Documentation of Current Medications in the Medical Record eCQM CMS68v13

Last modified on 10/08/2024 2:44 pm EDT

Description

Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter.

Guidance

This eCQM is an episode-based measure. An episode is defined as each eligible encounter during the measurement period. This measure is to be reported for every encounter during the measurement period.

Eligible clinicians reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.

By reporting 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.

This list must include all known prescriptions, over-the-counter products, herbals, vitamins, minerals, dietary (nutritional) supplements, cannabis/cannabidiol products AND must contain the medications' name, dosage, frequency, and route of administration.

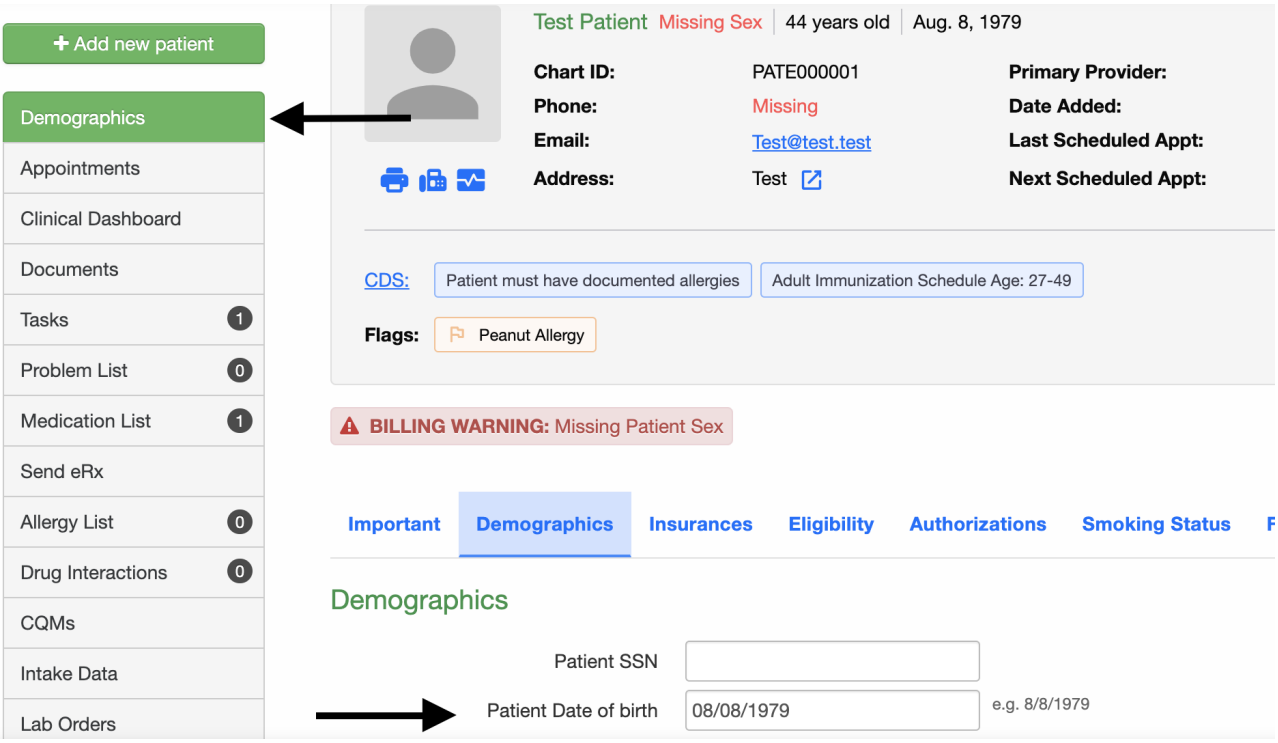
This measure should also be reported if the eligible clinician documented the patient is not currently taking any medications.

This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.

Initial Population

All visits occurring during the 12-month measurement period for patients aged 18 years and older.

