

**ASCO<sup>®</sup>**

**Advanced Care Planning:**  
Practice Administration and  
Reimbursement Guide

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AMERICAN SOCIETY OF CLINICAL ONCOLOGY  
KNOWLEDGE CONQUERS CANCER

# Advance Care Planning Services Practice Administration and Reimbursement Guide

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## Introduction

Advance care planning is an important component of patient-centered, quality cancer care. Per the American Society of Clinical Oncology (ASCO) Statement *Toward Individualized Care for Patients with Advanced Cancer* “Patients with advanced incurable cancer face complex physical, psychological, social, and spiritual consequences of disease and its treatment. Care for these patients should include an individualized assessment of the patient's needs, goals, and preferences throughout the course of illness.”<sup>1</sup>

Advance care planning may be utilized by oncologists to assist patients and their families in exploring, discussing, and documenting end-of-life wishes. Though many practices incorporate advance care planning into palliative care, it can be provided to patients at any time before, during, or after their treatment. All patients, even those with curable or non-malignant disease, should actively participate in key decisions regarding their care.<sup>2</sup> Advance care planning is a key component of shared decision making and may, although it is not required to, result in documentation of a living will, assignment of a health care proxy, or other advance directive.

Though advance care planning is an integral part of cancer care, the codes are not frequently reported to Medicare as a separate service. This may be due to lack of awareness or understanding of the codes, and uncertainty as to how to implement the services into the workflow of the practice. According to Medicare Physician and Other Supplier Public Use File data, Hematology/Oncology utilization of advance care planning services increased from 2016 to 2017, however it was followed by a decline in volume for 2018 and 2019. In 2019, among the 6,355 hematology/oncology physicians who submitted at least 500 office or hospital outpatient evaluation and management visits, only 145 providers billed Medicare at least 11 ACP services in either a facility or non-facility setting.

ASCO developed the *Advance Care Planning Services – Practice Administration and Reimbursement Guide* to assist practices in administering, recording, and being reimbursed for advance care planning. Practices may use this guide to help establish a dedicated advance care planning service in their practice. Some may already be providing advance care planning, but not separately reporting or finding it difficult to receive reimbursement.

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<sup>1</sup> Peppercorn JM, Smith TJ, Helft PR, et al. [American Society of Clinical Oncology Statement: Toward Individualized Care for Patients with Advanced Cancer](#). *Journal of Clinical Oncology*, 29(6):755-760, 2011.

<sup>2</sup> Institute of Medicine. [Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life](#). 2015.

## Coding, Reporting, and Reimbursement

In recent years, advance care planning has been recognized as a separately reportable and reimbursable service for Medicare and other payers. This guide contains the common codes used to report advance care planning and coverage under the Medicare program.

### Coding Guidance

There are two Current Procedural Terminology (CPT®)<sup>3</sup> codes to describe advance care planning services. CPT code 99497 accounts for the first 30 minutes of face-to-face advance care planning and 99498 represents each additional 30 minutes of the same session. Advance care planning services incorporate discussion of advance directives, such as Living Wills, Health Care Proxies, Power of Attorney, and/or Medical Orders for Life-Sustaining Treatment. Completion of these forms may be included in the advance care planning session but is not a required element of the service.

Advance care planning services may be reported on their own or in addition to other services such as office and outpatient Evaluation and Management Services (99202-99215), Transitional Care Management Services (99495-99496), and Chronic Care Management Services (99490-99491). A full list of the codes can be found in the American Medical Association CPT Professional Edition.<sup>4</sup>

### CPT Code Descriptions

99497 - Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498 - Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

Following CPT guidelines regarding time (a unit of time is attained when the midpoint has passed), CPT code 99497 may be reported for a service of 16 minutes or above. Add on code 99498 may be reported if the service is greater than 46 minutes. The reported diagnosis (ICD-10 CM code) should be the condition for which the provider is counseling the patient.

For the full set of guidelines, please refer to the latest version AMA CPT® Professional Edition.

