

Documentation and Verification of Current Medications in the Medical Record

*This measure is to be reported at **each** visit occurring during the reporting period for all patients aged 18 years and older.*

Measure description

Percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative¹ is documented by the provider

What will you need to report for each patient for this measure?

If you select this measure for reporting, you will report:

- Whether or you documented a list of the patient's current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verified² the list with the patient or authorized representative

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to document and/or verify current medications, due to:

- Documented reasons (eg, patient refuses to participate, urgent or emergent medical situation and to delay treatment would jeopardize the patient's health status, patient is not currently on any medications, patient is cognitively impaired and no authorized representative available)

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exclusions).

¹A person who is acting on the patient's behalf and who does not have a conflict of interest with the patient, when the patient is temporarily or permanently unable to act for himself or herself. This person should have the patient's best interests at heart and should be reasonably expected to act in a manner that is protective of the person and the rights of the patient. Preferably, this individual is appointed by the patient.

²Verification is defined as documentation of acknowledgement by the patient and/or authorized representative or provider that signifies discussion, assessment, or review to confirm accuracy of information.

Medication Management

Documentation and Verification of Current Medications in the Medical Record

PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy) / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
National Provider Identifier (NPI)		Date of Service	

Clinical Information

Billing Information

Step 1 Is patient eligible for this measure?

	Yes	No	Code Required on Claim Form
Patient is aged 18 years and older on date of encounter.	<input type="checkbox"/>	<input type="checkbox"/>	Verify date of birth on claim form.
There is a CPT Procedure Code, CPT Service Code, or G-code for this visit.	<input type="checkbox"/>	<input type="checkbox"/>	Refer to coding specifications document for list of applicable codes. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.
If No is checked for any of the above, STOP. Do not report a G-code.			

Step 2 Does patient meet or have an acceptable reason for not meeting the measure?

Current Medications with Dosages	Yes	No	Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
Documented AND verified with the patient ¹ or authorized representative ²	<input type="checkbox"/>	<input type="checkbox"/>	G8427
Not documented for the following reason: <ul style="list-style-type: none"> Documented reasons (eg, patient refuses to participate, urgent or emergent medical situation and to delay treatment would jeopardize the patient's health status, patient is not currently on any medications) 	<input type="checkbox"/>	<input type="checkbox"/>	G8430
Documented, but not verified for the following reason: <ul style="list-style-type: none"> Documented reasons (eg, patient is cognitively impaired and no authorized representative available) 	<input type="checkbox"/>	<input type="checkbox"/>	G8507
Document reason here and in medical chart. _____ _____ _____			If No is checked for all of the above, report G8428 (Provider documentation of current medications with dosages without documented patient verification.) OR G8429 (Incomplete or no provider documentation that the patient's current medications with dosages were assessed.)

¹Verification is defined as documentation of acknowledgement by the patient and/or authorized representative or provider that signifies discussion, assessment, or review to confirm accuracy of information.

²An authorized representative is a person who is acting on the patient's behalf and who does not have a conflict of interest with the patient, when the patient is temporarily or permanently unable to act for himself or herself. This person should have the patient's best interests at heart and should be reasonably expected to act in a manner that is protective of the person and the rights of the patient. Preferably, this individual is appointed by the patient.

Documentation and Verification of Current Medications in the Medical Record

Coding Specifications

Codes required to document a visit occurred:

A CPT procedure code, CPT service code, or HCPCS G-code is required to identify patients to be included in this measure.

All measure-specific coding should be reported ON THE SAME CLAIM.

CPT procedure codes for anesthesia services:

- 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00326, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00452, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00561, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00622, 00625, 00626, 00630, 00632, 00634, 00635, 00640, 00670, 00700, 00702, 00730, 00740, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00810, 00820, 00830, 00832, 00834, 00836, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01180, 01190, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01632, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01682, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01953, 01958, 01960, 01961, 01962, 01963, 01965, 01966, 01967, 01968, 01969, 01990, 01991, 01992, 01996, 01999

OR

CPT service codes

- 90801 (psychiatric diagnostic interview examination),
- 90802 (interactive psychiatric diagnostic interview examination),
- 92002, 92004 (ophthalmological services — new patient),
- 92012, 92014 (ophthalmological services — established patient),
- 92541, 92542, 92543, 92544, 92545, 92547, 92548 (vestibular function tests),
- 92557 (comprehensive audiometry threshold evaluation and speech recognition),
- 92567 (tympanometry [impedance testing]),
- 92568, 92569 (acoustic reflex testing),
- 92585 (auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system),
- 92588 (comprehensive or diagnostic evaluation [comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies]),
- 92626 (evaluation of auditory rehabilitation status),
- 96116 (neurobehavioral status exam),
- 96150, 96152 (health and behavior assessment/intervention),
- 97001, 97002 (physical therapy evaluation),
- 97003, 97004 (occupational therapy evaluation),
- 97802, 97803 (medical nutrition therapy),
- 98960 (education and training for patient self-management by a qualified, nonphysician health care professional),
- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99211, 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult)

OR

HCPCS G-codes

- G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination),
- G0108 (diabetes services),
- G0270 (medical nutrition therapy)

continued on next page

Documentation and Verification of Current Medications in the Medical Record

continued from previous page

Quality codes for this measure:

G-code descriptors

(Data Collection sheet should be used to determine appropriate code.)

- **G8427:** List of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative documented by the provider
- **G8430:** Provider documentation that patient is not eligible for medication assessment
- **G8507:** Provider documentation that patient is not eligible for patient verification of current medications
- **G8428:** Provider documentation of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) without documented patient verification
- **G8429:** Incomplete or no provider documentation that patient's current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were assessed