HEDIS® Tip Sheet

Effectiveness of Care Measure

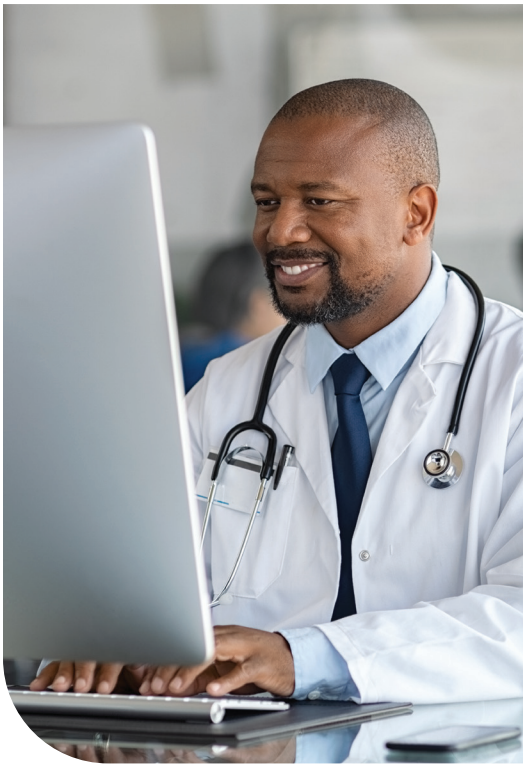
Learn How to Improve Your HEDIS[1] Rates for Transitions of Care Measure

Use this tip sheet to review key details of the Transitions of Care (TRC) measure, exclusions, billing codes, documentation required and best practices.

Measures

This measure assesses the percentage of inpatient discharge from acute or non-acute facilities for patients ages 18 and older who had the following four rates reported:

1. **Notification of inpatient admission.** Documentation includes receipt of notification of inpatient admission on the day of admission or within two days after the admission (three total days). This rate is collected through medical record review only; no administrative reporting is available.
2. **Receipt of discharge information.** Documentation includes receipt of discharge information on the day of discharge or within two days after the discharge (three total days). This rate is collected through medical record review only; no administrative reporting is available.
3. **Patient engagement after inpatient discharge.** Documentation includes patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the same date of discharge.



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[1]HEDIS®: Healthcare Effectiveness Data and Information Set

Measures (cont.)

4 Medication reconciliation post-discharge.
Documentation includes medication reconciliation on the date of discharge through 30 days after discharge (31 total days). Medication reconciliation:

- Is conducted by a prescribing provider, physician assistant, clinical pharmacist or registered nurse.
- Does not have to be completed in a face-to-face visit.
- Does not require the patient to be present.
- Is a type of review where the discharge medications are reconciled with the most recent medication list in the outpatient medical record.

Refer to the **Documentation required** section for more information.

Exclusions

- Patients enrolled in hospice or using hospice services at any time during the measurement year.
- Patients deceased during the measurement period.

Codes

Service type	Codes
Outpatient visits	**CPT:** 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347-99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483 **HCPCS:** G0402, G0438, G0439, G0463, T1015
Phone visits	**CPT:** 98966–98968, 99441–99443
Online assessments	**CPT:** 98969–98972, 99421–99423, 99444, 99458
Telehealth modifier	**HCPCS:** G0071, G2010, G2012, G2061, G2062, G2063
Transitional care management services	**CPT:** 99496 (TCM 7 day) and 99495 (TCM 14 day)
Medication reconciliation encounter	**CPT:** 99483, 99495, 99496
Medication reconciliation intervention	**CPT II:** 1111F

Documentation required

1 Notification of inpatient admission

Documentation in the medical record must include evidence of receipt of notification of inpatient admission with date/time stamped on the day of admission or within two days after the admission.

Examples:

- Communication between the inpatient providers or staff and member's primary care physician (PCP) or ongoing care provider (e.g., phone call, email, fax).
- Communication about the admission to member's PCP or ongoing care provider through a health information exchange; an automated admission via discharge and transfer (ADT) alert system; or a shared electronic medical record (EMR) system.
- Communication about admission to the member's PCP or ongoing care provider from member's health plan.
- Indication that the member's PCP or ongoing care provider admitted member to the hospital.
- Indication that a specialist admitted member to the hospital and notified member's PCP or ongoing care provider.
- Indication that the PCP or ongoing care provider placed orders for test and treatments during member's inpatient stay.

