



Advance Care Planning



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What's Changed?

- Added medical orders for life sustaining treatment and psychiatric advance directives as examples of advance directives (page 3)
- Added clarification on documentation and time-based coding requirements (pages 3–5)
- Added payment information for Federally Qualified Health Centers and Rural Health Clinics (page 5)
- Added additional resources (page 6)

You'll find substantive content updates in dark red.

Advance care planning (ACP) is a voluntary, face-to-face service between a physician or other qualified health care professional (QHP) and a patient, family member, caregiver, or surrogate 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. You can generally find them on your [state attorney general's office](#) website. Examples include:

- Living wills
- **Medical orders for life-sustaining treatment**
- Health care proxy
- Durable power of attorney for health care
- [Psychiatric advance directives](#)

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- [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.

Documentation Requirements

You must document your ACP discussion with a patient, family member, caregiver, or surrogate. In your documentation, include:

- The voluntary nature of the visit
- The explanation of advance directives
- Who was present
- The time spent discussing ACP during the face-to-face encounter
- Any change in health status or health care wishes if the patient becomes 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 the ACP services are part of the AWV or IPPE. You don't need to report a specific diagnosis to bill ACP.

Coding

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

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

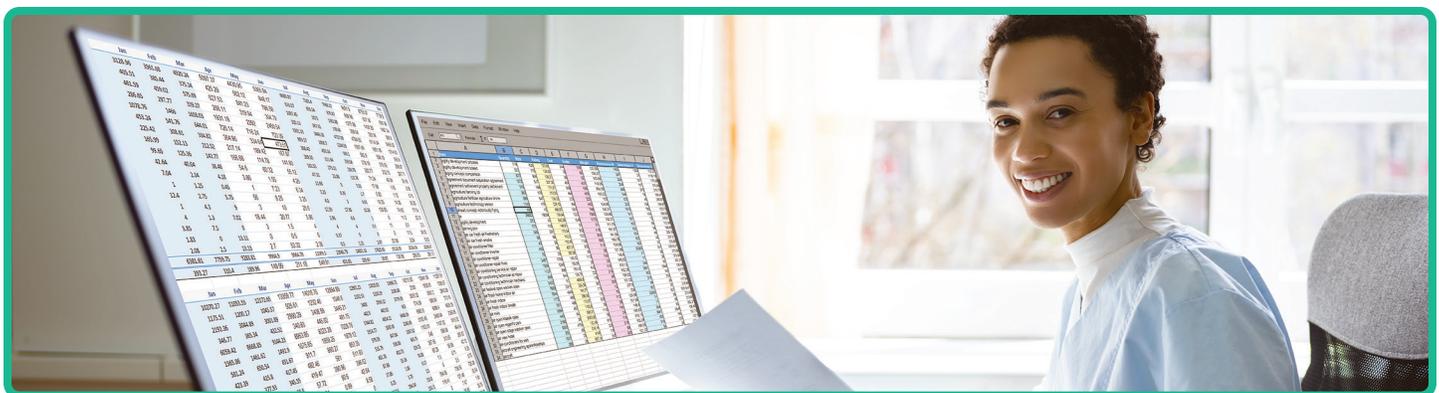
You must follow CPT rules about minimum time requirements to report and bill ACP.

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. Bill a different [Evaluation and Management](#) (E/M) service, like an office visit (if you meet the other service's requirements).

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



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Table 2. ACP Minutes & Corresponding CPT Codes & Units

ACP Minutes	CPT Code & Units
less than 15	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)

Billing & Payment

You can offer ACP services in facility and non-facility settings, and bill them in any care setting including an office, hospital, nursing home, 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 [annual wellness visit \(AWV\) or initial preventive physical exam \(IPPE\)](#)
- A separate [Medicare Part B](#) medically necessary service

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

- Delivered on the same day as a covered AWV (HCPCS codes G0438 or G0439)
- Offered by the same provider as a covered AWV
- Billed with modifier –33 (Preventive Services)

If we deny the AWV for exceeding the once-per-year limit, we can still pay for the ACP as a separate Part B medically necessary service. In that case, we apply the [deductible and coinsurance](#) to the ACP service.

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Example

A 68-year-old person takes multiple medications for heart failure and diabetes. They see their physician for the E/M of these 2 diseases, 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 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 and diabetes, as long as the ACP time doesn't overlap with active management of those 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 \(patient information\)](#)
- [Local Coverage Article A58664: Billing and Coding: Advance Care Planning](#)
- [Local Coverage Determination L38970: Advance Care Planning](#)
- [Section 200.11 of Medicare Claims Processing Manual, Chapter 4](#)

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