Transitions of Care
HEDIS Measure Overview

Thank you for being a valued provider for members in one or more of our health plans: Health Partners Plans Medicaid, Health Partners Plans CHIP, Jefferson Health Plans Medicare Advantage, and/or Jefferson Health Plans Individual and Family Plans.

What is the TRC measure?

The Transitions of Care (TRC) measure evaluates patient engagement provided within 30 days after an acute or nonacute discharge on or between Jan. 1 and Dec. 1 of the measurement year. This HEDIS measure has five sub-measures with the Star Rating Program.

- Notification of Inpatient Admission
- Receipt of Discharge Information
- Patient Engagement After Inpatient Discharge
- Medication Reconciliation Post-Discharge
- Average (This sub-measure is the average of the compliance rates of the other four sub-measures. It is intended to help indicate overall TRC performance.)

Please note that the information offered in this document is based on Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications. It is not meant to replace your clinical judgment.

Who is included in the TRC measure?

The eligible population for this measure includes Medicare patients 18 years old and older as of Dec. 31 of the measurement year who had an acute or non-acute discharge on or between Jan. 1 and Dec. 1 of the measurement year.

Exclusions:

- Patients in hospice or using hospice services.
- Discharges occurring after Dec. 1 of the measurement year.

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TRC Sub-Measures Descriptions and Actions Needed for Compliance

Notification of Inpatient Admission (TRC-NIA):

Documentation of receipt of notification of inpatient admission on the day of admission or the two following days.

To address the measure, the patient's outpatient medical record must include documentation by their primary care physician (PCP) practice of receipt of notification of inpatient admission on the day of admission or within the two following days.

- Evidence must include the date the documentation was received. This evidence is can only be collected via medical record review; there are no claims codes for TRC-NIA.
- If an observation stay turns into an inpatient admission, the admit notification must be documented as being received on the admit date of the observation stay or within the two following days.
- For planned admissions, documentation of a preadmission exam or advance admission notification is acceptable and:
  - Must clearly apply to the admission event and include the time frame for the planned inpatient admission.
  - Is not limited to the admit date or the two following days.
- Notification of admission by the patient or the patient's family to the PCP or ongoing care provider does not meet criteria.
- Any documentation that does not include a time frame or date stamp does not meet criteria.

Receipt of Discharge Information (TRC-RDI):

Documentation of receipt of discharge information on the day of discharge or the two following days.

To address the measure, the patient's outpatient medical record must include documentation by their PCP practice that discharge information is received on the day of discharge or within the two following days. Evidence must include a date stamp when the documentation was received. Any documentation that does not include a time frame or date stamp does not meet criteria.

- Evidence must include the date the documentation was received. This evidence can only be collected via medical record review; there are no claims codes for TRC-RDI.
- Discharge information may be included in:
  - A discharge summary.
  - A summary of care record.
  - Structured fields in an electronic health record (EHR).

Patient Engagement After Inpatient Discharge (TRC-PED):

Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.

Note: If a patient is unable to communicate, their PCP can interact with a caregiver.

To address the measure, the patient must be engaged within 30 days of discharge via:

- Outpatient visits, including office or home visits.
- A telephone visit.
- A synchronous telehealth visit where real-time interaction occurred between the patient and their PCP with audio and video communication.

Coding guidance for TRC-PED

Common Procedural Terminology (CPT)	
Outpatient visit – in the office or the patient's home	Via a telehealth visit, use CPT modifier GT or 95
Telehealth visit	98966, 98967, 98968, 99441, 99442, 99443
Transitional care management service	99495 or 99496

Medication Reconciliation Post-Discharge:

Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

To address the measure, a review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record is conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after discharge (31 total days). The medication reconciliation can be completed over the phone.

Note: MRP is an event-based measure. For each discharge event, there will be a care opportunity that needs to be addressed by a clinician.

Any of the following methods of documentation will meet HEDIS measure criteria:

- Provider reconciliation of the current medications along with the discharge medications.
- Documentation of current medications with a notation that references the discharge medications or a notation that discharge medications were reviewed.
- Current medication list, a discharge medication list and a notation that both lists were reviewed on the same day of service.
- Notation that no medications were prescribed or ordered upon discharge.
- Documentation in the discharge summary that discharge medications were reconciled with the current medications list in outpatient record and evidence that the discharge summary was filed in the outpatient record within 30 days after discharge.

Additional Considerations:

- Dose, route, and frequency do not have to be noted to meet the intent of the measure, but their 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 visit, during a home visit, telephonically or virtually.

Codes for Medication Reconciliation

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 following required elements:

- 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.

99483 Cont.:

- Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive 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. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.

99496:

Transitional care management services with the following required elements:

- 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

AND

- Face-to-face visit within 1-7 calendar days of discharge; in-person and telehealth visits are permissible.

99495:

Transitional care management services with the following required elements:

- 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 1-14 calendar days of discharge; in-person and telehealth visits are permissible.

1111F (within 30 days post-discharge):

Discharge medications reconciled with the current medication list in outpatient medical record.

Best Practices:

- Create a Transitions of Care visit type and template in your EMR to help facilitate documentation and billing of Transitional Care Management codes (99495 and 99496).
- Create a process to add CPT2 code 1111F to claims when appropriate if a Medication Reconciliation Post-Discharge (MRP) was performed.
- Consider a telephonic process for MRP within 30 days of discharge if a patient is not able to be seen in person.
- Optimize use of a Health Information Exchange (HIE) or electronic notification system between EMRs and the discharging facility to capture notification of or receipt of admit/discharge information.
- Assign a staff member, if possible, to work a daily discharge list and reach out to patients who need a post-discharge follow-up visit.
- Be aware of patients' inpatient stays.
- Follow up with patients as soon as possible following an acute stay discharge.

  Note: Patient engagement that takes place on the day of discharge is not measure compliant.

- Have processes in place with hospitals to facilitate sharing of discharge information.
- Work with hospitals to obtain access to electronic health records.
- Review discharge summaries to ensure they include the minimum required information.

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