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FACT SHEET
KNOWLEDGE • RESOURCES • TRAINING

Advance Care Planning

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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 or 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 non-physician practitioner (NPP), including 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. If a patient becomes incapacitated and is unable to get information (due to their condition or mental disorder) or state that they have an advance directive, then the provider may give advance directive information to the patient's family or surrogate in accordance with state law. 42 CFR 489.102(e) has more information.

Advance directives can differ from state to state, and you can generally find the forms 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

Documentation Requirements

You must document your ACP discussion with the patient or 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, or both, 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.

Billing Eligibility & Coding

We allow hospitals, physicians, and NPPs whose scope of practice and Medicare benefit category include the services described by the CPT codes in Table 1 and who are authorized to independently bill Medicare for those services to bill for ACP.

Table 1. CPT Codes & Descriptors

CPT Code	Billing Code Descriptor
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.

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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:

- In an office, a hospital, or a nursing home
- At home
- Through telehealth guidelines effective at the time of service

Note: For skilled nursing facility patients, we exclude professional services from consolidated billing.

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.
- We pay Federally Qualified Health Centers and Rural Health Clinics for ACP services under a special all-inclusive rate or prospective payment system, in which 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 using type of bill 81X or 82X when they're 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 Part B medically necessary service

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

- Provided on the same day as the covered AWV (HCPCS code 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 or 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, or both.

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. She and her physician 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

- 2016 Medicare Physician Fee Schedule Final Rule (Medicare PFS policy for ACP services)
- 2016 Medicare OPPS & ASC Final Rule (OPPS payment policy)
- 42 CFR Part 489, Subpart I (advance directives policy)
- Advance Care Planning (patient information)
- Medicare Claims Processing Manual, Chapter 4, section 200.11
- Medicare Claims Processing Manual, Chapter 18, section 140.8

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