Transitions of Care (TRC)

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

HEDIS measure

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) 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.

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 with a date and timestamp. Examples include:

- Communication between the emergency department, inpatient providers or staff, and the member's PCP or ongoing care provider (for example, 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

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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 in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through two days after discharge, 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

Patient engagement after inpatient discharge

Documentation of patient engagement (for example, 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 visit where real-time interaction occurred between the member and provider using audio and video communication
- An e-visit or virtual check-in

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

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.

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 (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 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)
- Notation in the medical record that no medications were prescribed or ordered upon discharge

Note:

- Documentation in any outpatient medical record that is accessible to the PCP or ongoing care provider is eligible for use in reporting
- Only documentation in the outpatient medical record meets the intent of the measure, however the member does not need to be present

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, 98967, 98968, 99441, 99442, 99443

Online assessments:

- CPT: 98969, 98970, 97971, 98972, 99421, 99422, 99423, 99444, 99458
- HCPCS: G2010, G2012, G2061, G2062, G2063

Medication reconciliation:

- CPT: 99483
- 99496 Transition of care management services (TCM) within seven days
- 99495 TCM within 14 days
- CPTII: 1111F

Exclusions:

- Exclude members who received hospice care any time during the measurement year
- Died during the measurement year