Advance Care Planning

Application for Primary Care

Objectives

- Identify the advanced directive documents and how to complete them.
- Explain the components of the Texas MOST form
- Discuss challenges with completion of advanced directives in those with different stages of cognitive impairment or who may be incapable of decision making.
- Review billing and coding for Advanced Care Planning

Advanced Care Planning Discussions

Why talk about end of life wishes?

"Having these discussions early, before people get to a point where they cannot speak for themselves anymore, is essential so that we can carry out their wishes to the fullest extent possible."

2nd year osteopathic medical student

Advanced Care Planning Discussions

Not 'one size fits all' and must be individualized to patient readiness and stage of health

Advances Directives

THEY'RE EASY TO COMPLETE! THEY'RE ONLINE!

Advanced Directive Documents

- MPOA – Medical Power of Attorney
- Directive to Physicians and Family or Surrogates

Additional documents

- OOH DNR - Out of Hospital Do Not Resuscitate order
- Texas MOST Form - **M**edical **O**rders for **S**cope of **T**reatment

MPOA – Medical Power of Attorney

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself.

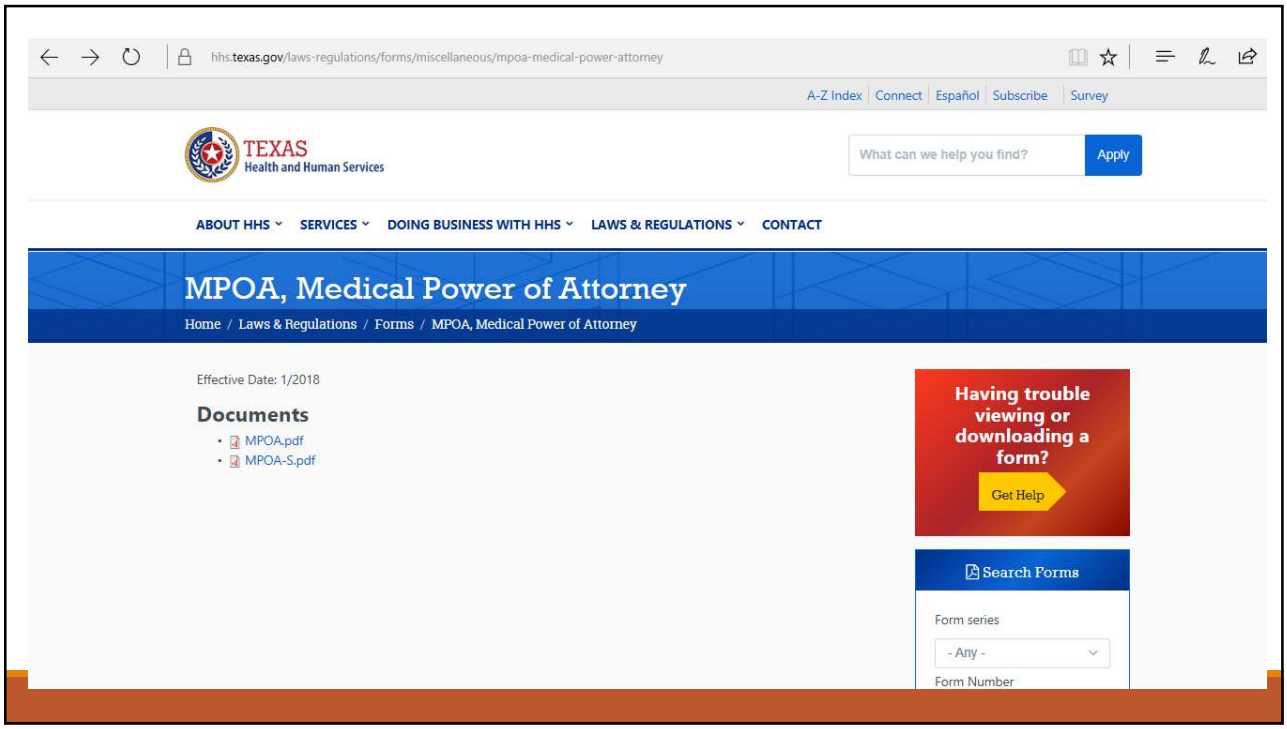
MPOA – Medical Power of Attorney

Also known as a Proxy Decision Maker, Surrogate Decision Maker, or Health Care Agent

