Integrating Advance Care Planning into Advanced Practice Registered Nurse Practice: Overcoming Barriers and Enhancing Billing Strategies

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Article

Abstract

Chronic disease and multimorbidity are leading drivers of adverse outcomes, mortality, and healthcare utilization in the United States, yet opportunities to align treatment with patient goals and preferences are often missed. Advance care planning (ACP) offers a structured, longitudinal process to elicit and document values, preferences, and priorities for future medical care. Advanced practice registered nurses (APRNs) are uniquely positioned to lead ACP efforts given their holistic approach, emphasis on patient advocacy, and longitudinal relationships with patients. In 2016, the Centers for Medicare & Medicaid Services introduced time-based Current Procedural Terminology (CPT) codes to reimburse clinicians, including APRNs, for ACP discussions. Despite this opportunity, ACP billing codes remain underutilized. While billing supports sustainability and recognition of APRN contributions, the primary concern is ensuring that patients receive high-quality ACP services. This article explores the role of APRNs in integrating ACP into practice, identifies barriers to ACP billing, and proposes strategies to enhance education, workflow design, and policy. The authors include a fictional case study that illustrates how a nurse practitioner might initiate an ACP discussion with an older adult with multiple comorbidities following hospitalization for heart failure and successfully bill for ACP services.

Key Words: advance directives, advance care planning, APRN practice, billing, advance directives and nursing education

Chronic disease is a leading driver of morbidity and mortality in the United States (U.S.), with approximately 76% of adults—representing 194 million individuals—reporting at least one chronic condition, and over 51% (130 million) reporting multiple chronic conditions (Murphy et al., 2024; Watson et al., 2025). Conditions such as heart disease, cancer, chronic obstructive pulmonary disease, stroke, and diabetes contribute to increased disability, diminished quality of life, higher healthcare utilization, financial burden, and reduced engagement in social and leisure activities (Watson et al., 2025). As these diseases progress or accumulate, opportunities to align treatment decisions with patient goals, values, and preferences are frequently missed (Rosa et al., 2023).

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Advance care planning (ACP) offers a structured approach for healthcare providers to elicit and document patient goals, values, and preferences. It is essential to distinguish ACP—an iterative, longitudinal process—from advance directives (ADs), which are legal documents that may or may not be completed during ACP and vary by setting and facilitator (Rosa et al., 2023). A modified Delphi panel created a consensus definition of ACP as a "process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care" (Sudore et al., 2017, p. 826). More recently, Hickman and colleagues (2023) conceptualized the *Care Planning Umbrella* as a holistic and dynamic framework that encompasses both immediate and advance decision-making throughout the lifespan. This model emphasizes understanding patients' or surrogates' evolving perceptions of quality of life, readiness for decision-making, and prognostic awareness, as well as the role of family and caregiver support (Hickman et al., 2023).

ACP supports the principles of the 4Ms framework—what matters, mentation, mobility, and medications—a cornerstone of age-friendly health systems (Institute for Healthcare Improvement, n.d.). Advance care planning emphasizes *what matters* by eliciting and documenting patient goals and preferences; addresses *mentation* by preparing for potential cognitive decline and changes in decision-making capacity; supports *mobility* by aligning care with patients' functional goals and limitations; and informs *medications* by guiding treatment intensity and deprescribing decisions.

A provision of the Affordable Health Care Choices Act (2009) sought to reduce financial barriers for overextended clinicians conducting ACP by proposing reimbursement for these discussions (van Zyl & Gross, 2018). However, the proposal faced political opposition fueled by rhetoric equating ACP with "death panels," leading to its removal from the final legislation (Frankford, 2015; van Zyl & Gross, 2018). In 2016, with strong public support, the Centers for Medicare & Medicaid Services (CMS) began reimbursing physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs) for voluntary ACP services under the Medicare Physician Fee Schedule and Hospital Outpatient Prospective Payment System (CMS, 2025; van Zyl & Gross, 2018). The introduction of time-based Current Procedural Terminology (CPT) codes 99497 and 99498 was intended to incentivize ACP conversations and allocate dedicated time for these discussions across care settings (Mehta & Kelley, 2019). Despite these incentives, ACP billing codes remain underutilized by clinicians. While billing is an important mechanism to support sustainability and visibility of ACP efforts, the central focus remains on improving access to high-quality, values-based care. The purpose of this article is to explore the role of APRNs in ACP, examine barriers to ACP billing, and identify strategies to support APRNs in advancing ACP across care settings.

