**Coding Snapshot: Advance Care Planning**

<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>$80.55</td>
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<tr>
<td><strong>99498:</strong> each additional 30 minutes (List separately in addition to the primary procedure)</td>
<td>$69.75</td>
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</tbody>
</table>

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 services² 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.