



ADVANCE CARE PLANNING Implementation for Practices

Overview

Many healthcare dollars are spent during the end of patients' lives, at least in part because many patients have not thought about or discussed how they would like to be treated – or not treated – during the final stage of their lives. While some patients have living wills or advance directives created in the context of a hospital admission or during estate planning, others may never have considered what they will want at the end of their life. Advance care planning is a service to help patients consider and prioritize their treatment goals.

While many practices have been discussing end of life issues with patients without reimbursement, now physicians or other qualified professionals may bill for these discussions. Beginning on January 1, 2016, Medicare will cover discussions related to Advance Care Planning.

To put Advance Care Planning into context, it is important to understand the differences in terminology for the various documents related to end of life planning.

Definition of Terms:

- **Living Will or Advance Directive:** This is a legal document, not a medical order. This is a document that identifies a legal representative (sometimes called a “surrogate” or “medical proxy”) and also provides general guidance about what treatment an individual would or would not want. Because it is not a medical order, it is not used to help doctors, emergency medical technicians, or hospitals treat you in an emergency situation. Every state has a sample advance directive document. (See Resources section below for how to access these samples.)
- **Power of Attorney:** A specific person may be designated to make decisions for you when you are unable to do so. It can be a spouse, adult child, family member, or friend. The power of attorney is usually part of the Advance Directive, but is sometimes a separate document because it may be broader than just healthcare decisions. Sometimes, depending on where the individual lives, it may be called a “medical (or healthcare) power of attorney,” “medical proxy,” or “healthcare agent.”
- **Physician (or Medical) Orders for Life-Sustaining Treatment (POLST or MOLST) or Physician Orders for Scope of Treatment (POST):** This document, which varies by state, is a medical order signed by a medical professional and used for treatment. It is generally used when the patient is nearing the end of life, such as with a terminal illness or seriously ill. This is the document that your doctor will discuss with you during your Advance Care Planning discussion. This does not name a “surrogate” or “medical proxy.” This document would be used together with the Living Will/Advance Directive to guide doctors in the event that the individual is unable to make his/her own decisions.

Implementation

- Advance Care Planning can occur at any time. It can be done at the same time as the Annual Wellness Visit (AWV) or as part of an E&M, Transition Care Management (TCM), or Chronic Care Management (CCM) visit. (See below for how to bill Advance Care Planning.)
- Some patients may have existing documents, such as a living will, Advance directive, or medical power of attorney. Over time, as the patient ages and conditions change, these documents may all need to evolve to accommodate these changing circumstances.
 - When scheduling the appointment, ask patients to bring any of these relevant documents with them to serve as a guide during the Advance Care Planning discussion with the physician.
 - Store these documents either as part of the medical record or in a separate place.
- Use a standard format to guide the discussion. Each state has a standard form, but there are also others available through hospice and aging organizations. Sample forms can be found using the “Resources” section below.

Although it is important to document wishes during an initial discussion, it is not intended to be a one-time decision. As a patient moves from hypothetical to actual health status changes, Advance Care Planning becomes an ongoing process that needs periodic review. Thus, after the initial planning appointment, an annual review of the end-of-life planning documents can help guide plans as patient conditions and/or attitudes change.

Billing for Advance Care Planning

The two new CPT codes describing advance care planning (ACP) services are:

- **99497** – Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; *first 30 minutes*, face-to-face with the patient, family member(s) and/or surrogate.
- **99498** – Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; *each additional 30 minutes*. (List separately in addition to code for primary procedure.)

Advance Care Planning CPT codes take effect in January 1, 2016. The work RVU for 99497 is 2.40 with an estimated payment of \$85.99 and the work RVU for 99498 is 2.09 with an estimated payment of \$74.88 (adjusted based on geography).

Medicare has not made a national coverage determination (NCD) regarding the service. In the absence of a national Medicare policy, contractors are responsible for local coverage decisions (LCD). However, by including Advance Care Planning services as an optional element of the Annual Wellness Visit (AWV) (for both the first visit and subsequent visits), beneficiaries can discuss Advance Care Planning with their clinician annually should they elect to do so.

