

Table of Contents

I.	2015 Physician Quality Reporting System Specifications	3
II.	2014 Meaningful Use Reporting System Specifications	7
	Calculation Algorithm 2015 Claims/Registry Individual Measure Flow	13
	Calculation Algorithm 2014 eMeasure Individual Measure Flow	14
III.	Analysis of Claims/Registry/EHR Data	15
	EHR Reliability and Performance Distribution	16
	(40 Provider Convenience Sample 2014)	
	Registry Reliability and Performance (PQRS 2013)	17
	Claims Data Reliability and Performance (PQRS 7/1/2013 – 12/31/2013)	18
	Disparities in Performance Rates by Race, Age and Gender	19
	(Claims 7/1/2013 – 12/31/2013)	
IV.	Original Feasability Testing Report	20
V.	References	21



I. 2015 Physician Quality Reporting System Specifications

Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:

Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known 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 **each visit** during the 12 month reporting period. Eligible professionals meet the intent of this measure by making their 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. Quality-data 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 quality-data 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 listed numerator options 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 for 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): 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, 96151, 96152, 97001, 97002, 97003, 97004, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, G0101, G0108, G0270, G0402, G0438, G0439

NUMERATOR:

Eligible professional attests to documenting, updating or reviewing a patient's current medications using all immediate resources available on the date of encounter. This list **must** include ALL known 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.

Route – Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical)

Not Eligible – A patient is **not** eligible if the following reason is documented: 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: *The eligible professional must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. G8427 should be reported if the eligible professional documented that the patient is not currently taking any medications*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:**Current Medications Documented****Performance Met: G8427:**

Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications

OR**Current Medications not Documented, Patient not Eligible****Other Performance Exclusion: G8430:**

Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional

OR**Current Medications with Name, Dosage, Frequency, or Route not Documented, Reason not Given****Performance Not Met: G8428:**

Current list of medications not documented as obtained, updated, or reviewed 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 were \$1,983 per case. Further findings of The Commonwealth Fund studies additionally identified 11% to 28% of the 4.3 million visit related ADEs (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).

A Systematic Review on "Prevalence of Adverse Drug Events in Ambulatory Care" finds that "The median ADE prevalence rate for retrospective studies was 3.3% (interquartile range [IQR] 2.3–7.1%) vs 9.65% (IQR 3.3–17.35%) for prospective studies. Median preventable ADE rates in ambulatory care-based studies were 16.5%, and 52.9% for hospital-based studies. Median prevalence rates by age group ranged from 2.45% for children to 5.27% for adults, 16.1% for elderly patients, and 3.45% for studies including all ages (Tache et al., 2011)".

The Agency for Healthcare Research and Quality's (AHRQ) The National Healthcare Disparities Report (2011) 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 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 2014 Ambulatory Care National Patient Safety Goals guide providers to maintain and communicate accurate patient medication information. Specifically, the section "Use Medicines Safely NPSG.03.06.01" includes the following: "Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor".

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.

II. 2014 Meaningful Use Reporting System Specifications

eMeasure Title	Documentation of Current Medications in the Medical Record		
eMeasure Identifier (Measure Authoring Tool)	68	eMeasure Version number	4
NQF Number	0419	GUID	9a032d9c-3d9b-11e1-8634-00237d5bf174
Measurement Period	January 1, 20xx through December 31, 20xx		
Measure Steward	Centers for Medicare & Medicaid Services		
Measure Developer	Quality Insights of Pennsylvania		
Endorsed By	National Quality Forum		
Description	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.		
Copyright	<p>Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. Quality Insights of Pennsylvania disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT [R]) or other coding contained in the specifications.</p> <p>CPT (R) contained in the Measure specifications is copyright 2007-2014 American Medical Association.</p> <p>LOINC (R) copyright 2004-2014 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms (R) (SNOMED CT [R]) copyright 2004-2013 [2013-09] International Health Terminology Standards Development Organization. All Rights Reserved.</p>		
Disclaimer	<p>These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.</p> <p>THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.</p>		
Measure Scoring	Proportion		
Measure Type	Process		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		

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 (ADE) 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 ADE 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 (VADEs) increased from 2.9 million in 1995 to 4.3 million visits in 2001.

