Priority Health	**BILLING POLICY No. 001**
ADVANCE CARE PLANNING	
Effective date: Nov. 11, 2024 **Date of origin: Sept. 2024**	**Review dates: None yet recorded**

APPLIES TO

- Commercial HMO, EPO, POS, and PPO group plans (fully funded and self-funded)
- Commercial MyPriority HMO, POS, and PPO individual plans
- Medicare plans, individual and employer group
- For Medicaid plans, see the Medicaid Provider Manual

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 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.

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 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.

CHANGE / REVIEW HISTORY

Date	Revisions made