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Advance Care Planning: Coding & Reimbursement

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Advance care planning is designed to help anyone—healthy or sick—communicate his or her wishes for medical treatment. The voluntary process involves educating patients on the types of medical decisions that may be required, encouraging advance consideration of those decisions, and letting family, caregivers, and/or surrogate decision makers know about the decisions made. Advance care planning allows patients to make decisions for care they want to receive if they are ever unable to speak for themselves. According to Joanne Lynn, MD, a geriatrician and hospice physician who heads the Center on Elder Care and Advanced Illness for the Altarum Institute, "Advance care planning is about planning for the 'what if's' that may occur across the entire lifespan."[1]

Healthcare leaders and providers must become comfortable talking about end-of-life care and death with patients, as the discussion is more important now than ever before, according to a recent report from the Institute of Medicine (IOM).[2] The report, *Dying in America*, found that end-of-life care is fragmented, which can lead to preventable hospitalizations. Creating a clear, holistic approach to integrating the clinical and social aspects of truly innovative end-of-life support into the conventional, well-established standard of care still eludes many well-intentioned stakeholders looking to bring much needed innovations into practice.[3]

For example, the Centers for Disease Control and Prevention (CDC) states that most people would prefer to die at home, yet only about one-third of adults have an advance directive expressing their wishes for end-of-life care.[1] In addition, between 65 percent and 76 percent of physicians whose patients had an advance directive were not aware that it existed. These gaps must be bridged so that patient preferences on end-of-life care are communicated before they lose the capacity to make those decisions themselves.

Understanding Advance Care Planning

Advance directives only work if the individual understands the document, his or her surrogate understands the individual's wishes, the physician is aware of the document's existence, the physician complies with the surrogate's instructions, and the document is revised as an individual's condition and goals change. Advance care planning documents include, but may not be limited to:

- Living will
- Durable power of attorney for healthcare
- Physician orders for life-sustaining treatment (POLST)
- Medical orders for life-sustaining treatment (MOLST)
- Healthcare proxy
- Do not resuscitate orders
- Organ or tissue donation.

There are a number of perceived barriers to advance care planning, including lack of patient awareness regarding the process, patient denial of death or inability to make his or her own decisions, concerns that patients may view the process as surrendering control, and lack of physician skill in initiating a discussion of end-of-life care and death. According to general practitioners, cancer patients are more involved in the process of advance care planning than non-cancer patients. Because patients with cancer often have a more predictable disease course, defining the right moment to initiate advance care planning may be easier among this patient population.[4] A 2000 survey by Steinhauser and colleagues of more than 1,400 patients, family members, or professionals involved with end-of-life care revealed that patients' most important goals are:[1]

- Pain and symptom management
- Preparation for death
- Achieving a sense of completion
- Decisions about treatment preferences
- Being treated as a "whole person."

In addition, patients strongly rated the importance of being mentally aware, understanding the course and prognosis of their disease process, the possibility of stopping treatments, options for palliative care, having funeral arrangements made, helping others, coming to peace with God or other spiritual issues, and not being a burden. Participants ranked freedom from pain as most important and dying at home as least important among criteria. In contrast to this finding, a report from the National Hospice and Palliative Medicine Organization found that the median length of time Medicare patients spent in hospice care in 2012 was only 19 days.[5]

Procedure Codes

Effective Jan. 1, 2015, clinicians can use two procedure codes for Advance Care Planning:

- **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 healthcare professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.
- **+99498**. Each additional 30 minutes. (List separately in addition to code for primary procedure.)

According to the *CPT® Manual*, a "physician or other qualified healthcare professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service.

This means that, unless there are insurer guidelines to the contrary, the individual who performs the advance care planning must be able to do so based on scope of practice and privileging, and also must bill for the service in his or her name and provider number. Additional authoritative coding guidance included in *CPT® Changes: An Insider's View 2015* states that the following elements of advance care planning must be performed and documented:

1. The performing provider performs a cognitive evaluation to determine the patient's capacity to understand risks, benefits, and alternatives to advance care planning choices.
2. The performing provider discusses the various advance care planning tools, such as living will, durable power of attorney, etc.
3. The performing provider reviews blank advance directive and orders for life-sustaining treatment forms with those present.
4. The performing provider reviews the patient's values and overall goals for treatment (e.g., the types of treatment the patient does or does not want), which may include a review of the types of life-sustaining treatments available.
5. The performing provider discusses the patient's diagnosis, prognosis, palliative care options, and procedures for avoiding hospital admission (or readmission).
6. The performing provider shares the patient's personal values and decisions and reviews the role of a designated agent as a substitute decision maker if the patient loses decisional capacity.
7. The performing provider answers all questions from the patient, family members, or surrogates.

