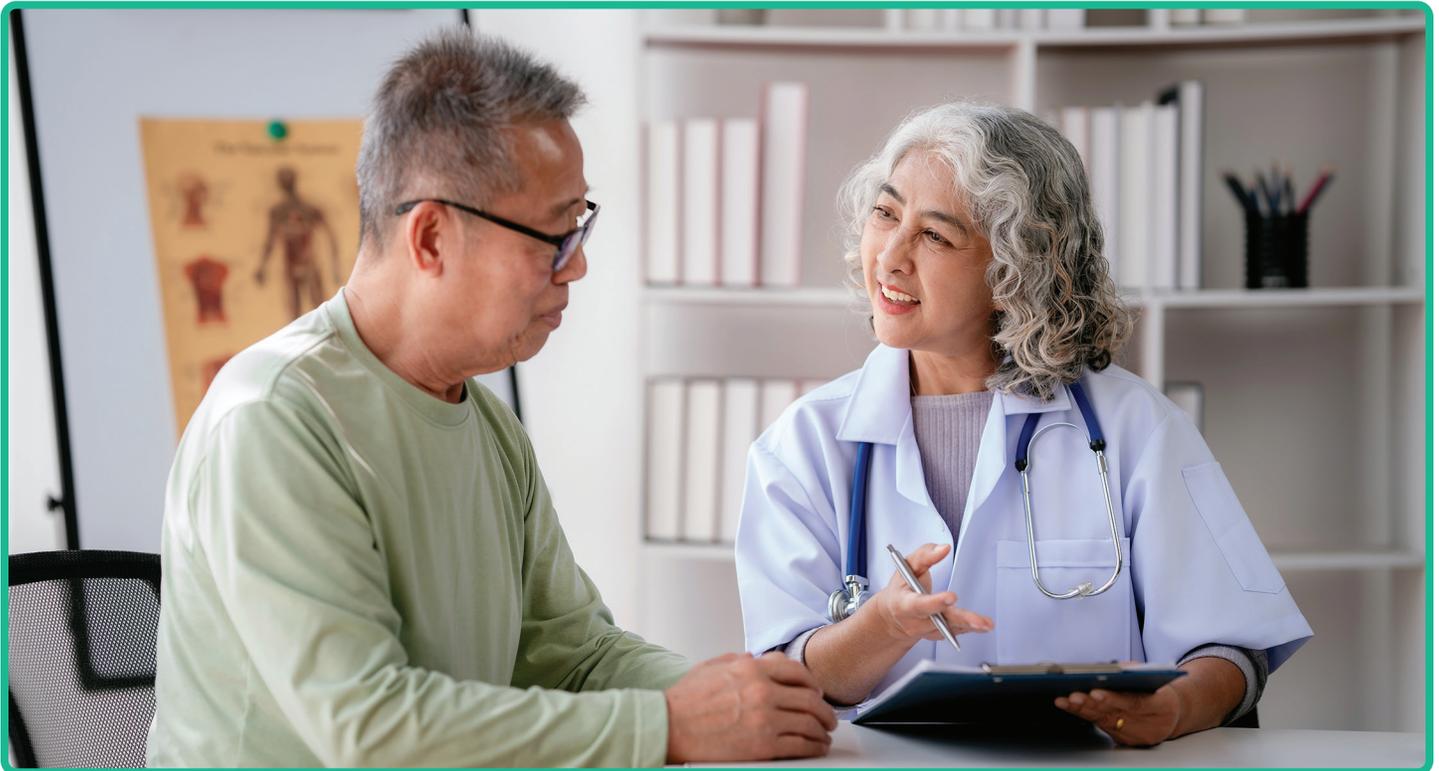




Advance Care Planning



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What's Changed?

Note: No substantive content updates.

Advance care planning (ACP) is a voluntary, face-to-face discussion between a physician or other qualified health care professional (QHP) and your patient, their family member, caregiver, or surrogate (as appropriate) to discuss the patient's health care wishes if they become unable to make their own medical decisions.

As part of this discussion, you may talk about [advance directives](#) with or without helping a patient complete legal forms. An advance directive appoints an agent and records a patient's medical treatment wishes based on their values and preferences. Advance directives can be different from state to state, and you can generally find them on your [state attorney general's website](#). Examples include:

- Do not resuscitate orders
- Health care powers of attorney
- Health care proxies
- Instruction directives
- Living wills
- Medical orders for life-sustaining treatment
- [Psychiatric advance directives](#)

Documentation Requirements

You must document your ACP discussion with the patient and their family member, caregiver, or surrogate (as appropriate). In your documentation, include:

- The fact that the visit was voluntary
- An explanation of advance directives
- Who was present
- The time spent discussing ACP during the face-to-face encounter
- Any change in the patient's health status
- The patient's health care wishes if they become unable to make their own decisions

Diagnosis

Report the condition you discuss with the patient using an [ICD-10-CM](#) code. This code shows an administrative exam or an exam diagnosis when ACP services are part of the annual wellness visit (AWV). You don't need to report a specific diagnosis to bill for ACP services.

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the [CMS Office of Minority Health](#):

- [Health Equity Technical Assistance Program](#)
- [Disparities Impact Statement](#)

"You" refers to a physician or other QHP. QHPs include nurse practitioners, physician assistants, and clinical nurse specialists.

Coding

Hospitals, physicians, or QHPs may bill for ACP services if they're within their scope of practice and the Medicare benefit category describes the services in Table 1.

Table 1. CPT Codes & 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)

ACP Services Are Time Based

You must follow CPT rules about minimum time requirements to report and bill for ACP services.

You should only discuss ACP issues during the time you're billing for ACP services. You shouldn't discuss any other active management of a patient's issues for the time reported when you bill ACP codes.

When you perform another service concurrently as a time-based service, **don't include** the time spent on the concurrent service with the time-based service.

Don't bill any ACP discussion of 15 minutes or less as ACP services. If you meet another service's requirements, bill a different [Evaluation and Management](#) (E/M) service, like an office visit.

A unit of time is billable when the midpoint of the allowable unit of time passes. Table 2 has more information.

Table 2. ACP Minutes & Corresponding CPT Codes & Units

ACP Minutes	CPT Code & Units
15 or less	Don't bill any ACP services
16–45	CPT code 99497 (1 unit)
46–75	CPT code 99497 (1 unit) and CPT code 99498 (1 unit)
76–105	CPT code 99497 (1 unit) and CPT code 99498 (2 units)

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Billing & Payment

You can offer ACP services in facility and non-facility settings and bill them in any care setting, including an office, a hospital, a nursing home, at home, and through [telehealth guidelines](#) effective at the time of service.

Critical access hospitals may bill ACP services using type of bill 85X with revenue codes 96X, 97X, and 98X. We base the Method II payment (optional payment method) on the lesser of the actual charge or the facility-specific Medicare Physician Fee Schedule per Section 1834(g)(2) of the [Social Security Act](#). Federally Qualified Health Centers and Rural Health Clinics are paid for ACP services under a special all-inclusive rate or prospective payment system, where ACP is part of the bundled services.

We pay for ACP as:

- An optional element of the [AWV](#)
- A separate [Medicare Part B](#) medically necessary service

We waive the ACP Part B deductible and coinsurance when the ACP is:

- Provided on the same day as the covered AWV (HCPCS codes G0438 or G0439)
- Provided by the same provider as the covered AWV
- Billed with modifier 33 (Preventive Services)
- Billed on the same claim as the AWV

If we deny the AWV billed with ACP for exceeding the once-per-year limit, we'll apply the ACP [deductible and coinsurance](#).

There are no limits on the number of times you can report ACP for a certain patient in a certain period. When billing ACP multiple times in a year, document changes in the patient's health status or wishes about their end-of-life care.



Example

A 68-year-old person takes multiple medications for heart failure, diabetes, and a new diagnosis of mild dementia. They see their physician for the E/M of these 3 conditions, and the physician adjusts their medications.

While discussing short-term treatment options, the patient also wants to address long-term treatment concerns. They talk about a possible heart transplant if the heart failure or dementia worsens. They also discuss ACP, including the patient's desire for care and treatment if they have a health event that adversely affects their decision-making abilities, and the physician helps the patient complete a legal advance directive form from their state attorney general's office.

According to CPT reporting instructions, the physician may report the ACP codes in addition to the E/M visit code describing the active management of the heart failure, diabetes, and dementia if the ACP time doesn't overlap with actively managing those E/M conditions.

Resources

- [42 CFR, Part 489, Subpart I \(advance directives policy\)](#)
- [2016 Medicare Physician Fee Schedule Final Rule \(Medicare PFS policy for ACP services\), pages 70955–70959](#)
- [2016 Medicare OPPS & ASC Final Rule \(OPPS payment policy\), pages 70305, 70451, and 70469–70470](#)
- [Advance Care Planning \(patient information\)](#)
- [Article A58664: Billing and Coding: Advance Care Planning](#)
- [Local Coverage Determination L38970: Advance Care Planning](#)
- [Section 200.11 of the Medicare Claims Processing Manual, Chapter 4](#)

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