Available online

Requires either 2 witness or a public notary

Does not require an attorney



Directive to Physicians

Directive to Physicians and Family or Surrogates

Also known as a Living Will

Available online

Requires either 2 witness or a public notary

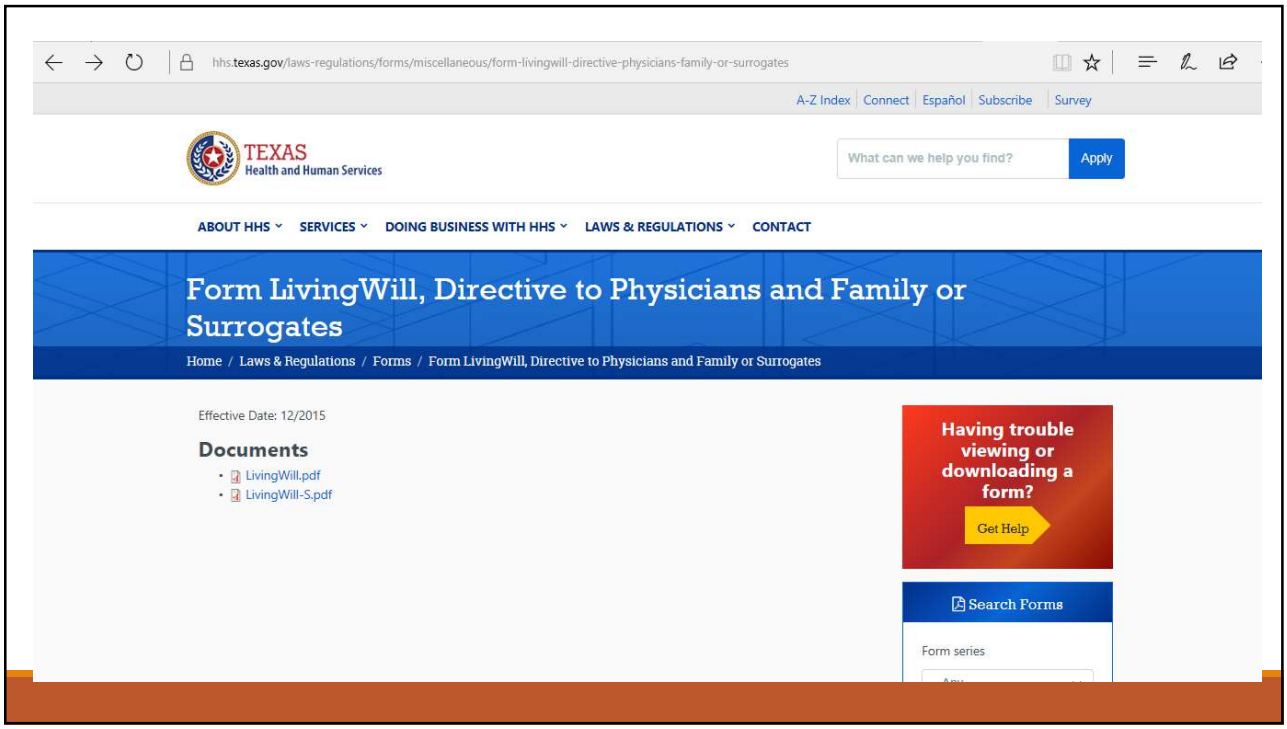
Does not require an attorney

Directive to Physicians

- 2 choices that apply to TERMINAL or IRREVERSIBLE Condition:
  - ____I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR
  - ____I request that I be kept alive in this terminal condition using available life-sustaining treatment.

Directive to Physicians - Definitions

- **Terminal Condition** – It is expected that the patient will die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care
- **Irreversible Condition** - The patient cannot care for him/herself or make decisions for hime/herself and is expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care.



Out of Hospital Do Not Resuscitate Order

Also know as:

"code status", "resuscitation status", "AND or Allow Natural Death", "DNAR or Do not Attempt Resuscitation"

Available online

Requires either 2 witness or a public notary

Does not require an attorney

DOES require a PHYSICIAN's signature

Not recognized within the hospital

Everyone who signs the document signs it TWICE

Figure: 25 TAC §157.25 (b)(2)

OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER
TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DO NOT RESUSCITATE

Person's full legal name — Date of birth — ☐ Male ☐ Female

A. Declaration of the adult person I am competent and at least 18 years of age. **I direct that none of the following resuscitation measures be initiated or continued for me:** cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Person's signature — Date — Printed name

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:

I am the: ☐ legal guardian, ☐ agent in a Medical Power of Attorney OR ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person:** cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature — Date — Printed name

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.039.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person:** cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature — Date — Printed name

D. Declaration by physician based on directive to physicians by a person now incompetent or noncapable communication to the physician by a competent person I am the above-noted person's attending physician and have:

☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent, OR ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature — Date — Printed name — Unit

E. Declaration on behalf of the minor person I am the minor's ☐ parent, ☐ legal guardian, OR ☐ managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. **I direct that none of the following resuscitation measures be initiated or continued for the person:** cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature — Date

Printed name

TWO WITNESSES (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature — Date — Printed name

Witness 2 signature — Date — Printed name

Notary in the State of Texas and County of _____. The above-noted person personally appeared before me and signed the above-noted declaration on this date: _____

Signature & seal: _____ Notary's printed name: _____ *Notary Seal*

[Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner.]

