**Quality ID #130 (NQF 0419): Documentation of Current Medications in the Medical Record
– National Quality Strategy Domain: Patient Safety
– Meaningful Measure Area: Medication Management**

<u>**2019 COLLECTION TYPE:**</u>
**MIPS CLINICAL QUALITY MEASURES (CQMS)**

<u>**MEASURE TYPE:**</u>
Process – High Priority

<u>**DESCRIPTION:**</u>
Percentage of visits for patients aged 18 years and older for which the MIPS eligible professional or MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list *__must __*include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND *__must __*contain the medications' name, dosage, frequency and route of administration

<u>**INSTRUCTIONS:**</u>
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.

**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.

<u>**DENOMINATOR:**</u>
All visits 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.*

> <u>**Denominator Criteria (Eligible Cases):**</u>
> Patients aged ≥ 18 years on date of encounter
> <u>**AND**</u>
> **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, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96150, 96151, 96152, 97127*, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99236, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, 99281, 99282, 99283, 99284, 99285, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, G0101, G0108, G0270, G0402, G0438, G0439, G0515

**NUMERATOR:**

MIPS eligible professional or MIPS eligible clinician attests to documenting, updating or reviewing a patient's current medications using all immediate resources available on the date of encounter. This list **_must_** include ALL known prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **_must_** contain the medications' name, dosages, frequency and route of administration

> **Definitions:**
> **Current Medications** – Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements 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 the following reason is documented:
> - 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 on the date of the encounter.
>
> **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. 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:_**  Eligible clinician attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible clinician **(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:**

Prescription medication use is common among adults of all ages, particularly older adults and adults with chronic conditions. On average, 81% of adults in the U.S. are taking at least one medication (prescription or nonprescription, vitamin/mineral, herbal/natural supplement); 29% are taking five or more. Older adults are the biggest consumers of medications with 17-19% of people 65 and older taking at least ten medications in a given week (Qato et al., 2008). 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 (2/3) result in providers prescribing at least one medication, hospitals have been the focus of medication safety efforts (Stock et al., 2009). Nassaralla et al. (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). In the outpatient setting, adverse drug events (ADEs) occur 25% of the time and over one-third of these are considered preventable (Tache et al., 2011). 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 (Sarkar et al., 2011). Another vulnerable group are chronically ill individuals. 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. Data indicate that reconciliation and documentation continues to be poorly executed with discrepancies occurring in 92% (74 of 80 patients) of medication lists among admittance to the emergency room. 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 there admission orders, were identified in at least 74 patients (Poornima et al., 2015). 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" (Poornima et al., 2015, p. 243).

Documentation of current medications in the medical record facilitates the process of medication review and reconciliation by the provider, which are 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 (AMA) Physician's Role in Medication Reconciliation (2007), 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" (American Medical Association, 2007, p.7). This is because clinical decisions based on information that is incomplete and/or inaccurate are likely to lead to medication error and ADEs. Weeks et al. (2010) noted similar barriers and identified the utilization of health information technology as an opportunity for facilitating the creation of universal medication lists.

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 (Campanella et al., 2016).

## CLINICAL RECOMMENDATION STATEMENTS:
The Joint Commission's 2015 Ambulatory 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: "Maintain and communicate accurate patient medication information. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected to reconcile current and newly ordered medications and to safely prescribe medications in the future." (Joint Commission, 2015, retrieved at: http://www.jointcommission.org/assets/1/6/2015_NPSG_AHC1.PDF).

