Measure #130: Universal Documentation and Verification of Current Medications in the Medical Record

DESCRIPTION:
Percentage of patients aged 18 years and older with written provider documentation that current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were verified with the patient or authorized representative

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using G-codes:
CPT service codes, CPT procedure codes, HCPCS G-codes and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Verification of patient's current medications with dosages is documented

Definitions:
Authorized representative – A person who is acting on the patient's behalf and who does not have a conflict of interest with the patient, when the patient is temporarily or permanently unable to act for himself or herself. This person should have the patient's best interests at heart and should be reasonably expected to act in a manner that is protective of the person and the rights of the patient. Preferably, this individual is appointed by the patient.
Not eligible – A patient is not eligible if one or more of the following condition(s) exist:
- Patient refuses to participate
- 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
- Patient cognitively impaired and no authorized representative available

Current medications – All medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) a patient may be taking routinely and/or on a PRN basis

Numerator Coding:
Current Medication Verification Documented
G8427: Written provider documentation was obtained confirming that current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were verified with the patient or authorized representative or patient assessed and is not currently on any medications.

OR

Current Medications not Documented, Patient not Eligible
G8430: Documentation that patient is not eligible for medication assessment

OR

Current Medications not Documented and/or Patient Verification not Documented, Reason not Specified
G8428: Current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were documented without documented patient verification
OR
G8429: Incomplete or no documentation that patient's current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were assessed

DENOMINATOR:
Patients aged 18 years and older

Denominator Coding:
A CPT procedure code, CPT service code, or HCPCS G-code is required to identify patients for denominator inclusion.
CPT procedure codes, CPT service codes, or HCPCS G-codes: 00140, 00142, 00170, 00400, 00402, 00810, 00832, 00851, 00910, 00920, 01380, 01382, 01400, 01732, 01810, 01820, 01829, 90801, 90802, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97802, 97803, G0101, G0108, G0270

RATIONALE:
Adverse drug events (ADEs) are one of the leading causes of hospitalizations and deaths in the U.S., with 13% of ADEs occurring in patients with a prior or documented allergy/reaction to the reactive drug. Using a medication list in the office setting promotes patient safety and reduces medical errors, both by improving documentation in general and, specifically, by improving communication between patients and providers.

CLINICAL RECOMMENDATION STATEMENTS:
In addition, as part of its efforts to promote patient safety and reduce the growing incidence of medical errors in the office setting, the Institute for Healthcare Improvement created a recommended medication list for patients and their families to carry with them to medical appointments to help providers reconcile medications during medical visits. Refer to: Institute for Healthcare Improvement, Medication List For Patients and Families, and Massachusetts Coalition for the Prevention of Medical Error (in collaboration with the Massachusetts Medical Society).]

<u>Evidence Supporting the Criterion of Quality Measure:</u>

<u>Overall Evidence Grading</u>: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved patient safety, reduced adverse drug events, reduced hospitalizations and death, and reduced costs, but not consistently high quality evidence

Ghandi, T., et al. (2000). "Drug complications in outpatients." <u>Journal of General Internal Medicine</u> 15: 149-154.

> A total of 75% of office visits to primary care providers involve the initiation or continuation of drug therapy and estimates of the proportion of outpatients experiencing an ADE per year range from 5-35%, with 13% of events occurring in patients with a prior or documented allergy/reaction to the causative drug. There is need for improved physician-patient communication and documentation of medications in the outpatient setting.
> Study quality level 2 (limited-quality patient-oriented evidence)

Gurwitz, J., et al. (2003). "Incidence and preventability of adverse drug events among older persons in the ambulatory setting." <u>JAMA</u> 289: 1107-1116.

> ADEs were identified as one of the most serious concerns regarding medication use in older persons cared for in the ambulatory setting. The authors recommend prevention strategies that target the prescribing and monitoring stages of pharmaceutical care and interventions focused on improving patient compliance and monitoring of prescribed medications.
> Study quality level 2 (limited-quality patient-oriented evidence)

Kaufman, D., et al. (2002). "Recent patterns of medication use in the ambulatory adult population of the United States." <u>JAMA</u> 287: 337 - 344.

> ADEs are among the leading cause of hospitalizations and death in the U.S. The substantial overlap between use of prescription medicine and use of herbals/supplements raises concerns about unintended interactions. Therefore, the authors recommend documentation of usage patterns to provide a basis for improving the safety of medication use.
> Study quality level 2 (limited-quality patient-oriented evidence)

Simmonds, M. (2000). "Anesthetists' records of pre-operative assessment." <u>Clinical Performance and Quality Health Care</u> 8(1): 22-27.

> Previous anesthesia, drug history, and allergies were recorded in only one to two-thirds of patient charts, thus identifying this as an opportunity for improvement, given the safety and subsequent cost implications.
> Study quality level 2 (limited-quality patient-oriented evidence)

Wilson, I. B., et al. (2007). "Physician-patient communication about prescription medications non-adherence." <u>Journal of General Internal Medicine</u> 22(1).

> There is a wide communication gap between physicians and elderly patients: one-third of all seniors surveyed and 24% of those with three or more chronic conditions did not talk to their doctors about all of their medicines in the past 12 months.
> Study quality level 2 (limited-quality patient-oriented evidence)