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# Advance Care Planning

Implementation Guide

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# Why Advance Care Planning (ACP)?

- Eighty percent of people say, if seriously ill, they would want to talk to their doctor about end-of-life (EOL) care
- Seven percent of people report having had an EOL conversation with their doctor
- ACP is built in as part of the Medicare initial preventive physical exam (IPPE) (should be business as usual)
- ACP can be added to the annual wellness visit (AWV) for additional billing (can be business as usual) with no copay for the patient

Effective Jan. 1, 2016, the Centers for Medicare & Medicaid Services (CMS) pays for voluntary ACP under the Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Prospective Payment System (OPPS). ACP enables Medicare beneficiaries to make important decisions and give them control over the type of care they receive and when they receive it.

ACP helps to ensure patient treatment preferences are documented, regularly updated and respected. This helps make the case patients are getting what they want at the EOL, and it can start with a conversation and documentation of their preferences with their provider.

If implemented effectively, it is anticipated that ACP will introduce the following benefits to your practice and your patients:

## Benefits to Your Practice

- Enhances patient-centered care and strengthens the provider-patient relationship
- The provider will understand the patient's wishes and guide treatment accordingly
- Reduces provider distress and burn-out
- Opportunity for direct practice revenue through billing for ACP conversations
- Significant savings to the system and subsequently to the practice if participating in shared savings or shared risk payment models – According to 2004 study, around 30 percent of all Medicare expenditures relates to a beneficiary's last year of life, and 10 percent refers to the previous month of life
- Directly aligned with the Medicare Quality Payment Program (QPP) and the Merit-based Incentive Payment System (MIPS)

## Benefits to Your Patients

- Allows an individual to express their preferences on what is important at the end of their life
- More likely to have patient preferences known and honored
- Opportunity to improve their quality of life
- Reduces the emotional burden and cost of unwanted interventions
- Reduces futile care
- Reduces patient suffering
- Improves family coping
- When performed as part of the AWV, no out-of-pocket responsibility
- Reduces the burden on caregivers

# When Can ACP be Included in Your Office Practice Workflow?

- ACP as part of the AWV
- ACP as part of IPPE
- “Same-day” ACP
  - Provider elects to engage in ACP during a scheduled visit with the patient
- “Stand-alone” ACP
  - Rare; patient typically has a terminal diagnosis
- ACP services may be billed by physicians and nonphysician practitioners whose scope of practice and Medicare benefit category include the services described by the CPT codes
- No specific diagnosis is required for the ACP codes to be billed
- Not limited to physician specialties

## Durable Power of Attorney for Health Care (POA)

### Advanced Directives (AD) Documents:

- Living Will: Documents an individual’s wishes for medical care if they are unable to communicate their decisions
- Durable Power of Attorney for Health care: Gives a designated person the legal authority to make decisions on behalf of an incapacitated individual

### POLST Documents:

- POLST, Medical Orders for Scope of Treatment (MOST)
- Medical orders that can be followed by emergency medical services (EMS), hospitals and extended care facilities (ECF), transitions across care settings

| Characteristics                   | Advance Directives   | POLST   |
|-----------------------------------|--|---|
| Population                        | All Adults   | Seriously Ill   |
| Time Frame                        | Future Care  | Current Care  |
| Type of Document                  | Legal Document   | Medical Order   |
| Who Can Complete Form             | Patient  | Health Care Professional  |
| Power of Attorney for Health Care | Cannot complete, may sign. You can assist a person to complete, ask the person what they want and check the boxes for them | Can engage in discussion if patient unable                        |
| Portability                       | Patient/Family responsibility  | Provider Responsibility   |
| Periodic Review                   | Patient/Family responsibility, suggest at decade birthday, change of health, annually depending on age                     | Provider Responsibility, as needed depending on course of illness |

# How do I Implement ACP in My Practice? 4-Step Approach

This guide will help you develop your plan for successful ACP implementation by walking you through the following steps:

- *Step 1 – Prepare for ACP and Identify Eligible Patients*
- *Step 2 – Perform Outreach and Engagement*
- *Step 3 – Perform ACP Visit*
- *Step 4 – Complete Appropriate and Effective Coding and Billing*

## Step 1 - Prepare for ACP as Part of Your Visits

Questions to consider as you prepare to implement or expand your ACP program:

- What is your current ACP workflow?
- Does your electronic health record (EHR) flag completed ACP forms for you? Where are the forms stored? If forms are not available in your EHR, you will want to find other options for being able to flag or query for patients who do or do not have completed forms stored.
- Where might your staff support you? Plan for staff education on ACP.
- Do you use pre-visit IPPE or AWP calls to ask for copies of AD documents?
- Do you have billing templates?
- Are ACP-related documents easily accessible (URLs or paper copies)?