PHYSICIAN'S STATEMENT I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical record. **I direct health care professionals** acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Physician's signature — Date — License #

Printed name

*** Directive by two physicians** on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative. The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. **I direct** health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature — Date — Printed name — Unit

Signature of second physician — Date — Printed name — Unit

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.003(1).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature — Guardian/Agent/Proxy/Relative signature

Attending physician's signature — Second physician's signature

Witness 1 signature — Witness 2 signature — Notary's signature

This document or a copy thereof must accompany the person during his/her medical transport.

Texas MOST

MOST is a physician order set and care planning tool based upon patient treatment preferences that travels with the patient from one site of treatment to another.

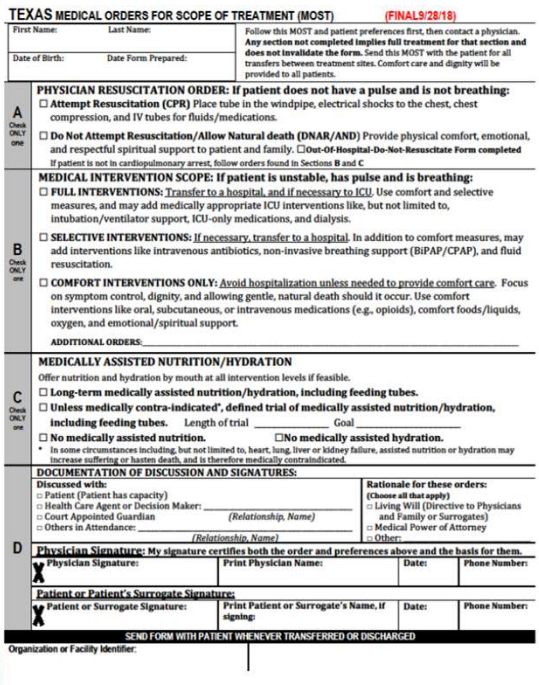
MOST

Also know as: **M**edical **O**rders for **S**cope of **T**reatment

Available online

Requires a Physician's signature

Trained facilitators can assist



TEXAS MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST) (FINAL9/28/18)

First Name: Last Name:

Date of Birth: Date Form Prepared:

Follow this MOST and patient preferences first, then contact a physician. **Any section not completed implies full treatment for that section and does not invalidate the form.** Send this MOST with the patient for all transfers between treatment sites. Comfort care and dignity will be provided to all patients.

A Check ONLY one

PHYSICIAN RESUSCITATION ORDER: If patient does not have a pulse and is not breathing:

☐ **Attempt Resuscitation (CPR)** Place tube in the windpipe, electrical shocks to the chest, chest compression, and IV tubes for fluids/medications.

☐ **Do Not Attempt Resuscitation/Allow Natural death (DNAR/AND)** Provide physical comfort, emotional, and respectful spiritual support to patient and family. ☐**Out-Of-Hospital-Do-Not-Resuscitate Form completed**

If patient is not in cardiopulmonary arrest, follow orders found in Sections **B** and **C**

B Check ONLY one

MEDICAL INTERVENTION SCOPE: If patient is unstable, has pulse and is breathing:

☐ **FULL INTERVENTIONS:** Transfer to a hospital, and if necessary to ICU. Use comfort and selective measures, and may add medically appropriate ICU interventions like, but not limited to, intubation/ventilator support, ICU-only medications, and dialysis.

☐ **SELECTIVE INTERVENTIONS:** If necessary, transfer to a hospital. In addition to comfort measures, may add interventions like intravenous antibiotics, non-invasive breathing support (BiPAP/CPAP), and fluid resuscitation.

☐ **COMFORT INTERVENTIONS ONLY:** Avoid hospitalization unless needed to provide comfort care. Focus on symptom control, dignity, and allowing gentle, natural death should it occur. Use comfort interventions like oral, subcutaneous, or intravenous medications (e.g., opioids), comfort foods/liquids, oxygen, and emotional/spiritual support.

ADDITIONAL ORDERS: _____

C Check ONLY one

MEDICALLY ASSISTED NUTRITION/HYDRATION

Offer nutrition and hydration by mouth at all intervention levels if feasible.

