Measure #47 (NQF 0326): Care Plan – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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 reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure’s denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The reporting modifier allowed for this measure is: 8P-reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 65 years and older

DENOMINATOR NOTE: *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 reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 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
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

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

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 Quality-Data Coding Options for Reporting Satisfactorily:
Advance Care Planning Discussed and Documented
Performance Met: CPT II 1123F: Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record

OR
Performance Met: 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 plan

OR
Advance Care Planning not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 1123F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

Performance Not Met: 1123F with 8P: Advance care planning not documented, reason not otherwise specified

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 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 at this time 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.