The National Quality Forum's 2010 update of the Safe Practices for Better Healthcare, states healthcare organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care (p. 40).
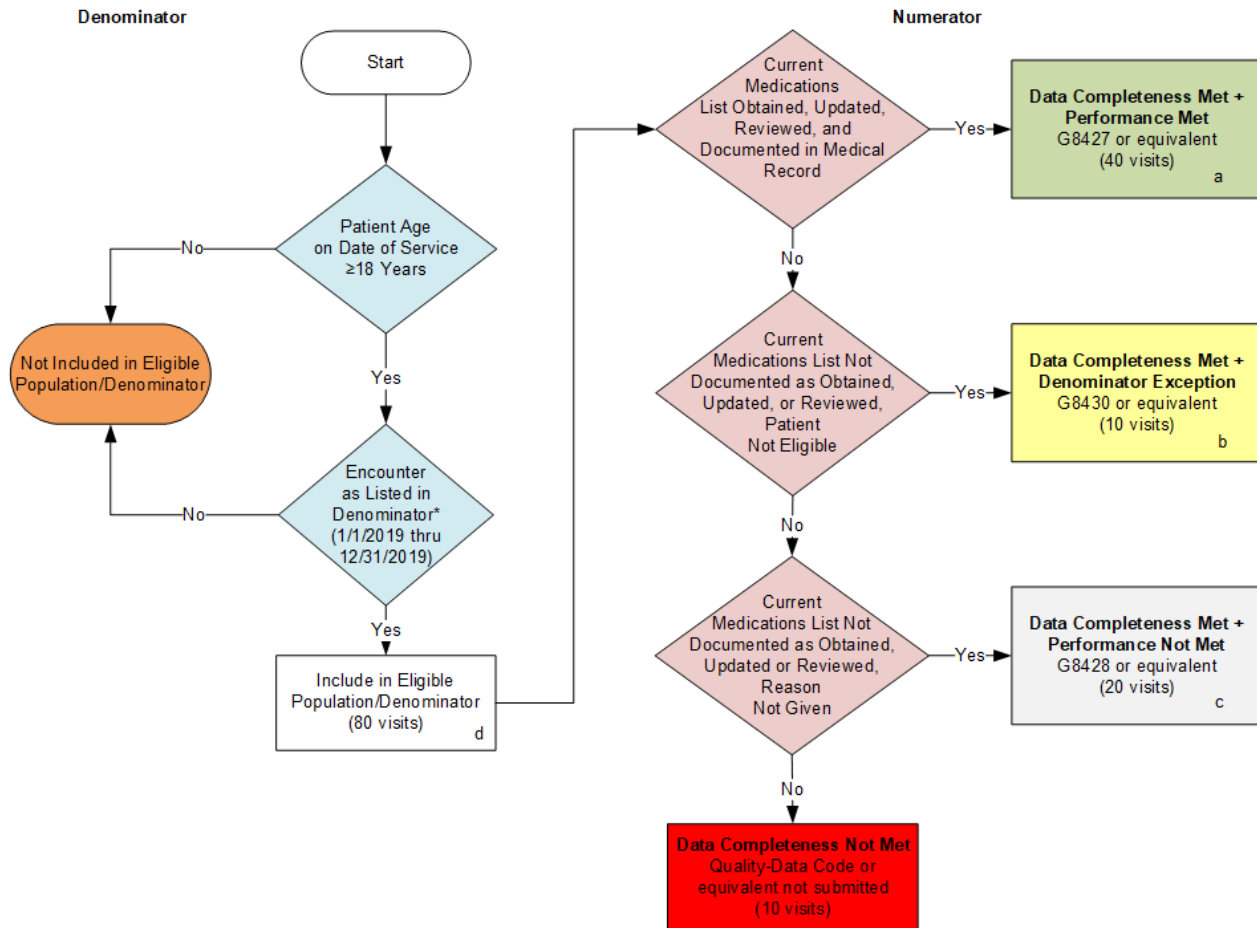
## COPYRIGHT:

# 2019 Clinical Quality Measure Flow for Quality ID #130 NQF #0419:
## Documentation of Current Medications in the Medical Record

**Denominator**

**Numerator**

Start

Patient Age on Date of Service ≥18 Years
— No →

Encounter as Listed in Denominator* (1/1/2019 thru 12/31/2019)
— No →

Not Included in Eligible Population/Denominator

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

Current Medications List Obtained, Updated, Reviewed, and Documented in Medical Record
— Yes → **Data Completeness Met + Performance Met** G8427 or equivalent (40 visits) — a

— No ↓

Current Medications List Not Documented as Obtained, Updated, or Reviewed, Patient Not Eligible
— Yes → **Data Completeness Met + Denominator Exception** G8430 or equivalent (10 visits) — b

— No ↓

Current Medications List Not Documented as Obtained, Updated or Reviewed, 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=**

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

**Performance Rate=**

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

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

NOTE: Submission Frequency: Visit

v3

**2019 Clinical Quality Measure Flow Narrative For Quality ID #130 NQF #0419:**
**Documentation of Current Medications in the Medical Record**

Please refer to the specific section of the specification to identify the denominator and numerator information for use in submitting this Individual Specification.

1. Start with Denominator

2. Check Patient Age:

   a. If Patient Age is greater than or equal to18 Years at Date of Service equals No during the measurement period, do not include in Eligible Population. Stop Processing.

   b. If Patient Age is greater than or equal to18 Years at Date of Service equals Yes during the measurement period, proceed to check Encounter Performed.

3. Check Encounter Performed:

   a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.

   b. If Encounter as Listed in the Denominator equals Yes, include in Eligible Population.

4. Denominator Population:

   a. 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 Current Medications List Obtained, Updated, Reviewed and Documented in Medical Record:

   a. If Current Medications List Obtained, Updated, Reviewed and Documented in Medical Record equals Yes, include in Data Completeness Met and Performance Met.

   b. 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.

   c. If Current Medications List Obtained, Updated, Reviewed and Documented in Medical Record equals No, proceed to check Current Medications List Not Documented as Obtained, Updated or Reviewed, Patient Not Eligible.

7. Check Current Medications List Not Documented as Obtained, Updated or Reviewed, Patient Not Eligible:

   a. If Current Medications List Not Documented as Obtained, Updated or Reviewed, Patient Not Eligible equals Yes, include in Data Completeness Met and Denominator Exception.

   b. 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.

   c. If Current Medications List Not Documented as Obtained, Updated or Reviewed, Patient Not Eligible equals No, proceed to check Current Medications List Not Documented as Obtained, Updated or Reviewed, Reason Not Given.

8. Check Current Medications List Not Documented as Obtained, Updated or Reviewed, Reason Not Given:

   a. If Current Medications List Not Documented as Obtained, Updated or Reviewed, Reason Not Given equals Yes, include in Data Completeness Met and Performance Not Met.

   b. 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.

    c. If Current Medications List Not Documented as Obtained, Updated or Reviewed, Reason Not Given equals No, proceed to check Data Completeness Not Met.

9. Check Data Completeness Not Met:

    a. 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=**

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

**Performance Rate=**

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