

Report in Brief

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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.