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

A Systematic Review on "Prevalence of Adverse Drug Events in Ambulatory Care" finds that "The median ADE prevalence rate for retrospective studies was 3.3% (interquartile range [IQR] 2.3–7.1%) vs 9.65% (IQR 3.3–17.35%) for prospective studies. Median preventable ADE rates in ambulatory care-based studies were 16.5%, and 52.9% for hospital-based studies. Median prevalence rates by age group ranged from 2.45% for children to 5.27% for adults, 16.1% for elderly patients, and 3.45% for studies including all ages (Tache et al., 2011)."

	<p>The Agency for Healthcare Research and Quality's (AHRQ) National's Healthcare Disparities Report (2011) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings 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.</p> <p>Weeks et al. (2010) noted fragmented medication records across the health care continuum, inaccurate reporting of medication regimens by patients, and provider failure to acquire all of 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.</p>
Clinical Recommendation Statement	<p>The Joint Commission's 2014 Ambulatory Care National Patient Safety Goals guide providers to maintain and communicate accurate patient medication information. Specifically, the section "Use Medicines Safely NPSG.03.06.01" includes the following: "Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor" (Joint Commission, 2014, retrieved at: http://www.jointcommission.org/assets/1/6/2014_AHC_NPSG_E.pdf).</p> <p>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.</p> <p>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.</p>
Improvement Notation	Higher score indicates better quality.
Reference	American Medical Association (2007). The physician's role in medication reconciliation: Issues, strategies and safety principles. Retrieved from http://www.ama-assn.org/resources/doc/cqi/med-rec-monograph.pdf

Reference	Stock, R., Scott, J., & Gurtel, S. (2009). Using an Electronic Prescribing System to Ensure Accurate Medication Lists in a Large Multidisciplinary Medical Group. <i>The Joint Commission Journal on Quality and Patient Safety</i> ; 35(5), 271-277.
Reference	Nassaralla, C.L., Naessens, J.M., Chaudhry, R., et al. (2007). Implementation of a medication reconciliation process in an ambulatory internal medicine clinic. <i>Quality and Safety in Health Care</i> 2007; (16), 90-94.
Reference	The Commonwealth Fund (2010). Adverse Drug Events: Ambulatory Care Visits for Treatment. Retrieved from http://www.commonwealthfund.org/Performance-Snapshots/Medication-Mistakes-and-Adverse-Drug-Events/Adverse-Drug-Events--Ambulatory-Care-Visits-for-Treatment.aspx
Reference	Institute for Safe Medication Practices (2007). A White Paper on Medication Safety in the U.S. and the Roles of Community Pharmacists. Retrieved from http://www.ismp.org/pressroom/viewpoints/CommunityPharmacy.pdf
Reference	Agency for Healthcare Research and Quality (2011). National Healthcare Disparities Report 2011. Retrieved from http://www.ahrq.gov/research/findings/nhqrdr/nhqr11/chap3.html
Reference	Weeks, D.L., Corbette, C.F., Stream, G. (2010). Beliefs of Ambulatory Care Physicians about Accuracy of Patient Medication Records and Technology-Enhanced Solutions to Improve Accuracy. <i>Journal for Healthcare Quality</i> ; 32(5), 12-21.
Reference	The Joint Commission (2014). Ambulatory Care National Patient Safety Goals. Retrieved from http://www.jointcommission.org/assets/1/6/2014_AHC_NPSG_E.pdf
Reference	National Quality Forum (2010). Safe Practices for Better Healthcare– 2010 Update. Retrieved from http://www.qualityforum.org/Projects/Safe_Practices_2010.aspx
Reference	Tache, S.V., Sonnichsen, A., & Ashcroft, D.M. (2011). Prevalence of Adverse Drug Events in Ambulatory Care: A Systematic Review. <i>The Annals of Pharmacotherapy</i> , 45(7-8), 977-989. doi: 10.1345/aph.1P627.
Definition	<p>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.</p> <p>Route: Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical)</p>
Guidance	<p>This measure is to be reported for every encounter during the measurement period.</p> <p>Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.</p> <p>This list must include all prescriptions, over-the-counter (OTC) products, herbals, vitamins, minerals, dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.</p> <p>This measure should also be reported if the eligible professional documented the patient is not currently taking any medications.</p> <p>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.</p>

Transmission Format	TBD
Initial Patient Population	All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period
Denominator	Equals Initial Patient Populations
Denominator Exclusions	None
Numerator	Eligible professional attests to documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration
Numerator Exclusions	Not Applicable
Denominator Exceptions	Medical Reason: 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
Measure Population	Not Applicable.
Measure Observations	Not Applicable.
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex.

