Transitions of Care (TRC)

APPLICABLE LINES OF BUSINESS

- Medicare

MEASURE DESCRIPTION

The percentage of discharges for patients 18 years of age or older, as of December 31 of the measurement year, who had an acute or non-acute inpatient discharge on or between January 1 and December 1 of the measurement year, who had each of the following:

- Notification of inpatient admission
- Receipt of discharge information
- Patient engagement after inpatient discharge
- Medication reconciliation post-discharge[i]

EXCLUSIONS

Patients are excluded if they:

- Received hospice care during the measurement year

PATIENT MEDICAL RECORDS SHOULD INCLUDE

All four components must be in the outpatient record and accessible by the PCP or ongoing care provider:

Component	Timing	Outpatient medical record requirements
Notification of inpatient admission	Receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 days total)	Must include the date of receipt and any of the following: • Communication from inpatient provider, hospital staff or emergency department regarding admission (phone call, email, or fax); referral to an emergency department does not meet the criteria • Documentation that the patient's PCP or ongoing care provider admitted the patient, or a specialist admitted with PCP notification • Communication about admission through a health information exchange; an admission, discharge, and transfer alert system (ADT); from a member's health plan; or a shared electronic medical record • Documentation indicating the patient's provider placed orders for tests and treatments any time during the member's inpatient stay • Documentation of a preadmission exam or a planned admission prior to the admit date; exam must pertain to the specific admission event

Component	Timing	Outpatient medical record requirements
Receipt of discharge information	Receipt of discharge information on the day of the discharge through 2 days after the discharge (3 days total)	Must include the date of receipt and ALL 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, documentation of pending tests, or documentation of no tests pending • Instructions for patient care post discharge
Patient engagement after inpatient discharge	Patient engagement provided within 30 days after discharge Do not include patient engagement that occurs on the date of discharge	Must include the date of engagement with any of the following: • An outpatient visit including office visits and home visits • A telehealth visit, which must meet criteria with acceptable coding (audio and/or video, e-visits, virtual check-ins) • A telephone visit, including documentation indicating a live conversation occurred with the patient will meet criteria, regardless of provider type. For example, medical assistants and registered nurses may perform the patient engagement. If the patient is unable to communicate with the practitioner, interaction between the caregiver and the provider meets criteria.
Medication reconciliation post-discharge	Medication reconciliation completed on the date of discharge through 30 days after discharge (31 total days)	Must include the medication list that resulted from reconciliation, the date performed, and note any of the following: • Provider reconciled the current and discharge medications • Reference to discharge medications (e.g., no changes in medications post discharge, same medications at discharge, discontinue all discharge medications, or discharge medications reviewed) • Current medication list and discharge lists reviewed on same date of service, and includes the discharge medication list • Discharge summary indicates medication list reconciled with current medications and is filed in outpatient record within 30 days post-discharge • No medications were prescribed or ordered upon discharge • List of current medications with evidence patient was seen for post-discharge hospital follow-up Documentation must indicate the provider is aware of the member's *inpatient* hospitalization. Stating "post op", "surgery", or "discharge" alone is not sufficient to demonstrate this. Must be conducted by a prescribing practitioner, clinical pharmacist, or RN. Other staff members (MA or LPN) may conduct the medication reconciliation, but it must be signed off by the prescribing practitioner. A medication reconciliation performed without the patient present meets criteria.

Examples of documentation that are not acceptable:

- Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission of discharge.
- Documentation of notification that doesn't include a date when the documentation was received.

PATIENT CLAIMS SHOULD INCLUDE

Visits with a practitioner can be with or without a telehealth modifier (see telehealth guide).

Type	Code	Description
CPT® II[ii]	1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.
CPT®	99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.
CPT®	99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least moderate complexity and a face-to-face visit within 14 days or discharge.
CPT®	99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least high complexity and a face-to-face visit within 7 days of discharge.

TIPS FOR SUCCESS

- Reduce errors at time of discharge by using a computer order entry system to generate a list of medication used before and during the hospital admission.
- Enroll your practice in an admission, discharge, and transfer alert system (ADT) to ensure timely receipt of information and create provider alerts and tracking for follow-up. Reach out to ProviderClinicalConsulting@premera.com to learn about Premera-sponsored ADT data options.
- Documentation of notifications must include a date when the document was received.
- Develop a centralized team or assigned roles to communicate with patients post-discharge.
- Implement a standard post-discharge call template to reduce patient risk and readmissions that incorporates:
    - Medication reconciliation
    - Confirms a follow-up appointment is scheduled and kept
    - Assesses patient comprehension of his or her diagnosis and discharge instructions
    - Assesses patient's or caregiver's ability to self-manage medications
    - Incorporates knowledge of the "red flags" of a worsening condition and what to do or who to contact
    - Whom to contact for questions or concerns about their care going forward
    - Summary of the conversation through a medical record accessible by the patient or caregiver, or sent to the patient and caregiver
- Include non-acute (surgical) admissions in post-discharge outreach and medication reconciliation even if post-surgical treatment is being performed through a specialist.
- If CPT II coding is not in place, develop EMR automated text, such as Smartphrases, to guide care teams in documenting medication reconciliation, such as:

    - .dischargemedrec - [Patient name] was discharged from inpatient hospitalization on [date]. Based on review of prior and discharge medications, below is the new medication list: [insert new list] (Note: Relying on the dynamic medication list in the EMR to meet the measure is not sufficient – the record of the encounter must list the medications that resulted from this particular reconciliation.)
- If on Epic EMR, use Vanishing Tips to provide end users with important reminders before signing their notes.
    - The Vanishing Tip contains variables that the provider must address before they are able to sign and close the note. Once the provider accepts their note, the tip will disappear and no longer be visible within the note. Ensure the medication list that was the result of reconciliation is in the chart note or can be pulled up in reference to the reconciliation later. EMR medication lists that update upon prescribing are not sufficient to demonstrate the medications that were in place upon reconciliation.

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[i] National Committee for Quality Assurance. HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans (2023), 294-303