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Background and Significance

Evaluating the effectiveness of ACP is complex due to its longitudinal and multifaceted nature. Illness trajectories vary greatly by length and course, with multiple time points for ACP implementation throughout the continuum. Additionally, ACP can include a range of activities, such as conversations with patients alone, with surrogates, or the completion of ADs. Given this complexity, outcomes data are mixed. Several key findings support ACP as a valuable, patient-centered intervention. Evidence has demonstrated that ACP improves proximal patient outcomes, including patient knowledge and readiness, patient communication with surrogates and clinicians, quality of patient-clinician and surrogate-clinician conversations, patient and surrogate mental health, and documentation of values and preferences (Malhotra et al., 2022; McMahan et al., 2021). Additionally, congruence between treatment preferences of patients and their surrogates or clinicians has improved over time (McMahan et al., 2021). However, evidence for distal outcomes, such as goal-concordant care and quality of life at the end of life, remains limited (Malhotra et al., 2022; McMahan et al., 2021).

The CMS decision to reimburse ACP services reflects growing recognition of their importance for patients with serious illness or those facing medical emergencies (McMahan et al., 2021). Advance care planning is defined by CMS (2025) as a voluntary, "face-to-face service between a Medicare physician (or other qualified health professional) and a patient to discuss a patient's healthcare wishes if they become unable to make decisions about their care" (p. 2). These services may include discussions about ADs, with or without completion of legal forms, and are billable across diverse settings including office visits, hospitals, long-term care, home, and telehealth (CMS, 2025). Advance care planning billing is not restricted by specialty, can be billed multiple times, and may be included as part of the Medicare Annual Wellness Visit or as a separate Part B service (CMS, 2023).

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Despite these provisions, ACP billing remains low. Fewer than 6% of Medicare Fee-for-Service beneficiaries had a billed ACP CPT code, and those who did were typically older, sicker, and had higher mortality rates (U.S. Department of Health and Human Services [DHHS], 2020). Additionally, beneficiaries with a billed ACP claim tended to live in counties with higher median household income, higher percentage of college graduates, and more primary care physicians. Nurse practitioners (NPs) ranked third in ACP billing behind internal medicine and family practice physicians, accounting for approximately 20% of submitted claims—yet only 2% of all NPs billed for ACP services (U.S. DHHS, 2020). Although billing data may not fully capture the scope of ACP conversations facilitated by APRNs, increasing the use of ACP billing codes offers an opportunity to formally recognize this essential work. Advanced practice registered nurses are well-positioned to lead ACP efforts, as the process aligns with core nursing principles of advocacy, communication, holistic care, and a commitment to health equity.

Role of APRNs in Advance Care Planning

Advanced practice registered nurses—including NPs, Clinical Nurse Specialists (CNS), Certified Nurse-Midwives (CNM), and Certified Registered Nurse Anesthetists (CRNA)—play a vital and evolving role in facilitating ACP across care settings. While NPs and CNSs are most often positioned to initiate, revisit, and sustain ACP conversations through their ongoing

relationships with patients and families, CNMs and CRNAs may also engage in these discussions when relevant to their care settings. Collectively, APRNs contribute to ensuring that patient values and preferences are integrated into care decisions throughout the continuum of care.