## Identify Patients for ACP Engagement

- Consider all patients coming in for AWP as a target audience.
- Use your EHR as a source for finding patients of high risk – often this is a registry report or population health report; this might be all patients over 65, those with ESRD, chronic diseases, malignancy or patients in extended care facilities.
- Ask your provider teams to identify their frail patients or patients requiring lots of attention:
  - Flag these patients in your EHR and/or pull a working list for outreach – it is recommended you organize the list by primary/preferred provider.
- Review the list of eligible patients and eliminate those who do not appear to have an urgent need for the ACP program.
- Remove patients who:
  - Are deceased
  - Moved away/no longer a patient
  - Already completed ACP within the past year or are currently in hospice care
- Establish decision support rules in your EHR to flag ACP eligible patients for on-going identification and outreach.

## Identify Patients for ACP Engagement (cont.)

Establish a patient outreach campaign which could include the following:

- Letter/postcard
- Telephone call
- Automated messages originating from the EHR
- Information available on patient portal

### Step 1 - Prepare for ACP as Part of Your Visits

#### Sample Letter

Dear Patient,

At \_\_\_\_\_ we believe in the benefits of advance care planning for everyone. At your next visit, your care provider team would like to discuss 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 while you are of clear mind and sound body. During your discussion, you and your doctor will create a document which tells providers and your loved ones what to do in the event you cannot decide for yourself. You and your doctor will discuss and complete a form which will become part of your medical record. It will serve as a care plan by your doctor, or by other health care 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.

Sincerely,

\_\_\_\_\_

As you prepare to implement Advanced Care Planning, it is advisable to develop a workflow for those involved in the process. This will assist in a smooth process if all involved know their roles. For example:

| Who             | Pre-Visit   | Visit | Post-Visit  | Yearly                        |
|-----------------|---|-------|---|-------------------------------|
| Office staff/MA | Schedule AWW – ask patient to bring any ACP documents – if none advise patient that ACP will be part of this wellness visit | None  | Ask patient for ACP documents and scan into EHR or make copies and store in an appropriate space. If documents are not complete ask patient to mail or return documents to the office | Schedule patient for next AWW |

## Step 1 - Prepare for ACP as Part of Your Visits (cont.)

| Who            | Pre-Visit  | Visit   | Post-Visit   | Yearly   |
|----------------|--|---|--|--|
| Provider       | Review chronic conditions and prep for ACP discussion  | Review ACP with Patient and family if available. Determine their needs and wishes. Documents may be completed during this visit or at another visit or the patient may complete at home and return with documents | Plan with the patient a time to return to complete documents as needed:<br><br>Advanced Directive, and/or POLST<br><br>Code and Bill | Review and update as necessary or at an urgent visit if condition worsen |
| Patient/Family | Bring any ACP documents as well as any paperwork designating a Durable Power of Attorney for Health Care | Share wishes, concerns or fears   | Review resource documents available to assist in making decisions  | Review ACP documents with provider and family                            |

## Step 2 – Perform Outreach and Engagement

For the patients determined to be good candidates for more urgent ACP services, look to see if they scheduled an office visit which will provide sufficient time to address ACP.

When you schedule AWP, ask patients to bring their ACP forms so you can review them and file them:

- If it can be added to their next appointment, consider sending an informative letter in advance with things like the purpose of the ACP, value to them, and request for them to bring their existing forms.
- If not, contact patient by telephone, letter or through the patient portal or other ways the patient has elected to receive communication.

## Step 3 – Perform ACP Visit (Medical Encounter)

Hold a conversation between the clinician and patient following a standard method aligns with patient's situation or condition and familiarity with the topic and assists you to complete needed documents. If a patient has an existing document, ensure the forms are scanned into the EHR or stored in an appropriate space.

## Step 3 – Perform ACP Visit (Medical Encounter) (cont.)

### Examples of structured conversations include:

- [Planning for End-of-Life Decisions with Your Patients](#) - American Medical Association and Stanford Medicine STEPSForward process for helping you support your patients in planning for EOL
- [Understanding Advance Directives](#) - The National Hospice and Palliative Care Organization's Caring Info patient tool to assist in understanding advance directives and how to prepare them
- [The Serious Illness Conversation Guide](#) – Ariadne Labs tool designed to support the difficult conversations with patients following diagnosis of a serious illness
- [Respecting Choices](#) – A step-based model for patients along the spectrum of current health; this resource is available for a cost for the materials

