Medication Reconciliation Post Discharge

TOOLKIT

Overview

- National Quality Forum (NQF 0097)

Medications are often changed while a patient is hospitalized. Continuity between inpatient and on-going care is essential. Medication reconciliation post-discharge is an important step to catch potentially harmful omissions or changes in prescribed medications. Implementing routine medication reconciliation after discharge from an inpatient facility is an important step to ensure medication errors are addressed and patients understand their new medications.

How to satisfy the measure

There are two ways to close the medication reconciliation gap:

1. Medication reconciliation performed within 30 days post discharge (CPT II code 1111F). Documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.
2. Medication reconciliation performed during a Transitions of Care (TRC) visit (CPT codes 99495 or 99496). These codes allow for the reimbursement of services. Only one TRC visit can be billed post patient discharge, PCP and Specialists cannot both bill for TRC.

When an eligible patient's discharge medication list and current outpatient medication lists are reconciled at a follow-up visit within 30 days after discharge and the appropriate CPT II code is filed on the associated claim, the gap is closed.

Medication reconciliation can only be conducted by the following provider types:

- Prescribing practitioner (MD, DO, PA, NP)
- Clinical Pharmacist
- Registered Nurse (RN)
- If a Medical Assistant (MA) completed the phone call, it must be reviewed and signed by a prescribing practitioner and documented sufficiently in the outpatient medical record

Measure Definition

Eligible Population

Denominator

Adults aged 18 years and older who are covered by an LHP product and were discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care.

Exclusions

Patients who used hospice services (does not include palliative care) at any time during the measurement year.

Performance Met

Numerator

- CPT II code 1111F or complete Legacy Epic "Post ED/Hospital Follow Up, Med Reconciliation" telephone encounter workflow
- CPT 99495 transitional care management communication
- CPT 99496 transitional care management communication

LEGACY HEALTH PARTNERS

Documentation, Coding, Billing

Documentation of reconciliation of discharge medication with current medication list in the medical record that meets criteria:

CPT II 1111F Discharge medications reconciled with the current medication list in outpatient medical record

FOR LEGACY MEDICAL GROUP:

Complete Legacy Epic "Post ED/Hospital Follow Up, Med Reconciliation" telephone encounter

–OR–

CPT 99495 if all of the following criteria are met

- There was successful or attempted communication with patient either face to face, via telephone, or electronic within 2 business days of discharge
- Medical decision making is **at least moderate in complexity**
- Face to face visit is within 14 calendar days of discharge

–OR–

CPT 99496 if all of the following criteria are met

- There was successful or attempted communication with patient either face to face, via telephone, or electronic within 2 business days of discharge
- Medical decision making is **high in complexity**
- Face to face visit is within 7 calendar days of discharge

PERFORMANCE REPORTING

- Claims data is used to close this gap.
- Because there is a 30-day requirement to close this gap, it is not recommended to rely on your LHP dashboard in Power BI to identify patients with an open medication reconciliation gap.
- Gaps met by claims data are typically closed on your LHP dashboard in Power BI within 90 days after a claim with the proper CPT or CPT II code is paid.

Process & workflow

Timing is an important element of this workflow. Appoint staff responsible for each task/step.

Component	Documentation in the outpatient chart note	Timing	Who can perform	Coding	Workflow Recommendations
Notification of Inpatient Admission	Document receipt of the notification of inpatient admission. Attach notification to patient's chart **Notifications/receipts must have a date stamp indicating when documentation was received by your PCP office.**	Day of admission or the following day	Clinical staff	N/A	• Monitor inpatient admission notification (use hospital portals or platforms available to your practice (e.g., Collective/PreManage) when patients are admitted to and discharged from the hospital or other acute care facility. • Document notification of inpatient admission in patient chart
Receipt of Discharge Information	Document receipt of notification of patient discharge and associated information in outpatient chart note. Attach notification to patient's chart. **Notifications/receipts must have a date stamp indicating when documentation was received by your PCP office.**	Done on day of discharge or the following day	Clinical staff	N/A	• Streamline a process to monitor and obtain hospital/SNF discharge notifications • Receive discharge summaries and comprehensive discharge medication lists and attach to patient chart. It is important to know what medications the patient has been taking or receiving prior to the outpatient visit in order to provide quality care. The medication list should include all medications (prescriptions, over-the-counter, herbals, supplements, etc.) with dose, frequency, route, and reason for taking it. • Document notification of inpatient discharge in patient chart
Patient Contact within 48 hours of discharge	Document contact with patient within 48 hours post discharge. If you are unsuccessful at contacting patient, document at least two attempts within the first 48 hours of discharge. Continue to attempt contact until successful.	Done within 48 hours after discharge – but not same day as discharge	Clinical staff	N/A	• Contact patient within 48 hours post-discharge and document patient contact in patient chart (not same day as discharge)

Component	Documentation in the outpatient chart note	Timing	Who can perform	Coding	Workflow Recommendations
Medication Reconciliation Post-Discharge	Document patient engagement and “the discharge medication list and outpatients medication list have been reconciled.” Include hospital discharge date in documentation.	To bill codes 99495 or 99496, patient must be seen within 7-14 days post discharge and all four components must be met including medication reconciliation	MD, DO, NP, PA, CNM, or CNS	99495 and 1111F – Moderate Complexity (equivalent to a 99214) within 14 days post discharge 99496 and 1111F – High Complexity (equivalent to a 99215) within 7 days post discharge	• Complete chart prep and communicate open medication reconciliation gaps to the provider • During the visit, the provider should verify whether the patient is actually taking the medication as prescribed or instructed. Clinicians should verify: ○ Based on what occurred in the visit, should any medication that the patient was taking or receiving prior to the visit be discontinued or altered? ○ Based on what occurred in the visit, should any prior medication be suspended pending consultation with the prescriber? ○ Have any new prescriptions been added? • Document in the outpatient chart note • Properly code appointment to close the gap, submit the claim, and confirm appropriate reimbursement for transitions of care codes ○ CPT 99495 and 1111F for moderate complexity within 14 days post discharge ○ CPT 99496 and 1111F for high complexity within 7 days post discharge)

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