

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

Edit Palliative Care Patient - 82Martin, Lucas Fox

Demographics ✓
Payer Information
Clinical Information
Health History
Providers
Pharmacy and DME
Authorized Contacts
Emergency Preparedness
Advance Directives
Patient Goals
Referral Information
My Notes

Advance Directives

Does this patient have an advance care plan or surrogate decision-maker AND the ability to provide legal documentation for the palliative medical record?

☒ Yes ☐ No Add Documents

Advance Directives

☐ Living Will
☐ Power of Attorney
☐ Physician Orders for Life-Sustaining Treatment
☒ Medical Orders for Life-Sustaining Treatment
☐ Other Legal Documents

Code Status
To assign Full Code to the patient, leave all options unchecked.

☒ Do Not Resuscitate
☒ Do Not Hospitalize
☒ Do Not Intubate
☐ Other

Surrogate Decision-Maker
Enter Surrogate Decision-Maker

Details From Advance Directives

Medical Treatment Preferences
Enter Treatment Preferences

Mental Health/Behavioral Treatment Preferences
Enter Mental Health/Behavioral Treatment Preferences

Cultural/Social Preferences
Enter Cultural/Social Preferences

Spiritual/Religious Preferences
Enter Spiritual/Religious Preferences

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.

Visit Information
Visit Date *
02/13/2025

Visit Start Time *
Enter Time

Visit End Time *
Enter Time

Travel Start Time
Enter Time

Travel End Time
Enter Time

Associated Mileage
Enter Mileage

Documentation Time (Minutes) ⓘ
Enter Time in Minutes

Surcharge ⓘ
Enter Amount

Primary Care Provider
Rose, Amy

Preparation Time (Minutes) ⓘ
Enter Time in Minutes

Service Location *
Office

☐ Confirm Service Location Edit Service Location

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.

Provider Visit

Subsequent - Established Patient Home ☐ 99347 - 20 (min) - Established Patient - Straightforward MDM or 20 mins ☐ 99348 - 30 (min) - Established Patient - Low Level MDM or 30 mins ☐ 99349 - 40 (min) - Established Patient - Moderate MDM or 40 mins ☒ 99350 - 60 (min) - Established Patient - High MDM or 60 mins total time	Prolonged Codes Home/Assisted Living Facility/Group Home ☐ 99358 - 60 (min) - 120 (max) - non F2F, prolonged E/M service before and/or after dir. contact first hour ☐ 99359 - 30 (min) - non F2F, prolonged E/M Before and or after direct patient care each addl. 30 minutes	Other Codes ☐ 96127 - Depression Screening ☐ 99483 - Cognitive Screening ☐ 99497 - Advance Care Planning First 30 ☐ 99498 - Advance Care Planning Addl. 30 mins
Clinical Quality Measures Advance Care Planning ☐ 1123F - Measure Met: Advance care planning discussed and documented; advance care plan or surrogate decision-maker documented in the medical record ☐ 1123F(8P) - Performance Not Met: advance care planning not documented, reason not otherwise specified ☐ 1124F - Measure 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	Falls Plan of Care ☐ 0518F - Measure Met: Fall plan of care documented ☐ 0518F(1P) - Measure Exception: Patient not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair ☐ 0518F(8P) - Measure Not Met: Fall plan of care not documented, reason not otherwise specified	Elder Maltreatment Screening ☐ G8535 - Measure Exception: Elder maltreatment screening not documented; documentation that patient is not eligible for the elder maltreatment screen at the time of the encounter ☐ G8536 - Measure Not Met: No documentation of an elder maltreatment screening, reason not given ☐ G8733 - Measure Met: Elder maltreatment screening documented as positive and a follow-up plan is documented ☐ G8734 - Measure Met: Elder maltreatment screening documented as negative, follow-up is not required ☐ G8735 - Measure Not Met: Elder maltreatment screening documented as positive, follow-up plan not documented and reason not given ☐ G8941 - Measure Exception: Elder maltreatment screening documented as positive, follow-up plan not documented, documentation the patient is not eligible for follow-up plan at the time of the encounter