Medication Reconciliation Post-Discharge (MRP)

We are committed to working with you to improve the quality of care and health outcomes for our members, your patients. The Healthcare Effectiveness Data and Information Set (HEDIS®) is one tool we use to measure many aspects of performance. This tip sheet details some of the key features of the HEDIS measure for medication reconciliation post-discharge.

What is the measure?
This measure reports the percentage of discharges from January 1 to December 1 of the measurement (current) year (MY) for members age 18 and older whose medications were reconciled on the date of discharge through 30 days after discharge (31 total days).

Eligible Members:
• Members who are age 18 or older as of December 31 of the MY
• Continuously enrolled from date of discharge through the 30 days after the discharge (31 days total)
• Acute or non-acute inpatient discharges on or between January 1 and December 1 of the MY. The member may have more than one acute or non-acute discharge during the MY.

Documentation Requirements

- Documentation of medication reconciliation completed by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after the discharge date must:
  - Be in the outpatient medical record
  - Include the date that medication reconciliation was performed
- Documentation of current medications:
  - Notation that the provider reconciled the current and discharge medications
  - Notation that references the discharge medications, for example:
    - No changes in medication since the discharge
    - Same medications at the discharge
  - Discontinue all discharge medications
  - A discharge medication list and notation that both lists were reviewed on the same date of service
  - With evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review
  - Documentation that no medications were prescribed or ordered upon discharge
  - Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record, with evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after the discharge (total of 31 days)

Note: Documentation in the outpatient chart meets the purpose of the measure, but an outpatient visit is not required.

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### Unacceptable Forms of Documentation

- Documentation that the discharge medications have been reviewed; no documentation that they were reviewed or reconciled with the current medications.

- List of the discharge medications and a list of the current medications are included in the record; no documentation that they have been reviewed or reconciled.

- Discharge medication and current medication reconciled on a date more than 30 days after the discharge date.

### CPT and CPT II Codes

These CPT and CPT II codes can be submitted with a claim or encounter to document compliance with medication reconciliation processes that are completed within 30 days of a member’s discharge:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99483</td>
<td>Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the required elements found in the coding guidelines. Consult the coding guidelines for the list of elements.</td>
</tr>
<tr>
<td>99495</td>
<td>Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)</td>
</tr>
<tr>
<td>99496</td>
<td>Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)</td>
</tr>
<tr>
<td>1111F</td>
<td>Discharge medications reconciled with the current medications list in outpatient record</td>
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</tbody>
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### Exclusions

Exclude members who received hospice care anytime during the measurement year.