Table of Contents

- [Population criteria](#)
- [Data criteria \(QDM Data Elements\)](#)
- [Reporting Stratification](#)
- [Supplemental Data Elements](#)

Population Criteria

- **Initial Patient Population =**
 - AND: "Patient Characteristic Birthdate: birth date" >= 18 year(s) starts before start of "Measurement Period"
 - AND: "Occurrence A of Encounter, Performed: Medications Encounter Code Set" during "Measurement Period"
- **Denominator =**
 - AND: "Initial Patient Population"
- **Denominator Exclusions =**
 - None
- **Numerator =**
 - AND: "Procedure, Performed: Current Medications Documented SNMD" during "Occurrence A of Encounter, Performed: Medications Encounter Code Set"
- **Denominator Exceptions =**
 - AND: "Procedure, Performed not done: Medical or Other reason not done" for "Current Medications Documented SNMD" during "Occurrence A of Encounter, Performed: Medications Encounter Code Set"

Data Criteria (QDM Data Elements)

- "Encounter, Performed: Medications Encounter Code Set" using "Medications Encounter Code Set Grouping Value Set (2.16.840.1.113883.3.600.1.1834)"
- "Patient Characteristic Birthdate: birth date" using "birth date LOINC Value Set (2.16.840.1.113883.3.560.100.4)"
- "Procedure, Performed not done: Medical or Other reason not done" using "Medical or Other reason not done SNOMEDCT Value Set (2.16.840.1.113883.3.600.1.1502)"
- "Procedure, Performed: Current Medications Documented SNMD" using "Current Medications Documented SNMD SNOMEDCT Value Set (2.16.840.1.113883.3.600.1.462)"

