

To find the category (Medicare Stars, Federal Employee Program®, etc.) this measure applies to, see our [chart of HEDIS® measures](#).

Transitions of Care (TRC)

We are committed to working with you to improve the quality of care and health outcomes for our members, your patients. The Healthcare Effectiveness Data and Information Set (HEDIS®) is one tool we use to measure many aspects of performance. This tip sheet details some of the key features of the HEDIS measure for transitions of care.

What is the measure?

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

1. Notification of Inpatient Admission

Documentation showing receipt of notification of inpatient admission on the day of admission or the following day must be made through medical record review.

2. Receipt of Discharge Information

Documentation of receipt of discharge information on the day of discharge or the following day must be made through medical record review.

3. Patient Engagement After Inpatient Discharge

Documentation of patient engagement provided within 30 days after discharge, including:

- Outpatient visit with or without a telehealth modifier
- Telephone visit
- Transitional care management services
- Home visit

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

4. Medication Reconciliation Post-Discharge

Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 days total).

- Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after the discharge

Denominator

The denominator is based on discharges, not on members. Members may appear more than once in the sample.

Only the last discharge applies if patient is readmitted within 30 days after discharge or in the case of a direct transfer to another acute or non-acute inpatient stay (such as a skilled nursing facility).

Note: Only one outpatient record can be used for all four indicators. The record may be from the member's primary care physician (PCP) or the ongoing care provider.

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HEDIS Measure: Transitions of Care (continued)

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 must include evidence of receipt of notification of inpatient admission on the day of admission or the following day, with a date and timestamp.

Examples of this documentation are:

- 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 via 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 a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider
- Indication that the PCP or ongoing care provider placed orders for test and treatments during the member's inpatient stay
- Indication that the admission was elective and the member's PCP or ongoing care provider was notified or had performed a preadmission exam.

Note:

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

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

Receipt of Discharge Information

Documentation must include evidence of receipt of discharge information on the day of discharge or the following day, with date and timestamp.

Discharge information may be included in a discharge summary or summary of care record or be 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 patient care

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HEDIS Measure: Transitions of Care (continued)

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.

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

Documentation must include evidence of patient engagement within 30 days after discharge. Either of the following will meet criteria:

- An outpatient visit, including office visits and home visits
- A synchronous telehealth visit where real-time interaction occurred between the member and provider by telephone or videoconferencing

Note: Documentation in an outpatient medical record meets the intent; an outpatient visit is not required.

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
- Revenue Codes: 0510-0517, 0519-0523, 0526-0529, 0982, 0983

Telehealth modifiers

- CPT: 95 and GT

Telephone visit

- CPT: 98966-98968, 99441-99443

Transition of care management services (TCM)

- CPT: 99496 (TCM within 7 days)
99495 (TCM within 14 days)

Medication Reconciliation Post-Discharge

Medication reconciliation conducted by a prescribing practitioner, 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.

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HEDIS Measure: Transitions of Care (continued)

Medication Reconciliation Post-Discharge (continued)

Any of the following will meet documentation criteria:

- Documentation of the current medications with a notation that 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
- 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)

Only documentation in the outpatient charge meets the intent of the measure, but an outpatient visit is not required.

Codes:

Medication Reconciliation

- CPT: 99496, 99495 and 1111F

Exclusions

Exclude members who received hospice care anytime during the measurement year.

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