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Advanced practice registered nurses' contributions are particularly significant in primary care, geriatrics, and palliative care—settings characterized by interdisciplinary collaboration, continuity of care, and a focus on shared decision-making and communication (Pedersen et al., 2025). In primary care, where NPs often practice both independently and collaboratively with physicians, they are well-positioned to initiate goals-of-care conversations. Their ongoing relationships with patients enable early identification of ACP opportunities, particularly for individuals with chronic illness or aging-related concerns (Hayes et al., 2025; Pedersen et al., 2025). In geriatric and palliative care settings, NPs draw on their advanced training to manage complex symptoms and provide holistic support. These settings foster normalization of values-based discussions, goals-of-care conversations, and completion of ADs (Fliedner et al., 2021). Nurse practitioners also serve as accessible, holistic providers in rural and underserved communities, where ACP is often underutilized (Spetz et al., 2017).

Advanced practice registered nurses are educated at the master's or doctoral level in accordance with the Consensus Model for APRN Regulation (Rounds et al., 2012). Their educational preparation and scope of practice align with core ACP activities, including assessing decisional capacity, facilitating values-based conversations, documenting ADs and Medical Orders for Life-Sustaining Treatment (MOLST), and educating patients and families about prognosis and treatment trade-offs (Hayes et al., 2025). Depending on state laws and institutional policies, APRNs may independently complete and sign ACP-related documentation (e.g., MOLST), thereby reducing delays and improving access to timely planning (Constantine et al., 2021).

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Advanced practice registered nurses are increasingly recognized as leaders in serious illness communication and end-of-life care. As ACP becomes a standard component of high-quality care, APRNs are assuming leadership roles in team education, quality improvement initiatives, and peer mentorship. Programs such as the End-of-Life Nursing Education Consortium (ELNEC) provide specialized palliative care education that equips APRNs to lead ACP efforts. Additional training in ACP facilitation (e.g., Respecting Choices, VitalTalk) further enhances APRNs' confidence and effectiveness, contributing to higher rates of AD completion and improved alignment between patient preferences and surrogate decision-making (Agyei et al., 2024; Splendore & Grant, 2017; Townsend et al., 2025).

Barriers to ACP

While APRNs are well-positioned to lead ACP discussions, they encounter numerous barriers in implementing and billing for these services. These challenges span institutional, educational, technological, and interpersonal domains, each requiring targeted solutions to ensure equitable access and effective delivery of ACP. Understanding these challenges and identifying opportunities to strengthen APRN engagement in ACP billing are essential for advanced nursing practice, ensuring sustainability, and expanding patient access to high-quality ACP services.

Significant barriers are role ambiguity and inconsistent institutional policies.

Significant barriers are role ambiguity and inconsistent institutional policies (Pedersen et al., 2025). In many healthcare settings, APRNs encounter unclear guidelines regarding their authority to initiate and bill for ACP services. This lack of clarity can lead to underutilization of ACP billing codes and missed opportunities for patient engagement. To address this, healthcare organizations should develop and disseminate standardized ACP billing policies, ideally led by hospital or health-system administration. Local compliance and quality departments can also play a role by providing policy templates and targeted education.

Limited training and knowledge of ACP facilitation and billing requirements further hinder APRN engagement. Many APRNs report discomfort or lack of confidence in conducting ACP conversations, often due to insufficient education and experience in this area (U.S. DHHS, 2020). Integrating targeted ACP education into graduate nursing curricula and continuing professional development programs is essential. Evidence based resources have demonstrated effectiveness in enhancing communication skills and confidence (Agarwal & Epstein, 2018). Including ACP billing competencies in annual mandatory education can also ensure ongoing proficiency.

Technological barriers, particularly documentation burden and inefficient electronic health record (EHR) workflows, contribute to time constraints and reduce the likelihood of ACP engagement. APRNs often face challenges in locating appropriate documentation fields or billing codes within the EHR. Collaborating with informatics teams to embed ACP

templates, smart phrases, and prompts into the EHR can streamline workflows and improve billing capture (Wu et al., 2022). Quality improvement initiatives that monitor documentation efficiency and ACP billing rates can further support system-level change.