☐ **Long-term medically assisted nutrition/hydration, including feeding tubes.**

☐ **Unless medically contra-indicated*, defined trial of medically assisted nutrition/hydration, including feeding tubes.** Length of trial _____ Goal _____

☐ **No medically assisted nutrition.** ☐**No medically assisted hydration.**

* In some circumstances including, but not limited to, heart, lung, liver or kidney failure, assisted nutrition or hydration may increase suffering or hasten death, and is therefore medically contraindicated.

D

DOCUMENTATION OF DISCUSSION AND SIGNATURES:

Discussed with:
- ☐ Patient (Patient has capacity)
- ☐ Health Care Agent or Decision Maker: _____ *(Relationship, Name)*
- ☐ Court Appointed Guardian
- ☐ Others in Attendance: _____ *(Relationship, Name)*

Rationale for these orders: **(Choose all that apply)**
- ☐ Living Will (Directive to Physicians and Family or Surrogates)
- ☐ Medical Power of Attorney
- ☐ Other: _____

Physician Signature: My signature certifies both the order and preferences above and the basis for them.

X **Physician Signature:**	**Print Physician Name:**	**Date:**	**Phone Number:**

Patient or Patient's Surrogate Signature:

X **Patient or Surrogate Signature:**	**Print Patient or Surrogate's Name, if signing:**	**Date:**	**Phone Number:**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Organization or Facility Identifier:

MOST

- Section A: Physician Resuscitation Order
- Section B: Medical Intervention Scope
- Section C: Medically Assisted Nutrition/Hydration
- Section D: Documentation of Discussion and Signatures

MOST

- Section A: Physician Resuscitation Order (2 Choices)
  - CPR
  - DNAR

A Check ONLY one

PHYSICIAN RESUSCITATION ORDER: If patient does not have a pulse and is not breathing:

☐ **Attempt Resuscitation (CPR)** Place tube in the windpipe, electrical shocks to the chest, chest compression, and IV tubes for fluids/medications.

☐ **Do Not Attempt Resuscitation/Allow Natural death (DNAR/AND)** Provide physical comfort, emotional, and respectful spiritual support to patient and family. ☐**Out-Of-Hospital-Do-Not-Resuscitate Form completed**

If patient is not in cardiopulmonary arrest, follow orders found in Sections **B** and **C**

MOST

- Section B: Medical Intervention Scope (3 choices)
  - Full Interventions
  - Selective Interventions
  - Comfort Measures Only

B
Check ONLY one

MEDICAL INTERVENTION SCOPE: If patient is unstable, has pulse and is breathing:

☐ **FULL INTERVENTIONS:** Transfer to a hospital, and if necessary to ICU. Use comfort and selective measures, and may add medically appropriate ICU interventions like, but not limited to, intubation/ventilator support, ICU-only medications, and dialysis.

☐ **SELECTIVE INTERVENTIONS:** If necessary, transfer to a hospital. In addition to comfort measures, may add interventions like intravenous antibiotics, non-invasive breathing support (BiPAP/CPAP), and fluid resuscitation.

☐ **COMFORT INTERVENTIONS ONLY:** Avoid hospitalization unless needed to provide comfort care. Focus on symptom control, dignity, and allowing gentle, natural death should it occur. Use comfort interventions like oral, subcutaneous, or intravenous medications (e.g., opioids), comfort foods/liquids, oxygen, and emotional/spiritual support.

ADDITIONAL ORDERS:_____

MOST

- Section C: Medically Assisted Nutrition/Hydration
  - Long-term medically assisted nutrition/hydration, including feeding tubes
  - Unless medically contra-indicated, defined trial of medically assisted nutrition/hydration, including feeding tubes (Length of trial _____ Goal _____)
  - No medically assisted nutrition or hydration

C
Check ONLY one

MEDICALLY ASSISTED NUTRITION/HYDRATION

Offer nutrition and hydration by mouth at all intervention levels if feasible.

☐ **Long-term medically assisted nutrition/hydration, including feeding tubes.**

☐ **Unless medically contra-indicated*, defined trial of medically assisted nutrition/hydration, including feeding tubes.** Length of trial _____ Goal _____

☐ **No medically assisted nutrition.** ☐ **No medically assisted hydration.**

* In some circumstances including, but not limited to, heart, lung, liver or kidney failure, assisted nutrition or hydration may increase suffering or hasten death, and is therefore medically contraindicated.

