

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**.

+ Add new patient

Demographics

Appointments

Clinical Dashboard

Documents

Tasks 1

Problem List 0

Medication List 1

Send eRx

Allergy List 0

Drug Interactions 0

CQMs

Intake Data

Lab Orders

Test Patient Missing Sex | 44 years old | Aug. 8, 1979

| | | |
|------------------|--|-----------------------------|
| Chart ID: | PATE000001 | Primary Provider: |
| Phone: | Missing | Date Added: |
| Email: | Test@test.test | Last Scheduled Appt: |
| Address: | Test 📍 | Next Scheduled Appt: |

CDS: Patient must have documented allergies Adult Immunization Schedule Age: 27-49

Flags: 🚩 Peanut Allergy

⚠ BILLING WARNING: Missing Patient Sex

Important
Demographics
Insurances
Eligibility
Authorizations
Smoking Status
F

Demographics

Patient SSN

Patient Date of birth

08/08/1979

e.g. 8/8/1979

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.

Appointment **Billing** Eligibility Vitals Growthcharts Flags Log Comm. Revisions Custom Data MU Helper

Institutional Claim Patient SuperBill Clinical Note Billing Details Other Forms

Billing Status

ICD Version

Patient Payment \$ Copay: \$20

Pre Authorization Approval

Referral #

Payment Profile

Billing Profile

Billing Pick List

Diagnosis Pick List

Credit Card Payment

HCFA Box 10 - Is patient's condition related to:

Employment

Auto Accident

Other Accident

Onset Date Type

Onset Date

Other Date Type

Other Date

Claim Billed: \$145.00 Adjustment: \$0.00 Insurer Paid: \$0.00 Patient Paid: \$0.00

ICD-10 Codes

| # | Code | Description |
|---|------|-------------|
| | | |

ICD-9 Codes to Convert

| # | Code | Description |
|---|------|-------------|
| | | |

NDC Codes

| NDC Code | Quantity | Units | Line Item |
|----------|----------|-------|-----------|
| | | | |

Custom Codes

| Code | Description | Price (\$) |
|------|-------------|------------|
| | | |

CPT Codes

| Code | Description | Price (\$) |
|---------|------------------------------|------------|
| 1 99213 | OFFICE O/P EST LOW 20-29 MIN | 145.00 |

Modifiers:

Quantity/Minutes:

Diagnosis Pointers:

HCPCS Codes

| Code | Description | Price (\$) |
|---------|--------------------|------------|
| 1 G0438 | Ppps initial visit | 0.00 |

Modifiers:

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.**

Send eRx

Allergy List 0

Drug Interactions 13

CQMs

Intake Data

Lab Orders

Intervention + New

| Datetime | Code | Description | Value | |
|--------------|---------------------|--|--------------------|---|
| Mar 30, 2023 | SNOMEDCT: 182922004 | Dietary regime (regime/therapy) | | <input type="button" value="edit"/> <input type="button" value="delete"/> |
| Dec 22, 2022 | SNOMEDCT: 390864007 | Referral for exercise therapy (procedure) | | <input type="button" value="edit"/> <input type="button" value="delete"/> |
| Aug 26, 2022 | SNOMEDCT: 413473000 | Counseling about alcohol consumption (procedure) | | <input type="button" value="edit"/> <input type="button" value="delete"/> |
| May 25, 2022 | HCPCS: G8417 | Bmi is documented above normal parameters and a follow-up plan is documented | Obesity (disorder) | <input type="button" value="edit"/> <input type="button" value="delete"/> |

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

Create Intervention ✕

Intervention: 428191000124101 Required

Appointment: **Encounter to Document Medications**
SNOMEDCT: 428191000124101

Abuse prevention assessment (procedure)
SNOMEDCT: 370881007

Abuse prevention management (procedure)
SNOMEDCT: 370884004

Actions to lose weight (regime/therapy)
SNOMEDCT: 248114003

Admission by palliative care physician (procedure)
SNOMEDCT: 305284002

Admission to palliative care department (procedure)
SNOMEDCT: 305381007

Type: Alcohol abuse prevention (procedure)
SNOMEDCT: 408945004

Datetime: Alcohol abuse prevention education (procedure)
SNOMEDCT: 408947007

Value: Alcohol abuse prevention management (procedure)
SNOMEDCT: 408948002

Alcohol abuse surveillance (regime/therapy)
SNOMEDCT: 737363002

Alcohol and/or drug services; methadone administration
SNOMEDCT: 408949002

Create

Create Intervention ✕

Intervention: Encounter to Document Medications

Appointment: **3/30/2023 11:30AM**

4/06/2023 11:30AM

3/28/2023 01:40PM

3/24/2023 11:10AM

3/23/2023 11:30AM

3/22/2023 11:10AM

3/21/2023 09:50AM

3/16/2023 11:30AM

3/08/2023 11:30AM

Highly recommended

Type: Performed
 Order

Datetime: 03/30/2023 01:37

SNOMEDCT: 428191000124101

Value: (optional)

Create

Numerator Exclusions

Not applicable

[Measure Information](#)