eCW Clinical Documentation Guide

Measure Name	**Medication Reconciliation Post-Discharge**
Relevance	ACO Quality Measure #12 *[GPRO: Care Coordination/Patient Safety Measure]* MIPS Clinical Quality Measure *[Registry 46: Process Measure]*
Measure Definition	***The percentage of patients, aged 18 years and older and discharged from an inpatient facility (e.g., hospital, skilled nursing facility or rehabilitation facility) who were seen, within 30 days of discharge, in the office by the medical professional providing on-going care (e.g., physician, prescribing practioner, registered nurse or clinical pharmacist) AND had the discharge medication list reconciled with the current medication list in the outpatient medical record*** This measure is reported as three rates stratified by age group: Reporting Criteria 1: 18-64 years of age Reporting Criteria 2: 65 years and older Total Rate: All patients 18 years of age and older
Measurement Period	The **Measurement Period** is defined as the current calendar year (January 1 - December 31)
Denominator	The **Denominator** consists of patients who: I. Are at least one of the following ages A. 18-64 years of age B. ≥ 65 years of age C. ≥ 18 years of age II. **AND**, Have been discharged from an inpatient facility during the Measurement Period III. **AND**, Have had an applicable office visit within 30 days of discharge from the inpatient facility IV. **Denominator Note**: A. This Denominator is based upon discharges followed by office visits B. A patient may appear in the Denominator more than once if multiple discharges, followed by office visits, occurred during the Measurement Period *(continued)*

Measure Name	**Medication Reconciliation Post-Discharge** *(continued)*
Numerator	The **Numerator** consists of patients, from the Denominator, who: I. Had the discharge medications reconciled with the current medication list A. Performed by a prescribing practioner, clinical pharmacist, or registered nurse B. **AND**, performed within 30 days of discharge II. **Numerator Notes** A. This measure is to be reported at an outpatient visit occurring within 30 days of each inpatient facility discharge during the Measurement Period B. This measure is not to be reported unless the patient has been discharged from an inpatient facility within 30 days prior to the outpatient visit C. There is no diagnosis associated with this measure
Exclusions and/or Exceptions	A patient is **excluded** from this measure if hospice services were provided during the Measurement Period
Measure Documentation	**To Qualify For This Measure** *(Denominator Documentation)* **I. The patient must have been discharged from an inpatient facility during the Measurement Period** **A. Qualifying inpatient facilities include:** 1. Hospital (excluding Observation and Emergency Department) 2. Skilled Nursing Facility 3. Rehabilitation Facility **B. Document the discharge from an inpatient facility in a structured data field** *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Measure Documentation *(continued)*	**1. For a discharge from the hospital, use the following structured data path:** *Progress Notes → HPI → Interim History →* [*Transition of care from hospital*] → [*Date of discharge from hospital*] **2. For discharge from another inpatient facility, use the following structured data path:** *Progress Notes → HPI → Interin History →* [*Transition of care from other inpatient facility*] → [*Date of discharge from inpatient facility*] 3. For each of the above options, the required structured data fields are outlined (boxed) 4. Record the discharge from the inpatient facility in the appropriate structured data field **a. Some configuration and mapping may first be required** 1) If necessary, add the "Transition of care from hospital" and/or "Transition of care from other inpatient facility" items to the "Interim History folder in HPI, as follows: a) From within a Progress Note or Virtual Visit, click the "HPI" link b) Click on the "Interim History" folder c) If "Transition of care from hospital" or "Transition of care from other inpatient facility" is not an available option (1) Click the carat next to the "Custom" button (2) Select "New Item" (a) A new window will open (b) Type "Transition of care from hospital" or "Transition of care from other inpatient facility" in the "Name" field (c) Check the "Structured Data" box (d) Click "OK" to save and close **2) If necessary, map the structured fields in your EMR to their Community counterparts in eCW** *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*

a) From within eCW, click the "Community" tab (top Menu bar)
b) Select "Mappings"
c) Select "Structured Data" from the list of options

