

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

**2016 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**  
**CLAIMS, REGISTRY**

**DESCRIPTION:**

Percentage of visits for patients aged 18 years and older for which the eligible professional 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

**INSTRUCTIONS:**

This measure is to be reported **each visit** during the 12 month reporting period. Eligible professionals 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 reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

**Measure Reporting via Claims:**

CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

**Measure Reporting via Registry:**

CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

**DENOMINATOR:**

All visits for patients aged 18 years and older

**Denominator Criteria (Eligible Cases):**

Patients aged  $\geq 18$  years on date of encounter

**AND**

**Patient encounter during the reporting period (CPT or HCPCS):** 90791, 90792, 90832, 90834, 90837, 90839, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92541, 92542, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, G0101, G0108, G0270, G0402, G0438, G0439

**NUMERATOR:**

Eligible professional 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** – 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

**NUMERATOR NOTE:** *The eligible professional must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. G8427 should be reported if the eligible professional documented that the patient is not currently taking any medications*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Current Medications Documented**

**Performance Met: G8427:**

Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient’s current medications

**OR**

**Current Medications not Documented, Patient not Eligible**

**Other Performance Exclusion: G8430:**

Eligible professional 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 professional

**OR**

**Current Medications with Name, Dosage, Frequency, or Route not Documented, Reason not Given**

**Performance Not Met: G8428:**

Current list of medications not documented as obtained, updated, or reviewed by the eligible professional, reason not given

**RATIONALE:**

In the American Medical Association’s (AMA) *Physician’s Role in Medication Reconciliation* (2007), 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. Consequently, clinical judgments may be based on incomplete, inaccurate, poorly documented or unavailable information about the patient and his or her medication.

As identified by The Agency for Healthcare Research and Quality in the National Healthcare Disparities report (2013), "different providers may prescribe medications for the same patient. Patients are responsible for keeping track of all their medications, but medication information can be confusing, especially for patients on multiple medications. When care is not well coordinated and some providers do not know about all of a patient's medications, patients are at greater risk for adverse events related to drug interactions, overdosing, or underdosing."

In addition, providers need to periodically review all of a patient's medications to ensure that they are taking what is needed and only what is needed. Medication reconciliation has been shown to reduce both medication errors and adverse drug events (Whittington & Cohen, 2004).

Medication safety efforts have primarily focused on hospitals; however, the majority of health care services are provided in the outpatient setting where two-thirds of physician visits result in writing at least one prescription (Stock et al., 2009). Chronically ill patients are increasingly being treated as outpatients, many of whom take multiple medications requiring close monitoring (Nassaralla et al., 2007).

Adverse drug events (ADEs) prove to be more fatal in outpatient settings (1 of 131 outpatient deaths) than in hospitals (1 of 854 inpatient deaths) (Nassaralla et al., 2007). According to the first study to utilize nationally-representative data to examine annual rates of ADEs in the ambulatory care setting "Adverse Drug events in U.S. Adult Ambulatory Medical Care," ADE rates increase with age, adults 25-44 years old had a rate of 1.3 per 10,000 person per year, those 45-64 had a rate of 2.2 per 10,000 per year, and those 65 years and older had the highest rate, at 3.8 ADEs per 10,000 persons per year. This study estimates that 13.5 million ADE related visits occurred between 2005-2007, estimating that approximately 4.5 million ambulatory ADE visits occur each year. These 4.5 million visits are associated with approximately 400,000 hospitalizations annually. According to the Institute of Medicine (IOM), in the US, as many as 98,000 deaths per year are attributable to preventable adverse events that occur in the hospitals setting with annual costs of between \$17 billion and \$29 billion. (Sarkar et al., 2011)

Additionally, findings of The Commonwealth Fund (2010) studies identified 11% to 28% of the 4.3 million visit related ADEs (VADE) in 2001 might have been prevented with improved systems of care and better patient education, yielding an estimate of 473,000 to 1.2 million potentially preventable VADEs annually and potential cost-savings of \$946 million to \$2.4 billion.

According to the AMA's published report, *The Physician's Role in Medication Reconciliation*, the rate of medication errors during hospitalization was estimated to be 52 per 100 admissions, or 70 per 1,000 patient days in 2005. Emerging research suggests the scope of medication-related errors in ambulatory settings is as extensive as or more extensive than during hospitalization. Ambulatory visits result in a prescription for medication 50 to 70% of the time. One study estimated the rate of ADEs in the ambulatory setting to be 27 per 100 patients. It is estimated that between 2004 and 2005, in the United States 701,547 patients were treated for ADEs in emergency departments and 117,318 patients were hospitalized for injuries caused by an ADE. Individuals aged 65 years and older are more likely than any other population group to require treatment in the emergency department for ADEs. (AMA, 2007).