MOST

- Section D: Documentation and Signatures
  - Discussed with:
    - Patient
    - Health Care Agent or Decision Maker
    - Court Appointed Guardian
    - Others in Attendance
  - Rationale for these orders:
    - Living Well
    - Medical Power of Attorney
    - Other
  - Physician Signature
  - Patient or surrogate Signature
  - Document name of facilitator if applicable

D

DOCUMENTATION OF DISCUSSION AND SIGNATURES:

Discussed with:	**Rationale for these orders:** (Choose all that apply)
□ Patient (Patient has capacity) □ Health Care Agent or Decision Maker: _____ (Relationship, Name) □ Court Appointed Guardian □ Others in Attendance: _____ (Relationship, Name)	□ Living Will (Directive to Physicians and Family or Surrogates) □ Medical Power of Attorney □ Other: _____

Physician Signature: My signature certifies both the order and preferences above and the basis for them.

X **Physician Signature:**	**Print Physician Name:**	**Date:**	**Phone Number:**

Patient or Patient's Surrogate Signature:

X **Patient or Surrogate Signature:**	**Print Patient or Surrogate's Name, if signing:**	**Date:**	**Phone Number:**

POLST or MOST Paradigm

- **M**edical **O**rders for **S**cope of **T**reatment
- **P**hysician **O**rders for **L**ife **S**ustaining **T**reatment
- It is both a physician order set and a care planning tool
- Used as a tool for discussing and documenting treatment preferences for end of life treatment
- Does not replace MPOA, Advanced Directive, or OOH-DNR

Rationale for MOST + Advance Directive

- Advanced Directives may not be available when needed (not transferred with the patient)
- Advanced Directives may not be as specific
- Advanced Directives may be difficult to apply to emergent situations
- Advanced Directives do not immediately translate into medical orders

Intent of MOST

- To help deliver the treatment that is wanted and needed at the end of life
- To improve communication between sites of care
- To lessen the risk of non-beneficial and medically inappropriate interventions

Patients who **most** need a MOST

- anticipated prognosis of 12 months or less
- one or more chronic illnesses
- advanced age or frailty
- individuals in a long term care facility
- individuals with a terminal or end-stage diagnosis

Case Discussion- Mr. Albright

Mr. Albright is a 71 year old man with sever chronic obstructive pulmonary disease and mild dementia. He is admitted to a nursing home after a hospital stay for pneumonia.

He develops increasing shortness of breath and decreasing responsiveness over 24 hours

The nursing staff call EMS who find the patient unresponsive with a respiratory rate of 12 breaths per minute and oxygen saturation of 82% on room air.

The patient had discussed his desire to forgo aggressive, life-sustaining measures with his family and nursing personnel, and completed a Medical Power of Attorney Document

Case Discussion- Mr. Albright

Although a Do Not Attempt Resuscitation (DNAR) order was written, the emergency team was not informed, and there were no orders for respiratory failure

The emergency team inserts a nasal pharyngeal airway, administers supplemental oxygen, and transports the patient to the ER

The patient remains unresponsive and his Chest X-Ray shows large lung volumes with consolidation. Arterial blood gases show marked respiratory acidosis

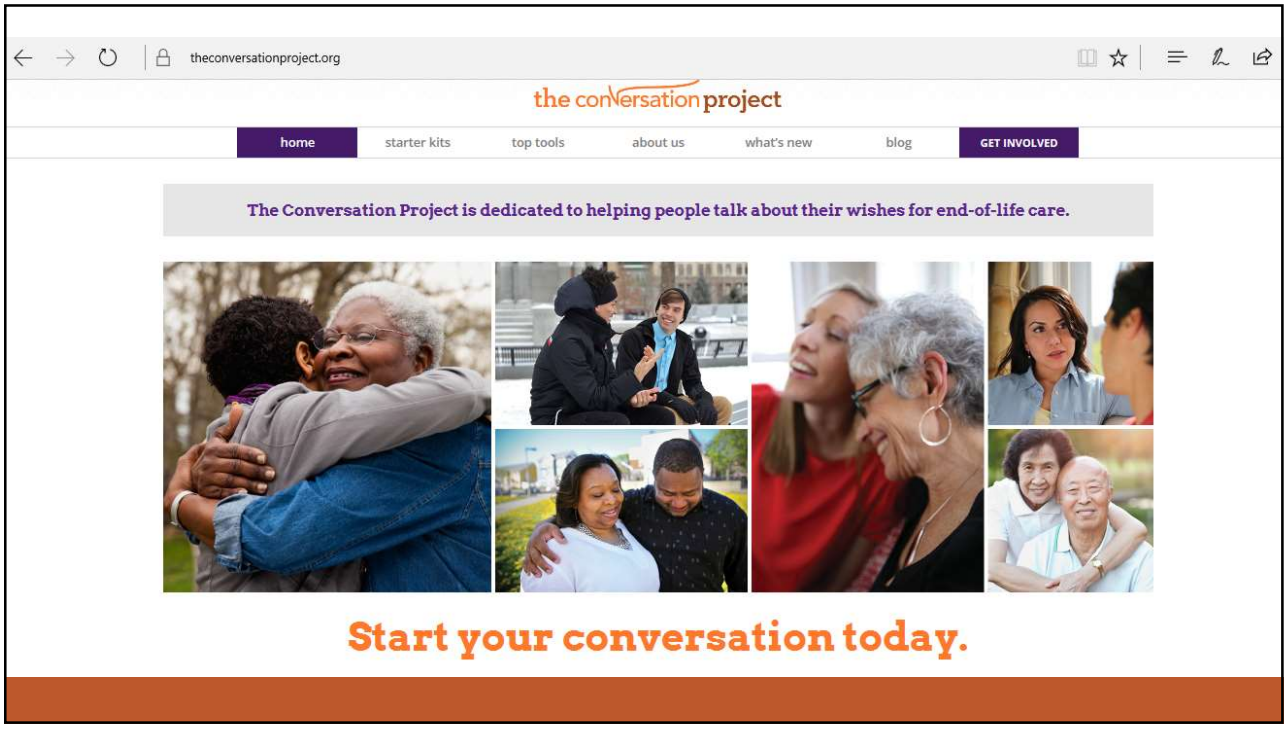
The ER physician does not have any documentation of prior code status, assumes Full Code, and the patient is intubated, sedate, and transferred to the ICU.

