

📌 Measure #130: Documentation of Current Medications in the Medical Record

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a list of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route

INSTRUCTIONS:

This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. This measure is intended to determine whether or not documentation of a current medication list occurred for all patients aged 18 years and older. 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 codes, G-codes, and patient demographics 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 via claims, submit the CPT codes, 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 codes, G-codes, and patient demographics are used to identify patients who 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 patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, G0101, G0108, G0270

NUMERATOR:

Current medications including name, dosages, frequency and route documented by the provider

Definitions:

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 OR documentation of no medications currently prescribed.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Current Medications with Name, Dosages, Frequency and Route Documented

G8427: List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route

OR

Current Medications with Dosages not Documented, Patient not Eligible

G8430: Provider documentation that patient is not eligible for medication assessment

OR

Current Medications with Name, Dosages, Frequency, Route not Documented, Reason not Specified

G8428: Current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) with drug name, dosage, frequency and route not documented by the provider, reason not specified

RATIONALE:

Medication safety efforts have primarily focused on hospitals; however, the majority of health care services are provided in the outpatient setting. 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 (Nassarella, et al, 2007). Since 2002, there has been a sharp increase in the number of ambulatory care visits secondary to adverse drug events. The National Scorecard for U.S. Health System Performance identified increased utilization of ambulatory care services and demonstrates that inadequate medication reconciliation often leads to poor safety.

Adverse drug events prove to be more fatal in outpatient settings (1 of 131 outpatient deaths) than in hospitals (1 of 854 inpatient deaths) (Nassarella, 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 adverse drug events 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 adverse drug events increased from 2.9 million in 1995 to 4.3 million visits in 2001.

Community-dwelling individuals in the U.S. made ambulatory care visits for the treatment of adverse drug events (VADEs) at a rate of 3.3 to 4.0 per 1,000 visits, or 10.9 to 15.3 per 1,000 population during 1995–2001 (Zhan et al. 2005). Fields, et al (2005) concluded adverse drug events (ADE) in the ambulatory setting substantially increase the healthcare costs of elderly persons and estimated costs associated with adverse drug events among older adults in the ambulatory setting were \$1,983 per case. The Commonwealth Fund (2010) identified implications based on previous studies of ADEs in ambulatory care (Gandhi et al. 2003; Gurwitz, et al. 2003) and the assumption can be generalized to the data, 11 percent to 28 percent 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. Further, assuming the average cost of treating a preventable ADE is \$1,983 the potential cost-savings that could be achieved by reducing VADEs would be \$946 million to \$2.4 billion.

In the Institute for Safe Medication Practices White Paper (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.

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 regimen.

The National Healthcare Disparities Report (2008) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings 50 per 1,000 person-years. In 2005, the Agency for Healthcare Quality (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.

CLINICAL RECOMMENDATION STATEMENTS:

After a comprehensive and thorough search of Cochrane Library, National Quality Measures Clearing House, and relevant specialty society web sites, it was identified a relevant clinical recommendation, which addresses the intent, numerator and denominator of this measure is not available for reference. However, the following supportive documents from various specialty associations and organization's recognize the importance and need for this process to occur consistently in safe clinical practice.

In 2007, the American Medical Association published *The Physician's Role in Medication Reconciliation*, which identified the best 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. American Medical Association: *The Physician's Role in Medication Reconciliation*. Accessed June 1, 2010 <http://www.ama-assn.org/ama1/pub/upload/mm/370/med-rec-monograph.pdf>

While the role of the physician is important, all health care professionals are responsible for providing accurate information related to medication safety. The American Academy of Audiology issued a Position Statement which supports that audiologists obtain a comprehensive medical and family history as well as a list of all medications the patient is taking that could influence test results.

The American Physical Therapy Association (APTA) House of Delegates adopted a position statement which stated; *"Physical therapist patient/client management integrates an understanding of a patient's/client's prescription and nonprescription medication regimen with consideration of its impact upon health, impairments, functional limitations, and disabilities. The administration and storage of medications used for physical therapy interventions is also a component of patient/client management and thus within the scope of physical therapist practice."* (American Physical Therapy Association)

In addition to medication name and dosage, documentation and verification should also include frequency and route to be in alignment with recommendations presented by the Institute for Safe Medication Practices and the Institute for Healthcare Improvement and the Agency for Healthcare Research and Quality. This modification would also align expectations for outpatient documentation and verification with those of the hospital setting to improve continuity of information transfers between settings.

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. [Institute for Healthcare Improvement Medication List for Patients and Families and the Massachusetts Coalition for the Prevention of Medical Error (in collaboration with the Massachusetts Medical Society), <http://www.ihl.org/IHI/Topics/OfficePractices/Access/Tools>]

American Academy of Audiology: Position Statement on the Audiologist's Role in the Diagnosis and Treatment of Vestibular Disorders. Accessed 5/26/2010,

<http://www.audiology.org/resources/documentlibrary/Pages/VestibularDisorders.aspx?PF=1b>

Patients who are seen for vestibular evaluation often present with complicated medical and case histories as well as a complex description of their symptoms. Prior to undertaking the evaluation, it is important for audiologists to obtain a comprehensive medical and family history as well as a list of all medications the patient is taking that could influence test results.