NATIONAL ASSOCIATION OF Community Health Centers®

Reimbursement Tips:

Advance Care Planning (ACP)

Overview

Advance Care Planning is a personalized and supportive process between a physician and a patient that allows individuals to discuss, document, and communicate their preferences for future medical care and end-of-life decisions, ensuring their values and wishes are respected when they can no longer make decisions for themselves.

This Tip Sheet provides FQHCs with simplified, easy-to-understand instructions for providing and billing Medicare for Advance Care Planning. Also see NACHC resource: *Medicare Billing Lingo, Defined!* for definitions of terms used throughout this document.

Eligible Patients

- Medicare Part B beneficiaries.
- May be a new or established FQHC patient.
- Provide consent for services.

Authorized Billing Providers

Who they are:

- Physicians (MD,DO)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Certified Nurse Midwives (CNM)

Notes: ACP services are categorized as Evaluation and Management (E/M) services, requiring FQHC practitioners to be qualified to perform and bill for E/M level services in the state where they practice. Licensed Clinical Social Workers (CSWs) and Clinical Psychologists (CPs) are recognized as FQHC practitioners, but they are not authorized to independently furnish or bill for ACP services, as these are E/M services.

What they do:

- ✔ Obtain patient consent for services (verbal or written).
- ✔ Furnish ACP services personally during a face-to-face visit with the patient, family member, or surrogate.
- ✔ Help the patient clarify their values, goals, and preferences for future medical care, and address questions about specific interventions.
- ✔ Provide information about medical conditions, including any existing ones, and treatment options for the purpose of advance directives or other legal documents.
- ✔ Explain the purpose of advance directives or other legal documents and assist with their completion.
- ✔ Communicate the patient's preference with the care team to ensure alignment with the care plan.
- ✔ Provide emotional support throughout the process.
- ✔ Document the discussion in the medical record, even if no legal forms are completed.

Notes:

- *While completing legal forms such as an advance directive or healthcare proxy designation is often a helpful outcome of these discussions, it is not a requirement for ACP to take place. The focus is on ensuring the patient's wishes are clearly understood and documented appropriately.*
- *A surrogate is defined by Medicare as a healthcare agent, designated decision maker, family member, or caregiver.*

Auxiliary Personnel

Who they are (examples):

- Nurses (nurse care manager, clinical nurse specialist (CNS), Registered Nurse (RN), Licensed Practical Nurse (LPN))
- Social Workers
- Medical Assistants

Note: ACP service elements as described below may be completed by auxiliary personnel (as indicated by scope of practice, education, and training limits set by their individual State) under supervision of the authorized billing provider. As ACPs qualify as FQHC visits reimbursed at the PPS rate, the visit must be a face-to-face encounter (see Medicare Billing Lingo, Defined!) between the patient and qualified practitioner (see list of authorized billing providers above).

What they may do (under direct supervision):

- ✔ Schedule the ACP session, coordinate with multidisciplinary team members, and ensure follow-up appointments as needed.
- ✔ Prepare patients for the consent discussion with the authorized provider.
- ✔ Assist patients and their families by providing educational materials about ACP, helping them reflect on their values and preferences, and preparing them for conversations with qualified healthcare providers.
- ✔ Gather relevant patient information, such as prior advance directives or healthcare proxy documentation, to assist the physician or other qualified healthcare professional in guiding the discussion.
- ✔ Provide the patient and family with standardized forms (i.e., advance directives) and assist with the completion of those forms.

Services Elements, Coding & Billing

CODE	*Service Elements*	*Service Provider*	*FQHC Medicare Billing Code & Rate*
CPT® 99497	Advance care planning (ACP) by the physician or other qualified health care practitioner, first 30 minutes; face-to-face with the patient, family, and/or surrogate: • Explanation and discussion of an advance directive in case an injury or illness prevents them from making their own health care decisions. • Completion of advance directives or other such forms, when performed. • Future care decisions they might need or want to make. • Assistance with how patient can let others know about their care preferences. • Identification of the patient's caregiver. *Active management of any identified problem(s) is not part of the ACP visit. A separate visit would be scheduled to provide care or support for any medical problems.*	Authorized Billing Provider	G0466: PPS qualifying medical visit, new patient: $271.88 G0470: PPS medical visit, established patient $202.65 G2025: Distant site FQHC telehealth service: $94.45 • Apply modifier 95 for audio-video visits. • Apply modifier FQ and, if also requested, modifier 93 for audio-only visits.
CPT® +99498	Each additional 30 minutes of APC services *FQHCs may not bill add-on codes to Medicare under the PPS payment system.*	Authorized Billing Provider	*Not billable to Medicare by FQHCs*

The reimbursement rate is based on the 2025 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI. Code descriptions taken from the AMA's CPT 2025 Manual, Professional Edition.

