

HEDIS MEASURE OVERVIEW

Medication Reconciliation Post-Discharge (MRP)

Please note: The information offered in this flyer is based on Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications. It is not meant to preclude your clinical judgment.

The Medication Reconciliation Post-Discharge (MRP) stand-alone measure was anticipated to retire in measurement year 2022 given its inclusion in the calculation of the Transitions of Care (TRC) – Average measure. However, based on the latest Centers for Medicare & Medicaid Services (CMS) information, the stand-alone Star measure is still active and is calculated the same as the display measure version.

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.

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

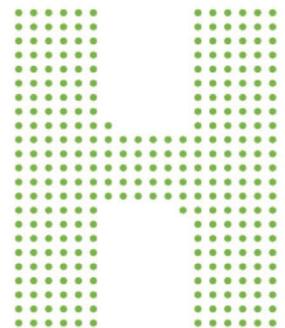
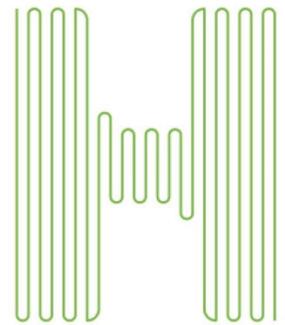
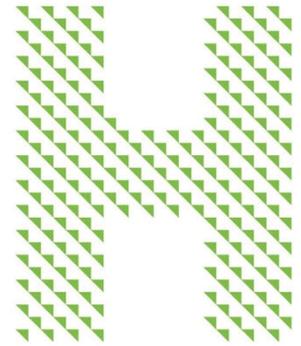
Patients in hospice or using hospice services are excluded from this measure.

Performing well on the MRP measure

To address the measure, a medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days). Licensed practical nurses and other nonlicensed staff can perform the medication reconciliation, but it must be co-signed anytime in the measurement year by an approved provider. When patients are directly transferred to another facility, perform reconciliation for final discharge.

Documentation in the medical record must include evidence of medication reconciliation and the date it was performed. Any of the following methods of documentation will meet the HEDIS measure 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)



Humana®

- 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
- Documentation of the current medications with evidence that the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the patient was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the patient’s hospitalization or 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, by telephone or virtually.
- If transitional care management services codes are not applicable, submit CPT II code 1111F.

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.
 - If a patient is unable to visit the office, medication reviews can be completed via all telehealth methods including audio-only visits and virtual check-ins, such as sharing information via secure email and patient portals. Neither an outpatient visit nor patient presence is required.
- 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.
- Follow up for all dates in the calendar year rather than omitting December events.
- Target outreach to close medication reconciliation gaps in 10 days after discharge rather than the 30 days required by HEDIS.
- Include observation stays rather than inpatient admissions only (as HEDIS requires) to better impact Plan All-Cause Readmissions (PCR).
- Once medication reconciliation is complete, submit CPT II code 1111F on the patient’s claim.



Coding for the medication reconciliation measure

<p>99483</p>	<p>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:</p> <ul style="list-style-type: none"> • 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 <p>Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.</p>
<p>99496 (Days 1–7 post-discharge)</p>	<p>Transitional care management services with the following required elements:</p> <ul style="list-style-type: none"> • 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
<p>99495 (Days 8–14 post-discharge)</p>	<p>Transitional care management services with the following required elements:</p> <ul style="list-style-type: none"> • 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
<p>1111F (Within 30 days post-discharge*)</p>	<p>Discharge medications reconciled with the current medication list in outpatient medical record</p> <p>* The 30-day limit relates to the measure specifications, not to a time limit on when the code can be used.</p>

The codes provided in this document are limited to those that will address care opportunities for the measures included based on current guidelines. This information is subject to change and, therefore, not intended to serve as official coding or legal advice. All coding should be considered on a case-by-case basis and be supported by medical necessity and the appropriate documentation in the medical record.

NCQA copyright notice and disclaimer

The HEDIS measure specifications were developed by and are owned by NCQA. The HEDIS measure specifications are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measure specifications. NCQA holds a copyright in these materials and can rescind or alter these materials at any time. These materials may not be modified by anyone other than NCQA. Use of the Rules for Allowable Adjustments of HEDIS to make permitted adjustments of the materials does not constitute a modification. Any commercial use and/or internal or external reproduction, distribution and publication must be approved by NCQA and are subject to a license at the discretion of NCQA. Any use of the materials to identify records or calculate measure results, for example, requires a custom license and may necessitate certification pursuant to NCQA's Measure Certification Program. Reprinted with permission by NCQA. © 2024 NCQA, all rights reserved.

Limited proprietary coding is contained in the measure specifications for convenience. NCQA disclaims all liability for use or accuracy of any third-party code values contained in the specifications.

The full text of this notice and disclaimer is available here:

<http://apps.humana.com/marketing/documents.asp?file=4274309>

