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

2016 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.

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.*

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, 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

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**.

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.

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 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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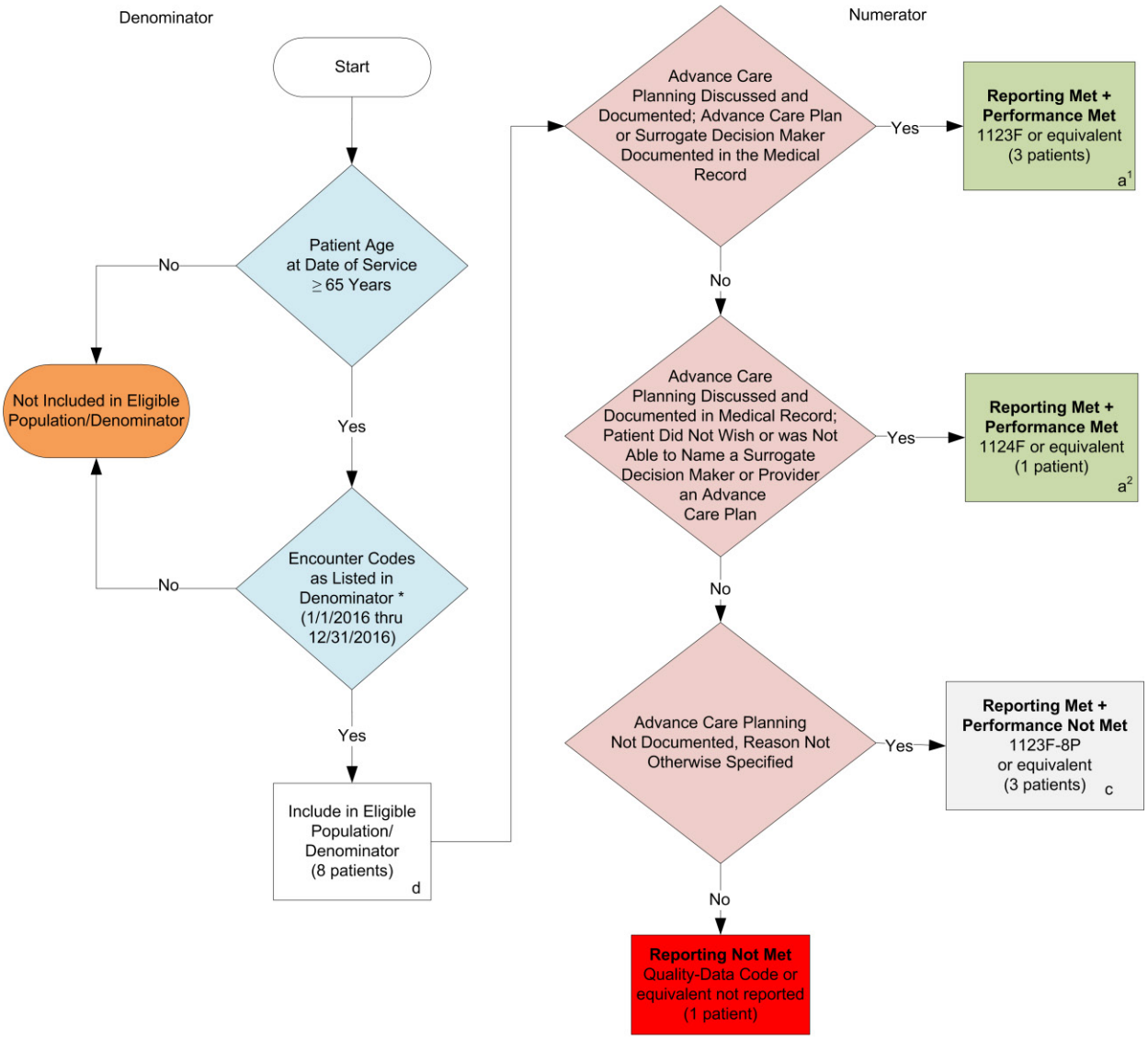
2016 Claims/Registry Individual Measure Flow
PQRS #47 NQF #0326: Care Plan



