Quality ID #47 (NQF 0326): Advance Care Plan
– National Quality Strategy Domain: Communication and Care Coordination
– Meaningful Measure Area: Care is Personalized and Aligned with Patient's Goals

2022 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. There is no diagnosis associated with this measure. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

***NOTE**: This measure is appropriate for use in all healthcare settings (e.g., inpatient, nursing home, ambulatory) except the emergency department. For each of these settings, there should be documentation in the medical record(s) that advance care planning was discussed or documented.*

***NOTE:** Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.*

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All patients aged 65 years and older

> ***DENOMINATOR NOTE:** MIPS eligible clinicians indicating the Place of Service as the emergency department will not be included in this measure.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 65 years on date of encounter
> **AND**
> **Patient encounter during the performance period (CPT or HCPCS):** 90791, 90832, 90834, 90837, 90845, 90846, 90847, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439
> **WITHOUT**
> **Place of Service (POS):** 23

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AND NOT
DENOMINATOR EXCLUSION:
Hospice services received by patient any time during the measurement period: G9692

NUMERATOR:
Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Definition:
Documentation that Patient did not Wish or was not able to Name a Surrogate Decision Maker or Provide an Advance Care Plan – May also include, as appropriate, the following:

- That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship.

Numerator Instructions:
If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, submit **1124F**.

NUMERATOR NOTE: *The CPT Category II codes used for this measure indicate: Advance Care Planning was discussed and documented. The act of using the Category II codes on a claim indicates the provider confirmed that the Advance Care Plan was in the medical record (that is, at the point in time the code was assigned, the Advance Care Plan in the medical record was valid) or that advance care planning was discussed. The codes are required annually to ensure that the provider either confirms annually that the plan in the medical record is still appropriate or starts a new discussion.*

The provider does not need to review the Advance Care Plan annually with the patient to meet the numerator criteria; documentation of a previously developed advanced care plan that is still valid in the medical record meets numerator criteria.

Services typically provided under CPT codes 99497 and 99498 satisfy the requirement of Advance Care Planning discussed and documented, minutes. If a patient received these types of services, submit CPT II ***1123F*** *or* ***1124F****.*

Numerator Options:

Performance Met:	Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record **(1123F)**
OR	
Performance Met:	Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan **(1124F)**
OR	
Performance Not Met:	Advance Care Planning not documented, reason not otherwise specified **(1123F *with* 8P)**

RATIONALE:
It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity. The Work Group has determined that the measure should remain as specified with no required timeframe

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based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change. In the stable patient, it would be very difficult to define the correct interval. It was felt by the Work Group that the error rate in simply not having addressed the issue at all is so much more substantial (Teno, 1997) than the risk that an established plan has become outdated that we should not define a specific timeframe at this time. As this measure is tested and reviewed, we will continue to evaluate if and when a specific timeframe should be included.

CLINICAL RECOMMENDATION STATEMENTS:

Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation.

Oral statements:

- Conversations with relatives, friends, and clinicians are most common form; should be thoroughly documented in medical record for later reference.
- Properly verified oral statements carry same ethical and legal weight as those recorded in writing.

Instructional advance directives (DNR orders, living wills):

- Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.
- May be revoked or altered at any time by the patient.
- Clinicians who comply with such directives are provided legal immunity for such actions.

Durable power of attorney for health care or health care proxy:

- A written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. (AGS)

The National Hospice and Palliative Care Organization provides the Caring Connection web site, which provides resources and information on end-of-life care, including a national repository of state-by-state advance directives.