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<sup>3</sup> CPT Copyright 2021 American Medical Association. All rights reserved.

<sup>4</sup> American Medical Association. [AMA CPT® Professional 2021](#). 2021.

## Medicare Coverage and Reporting Guidelines

Advance care planning services (99497 and 99498) are a Medicare benefit and are reimbursable under Medicare Physician Fee Schedule (MPFS). Per Medicare guidance, advance care planning may be provided “by physicians or using a team-based approach provided by physicians, non-physician practitioners and other staff under the order and medical management of the beneficiary’s treating physician.”<sup>5</sup>

There are no limits on the number of times a year advance care planning can be provided to a patient. However, the documentation must indicate there is a change in the patient’s health status or wishes regarding end-of-life care as well as the time spent with the patient, family member(s), and/or surrogate.

Like other services, non-physician practitioners (for example clinical nurse specialists, nurse practitioners, or physician assistants) can report advance care planning services for a reduced reimbursement rate. Incident-to rules apply when these services are furnished as part of an established care plan incidental to the services of the billing practitioner with a minimum of direction.

There are differences in how advance care planning is billed and reimbursed in office versus hospital settings. The following information is specific to traditional Medicare; other plans, including Medicare Advantage, may have different rules.

### Office Setting

Advance care planning may be provided by a physician, non-physician practitioner, or other capable employee under direct supervision of the billing physician/practitioner when performed in an office setting.<sup>6</sup> Office-based advance care planning services are reimbursed via the Medicare Physician Fee Schedule to the billing physician/practitioner. Incident-to rules apply whenever the service is performed by a person other than the billing physician/practitioner.<sup>7</sup>

### Hospital Setting

Advance care planning may be provided and billed by a physician or non-physician practitioner when provided at a hospital or other facility. Only time personally spent by the billing physician/non-physician practitioner may be considered when determining the appropriate billing code(s) for the service.

Alternatively, advance care planning may be provided and billed by a capable employee of a hospital and billed by the facility under the Inpatient or Outpatient Prospective Payment Systems. Note that inpatient

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<sup>5</sup> Centers for Medicare and Medicaid Services. [Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services](#). 2016.

<sup>6</sup> Ibid.

<sup>7</sup> Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services

services will be billed under the applicable diagnosis related group and outpatient services may not be paid separately when billed with another covered service.

Medicare will waive the patient's deductible and coinsurance for advance care planning service when the service meets all of the following criteria:

1. Provided on the same day as a covered Annual Wellness Visit (HCPCS codes G0438 or G0439).<sup>8</sup>
2. Offered by the same provider as a covered Annual Wellness Visit.
3. The ACP service is reported with modifier -33 (preventive service).<sup>9</sup>

Private payer guidelines on patient cost-sharing may vary. Check each payer and patient's policy to confirm.

## Coding Scenarios

Below are a variety of scenarios which demonstrate how Advance Care Planning Services may be reported:

1. A physician or qualified healthcare provider has a 16-minute, face-to-face discussion with a patient to determine if they have advance directives on file such as a living will or assigned health care power of attorney.

*Report CPT code 99497 when at least 16 minutes have passed, which exceeds the 15-minute midpoint required to bill the code.*

2. An advance practice provider spends 60 minutes with the patient and their family to discuss hospice care and who will make medical decisions for the patient if they are unable to do so. The advance directive paperwork on file is reviewed with the patient and family member to ensure it is correct and up to date.

*Report CPT code 99497 for the first 30 minutes, plus CPT code 99498 for the additional 30 minutes of service. CPT codes 99497 AND 99498 can only be reported when the time threshold of 46 minutes has been met (ex. 99497 for the first 30 minutes, 99498 for 16 minutes or more). CPT code 99498 may be reported for each 30-minute of time beyond the first hour. For example, if the APP spends 76 minutes conducting an ACP visit, CPT code 99497 plus two units of 99498 may be billed. There are currently no limits on the number of times 99498 may be reported per CPT guidelines, however payers may implement their own limitations.*

3. *If the attending provider of record (who may be a physician or a nurse practitioner) is an employee of the designated hospice, they may not receive compensation from the hospice for those services under Part B. These physician professional services are billed to Medicare Part A by the hospice.*

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<sup>8</sup> Centers for Medicare and Medicaid Services. [Medicare Wellness Visits](#). 2021.

