## Quality ID #130: Documentation of Current Medications in the Medical Record

**MEASURE TYPE:**
Process – High Priority

**DESCRIPTION:**
Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter.

**INSTRUCTIONS:**
This measure is to be submitted at **each denominator eligible visit** during the 12-month performance period. Merit-based Incentive Payment System (MIPS) eligible clinicians meet the intent of this measure by making their best effort to document a current, complete and accurate medication list during each encounter. There is no diagnosis associated with this measure. This measure may be submitted by MIPS eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

*NOTE: Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.*

**Measure Submission Type:**
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

**DENOMINATOR:**
All visits occurring during the 12-month measurement period for patients aged 18 years and older

> **DENOMINATOR NOTE**: *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 ≥ 18 years on date of encounter
> **AND**
> **Patient encounter during the performance period (CPT or HCPCS):** 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 90839, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92548, 92550, 92557, 92567, 92568, 92570, 92588, 92626, 96116, 96156, 96158, 97129, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 98960, 98961, 98962, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99236, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99424, 99491, 99495, 99496, G0101, G0108, G0270, G0402, G0438, G0439

**NUMERATOR:**

Eligible clinician attests to documenting, updating, or reviewing the patient's current medications using all immediate resources available on the date of the encounter

> **Definitions:**
> **Current Medications** – Medications the patient is presently taking including all prescriptions, over-the-counters, herbals, vitamins, minerals, dietary (nutritional) supplements, and cannabis/cannabidiol products with each medication's name, dosage, frequency and administered route.
> **Route** – Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical).
> **Not Eligible (Denominator Exception)** – A patient is "not eligible" if there is documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status).
>
> *NUMERATOR NOTE: The MIPS eligible clinician must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. MIPS eligible clinicians submitting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.*
>
> *This list **must** include ALL known prescriptions, over-the-counter (OTC) products, herbals, vitamins, minerals, dietary (nutritional) supplements, cannabis/cannabidiol products AND **must** contain the medications' name, dosage, frequency and route of administration.*
>
> *By submitting the action described in this measure, the provider attests to having documented a list of current medications utilizing all immediate resources available at the time of the encounter. **G8427** should be submitted if the MIPS eligible clinician documented that the patient is not currently taking any medications.*
>
> **Numerator Options:**

| | |
|---|---|
| **Performance Met:** | Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications **(G8427)** |

**OR**

| | |
|---|---|
| **Denominator Exception:** | Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an urgent or emergent medical situation) **(G8430)** |

**OR**

| | |
|---|---|
| **Performance Not Met:** | Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given **(G8428)** |

## RATIONALE:

According to the National Center for Health Statistics, during the years of 2013-2016, 48.4% of patients (both male and female) were prescribed at least one prescription medication with 12.6% taking 5 or more medications. Additionally, 89.8% of patients (both male and female) aged 65 years and older were prescribed at least one medication with 40.9% taking 5 or more medications [1]. In this context, maintaining an accurate and complete medication list has proven to be a challenging documentation endeavor for various health care provider settings. While most of outpatient encounters (two-thirds) result in providers prescribing at least one medication, hospitals have been the focus of medication safety efforts [2]. Nassaralla, Naessens, Chaudhry, Hansen, and Scheitel (2007) caution that this is at odds with the current trend, where patients with chronic illnesses are increasingly being treated in the outpatient setting and require careful monitoring of multiple medications. Additionally, Nassaralla et al. (2007) reveal that it is in fact in outpatient settings where more fatal adverse drug events (ADE) occur when these are compared to those occurring in hospitals (1 of 131 outpatient deaths compared to 1 in 854 inpatient deaths) [3]. In the outpatient setting, ADEs occur 25% of the time and over one-third of these are considered preventable [4].

Particularly vulnerable are patients over 65 years, with evidence suggesting that the rate of ADEs per 10,000 person per year increases with age; 25-44 years old at 1.3; 45-64 at 2.2, and 65 + at 3.8 [5]. Other vulnerable groups include individuals who are chronically ill or disabled [6]. These population groups are more likely to experience ADEs and subsequent hospitalization.

