HEDIS Measure

Florida Blue

Transitions of Care (TRC)

By working together, we can improve health outcomes for your patients, our members. The Healthcare Effectiveness Data and Information Set (HEDIS®) helps us measure many aspects of performance. This tip sheet provides key details of the HEDIS measure for Transitions of Care.

What is the measure?
The measure assesses the percentage of discharges (acute and/or non-acute) between January 1 and December 1 for members age 18 or older who had **each** of four reported indicators during the measurement year:

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

Note: Members may be in the measure more than once if there are multiple admissions.

Exclusions

- Members in hospice or using hospice services anytime during the measurement year are a required exclusion
- Members who died any time during the measurement year

Notification of Inpatient Admission

Admission refers to the date of inpatient admission or date of admission for an observation stay that turns into an inpatient admission.

Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through two days after admission (three days total) with a date when the documentation was received. Examples include:

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

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Note: The following notations or examples of documentation ***do not*** count as numerator compliant:

- Documentation that the member or their family notified the member's PCP or ongoing care provider of the admission
- Documentation of notification that does not include a timeframe or date

Receipt of Discharge Information

Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through two days after discharge, with evidence of a date when the documentation was received.

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 all of the following:

- Name of practitioner responsible for the member's care during the inpatient stay
- Procedures or treatment provided
- Diagnoses at discharge
- Current medication list (including medication allergies)
- Test results, or documentation of pending test, or no test pending
- Instructions to the PCP or ongoing care provider for care post-discharge

Note: If the PCP or ongoing care provider is the discharging provider, the discharge information must be documented in the medical record on the day of discharge through two days after the discharge (three days total).

Patient Engagement After Inpatient Discharge

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

Note***:*** **Do not include patient engagement that occurs on the same date of discharge.**

Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any of the following will meet criteria:

- An outpatient visit, including office visits and home visits
- A telephone visit
- A synchronous telehealth visits where real-time interaction occurred between the member and provider using audio and video communication
- An e-visit or virtual check-in

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

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Medication Reconciliation Post-Discharge

Medication reconciliation conducted by a prescribing practitioner, physician assistant, clinical pharmacist, or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (total of 31 days)

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

Any of the following will meet documentation criteria:

- Documentation of the current medications with a notation indicating the 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 member'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 received on the same date of service
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review (evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge)
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record; there must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (total of 31 days)
- Notation in the medical record that no medications were prescribed or ordered upon discharge

Note:

- Only documentation in the outpatient medical record meets the intent of the measure, however the member does not need to be present.
- Documentation of "post-op/surgery follow-up" without a reference to "hospitalization," "admission" or "inpatient stay" does not meet criteria.

Definitions

Medication Reconciliation: A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.

Medication List: A list of medications in the medical record. The medication list may include medication names only, dosages and frequency, over the counter (OTC) medications and herbal or supplemental therapies.

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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

Telephone Visits
CPT: 98966 – 98968, 99441 – 99443

Online Assessments
CPT: 98969 – 98972, 99421 – 99423, 99444, 99457 – 99458

HCPCS: G2010, G2012, G2061 – G2063

Medication Reconciliation
CPT: 99483
99496 Transition of care management services (TCM) within seven days
99495 TCM within 14 days

CPTII: 1111F

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