<sup>9</sup> Centers for Medicare and Medicaid Services. [Advance Care Planning](#). 2020.

<sup>10</sup>A physician meets with a patient for an office or outpatient Evaluation and Management service. Once the E/M service is complete, the physician orders advance care planning and directs the patient to meet with a social worker for 30 minutes to discuss their advance directives.

*Report CPT code 99497 in addition to the appropriate office or outpatient Evaluation and Management Service. Per CPT guidelines and CMS NCCI edits an advance care planning service may be reported in addition to an office and outpatient E/M with no modifier required. Commercial payer policies may require a modifier.*

4. A Medicare patient meets with the physician for their annual Medicare Wellness Visit (MWV). In addition, there is a separate 16-minute discussion between the physician and patient regarding advance directives.

*Report HCPCS code G0438 plus 99497 appended with modifier -33 (indicates 99497 is part of a preventive service). Since the advance care planning service is being reported in conjunction with the MWV, the patient's visit is not subject to a deductible and coinsurance.*

5. A provider has a follow up visit in the hospital setting with a cancer patient to address pain. The pain is discussed during a low complexity subsequent hospital visit (CPT code 99231). A 30-minute advance care planning service is also conducted with the patient's family in which goals of care, future treatment options and code status are discussed. The advance care planning discussion is documented along with total time spent. CPT code 99497 is reported for the advance care planning service.

A hospital E/M and an ACP service may be reported on the same date of service based on time, but add a note to the E/M time documentation which indicates an additional 30 minutes were spent in ACP goals of care discussion (see separate note for the ACP discussion). Do not count any time spent for ACP towards the E/M total time.

## Practice Administration and Workflow

### Educating Patients and Families about Advance Care Planning

Patients may be hesitant to request or accept advance care planning services due to misperceptions that having an advance directive is only for the very frail or will result in automatic withholding of treatment. Educating all patients, regardless of disease or status, may help to remove any stigma associated advance care planning. The topic of advance care planning may be included in new patient packets; brochures or signs available in the waiting room; or included in reading libraries.

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<sup>10</sup> Centers for Medicare and Medicaid Services. [Medicare Claims Processing Manual Chapter 11-Processing Hospice Claims. 2020.](#)

In one practice in Maine, new patients receive a booklet adapted from the Maine Hospital Association that discusses advance directives.<sup>11</sup> The booklet is provided to patients to review on their own and with<sup>12</sup> their family, is reviewed during advance care planning visits, and includes forms to be filled out and scanned into the electronic health record for documentation.

### Initiating Advance Care Planning Services

One of the first steps for implementing a successful workflow for advance care planning is to determine the process for ordering and initiating the service. Options range from the managing oncologist recommending advance care planning as needed, to the specification of automatic triggers based on changes in care plan or patient status.

- New patients without an advance directive: Advance care planning is not limited to patients with advanced cancer or those receiving palliative care. Any person, regardless of age or clinical status, may benefit from an advance directive or designated health care proxy.

A New Mexico practice uses a standard intake questionnaire for all Oncology Care Model<sup>13</sup> patients which includes a question on whether the patient already has an advance directive. If a patient responds that they do not have a current advance directive or health care proxy, a medical assistant alerts the physician that the patient may need an advance care planning conversation.

