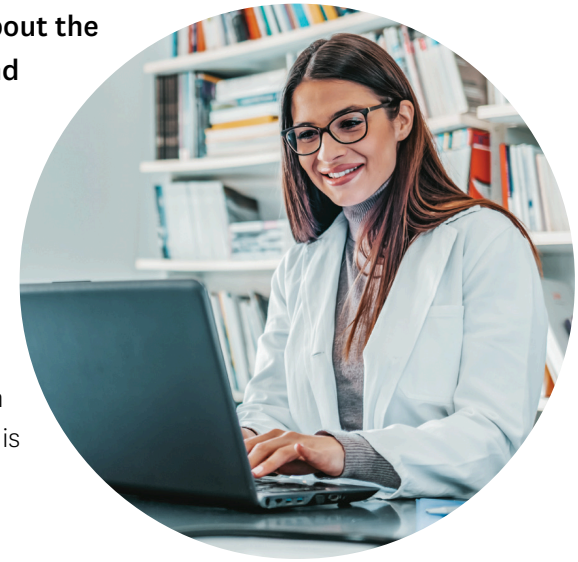
HEDIS® Tip Sheet

Effectiveness of Care Measure

Transitions of Care

Improve your HEDIS[1] rates by using this tip sheet for key details about the Transitions of Care (TRC) measure, exclusions, its billing codes, and guidance for required documentation and best practices.



Measure

Assesses the percentage of inpatients discharged 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 admission (three days total). 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 days total). 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, home visits, telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.
4. **Medication reconciliation post-discharge.**
   - Is conducted by a prescribing provider, physician assistant, clinical pharmacist or registered nurse.
   - Does not require a face-to-face visit.
   - Does not require the patient to be present.
   - Involves reconciling discharge medications with the most recent medication list in the outpatient medical record.

Refer to the Documentation required section for more information.

Exclusions

Patients who meet any of the following criteria are excluded from the measure:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these patients must use only the run date of the file to determine if the patient elected to use a hospice benefit during the measurement year.
- Patients who died during the measurement year.
- Both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

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Common codes

Use the appropriate service codes when billing.

Service type	Codes
Medication reconciliation encounter	CPT: 99483, 99495, 99496
Medication reconciliation intervention	CPT-CAT-II: 1111F
Transitional care management services	CPT: 99496 (TCM 7 day) and 99495 (TCM 14 day)
Outpatient and telehealth	CPT: 98966-98968, 98970-98972, 98980, 98981, 99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99421-99423, 99429, 99441-99443, 99455-99458, 99483 HCPCS: G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250- G2252, T1015

Documentation required

1. Notification of inpatient admission

Documentation in the medical record must include evidence of receipt of notification of inpatient admission on the day admission through two days after admission.

Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received.

Examples:

- Communication between the inpatient providers or staff and patient's primary care physician (PCP) or ongoing care provider (e.g., phone call, email, fax).
- Communication about admission between emergency department and the patient 's PCP or ongoing care provider (e.g., phone call, email, fax).
- Communication about the admission to patient '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. When using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through two days after the admission (three total days) meets criteria.
- Communication about admission to the patient's PCP or ongoing care provider from patient's health plan.
- Indication that the patient's PCP or ongoing care provider admitted patient to the hospital.
- Indication that a specialist admitted patient to the hospital and notified patient's PCP or ongoing care provider.
- Indication that the PCP or ongoing care provider placed orders for test and treatments during patient's inpatient stay.

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Documentation required

- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The time frame that the planned inpatient admission must be communicated is not limited to the day of admission through two days after the admission (three total days); documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria. It must indicate preadmission exam and not pre-op exam. Provider must be aware that the patient will be admitted to the hospital.

The following documentation will not be accepted:

- Documentation that the patient or family notified patient's PCP or ongoing care provider of the admission.
- Documentation of notification that does not include evidence of receipt of notification of inpatient admission on the day of admission through 30 days after admission.

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 discharge.

Documentation in the medical record must include evidence of receipt of discharge information with evidence of the date when the documentation was received.

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

- Name of practitioner responsible for the patient's care during the inpatient stay.
- Procedures or treatment provided.
- Diagnoses at discharge.
- Current medication list.
- Testing results, or documentation of pending tests or no tests.
- 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:

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

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

The following documentation will not be accepted:

- Notification from family patient/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

4. Medication reconciliation post-discharge

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

Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse.

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	Current medication list in the progress notes	• Notation that 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			
Practice	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 qualify as 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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Practice	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 patients that your office needs to know about their hospital admissions and discharges. This can help improve care coordination and maintain patient 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 patient's records are updated with current medications, treatments available, pending test results, referrals and discharge plans.	✓	✓	✓	✓

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