Medication Reconciliation

What is medication reconciliation

CMS defines medication reconciliation as “the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from the patient, hospital or other provider.”

As part of CMS Meaningful Use program, a measure for medication reconciliation was established as best practice for providers. The objective that CMS defines is, “the eligible professional who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.”

As part of the Tailored Plan, the state requires medication reconciliation as part of ongoing care management of members. This is an integral requirement in member transitions of care.

Why is medication reconciliation important?

✓ Ensures medication adherence.
✓ Assists in avoiding medication errors such as omissions, dosing errors and drug interactions.
✓ Ensures the member understands any new medication or rewritten prescriptions.

How do I conduct medication reconciliation?

✓ Document a list of current medications in the EHR (including over-the-counter medications).
✓ Use a list of medications as prescribed (from member, hospital discharge, other provider).
✓ Compare the two lists, validating with the member.
✓ Make notes of discrepancies for the clinical decisions based on the comparison.
✓ Document that medications have been reconciled.
✓ Communicate the new list of medications to the member/caregiver.