Transitions of Care (TRC)

Healthcare Effectiveness Data Information Set® (HEDIS) is a widely used set of performance measures developed and maintained by the NCQA. These are used to drive improvement efforts surrounding best practices.

This HEDIS measure looks at the percentage of patients 18 years of age and older who had each of the following (four rates are reported):

- **Notification of inpatient admission:** Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days)
- **Receipt of discharge information:** Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days) with evidence of the date when the documentation was received
- **Patient engagement after inpatient discharge:** Documentation of patient engagement (for example, office visits, visits to the home, telehealth) provided within 30 days after discharge
- **Medication reconciliation post-discharge:** Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days)

Note: HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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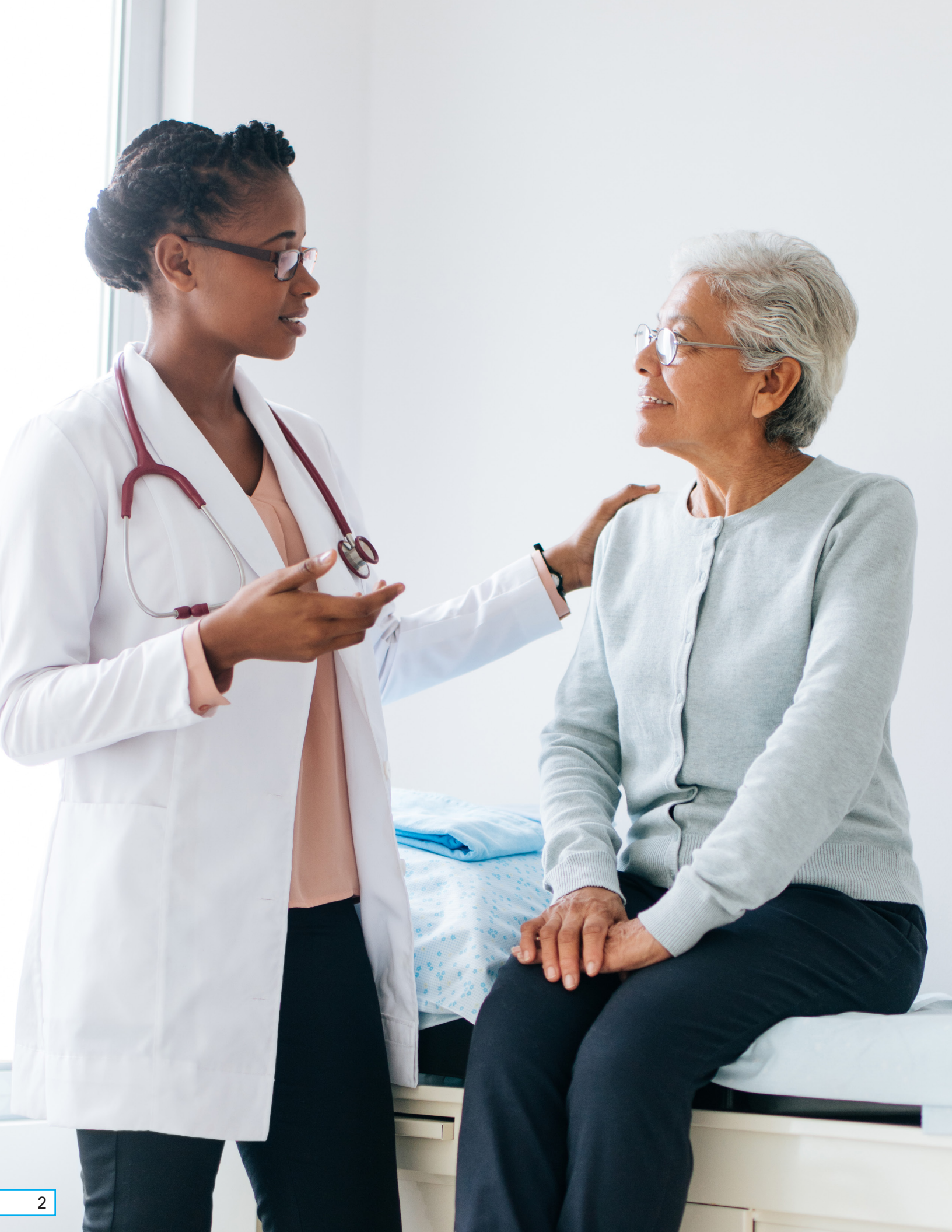


Pathway to Success:

Tools and Resources

Streamline best practice workflows to aid in quality performance improvement for hospital measures such as TRC. Hospital census awareness is one of the easiest and largest levers of influence available to support providers.

