Advance Care Planning - Coding and Billing

Advanced Care Planning CPT codes:

99497 - Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by a 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 (add separately in addition to code 99497)

ACP documentation if patient has capacity:

Advance Care Planning services were explained to the patient. The patient was competent to make decisions on their behalf and the conversation was offered as voluntary and the patient given an opportunity to decline the services. The patient chose to have the discussion and in the course of discussion the risks, benefits, and alternatives to the advance directive options were reviewed. The patients values and overall goals for treatment were discussed. The patients options for palliative and end-of-life care, should the time arise, and how to avoid hospital readmissions were discussed and reviewed. The Colorado MOST form was reviewed with the patient and family. The form was signed along with a documented change in health status and/or wishes regarding end-of-life care. 16 minutes was spent discussing Advance Care Planning.

ACP documentation if patient lacks capacity:

Advance Care Planning services were explained to the health care proxy or MDPOA. The health care proxy or MDPOA was present and able to make decisions on behalf of the patient. The conversation was offered as voluntary and the health care proxy or MDPOA given an opportunity to decline the services. The health care proxy or MDPOA chose to have the discussion and in the course of discussion the risks, benefits, and alternatives to the advance directive options were reviewed. The patient's values and overall goals for treatment were discussed. The patients options for palliative and end-of-life care, should the time arise, and how to avoid hospital readmissions were discussed and reviewed. The Colorado MOST form was reviewed with the health care proxy or MDPOA. The form was signed along with a documented change in health status and/or wishes regarding end-of-life care. 16 minutes was spent discussing Advance Care Planning

You may report advance care planning CPT codes in the following situations:

- Advance care planning is the primary service delivered in a patient visit. These code(s) can be used alone.
- Evaluation and Management (E/M) and advance care planning services can be provided on the same day. Both codes should be reported with modifier-25 added.
- Advance care planning can be reported during a Medicare Annual Wellness Visit (AWV). The AWV CPT code should be reported with modifier-33 added to avoid a patient copay.
- Advance care planning services can be reported on the same day as Transitional Care Management (TCM) and Chronic Care Management (CCM) services.

Practical Advice:

In the nursing home setting the ACP discussion and CPT code billing occur most commonly when patients are Full Code and change to DNR after the discussion, OR patients are DNR and add a designation of do-not-hospitalize after the discussion. These discussions typically last the required 16min to walk through all the discussion points for changing code status or reasons to be do-not-hospitalize. Reviewing a MOST form with a patient or MDPOA in which they do not change the code status or any other changes in wishes regarding end-of-life care typically does not last the minimum required 16min. Therefore it is beneficial for a Physician or APP in the SNF/LTC setting to be the ones having the ACP conversations all the time. Either it will not take much time because they are not changing anything or it takes the required 16min to bill for ACP because they are changing their code status or end-of-life care preferences. These are meaningful and valuable conversations that promote less costly and more humane approaches to end of life care.