Date of birth information can be entered in DrChrono in the patient chart under the**Demographics** tab with the **Patient's Date of Birth**.

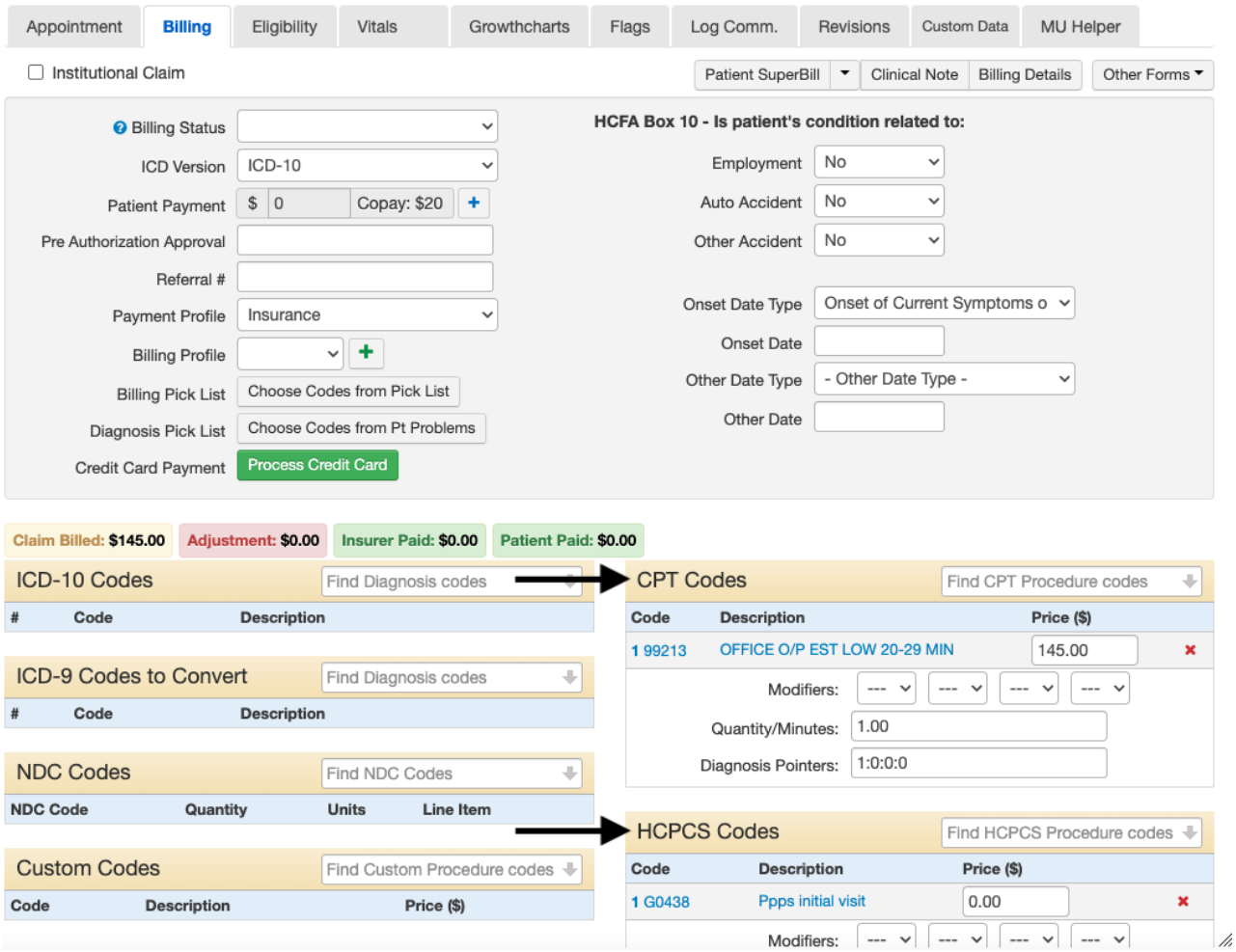


With A Qualifying Encounter During the Measurement Period

CPT Codes

HCPCS Codes

CPT and HCPCS codes can be entered into the billing section for the encounter. Below is an example from the appointment window.