(1) A "Mapper" window will open
(2) Complete the following fields for both sides (Community and Local)

(a) Section = HPI
(b) Category = Interim History
(c) Item = "Transition of care from hospital" or "Transition of care from inpatient facility"

(3) From the Community side, select the desired reporting field

(a) E.g., "Date of discharge from the hospital"
(b) E.g., "Date of discharge from other inpatient facility""

(4) Click "Add"

(a) The field will automatically be added to the Local side
(b) The fields will automatically be mapped to each other
(c) (Mapped fields display in blue font)
(d) Associated options are also automatically added and mapped

b. Enter the date of the inpatient discharge in the appopriate structured data field

II. The patient must be seen for an applicable outpatient visit within 30 days of discharge from the inpatient facility

A. The following E&M codes identify applicable outpatient encounters:

(continued)

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Measure Documentation *(continued)*	1. 90791 -90792 2. 90832, 90834, 90837, 90839 and 90845 3. 99201 - 99205 and 99211 - 99215 4. 99324 - 99328, 99334 - 99337, 99341 - 99345, and 99347 - 99350 5. 99495-99496 6. G0402, and G0438 - G0439 **B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit** *(Progress Notes → Billing)*
	<u>To Satisfy This Measure</u> *(Numerator Documentation)* **I. Perform a Medication Reconciliation on or within 30 days of discharge** **A. Medication Reconciliation is defined as:** 1. Documentation of the current medications with a notation that references the discharge medications a. E.g., No changes in meds since discharge b. E.g., Same meds at discharge c. E.g., Discontinue all discharge meds 2. Documentation of the patient's current medications with a notation that the discharge medications were reviewed 3. Documentation that the provider "reconciled the current and discharge meds" 4. Documentation of a current medication list, a discharge medication list and notation that the appropriate practioner reviewed both lists on the same date of service 5. Notation that no medications were prescribed or ordered upon discharge **B. The Medication Reconciliation must be performed by one of the following clinicians:** *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Measure Documentation *(continued)*	1. Physician 2. Prescribing Practioner 3. Clinical Pharmacist 4. Registered Nurse **C. The current medication list must include the following:** 1. All medications, including: a. Prescription Medications b. Over-the-Counter Medications c. Herbals d. Supplements 2. Dose 3. Frequency 4. Route 5. Reason for taking the medication D. It is also important to verify whether the patient is actually taking the medication as prescribed or instructed **II. Document that Medication Reconciliation was performed in one of the following ways:** **A. Record the performance of Medication Reconciliation in structured data fields** **1. For discharge from a hospital, use the following structured data path:** ***Progress Notes → HPI → Interim History*** ↓ ***Transition of care from hospital*** → ***Discharge medications reviewed and reconciled from hospital*** → ***Select option*** *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Measure Documentation *(continued)*	a. The required structured data fields are outlined (boxed) b. If necessary, configure and map the sturctured data fields, as detailed previously in this document c. Note: These structured data fields can be located in another customizable section of the Progress Note as long as they are mapped to the Community elements identified in the path above d. Options for the final structured data field ("Select option") are: 1) Medications left unchanged 2) Medications changed (e.g., discontinued, changed or added) **2. For discharge from another inpatient facility (Skilled Nursing Facility or Rehabilitation Facility, use the following structured data path:** ***Progress Notes → HPI → Interim History*** ↓ ***Transition of care fromother inpatient facility*** → ***Discharge medications reviewed and reconciled from hospital*** → ***Select option*** a. The required structured data fields are outlined (boxed) b. If necessary, configure and map the sturctured data fields, as detailed previously in this document c. Note: These structured data fields can be located in another customizable section of the Progress Note as long as they are mapped to the Community elements identified in the path above d. Options for the final structured data field ("Select option") are: 1) Medications left unchanged 2) Medications changed (e.g., discontinued, changed or added) **3. Document the reason for discontinuing a medication in the associated Progress Note** **4. Document any medication allergies or intolerances in the "Allergies" section of the patient's chart in eCW** **B. <u>OR</u>, Record the performance of Medication Reconciliation as a procedure** **1. The following CPTII code satisfies the Numerator:** 1111F ("Discharge medications reconciled with the current medication *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Measure Documentation *(continued)*	list in outpatient medical record) **2. Record the CPT II code in the Billing section of the Progress Note for the subsequent face-to-face visit (within 30 days of discharge)** *(Progress Notes → Billing)* **3. Document the reason for discontinuing a medication in the associated Progress Note** **4. Document any medication allergies or intolerances in the "Allergies" section of the patient's chart in eCW**