Case Discussion- Mr. Albright

- What went wrong?
- Did the patient receive unwanted care?
- What could have prevented him from receiving unwanted care?

Conversations

TIPS FOR PATIENTS AND PROVIDERS

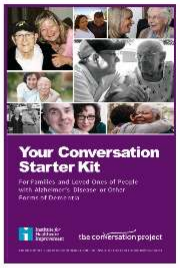


theconversationproject.org/starter-kits

Conversation Starter Kit for Families and Loved Ones of People with Alzheimer's Disease or Other Forms of Dementia

This Starter Kit is specifically designed to help families and loved ones of people with Alzheimer's disease or another form of dementia who want guidance about "having the conversation." We appreciate the difficulty — and the importance — of having these conversations.

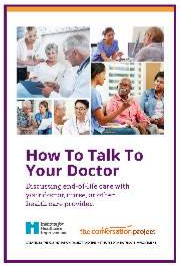
- Languages:
  - English
  - French
  - Spanish
- **Co-branded version**: For organizations planning to distribute the *Starter Kit for Families and Loves Ones of People with Alzheimer's*, we have a version to which you can add your logo and local contact information. Available for purchase **here**.



How To Talk To Your Doctor

After you've had the conversation with your loved ones, the next step is talking to your doctor or nurse about your wishes. Don't wait for a medical crisis; talking with your doctor or nurse now makes it easier to make medical decisions when the time comes.

- Languages:
  - Chinese
  - English
  - French
  - Korean
  - Spanish



Don't delay!

As your loved one's disease progresses and his or her ability to think and share thoughts declines, it will become more difficult for your loved one to express his or her wishes.

Knowing those wishes will be a critical guide to help you through the many decisions that you may have to make.

Start the Conversation now!

"It's always too soon until it's too late"

Conversations with individuals with cognitive impairment – tips for providers

- Take into consideration: Education, Culture, Primary Language, Health Literacy, Capacity
- Keep it simple and straightforward
- Reassure them that this conversation is for everyone (i.e. it does not mean that they are dying)
- Involve family
- **The most important thing is to find out who the patient wants to make medical decision for them when they are not able to make decisions for themselves.**

Conversations with individuals with cognitive impairment – tips for family

- View the conversation as an opportunity to show that you are there for your loved one. Promise that you will be their voice, even when they loose the capacity to make decisions.
- Be gentle and listen carefully
- Have the conversation *both ways*
- If the conversation is overwhelming or confusing, ask if they would rather have a trusted loved one make these decisions for them.
- Take advantage of clear moments
- Have the conversation in small bites, and keep it simple
- Recognize that it can be hard on family members, and share your experience with a trusted family member or friend

Conversations with individuals with cognitive impairment – tips for family

- Be concrete rather than open-ended
  - "If you're unable to talk to your doctors and you want me to be the one to talk to them, I'll be there for you" or "If you think Susan would fight hardest for your wishes, she's your pick."
- Be specific
  - "What do you worry about most – that you'll be a burden to your family? That you won't be able to stay at home?"
- Ask for clarification
  - What do you mean when you say you 'don't want to be a vegetable'?
  - "tell me more"

