Medication Reconciliation Post-Discharge

Medication Reconciliation Post-Discharge (MRP) is a review in which discharge medications are reconciled with the most recent medication list in the outpatient medical record.[1] Although medication-related errors contribute to 26% of hospital readmissions, a 2016 study found that implementing a team-based transition of care service that includes medication reconciliation decreased 30-day readmission rates by 8.9%.[2,3]

An important HEDIS measure examines the percentage of discharges for Medicare members age 18 years and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days). It includes members discharged from an acute or nonacute inpatient setting and excludes members in hospice or those receiving hospice care. The measure assesses discharges, not unique members.[1]

How do I conduct an MRP?[4,5]

An MRP can be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse. Consider the following tips to conduct an MRP and reduce medication errors:

Compile	a comprehensive list of medications the patient is currently taking
Clarify	name, dosage, route, frequency, and indication of each drug
Compare	current medications with medication changes at discharge
Correct	discrepancies* and document changes
Communicate	accurate medication information to physician, patient, and caregiver

* Drug omissions, therapy duplications, dosing errors, drug-drug and/or drug-disease interactions, etc.

How do I document an MRP?[1]

Include one of the following with a date of service in the outpatient medical record:

- Discharge summary with documentation that discharge medications were reconciled with the most recent medication list in the outpatient medical record, *or*
- Notation that no medications were prescribed or ordered upon discharge, *or*
- Record of current medications and any notation of the following:
  - Member was seen for post-discharge hospital follow-up and medications were reviewed
  - Current medications have been reconciled with discharge medications
  - Discharge medications were reviewed or referenced (e.g., same medications at discharge, discontinue all discharge medications)

CPT codes to be used within 30 days of discharge:

- 1111F - Discharge medications reconciled with the current medication list in outpatient medical record. A face to-face encounter is not required.
- 99495 - Medical decision making of at least moderate complexity, with communication with the patient and/or caregiver within two business days of discharge, and a face-to-face visit within 14 calendar days of discharge.
- 99496 - Medical decision making of high complexity, with communication with the patient and/or caregiver within two business days of discharge, and a face-to-face visit within 7 calendar days of discharge.
- 99483 - Assessment and care planning for a patient with cognitive impairment.

References

1. HEDIS 2021, Volume 2. National Committee for Quality Assurance (NCQA) *Medication Reconciliation Post-Discharge (MRP).*
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3. Hitch B, Parlier AB, et al. Evaluation of a Team-Based, Transition-of-Care Management Service on 30-Day Readmission Rates. *N C Med J*. 2016;77(2):87-92. doi:10.18043/ncm.77.2.87
4. Action of patient Safety (High5s)- Medication Reconciliation SOP. The High5s Project- Standard Operating Protocol of Medication Reconciliation. Version 3, September 2014.
5. Lutz R. How Pharmacists Can prevent Medication Errors in Transitions of Care. Pharmacy Times. June 12, 2015. Accessed April 10, 2018.

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