Quality ID #130: Documentation of Current Medications in the Medical Record

2026 COLLECTION TYPE:
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of visits for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter.

INSTRUCTIONS:

Reporting Frequency:
This measure is to be submitted at each denominator eligible visit for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:
This measure is intended to reflect the quality of services provided for patients on medications. This measure may be submitted by MIPS eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:
This measure contains one strata defined by a single submission criteria.
This measure produces a single performance rate.

Implementation Considerations:
For the purposes of MIPS implementation, this visit measure is submitted each time a patient has a denominator eligible encounter during the performance period. MIPS eligible clinicians 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.

By submitting the action described in this measure, the provider attests to having documented a list of current medications utilizing all immediate resources available on the day of the encounter. G8427 should be submitted if the MIPS eligible clinician documented that the patient is not currently taking any medications.

Telehealth:
TELEHEALTH ELIGIBLE: This measure is appropriate for and applicable to the telehealth setting. Patient encounters conducted via telehealth using encounter code(s) found in the denominator encounter criteria are allowed for this measure. Therefore, if the patient meets all denominator criteria for a telehealth encounter, it would be appropriate to include them in the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:
The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more

information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All visits occurring during the 12-month performance period.

DENOMINATOR NOTE:
**Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):
Any patient, regardless of age
AND
Patient encounter during the performance period (CPT or HCPCS): 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 90839, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92548, 92549, 92650*, 92651, 92652, 92653, 92550, 92557, 92567, 92568, 92570, 92588, 92622, 92626, 96116, 96156, 96158, 97129, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98960, 98961, 98962, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99236, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99424, 99491, 99495, 99496, G0101, G0108, G0270, G0402, G0438, G0439

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.

Definitions:
Current Medications – Medications the patient is presently taking including all prescriptions, over-the- counters, herbals, vitamins, minerals, dietary (nutritional) supplements, and cannabis/cannabidiol (CBD) products 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 (Denominator Exception) – A patient is "not eligible" if there is 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 NOTE:
The MIPS eligible clinician must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. MIPS eligible clinicians submitting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.

*This list **must** include ALL known prescriptions, over-the-counter (OTC) products, herbals, vitamins, minerals, dietary (nutritional) supplements, cannabis/cannabidiol (CBD) products AND **must** contain the medications' name, dosage, frequency and route of administration.*

Numerator Options:

Performance Met:	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications (G8427)

OR

Denominator Exception:	Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an acute health crisis where time is of the essence and delay of treatment would jeopardize the patient's health status) (G8430)
OR	
Performance Not Met:	Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given (G8428)

RATIONALE:

According to the National Center for Health Statistics, during the years of 2013-2016, 48.4% of patients (both male and female) were prescribed at least one prescription medication with 12.6% taking 5 or more medications. Additionally, 89.8% of patients (both male and female) aged 65 years and older were prescribed at least one medication with 40.9% taking 5 or more medications [1]. In this context, maintaining an accurate and complete medication list has proven to be a challenging documentation endeavor for various health care provider settings. While most of outpatient encounters (two-thirds) result in providers prescribing at least one medication, hospitals have been the focus of medication safety efforts [2]. Nassaralla, Naessens, Chaudhry, Hansen, and Scheitel (2007) caution that this is at odds with the current trend, where patients with chronic illnesses are increasingly being treated in the outpatient setting and require careful monitoring of multiple medications. Additionally, Nassaralla et al. (2007) reveal that it is in fact in outpatient settings where more fatal adverse drug events (ADE) occur when these are compared to those occurring in hospitals (1 of 131 outpatient deaths compared to 1 in 854 inpatient deaths) [3]. In the outpatient setting, ADEs occur 25% of the time and over one-third of these are considered preventable [4]. Particularly vulnerable are patients over 65 years, with evidence suggesting that the rate of ADEs per 10,000 person per year increases with age; 25-44 years old at 1.3; 45-64 at 2.2, and 65 + at 3.8 [5]. Other vulnerable groups include individuals who are chronically ill or disabled [6]. These population groups are more likely to experience ADEs and subsequent hospitalization.

