Medication Reconciliation Post-Discharge (MRP)

What: The MRP measure is defined as a review of the discharge medications, which is then reconciled with the most recent medication list in the outpatient medical record.[1]

Why: Individuals discharged from the hospital frequently become confused regarding prescribed medications. Medication reconciliation has been shown to reduce adverse drug events (ADEs) and readmissions.[2]

Who: Medication reconciliation will be conducted by a prescribing practitioner, clinical pharmacist or registered nurse, for all Medicare beneficiaries ages 18 and older.[1]

When: On the date of discharge through 30 days after discharge (31 total days) [1], at the first postoperative visit or by telephone.

Where: Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.[1]

How: Medication reconciliation involves a three-step process: (1) verification (collecting an accurate medication history); (2) clarification (ensuring that the medication and doses are appropriate); and (3) reconciliation (documenting each change and ensuring it aligns with all other medication information).[3]

There are two important elements to recording the completion of MRP:

1. Coding with CPT, CPT II.

Codes	Definition
CPT 99496	Transitional Care Management – high complexity, face-to-face visit within seven days of discharge[3]
CPT 99495	Transitional Care Management – at least moderate complexity, face-to-face visit within 14 days of discharge[3]
CPT II* 1111F	Discharge medication reconciled with the current medication list in the outpatient medical record[4]

*CPT II codes are billed in the procedure code field, just as CPT Category I codes are billed. CPT II codes describe clinical components usually included in evaluation and management of clinical services; therefore, they are not associated with any relative value[5] and, as such, CPT II charges will be denied. Be assured that, despite the denial, the data is used for quality reporting purposes.

2. Documentation in the medical record must include evidence of medication reconciliation and the date it was performed.[1]

    Any of the following meets the criteria:

    - Documentation that the provider reconciled the current and discharge medications.
    - Documentation of the current medications with a notation that references the discharge medications (such as: "no changes in medications since discharge," "same medications as at discharge," or "discontinue all discharge medications").
    - Documentation of the member's current medications with a 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.
    - Evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review.
    - Documentation in the discharge summary that the discharge medications were reconciled with the current medications. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
    - Notation that no medications were prescribed or ordered upon discharge.[1]

[1]NCQA's HEDIS 2017 Technical Specification for Health Plans, Volume 2, Washington, D.C., 2016.
[2]Practice Management Information Corporation CPT Plus 2015: Digital Series, Los Angeles, CA, 2014.
[3]Institute for Healthcare Improvement Accuracy at Every Step: The Challenge of Medication Reconciliation. Retrieved from:
    www.ihi.org/resources/Pages/ImprovementStories/AccuracyatEveryStep.aspx.
[4]American Medical Association: CPT Category II Codes Alphabetical Clinical Topics Listing Updated February 12, 2016. Retrieved from: www.ama-assn.org/ama/pub/physicianresources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-ii-codes.page.
[5]California Quality Collaborative: CPT Category II Codes Tip Sheet (n.d.). Retrieved from: www.calquality.org/storage/documents/compass/CPTCategoryIICodeTipSheet.pdf.