Billing for Adult Advance Care Planning Discussions

Adult advance care planning involves early conversations between patients and their practitioners, both before an illness progresses and during the course of treatment, to decide on the type of care that is appropriate. ACP should be revisited every time a person's medical condition changes.

As of 2016, the Centers for Medicare and Medicaid proposed assignment of CPT codes 99497 and 99498. **Medicaid will not pay for these ACP codes.**

Fees and RVUs

Code	Description	Physician	Health Care Provider (ie, APN)
99497	ACP 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.	CMS Allowed Amount $84.81 and 1.5 WRVU	CMS Allowed Amount $72.08 and 1.5 WRVU
99498	ACP 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).	CMS Allowed Amount $79.69 and 1.4 WRVU	CMS Allowed Amount $67.74 and 1.4 WRVU

Who Can Provide Care and Where?

Who		Where
Physician		Inpatient
APN		Emergency Room
NP		Outpatient Hospital
PA		Outpatient Office
CNS		Home
LCSW		Skilled Nursing Facility

Who Should Receive ACP?

- Dementia patients who still possess decision-making capability but anticipates further decline
- End stage chronic illness- CHF, renal disease, AIDS
- Severe, recurrent psychiatric illnesses
- Individuals who lack decision making capabilities and rely on guardian to make decisions and plan for the patient's disease process
- Persons at risk for stroke
- Debility/frailty (e.g., those at risk for delirium associated with an acute illness)

Deductible/Coinsurance

- Deductible/coinsurance applies when reasonable & necessary for the diagnosis or treatment of injury or illness (E/M hospital service)
- No deductible/coinsurance applies when conducted as a voluntary, separately payable part of an Annual Wellness Visit (AWV)

Billing Guidelines

- Can be billed on the same day as furnishing an E/M service to a patient (except critical care).
- Use modifier -25 on the E/M service
- May also be used as an independent code
- Use the same diagnosis code associated with the E/M service, or use a diagnosis code for the disease that prompts the need for Advance Care Planning services (i.e. Alzheimer's disease with early onset G30.0)

Limitations to Billing for ACP

- Time must be clearly defined for Advance Care planning
  - When billing with other time dependent codes (i.e. discharge care planning), must specify amount of time devoted to each service
- Cannot be billed in conjunction with the following services:
  - Critical Care (99291-99292)
  - Neonatal Critical Care (99468-99469)
  - Pediatric Critical Care (99471-99476)
  - Neonatal Intensive Care Services (99477-99480)

For More Information

If you have questions about billing for an advance care planning conversation, call Advocate Hospice at 1.800.564.2025, option 4.

Advocate Health Care

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