CPT® Assistant, December 2014, provides still more information on the use of these codes. This coding reference states that the patient must have an understanding of his or her current medical condition, potential complications, and expectations of the current plan of care. This information is generally communicated using disease-specific scenarios that describe real clinical situations the patient may experience. Last, clinicians may find it necessary to periodically assess the patient's physical, emotional, social, and spiritual well-being, with regular revision of the care plan based on the changing needs of the patient and family.

The Advance Care Planning codes are time-based; therefore, the medical record must accurately identify the amount of time spent in discussion with the patient. During the time Advance Care Planning is billed, there is no active management of the patient's disease process or other services performed.

Some payers may require the following HCPCS Level II code in place of the CPT procedure codes:

- **S0257**. Counseling and discussion regarding advance directives or end-of-life care planning and decisions, with patient and/or surrogate. (List separately in addition to code for appropriate evaluation and management service.)

Medicare Coverage

Effective Jan. 1, 2016, the Centers for Medicare & Medicaid Services (CMS) established coverage and reimbursement for Advance Care Planning. The patient is responsible for coinsurance and deductible for this service, unless it is performed as part of an annual wellness visit.[6] Advance care planning services furnished on the same day, by the same provider and billed on the same claim as an annual wellness visit, are considered to be a preventive service. In order to ensure that the deductible and coinsurance are waived for the advance care planning, the procedure code(s) must

include modifier 33 (preventive services).

According to the CMS 2016 Medicare Physician Fee Schedule Final Rule:[7]

1. Advance care planning will be paid when the described service is reasonable and necessary for the diagnosis or treatment of illness or injury.
2. Since the services are by definition voluntary, Medicare beneficiaries may decline to receive them.
3. If advance care planning services are performed outside an annual wellness visit, the performing practitioner is encouraged to notify the beneficiary that Part B cost sharing will apply as it does for other physician services (e.g., coinsurance and deductible).
4. CMS plans to monitor utilization of the advance care planning codes over time to ensure that they are used appropriately.
5. When adopting CPT codes for payment, CMS generally also adopts CPT coding guidance.
6. In an exception to CPT guidelines, CMS stated, "We note that the CPT code descriptors describe the services as furnished by physicians or other qualified health professionals, which for Medicare purposes is consistent with allowing these codes to be billed by the physicians and NPPs whose scope of practice and Medicare benefit category include the services described by the CPT codes and who are authorized to independently bill Medicare for those services. Therefore only these practitioners may report CPT codes **99497** or **99498**."

   However, the agency recognized that there may be elements of the advance care planning service that are performed by qualified clinical staff under the supervision of the physician. "Accordingly, we [CMS] expect the billing physician or NPP to manage, participate and meaningfully contribute to the provision of the services, in addition to providing a minimum of direct supervision."

Although only the supervising physician or non-physician practitioner (NPP) can bill for advance care planning, the billing provider must personally document his or her meaningful contribution to the discussion and any other staff member performing services must separately document their participation.

While Medicare guidelines state that advance care planning can be charged on the same day as an annual wellness visit or other patient encounter, bundling edits prevent separate payment of advance care planning when it is performed on the same day as therapeutic treatment or other procedures. For example, advance care planning is bundled and will not be paid separately on the same day as:

- Radiation treatment management
- Clinical treatment planning
- Special treatment procedure
- Simulation
- Computer planning, including calculations and treatment devices
- Physics services
- Treatment delivery, including IMRT, SRS, SBRT, and proton therapy
- Hyperthermia
- Brachytherapy
- Hydration
- Therapeutic drug administration
- Chemotherapy treatment.

Other Payers & Regulations

Near the end of calendar year 2014, Massachusetts became the first state to require doctors, hospitals, nursing homes, and other health providers to offer end-of-life counseling to terminally ill patients.[8] The state has a sample brochure to help initiate the discussion, and there was widespread agreement in Massachusetts that more end-of-life planning is a good idea.

