

Advance Care Plan

*This measure is to be reported for all patients aged 65 years and older seen by the clinician — a minimum of **once** during the reporting period.*

Measure 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

What will you need to report for each patient aged 65 years and older for this measure?

If you select this measure for reporting, you will report:

- Whether or not you documented a surrogate decision-maker or advance care plan in the medical record OR
- Whether or not you documented that you discussed an advance care plan in the medical record but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan¹

What if this process or outcome of care is not appropriate for your patient?

Some measures provide an opportunity for the physician or eligible health professional to document when a process or outcome of care is not appropriate for a given patient (also called performance exclusions). Because this measure is applicable to most if not all patients, there are no allowable performance exclusions.

¹May also include, as appropriate, 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.

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PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy) / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
National Provider Identifier (NPI)		Date of Service	

Clinical Information			Billing Information
Step 1 Is patient eligible for this measure?			
	Yes	No	Code Required on Claim Form
Patient is aged 65 years and older on date of encounter.	<input type="checkbox"/>	<input type="checkbox"/>	Verify date of birth on claim form.
There is a CPT E/M Service Code for this visit.	<input type="checkbox"/>	<input type="checkbox"/>	Refer to coding specifications document for list of applicable codes. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.
If No is checked for any of the above, STOP. Do not report a CPT category II code.			
Step 2 Does patient meet or have an acceptable reason for not meeting the measure?			
Advance Care Planning	Yes	No	Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
Documented — advance care plan or surrogate decision-maker documented in medical record	<input type="checkbox"/>	<input type="checkbox"/>	1123F
Documented as discussed — patient did not wish or was not able to name a surrogate decision-maker or provide an advance care plan ¹	<input type="checkbox"/>	<input type="checkbox"/>	1124F ²
			If No is checked for all of the above, report 1123F-8P (Advance care planning not documented, reason not otherwise specified.)

¹May also include, as appropriate, 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.

²If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, report 1124F.

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Coding Specifications

Codes required to document a visit occurred:

A CPT E/M service code is required to identify patients to be included in this measure.

All measure-specific coding should be reported ON THE SAME CLAIM.

CPT E/M service codes

- 99201, 99202, 99203, 99204, 99205 (office-new patient),
- 99212, 99213, 99214, 99215 (office-established patient),
- 99218, 99219, 99220 (initial observation care),
- 99221, 99222, 99223 (initial inpatient),
- 99231, 99232, 99233 (subsequent inpatient hospital care),
- 99234, 99235, 99236 (observation or inpatient hospital care),
- 99291¹ (critical care),
- 99304, 99305, 99306, 99307, 99308, 99309, 99310 (nursing facility),
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 (domiciliary),
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 (home visit)

Quality codes for this measure:

CPT II Code descriptors

(Data collection sheet should be used to determine appropriate code.)

- **CPT II 1123F:** Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record
- **CPT II 1124F:** 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 plan²
- **CPT II 1123F-8P:** Advance care planning not documented, reason not otherwise specified

¹Clinicians indicating the place of service as the emergency department (23) will not be included in this measure.

²May also include, as appropriate, 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.

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