TRIARQ HEALTH | Quick Guide

Documentation of Current Medications in the Medical Record (CMS68)

The following is for educational purposed only and is not intended to be clinical or legal advice. The information provided in the Measure Details section is based on specification published by CMS at https://ecqi.healthit.gov/ecqm/ec/2023/cms068v12

Measure Details

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

Denominator

Equals Initial Population

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

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 Exclusion

NA

Overview

What is Documented	When is it Documented	Where in QMER
Qualifying Encounter	During Measurement Period (2023)	Coded SOAP Note
Medication Reconciliation	Each visit during Measurement Period (2023)	RxMeds Module

Exclusions/Exceptions	Where in QEMR
Medical Reasons for not documenting or reviewing the patient's current medication list	History Module

2022 to 2023 Changes
NA

Set Up

All codification shown is an example for incrementation, for a full list of accepted codes please visit Value Set Authority Center.

Qualifying Encounter

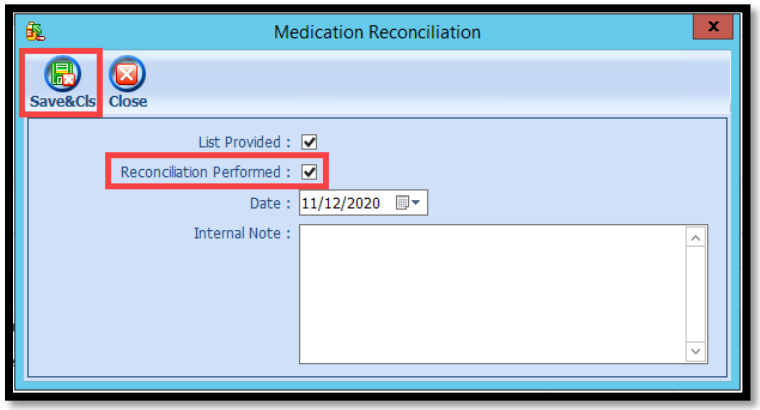
No set up required

Medication Reconciliation

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 documented using appropriate date based upon Measure Description.

Exam Coding

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

Measure Specific Codes

The codification shown in this document are examples of qualifying documentation. To see a full list please visit Value Set Authority Center.

CMS 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 (OTC) 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.