Priority Health	BILLING POLICY No. 001
ADVANCE CARE PLANNING	
Effective date: Nov. 11, 2024 **Date of origin: Sept. 2024**	**Review dates: 2/2025,08/2026**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual agreements and industry standards for Advance Care planning.

DEFINITION

Advance care planning (ACP) is a process that enables individuals to make plans about their future health care. Advance care plans provide direction to health care professionals when a person can't either make and/or communicate with their own health care choices. ACP applies to adults at all stages of life. Participation in ACP has been shown to reduce stress and anxiety for patients and their families and lead to improvements in end-of-life care.

ACP services may include conversations regarding advanced directives, including assisting the patient in completing legal forms.

The main components of ACP include the nomination of a substitute decision maker and the completion of an advance care directive.

BILLING, COMMERCIAL PLANS

ACP benefits should only be coded multiple times when a member has a change in health status or wishes. ACP services are reimbursable as a preventive service once per quarter. Additional billings will be considered if documentation supports a change in health status or wishes. Cost share may apply – see plan benefits.

ACP services are time-based. This time should only include the period of ACP discussion and not any time spent on concurrent services. The time associated with ACP must be documented in the medical record.

Codes

Advance care planning includes the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional.

- **99497**: First 16 to 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- **99498**: Each additional 30 minutes

ACP conversations lasting less than 15 minutes should be included in another E&M code

Modifiers

Modifier 33 should be billed when considered a preventive service.

Diagnosis (DX)

The DX should pertain to the condition leading to ACP.

Documentation required

- Indication that the visit was voluntary
- Who was present for the visit
- A designated person to make decisions on behalf of the patient if the patient cannot speak for themselves
- Preferred types of medical care
- Preferred comfort level
- Any change of health status from previous ACP visit
- Indication of whether an advance directive or POLST (physician orders for life-sustaining treatment) document has been completed and explanation of any advanced directive

BILLING, MEDICARE

Billed with an annual wellness visit

ACP services will be paid as preventive once per year if billed with an annual wellness visit (AWV). This must be billed on the same day and by the same provider as the AWV. A change in health status or wishes isn't required for services billed with the AWV.

Not billed with an annual wellness visit

ACP is covered as a separately billed service subject to the member's deductible and cost share if not a voluntary element during the AWV. ACP benefits should only be coded multiple times per year when a member has a change in health status or wishes. Changes must be included in the documentation.

ACP services are time-based. This time should only include the period of ACP discussion and not any time spent on concurrent services. Time associated with ACP must be documented in the medical record.

Codes

ACP includes the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional.

- **99497**: First 16 to30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- **99498**: Each additional 30 minutes

ACP conversations lasting less than 15 minutes should be included in another E&M code.

Modifiers

When billed as part of an AWV codes 99497 and 99498 should be billed on the same claim as AWV using modifier 33.

Diagnosis

The DX should pertain to the condition leading to ACP.

Documentation required

- Indication that the visit was voluntary
- Who was present for the visit
- A designated person to make decisions on behalf of the patient if the patient can't speak for themselves
- Preferred types of medical care
- Preferred comfort level
- Any change of health status from previous ACP visit
- Patient consent for ACP performed as part of an AWV
- Indication of whether an advance directive or POLST (physician orders for life-sustaining treatment) document has been completed and explanation of any advanced directive

PROVIDERS ELIGIBLE TO BILL ACP

ACP/counseling is payable to any qualified health professional as defined by the state with the training necessary to provide this service.

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry-standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 4, 2025	Added "Disclaimer" section
August 2026	Reviewed, no updates