A Systematic Review on "Prevalence of Adverse Drug Events in Ambulatory Care" finds that "In the ambulatory care setting, adverse drug events (ADEs) have been reported to occur at a rate of 25%. Approximately 39% of these ADEs were preventable. Since many ADEs are associated with medication errors, and thus potentially preventable, understanding the nature of medication errors in ambulatory care settings can direct attention toward improvement of medication safety in ambulatory care." Data extracted and synthesized across studies indicated the median preventable ADE rates in ambulatory care-based studies were 16.5%. (Tache et al., 2011).

The Agency for Healthcare Research and Quality's (AHRQ) *The National Healthcare Disparities Report* (2011) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings as 50 per 1,000 person-years. In 2005, AHRQ reported data on adults age 65 and over who received potentially inappropriate prescription medicines in the calendar year, by race, ethnicity, income, education, insurance status, and gender. The disparities were identified as follows: older Asians were more likely than older whites to have inappropriate drug use (20.3% compared with 17.3%); older Hispanics were less likely than older non-Hispanic Whites to have inappropriate drug use (13.5% compared with 17.6%); older women were more likely than older men to have inappropriate drug use (20.2% compared with 14.3%); there were no statistically significant differences by income or education.

Weeks et al. (2010) noted that fragmented medication records across the health care continuum, inaccurate reporting of medication regimens by patients, and provider failure to acquire all of the necessary elements of medication information from the patient or record, present significant obstacles to obtaining an accurate medication list in the ambulatory care setting. Because these obstacles require solutions demonstrating improvements in access to information and communication, the Institute of Medicine and others have encouraged the incorporation of IT

solutions in the medication reconciliation process. In a survey administered to office-based physicians with high rates of EMR use, Weeks, et al found there is an opportunity for universal medication lists utilizing health IT.

**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: [National Patient Safety Goals Effective January 1, 2015](#)).

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. Improving the safety of healthcare delivery saves lives, helps avoid unnecessary complications, and increases the confidence that receiving medical care actually makes patients better, not worse. Every healthcare stakeholder group should insist that provider organizations demonstrate their commitment to reducing healthcare error and improving safety by putting into place evidence-based safe practices.

The AMA's published report, *The Physician's Role in Medication Reconciliation*, identified the best practice medication reconciliation team as one that is multidisciplinary and—in all settings of care—will include physicians, pharmacists, nurses, ancillary health care professionals and clerical staff. The team's variable requisite knowledge, skills, experiences, and perspectives are needed to make medication reconciliation work as safely and smoothly as possible. Team members may have access to vital information or data needed to optimize medication safety. Because physicians are ultimately responsible for the medication reconciliation process and subsequently accountable for medication management, physician leadership and involvement in all phases of developing and initiating a medication reconciliation process or model is important to its success.

