Coding Snapshot: Advance Care Planning
Updated April 2024

<table>
<thead>
<tr>
<th>Description</th>
<th>Reimbursement</th>
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<tbody>
<tr>
<td><strong>99497</strong>: 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</td>
<td>$81.89</td>
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<tr>
<td><strong>99498</strong>: each additional 30 minutes (List separately in addition to the primary procedure)</td>
<td>$70.90</td>
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Midpoint rule applies. Figure reflects the 2024 estimated national amount for the non-facility setting. 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

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\(^2\) A full list of codes reported separately can be found in the latest edition of the American Medical Association.