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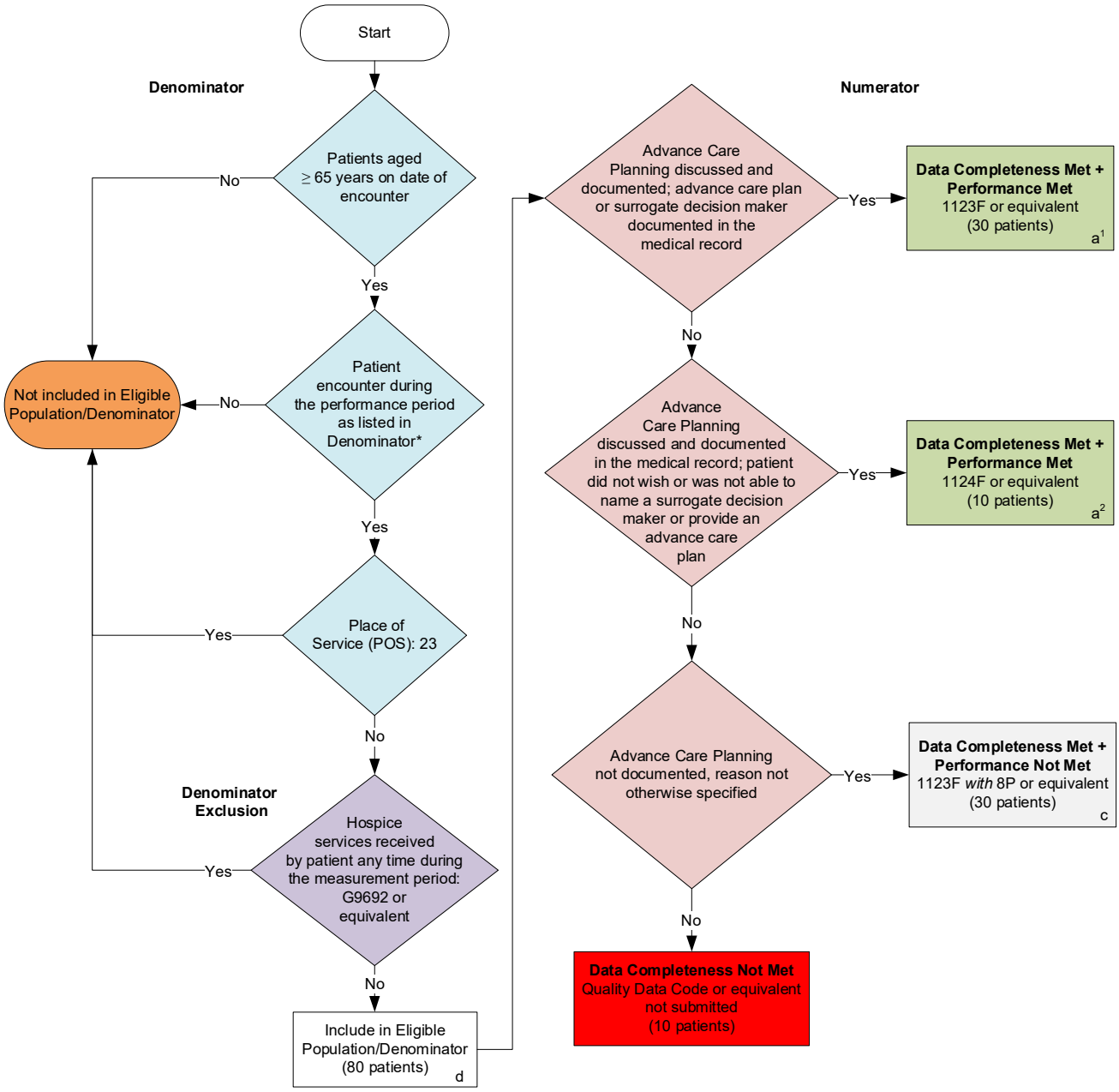
2022 Clinical Quality Measure Flow for Quality ID #47 (NQF 0326): Advance Care Plan

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a^1+a^2=40 patients) + Performance Not Met (c=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=
Performance Met (a^1+a^2=40 patients) = 40 patients = **57.14%**
Data Completeness Numerator (70 patients) = 70 patients

* See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

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2022 Clinical Quality Measure Flow Narrative for Quality ID #047 (NQF 0326): Advance Care Plan

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator

2. Check *Patients aged greater than or equal to 65 years on date of encounter*:

    a. If *Patients aged greater than or equal to 65 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients aged greater than or equal to 65 years on date of encounter* equals Yes, proceed to *Patient encounter during the performance period as listed in Denominator**.

3. Check *Patient encounter during the performance period as listed in Denominator**:

    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator.* Stop processing.

    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to *Place of service (POS)*.

4. Check *Place of service (POS):*
    a. If *Place of service (POS)* equals Yes, do not include in *Eligible Population/Denominator.* Stop processing.

    b. If *Place of service (POS)* equals No, proceed to *Hospice services received by patient any time during the measurement period*.

5. *Hospice services received by patient any time during the measurement period*:

    a. If *Hospice services received by patient any time during the measurement period* equals No, include in *Eligible Population/Denominator.*

    b. If *Hospice services received by patient any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator.* Stop processing.

6. Denominator Population:

    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.

7. Start Numerator

8. Check *Advance Care Planning discussed and documented; advance care plan or surrogate decision make documented in the medical record*:

    a. If *Advance Care Planning discussed and documented; advance care plan or surrogate decision make documented in the medical record* equals Yes, include in *Data Completeness Met and Performance Met*.

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- *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 30 patients in the Sample Calculation.

b. If *Advance Care Planning discussed and documented; advance care plan or surrogate decision make documented in the medical record* equals No, proceed to *Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan*.

9. Check *Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan*:

   a. *Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan* equals Yes, include in *Data Completeness Met and Performance Met*.

      - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 10 patients in the Sample Calculation.

   b. If *Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan* equals No, proceed to *Advance Care Planning not documented, reason not otherwise specified*.

10. Check *Advance Care Planning not documented, reason not otherwise specified*:

    a. If *Advance Care Planning not documented, reason not otherwise specified* equals Yes, include in *Data Completeness Met and Performance Not Met*.

       - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.

    b. If *Advance Care Planning not documented, reason not otherwise specified* equals No, proceed to *Data Completeness Not Met.*

11. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a^1 plus a^2 equals 40 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.5 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 40) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-process

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