Advance Care Planning
Have you had the conversation?
What is Advanced Care Planning

• **Process** that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care.

• The **goal** of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.

• For many people, this process may include choosing and **preparing** another trusted person or persons to make medical decisions in the event the person can no longer make his or her own decisions.”
Care: Discuss wishes for future care if you became sick or hurt? Do you have someone who will speak for you if you cannot?

Choice: Review and complete a free Durable Power of Attorney for Health Care form. Consider who would act as your health care decision maker, this individual will speak on your behalf if you cannot.

Voice: Make sure everyone knows and understands your wishes. Share completed copies with your family, friends, doctors and caregivers.
Advance Care Planning Continuum

Age 18

Complete an Advance Directive

Update Advance Directive Periodically

Diagnosed with Serious or Chronic, Progressive Illness (at any age)

Complete a MOLST Form

Treatment Wishes Honored

Coalition for Compassionate Care of California. California POLST education program
# Type of Advance Care Documents

<table>
<thead>
<tr>
<th>Living Will</th>
<th>Durable Power of Attorney for Health Care</th>
<th>MOLST</th>
</tr>
</thead>
<tbody>
<tr>
<td>For anyone 18 and older</td>
<td>For anyone 18 and older</td>
<td>For terminally ill at any age</td>
</tr>
<tr>
<td>Legal form: • signed by a lawyer</td>
<td>Legal form: • Signed by patient • 2 witnesses or a notary</td>
<td>Medical Order • Signed by a physician, nurse practitioner or Physician Assistant • Signed by the decision maker or DPOA</td>
</tr>
<tr>
<td>• Allows a person to state treatments that he or she would want or would not want towards the end of their life.</td>
<td>Appoints a decision maker</td>
<td>• Allows the decision maker to determine the wanted care • Makes decisions into a medical order</td>
</tr>
<tr>
<td></td>
<td>In effect if unable to communicate their wishes for medical treatment for themselves.</td>
<td>Medical order that is portable across all care settings</td>
</tr>
</tbody>
</table>

Maureen Glynn, ESQ
Starting the Conversation

Who are the supports in your life?

Who should speak for you if you cannot speak for yourself?

Have you ever thought about the kind of care you’d want if you got really sick someday?
## Use of ACP Medicare Billing Codes in US

<table>
<thead>
<tr>
<th>Year</th>
<th># Medicare beneficiaries 65 and older</th>
<th># ACP visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>496,085</td>
<td>538,275</td>
</tr>
<tr>
<td>2017</td>
<td>574,802</td>
<td>633,214</td>
</tr>
</tbody>
</table>

JAMA Internal Medicine March 11, 2019
Belanger, Loomer, Teno, Mitchell, Adhikari, Gozalo
## Use of ACP Medicare Billing Codes in RI

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Beneficiaries</th>
<th>Total # of ACP Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>179,324</td>
<td>2,526</td>
</tr>
<tr>
<td>2017</td>
<td>Unavailable</td>
<td>Unavailable</td>
</tr>
</tbody>
</table>

Jama Internal Medicine March 11, 2019
Pelland, Morphis, Harris, Gardner
Among 2017 ACP Claims

- 63.2% billed in the office setting
- 10.1% in patient setting
- 17.6% nursing home setting
- 40% during annual wellness visit

Jama Internal Medicine March 11, 2019
Pelland, Morphis, Harris, Gardner
What are CMS ACP Codes

- Effective January 1, 2016
- Reimbursing qualified health care providers if they choose to have advance care planning, hospice, or end-of-life discussions with their Medicare patients
  - No Co-pay if done on Wellness exam
  - Can bill more than once
Documentation

1. Who was present
2. Total time in minutes
3. What was discussed
4. Review of DPOA, MOLST
5. Outcome of the conversation
6. Given the opportunity to decline
ACP Billing Codes

99497
• Covers a discussion of advance directives with the patient, family member, or other representative with or without completing relevant legal forms for up to 30 minutes
• Average Reimbursement: $85

99498
• Additional code that covers an additional 30 minutes of discussion regarding
• Average Reimbursement: Additional $75
### Advanced Care Planning Documentation

<table>
<thead>
<tr>
<th>Time Range</th>
<th>Code(s) Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-45 minutes</td>
<td>Use 99497</td>
</tr>
<tr>
<td>46-75 minutes</td>
<td>Use 99497 + 99498</td>
</tr>
<tr>
<td>76-104 minutes</td>
<td>Use 99497 + 99498 + 99498</td>
</tr>
</tbody>
</table>
“Incident to”

- Provider initiates the discussion and available for any patient questions
- A licensed team member provides further education on the details of ACP with the provider ‘supervision
I’d like to introduce you to our nurse who will talk with you about choosing a medical decision maker advocate and discuss how you might have a conversation with that person.
For more information, visit:

www.myccv.org

www.ihi.org/CMSpayment