Reimbursement Tips: Advance Care Planning (ACP)

ACP is a time-based service. CMS, in its Advance Care Planning MLN Fact Sheet, emphasized that the coding rules for minimum time requirements must adhere to CPT rules. These rules specify that a unit of time is reached when the mid-point is passed. For example:

- Do not bill for ACP services lasting 15 minutes or less.
- Thirty (30) minutes is reached when at least 16 minutes have passed.
- For an additional 30 minutes, the time threshold starts when at least 46 minutes of service beyond the initial 30 minutes has been provided.

While FQHCs do not bill for additional time beyond the CPT 99497 service, it is important to understand how to code additional time for ACP services if CPT +99498 is billable to other payors.

APC code 99497 is a qualifying service listed under PPS G0466 and G0467. If it is the only service rendered by an authorized billing provider, it is paid as a stand-alone billable service. If it is furnished on the same day as another Medicare PPS G code medical service, only one service is paid. Also, ACP is not separately billable or reimbursed if it is included as part of an Annual Wellness Visit (See NACHC Medicare Wellness Visits: IPPE and AWV Reimbursement Tip Sheet). CMS has not placed frequency limitations on standalone ACP visits.

Medicare will pay 80% of the lesser of the FQHC's actual charges or the geographically adjusted PPS rates. Patients pay 20% coinsurance based upon the lesser of the submitted charges of the local PPS payment rates for G0466 and G0467.

ACP is a face-to-face service (see Medicare Billing Lingo, Defined!) and CMS does include it on the Medicare telehealth services list during the COVID-19 telehealth extension through December 31, 2025.

Documentation

Be sure to capture the following documentation elements when billing for ACP services:

- ✔ Patient consent
- ✔ Information or educational materials provided to patient
- ✔ Explanation and content of any advance directives
- ✔ Details of patient's future medical or end-of-life preferences
- ✔ Family or surrogates involved in the ACP discussion
- ✔ Voluntary aspect of the encounter
- ✔ Any legal documents completed
- ✔ Date of the visit and the mode (telehealth or in-person)
- ✔ Time spent discussing ACP during the encounter

Because ACP is a time-based service, the details of the documentation should vary based upon the length and complexity of the discussion. Any time spent personally by the authorized billing provider assisting the patient with completion of advance directive forms should also be documented. Document which forms, if any, were completed, and maintain a copy in the patient's medical record.

An advance directive is a legal document that records a patient's medical treatment wishes and designates an individual to act upon those wishes if a patient is unable to do so themselves. Examples of advance directives include, but are not limited to: Living Will, Durable Power of Attorney (Healthcare), Health Care Proxy, Psychiatric Advance Directives, and Medical Orders for Life-Sustaining Treatment (MOLST).

Co-Occurring Care Management Services

ACP may be furnished during the same reporting period as those care management services billable by FQHCs using the individual care management HCPCS codes or, if not prepared to do so on January 1, 2025, the HCPCS code G0511 until July 1, 2025 (see NACHC resource: Summary of Medicare Care Management Services).

References

- AMA. 2025 CPT Codebook
- AAPC. 2025 HCPCS Level II Codebook
- CMS. CY 2025 Physician Fee Schedule Final Rule. https://www.federalregister.gov/public-inspection/2024-25382/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule
- CMS FQHC PPS Codes. Accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf
- CMS List of Telehealth Services https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- CMS MLN Advance Care Planning Fact Sheet. Accessed https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf
- Medicare Claims Processing Manual. Chapter 9: Rural Health Clinics/Federally Qualified Health Centers https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf
- Medicare Benefit Policy Manual. Chapter 13: Rural Health Clinics/Federally Qualified Health Centers https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf
- Outreach: Medicare Wellness Visits. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

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