Billing Codes for Advance Care Planning Conversations

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 provider (NP, PA), face-to-face with the patient, family member(s) and/or surrogate), first 16-30 minutes

99498 – if the conversation is 46 minutes or more. (List separately in addition to code for primary procedure.)

**There are no limits to the number of time ACP can be reported for a given beneficiary in a given time period.*

"Incident to" rules apply in the Outpatient Setting

Billing provider performs an initial service, a non-billing team member (e.g. RN, SW) helps deliver part of the service, with ongoing direct supervision and involvement of the billing provider.

Example: *Physician starts an advance care planning conversation, then says "I'd like to introduce you to our nurse who will talk with you about choosing a [surrogate medical decision maker] and think with you about how you might have a conversation with that person," then debriefs afterwards with the patient Consider for "what matters most," palliative care, or hospice conversations*

Points to Know

- These codes can be billed when conversations are had with the legally appropriate proxy decision-maker, even if the patient is not in the room.
- The conversation has to be in-person (cannot use for telehealth).
- There are no place-of-service limitations – you can use it in acute care, nursing home, home, etc.
- Patients incur Part B cost sharing copay, except with Annual Wellness Visit.
- These codes can be billed on the same date of service (or different date) as most other Evaluation and Management (E/M) codes, as well as transitional care management services (TCM) or chronic care management services (CCM).

  - ^ If billing for medical management at the same time…
    If based on medical decision making → bill as you normally would
      - Then also bill based on time for advance care planning conversation

    If based on time → do not double count time

- If not billing for medical management…
  - Use 99497 if you exceed 15 minutes
  - Use 99497 + 99498 if you exceed 45 minutes
  - Use 99497 + 99498 + 99498 if you exceed 75 minutes

- Codes are currently approved for Medicare, private payers will vary (consult billing department)

- For patients that have Medicare Part C; Medicare Advantage, etc. how is the billing done? "Medicare Advantage Plans must cover all of the services that Original Medicare covers except hospice care…The plan can choose not to cover the costs of services that aren't medically necessary under Medicare."

Documentation requirements for Advance Care Planning (ACP) Conversations

- Start and end times
- Patient/surrogate/family "given opportunity to decline"
- Details of content
  - Who was involved?
  - Start and end time
  - What was discussed?
  - Understanding of illness
  - Spiritual factors
  - Reflections on family/personal losses
  - Why are they making the decision they are making?
  - Was any advance directive offered/filled out?
  - Follow-up

Estimated reimbursement

99497 = 2.4 RVUs (average national payment: $85.99)

99498 = 2.09 RVUs (average national payment: $74.98)

Adapted from Institute for Healthcare Improvement STAT Call Series January 2016
End of Life Conversations: Preparing your team for Success and CMS Reimbursement
Center to Advance Palliative Care: Billing the Physician Fee Schedule for ACP Services August 2016
Last updated 5/15/18