A multiplicity of providers and inadequate care coordination among them has been identified as barriers to collecting complete and reliable medication records. A study conducted by Poornima et al. (2015) indicates that reconciliation and documentation continue to be poorly executed with discrepancies occurring in 92% of patients (74 of 80) admitted to the emergency room. Of 80 patients included in the study, the home medications were re-ordered for 65% of patients on their admission. Of the 65%, 29% had a change in their dosing interval, while 23% had a change in their route of administration, and 13% had a change in dose. A total of 361 medication discrepancies, or the difference between the medications patients were taking before admission and those listed in their admission orders, were identified in at least 74 patients. The study found that “Through an appropriate reconciliation programme, around 80% of errors relating to medication and the potential harm caused by these errors could be reduced” [7]. Presley et al. (2020) also recognized specific barriers to sufficient medication documentation and reconciliation in rural and resource-limited care settings [8].

Documentation of current medications in the medical record facilitates the process of medication review and reconciliation by the provider, which is necessary for reducing ADEs and promoting medication safety. The need for provider to provider coordination regarding medication records, and the existing gap in implementation, is highlighted in the American Medical Association’s Physician’s Role in Medication Reconciliation, which states that "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" [9]. This is because clinical decisions based on information that is incomplete and/or inaccurate are likely to lead to medication error and ADEs. Weeks, Corbette, & Stream (2010) noted similar barriers and identified the utilization of health information technology as an opportunity for facilitating the creation of universal medication lists [10].

One 2015 meta-analysis showed an association between electronic health record (EHR) documentation with an overall risk ratio (RR) of 0.46 (95% CI = 0.38 to 0.55; P < 0.001) and ADEs with an overall RR of 0.66 (95% CI = 0.44 to 0.99; P =

0.045). This meta-analysis provides evidence that the use of the EHR can improve the quality of healthcare delivered to patients by reducing medication errors and ADEs [11].

CLINICAL RECOMMENDATION STATEMENTS:

The Joint Commission's 2023 Ambulatory Health Care National Patient Safety Goals guide clinicians to maintain and communicate accurate patient medication information (2023). Specifically, the section NPSG.03.06.01 "Maintain and communicate accurate patient medication information" states the following: "Obtain and/or update information on the medications the patient is currently taking. This information is documented in a list or other format that is useful to those who manage medication. Compare the medication information the patient brought to the organization with the medications ordered for the patient by the organization in order to identify and resolve discrepancies." [12]

The Joint Commission's 2023 Hospital National Patient Safety Goals also addressed documenting current medications (2023). Specifically, the section NPSG.03.06.01 "Maintain and communicate accurate patient information" states the following: "Obtain information on the medications the patient is currently taking when they are admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications." [13]

The National Quality Forum's Safe Practices for Better Healthcare - 2010 Update, states the following: "The healthcare organization must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care". [14]

REFERENCES:

