Transitions of Care (TRC)

Provider Guide

TRANSITIONS OF CARE (TRC) PROVIDER GUIDE

Measure Description: The percentage of discharges for Medicare members 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 2 days after the admission (3 total days).
- **Receipt of Discharge Information.** Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- **Patient Engagement After Inpatient Discharge.** Documentation of patient engagement (e.g., 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).

Measure Importance: Medicare Stars measure

TRANSITIONS OF CARE GAP CLOSURE AT-A-GLANCE

Sub-measure	Time frame	Administrative	Medical Record Review
Notification of Inpatient Admission	Day of admission through 2 days after the admission (3 total days).		Received notification from [ ] on XX/XX/20XX that patient was admitted inpatient to [facility name] on XX/XX/20XX.
Receipt of Discharge Information	Day of discharge through 2 days after the discharge (3 total days).		Received notification from [ ] on XX/XX/20XX that patient was discharged from an inpatient admission at [facility name] on XX/XX/20XX.

Sub-measure	Time frame	Administrative	Medical Record Review
Patient Engagement After Inpatient Discharge	Within 30 days after discharge	**Outpatient and Telehealth:** 98000-98016, 98966-98968, 98970-98972, 98980-98981, 99202-99205, 99211-99215, 99242-99245, 99341-99342, 99344-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-9, 9412, 99421-99423, 99429, 99441-99443, 99455-99458, 99483 **Transitional Care Management Services:** 99495-99496	Evidence of engagement with the patient indicating that it was in follow up to a recent inpatient discharge.
Medication Reconciliation Post-Discharge	Date of discharge through 30 days after discharge (31 total days).	**Medication Reconciliation Encounter:** 99483, 99495, 99496 **Medication Reconciliation Intervention:** 1111F, 99605, 99606	Patient Name, Date of Birth, Date of Service and Provider Acknowledgment of recent inpatient discharge. Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.

NOTIFICATION OF INPATIENT ADMISSION

Completed by Medical Record Review only

Transitions of Care (TRC) Provider Guide

Documentation in any outpatient medical record that is accessible to the PCP or ongoing care provider is eligible for use in reporting. This must include:

- Time Frame: Documentation of receipt of notification of inpatient admission on the day of admission or on the day of admission through 2 days after the admission (3 total days).
- 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.
- About admission between emergency department and the member's PCP or ongoing care provider.
- 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.
- 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 2 days after the admission (3 total days) meets criteria.
- 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.
- A specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider.
- 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 2 days after the admission (3 total days).

Suggested Workflow:

- Provider office receives notification of inpatient admission from Health Information Exchange, Electronic Medical Record, Facility or Health Plan.
- Provider documents and acknowledges receipt of notification of inpatient admission in the medical record.

Appropriate Documentation Verbiage example:

- Received notification on XX/XX/20XX that patient was admitted inpatient to [facility name] on XX/XX/20XX.

The following notations or examples of documentation DO NOT count as closing the care gap:

- Notification of Inpatient Admission Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission or discharge.
- Documentation of notification that does not include a time frame or date when the documentation was received.

RECEIPT OF DISCHARGE INFORMATION

Completed by Medical Record Review only

Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) in any outpatient medical record that is accessible to the PCP or ongoing care provider is eligible for use in reporting with evidence of the date when the documentation was received.

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.

Appropriate Documentation Verbiage example:

Received notification on XX/XX/20XX that patient was discharged from an inpatient admission at [facility name] on XX/XX/20XX.

Include copy of notification if provided in writing.

PATIENT ENGAGEMENT AFTER INPATIENT DISCHARGE

Administrative or Medical Record Review

Administrative Gap Closure: Patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge. The following meet criteria for patient engagement (captured via medical claims received by the health plan):

- An outpatient visit
- A telephone visit
- Transitional care management services
- An e-visit or virtual check-in

Medical Record Review Gap Closure: Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. 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 real-time, occurred between the member and provider).

CPT codes for Administrative Gap Closure - Preferred Method
Please refer to the table above for codes.

MEDICATION RECONCILIATION POST-DISCHARGE

Administrative or Medical Record Review

Administrative: Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days) identified through medical claims submitted to the health plan.

CPT Codes for Administrative Gap Closure (Preferred Method):

Medication Reconciliation Encounter & Medication Reconciliation Intervention: *Please refer to the table above.*

Medical Record Review Gap Closure: Documentation of the current medications with a notation that the provider reconciled the current and discharge medications. Any of the following documentation elements meet criteria:

- Date of Service and Provider
- Current medications with a notation that the provider reconciled the current and discharge medications.
- Current medications with a notation that references the discharge medications were reviewed (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Current medication list with a notation that the discharge medications were reviewed.
- 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.

Notes:

- 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.

- A medication reconciliation performed without the member present meets criteria. Can review in the EMR and document medication reconciliation as described above.