DOCUMENTATION TIPS

MIPS #47: Advance Care Plan

Electronic health records (EHRs) collect and organize notes, medication lists, and patient information using various formats. With providers also documenting this information in unique ways, this can potentially cause confusion and an increased timeline for measure mapping with DataDerm. This tip sheet can help you manage reporting requirements for performance measures and streamline standard documentation practices to allow seamless data pull into DataDerm.

The DataDerm team will work with you to connect DataDerm with your EHR to extract data. To make the process as smooth as possible, it helps to document key elements of patient care. DataDerm cannot read scanned images of any kind, including scanned images for labs, letters to physicians, pathology reports, follow-up plans, and dates. If you have scanned images with information needed for your measures, please add a note in your chart with the date and required patient information for this data to be accurately collected.

This tip sheet can assist paper-based practices in standardizing documentation practices. Keeping notes in the patient's paper chart of all documentation requirements will assist you when reporting for this measure.

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For all patients 65 years and older, document the following in your notes:

- The CPT or HCPCS code for the patient encounter during the reporting period:
  - 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
- Note in the medical record that the patient has an advance care plan or a surrogate decision maker.
- If the patient is not eligible for the care plan, note in the medical record if applicable:
  - Place of Service was in the emergency department; OR
  - Hospice services received by patient any time during the measurement period (G9692)
- If a care plan or a surrogate decision maker is not in the medical record, document reason(s) for patient not having one. If applicable, include:
  - The patient did not wish or was unable to name a surrogate or advance care plan.
  - The patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning

Additional Tips:

- Collect ***once per performance period*** for patients 65 and older seen during the performance period.
- See measure specifications for additional codes that can assist in seamless measure mapping from your EHR to DataDerm, if applicable (e.g. 1123F).

For more information, contact the American Academy of Dermatology:
WEBSITE: aad.org

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