Eligible Professional Meaningful Use Core Measures Measure 6 of 13

Stage 1
Last Updated: April 2013

Medication Allergy List	
Objective	Maintain active medication allergy list.
Measure	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.
Exclusion	No exclusion.

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Definition of Terms

Active Medication Allergy List – A list of medications to which a given patient has known allergies.

Allergy – An exaggerated immune response or reaction to substances that are generally not harmful.

Unique Patient – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term ''unique patient'' relate to what is contained in the patient's medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.

- NUMERATOR: Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.

The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an EP to meet this measure.

Additional Information

- For patients with no active medication allergies, an entry must still be made to the active medication allergy list indicating that there are no active medication allergies.
- An EP is not required to update this list at every contact with the patient. The measure ensures that the EP has not ignored having a medication allergy list for patients seen during the EHR reporting period and that at least one piece of information on medication allergies is presented to the EP. The EP can then use their judgment in deciding what further probing or updating may be required given the clinical circumstances at hand.

Related Meaningful Use FAQs

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at https://questions.cms.gov/ and enter the New ID # into the Search Box, clicking the "FAQ #" option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the "Text" option.)

- What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? ***New ID #2813***, ***Old ID #10095***
- For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? ***New ID #2765***, ***Old ID #10068***
- How does an EP determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"? ***New ID #3307***, ***Old ID #10664***
- When a patient is only seen by a member of the EP's clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP's denominator? ***New ID #3309***, ***Old ID #10665***
- Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP's patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology? ***New ID #3065***, ***Old ID #10466***
- If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient's information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures? ***New ID #3077***, ***Old ID #10475***

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	
§170.302(e) Maintain active medication allergy list	Enable a user to electronically record, modify, and retrieve a patient's active medication allergy list as well as medication allergy history for longitudinal care.
§170.302(n) Automated measure calculation	For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.

Standards Criteria
N/A