Conversations with individuals with cognitive impairment

- Early Stage: The individual may wish to discuss their wishes with loved ones and primary care provider.
  - In early stages the individual may have sufficient capacity to complete all of their advanced directives
- Mid-Stages: There may still be moments when it's possible to discuss end of life wishes, or have glimpses to their wishes. For example reminding them about a prior situation of death or dying and reminisce about how that felt.
  - In mid-stages the individual may not have sufficient capacity to complete a directive to physicians, but likely will still have the capacity to communicate who they want for their proxy decision maker
- Later Stages: When the individual is no longer able to express their wishes, families come together to reach consensus about the values expressed in the past.
  - In later stages the individual lacks decision making capacity

Medical Decision-Making Capacity

Can the individual:

- Clearly and consistently communicate a choice
- Understand all the relevant information
- Understand the situation and the consequences of treatment options
- Reason about the treatment choices

Conversations with *family* of those with cognitive impairment

- Find out what family already know about dementia and then educate family members accordingly
- Help family recognize that Alzheimer's Disease and other types of Dementia are *terminal diseases*
- Regarding end of life wishes, remind family "As you answer these questions, remember that you are speaking for your loved one – not for yourself"
- Prompt family to consider what is most important to the individual
  - For example – How might their loved one might complete the following statement:
  - What matters to me at the end of life is_____

  [To receive good care, to not be in pain, being able to say goodbye to the ones I love, to be at home]

Conversations with *family* of individuals who lack decision making capacity

- Guardianship paperwork should be in place
- Guardian of adults can be parents, siblings, adult children, or appointed individual (guardianship services)
- Gauge family member's/guardian's understanding of the patients diagnosis and educate about anticipated prognosis.
- Conversation will be different depending on patient's condition, anticipated prognosis, and current and projected quality of life.
- Though only one appointed guardian, multiple family members may be involved in making the decision

Case Discussion- Mrs. Lewis

Mrs. Lewis is an 88 yr. old woman with a past medical of cerebrovascular accidents, vascular dementia, COPD, low back pain, and severe peripheral vascular disease.

She underwent right femoral-popliteal bypass and right below knee amputation in January. Next she was transferred to a Skilled Nursing Unit (SNF) for rehab. She is chair and bed bound and developed a stage 2 sacral pressure ulcer at the SNF. She plateaued with respect to her progress with physical therapy, and at the time of discharge she was able to transfer from bed to chair with standby assistance, and needed help with toileting and showers for safety.

She was discharged from SNF to her daughter's home with home health services in March.

Case Discussion- Mrs. Lewis

A few weeks later Mrs. Lewis was brought back to the hospital as she was noted to be lethargic and with fever. The workup suggested that the source of the fever was the infected sacral ulcer and there was a strong possibility that she may have Osteomyelitis. She was started on intravenous antibiotics and was transferred to rehab a few days later to complete her 4 weeks of IV antibiotic therapy.

She also suffered a stroke during this admission which resulted in right arm weakness. She was much weaker after the second hospitalization and was noted to be coughing and choking during meals. The speech therapist evaluated her and placed her on a puree diet with honey thick liquids. Despite the staff and family's best attempts to feed her, her intake of both solids and liquids remained very poor and she has lost 5% of her body weight in a month.

Case Discussion- Mrs. Lewis

At the end of April she was readmitted to the hospital with hypernatremia and dehydration. She improved with intravenous fluids but her oral intake remained poor and unpredictable. There was some discussion about placing a feeding tube but no decision is made.

You are seeing the patient and daughter today and feel that it may be a good opportunity to establish goals of care and complete a Texas MOST form.

Case Discussion- Mrs. Lewis

- What would your next steps be?
- Who would you talk to?
- How would you start the conversation?
- What types of questions would you ask?

Case Discussion- Mrs. Lewis

Next Steps

1. Establish that the patient's daughter is the appropriate health care designee
2. Introduce the need to have a discussion about overall goals of care
3. Establish what would be an acceptable quality of life for the patient
4. Assist the family with completing the MOST form

Billing and Coding

ACP Billing for Medicare Patients

- Medicare pays for ACP as either:
  - A separate Part B medically necessary service
  - An optional element of a patient's Annual Wellness Visit
- There are no limits on the number of times you can perform ACP, just document the change in patient's health status or change in patient's end of life wishes.
- Physician's of any specialty and Non-physician practitioners (PA/NP's) may bill ACP services.
- ACP services can occur in any medical setting.
- No specific diagnosis is needed to bill the ACP codes.
- Can be billed along with an Evaluation and Management (E/M) code.

Hospitals, physicians, and NPPs should use the CPT codes in Table 1 to file claims for ACP services.