When Advance Care Planning services occur at the same time as the Annual Wellness Visit (AWV):	When Advance Care Planning services occur during another visit (such as E&M, CCM, or TCM):
<ul style="list-style-type: none"> • Bill using <i>modifier -33</i> • No Part B coinsurance or deductible (consistent with the AWV) 	<ul style="list-style-type: none"> • Cost sharing (copay/deductible) applies as for other physicians' services

Advance Care Planning can be billed on the same day or a different day as other E/M services. It may also be used during the same service period as TCM or CCM services and within global surgical periods. This is a physicians' service, however, "incident to" rules apply when these services are furnished by a non-physician practitioner or other qualified staff member (such as a PA or NP or a licensed social worker) incident to the services of the billing clinician, including a minimum of direct supervision. Advance Care Planning may be provided by any specialty, including the primary care physician, cardiologist, oncologist, and/or other specialist.

It is important that a diagnosis or multiple diagnoses supporting the need for Advance Care Planning are properly documented in the record.

Resources/Standard Forms:

- Five Wishes – This form from Aging with Dignity can be used in 42 states and the District of Columbia. It is available for minimal cost in 28 languages either in paper form or an online version. <https://agingwithdignity.org/five-wishes/about-five-wishes>
- Physician Orders for Life Sustaining Treatment (POLST) – <http://www.polst.org/> - This website has links to the programs in every state that has an end-of-life program. (Five states currently do not: AK, AL, AR, NE, & SD.)
- Maryland's Medical Order for Life Sustaining Treatment (MOLST) - http://marylandmolst.org/pages/molst_form.htm. This form is used by NY, MA, OH, and MD.
- For patients who do not have a living will/Advance directive, the National Hospice and Palliative Care Organization has information as well as links to every state's advance directive forms. <http://www.caringinfo.org/i4a/pages/index.cfm?pageid=1>
- Decision Aids for Advance Care Planning: An Overview of the State of the Science. Mary Butler, PhD, MBA; Edward Ratner, MD; Ellen McCreedy, MPH; Nathan Shippee, PhD; and Robert L. Kane, MD. [Ann Intern Med. 2014;161\(6\):408-418](https://doi.org/10.1093/ajph.2014.104.408). This article, commissioned as a technical brief by the Agency for Healthcare Research and Quality (AHRQ), provides an overview of the science and value of different planning aids.
- Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV) - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9271.pdf>

Sample Letter for Patients

[insert logo here]

Dear Medicare Patient:

Beginning January 1, 2016, Medicare will pay for **Advance Care Planning**. This is when you and your doctor will talk about what kind of treatment you want in different circumstances at the end of your life. It may be hard to talk about, but it is important to make plans for the end of your life while you are of clear mind and sound body. During your discussion, you and your doctor will create a document that tells your doctors and your loved ones what to do in the event you cannot make a decision for yourself. You and your doctor will discuss and complete a form that will become part of your medical record. It will serve as a care plan by your doctor, or by other healthcare providers, in the event you are unable to make decisions about your care for yourself.

You may already have a living will or advance directive created at another time. If so, please bring a copy to the visit with your doctor. It will help you and your doctor talk about the different options for your care at the end of life.

This discussion may occur during your Annual Wellness Visit or separately as part of another preventive visit. You may wish to discuss this with your spouse, children, or other loved ones so that they know what you want. If you already have a living will, then bring it with you to your Advance Care Planning visit. It is good to review periodically in case your decision has changed.

Definition of Terms:

- **Living Will or Advance Directive:** This is a legal document, not a medical order. This is a document that appoints someone to be your legal representative and also provides instructions about how you wish to be treated and cared for at the end of your life. It is not used to help doctors, emergency medical technicians, or hospitals treat you in an emergency situation. If you already have a living will, please bring it to your appointment.
- **Power of Attorney:** This legal document is used for you to give a specific person the ability to make decisions for you when you are unable to do so. It can be a spouse, adult child, family member, or friend. You can also name an alternate person in case something happens to the primary person you name. The power of attorney is usually part of the Advance Directive, but is sometimes a separate document. Sometimes, depending on where you live, it is called a “medical (or healthcare) power of attorney,” “medical proxy,” or “healthcare agent.”
- **Physician (or Medical) Orders for Life-Sustaining Treatment (POLST or MOLST), or Physician Order for Scope of Treatment (POST):** This is the document that your doctor will discuss with you during your Advance Care Planning discussion. This document would be used together with your Living Will/Advance Directive to guide your loved ones and your doctors in the event that you are unable to make your own decisions.

If you are discussing Advance Care Planning with your doctor during your Annual Wellness Visit, you will not owe a copayment or deductible. If the discussion occurs during another appointment, such as a regular visit or a Chronic Care Management visit, then the usual copayments will apply.

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