Productivity pressures and undervaluing of ACP within performance metrics also pose challenges. In many clinical environments, productivity is measured by volume rather than quality, which may discourage time-intensive ACP discussions (Hafid et al., 2021). Aligning ACP billing with value-based care metrics, patient satisfaction measures, and quality-of-life outcomes can help elevate its importance. Including ACP as a recognized productivity indicator in performance reviews and quality dashboards reinforces its value in clinical practice.

Effective ACP requires interprofessional coordination, yet APRNs may encounter fragmented communication and lack of collaboration across disciplines. Strengthening interdisciplinary teamwork through shared decision-making training, case conferences, and ACP rounds involving physicians, social workers, and other team members can enhance care continuity. Developing communication protocols and referral pathways for ACP initiation and follow-up, along with team-based education, can foster a more cohesive approach.

Finally, limited awareness and understanding of ACP among patients and caregivers can impede engagement. Advanced practice registered nurses can play a pivotal role in promoting patient education by leveraging established resources. Disseminating these tools within healthcare organizations and communities, while leveraging public awareness campaigns and resources, can empower patients to participate actively in ACP.

Understanding and addressing these barriers is essential to advance APRN practice and expand access to meaningful ACP. Table 1 summarizes key challenges and outlines actionable strategies to address them across individual, institutional, and system levels. These solutions emphasize the importance of education, workflow redesign, interprofessional collaboration, and patient engagement in promoting sustainable ACP integration across diverse care settings (Rosa et al., 2023).

Table 1. *Barriers to ACP and Potential Solutions*

Barriers	Potential Solutions
Role ambiguity and variable institutional policies	• Develop and disseminate clear institutional ACP billing policies led by hospital, health-system, or practice administration • Provide local policy templates and education through compliance and quality departments

Limited training and knowledge of ACP, billing codes, and documentation requirements	• Implement targeted education into APRN curricula and continuing professional development programs, including:
	  • ELNEC Graduate Curriculum (https://elnec.reliasacademy.com/elnec-graduate-curriculum)
	  • VitalTalk (https://vitaltalk.org/)
	  • Respecting Choices (https://respectingchoices.org/)
	  • Serious Illness Conversation Guide (Ariadne Labs; https://www.ariadnelabs.org/serious-illness-care/for-clinicians/)
	• Include ACP billing competencies in annual training

Documentation burden and inefficient EHR workflows	• Collaborate with informatics teams to embed ACP templates, smart phrases, and prompts into the EHR • Pilot quality improvement initiatives that track ACP documentation efficiency and billing capture
Productivity pressures and undervaluing of ACP	• Align ACP billing with value-based care metrics, quality-of-life outcomes, and patient satisfaction measures • Include ACP discussions as recognized productivity indicators within performance reviews and quality dashboards

Limited interprofessional coordination	• Strengthen collaboration through shared decision-making training, case conferences, and interdisciplinary ACP rounds involving physicians, social workers, and APRNs • Develop communication protocols and referral pathways for ACP initiation and follow-up across disciplines • Promote team-based ACP education in continuing professional development programs

Lack of awareness and understanding of ACP by patients and caregivers	• Expand access to patient-facing education through evidence-based resources and national campaigns, including:
	  • Five Wishes (Aging with Dignity; https://www.fivewishes.org/)
	  • Prepare for Your Care (https://prepareforyourcare.org/en/prepare/welcome)
	  • My Care, My Choice, My Voice (Healthcentric Advisors; https://healthcentricadvisors.org/learning-resources/myccv/)
	  • Go Wish card game (Coda Alliance; https://codaalliance.org/)
	  • Public awareness campaigns by national organizations (e.g., The Conversation Project, National Institute on Aging)
	  • Medicare ACP bulletins and community workshops through health systems and Area Agencies on Aging

Key: ACP = advance care planning; APRN = advanced practice registered nurse; EHR = electronic health record; ELNEC = End-of-Life Nursing Education Consortium.

