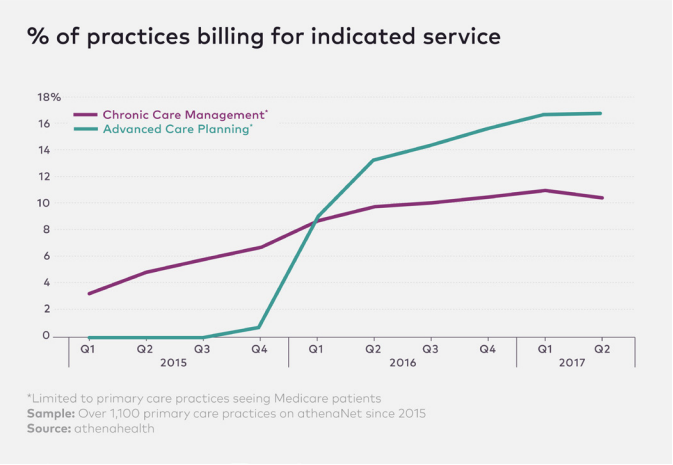
Although it's most closely associated with older patients, advance care planning (ACP) refers to end-of-life care for people of any age. In 2016, Medicare introduced CPT codes 99497 and 99498 for the service, which is well-regarded by patients -- a 2015 Kaiser Family Foundation survey found that 89 percent of survey respondents said doctors should discuss end-of-life care issues with their patients.

Chronic care management allows providers to bill for reimbursement when caring for patients with multiple chronic conditions, using code 99490, which rolled out in 2015.

Previous athenahealth research found that in the early going, few clinicians were using the codes. Now, recent athenahealth analysis, which considered Medicare claims data from 1,100 primary care practices between early 2015 and mid-June of this year, shows that uptake accelerated but has since leveled off.

"Most practices that are billing for these services started to do so within the first few months of the codes' being offered," says Gray. "But since then, the adoption rate has dropped off considerably. Most of the claims we see are coming from relatively few providers."

During the second quarter of 2017, Gray notes, just 17 percent of primary care practices filed claims for ACP, and only 10 percent billed for CCM. "What I'd like to know is, what's holding providers back?"



Billing barriers

To be sure, practices face typical barriers any time they have the opportunity to provide a new service. One clinic might find the billing process too complicated, while another might not want to contend with limitations on use or be concerned about the lack of research around reported benefits.

And then there's the challenge of finding space in the workflow: CCM offers clinics at least $43 per month for each patient to whom they provide ongoing care-coordination services, and reimbursement for ACP is $75 or more, but payments on their own don't always convince practice managers that implementation is worth their time.

"We're billing for chronic care management, and overall I'd say it's been an asset to our practice, but we're not quite there with advance care planning," says Thomas Wiggins, M.D., owner of Medical Park Family Care in Anchorage, Alaska. He and his team have run the numbers, Wiggins says, "and the time we'd have to spend meeting Medicare's guidelines is too much considering what we'd get in return."

Willamette Heart and Family Services in McMinnville, Oregon, has also come to embrace chronic care management by partnering with CareSync, a member of athenahealth's More Disruption Please program, to automate CCM tasks.

But the practice remains lukewarm about billing for ACP. "It's not that we don't offer advance care planning," says practice manager Sarah Hurty. "It's just that we have so many other things going on, we haven't incorporated it into our regular processes."

The holdup, Hurty explains, has mostly to do with the sensitive nature of the advance care discussion. "You can't just have anyone do it; it has to be a physician or another professional who's been trained to have that talk."

For clinicians in her practice, she says, that training has yet to happen, mainly because they're not sure how to fit ACP into their workflow. "So right now our physicians do it only when the patient asks, or in cases where advance care planning is obviously needed."

Plan for planning

The on-demand approach to advance care planning is certainly better than having no approach at all, says Judi Lund Person, vice president of Regulatory and Compliance for the National Hospice and Palliative Care Organization. Still, she says, practices can do better, and she's convinced that Medicare's new incentives will spur greater adoption. "I can't see any reason not to jump on this now."

Providers can go to organizations like the NHPCO with any questions they have about end-of-life conversations, Person says. She also suggests visiting online resources like the non-profit VITALtalk, and asking community hospices for training and advice.

"I've looked at the coding for ACP, and I don't think the requirements are the real issue," Person says. "I think it's more about providers being nervous — and they don't realize their patients are actually willing to talk about it."

Willamette Heart's Hurty says her practice will pursue such training eventually. She's also considering making ACP an optional component of annual wellness visits. "We'll probably put a question on the intake paperwork like, 'Are you interested in setting up a plan in case you have an accident and can't make decisions about your own care?' "

Language like that would initiate the ACP conversation and open the door to a new stream of revenue, Hurty predicts. “And I also think it would make the process less awkward,” she says. “We wouldn’t feel like we’re telling them they need to prepare to die.”

Chris Hayhurst is a writer based in Northampton, Massachusetts.