Denominator

Equals initial population.

Denominator Exclusions

None

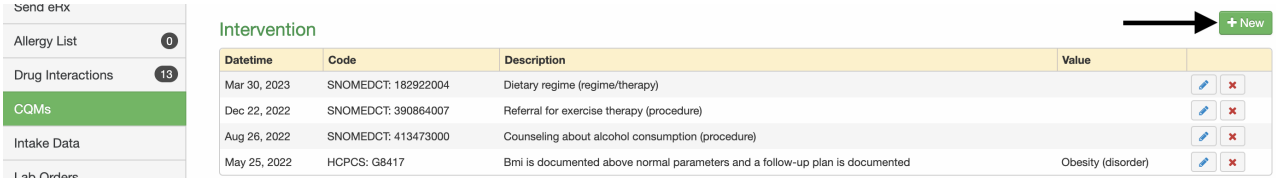
Denominator Exceptions

Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., 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).

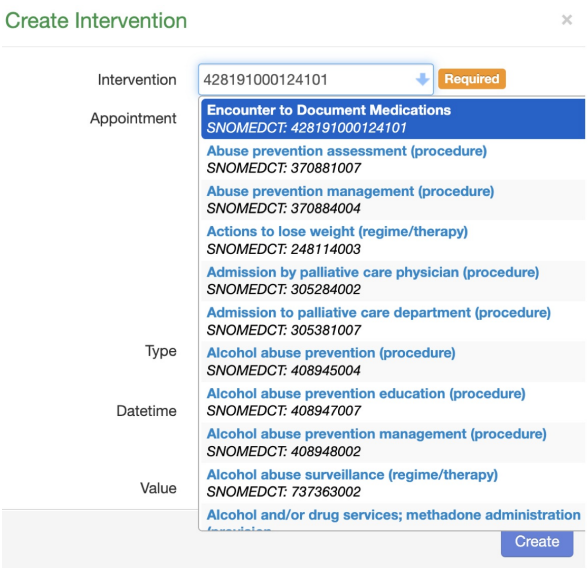
Numerator

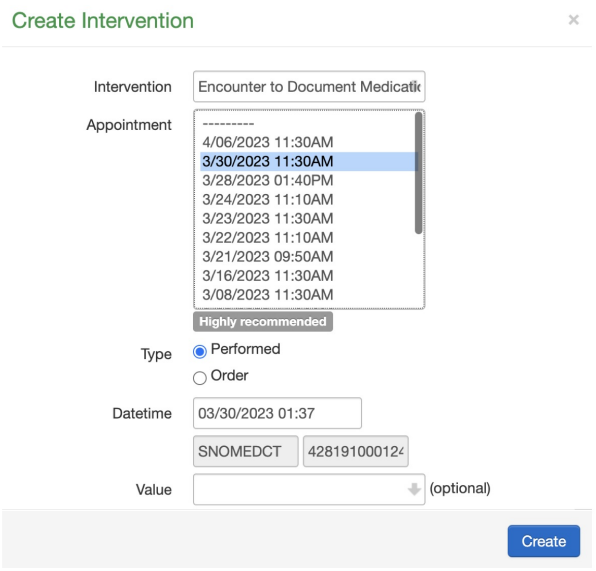
Eligible clinician attests to documenting, updating, or reviewing the patient's current medications using all immediate resources available on the date of the encounter.

The SNOMEDCT code **428191000124101** can be added to the patient's chart under the **Intervention** tab of the CQMs section. **Click +New**.



You can enter the code or search by key terms. Select an appointment date and **ordered** or **performed**. Click **Create** when finished.





Numerator Exclusions

Not applicable

Measure Information