Tip Sheet

Medication Reconciliation Post-Discharge

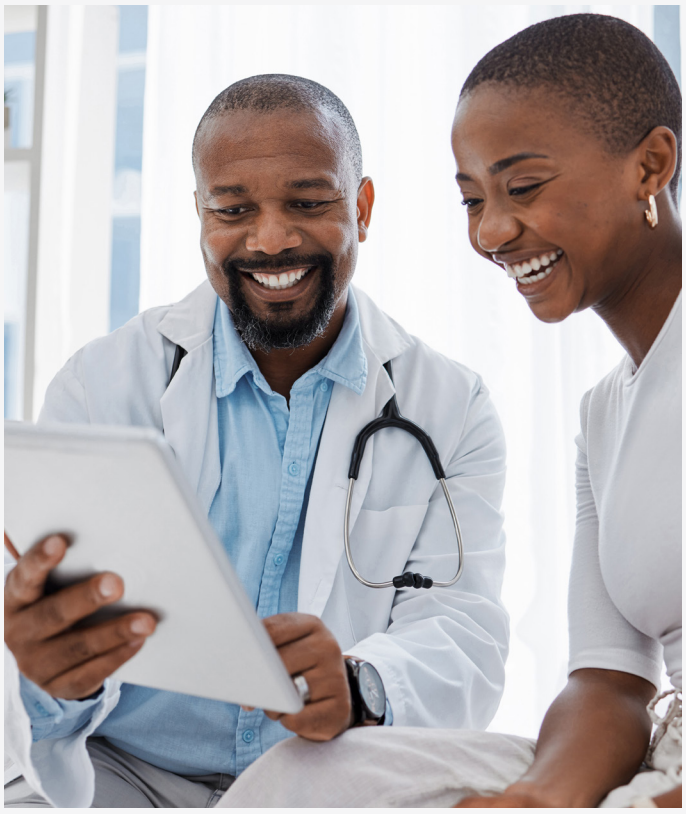
The Importance of Medication Reconciliation

Medication reconciliation—the process of comparing a patient's medication orders to all the medications the patient has been taking—is critical to the health of your patients and can help prevent medication errors such as omissions, duplications, dosing errors, and drug interactions.

The National Committee for Quality Assurance (NCQA) and HEDIS assess the medication reconciliation post-discharge (MRP) measure as the percentage of discharges from January 1 through December 1 of the measurement year for all members 18 years of age and older for whom medications were reconciled on the date of discharge through 30 days after discharge (31 total days). MRP is an event-based measure. For each discharge event, there will be a care opportunity that needs to be addressed by a clinician.

Medical Record Documentation Best Practices

- Document the date your office completed the review and reconciliation as well as the credentials of the person completing the reconciliation. Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist or registered nurse.
- Create a Transitions of Care visit type and template in your EMR to help facilitate documentation and billing of Transition of Care management codes.
- Remember that an outpatient visit is not required, and medication reconciliation can be completed over the phone.
- Leverage your health information exchange (HIE) to capture notification of or receipt of admit/discharge information.
- Establish hospital partnerships to facilitate sharing of discharge information and to obtain access to electronic health records.
- Assign a staff member, if possible, to work a daily discharge list and reach out to patients who need a post-discharge follow-up visit.
- Communicate the final (post-reconciliation) medication list to the patient, either during an office visit, a home visit, telephonically or virtually.



If no medications were prescribed or ordered upon discharge, this must be notated in the medical record.

Medication Reconciliation Post-Discharge continues to be included as a Medicare measure in our Quality Care Plus (QCP) incentive program. For more information, visit HPPlans.com/quality.

Allowable Methods of Documentation

- Documentation of current medications and notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
- Documentation of all medications and notation that the current and discharge medications were reconciled.
- Documentation of current medications and notation referencing the discharge medications (e.g., same medications at discharge, no changes in medications since discharge, discontinue all discharge medications).
- Documentation of the current medications with evidence that the member was seen for a post-discharge hospital follow-up visit with evidence of medication review or reconciliation.

If you have any questions, please call the Provider Services Helpline at 1-888-991-9023 (Monday - Friday, 9 a.m. to 5:30 p.m.).

Codes for Medication Reconciliation

CPT Transition of Care Codes: **99495, 99496**

CPT II: **1111F**

More information can be found in the QCP Manual.

Proper Billing

In addition to including the appropriate documentation in your patients' medical records, you must bill the below CPT II code in order to receive credit for this measure. You may bill the transition of care codes if you have a face-to-face visit with your patients.