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Bill Dunbar and Associates

Coding Advisor
Evaluation and Management

Advance Care Planning

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 each additional 30 minutes (List separately in addition to code for primary procedure)

A unit of time is attained when the mid-point is passed.

Time Spent	Code
Less than 16 min.	Do not code
16 min. – 45 min.	99497
46 min. – 60 min.	99497 and 99498 X 1

Advance care planning codes are used to report the face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms.

An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capability at that time.

Examples of written advance directives include, but are not limited to:

- Health Care Proxy
- Durable Power of Attorney for Health Care
- Living Will
- Medical Orders for Life-Sustaining Treatment (MOLST)
- Psychiatric advance directives

Because the purpose of the visit is the discussion, no active management of the problem(s) is undertaken during the time period reported.

The dialogue often includes topics such as:

- The purpose of the Advanced Care Planning
- Planning for the unexpected
- How to discuss the choices with loved ones
- The selection of a surrogate decision maker
- The technical components of completing, distributing, and maintaining written plans.

Coding Guidelines

- There is no limitation on how many times advance care planning can be billed
- An E/M may be reported separately on the same day except for the following services:
  - Critical Care (99291, 99292)
  - Inpatient Neonatal and Pediatric Critical Care (99468-99476)
  - Initial and Continuing Intensive Care Services (99477-99480)
  - Cognitive Assessment and Care Plan Services (99483)
- If Advance Care Planning is provided with an Annual Wellness Visit, **Modifier 33** should be appended to the Advance Care Planning Code so that the copay and deductible will be waived.

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Advance Care Planning (cont'd)

CMS Documentation Requirements

- Voluntary nature of the visit
- The explanation of advance directives
- Who was present
- 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

CMS Additional Information and Resources

Are there limits on how often I can bill CPT codes 99497 and 99498?

Per CPT, there are no limits on the number of times ACP can be reported for a given beneficiary in a given time period. Likewise, the Centers for Medicare & Medicaid Services has not established any frequency limits. When the service is billed multiple times for a given beneficiary, we would expect to see a documented change in the beneficiary's health status and/or wishes regarding his or her end-of-life care.

Does the beneficiary/practice have to complete an advance directive to bill the service?

No, the CPT code descriptors indicate "when performed," so completion of an advance directive is not a requirement for billing the service.

CMS ACP 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:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

Documentation must support and justify the medical necessity of the service(s) and procedure(s) provided and the code(s) utilized. Please check with individual payers for their policy.