

	Advance Care Planning	
	<b>Policy Number:</b> POL-PP-193	<b>Original Creation Date:</b> 9/1/2020
	<b>Version Number:</b> 6	<b>Version Effective Date:</b> 9/1/2025
	<b>Policy Status:</b> Active	<b>Next Review Date:</b> 9/1/2026

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: <https://providers.bluekc.com/ContactUs/PaymentPolicies>.

PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/> PROFESSIONAL	<input type="checkbox"/> FACILITY	<input type="checkbox"/> DME	<input type="checkbox"/> AMBULATORY SURGERY	<input checked="" type="checkbox"/> LAB	<input checked="" type="checkbox"/> OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/> COMMERCIAL	<input checked="" type="checkbox"/> BLUE MEDICARE ADVANTAGE	<input checked="" type="checkbox"/> ACA QHP <sup>1</sup>	<input checked="" type="checkbox"/> SMALL GROUP ACA	<input checked="" type="checkbox"/> JAA <sup>2</sup>	<input checked="" type="checkbox"/> FEP <sup>3</sup>	<input type="checkbox"/> DENTAL

<sup>1</sup> ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family    <sup>2</sup> JAA: Joint Administrative Account    <sup>3</sup> FEP: Federal Employee Program

### Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.

### Description/Application

Advance care planning is a face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms.

Examples of written advanced directives include but are not limited to.

- Health Care Proxy
- Durable Power of Attorney for Health Care
- Living Will and
- Medical Orders for Life-Sustaining Treatment (MOLST)

Documentation may be needed to confirm the validity of the billed modifier before payment is made.

### Policy

Total time spent with patient/family/surrogate in counseling and discussion of an advance directive must be documented in order to be considered for reimbursement.

When using codes 99497, 99498, no active management of the problem(s) is undertaken during the time period reported.

Codes 99497 and 99498 may be reported separately if performed on the same day as another Evaluation and management service.

Do not report 99497 and 99498 on the same date of service as critical and intensive observation codes (99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480, 99483).

### Coding

CPT Code	Description
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 includes the explanation and discussion of advanced 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)

### References and Resources

Centers for Medicare and Medicaid Services

American Medical Association

**Related Documents**

N/A

**Revision History**

<b>Version</b>	<b>Date</b>	<b>Summary of Revisions</b>
001	9/1/2020	Initial version
002	9/1/2021	Annual review, no updates, or changes were made to the policy
003	9/1/2022	Annual Review, there were no updates or changes made to this policy
004	9/1/2023	Annual review, no updates, or changes were made to the policy
005	9/1/2024	Annual review, no updates, or changes were made to the policy
006	9/1/2025	Annual review, no updates, or changes were made to the policy