- Initiation or change in treatment: Advance care planning may be included in the patient education session done prior to surgery, chemotherapy, immunotherapy or radiation therapy.
- Progression of disease or change in performance status: Patients who experience a progression of disease, lack of response to treatment, or have newly developed difficulties with activities of daily living may wish to update their written or communicated goals of care.
- Hospitalization: The hospitalization of a patient with advanced cancer may result in a palliative care referral and conversation with the patient about palliative or hospice care.
- Acute exacerbation of disease or initiation of palliative care: Whereas advance directives may benefit all persons, medical orders (e.g., MOLT, POLST, TROPP, etc.) are intended for patients who are very sick or frail.<sup>14</sup> A copy of the medical orders should be given to the patient, kept by all physician actively involved in care, and uploaded to available registries.

Practices may actively encourage patients to participate in advance care planning at specified intervals and/or provide materials to all patients informing them of services available as they desire. Whether

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<sup>11</sup> Maine Hospital Association. [Maine Health Care Advance Directive Form](#). 2008.

<sup>12</sup>

<sup>13</sup> Center for Medicare & Medicaid Innovation. [Oncology Care Model](#). 2021.

<sup>14</sup> National POLST. [Advance Directives](#). 2021.



advance care planning is referred by the managing physician, initiated by the patient, or identified by another clinical team member, all services must be ordered by a physician or other qualified healthcare provider. In all cases, advance care planning is optional under the Medicare program and patients must be given the option to decline.<sup>15</sup>

## Performing Advance Care Planning

Standards on the performance of advance care planning is beyond the scope of this *Guide*. Advance care planning visits may include one or more of the following:

- Education about the patient’s disease, prognosis, and care plan.
- Review of patient’s support system, including family, friends, and organizations.
- Discussion of the patient’s goals of care, end-of-life wishes, and what events may trigger the need to revisit advance directives and communicated wishes.
- Completion of advance directives. Some states may require use of a notary public to witness signature of advance directive forms.

## Staffing Models for Advance Care Planning

Numerous staffing models are available to practices who wish to increase provision of advance care planning. As mentioned in Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services, advance care planning may be “provided by physicians or using a team-based approach provided by physicians, nonphysician practitioners, and other staff under the order and medical management of the beneficiary’s treating physician.”<sup>16</sup> Options included, but are not limited to:

- Oncologist: The patient’s managing oncologist may wish to provide advance care planning services, in addition to regular discussions of diagnosis, prognosis, and goals of care. If the managing oncologist does refer a patient for advance care planning by another provider, they should remain engaged in reviewing the result of the discussion.
- Palliative care physician / advance practice provider: Practices may have an employed or affiliated palliative care physician(s) and/or may train an advanced practice provider(s) in performance of advance care planning.
- Clinical social workers: A patient’s end-of-life wishes may be influenced by “psychological, social, and spiritual and financial concerns.”<sup>17</sup> Clinical social workers may be utilized to perform advance care planning visits or be consulted for patients with psycho-social issues which may adversely impact the patient’s compliance with treatment and/or palliative care.

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<sup>15</sup> [Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services.](#)

<sup>16</sup> Ibid.

<sup>17</sup> ACP Decisions. [Clinical Social Workers: Champions of Advance Care Planning.](#) ACP Decisions. 2020.

- Patient navigators: patients commonly have a positive rapport with their nurse or other patient navigator. The recommendation from, performance by, and/or inclusion of the patient navigator may increase patient acceptance of advance care planning.<sup>18</sup>

## Discussion Guides

Patients with cancer can often be overwhelmed with the amount of information given during their visits, educational sessions, and support group meetings. Providers of advance care planning should supplement verbal education and discussion with written information and documentation of decisions that the patient may take home and revisit as needed. A number of discussion guides are available and, in some cases, are complemented with training programs and implementation services.

