Quality ID #047 (CBE 0326): Advance Care Plan

2026 COLLECTION TYPE:
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:
Process – High Priority

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:

Reporting Frequency:
This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinical Applicability:
This measure is intended to reflect the quality of services provided for 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. There is no diagnosis associated with this measure. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator 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 Strata and Performance Rates:
This measure contains one strata defined by a single submission criteria.
This measure produces a single performance rate.

Implementation Considerations:
For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient for the performance period. The most advantageous quality data code (QCD) will be used if the measure is submitted more than once.

Telehealth:
TELEHEALTH ELIGIBLE: This measure is appropriate for and applicable to the telehealth setting. Patient encounters conducted via telehealth using encounter code(s) found in the denominator encounter criteria are allowed for this measure. Therefore, if the patient meets all denominator criteria for a telehealth encounter, it would be appropriate to include them in the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:
The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical

topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All patients aged 65 years and older.

DENOMINATOR NOTE:
MIPS eligible clinicians indicating the Place of Service as the emergency department will not be included in this measure.

**Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter
AND
Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90846, 90847, 96116, 96130, 96132, 96110*, 96112, 96156, 96105, 96125, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439
WITHOUT
Place of Service (POS): 23
AND NOT
DENOMINATOR EXCLUSION:
Hospice services received by patient any time during the measurement period: G9692

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.

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 Instructions:
If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, submit 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.

Services typically provided under CPT codes 99497 and 99483 satisfy the requirement of Advance Care Planning discussed and documented, minutes. If a patient received these types of services, submit CPT II 1123F or 1124F.

Numerator Options:

Performance Met:	Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record (1123F)
OR	
Performance 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 (1124F)
OR	
Performance Not Met:	Advance Care Planning not documented, reason not otherwise specified (1123F with 8P)

RATIONALE:

Advance care planning is a continuous process of conversation and documentation to align a patient's care and interventions with their beliefs, values and preferences, in the event they become unable to make those decisions. The Centers for Medicare & Medicaid Services (CMS) describe advance care planning as a face-to-face service to discuss a patient's health wishes that may or may not include completing relevant documentation (Centers for Medicare & Medicaid Services (CMS), 2019).

A number of documents may be completed as a result of the advance care planning conversation in order to capture a patient's wishes and goals for care. These documents are generally referred to as "advance directives" and can include: Durable Power of Attorney for Health Care (DPAHC), living will, and combined directives. In addition to these documents, a patient may have a Physician Orders for Life-Sustaining Treatment (POLST), also referred to as Medical Orders for Scope of Treatment (MOLST). A patient may also identify a surrogate decision maker to serve as their representative and decision maker in the event they cannot make decisions for themselves (Silveira, Arnold, & Givens, 2020).

Although it is widely agreed that advance care planning is a critical part of patient care, only about 50% of older adults have engaged in advance care planning. Of those older adults, about one-third have documented their wishes and only 10%–20% discussed their wishes with clinicians (Yadav, et al., 2017); (McMahan, Tellez, & Sudore, 2021). A 2017 study found that 70% of providers indicated they only have advance care planning conversations with their patients experiencing advanced illness (Bires, Franklin, Nichols, & Cagle, 2018). The benefits of advance care planning may only be realized if the care team has access to and follows the patient's advance care plan.

Advance care planning can lead to decreased psychological distress and hospitalizations as well as improved end-of-life care, increased trust in providers and improved quality of life, and can facilitate hope. It has also been associated with increased knowledge about treatment options, documentation of advance care planning, patient-surrogate congruence, goal concordant care and compliance with patient wishes, among others (McMahan, Tellez, & Sudore, 2021); (Rosenberg, Popp, Dizon, El-Jawahri, & Spence, 2020); (Martin, 2016); (Bischoff, Sudore, Miao, Boscardin, & Smith, 2013).

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.