A multiplicity of providers and inadequate care coordination among them has been identified as barriers to collecting complete and reliable medication records. A study conducted by Poornima et al. (2015) indicates that reconciliation and documentation continue to be poorly executed with discrepancies occurring in 92% of medication lists among admittance to the emergency room (74 of 80 patients). Of 80 patients included in the study, the home medications were re ordered for 65% of patients on their admission and of the 65% the majority (29%) had a change in their dosing interval, while 23% had a change in their route of administration, and 13% had a change in dose. A total of 361 medication discrepancies, or the difference between the medications patients were taking before admission and those listed in their admission orders, were identified in at least 74 patients. The study found that "Through an appropriate reconciliation programme, around 80% of errors relating to medication and the potential harm caused by these errors could be reduced" [7]. Presley et al. (2020) also recognized specific barriers to sufficient medication documentation and reconciliation in rural and resource-limited care settings [8].

Documentation of current medications in the medical record facilitates the process of medication review and reconciliation by the provider, which is necessary for reducing ADEs and promoting medication safety. The need for provider to provider coordination regarding medication records, and the existing gap in implementation, is highlighted in the American Medical Association's Physician's Role in Medication Reconciliation, which states that "critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes" ]9]. This is because clinical decisions based on information that is incomplete and/or inaccurate are likely to lead to medication error and ADEs. Weeks, Corbette, & Stream (2010) noted similar barriers and identified the utilization of health information technology as an opportunity for facilitating the creation of universal medication lists [10].

One 2015 meta-analysis showed an association between EHR documentation with an overall RR of 0.46 (95% CI = 0.38 to 0.55; P < 0.001) and ADEs with an overall RR of 0.66 (95% CI = 0.44 to 0.99; P = 0.045). This meta-analysis provides evidence that the use of the EHR can improve the quality of healthcare delivered to patients by reducing medication errors and ADEs [11].

References:
1. National Center for Health Statistics. (2018). Health, United States, 2018: Supplementary Table 38. Prescription drug use in the past 30 days, by sex, race and Hispanic origin, and age: United States, selected years 1988–1994 through 2013–2016 Retrieved from https://www.cdc.gov/nchs/data/hus/2018/038.pdf
2. Stock, R., Scott, J., & Gurtel, S. (2009). Using an electronic prescribing system to ensure accurate medication lists in a large multidisciplinary medical group. *The Joint Commission Journal on Quality and Patient Safety*, 35(5), 271-277
3. Nassaralla, C. L., Naessens, J. M., Chaudhry, R., Hansen, M. A., & Scheitel, S. M. (2007). Implementation of a medication reconciliation process in an ambulatory internal medicine clinic. *Quality and Safety in Health Care*, 16(2), 90-94. http://doi.org/10.1136/qshc.2006.021113
4. Tache, S. V., Sonnichsen, A., & Ashcroft, D. M. (2011). Prevalence of adverse drug events in ambulatory care: A systematic review. *The Annals of Pharmacotherapy*, 45(7-8), 977-989. http://doi.org/10.1345/aph.1P627'
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VA-MARQUIS). *American Journal of Health-System Pharmacy*, 77, 128-137. https://doi.org/10.1093/ajhp/zxz275

9.  American Medical Association. (2007). The physician's role in medication reconciliation: Issues, strategies, and safety principles. Retrieved from https://pogoe.org/sites/default/files/Medication%20Reconciliation.pdf
10. Weeks, D. L., Corbette, C. F., & Stream, G. (2010). Beliefs of ambulatory care physicians about accuracy of patient medication records and technology-enhanced solutions to improve accuracy. *Journal for Healthcare Quality*, 32(5), 12-21. http://doi.org/10.1111/j.1945-1474.2010.00097.x
11. Campanella, P., Lovato, E., Marone, C., Fallacara, L., Mancuso, A., Ricciardi, W., & Specchia, M. L. (2016). The impact of electronic health records on health care quality: A systematic review and meta-analysis. *European Journal of Public Health,* 26(1), 60-64. https://doi.org/10.1093/eurpub/ckv122

## CLINICAL RECOMMENDATION STATEMENTS:

The Joint Commission's 2020 Ambulatory Health Care National Patient Safety Goals guide providers to maintain and communicate accurate patient medication information. Specifically, the section "Use Medicines Safely NPSG.03.06.01" states the following: "Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient  written information about the medicines they need to take.. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor." [1]

The National Quality Forum's Safe Practices for Better Healthcare - 2010 Update, states the following: "the healthcare organization must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care" [2].

