

Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record

**2013PQRS OPTIONS FOR INDIVIDUAL MEASURES:  
CLAIMS, REGISTRY**

**DESCRIPTION:**

Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list **must** include ALL 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 at **each visit** during the 12 month reporting period. Eligible professionals meet the intent of this measure by making a 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. G-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 G-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 numerator options as described in the quality-data codes 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 occurring during the 12 month reporting period for patients aged 18 years and older on the date of the encounter where one or more CPT or HCPCS codes listed below are reported on the claims submission for that encounter.

**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, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0270, G0402, G0438, G0439

### **NUMERATOR:**

Eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list **must** include ALL 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.

**Not Eligible** – A patient is **not** eligible if the following reason exist:

- 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:** *By reporting **G8427**, the eligible professional is attesting the documented medication information is current, accurate and complete to the best of his/her knowledge and ability at the time of the patient encounter. This code should also be reported if the eligible professional documented that the patient is not currently taking any medications. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.*

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

##### **Current Medications Documented**

**G8427:** Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability

**OR**

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

**G8430:** Eligible professional attests the patient is not eligible for medication documentation

**OR**

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

**G8428:** Current medications **not** documented 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.

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 Commonwealth Fund report (2010) about 11 to 15 of every 1,000 Americans visit a health care provider because of ADEs in a given year, representing about three to four of every 1,000 patient visits during 1995 to 2001. The total number of visits to treat ADEs increased from 2.9 million in 1995 to 4.3 million visits in 2001.

ADEs in the ambulatory setting substantially increased the healthcare costs of elderly persons and estimated costs of \$1,983 per case. Further findings of The Commonwealth Fund studies additionally identified 11% to 28% of the 4.3 million VADEs 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.

In the Institute for Safe Medication Practices *The White Paper on Medication Safety in the U.S. and the Roles of Community Pharmacists* (2007), the American Pharmaceutical Association identified that Americans spend more than \$75 billion per year on prescription and nonprescription drugs. Unnecessary costs include: improper use of prescription medicines due to lack of knowledge costs the economy an estimated \$20-100 billion per year; American businesses lose an estimated 20 million workdays per year due to incorrect use of medicines prescribed for heart and circulatory diseases alone; failure to have prescriptions dispensed and/or renewed has resulted in an estimated cost of \$8.5 billion for increased hospital admissions and physician visits, nearly one percent of the country's total health care expenditures.

In 2005, the rate of medication errors during hospitalization was estimated to be 52 per 100 admissions, or 70 per 1,000 patient days. 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).

The Agency for Healthcare Quality's (AHRQ) *The National Healthcare Disparities Report* (2008) 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 all 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 2011 National Patient Safety Goals guides providers to maintain and communicate accurate patient medication information guiding elements of performance to obtain and/or update information on the medications the patient is currently taking. 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.