SAMPLE CALCULATIONS:

Reporting Rate=

Performance Met (a^1+a^2=4 patients) + Performance Not Met (c=3 patients) = 7 patients = **87.50%**

Eligible Population / Denominator (d=8 patients) = 8 patients

Performance Rate=

Performance Met (a^1+a^2=4 patients) = 4 patients = **57.14%**

Reporting Numerator (7 patients) = 7 patients

* See the posted Measure Specification for specific coding and instructions to report this measure.

NOTE: Reporting Frequency – Patient-process

v2

2016 Claims/Registry Individual Measure Flow
PQRS #47 NQF #0326: Care Plan

Please refer to the specific section of the Measure Specification to identify the denominator and numerator information for use in reporting this Individual Measure.

1. Start with Denominator
2. Check Patient Age:
    a. If the Age is greater than or equal to 65 years of age on Date of Service and equals No during the measurement period, do not include in Eligible Patient Population. Stop Processing.
    b. If the Age is greater than or equal to 65 years of age on Date of Service and equals Yes during the measurement period, proceed to check encounter performed.
3. Check Encounter Performed:
    a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Patient Population. Stop Processing.
    b. If Encounter as Listed in the Denominator equals Yes, include in the Eligible population, proceed to check discharge timing and facility.
4. 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 8 patients in the sample calculation.
5. Start Numerator
6. Check Advanced Care Planning Discussed and Documented; Advance Care Plan or Surrogate Decision Maker Documented in the Medical Record:
    a. If Advanced Care Planning Discussed and Documented; Advance Care Plan or Surrogate Decision Maker Documented in the Medical Record equals Yes, include in Reporting Met and Performance Met.
    b. Reporting Met and Performance Met letter is represented in the Reporting Rate and Performance Rate in the Sample Calculation listed at the end of this document. Letter a1 equals 3 patients in Sample Calculation.
    c. If Advanced Care Planning Discussed and Documented; Advance Care Plan or Surrogate Decision Maker Documented in the Medical Record equals No, proceed to Advanced Care Planning Discussed and Documented in Medical Record; Patient Did Not Wish or was Not Able to Name a Surrogate Decision Maker or Provide an Advance Care Plan.
7. Check Advanced Care Planning Discussed and Documented in Medical Record; Patient Did Not Wish or was Not Able to Name a Surrogate Decision Maker or Provide an Advance Care Plan:
    a. If Advanced Care Planning Discussed and Documented in 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 Reporting Met and Performance Met.

b. Reporting Met and Performance Met letter is represented in the Reporting Rate in the Sample Calculation listed at the end of this document. Letter a2 equals 1 patient in the Sample Calculation.

c. If Advanced Care Planning Discussed and Documented in 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.

8. 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 Reporting Met and Performance Not Met.

   b. Reporting Met and Performance Not Met letter is represented in the Reporting Rate in the Sample Calculation listed at the end of this document. Letter c equals 3 patients in the Sample Calculation.

   c. If Advance Care Planning Not Documented, Reason Not Otherwise Specific equals No, proceed to Reporting Not Met.

9. Check Reporting Not Met:

   a. If Reporting Not Met equals No, Quality Data Code or equivalent not reported. 1 patient has been subtracted from the reporting numerator in sample calculation.

SAMPLE CALCULATIONS:

Reporting Rate=

Performance Met (a^1+a^2=4 patients) + Performance Not Met (c=3 patients) = 7 patients = **87.50%**
Eligible Population / Denominator (d=8 patients) = 8 patients

Performance Rate=

Performance Met (a^1+a^2=4 patients) = 4 patients = **57.14%**
Reporting Numerator (7 patients) = 7 patients