Coding Snapshot: Advance Care Planning

Updated April 2024

Description	Reimbursement
99497: Advance care planning including the explanation and discussion of advance directives, by the physician or other qualified health care profession; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	**$81.89**
99498: each additional 30 minutes (List separately in addition to the primary procedure)	**$70.90**

Midpoint rule applies. Figure reflects the 2024 *estimated* national amount for the non-facility setting. Actual amounts will vary by location.

Reporting

No active management of the problem should occur during Advance Care Planning.

Frequency Limits: CMS has no annual frequency limits, however multiple services for a beneficiary may occur with justification; for example, if there is a change in the patient's health status or a change in the patient's wishes[1].

Advance Care Planning can be reported separately if performed on the same date as the following services[2] if the time and documentation supports each service independently:

- ✓ Office and outpatient Evaluation and Management
- ✓ Hospital inpatient/observation admit and discharge, discharge management
- ✓ Consultations
- ✓ Transitional Care Management

Advance Care Planning cannot be reported on the same date of service with:

- ☒ Critical Care Services
- ☒ Subsequent intensive care for the recovering infant (2501-2500 g)
- ☒ Cognitive Assessment and Care Plan Services

[1] Office of the Inspector General. "Medicare Providers Did Not Always Comply with Federal Requirements When Billing for Advance Care Planning." November 2022.

[2] A full list of codes reported separately can be found in the latest edition of the American Medical Association.

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