REFERENCES:

Advance Care Plan Decisions. (2019) Why Advance Care Planning is a Crucial Part of Population Health Strategy. Retrieved July 23, 2020, from https://acpdecisions.org/why-advance-care-planning-is-a-crucial-part-of-population-health-strategy/

Bires, J. L., Franklin, E. F., Nichols, H. M., & Cagle, J. G. (2018). Advance Care Planning Communication: Oncology Patients and Providers Voice their Perspectives. *Journal of Cancer Education, 33*(5), 1140–1147. Retrieved from https://doi.org/10.1007/s13187-017-1225-4

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Lendon, J.P, Caffrey, C. & Lau, D. (2018). Advance directive documentation among adult day services centers and use among participants, by region and center characteristics : National Study of Long-Term Care Providers, 2016. National Health Statistics Reports, 117. https://stacks.cdc.gov/view/cdc/58975

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McMahan, R. D., Tellez, I., & Sudore, R. L. (2021). Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and Where Do We Go? A Scoping Review. *Journal of the American Geriatrics Society, 69*(1), 234–244. Retrieved from https://doi.org/10.1111/jgs.16801

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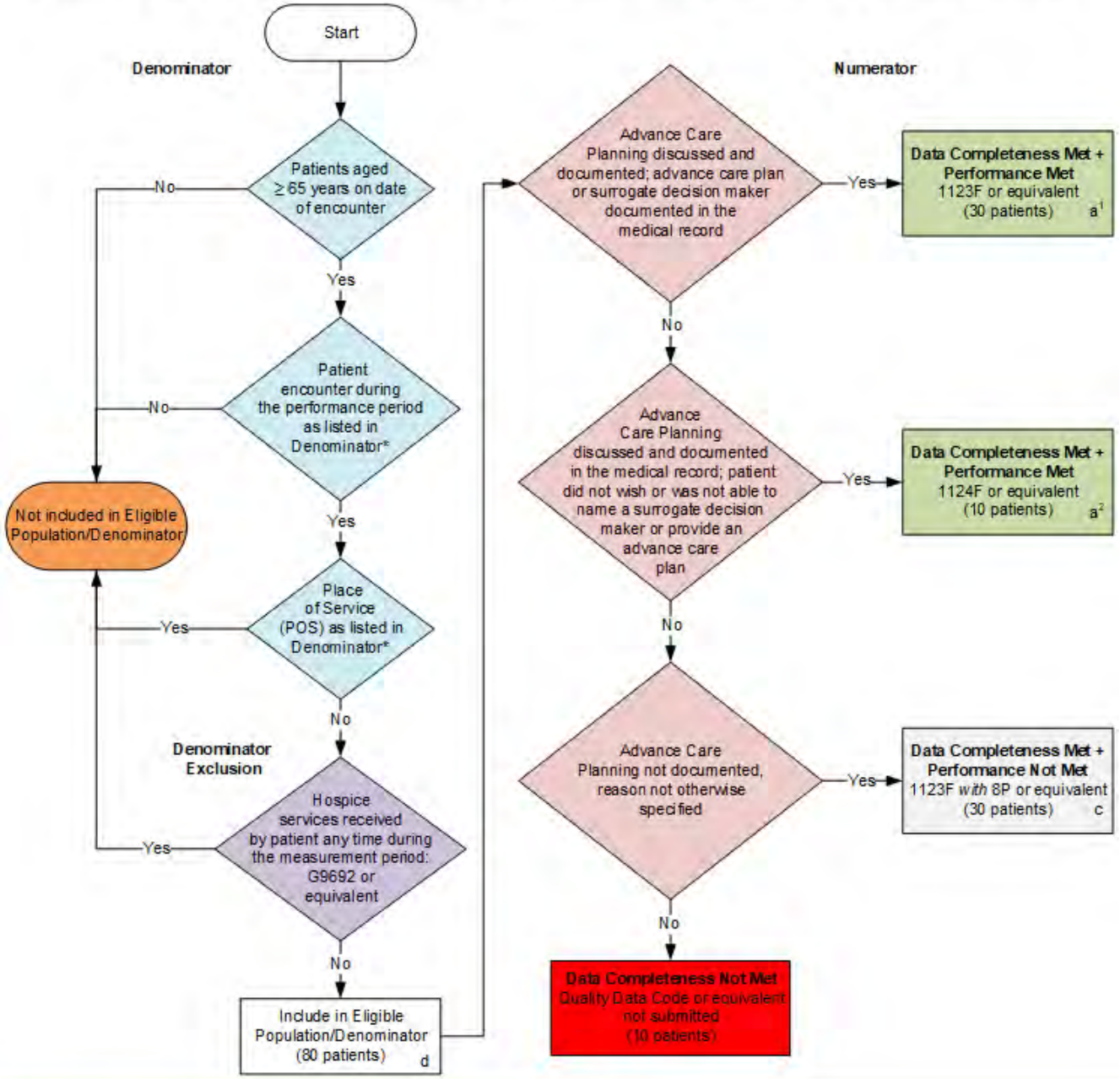
Silveira, M., Arnold, R., & Givens, J. (2020). *Advance Care Planning and Advance Directives.* UpToDate. Wolters Kluwer. Retrieved July 22, 2020, from https://www.uptodate.com/contents/advance-care-planning-and-advance-directives

