Billing for Advance Care Planning Services under Medicare

Question:
What should I know about billing for advance care planning services under Medicare?

Answer:
Providers may bill for advance care planning if they have a voluntary, face to face discussion with a patient regarding advance directives. The first 30 minutes of the discussion would be billed with CPT Code 99497 and each additional 30 minutes would be billed with CPT Code 99498.

A March 22, 2016, Frequently Asked Questions Bulletin issued by CMS, provides the following additional information regarding advance care planning services;

> **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.
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> **What must be documented for the service?**
> Examples of appropriate documentation would include an account of the discussion with the beneficiary (or family members and/or surrogate) regarding the voluntary nature of the encounter; documentation indicating the explanation of advance directives (along with completion of those forms, when performed); who was present; and the time spent in the face-to-face encounter.
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> **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.