- Respecting Choices®: Founded by a clinical ethicist at Gunderson Medical Foundation and Lutheran Medical Center, Respecting Choices includes patient and facilitator materials, facilitator education and certification, and implementation services to assist organizations to successfully integrate advance care planning into their care delivery.<sup>19</sup>
- Five Wishes® is an advance directive document recognized as legally valid in 46 states and the District of Columbia. Overseen by Aging with Dignity, Five Wishes is accompanied by conversation guides, a physician toolkit, training, and consulting services.<sup>20</sup>
- The Conversation Project® is an initiative of the Institute for Healthcare Improvement. The Conversation Project is focused on public engagement with guides available for patients or family members who wish to initiate advance care planning conversations. Practices may direct patients or caregivers to available discussion guides and be familiar with such materials in case a patient brings their workbook to an office visit.<sup>21</sup>
- Advanced Cancer Care Planning: Available from ASCO® answers, Advanced Cancer Care Planning is a decision-making guide for patients and families facing serious illness. The guide covers care options for advance cancer, including standard treatments, clinical trials, palliative care, and hospice care; use of advance directives and health care proxies; and initiation of conversations with children, family, friends, and the health care team.<sup>22</sup> ASCO's Cancer.NET has other resources available for patients to understand their care and document their health care wishes in writing.<sup>23</sup>

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<sup>18</sup> Gabbard J, Pajewski NM, Callagan KE, et al. [Effectiveness of a Nurse-Led Multidisciplinary Intervention vs Usual Care on Advance Care Planning for Vulnerable Adults in an Accountable Care Organization](#). *JAMA Internal Medicine*, 181(3):361-369, 2021.

<sup>19</sup> <https://respectingchoices.org>

<sup>20</sup> <https://fivewishes.org>

<sup>21</sup> <https://theconversationproject.org>

<sup>22</sup> American Society of Clinical Oncology. [Advanced Cancer Care Planning: A Decision-Making Guide for Patients and Families Facing Serious Illness from the American Society of Clinical Oncology](#). 2020.

<sup>23</sup> <https://www.cancer.net/navigating-cancer-care/advanced-cancer/putting-your-health-care-wishes-writing>

- ACP Decisions: My ACP Decisions is an online platform for patients and clinicians to watch and share information on goals of care and improve conversations regarding advance care planning.<sup>24</sup>

## Documentation of Advance Care Planning Services

Thorough documentation of advance care planning services can assist both the facilitator and patient recall the details of all conversations, inform the managing oncologist and other care team members of the result of patient wishes, and ensure that services may be properly billed. Documentation should include:

Who was included in the advance care planning session: patient, family, health care team, and others.

- What was discussed during the advance care planning session.
- Time spent face-to-face with the patient, separate from other services on the same date of service.
- Presence of an advance directive, health care proxy, or medical orders.
- Code status, types of medical care preferred, preferred comfort level, and other wishes of the patient.
- Need for further sessions, either scheduled immediately or upon certain changes in illness or treatment.
- Referrals to social work, psycho-oncology, palliative care, hospice care, or other services based on patient needs uncovered during advance care planning.

Along with documentation within a visit note, all resulting legal and supporting documents should be uploaded to a specified location in the electronic health record and uploaded into available advance directive or medical order registries.<sup>25</sup>

## Patient Portals

Patient portals may be an effective way to provide patients access to information regarding Advance Care Planning Services. According to a 2020 article in the American Journal of Hospice and Palliative Medicine, “Patient portals can offer an opportunity to engage in ACP outside of an office visit, with existing research showing that some patients perceive an online mechanism to engage as more convenient than a traditional paper copy.”<sup>26</sup> A patient portal may include:

- Educational materials.
- Advance care planning and advance directive forms.
- Questionnaires for patients to complete prior to a visit or an advance care planning session.

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<sup>24</sup> <https://acpdecisions.org>

<sup>25</sup> Moses A, Dharod A, Williamson J, et al. [Considerations for Integrating Advance Care Planning Into the Electronic Health Record: A Primer for Clinicians](#). American Journal of Hospice and Palliative Medicine, 37(12):1004-1008, 2020.

<sup>26</sup> Ibid.

- Options for a patient to schedule an advance care planning session with a provider.