References:

1.  The Joint Commission. (2020). Ambulatory Health Care National Patient Safety Goals. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2020/simplified_2020-ahc-npsg-eff-july-final.pdf
2.  National Quality Forum. (2010). Safe practices for better healthcare - 2010 update. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2020/simplified_2020-ahc-npsg-eff-july-final.pdf

## COPYRIGHT:

# 2023 Clinical Quality Measure Flow for Quality ID #130: Documentation of Current Medications in the Medical Record

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

**Denominator**                                      **Numerator**

Start

Patients aged ≥ 18 years on date of encounter — No → Not included in Eligible Population/Denominator

Yes ↓

Patient encounter during the performance period as listed in Denominator* — No → Not included in Eligible Population/Denominator

Yes ↓

Include in Eligible Population/Denominator (80 visits) — d

Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications — Yes → **Data Completeness Met + Performance Met** G8427 or equivalent (40 visits) — a

No ↓

Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list — Yes → **Data Completeness Met + Denominator Exception** G8430 or equivalent (10 visits) — b

No ↓

Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given — Yes → **Data Completeness Met + Performance Not Met** G8428 or equivalent (20 visits) — c

No ↓

**Data Completeness Not Met** Quality Data Code or equivalent not submitted (10 visits)

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**SAMPLE CALCULATIONS**

**Data Completeness=**

$$\frac{\text{Performance Met (a=40 visits) + Denominator Exception (b=10 visits) + Performance Not Met (c=20 visits)}}{\text{Eligible Population / Denominator (d=80 visits)}} = \frac{70 \text{ visits}}{80 \text{ visits}} = \mathbf{87.50\%}$$

**Performance Rate=**

$$\frac{\text{Performance Met (a=40 visits)}}{\text{Data Completeness Numerator (70 visits) – Denominator Exception (b=10 visits)}} = \frac{40 \text{ visits}}{60 \text{ visits}} = \mathbf{66.67\%}$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Visit

*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 18 years on date of encounter*:

   a. If *Patients aged greater than or equal to 18 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 18 years on date of encounter* equals Yes, proceed to check *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, include in *Eligible Population/Denominator*.

4. Denominator Population:

   • Denominator Population is all Eligible Visits in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 visits in the Sample Calculation.

5. Start Numerator

6. Check *Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications*:

   a. If *Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications* 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 equals 40 visits in the Sample Calculation.

   b. If *Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications* equals No, proceed to check *Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list*.

7. Check *Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list*:

   a. If *Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list* equals Yes, include in *Data Completeness Met and Denominator Exception*.

      • *Data Completeness Met and Denominator Exception* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 10 visits in the Sample Calculation.

   b. If *Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list* equals No, proceed to check *Current list of medications not documented as obtained, updated,*

*or reviewed by the eligible clinician, reason not given*.

8.  Check *Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given*:

    a.  If *Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given* 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 20 visits in the Sample Calculation

    b.  If *Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given* equals No, proceed to check *Data Completeness Not Met*.

9.  Check *Data Completeness Not Met*:

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

## Sample Calculations:

Data Completeness equals Performance Met (a equals 40 visits) plus Denominator Exception (b equals 10 visits) plus Performance Not Met (c equals 20 visits) divided by Eligible Population / Denominator (d equals 80 visits). All equals 70 visits divided by 80 visits. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 visits) divided by Data Completeness Numerator (70 visits) minus Denominator Exception (b equals 10 visits). All equals 40 visits divided by 60 visits. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Visit

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.