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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.

- Nearly 70 percent of Americans die in a hospital, nursing home or long-term-care facility. 
  *Centers for Disease Control and Prevention (CDC), 2005:*

- Seven out of 10 Americans say they would prefer to die at home. 
  *Time/CNN Poll, 2000:*
  http://www.time.com/time/magazine/article/0,9171,997968,00.html

- Only 25 percent of Americans die at home. 
  *CDC, 2005:*

- More than 80 percent of patients with chronic diseases say they want to avoid hospitalization and intensive care when they are dying. 
  *Dartmouth Atlas of Health Care, 2005:*

Source: *Public Broadcasting Station (PBS), Frontline – Facing Death, Nov. 10, 2010:*

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
Benefits to Your Practice (cont.)

- 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: (https://blog.medicaresolutions.com/end-of-life-care-coverage/)
- 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 non-physician 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

Advance Directives (AD) versus Provider Order of Life-Sustaining Treatment (POLST)

AD Documents:
- Living Will: Documents an individual’s wishes for medical care if they are unable to communicate their decisions
- Power of Attorney (POA): Gives a designated person the legal authority to make decisions on behalf of an incapacitated individual
Advance Directives (AD) versus Provider Order of Life-Sustaining Treatment (POLST) (cont.)

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

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

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 AWV calls to ask for copies of AD documents?
Questions to consider as you prepare to implement or expand your ACP program (cont.):

- 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 AWV 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 >65, with End-Stage Renal Disease (ESRD), malignancy, or patients who live 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 with providers and eliminate those who do not appear to be an urgent need for the ACP program – use the “Surprise Question” below. Those pulled off the list will be part of general outreach for inclusion with AWV.
- 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.

**Surprise Question:**

“Would I be surprised if this patient died within the next year?”

- Yes – Do not include on the outreach list at this time, save for review at the moment of next AWV.
- No – Include on outreach list for ACP and activate discussion for a POLST.

Establish a patient outreach campaign, which could include the following:

- Letter/postcard mailing
- Phone calls
Step 1 - Prepare for ACP as Part of Your Visits (cont.)

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,

___________

Process Steps by Role

<table>
<thead>
<tr>
<th>Who</th>
<th>Pre-Visit</th>
<th>Visit</th>
<th>Post-Visit</th>
<th>Yearly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Staff</td>
<td>Ask to bring in their living will if they have one, flag needed</td>
<td>Make copies of living will and medical POA if available</td>
<td>Share Resources Information, coding/billing</td>
<td>Recall patient to schedule AWV</td>
</tr>
<tr>
<td>Provider</td>
<td>Review chronic conditions, prep for AD versus POLST</td>
<td>Review with patient at the visit and document their wishes</td>
<td>Decide how soon should follow-up be to complete POLST, AD, coding/billing</td>
<td>Review and update yearly or at an urgent visit if condition worsens</td>
</tr>
<tr>
<td>Patient/Family</td>
<td>Review and bring living will and designate a medical POA</td>
<td>Share wishes and discuss fears, bring family along if needed</td>
<td>Look at other resources available to help make decisions, copies of documents to other care providers</td>
<td>Review wishes with other family members</td>
</tr>
</tbody>
</table>
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 AWV, 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 the patient by phone or letter to give the overview and value of ACP and invite them to schedule an appointment to meet with their provider.

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 it is updated and any changes are written down and copies shared back with the patient and family.

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 CaringInfo 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
  - Ensure that the patient has copies of their forms and has copies for loved ones
Now What? Post-Encounter Follow-up (cont.)

- 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:

- Provided on the same day as a covered AWV
- Furnished by the same provider as a covered AWV
- Billed with modifier -33 (preventive services)

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

Step 4 – Complete Appropriate and Effective Coding and Billing (cont.)

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:
• Nevada POLST - http://www.nevadapolst.org/
• New Mexico Medical Orders for Scope of Treatment (MOST) - http://www.nmmost.org/
• Oregon POLST - http://oregonpolst.org/
Forms and Tools for Providers (cont.)

AD Forms or Websites for Each State
- Nevada - [http://dhcfp.nv.gov/Resources/PI/AdvanceDirectives/](http://dhcfp.nv.gov/Resources/PI/AdvanceDirectives/)
- New Mexico
  - General info: [https://coc.unm.edu/advance-directives/index.html](https://coc.unm.edu/advance-directives/index.html)
  - AD form: [https://coc.unm.edu/common/pdf/optionalhcad.pdf](https://coc.unm.edu/common/pdf/optionalhcad.pdf)
- Oregon - [http://oregonpolst.org/advance-directives](http://oregonpolst.org/advance-directives)

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)](#) – 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 - 5 Wishes document for each state. Forms cost but are minimal.

Contact Us

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

Nevada - (702) 384-9933
New Mexico - (505) 998-9898
Oregon - (503) 279-0100
Utah - (801) 892-0155