

Coding Snapshot: Advance Care Planning

Updated December 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	\$86.56
99498: each additional 30 minutes (List separately in addition to the primary procedure)	\$77.87

Midpoint rule applies. For example, 99497 may be reported when 16 minutes, or over half the time, has been attained. Figure reflects the 2026 *estimated* national amount for the non-facility setting from the Medicare Physician Fee Schedule Final Rule for non-qualifying APM providers. 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 wishes¹.

Advance Care Planning can be reported separately if performed on the same date as the following services² if the time and documentation support 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.