Advanced Care Planning

We've observed many of our physicians providing primary care are not completing ACP services. ACP helps patients prepare for current and future decisions about their medical treatment and place of care. Unfortunately, many patients face medical decision-making at a time they lack the capacity to make decisions for themselves and end up receiving care that is discordant from their personal preferences. Please be sure to have these conversations with your patients and recognize these services are billable to Medicare on a fee-for-services basis.

Additionally, the ACO has resources to help patients who desire to have assistance in completing their ACPs. The Beaumont ACO's AIM team is trained in Advanced Care Planning and accepts referrals as needed. Please forward them to Donna Mimikos at Donna.Mimikos@beaumont.org or 947-522-0026. Additionally, the ACO has developed an ACP Tip Sheet to assist providers in delivering these services. Please click the link to view the ACP Tip Sheet.

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ADVANCE CARE PLANNING TIP SHEET

ACP is a face-to-face service between a physician or a qualified health care professional and a patient to discuss the patient's health care wishes if they become unable to make decisions about their care. As part of this discussion, the provider may talk about advance directives with or without completing relevant legal forms. An **advance directive** is a document that appoints an agent and/or records the person's wishes about their medical treatment based on personal values and preferences, to be used at a future time if the individual is unable to speak for themselves.

ELIGIBILITY: Advanced Care Planning can occur at any time. It can be done at the same time as the Annual Wellness Visit, as part of an E&M or Transition Care Management visit or Chronic Care Management visit.
If ACP service is provided outside of the AWV, Part B cost sharing (copay/deductible) would apply. ACP may be face-to-face with surrogate if patient unable to participate.

BILLING AND CODING:

There are 2 CPT codes describing advance care planning services:

- ***99497*** – Advance Care Planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by physician or other qualified health professional; *first 30 minutes (minimum of 16 minutes)*.
  The work RVU for 99497 is 2.40

- ***99498*** – Advance Care Planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by physician or other qualified health care professional; each additional 30 minutes.

  (List separately in addition to 99497. A total of at least 46 minutes)
  The work RVU for 99498 is 2.09

When Advance Care Planning services occur **at the same time** as the Annual Wellness Visit:

Bill using ***modifier -33***
No Part B coinsurance or deductible

When Advance Care Planning services occur during another visit (such as E&M, CCM or TCM):

Modifier 25 with E/M or TCM or CCM codes. Copay/deductible apply

Medicare waives the copay and deductible for ACP if following requirements are met: Provided on the same day as Medicare wellness visit (codes G0438 or G0439) by the same provider and billed with modifier –33 (Preventive Services).

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The deductible and coinsurance DO APPLY when ACP is provided outside the AWV. Time for the ACP discussion may not be used to meet the time-based criteria for an E/M service code.

FREQUENCY OF SERVICES:

There are no limits on the number of times ACP can be billed in a given time period. If the service is billed multiple times in a year, the provider should document changes in the beneficiary's health status and/or wishes regarding his or her end-of-life care. In general, as a patient's health status changes, ACP 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 or wishes change.

DIAGNOSIS:

No specific diagnosis is required for the ACP codes to be billed. It would be appropriate to report a well exam diagnosis or a condition for which counseling is provided.

PROVIDER AND LOCATION ELIGIBILITY

There are no specialty or facility limitations on the ACP codes. The codes are payable to all practitioners in all settings and are not limited to physician specialties.

Services can be provided by physicians or using a team-based approach provided by physicians, non-physician practitioners and other staff under the order and medical management of the treating physician.

When the services are furnished incident to the billing physician, all applicable state law and scope of practice requirements must be met, and there must be a minimum of direct supervision in addition to other incident to rules.

Telephonic or telehealth conversations can be billed. CMS recently added ACP codes to the list of services eligible to be furnished under the telehealth benefit.

Documentation; DOT PHRASE: .respectingchoices

- Use a standard format to guide the discussion.
- appropriate documentation may include an account of the discussion with beneficiary (or family/ surrogate) regarding value and importance of ACP
- *exploration of personal, cultural, or spiritual beliefs that might influence medical decisions.*
- can include, but does not require, completing or updating the forms.
- the names of participants
- total time spent (may include start and end time of the conversation)
- If patient has existing documents, such as a living will, advanced directive, or medical power of attorney, those documentation can serve as a guide during the Advanced Care Planning discussion.
- Store these documents either as part of the medical record or in a separate place.