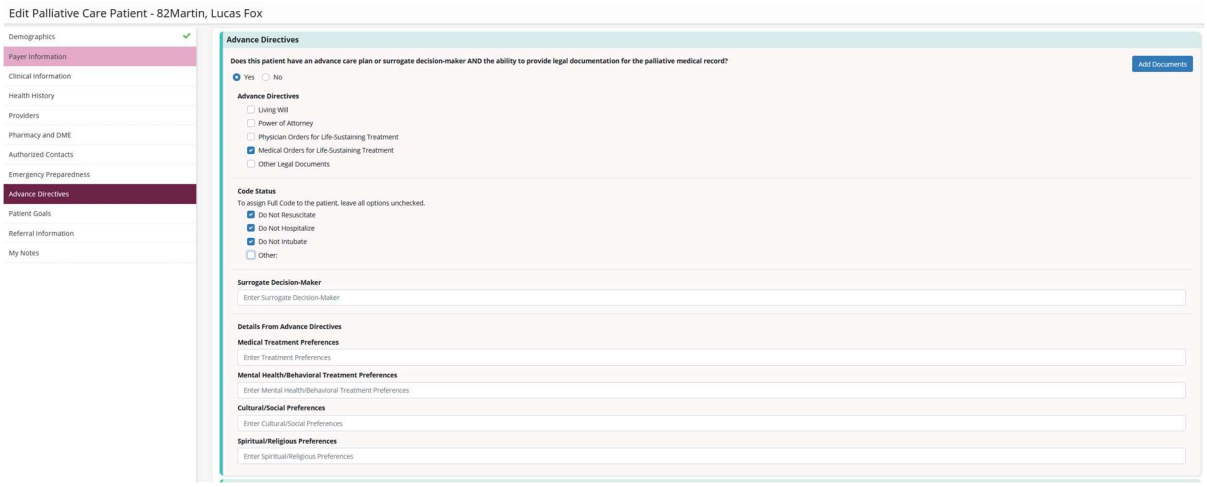
CQM 47 Advance Care Plan

Documentation Step-by-Step

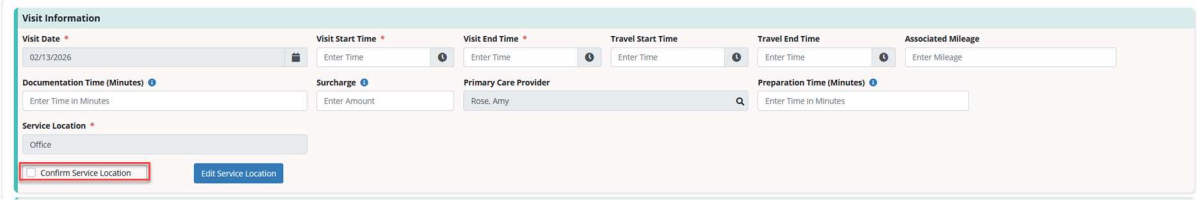
Users must document using a billable visit for a patient with a CPT code that qualifies for the measure (this is most routine CPT codes).

Workflow: Patient Chart > Select Patient > Edit Profile > Advance Directives



This measure has exclusion criteria including Place of Service 23 - Emergency Room - Hospital. Confirm the encounter was **NOT** billed with Place of Service 23 - Emergency Room - Hospital.

This exclusion criteria is handled by the Axxess Palliative Care solution. Users must confirm their place of service for every visit and if POS 23 is used then that patient will not be included in the count for this measure.



At the end of the visit the user will see a list of G codes under the header Advance Care Planning and can select the most appropriate code.

Performance Met (1123F) - Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record.

Performance Met (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.

Performance Not Met (1123F with 8P) - Advance care planning not documented, reason not otherwise specified.