Reimbursement Guidelines and Requirements

Two time-based CPT codes, 99497 and 99498, are used to document and bill for ACP services. CPT code 99497 covers the initial 30 minutes of ACP and is billable starting at 16 minutes, and CPT code 99498 is used for each additional 30 minutes beyond the initial discussion (Jones et al., 2016). Table 2 provides a reference for APRNs documenting ACP encounters using CPT codes 99497 and 99498, offering examples of time thresholds to facilitate accurate and compliant billing. These codes may include conversations about ADs, such as living wills or healthcare proxies, but do not require completion of legal forms.

Table 2. ***Time Thresholds and Ranges for Medicare Reimbursement for ACP Services***

ACP Time in Minutes	ACP CPT Code(s)
0-15	Not separately billable
16-45	99497
46-75	99497 and 99498
76-105	99497 and 99498 x 2
106-135	99497 and 99498 x 3

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There is no limit to the number of times ACP codes can be billed per beneficiary.

Advance care planning services are billable across multiple settings, including office visits, hospitals, skilled nursing facilities, home care, and telehealth. There is no limit to the number of times ACP codes can be billed per beneficiary. To ensure compliance, documentation must accurately reflect the voluntary nature of the conversation, time spent, participants involved, and the content and outcomes of the discussion (CMS, 2025). Advanced practice registered nurses are encouraged to use a structured ACP note or embed a clearly identifiable ACP section within their medical documentation, particularly when billing alongside evaluation and management (E & M) services based on medical complexity (Jones et al., 2016; Jones & Rodgers, 2025).

Case Study: Integrating ACP in Primary Care

Following is a fictional, composite case study developed by the authors for illustrative purposes. The case details how an NP might initiate, document, and bill for an ACP conversation in the primary care setting. The case highlights the critical role of NPs to initiate and lead ACP discussions. Through proactive ACP, the NP helps ensure that patient care aligns with values and preferences, reduces the likelihood of unwanted interventions, and supports continuity of care across settings. The ability to bill for ACP services further reinforces the sustainability of these conversations within routine practice and underscores the value of APRN contributions to high-quality, person-centered care.

Patient Background. Mr. J is a 68-year-old male with a history of congestive heart failure (CHF), type 2 diabetes mellitus, hypertension, and chronic kidney disease stage 3. He lives with his spouse, is independent with activities of daily living, but has noticed increasing fatigue and shortness of breath over the past year. Recently, he was hospitalized for an acute CHF exacerbation requiring intravenous diuretics and a brief intensive care unit stay. Following discharge, Mr. J presents to his primary care provider for a scheduled follow-up visit.

Clinical Context. At the visit, the NP reviews Mr. J's hospital discharge summary, current medications, and daily blood pressure, and weight log. His symptoms have stabilized, but he continues to experience exertional dyspnea, decreased stamina, and frailty. He has regular follow-up visits with cardiology for heart failure management. Given his age, multiple comorbidities, and recent hospitalization for a worsening serious illness, the NP recognizes an opportunity to initiate an ACP discussion.

Advance Care Planning Conversation. The NP begins by asking Mr. J about his goals and values in the context of his chronic illness trajectory. Mr. J shares that maintaining independence and staying at home with his spouse are most important to him. He wishes to avoid recurrent hospitalizations if possible. The NP explains potential future scenarios related to his heart failure, including the possibility of progressive decline and the need for more intensive treatments. Together, they review available care options through home health and palliative care support and discuss his future preferences regarding rehospitalization or aggressive interventions. The NP encourages Mr. J to discuss these values with his spouse and to consider completing AD to outline his wishes. The NP and Mr. J plan together to revisit this ACP discussion at his next primary care follow-up visit.

Documentation and Billing. The ACP discussion lasts approximately 25 minutes, during which the NP documents the conversation, including Mr. J's stated goals, treatment preferences, and the plan for ongoing ACP discussions with his family. Based on the length and content of the conversation, the NP bills for ACP services using the appropriate CPT code (99497: first 30 minutes, face-to-face, ACP, with the patient and/or family member).