Exclusion and/or Exception Documentation	**<u>To Exclude a Patient From This Measure</u>** *(Exclusion/Exception Documentation)* **Document that Hospice services were provided to the patient during the Measurement Period** **A. Record the receipt of Hospice services in a structured data field** **1. eCW recommends the following structured data path:** ***Progress Notes → HPI → Interim History*** ↓ ***Specialized Care*** → ***Patient received Hospice care*** → ***Select "Yes"*** 2. The required structured data fields are outlined (boxed) in the path, above **a. Some configuration and mapping may first be required** 1) If necessary, add the "Specialized Care" item to the "Interim History folder in HPI, as follows: a) From within a Progress Note or Virtual Visit, click the "HPI" link b) Click on the "Interim History" folder c) If "Specialized Care" is not an available option *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Exclusion and/or Exception Documentation *(continued)*	(1) Click the carat next to the "Custom" button (2) Select "New Item" (a) A new window will open (b) Type "Specialized Care" in the "Name" field (c) Check the "Structured Data" box (d) Click "OK" to save and close **2) If necessary, map the structured fields in your EMR to their Community counterparts in eCW** a) From within eCW, click the "Community" tab (top Menu bar) b) Select "Mappings" c) Select "Structured Data" from the list of options (1) A "Mapper" window will open (2) Complete the following fields for both sides (Community and Local) (a) Section = HPI (b) Category = Interim History (c) Item = Specialized Care (3) From the Community side, select the desired reporting field (E.g., "Patient received Hospice care") (4) Click "Add" (a) The field will automatically be added to the Local side (b) The fields will automatically be mapped to each other (c) (Mapped fields display in blue font) (d) Associated options are also automatically added and mapped *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Exception and/or Exclusion Documentation *(continued)*	**B. <u>OR</u>, Record the receipt of Hospice services as a procedure** 1. The following CPT II code satisfies the Numerator: G9691 ("Hospice service provided during the measurement period") 2. Record the CPT II code in the Billing section of a Progress Note or Virtual Visit *(Progress Note/Virtual Visit → Billing)*
Trouble-Shooting	**<u>Having Problems? Check Out the Following Trouble-Shooting Tips</u>** **I. Verify that all structured data fields used are mapped to the correct Community elements in your EMR** A. For further assistance with mapping problems, contact an eCW Technical Service representative B. **<u>OR</u>**, Contact Ed Worthington or Kelly Saxton @ NPO
	II. Document a new allergy or intolerance in the "Allergies" section of the patient's chart, as follows" A. Access the "Allergies" section of the patient's chart in one of the following ways: 1. From the "Allergies/Intolerance" window, click "Add" 2. The "Past Medical History" window will open a. "**Structured/Non-Structured**" Field 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "**Agent/Substance**" Field **1) For a Structured (Drug) Allergy** *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
Trouble-Shooting *(continued)*	a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window **2) For a Non-Structured A (Non-Drug/Other) Allergy** a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) **OR**, free-type an Allergy into the "Agent/Substance" field c. "**Reaction**" Field 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) **OR,** free-type a reaction into the empty field d. "**Type**" Field 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "**Status**" Field 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options 2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options
	III. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505) *(continued)*

Measure Name	Medication Reconciliation Post-Discharge *(continued)*
For More Information	**For More Information** I. NQF 0097: "**Medication Reconciliation Post-Discharge**" II. eClinicalWorks "**MIPS - Registry 46 (NQF 0097): Medication Reconciliation Post-Discharge**"