### Documentation

- If the patient does not want to discuss ACP, document EOL planning was offered but refused
- Forms do not need to be completed to bill for ACP, just document time spent on ACP and basics of the conversation (who was there, what was discussed, what you explained to the patient and family and what forms were reviewed)
- Best practice is to complete and file any appropriate ACP legal paperwork (AD, POLST, etc.). Decide where papers are stored (keep original copies? Scan into EHR?). Need to check laws for original versus copies as valid.
- If you bill for extended time on ACP, it is important a diagnosis or multiple diagnoses supporting the need for an extension are properly documented in the record

### Now What? Post-Encounter Follow-up

- The following steps should be performed in follow-up to the ACP-related visit:
- Ensure the forms are scanned in the system and available for review by others
- If the state has a Registry encourage the patient to submit their documents. Currently Nevada, Idaho have state registries. Washington, Utah, Oregon and New Mexico use [www.uslivingwillregistry.com](http://www.uslivingwillregistry.com) (there is a fee to use this site)
  - Nevada's Registry is <http://nevadalockbox.nv.gov>
  - Idaho's Registry is <https://sos.idaho.gov/Health-care-directive-registry-index>
- Invite the patient to share with their families and make these forms available to caretakers
- If appropriate, ensure the forms are shared with the care settings or providers who need to have them, send securely and with HIPAA compliance
- Support making their preferences available at the point of care including submission of completed forms to communitywide health information exchanges (HIEs)
- Update preferences as clinical situation changes

## Step 4 – Complete Appropriate and Effective Coding and Billing

99497

CPT  
CODE

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 care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498

CPT  
CODE

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 care professional; each additional 30 minutes (list separately in addition to code for primary procedure)

**Medicare waives both the coinsurance and the Medicare Part B deductible for ACP when it is:**

**NO  
COPAY**

Provided on the same day as a covered AWW

**NO  
COPAY**

Furnished by the same provider as a covered AWW

**NO  
COPAY**

Billed with modifier -33 (preventive services)

The deductible and coinsurance DOES apply when ACP is provided outside the covered AWW.

Helpful summary information sheet from the Institute for Healthcare Improvement (IHI):

<https://theconversationproject.org/wp-content/uploads/2016/06/CMS-Payment-One-Pager.pdf>

### **Are there limits on how often I can bill CPT codes 99497 and 99498?**

Per CPT, there are no limits on the number of times ACP can be reported for a given beneficiary in a given time. Likewise, CMS has not established any frequency limits. When the service is billed multiple times for a given recipient, we would expect to see a documented change in the beneficiary's health status and/or wishes regarding his or her EOL care.

Find more FAQs here: [Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning](#)

Refer to the CMS Physician Fee Schedule lookup here: <https://www.cms.gov/apps/physician-fee-schedule/>

# Where Can I get Additional Information about ACP?

## Resources for Medicare (CMS)

- [Advance Care Planning Fact Sheet](#) – A summary of the ACP services
- [Frequently Asked Questions \(FAQs\) about Billing the Physician Fee Schedule for ACP](#) – A helpful summary of FAQs regarding the ACP service codes and billing to the Physician Fee Schedule
- [End-of-Life Conversations: Medicare Reimbursement FAQs](#) – A summary document of billing FAQs and a guide for providers, part of the conversation ready project from IHI

## Forms and Tools for Providers

- [Serious Illness Conversation Guide](#) from Ariadne Labs - Provider facing one-pager with guidance on the flow of the conversation and recommended language
- [Advanced Care Planning: Implementation for Practices](#) - Toolkit by American College of Physicians (this has a good sample letter for patients)
- [National Hospice and Palliative Care Organization – CaringInfo](#) – A website with useful tools and resources
- [Leaving Well Coalition \(www.leavingwell.org\)](#) - The Leaving Well Coalition exists to ensure every person in Utah can live well to the EOL by sharing the conversation about their values, making their wishes known and receiving the care they desire. Includes links to POLST, AD forms, Spanish-language forms and patient-centered tools.

## POLST Forms

National POLST Paradigm: <http://polst.org/> - The website has links to the programs in every state who has an EOL program:

- Idaho POLST - <https://honoringchoicesidaho.org>
- Nevada POLST - <http://www.nevadapolst.org/>
- New Mexico Medical Orders for Scope of Treatment (MOST) - <http://www.nmmost.org/>
- Oregon POLST - <http://oregonpolst.org/>
- Utah POLST - <https://bemsp.utah.gov/operations-and-response/ems-operations/advance-care-directives/>
- Washington POLST - <https://wsma.org/>

