



# Advance Care Planning

## Have you had the conversation?



VNA of Care New England  
A MEMBER OF CARE NEW ENGLAND

# 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.”



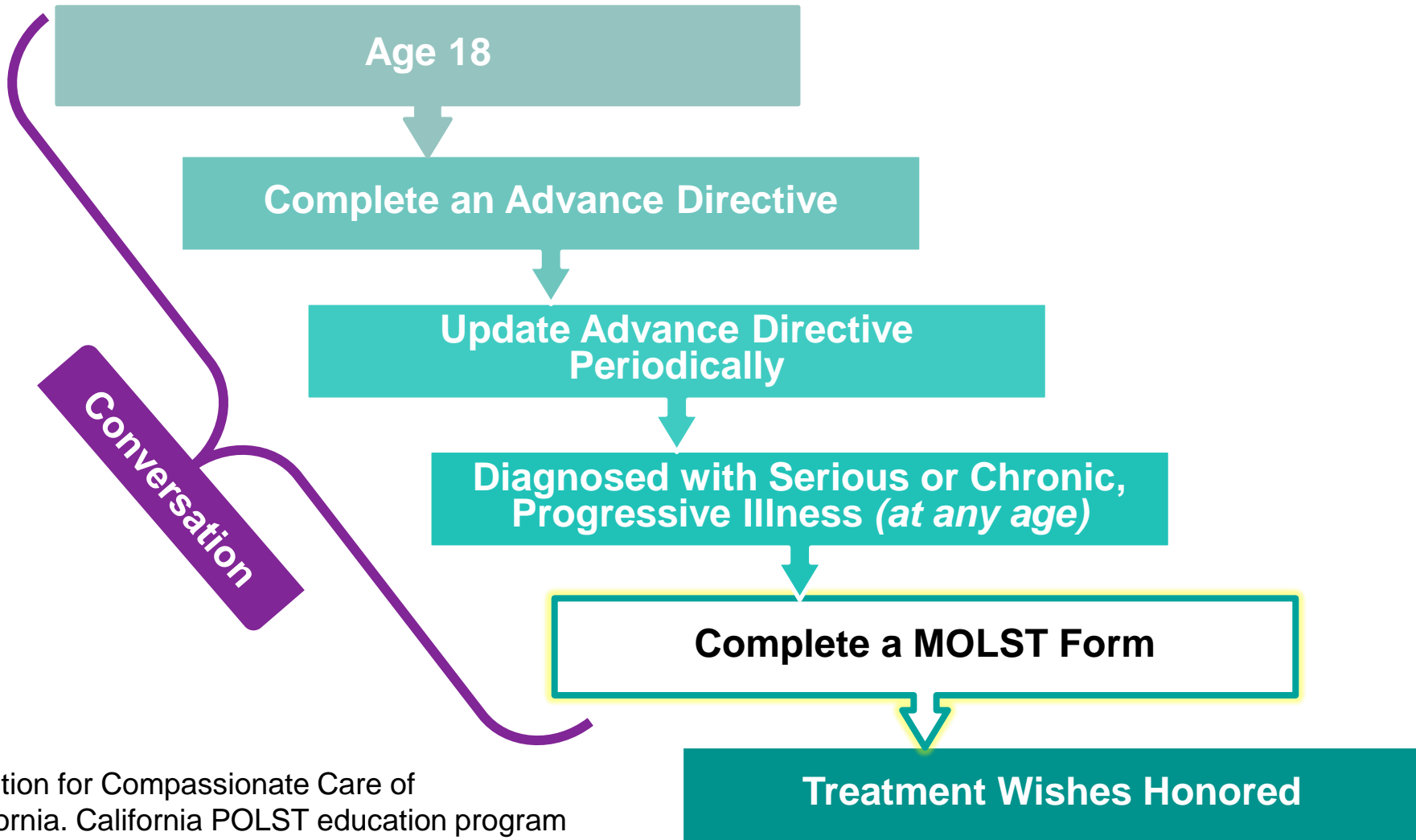
**Care:** Discuss wishes for future care if you became sick or hurt? Do you have someone who will speak for you if you cannot?

**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



Coalition for Compassionate Care of California. California POLST education program

# Type of Advance Care Documents

Living Will	Durable Power of Attorney for Health Care	MOLST
For anyone 18 and older	For anyone 18 and older	For terminally ill at any age
Legal form: <ul style="list-style-type: none"> <li>signed by a lawyer</li> </ul>	Legal form: <ul style="list-style-type: none"> <li>Signed by patient</li> <li>2 witnesses or a notary</li> </ul>	Medical Order <ul style="list-style-type: none"> <li>Signed by a physician, nurse practitioner or Physician Assistant</li> <li>Signed by the decision maker or DPOA</li> </ul>
<ul style="list-style-type: none"> <li>Allows a person to state treatments that he or she would want or would not want towards the end of their life.</li> </ul>	Appoints a decision maker	<ul style="list-style-type: none"> <li>Allows the decision maker to determine the wanted care</li> <li>Makes decisions into a medical order</li> </ul>
	In effect if unable to communicate their wishes for medical treatment for themselves.	Medical order that is portable across all care settings

# 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

Year	# Medicare beneficiaries 65 and older	# ACP visits
2016	496,085	538,275
2017	574,802	633,214

JAMA Internal Medicine March 11, 2019

Belanger, Loomer, Teno, Mitchell, Adhikari, Gozalo

# Use of ACP Medicare Billing Codes in RI

Year	Total Beneficiaries	Total # of ACP Visit
2016	179,324	2,526
2017	Unavailable	Unavailable

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

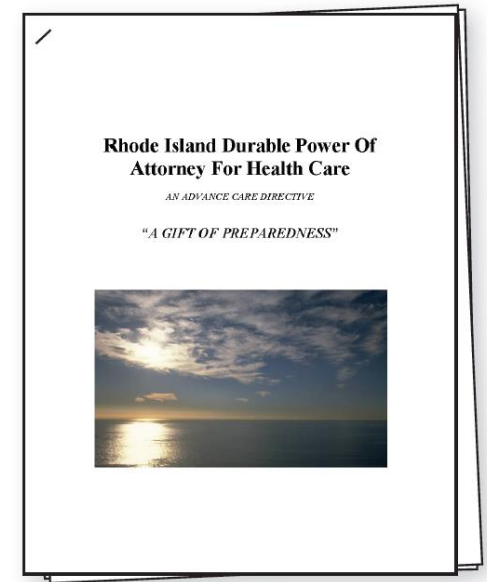
# What are CMS ACP Codes

- 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

<b>16-45 minutes</b>	<b>Use 99497</b>
<b>46-75 minutes</b>	<b>Use 99497 + 99498</b>
<b>76-104 minutes</b>	<b>Use 99497 + 99498 + 99498</b>

# “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

## ‘Incident To’ Conversation

**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](http://www.myccv.org)

[www.ihl.org/CMSPayment](http://www.ihl.org/CMSPayment)