## Care Delivery, Quality, and Payment Models Supporting Advance Care Planning

### ASCO/COA Oncology Medical Home Standards

An advance care planning program is a key feature of the ASCO/COA Oncology Medical Home Standards, recently published in JCO Oncology Practice.<sup>27</sup>

Oncology Medical Home practices will offer an advance care planning discussion and complete a goals of care discussion with all patients that recognizes the individual patient’s needs and preferences. Palliative care will be introduced early in the patient care process for all patients with cancer; for patients with advanced cancer and/or metastatic cancer or patients with limiting co-morbid conditions the practice performs an advance care planning discussion including review of advance directives, agent for medical decision making, goals of care, and symptom management; and provide patient-centered access to care for patients at the end of life to avoid unnecessary and unwanted ED visits and potential hospitalizations.

### Oncology Care Model

One of the required practice redesign activities, practices participating in the Oncology Care Model must document a care plan containing the 13 components of the Institute of Medicine (IOM) Care Management Plan.<sup>28</sup> According to the IOM, care plans should ensure that patients are provided “with end-of-life care consistent with their needs, values, and preferences.”<sup>29</sup>

### Patient Centered Oncology Payment Model

In its 2019 update to the Patient Centered Oncology Payment Model (PCOP), ASCO included a care delivery requirement that each practice provide “dedicated advance care planning session, facilitated by a trained professional.”<sup>30</sup> National Quality Forum (NQF) Measure 0326 – Advance Care Plan is included as one available quality measure within PCOP.<sup>31</sup>

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<sup>27</sup> Woofter K, Kennedy E, Adelson K, et al. [Oncology Medical Home: ASCO and COA Standards](#). JCO Oncol Pract. 2021 Jul 13;OP2100167. doi: 10.1200/OP.21.00167. Epub ahead of print

<sup>28</sup> Booz Allen Hamilton. [Oncology Care Model: Key Drivers and Change Package](#). 2020.

<sup>29</sup> Institute of Medicine. [Delivering High-Quality Cancer Care](#). 2013.

<sup>30</sup> Ward JC, Bourbeau B, Chin AL, et al. [Updates to the ASCO Patient-Centered Oncology Payment Model](#). JCO Oncology Practice, 16(5):263-269, 2020.

<sup>31</sup> <https://www.qualityforum.org/QPS/0326>

## Medicare's Quality Payment Program

Adapted from NQF Measure 0326, Quality ID #47 – Advance Care Plan is available for practices to report as a claims measure<sup>32</sup> or MIPS CQM.<sup>33</sup> Implementation of advance care planning within a practice is also available as a reportable improvement activity.<sup>34</sup>

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<sup>32</sup> [https://qpp.cms.gov/docs/QPP\\_quality\\_measure\\_specifications/Claims-Registry-Measures/2021\\_Measure\\_047\\_MedicarePartBClaims.pdf](https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Claims-Registry-Measures/2021_Measure_047_MedicarePartBClaims.pdf)

<sup>33</sup> [https://qpp.cms.gov/docs/QPP\\_quality\\_measure\\_specifications/CQM-Measures/2021\\_Measure\\_047\\_MIPSCQM.pdf](https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2021_Measure_047_MIPSCQM.pdf)

<sup>34</sup> <https://qpp.cms.gov/mips/explore-measures?tab=improvementActivities&py=2021>

### Recommended Best Practices for the Administration of Advance Care Planning Services

- 1) Educate all patients about the importance of advance directives and availability of advance care planning services within the practice.
- 2) Establish practice-wide standards for ordering and initiating advance care planning, considering new patient referral, initiation or change in treatment, progression of disease, change in performance status, hospitalization, acute exacerbation of disease, or initiation of palliative care.
- 3) Acquire patient consent prior to performing advance care planning services.
- 4) Train staff on facilitating advance care planning discussions between patients, family members, and care teams.
- 5) Develop or adopt written discussion guides and supplemental materials that may be used by patients and facilitators.
- 6) Document time spent in the advance care planning session, separate from other services on the same day; topics of discussion; resulting decisions; and any signed documents resulting from the advance care planning session.
- 7) Utilize CPT codes 99497 and 99498 to bill the Medicare program for advance care planning. For patients with other health coverage, check payer-specific requirements.