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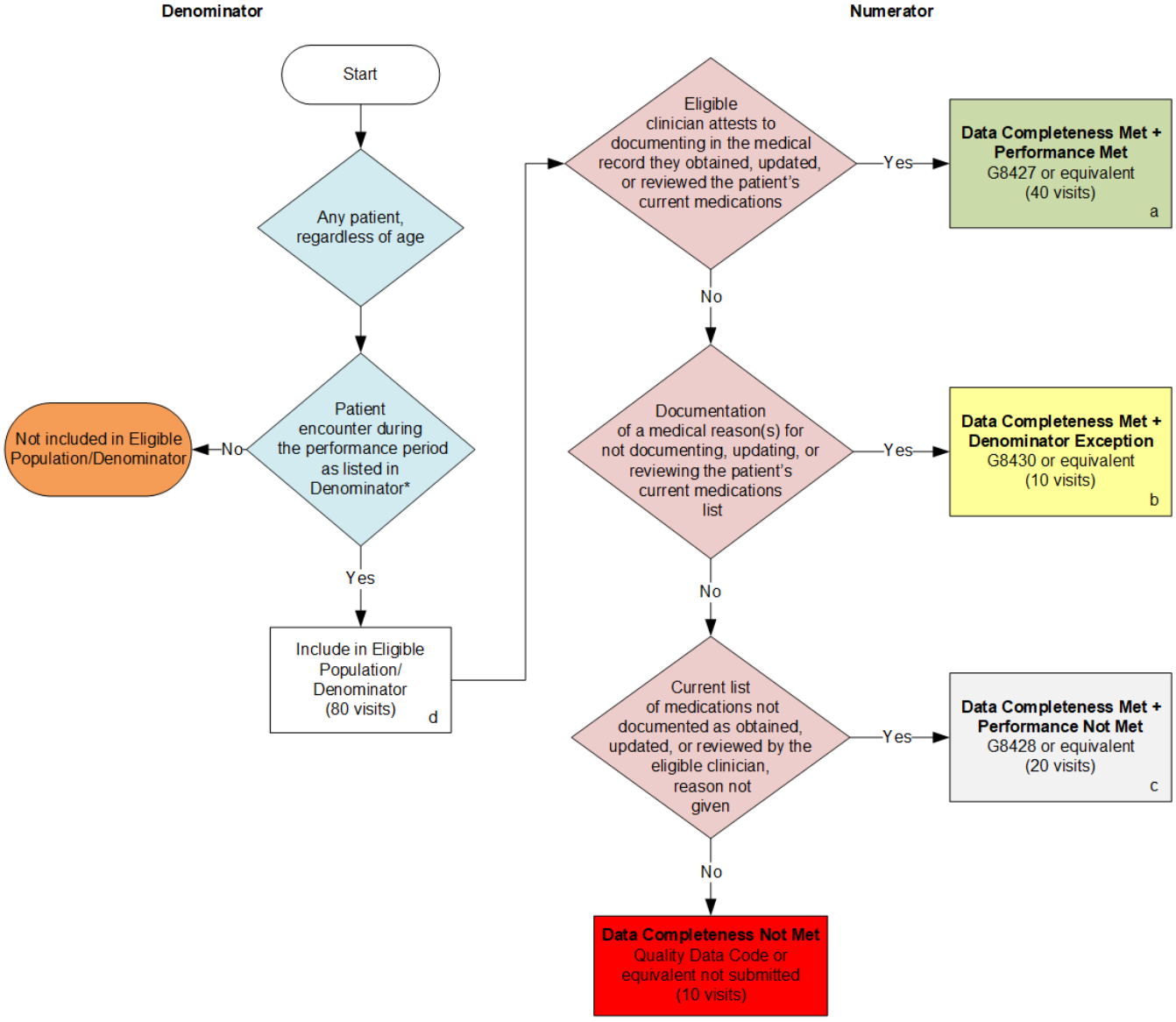
2026 Clinical Quality Measure Flow for Quality ID #130: Documentation of Current Medications in the Medical Record

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 visits) + Denominator Exception (b=10 visits) + Performance Not Met (c=20 visits) = 70 visits = **87.50%**

Eligible Population / Denominator (d=80 visits) = 80 visits

Performance Rate=

Performance Met (a=40 visits) = 40 visits = **66.67%**

Data Completeness Numerator (70 visits) – Denominator Exception (b=10 visits) = 60 visits

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Visit

v10

2026 Clinical Quality Measure Flow Narrative for Quality ID #130: Documentation of Current Medications in the Medical Record

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Any patient, regardless of age*
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Denominator Population:
    - Denominator Population is all Eligible Visits in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 visits in the Sample Calculation.
5. Start Numerator
6. Check *Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications*:
    a. If *Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications* equals Yes, include in *Data Completeness Met and Performance Met.*
        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 visits in the Sample Calculation.
    b. If *Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications* equals No, proceed to check *Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list*.
7. Check *Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list*:
    a. If *Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list* equals Yes, include in *Data Completeness Met and Denominator Exception*.
        - *Data Completeness Met and Denominator Exception* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 10 visits in the Sample Calculation.
    b. If *Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list* equals No, proceed to check *Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given*.
8. Check *Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given*:

a. If *Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met.*

   - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 20 visits in the Sample Calculation

b. If *Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given* equals No, proceed to check *Data Completeness Not Met*.

9. Check *Data Completeness Not Met*:

   - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 visits have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a equals 40 visits) plus Denominator Exception (b equals 10 visits) plus Performance Not Met (c equals 20 visits) divided by Eligible Population / Denominator (d equals 80 visits). All equals 70 visits divided by 80 visits. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 visits) divided by Data Completeness Numerator (70 visits) minus Denominator Exception (b equals 10 visits). All equals 40 visits divided by 60 visits. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Visit

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.