

Documentation of Current Medications in the Medical Record (CMS68)

<https://ecqi.healthit.gov/ecqm/ep/2022/cms068v11>

Measure Details

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

Initial Population: ALL visits for patients 18 years and older during 2022.

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

Denominator: Equals Initial Population.

Exclusions:

- 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)

Documentation Overview

What is Documented	When is it Documented	Where in QMER
All Medications *	EACH visit in 2022	RxMed Module
Medication Reconciliation	EACH visit in 2022	RxMed Module

Notes

* This included all known prescriptions, over-the-counter products, herbals, vitamins, minerals, dietary supplements AND must contain the name, dose, frequency, and route of administration

Exclusions/Exceptions	Where in QEMR
Urgent/Emergent medical situation	History Module

Set Up

No additional set up is required.

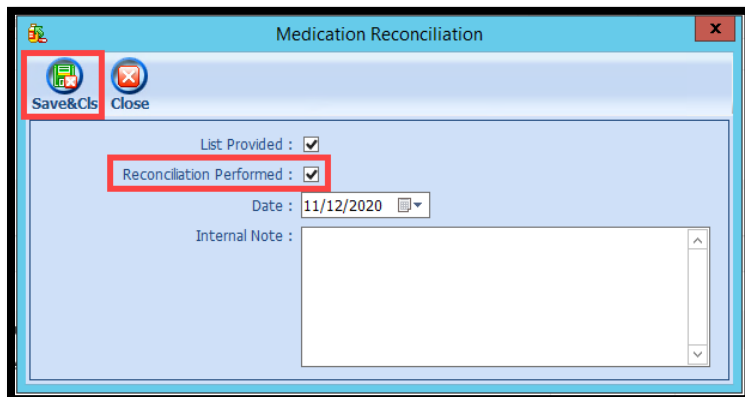
Workflow

All medications listed in Medication History must contain *Medication Name, Dose, Route and Directions* before reconciliation to be performed.

1. Click **Med. Recon.** Hot button



2. Click **Reconciliation Performed** checkbox
 - **List Provided** – Uncheck if patient did not provide list on current date
 - **Internal Notes** – Optional field
3. Click **Save & Close** hot button



Incrementing Details

Occur Dates

To increment ANY measure using the History Module the Occur Dater MUST be completed.

Exam Coding

If exam notes (Past Exams) are not coded with Diagnosis Code and CPT code measures will not increment.

Measure Specific Codes

Some of the SnoMed, LOINC, ICD10 and CPT Codes list are one of many available for some measures, if you practice would like to use an alternate code than what is listed in the set up section, please reach out to support for additional options.