DOCUMENTATION TIPS

MIPS #46: Medication Reconciliation Post-Discharge

Electronic health records (EHRs) collect and organize notes, medication lists, and patient information using various formats. With providers also documenting this information in unique ways, this can potentially cause confusion and an increased timeline for measure mapping with DataDerm. This tip sheet can help you manage reporting requirements for performance measures and streamline standard documentation practices to allow seamless data pull into DataDerm.

The DataDerm team will work with you to connect DataDerm with your EHR to extract data. To make the process as smooth as possible, it helps to document key elements of patient care. DataDerm cannot read scanned images of any kind, including scanned images for labs, letters to physicians, pathology reports, follow-up plans, and dates. If you have scanned images with information needed for your measures, please add a note in your chart with the date and required patient information for this data to be accurately collected.

This tip sheet can assist paper-based practices in standardizing documentation practices. Keeping notes in the patient's paper chart of all documentation requirements will assist you when reporting for this measure.

MIPS 138: Heading Here Can be on 2 lines

For all patients 18 and older, document the following in your notes:
90791, 90792, 90832, 90834, 90837, 90839, 90845, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324,99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, G0402, G0438, G0439

AND

- Patient discharged from an inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) within the last 30 days

AND

- Submissions are stratified into three criteria by age group:
    - Submission Criteria 1: 18-64 years of age
    - Submission Criteria 2: 65 years and older
    - Total Rate: All patients 18 years of age and older
- Note in the medical record that medication reconciliation was conducted by the provider on or within 30 days of discharge
    - Documentation in the outpatient medical record must include evidence of medication reconciliation **and** the date on which it was performed
- If the patient is not eligible for this measure, note in the medical record if applicable:
    - Patient had hospice services any time during the measurement period (G9691)

Additional Tips:

- Collect at an outpatient visit occurring within 30 days of ***each inpatient facility discharge date*** during the performance period.
- See measure specifications for additional codes that can assist in seamless measure mapping from your EHR to DataDerm, if applicable (e.g. 1111F).

For more information, contact the American Academy of Dermatology:
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