Reporting Stratification

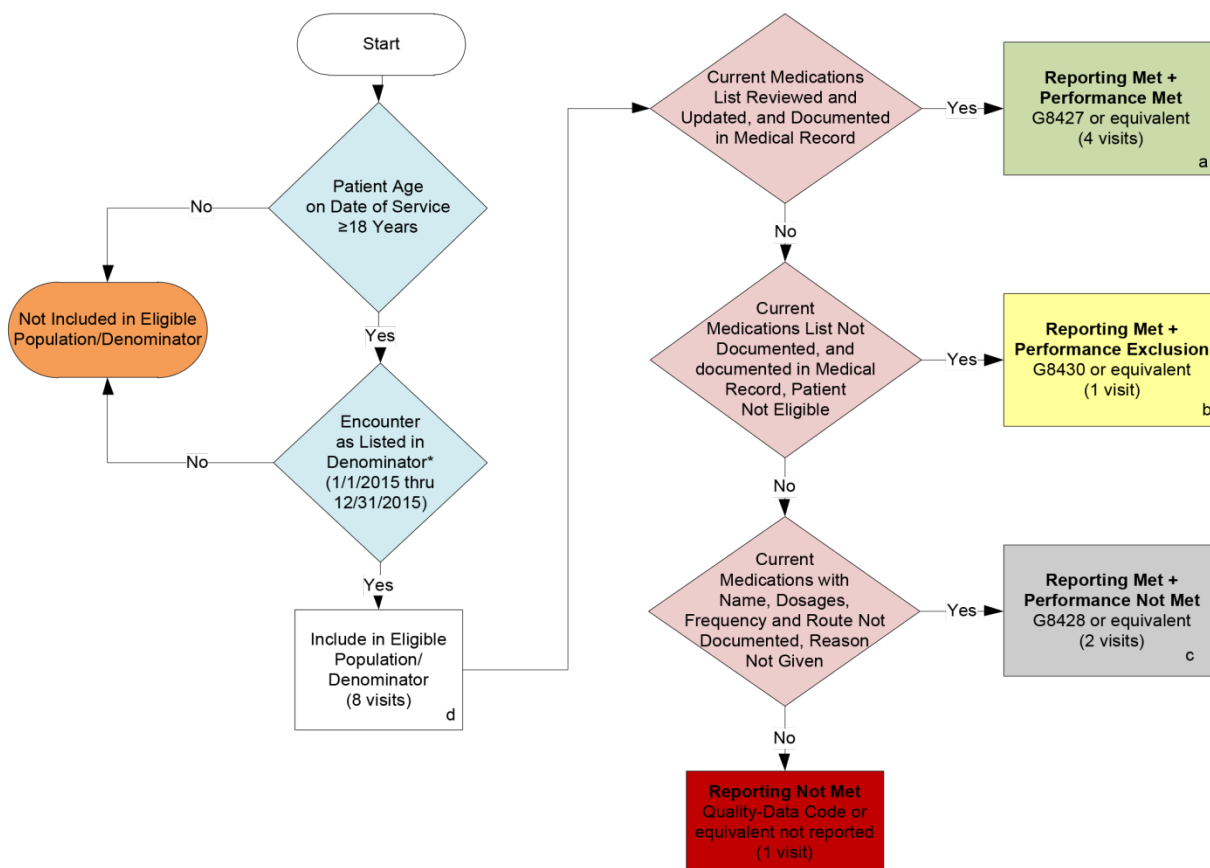
- None

Supplemental Data Elements

- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity CDCREC Value Set (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer SOP Value Set (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race CDCREC Value Set (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex AdministrativeSex Value Set (2.16.840.1.113762.1.4.1)"

Calculation Algorithm/Measure Logic/Performance Calculation 2015 Claims/Registry Individual Measure Flow

2015 Claims/Registry Individual Measure Flow
PQRS #130 NQF #0419 Documentation of Current Medications in the Medical Record



SAMPLE CALCULATIONS:

Reporting Rate=

$$\frac{\text{Performance Met (a=4 visits)} + \text{Performance Exclusion (b=1 visit)} + \text{Performance Not Met (c=2 visits)}}{\text{Eligible Population / Denominator (d=8 visits)}} = \frac{7 \text{ visits}}{8 \text{ visits}} = 87.50\%$$