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Documentation required (cont.)

The following documentation will not be accepted:

- Documentation that the member or family notified member's PCP or ongoing care provider of the admission.
- Documentation of notification that does not include a time frame or date and time stamp.

2 Receipt of discharge information

Documentation in the medical record must include receipt of discharge information with date/time stamped on the day of discharge or within two days after the discharge.

Examples:

Discharge information may be included in a discharge summary or summary of care record or located in structured fields in an electronic health record. At a minimum, the discharge information must include the following:

- Name of practitioner responsible for the patient's care during the inpatient stay.
- Procedures or treatment provided.
- Diagnoses at discharge.
- Current medication list and allergies.
- Test results or documentation of pending/no pending test(s).
- Instructions for patient care post discharge.

3 Patient engagement after inpatient discharge

Documentation must include evidence of patient engagement within 30 days after discharge.

Examples:

Any of the following will meet criteria:

- Outpatient visits, including office and home visits.
- Phone visits.
- Telehealth visits where real-time interaction occurred between the member and provider using audio and video communication.
- E-visits or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider).

Note: If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria.

The following documentation will not be accepted:

- Notification from family member/caregiver of the admission or discharge.
- Documentation that does not include dates of admission or discharge notification to your office.
- Patient engagement that occurs on the date of discharge is not compliant.

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Documentation required (cont.)

4 Medication reconciliation post-discharge

Documentation in the medical record must include evidence of medication reconciliation and the date it was performed.

Examples:

The table below summarizes the Medication Reconciliation criteria. Any of the following meets the documentation criteria:

Service type	In chart	Documentation dated within 30 days of discharge and signed by correct provider type
30-days post-discharge visit made	Current medication list in the progress notes	• Notation provider aware of admission, and • Evidence of medication reconciliation of discharge and current medications.
No visit	Current medication list	• Notation of no new medications ordered on discharge, or • Notation to discontinue discharge medications, or • No changes to discharge medications, or • Notation that current and discharge medications reconciled, or • Notation that discharge medications were reviewed.
No visit	Current medication list discharge summary	• Documentation in discharge summary that the discharge medications were reconciled with the most recent outpatient medications, and • Discharge summary filed in chart within 30 days.

Best practices

	Rates reported			
	Notification of inpatient admission	**Receipt of discharge information**	**Patient engagement after inpatient discharge**	**Medication reconciliation post-discharge**
You can reduce errors at time of discharge by using the computer order entry system to generate a list of medication used before and during the hospital admission.				✔
Wellcare submits daily ADT data through Cozeva® for providers to use and to have a list of patients that are admitted. The ADT data submitted through Cozeva will count for notifications to PCP. The Plan cannot see a notification made within a notification system outside of Cozeva. Hence, documentation would have to be in the medical record for the Plan to see the notification.	✔			

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	Rates reported			
	Notification of inpatient admission	**Receipt of discharge information**	**Patient engagement after inpatient discharge**	**Medication reconciliation post-discharge**
The discharge documentation must include the provider responsible for post-discharge care and instructions for post-discharge care. The Plan will look for the discharge documentation in the chart. There must be a discharge summary uploaded in the chart with a discharge date/proof that it has been received within three days (date stamped). At a minimum, the discharge information must include the following: • Name of practitioner responsible for the patient's care during the inpatient stay. • Procedures or treatment provided. • Diagnoses at discharge. • Current medication list and allergies. • Test results or documentation of pending/notifications.			✔	
Establish the following office practices: • Inform members that their hospital admissions and discharges are important for your office to be aware of. This can help improve care coordination and maintain member safety. • Post signs in exam rooms that discuss the importance of notifying your office as soon as possible when admitted to the hospital. • Ensure that members' records are updated with current medications, treatments available, pending test results, referrals and discharge plans.	✔	✔	✔	✔