## AD Forms or Websites for Each State

- Nevada - <http://dhcfp.nv.gov/Resources/PI/AdvanceDirectives/>
- New Mexico
  - General info: <https://coc.unm.edu/advance-directives/index.html>
  - AD form: <https://coc.unm.edu/common/pdf/optionalhcad.pdf>
- Oregon - <http://oregonpolst.org/advance-directives>
- Utah - <https://ucoa.utah.edu/Directives>
- Washington - <https://wsma.org>

## Patient-Facing Tools and Resources

- [Understanding Advanced Directives](#) – A summary of the basics of advance directives, the various types and how to get started on completing them
- [The Conversation Project \(theconversationproject.org\)](http://theconversationproject.org)- A website with tools and resources to support families in having the conversation about end of life care wishes, includes the following tools:
  - [Conversation Starter Kit](#) – A patient’s guide for starting the conversation with loved ones about EOL wishes
  - [Talk to Your Doctor](#) – A patient’s guide for having the conversation with their health care team about their EOL wishes
- [Patient Values Worksheet](#) – A patient work sheet to self-assess values at EOL, from the End-of-Life Washington Aging with Dignity. There may be a minimal charge for the form.

## Contact Us

Contact a project facilitator in your state for personalized assistance or fill out our [Contact Us form](#) on our website.

- [Gcox@comagine.org](mailto:Gcox@comagine.org) for Washington and Idaho
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## Advanced Care Planning COVID-19 Addendum

### The conversation Project

#### New Guide: [Being Prepared in the Time of COVID-19](#)

[Click here to download a brand new guide specific to COVID-19.](#) With the generous support from the Cambia Health Foundation, The Conversation Project and Ariadne Labs teamed up to create this new tool to help people take action and be prepared. We can’t control how this pandemic plays out. But we can control who speaks for us if we’re unable to speak for ourselves, and we can take the time to make sure they know what matters most to us. Have this conversation today.

#### [Who Will Speak For You? How to choose and be a health care proxy](#)

While this guide was created before the COVID-19 pandemic, choosing a health care proxy – the person who will make decisions about your medical care if you become unable to make them for yourself – is just as important today. This user-friendly guide offers facts and tips necessary to make sound decisions about choosing, and being, a health care proxy.

Language translations available here: <https://theconversationproject.org/starter-kits/#proxy-kit>

<https://respectingchoices.org/covid-19-resources/#planning-conversations>

Respecting Choices COVID-19 tools and resources available are currently free and open to all.

## Resources for having Proactive Planning Conversations in the context of COVID-19

| Name  | Description   | For Use By  | End-recipient                |
|---|---|---|------------------------------|
| <a href="#"><u>Proactive Care Planning for COVID-19</u></a>                                 | Conversation guide to print and use when having an ACP conversation with a patient.   | Any clinician having ACP Conversations  | Patient                      |
| <a href="#"><u>Proactive Care Planning with HC Agents for COVID-19</u></a>                  | Conversation guide to print and use when having an ACP conversation with the health care agent of a non-decisional patient.                                   | Any clinician having ACP Conversations  | Health Care Agent            |
| <a href="#"><u>Medical Priorities and Treatment Options</u></a>                             | 1-page document patient/agent to read along during the conversation. For Use in Conversation Only.  | Any clinician having ACP Conversations  | Patient or Health Care Agent |
| <a href="#"><u>Scheduling Proactive Care Planning for COVID-19</u></a>                      | Abbreviated 2-page document for use by any team members to call and schedule time a for clinician to have conversation with an individual.                    | Any staff proactively contacting individuals to schedule conversations  | Patient                      |
| <a href="#"><u>Scheduling HC Agents to Proactive Care Planning for COVID-19</u></a>         | Abbreviated 2-page document for use by any team member to call and schedule time for clinician to have conversation with the Health Care Agent of individual. | Any member of teams who are proactively contacting Health Care Agent of high-risk individuals to have ACP conversations | Health Care Agent            |
| <a href="#"><u>Recorded Webinar: How to have a proactive care planning conversation</u></a> | 26-minute video walks through the use of the Proactive Care Planning for COVID-19 conversation guide and tools in this section.                               | Clinicians who will facilitate ACP conversations  | Clinicians                   |

## ACP Materials to Share with Patients and Health Care Agents

| Name  | Description   | For Use By                              | End-recipient                    |
|---|---|---|----------------------------------|
| <a href="#"><u>Proactive Care Planning for COVID-19 for Individuals</u></a>       | The importance of knowing treatment preferences before a medical crisis | Individuals and their agents/loved ones | Individuals and their families   |
| <a href="#"><u>Proactive Care Planning for COVID-19 for Healthcare Agents</u></a> | The importance of knowing treatment preferences before a medical crisis | Health Care Agent of individuals        | Health Care Agent of individuals |