Providers are offered email updates daily through features like the opt-in alerts hub within Availity. This capability utilizes admission-discharge-transfer (ADT) notifications obtained from participating hospital/facilities nationwide and is made available directly to providers for assisting with transitional care planning.

Record Your Efforts

Notification of Inpatient 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. Any of the following examples meet criteria:

- Communication between inpatient providers or staff and the member's PCP or ongoing care provider (for example, phone call, email, fax)
- Communication about admission between emergency department and the member's PCP or ongoing care provider (for example, phone call, email, fax)
- Communication about 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
- Communication about admission with the member's PCP or ongoing care provider through 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 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
- 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 tests and treatments any time during the member's inpatient stay
- 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. The planned admission documentation or preadmission exam must clearly pertain to the denominator event.

Note: When an ED visit results in an inpatient admission, notification that a provider sent the member to the ED does not meet criteria. Evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria.

Receipt of Discharge Information

Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR. At a minimum, the discharge information must include all of the following:

- The practitioner responsible for the member'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 pending
- Instructions for patient 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 total days).

When using a shared EMR system, documentation of a **received date** in the EMR 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 discharge through two days after the discharge (three total days) meets criteria.

Patient Engagement After Inpatient Discharge

Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge, such as any of the following meet criteria:

- An outpatient visit, including office visits and home visits
- A telephone visit
- A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication
- An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not in real-time, occurred between the member and provider)

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

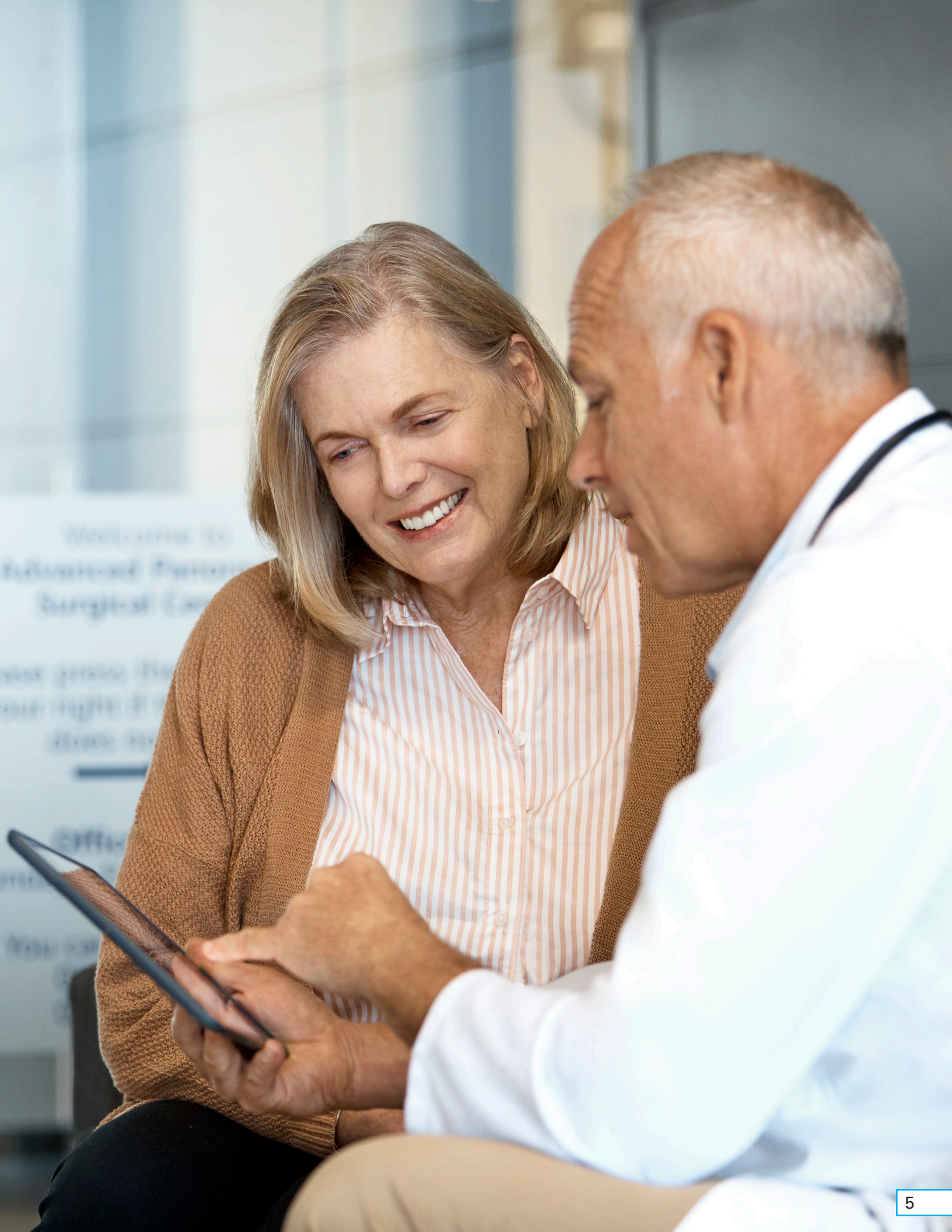
Medication Reconciliation Post-Discharge

Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet 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 (for example, 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 reviewed 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 (31 total days).
- Notation that no medications were prescribed or ordered upon discharge

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year
- Members who die any time during the measurement year



Services	CPT®/HCPCS
Transitional care management services	**CPT** 99495, 99496
Outpatient and telehealth	**CPT** 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455, 99456, 99457, 99458, 99483
	HCPCS **G0071:** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or five minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only **G0402:** Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment **G0438:** Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit **G0439:** Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit **G0463:** Hospital outpatient clinic visit for assessment and management of a patient **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous seven days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment **G2012:** Brief communication technology-based service, for example virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5 to 10 minutes of medical discussion **G2250:** Remote assessment of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment **G2251:** Brief communication technology-based service, for example virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5 to 10 minutes of clinical discussion

Services	CPT®/HCPCS
Outpatient and telehealth (cont.)	**G2252:** Brief communication technology-based service, for example virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11 to 20 minutes of medical discussion **T1015:** Clinic visit/encounter, all-inclusive
Medication reconciliation encounter	**CPT** 99483, 99495, 99496
Medication reconciliation intervention	**CPT-CAT-II** **1111F:** Discharge medications reconciled with the current medication list in outpatient medical record

Note: The codes listed are informational only; this information does not guarantee reimbursement. If applicable, refer to your provider contract or health plan contact for reimbursement information. For a complete list of CPT codes, go to the American Medical Association website at ama-assn.org.

Helpful Tips:

- Documentation of **post-op/surgery follow-up** without a reference to **hospitalization**, **admission**, or **inpatient stay** does not imply a hospitalization and is not considered evidence that the provider was aware of a hospitalization.
- Performing medication reconciliation after every discharge ensures that patients understand all their medications: new, current, and discontinued.
- Obtain timely discharge summaries.
- Submit claims and encounter data in a timely manner.
- If using an electronic medical record (EMR) system, consider electronic data sharing with your health plan to capture all coded elements. Contact your provider contract or health plan contact for additional details and questions.
- If your patient resides in a skilled nursing facility (clinicians manage routine medications), it is important to accurately capture this documentation in the medical record.

Patient Care Opportunities

You can find patient care opportunities within the Patient360 application located on Availity Essentials Payer Spaces. To access the Patient360 application, you must have the Patient360 role assignment. From the Availity homepage, select Payer Spaces, then choose the health plan from the menu. Choose the Patient360 tile from the Payer Space Applications menu and complete the required information on the screen. Gaps in care are located in the Active Alerts section of the Member Summary.

BlueCross BlueShield of North Carolina MEDICARE

https://www.bluecrossnc.com/providers/networks-programs/blue-medicare/healthy-blue-medicare