Advance Care Planning

Advance care planning's (ACP) mission is to help ensure that patients receive medical care consistent with their values, goals and preferences during serious and/or chronic illness. ACP is used to help understand patients' values and encourage their thinking about the future in a non-threatening manner.

During ACP conversations, it is important to keep a record of your interaction with the patient. This guide provides the guidelines for documenting ACP conversations and an example to help you along the way. A section for coding tips is also provided to assist you with billing.

Document the Conversation

Use the following checklist when documenting your ACP conversation:

- Patient name or healthcare agent name
- Voluntary nature of the conversation
- Topics discussed
- Documents discussed/completed
- Medical necessity for the conversation
- Start/end time of the conversation

Documentation Example

Include the following topics when documenting your ACP conversation:

Patient Name: If the patient is able to participate and willing to discuss ACP.

OR

Healthcare Agent Name: If the patient is unable to participate and the healthcare agent was willing to discuss ACP for [Patient Name]. [Patient Name] was unable to participate in this conversation due to [explanation].

Current Medical State of the Patient: This section can include the reason for ACP, Annual Wellness Visit, change in clinical status, recent hospitalization or patient expressed interest in ACP.

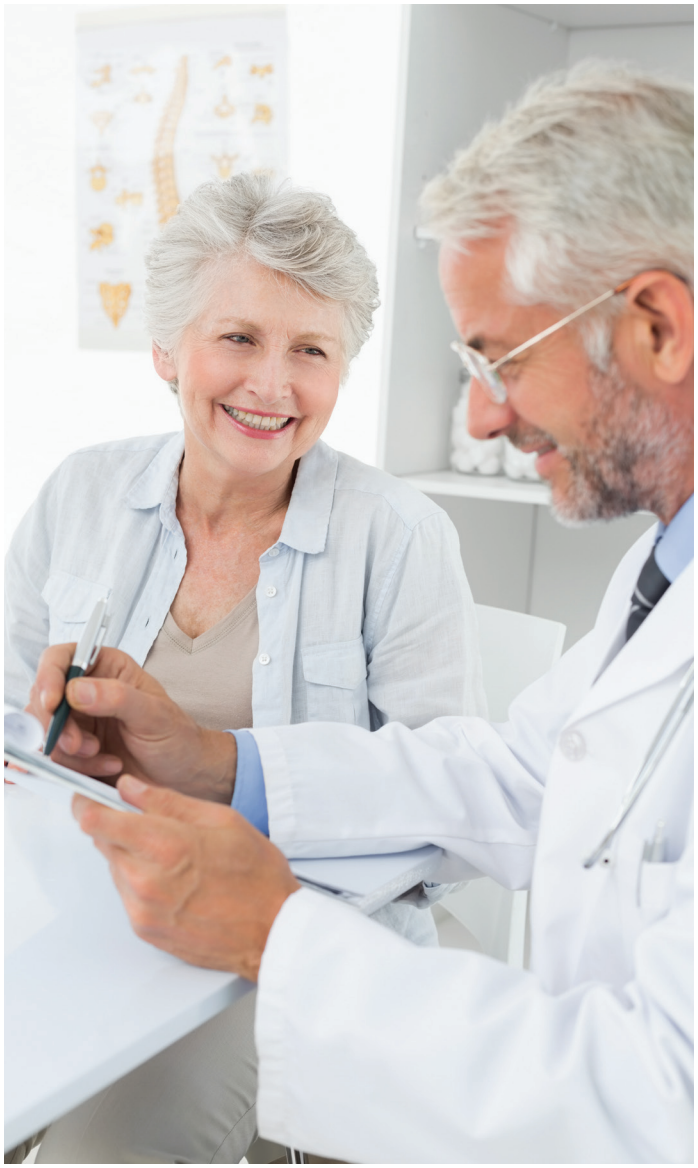
Voluntary Nature of the Discussion: Although this information may vary from patient to patient, review the following topics:

- Identification of a healthcare proxy and inclusion of proxy in discussions.
- The value and importance of ACP.
- Patient/family experiences with someone who has been seriously ill or couldn't speak for himself or herself.
- Exploration of personal, cultural or spiritual beliefs that might influence medical decisions.
- Exploration of care goals in the event of a sudden injury or illness. Include any interventions or procedures patients would or would not want in the event they were unable to speak for themselves. You can tailor this to the patient's personal medical situation.

Documents Discussed/Completed: The following documents were discussed and/or completed as needed or desired.

- Advance directive
- Power of attorney for healthcare
- Physician Orders for Life-Sustaining Treatment (POLST)

Start time: _____ **End time:** _____



Coding Tips

Use the following CPT/ICD-10 codes to file any ACP claims:

ACP Claims	
Code	**Description**
99497	Advance care planning includes the explanation and discussion of advance directives such as standard forms (upon the completion of such forms when performed). ACP is performed by the physician or other qualified health care professional involving the 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).
Z51.5	Encounter for palliative care
Note: By filing ICD-10 code Z51.5, the patient is eligible for palliative care exclusions from their HEDIS measures.	

Use the following modifiers when reporting ACP codes with other services:

ACP Codes With Other Services	
Modifier	**Description**
-25	When reporting with all other E/M codes, except when reporting critical care codes.
-33	When reporting with Medicare Annual Wellness Visit to avoid patient copay.

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ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO).