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FACT SHEET
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Advance Care Planning

What's Changed?

Note: No substantive content updates.

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Advance care planning (ACP) is a voluntary, face-to-face discussion between you 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.

"You" refers to a physician or other qualified health care professional (QHP). QHPs include nurse practitioners, physician assistants, and clinical nurse specialists.

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 differ from state to state, and you can generally find them through your state attorney general. 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

Article A58664: Billing and Coding: Advance Care Planning has more ACP information.

Documentation Requirements

You must document your ACP discussion with the patient, 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

Note: If you bill these services more than once, document a change in the patient's health status or wishes about end-of-life care in their medical record.

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.

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

Follow CPT rules about minimum time requirements for reporting and billing ACP services.

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

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

Bill a different Evaluation and Management (E/M) service, like an office visit, for an ACP discussion of 15 minutes or less.

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	99497 (1 unit)
46–75	99497 (1 unit) **and** 99498 (1 unit)
76–105	99497 (1 unit) **and** 99498 (2 units)

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.

Location-Specific Requirements

- 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.
- For patients enrolled in hospice, you can bill ACP services under Medicare Part B only if you aren't employed by the hospice agency; otherwise, bill the ACP services on the type of bill 81X or 82X when performed by hospice-employed physicians or by physicians who are under arrangement with the hospice.

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 woman takes multiple medications for heart failure, diabetes, and a new diagnosis of mild dementia. She sees her physician for the E/M of these 3 conditions, and the physician adjusts her medications.

While discussing short-term treatment options, the patient also wants to address long-term treatment concerns. She talks about a possible heart transplant if her heart failure or dementia worsens. They also discuss ACP, including the patient's desire for care and treatment if she has a health event that adversely affects her decision-making abilities, and the physician helps the patient complete a legal advance directive form from the 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 489, Subpart I (advance directives policy)
- 2016 Medicare Physician Fee Schedule Final Rule (Medicare PFS policy for ACP services)
- 2016 Medicare OPPS & ASC Final Rule (OPPS payment policy)
- Advance Care Planning (patient information)
- Medicare Claims Processing Manual, Chapter 4, section 200.11
- Medicare Claims Processing Manual, Chapter 18, section 140.8