It is important to review individual payer policies because insurance policy requirements take precedence over other coding guidance. For example, BlueCross BlueShield of North Carolina includes the following in a Corporate Reimbursement Policy:[9]

"Care management services, which include chronic care management (**99490**), complex chronic care management (**99487**, **99489**), transitional care management (**99495, 99496**), and advance care planning (**99497, 99498, S0257**) are considered incidental to other evaluation and management services and not eligible for separate reimbursement."

Anthem in Virginia states that there is no separate payment for advance care planning, but these services are considered to be an integral component of Anthem's value-based payment innovation programs.[10]

However, PriorityHealth states that payment for advance care planning is considered preventive and not subject to co-pays, deductibles, or coinsurance.[11]

Coding Scenario 1

The physician completes all elements of advance care planning and documents that the discussion required 36 minutes. Code assignment would include only code **99497**; an additional 30-minute time increment cannot be charged unless the "midpoint" has been passed. This means that add-on code **+99498** for each additional 30 minutes would not be reported unless there was a total documented time of at least 46 minutes (30 minutes for code **99497** and at least 16 minutes for add-on code **99498**).

Coding Scenario 2

The non-physician practitioner spends 15 minutes completing the advance care planning discussion. The patient was well-versed on the topic and did not require an extensive dialogue. This service would not be separately coded and billed. In order to bill procedure code **99497** (30 minutes of discussion time), the time midpoint must be passed. This means that unless there is at least 16 minutes of documented advance care planning counseling time, there is no billable service to charge.

Coding Scenario 3

The patient presents for an established patient visit and advance care planning. The

physician documents a Level 3 established patient visit and 25 minutes of advance care planning. Codes for this encounter include **99213-25** (Level 3 established patient visit) and **99497** (first 30 minutes of advance care planning). **Modifier 25** reports that the patient visit is significant and separately identifiable from the advance care planning service. This means that medical record documentation must clearly support two separate services: the established patient visit and the advance care planning.

Coding Scenario 4

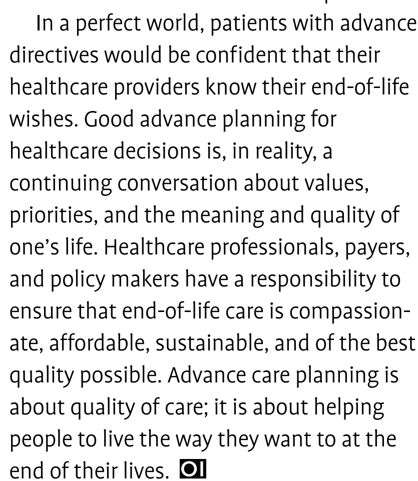
The patient presents for a subsequent Medicare annual wellness visit and advanced care planning that required 54 minutes. The physician separately documents the elements of the annual wellness visit and advanced care planning discussion. Codes for this encounter include:

- **G0439**. Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit.
- **99497-33**. Advanced care planning, first 30 minutes; preventive service.
- **+99498-33**. Advanced care planning, each additional 30 minutes; preventive service.

Closing Thoughts

End-of-life care decisions are deeply personal, and are based on individual patient values and beliefs. Death is both a human and a medical event, and patients vary greatly in what they want at the end of their lives. Some people want to continue aggressive treatment up to the time of death; these individuals are willing to endure treatment side effects and hospitalization in the hope of gaining weeks or months of additional life. Others prefer to focus on their quality of life, and may choose to concentrate on closure and comfort care in familiar surroundings, including pain control and relief from uncomfortable disease symptoms while retaining their dignity.

Most Americans living today will cope with one or more chronic conditions for an extended period of time, spend some years living with disabilities (functional and/or cognitive impairment) at the end of life, and face decisions that will affect the timing and quality of death. Public policy and healthcare systems will continue to develop more effective ways to ensure that advance care planning is routine for all adults, address the various communication styles of individuals, and ensure that patients' goals and wishes are reflected in treatment plans.[1]



In a perfect world, patients with advance directives would be confident that their healthcare providers know their end-of-life wishes. Good advance planning for healthcare decisions is, in reality, a continuing conversation about values, priorities, and the meaning and quality of one's life. Healthcare professionals, payers, and policy makers have a responsibility to ensure that end-of-life care is compassionate, affordable, sustainable, and of the best quality possible. Advance care planning is about quality of care; it is about helping people to live the way they want to at the end of their lives. OI

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