Eligible Professional
Medicaid EHR Incentive Program
Modified Stage 2
Objectives and Measures for 2017
Objective 7 of 10
Updated: November 2016

Medication Reconciliation	
Objective	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.
Measure	The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
Exclusion	Any EP who was not the recipient of any transitions of care during the EHR reporting period.

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Definition of Terms

Medication Reconciliation – The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider.

Transition of Care - The movement of a patient from one setting of care (for example, a hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Referral - Cases where one provider refers a patient to another, but the referring provider maintains his or her care of the patient as well.

Denominator for Transitions of Care and Referrals: The denominator includes transitions of care and referrals (as finalized in the Stage 2 rule where the definition of transitions of care includes: "When the EP is the recipient of the transition or referral, first encounters with a new patient and encounters with existing patients where a summary of care record (of any type) is provided to the receiving EP"(77 FR 53984).

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

- DENOMINATOR: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.
- NUMERATOR: The number of transitions of care in the denominator where medication reconciliation was performed.
- THRESHOLD: The resulting percentage must be more than 50 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who was not the recipient of any transitions of care during the EHR reporting period.

Additional Information

- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- In the case of reconciliation following transition of care, the receiving EP should conduct the medication reconciliation.
- The electronic exchange of information is not a requirement for medication reconciliation.
- The measure of this objective does not dictate what information must be included in medication reconciliation. Information included in the process of medication reconciliation is appropriately determined by the provider and patient.
- We define "new patient" as a patient never before seen by the provider. A provider may use an expanded definition of "new patient" for the denominator that includes a greater number of patients for whom the action may be relevant within their practice, such as inclusion of patients not seen in 2 years.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(7)(i) and (ii). For further discussion please see 80 FR 62811.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (b)(4).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.314 (b)(4) Clinical Information Reconciliation	Enable a user to electronically reconcile the data that represent a patient's active medication, problem, and medication allergy list as follows. For each list type: (i) Electronically and simultaneously display (i.e., in a single view) the data from at least two list sources in a manner that allows a user to view the data and their attributes, which must include, at a minimum, the source and last modification date. (ii) Enable a user to create a single reconciled list of medications, medication allergies, or problems.

	(iii)	Enable a user to review and validate the accuracy of a final set of data and, upon a user's confirmation, automatically update the list.

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria
N/A