Performance Rate=

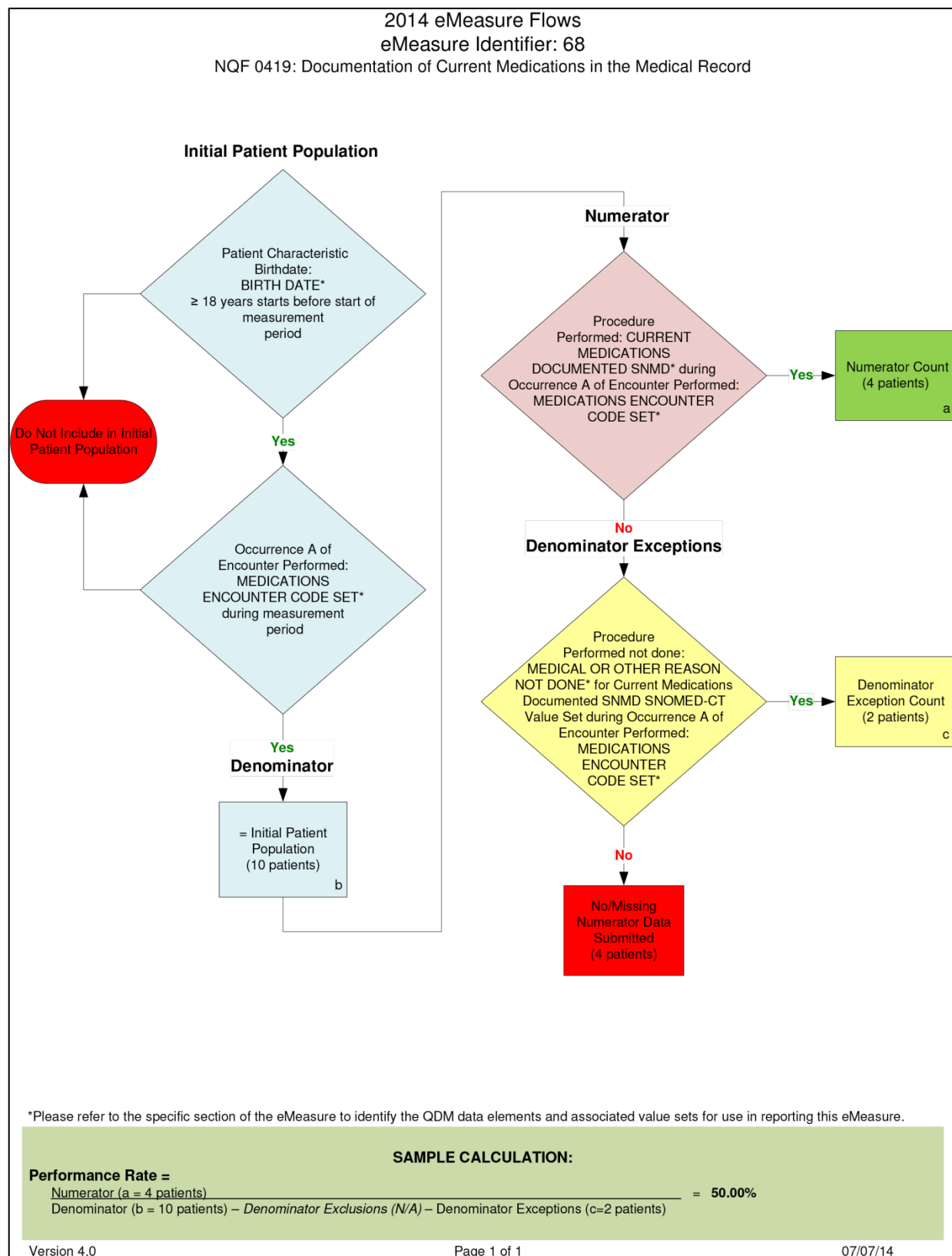
$$\frac{\text{Performance Met (a=4 visits)}}{\text{Reporting Numerator (7 visits) - Performance Exclusion (b=1 visit)}} = \frac{4 \text{ visits}}{6 \text{ visits}} = 66.67\%$$

*See the posted Measure Specification for specific coding and instructions to report this measure.

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Calculation Algorithm/Measure Logic/Performance Calculation 2014 eMeasure Individual Measure Flow



*Please refer to the specific section of the eMeasure to identify the QDM data elements and associated value sets for use in reporting this eMeasure.

III. Analysis of Claims/Registry/EHR Data

Average Performance Rates by Year (PQRS – all reporting methods):

2010 – 74.7%

2011 – 85.7%

2012 – 85.6%

Performance Score Distribution, by Data Source

Provider-level performance scores suggest that there are still gaps in care and opportunities for improvement, particularly for providers reporting using registry and EHR data.

Data Source*	Number of Providers (by Provider)	Mean	Median	10 th Percentile	25 th Percentile	75 th Percentile	90 th Percentile
Claims	92,991	94.3%	100.0%	81.3%	98.3%	100.0%	100.0%
Registry	19,176	82.3%	97.4%	32.2%	78.2%	100.0%	100.0%
EHR	40	69.9%	80.7%	34.2%	47.1%	93.7%	98.5%

*Claims submitted 7/1/2013 – 12/31/2013. Registry submitted 1/1/2013 through 12/31/2013. EHR data from convenience sample of three practices for encounters in 2014.

Performance Measure Score Reliability:

Provider-specific reliability demonstrates a sufficient level of reliability to detect real difference in performance scores.

In general, reliability scores vary from 0.0 to 1.0, with a score of zero indicating that all variation is attributable to measurement error (noise, or variation across patients within providers) whereas a reliability of 1.0 implies that all variation is caused by real difference in performance across accountable entities.

