# Documentation 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[1] (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including the drug name, dosage, frequency, and route

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

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

- Whether you documented a list of the patient's current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) including drug name, dosage, frequency, and route

## 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 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).

[1]Current Medications may be defined as all medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) a patient may be taking routinely and/or on a PRN basis OR documentation of no medications currently prescribed.


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