Advance Care Planning (ACP)

Goal: To increase the percentage of adults 66 years and older who had an annual discussion about preferences for resuscitation, life-sustaining treatment, and end of life care in the measurement year.

*Members in hospice are excluded from the eligible population
*Services rendered during a Telehealth visit is acceptable for measure

Measurement Requirements:

Advanced Care Planning

- Presence of advanced care plan in record **OR**
- Documentation of advanced care planning **discussion** and date performed **in 2023 OR**
- Notation of previously executed advanced care plan

To achieve this goal, Mercy Care Advantage:

- PCP annual wellness visit letter detailing advance directive topics
- Annual Wellness Visit webinar with PCP's
- Member brochure "Getting the most out of your Annual Visit" to improve member compliance and enhance PCP/member relationship
- Provider Newsletter article to improve compliance through provider awareness
- HEDIS Gaps in Care Reports available to providers through Mercy Care Plan website secure provider portal containing a comprehensive list of members needing care
- Member Health and Wellness Calendar to increase member awareness and importance of completing an advanced directive
- Assessment questions on advanced directives in Case Tracker Dynamo completed by the Case Management Staff
- COA supplemental mapping of HEDIS data collection

Evidence of advanced care planning must include ONE of the following THREE:

- The presence of an advanced care plan
    - Advanced Directive: Living Will, healthcare power of attorney, health care proxy
    - Actionable medical orders: written instructions initiating, continuing withholding, or withdrawing specific forms of life-sustaining treatment (eg: Physicians Orders for Life sustaining Treatment (POLST), Five Wishes)
    - Living Will
    - Surrogate decision maker – A written document designating someone other than the member to make medical treatment choices (not just future treatment choices)

OR

- Documentation of an advanced care planning discussion with the provider and the date it was discussed in the measurement year

- Notation of a discussion or initiation of a discussion by a provider
- Oral statements such as conversations with relatives or friends about life-sustaining treatment and end-of-life care, or patient designation of an individual who can make decisions on behalf of the patient, documented in the medical record

OR

- Notation that the member previously executed an advanced care plan

Documentation that a member declined to discuss advance care planning is considered evidence that the provider initiated a discussion and meets criteria.

Documentation that a provider asked the member if an advance care plan is in place, and the member indicated that a plan is not in place is not considered a discussion or initiation of a discussion.

Advanced Care Planning		
Code System	**Code**	**Definition**
CPT	99497	Advanced care planning including the explanation and discussion of advanced directives such as standard forms (with completion of such forms) when performed by the physician or other qualified health care professional: first 30 minutes, face to face with the patient, family member(s), and/or surrogate. The service carries an eligible charge, and a co-payment for the patient unless performed as part of an Annual Wellness Visit
CPT II	1123F	Advanced care planning discussed and documented: advanced care plan or surrogate decision maker documented in the medical record
CPT II	1124F	Advanced care planning discussed and documented: patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
CPT II	1157F	Advanced care plan or similar legal document present in the medical record
CPT II	1158F	Advanced care planning discussion documented in the medical record
HCPCS	S0257	Counseling and discussion regarding advanced directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)
ICD10CM	Z66	Do not resuscitate