Data Source	Number of Providers (by Provider)	Between-Provider Variance	Reliability Coefficient Mean	Reliability Coefficient Median	Reliability Coefficient Std Dev	Reliability Coefficient Min/Max
Claims	92,991	.024	.967	1.0	.109	.158 – 1.0
Registry	19,176	.042	.980	.999	.071	.253 – 1.0
EHR	40	.049	.989	.991	.013	.931 – 1.0

Critical Data Element Testing (Validity):

Clinical reviewers abstracted 255 cases from 40 providers to assess validity of EHR reports of 2014 encounters at three practices. In this approach, the manually abstracted records for each case is considered the gold standard when compared to the electronically-extracted EHR report. This methodology assesses the validity of critical data elements. Post-hoc power analysis indicates that—based on the number of cases abstracted, the prevalence of the numerator condition, and the specificity—our sample of 255 cases had greater than 80% power to detect at least substantial Kappa scores between the EHR extract and chart abstracted data with 95% confidence.

Numerator criteria agreement:

Unadjusted agreement: 87.8%

Simple Kappa Coefficient (chance-adjusted): 0.63 (95% Confidence Interval: 0.51 - 0.75).

These numerator agreement scores suggest that validity is substantial. Most discrepancies were due to EHR under reporting measure performance.

EHR Reliability and Performance Distribution (40 Provider Convenience Sample 2014)

MIN_VAL	INVAR	N	MEAN	STD	MIN	p1	p5	p10	p20	p25	p30	p40	p50	p60	p70	p75	p80	p90	p95	p99	MAX
1	DENOMINATOR	40	778.30	1461.28	67	67	90.5	155.5	225	253.5	269.5	331.5	368	467	494	604.5	800.5	1073.5	3749	7973	7973
1	NUMERATOR	40	657.00	1353.02	14	14	25	64	106.5	123.5	151	205.5	267	315	416.5	562.5	688.5	1058.5	3688.5	6929	6929
1	RATE	40	0.70	0.27	0.07	0.07	0.22	0.34	0.45	0.47	0.49	0.64	0.81	0.88	0.92	0.94	0.96	0.99	0.99	1.00	1.00
1	RELIABILITY	40	0.99	0.01	0.93	0.93	0.97	0.98	0.98	0.99	0.99	0.99	0.99	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
1	NOISE_VAR	40	0.001	0.001	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.001	0.001	0.001	0.001	0.001	0.002	0.004	0.004
1	SIGNAL_VAR	40	0.05	0																	
10	DENOMINATOR	40	778.30	1461.28	67	67	90.5	155.5	225	253.5	269.5	331.5	368	467	494	604.5	800.5	1073.5	3749	7973	7973
10	NUMERATOR	40	657.00	1353.02	14	14	25	64	106.5	123.5	151	205.5	267	315	416.5	562.5	688.5	1058.5	3688.5	6929	6929
10	RATE	40	0.70	0.27	0.07	0.07	0.22	0.34	0.45	0.47	0.49	0.64	0.81	0.88	0.92	0.94	0.96	0.99	0.99	1.00	1.00
10	RELIABILITY	40	0.99	0.01	0.93	0.93	0.97	0.98	0.98	0.99	0.99	0.99	0.99	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
10	NOISE_VAR	40	0.001	0.001	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.001	0.001	0.001	0.001	0.001	0.002	0.004	0.004
10	SIGNAL_VAR	40	0.05	0																	
20	DENOMINATOR	39	792.90	1477.43	67	67	67	133	238	263	271	336	375	468	496	701	818	1202	5566	7973	7973
20	NUMERATOR	39	673.49	1366.63	22	22	28	65	108	125	156	218	279	315	456	643	689	1180	5498	6929	6929
20	RATE	39	0.72	0.25	0.19	0.19	0.25	0.38	0.46	0.47	0.50	0.64	0.82	0.89	0.93	0.94	0.97	0.99	0.99	1.00	1.00
20	RELIABILITY	39	0.99	0.01	0.92	0.92	0.96	0.97	0.98	0.98	0.98	0.99	0.99	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
20	NOISE_VAR	39	0.00	0.001	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.001	0.001	0.001	0.001	0.001	0.002	0.004	0.004
20	SIGNAL_VAR	39	0.04	0																	

Registry Reliability and Performance (PQRS 2013)

