HEDIS MEASURE OVERVIEW

Transitions of Care (TRC)

Please note: The information offered in this flyer is based on Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications. It is not meant to preclude your clinical judgment.

The Transitions of Care (TRC) measure assesses instances of admission and discharge information delivered to a patient's physician, as well as evaluating patient engagement provided after an acute or nonacute discharge on or between Jan. 1 and Dec. 1 of the measurement year. This HEDIS measure consists of four component measures:

- **Notification of Inpatient Admission**
- **Receipt of Discharge Information**
- **Patient Engagement After Inpatient Discharge**
- **Medication Reconciliation Post-Discharge**

The measure is an average of the four component measures to create a score for the TRC measure.

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 nonacute inpatient discharge on or between Jan. 1 and Dec. 1 of the measurement year.

Exclusions

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

TRC component 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, documentation in the patient's outpatient medical record must include evidence 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 can only be collected via medical record review; there are no claim codes for TRC–NIA.
- If the discharge is preceded by an observation stay, use the admit date from the acute or nonacute inpatient stay.
- 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

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- Notification of admission by the patient or the patient's family to the primary care physician (PCP) or ongoing care provider does not meet criteria.
- Any documentation of notification that does not include a time frame or date stamp does not meet criteria.
- When using a shared electronic health record (EHR) system, documentation of a "received date" in the EHR is not required to meet criteria. Evidence that the information was filed in the EHR and is accessible to the PCP or ongoing care provider on the day of discharge through two days after the discharge (three total days) meets 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 his/her PCP practice that discharge information was 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.†

† When using a shared EHR system, documentation of a "received date" in the EHR is not required to meet criteria. Evidence that the information was filed in the EHR and is accessible to the PCP or ongoing care provider on the day of discharge through two days after the discharge (three total days) meets criteria.

- Evidence must include the date the documentation was received. This evidence can only be collected via medical record review; there are no claim codes for TRC–RDI.
- Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structural fields in an EHR. At a minimum, the discharge information **must** include **all** of the following:
  - The 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 test pending
  - Instructions for patient care post-discharge

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 (not the date of discharge).

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 his/her PCP with audio and video communication
- An e-visit or virtual check-in (asynchronous where two-way interaction, which was not real-time, occurred between the patient and provider)

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

Measure best practices

- Work with hospitals to obtain access to EHRs.
- Have processes in place with hospitals to facilitate sharing of admission and discharge information.
- For NIA and RDI admission and discharge information must be in the chart the day of admission/discharge or within two days after (total of three days) to meet the measure requirements
- Review discharge summaries to ensure that the minimum required information is included.
- Be aware of patients' inpatient stays and obtain timely discharge summaries.
- 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.

Coding guidance for TRC–PED

Current Procedural Terminology (CPT®)	
Outpatient visit – in the office or the patient's home	Consult coding manual for appropriate code(s)
Telehealth visit (audio only)	98966, 98967, 98968, 99441, 99442, 99443
Transitional care management service	99495, 99496 (see description below)
Online assessments	98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458

Medication Reconciliation Post-Discharge (TRC–MRP) – Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

To address the measure, a medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days). Licensed practical nurses and other nonlicensed staff can perform the medication reconciliation, but it must be co-signed anytime in the measurement year by an approved provider. When patients are directly transferred to another facility, perform reconciliation for final discharge.

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

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

- Documentation of the current medications with a notation that the healthcare provider reconciled the current and discharge medications
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications)
- Documentation of the patient's current medications with a notation that the discharge medications were reviewed
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service

- Documentation in the discharge summary that the discharge medications were reconciled with the current medications (There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge [31 total days].)
- Evidence that the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review
- Notation that no medications were prescribed or ordered upon 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.
- Neither a visit nor patient presence is required for a medication reconciliation. A final (post-reconciliation) medication list should be communicated to the patient. If transitional care management services codes are not applicable, submit CPT II code 1111F.

Coding for TRC – 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 • Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive 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 (Days 1–7 post-discharge)	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 • Face-to-face visit within seven calendar days of discharge

99495 (Days 8–14 post-discharge)	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 14 calendar days of discharge
1111F (Within 30 days post-discharge*)	Discharge medications reconciled with the current medication list in outpatient medical record * The 30-day limit relates to the measure specifications, not to a time limit on when the code can be used.

The codes provided in this document are limited to those that will address care opportunities for the measures included based on current guidelines. This information is subject to change and, therefore, not intended to serve as official coding or legal advice. All coding should be considered on a case-by-case basis and be supported by medical necessity and the appropriate documentation in the medical record.

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