Coding Snapshot: Advance Care Planning

Updated January 2025

Description	Reimbursement
99497: Advance care planning including the explanation and discussion of advance directives, by the physician or other qualified health care profession; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	$79.57
99498: each additional 30 minutes (List separately in addition to the primary procedure)	$68.90

Midpoint rule applies. For example, 99497 may be reported when 16 minutes, or over half the time, has been attained. Figure reflects the 2025 *estimated* national amount for the non-facility setting from the Medicare Physician Fee Schedule Final Rule. Actual amounts will vary by location.

Reporting

No active management of the problem should occur during Advance Care Planning.

Frequency Limits: CMS has no annual frequency limits, however multiple services for a beneficiary may occur with justification; for example, if there is a change in the patient's health status or a change in the patient's wishes[1].

Advance Care Planning can be reported separately if performed on the same date as the following services[2] if the time and documentation supports each service independently:

- ✓ Office and outpatient Evaluation and Management
- ✓ Hospital inpatient/observation admit and discharge, discharge management
- ✓ Consultations
- ✓ Transitional Care Management

Advance Care Planning cannot be reported on the same date of service with:

- ☒ Critical Care Services
- ☒ Subsequent intensive care for the recovering infant (2501-2500 g)
- ☒ Cognitive Assessment and Care Plan Services

[1] Office of the Inspector General. "Medicare Providers Did Not Always Comply with Federal Requirements When Billing for Advance Care Planning." November 2022.

[2] A full list of codes reported separately can be found in the latest edition of the American Medical Association.

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