Billing for Advance Care Planning Visits for Medicare Beneficiaries

As of January 1, 2016, the Centers for Medicare and Medicaid Services (CMS) pay providers for properly documented visits and coding for Advance Care Planning. Below are the codes and descriptions finalized by CMS regarding Advance Care Planning Visits.

CPT code 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 professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate; and

An add-on CPT code 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 professional; each additional 30 minutes (list separately in addition to code for primary procedure).

These codes encourage providers to plan and document visits solely for the purpose of clarifying goals of care, and to complete the necessary legal and standardized documents to establish the plan of care. The provider must be face-to-face with the patient, the surrogate, or the family. Patients are responsible for co-pays for Advance Care Planning services, if applicable, except when the services are provided as part of an Annual Wellness Visit, in which case there is no co-payment.

For providers billing under the Medicare Physician Fee Schedule, Advance Care Planning services can be furnished on the same day or a different day as other Evaluation and Management services, and both will be paid, assuming all other requirements are met.

For providers billing under the Medicare Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs), Advance Care Planning is a stand-alone billable visit. If furnished on the same day as another billable visit, only one visit will be paid.