Florida Blue

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Medication Reconciliation Post Discharge (MRP) Documentation and CPT® II Code Frequently Asked Questions

What is the Medication Reconciliation Post Discharge (MRP) quality measure?

MRP is one of the Transitions of Care (TRC) sub-measures that assesses the percentage of discharges (acute and/or non-acute) for members age 18 or older whose medications were reconciled on the date of discharge through 30 days after discharge (31 total days). To access the TRC quality measure tip sheet, click here.

What is a medication reconciliation post discharge?

A type of review completed by a prescribing practitioner, clinical pharmacist or registered nurse in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.

How can providers improve MRP rating?

Upon receiving discharge notification, providers must call the patient within 48 hours post discharge to schedule a follow-up visit (virtual or face-to-face). The follow-up visit should be within two to 30 days of the inpatient hospital or other acute care facility discharge.

Who can complete the medication reconciliation?

Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist or registered nurse.

When should the medication reconciliation be completed?

Medication reconciliation post discharge should be completed on the date of discharge through 30 days after discharge (total of 31 days) and documented in the outpatient record.

What else should be documented in the outpatient medical record?

The outpatient medical record must include evidence of medication reconciliation and the date it was performed. It must also clearly state the member was seen for post-discharge hospital follow up with evidence of medication reconciliation and include the current medications. Documentation in the outpatient medical records must include the current medication list, any new medications or changes to medication related to the hospitalization and a review.

Does a medication reconciliation need to be performed with the member present?

No, a medication reconciliation performed without the member present meets the criteria.

What is required for members who have had more than one hospitalization?

Members who have had more than one hospitalization must have an MRP performed after each inpatient or skilled nursing facility discharge.

Are any members excluded from the MRP measure?

Yes, members who received hospice care anytime during the measurement year are excluded from the MRP measure.

What are some best practices to consider?

- Access daily discharge reports from Provider Link™
- Registered nurses are encouraged to review and reconcile medications telephonically and schedule follow-up visit within seven days of discharge
- Prior to the visit, flag the chart with an MRP reminder for the provider
- Check if a CPT II code 1111F was submitted as part of your claim's submission
- Clearly document the reason for the visit as "follow-up visit after hospitalization"
- Check Provider Link for "open" MRP care gap reports. Submit MRP documentation through Provider Link or by faxing medical records to 904-565-4274

How to Document in the Outpatient Chart and Code for MRP Completion

MRP Documentation Requirements	MRP Compliance Using CPT or CPT II codes
Documentation in the outpatient medical record must include evidence of medication reconciliation and the date it was performed. Any of the following will meet documentation criteria: • Documentation of the current medications with a notation that the 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 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 both lists were reviewed on the same date of service • Documentation of the current medications with evidence 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 most recent medication list in the outpatient medical record; there must be evidence the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (total of 31 days) Notation in the medical record no medications were prescribed or ordered upon discharge	The following CPT and CPT II codes can be submitted with a claim or encounter to document compliance with medication reconciliation processes completed within 30 days of a member's discharge. **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 required elements found in the coding guidelines. Consult the coding guidelines for the list of elements. **99495** - Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge) **99496** - Transitional care management services with high medical decision complexity (face-to-face visit within seven days of discharge) **1111F** - Discharge medications reconciled with the current medications list in outpatient record

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