Medication Reconciliation Post-Discharge (MRP) is part of the Transition of Care (TRC) composite Healthcare Effectiveness Data and Information Set (HEDIS®) measure. MRP calculates the annual percentage of adult patients whose medications were reconciled within 30 days of discharge from hospitalization. Medication reconciliation is defined as a review in which discharge medications are reconciled with the most recent medication list in the outpatient medical record.

Please note: Information in this flyer is based on HEDIS technical specifications. It is not meant to preclude clinical judgment. Treatment decisions should always be based on the physician’s or clinician’s clinical judgment.

Who is included in the MRP measure?
MRP includes patients 18 years old and older who had an inpatient discharge on or between Jan. 1 and Dec. 1 of the measurement year. If a patient is readmitted or directly transferred to an inpatient care setting within 30 days of discharge, the final discharge date is included in the measure unless dated after Dec. 1. The original discharge is not counted for the measure.

Exclusions
Patients in hospice or using hospice services are excluded from this measure.

Performing well on the MRP measure
Practices must ensure that medications are reconciled by a prescribing practitioner, clinical pharmacist or registered nurse no later than 30 days after the patient’s discharge date (31 total days). Evidence of the reconciliation and the date it was done must be documented in the outpatient record.

Documentation in the medical record must include evidence of medication reconciliation and the date it was performed. Any of the following meets criteria:

- Documentation that the healthcare provider reconciled the current and discharge medications
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications)
- Documentation of the patient’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
- 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])
- Evidence that the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review
- Notation that no medications were prescribed or ordered upon discharge
Additional considerations

- Dose, route and frequency do not need to be noted to meet the measure’s intent, but inclusion is highly recommended.
- The final (post-reconciliation) medication list should be communicated to the patient by the physician or clinical office staff. This communication can occur during an office or home visit, telephonically or virtually.

Coding for medication reconciliation

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| 99483  | 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 following required elements:  
  - Cognition-focused evaluation, including a pertinent history and examination  
  - Medical decision-making of moderate or high complexity  
  - Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity  
  - Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR])  
  - Medication reconciliation and review for high-risk medications  
  - Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s)  
  - Evaluation of safety (e.g., home), including motor vehicle operation  
  - Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on caregiving tasks  
  - Development, updating or revision, or review of an advance care plan  
  - Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups), shared with the patient and/or caregiver with initial education and support  
  Typically, 50 minutes are spent face to face with the patient and/or family or caregiver. |
| 99496  | Transitional care management services with the following required elements:  
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge  
  - Medical decision-making of high complexity during the service period  
  - Face-to-face visit within seven calendar days of discharge |
| 99495  | Transitional care management services with the following required elements:  
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge  
  - Medical decision-making of at least moderate complexity during the service period  
  - Face-to-face visit within 14 calendar days of discharge |
| 1111F  | Discharge medications reconciled with the current medication list in outpatient medical record  
  *The 30-day limit relates to the measure specifications, not to a time limit on when the code can be used. |

Measure best practices

- Be aware of your patients’ inpatient stays.
- Obtain timely discharge summaries.
- Review and reconcile discharge medications against existing outpatient medications.
- See patients in your office as soon as possible, preferably within seven days after an acute stay discharge.
- Review all discharge summaries, document all medication reconciliations in outpatient medical records (which may be done on the discharge summary filed in the outpatient medical record) and submit the appropriate codes to the health plan.
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