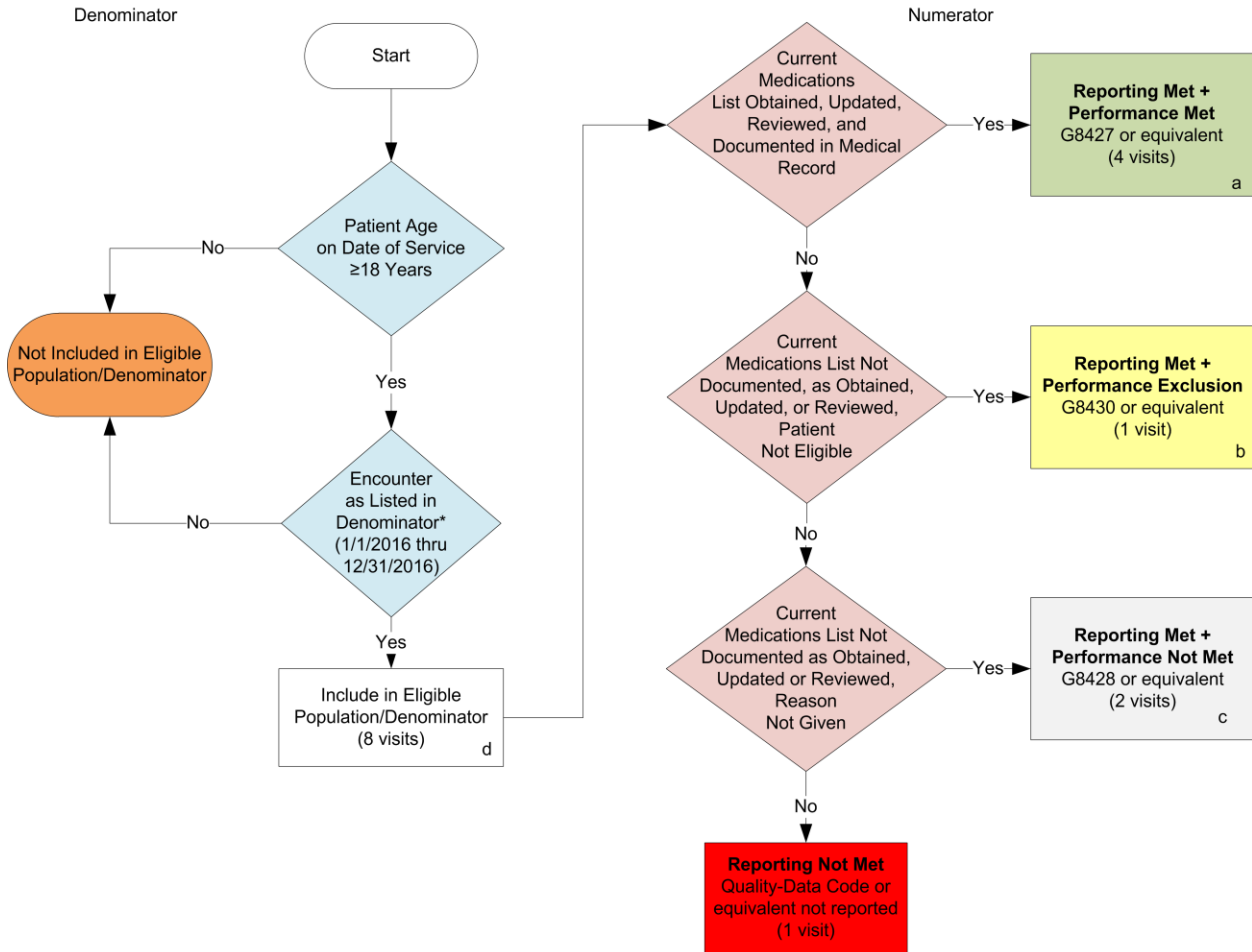
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**2016 Claims/Registry Individual Measure Flow**  
**PQRS #130 NQF #0419: Documentation of Current Medications in the Medical Record**



**SAMPLE CALCULATIONS:**

**Reporting Rate=**  

$$\frac{\text{Performance Met (a=4 visits)} + \text{Performance Exclusion (b=1 visit)} + \text{Performance Not Met (c=2 visits)}}{\text{Eligible Population / Denominator (d=8 visits)}} = \frac{7 \text{ visits}}{8 \text{ visits}} = 87.50\%$$

**Performance Rate=**  

$$\frac{\text{Performance Met (a=4 visits)}}{\text{Reporting Numerator (7 visits) - Performance Exclusion (b=1 visit)}} = \frac{4 \text{ visits}}{6 \text{ visits}} = 66.67\%$$

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

NOTE: Reporting Frequency: Visit

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 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.

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**2016 Claims/Registry Individual Measure Flow**  
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Please refer to the specific section of the Measure Specification to identify the denominator and numerator information for use in reporting this Individual Measure.

1. Start with Denominator
2. Check Patient Age:
  - a. If the Age is greater than or equal to 18 years of age at Date of Service equals No during the measurement period, do not include in Eligible Patient Population. Stop Processing.
  - b. If the Age is greater than or equal to 18 years of age 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 Patient Population. Stop Processing.
  - b. If Encounter as Listed in the Denominator equals Yes, include in the Eligible population.
4. 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 8 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 Reporting Met and Performance Met.
  - b. Reporting Met and Performance Met letter is represented in the Reporting Rate and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 4 visits in 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 Reporting Met and Performance Exclusion.
  - b. Reporting Met and Performance Exclusion letter is represented in the Reporting Rate and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 1 visit in 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 Reporting Met and Performance Not Met.
- b. Reporting Met and Performance Not Met letter is represented in the Reporting Rate in the Sample Calculation listed at the end of this document. Letter c equals 2 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 Reporting Not Met.

9. Check Reporting Not Met:

- a. If Reporting Not Met, the Quality Data Code or equivalent was not reported. 1 visit has been subtracted from the reporting numerator in the sample calculation.

**SAMPLE CALCULATIONS:**

**Reporting Rate=**

$$\frac{\text{Performance Met (a=4 visits) + Performance Exclusion (b=1 visit) + Performance Not Met (c=2 visits)}}{\text{Eligible Population / Denominator (d=8 visits)}} = \frac{7 \text{ visits}}{8 \text{ visits}} = 87.50\%$$

**Performance Rate=**

$$\frac{\text{Performance Met (a=4 visits)}}{\text{Reporting Numerator (7 visits) - Performance Exclusion (b=1 visit)}} = \frac{4 \text{ visits}}{6 \text{ visits}} = 66.67\%$$