Table 3. ***Example of Documentation***

Pertinent Diagnoses: congestive heart failure (CHF), type 2 diabetes mellitus, hypertension, and chronic kidney disease stage 3. The patient consented to a voluntary ACP conversation today.
Summary of Conversation: Discussed Mr. J's recent acute hospitalization for CHF exacerbation and potential future scenarios related to his CHF. Introduced concepts outlined in a living will and a Medical Orders for Life-Sustaining Treatment (MOLST) form, including intensive treatments, resuscitation, mechanical ventilation, and artificial nutrition and hydration. Mr. J identified maintaining his independence and being at home with his spouse as priorities in his care.
Outcomes of Conversation and Documents completed: Mr. J will talk with his spouse about today's ACP discussion and consider completing advance directive documents with follow-up visit.
I spent 25 minutes providing separately identifiable ACP services with the patient in a voluntary, in-person conversation discussing the patient's goals, values, and preferences as detailed in the above note.
-Signed NP Primary Care Provider

Recommendations

Nurses have consistently demonstrated their leadership in transforming healthcare systems, as highlighted in Dying in America (Institute of Medicine, 2015) and The Future of Nursing 2020–2030 (National Academies of Sciences, 2021). To advance equitable and sustainable ACP, a coordinated call to action is needed across key groups:

Clinicians

Advanced practice registered nurses should actively pursue opportunities to enhance their ACP knowledge, competencies, and confidence through professional development. Participation in structured training programs and seeking feedback from experienced facilitators can improve ACP delivery. Advanced practice registered nurses should also mentor peers and interdisciplinary team members to foster broader awareness and engagement in ACP and ACP billing practices.

Leadership

Nurse leaders play a critical role in shaping organizational culture and attitudes toward ACP (Izumi, 2017; Rietze & Stajduhar, 2015). They must engage in system-level change, organizational management, and professional advocacy to promote equitable ACP efforts at local, regional, and national levels (Whitehead et al., 2022). Leadership efforts should be driven by institutional, academic, and professional nursing organizations to prioritize ACP education, workflow optimization, and billing competency. Although APRNs are responsible for ongoing professional development, leadership support and institutional prioritization are essential for sustainable ACP integration.

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Education

Graduate nursing curricula must include dedicated content on facilitating ACP, including documentation and billing. Although palliative care education is included in the American Association of Colleges of Nursing (AACN) Essentials (2021), ACP facilitation is not a core competency, leading to inconsistent ACP implementation across graduate nursing programs. Nurse educators should incorporate both didactic instruction and simulation-based experiences to cultivate APRN competency in ACP facilitation and documentation (Whitehead et al., 2022).

Research and Quality Improvement

The evidence for goal-concordant care and quality of life at the end of life as ACP outcomes remains limited (Malhotra et al., 2021; McMahan et al., 2021). Nurse researchers should consider examining billing patterns and patient outcomes related to APRN-delivered ACP. Additionally, using innovative strategies, such as implementation science, may accelerate the adoption and sustainability of evidence-based ACP models. Quality improvement initiatives, including those led by Doctor of Nursing Practice (DNP)-prepared nurses, can evaluate workflow efficiency, identify barriers, and demonstrate the direct impact of APRN-led ACP on patient experience and system performance.

Conclusion

Advance care planning is a cornerstone of person-centered care...

Advance care planning is a cornerstone of person-centered care, particularly for individuals with chronic illness and complex health needs. Advanced practice registered nurses are uniquely positioned to lead ACP across diverse care settings. However, systemic, institutional, and educational barriers continue to limit their full engagement, particularly in billing for ACP services. Addressing these challenges requires a multi-level strategy involving clinicians, educators, leaders, and researchers. By investing in ACP education and optimizing workflows, the nursing profession can empower APRNs to fully integrate ACP into practice, ultimately improving care quality, honoring patient preferences, and advancing health equity.

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