Yadav, K., Gabler, N., Cooney, E., Kent, S., Kim, J., Herbst, N., . . . Courtright, K. (2017). Approximately One in Three US Adults Completes Any Type of Advance Directive for End-Of-Life Care. *Health Affairs, 36*(7), 1244–51. Retrieved from https://doi.org/10.1377/hlthaff.2017.0175

2026 Clinical Quality Measure Flow for Quality ID #047 (CBE 0326): Advance Care Plan

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a^1+a^2=40 patients) + Performance Not Met (c=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=
Performance Met (a^1+a^2=40 patients) = 40 patients = **57.14%**
Data Completeness Numerator (70 patients) = 70 patients

* See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

2026 Clinical Quality Measure Flow Narrative for Quality ID #047 (CBE 0326): Advance Care Plan

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

1. Start with Denominator

2. Check *Patients aged greater than or equal to 65 years on date of encounter*:

    a. If *Patients aged greater than or equal to 65 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients aged greater than or equal to 65 years on date of encounter* equals Yes, proceed to *Patient encounter during the performance period as listed in Denominator**.

3. Check *Patient encounter during the performance period as listed in Denominator**:

    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator.* Stop processing.

    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to *Place of service (POS) as listed in Denominator**.

4. Check *Place of service (POS) as listed in Denominator*:*

    a. If *Place of service (POS) as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator.* Stop processing.

    b. If *Place of service (POS) as listed in Denominator**equals No, proceed to *Hospice services received by patient any time during the measurement period*.

5. *Hospice services received by patient any time during the measurement period*:

    a. If *Hospice services received by patient any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator.* Stop processing
    b. If *Hospice services received by patient any time during the measurement period* equals No, include in *Eligible Population/Denominator.*

6. 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 80 patients in the Sample Calculation.

7. Start Numerator

8. Check *Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record*:

    a. If *Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record* equals Yes, include in *Data Completeness Met and Performance Met*.

- *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 30 patients in the Sample Calculation.

b. If *Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record* equals No, proceed to *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*.

9. Check *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*:

   a. If *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* equals Yes, include in *Data Completeness Met and Performance Met*.

      - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 10 patients in the Sample Calculation.

   b. If *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* equals No, proceed to *Advance Care Planning not documented, reason not otherwise specified*.

10. 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 *Data Completeness Met and Performance Not Met*.

       - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.

    b. If *Advance Care Planning not documented, reason not otherwise specified* equals No, proceed to *Data Completeness Not Met.*

11. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a^1 plus a^2 equals 40 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.