Table 1. CPT Codes and Descriptors

CPT Codes	Billing Code Descriptors
99497	Advance care planning including 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; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
99498	Advance care planning including 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; each additional 30 minutes (List separately in addition to code for primary procedure)

Documentation

- Appropriate documentation would include:
  - An account of the discussion with the patient (&/or family / surrogate)
  - The explanation of the advanced directives
  - Which forms were completed
  - Who was present
  - Time spent in the face-to-face encounter
  - Consider documenting the voluntary nature of the encounter
  - Consider documenting the patient's capacity to make the decision

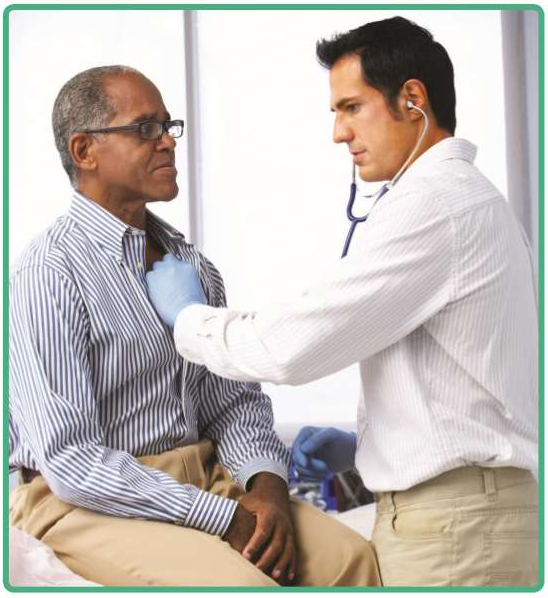
When ACP may occur in outpatient setting

- Routine visit
- Scheduled visit for ACP
- Medicare Annual Wellness Visit
- Dementia Care Plan

A 68-year-old male with heart failure and diabetes is on multiple medications. He is seen by his physician for the Evaluation and Management (E/M) of these two diseases, including adjusting medications as appropriate.

In addition to discussing the patient's short-term treatment options, the patient expresses his interest in discussing long-term treatment options. The doctor and patient talk over the possibility of a heart transplant if his congestive heart failure worsens. They also discuss ACP, including the patient's desire for care and treatment if he suffers a health event that adversely affects his decision-making abilities.

In this case, the physician reports a standard E/M code for the E/M service and one or both of the ACP codes depending on the duration of the ACP service. The ACP service described in this example does not necessarily have to occur on the same day as the E/M service.



Routine Visit:

- CPT codes 99497 and 99498 may be billed on the same day or a different day as most other E/M services, and during the same service period as transitional care management services or chronic care management services and within global surgical periods.

Documentation Example:

S/Patient here for follow up stable chronic health conditions of heart failure and diabetes. He also requests counseling on ACP. Discussed Medical Power of Attorney and Directive to Physicians, and patient desires to complete today.

A/P Medical Power of Attorney and Directive to Physicians completed today and will be scanned to chart. 30 min spent in ACP counseling during today's visit.

Bill 99213 + 99497

Scheduled visit for ACP

Documentation Example:

Patient here for ACP, accompanied by his daughter. Medical Power of Attorney, Directive to Physicians, and Out of Hospital DNR discussed. Patient questions answered. Medical Power of Attorney Completed today and will be scanned to chart. Patient desires additional time to think about the Directive to Physicians. 35 min visit with 100% time spent in ACP counseling.

Bill 99497

Medicare Annual Wellness Visit

- When Advance Care Planning services occur at the same time as the Annual Wellness Visit (AWV):
  - Bill using modifier -33
  - No Part B coinsurance or deductible (consistent with the AWV)
  - Bill G0438-33 (initial) or G0439-33 (subsequent)

Dementia Care Plan

The CPT Code 99483 includes advance care planning as one of the components of the care planning process.

https://alz.org/professionals/healthcare-professionals/care-planning

NON- Medicare Recipients

- Consider using regular office visit codes, but billing based on time:
  - 99214 (25min)
  - 99215 (40min)
- Document total time and amount of time (>50% of the visit) that was spent in counseling about advanced care planning.

Advanced Directive Documents

- MPOA – Medical Power of Attorney
- Directive to Physicians and Family or Surrogates

Additional documents

- OOH DNR - Out of Hospital Do Not Resuscitate order
- Texas MOST Form - **M**edical **O**rders for **S**cope of **T**reatment

Resources

- **Texas Advanced Directive Forms** https://hhs.texas.gov/laws-regulations/forms/advance-directives
- **Texas MOST** http://texasmost.com/
- **The Conversation Project** https://theconversationproject.org/
- **Respecting Choices** http://www.northtexasrespectingchoices.com/
- **Five Wishes Document** https://fivewishes.org/
- **National POLST Organization Website** https://polst.org/
- **Alzheimer's Association** https://alz.org/professionals/healthcare-professionals/care-planning
- **CMS** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

Questions?