MIN_VAL	INVAR	N	MEAN	STD	MIN	p1	p5	p10	p20	p25	p30	p40	p50	p60	p70	p75	p80	p90	p95	p99	MAX
1	DENOMINATOR	19176	465.86	615.46	1.00	1.00	2.00	8.00	36.00	55.00	80.00	146.00	237.00	359.00	529.00	639.50	787.00	1239.00	1677.00	2781.00	9445.00
1	NUMERATOR	19176	369.30	535.14	1.00	1.00	1.00	4.00	19.00	30.00	45.00	88.00	153.00	252.99	396.99	499.50	624.00	1035.02	1432.96	2442.02	9445.00
1	RATE	19176	0.82	0.28	0.00	0.00	0.10	0.32	0.67	0.78	0.86	0.94	0.97	0.99	1.00	1.00	1.00	1.00	1.00	1.00	1.00
1	RELIABILITY	19176	0.98	0.07	0.25	0.57	0.91	0.96	0.99	0.99	0.99	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
1	NOISE_VAR	19176	0.001	0.008	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.001	0.002	0.004	0.032	0.125
1	SIGNAL_VAR	19176	0.04	0.00																	
10	DENOMINATOR	16242	526.80	631.47	10.00	12.00	23.00	38.00	76.00	102.00	132.00	205.00	303.00	431.00	604.00	717.00	859.00	1320.00	1757.00	2893.00	9445.00
10	NUMERATOR	16242	435.43	556.35	10.00	11.00	17.99	27.00	53.00	71.00	91.00	147.00	225.00	332.98	490.00	594.00	715.00	1131.98	1512.00	2511.06	9445.00
10	RATE	16242	0.85	0.24	0.00	0.06	0.23	0.44	0.73	0.82	0.87	0.94	0.97	0.99	1.00	1.00	1.00	1.00	1.00	1.00	1.00
10	RELIABILITY	16242	0.98	0.04	0.63	0.78	0.91	0.95	0.98	0.99	0.99	0.99	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
10	NOISE_VAR	16242	0.000	0.001	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.001	0.001	0.003	0.007	0.015
10	SIGNAL_VAR	16242	0.03	0.00																	
20	DENOMINATOR	15248	553.60	636.97	20.00	22.00	35.00	51.00	95.00	122.00	154.00	231.00	332.00	461.00	636.00	756.00	897.00	1358.00	1786.00	2956.00	9445.00
20	NUMERATOR	15248	462.87	563.38	20.00	21.00	29.00	40.00	70.00	90.00	114.00	173.00	256.00	366.02	525.99	627.03	756.99	1166.98	1560.98	2568.06	9445.00
20	RATE	15248	0.86	0.23	0.01	0.09	0.29	0.48	0.75	0.83	0.88	0.94	0.97	0.99	1.00	1.00	1.00	1.00	1.00	1.00	1.00
20	RELIABILITY	15248	0.98	0.03	0.74	0.83	0.92	0.95	0.98	0.98	0.99	0.99	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
20	NOISE_VAR	15248	0.000	0.001	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.001	0.002	0.004	0.007
20	SIGNAL_VAR	15248	0.02	0.00																	

Claims Data Reliability and Performance (PQRS 7/1/2013 – 12/31/2013)

MIN_VAL	INVAR	N	MEAN	STD	MIN	p1	p5	p10	p20	p25	p30	p40	p50	p60	p70	p75	p80	p90	p95	p99	MAX
1	DENOMINATOR	92991	124.59	210.93	1.00	1.00	1.00	2.00	4.00	6.00	9.00	19.00	34.00	62.00	115.00	154.00	204.00	369.00	539.00	981.00	3466.00
1	NUMERATOR	92991	117.01	203.23	1.00	1.00	1.00	1.00	4.00	6.00	8.00	17.00	30.00	56.00	104.00	141.00	189.00	347.00	514.00	950.00	3439.00
1	RATE	92991	0.94	0.15	0.00	0.15	0.64	0.81	0.95	0.98	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
1	RELIABILITY	92991	0.97	0.11	0.16	0.36	0.78	0.92	0.99	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
1	NOISE_VAR	92991	0.002	0.009	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.002	0.007	0.042	0.125
1	SIGNAL_VAR	92991	0.02	0.00																	
10	DENOMINATOR	63377	180.01	235.15	10.00	10.00	13.00	16.00	25.00	31.00	38.00	58.00	88.00	134.00	198.00	241.00	292.00	459.00	641.00	1101.00	3466.00
10	NUMERATOR	63377	170.10	227.48	10.00	10.00	12.00	15.00	23.00	28.00	35.00	53.00	81.00	123.00	184.00	225.00	275.00	437.00	613.00	1073.00	3439.00
10	RATE	63377	0.95	0.13	0.01	0.33	0.70	0.82	0.93	0.96	0.98	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
10	RELIABILITY	63377	0.97	0.07	0.52	0.63	0.80	0.90	0.97	0.99	0.99	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
10	NOISE_VAR	63377	0.001	0.002	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.002	0.004	0.009	0.015
10	SIGNAL_VAR	63377	0.02	0.00																	
20	DENOMINATOR	53415	210.24	244.25	20.00	20.00	24.00	29.00	42.00	50.00	60.00	86.00	122.00	172.00	238.00	280.00	333.00	501.00	686.00	1152.00	3466.00
20	NUMERATOR	53415	199.20	236.66	20.00	20.00	23.00	27.00	39.00	46.00	55.00	79.00	113.00	159.00	222.00	263.00	314.00	479.00	659.00	1126.00	3439.00
20	RATE	53415	0.95	0.12	0.02	0.39	0.72	0.83	0.94	0.96	0.98	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
20	RELIABILITY	53415	0.98	0.05	0.65	0.73	0.86	0.92	0.97	0.98	0.99	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
20	NOISE_VAR	53415	0.000	0.001	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.001	0.002	0.005	0.007

**Disparities in Performance Rates by Race, Age and Gender
(Claims 7/1/2013 – 12/31/2013)**

Race	Performance Rate
Unknown	93.3%
White	94.0%
Black	93.5%
Other	93.9%
Asian	94.2%
Hispanic	93.7%
North American Native	93.3%

CHI-SQUARE DF=6 Value=387.5336 Prob <.0001
N = 11585674

Age Category	Performance Rate
18-29	92.1%
30-39	92.5%
40-49	93.2%
50-59	94.1%
60-69	94.2%
75+	93.7%

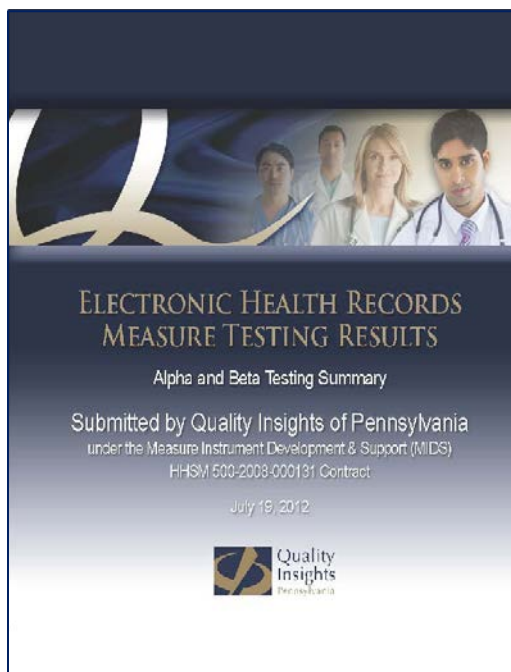
CHI-SQUARE DF=5 Value=3379.6839 Prob <.0001
N = 11585674

Gender	Performance Rate
Male	94.0%
Female	93.8%

CHI-SQUARE DF=5 Value=3379.6839 Prob <.0001
N = 11585674

IV. Original Feasability Testing Report

To access the Feasability Report, double-click on the report image below:



V. References

NOTE: References with an asterisk (*) denote articles that are included as PDFs in the zip file folder on page 22

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*Weeks, D.L., Corbette, C.F., Stream, G. (2010). Beliefs of Ambulatory Care Physicians about Accuracy of Patient Medication Records and Technology-Enhanced Solutions to Improve Accuracy. *Journal for Healthcare Quality*; 32(5), 12-21.

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