BlueCross BlueShield Nebraska

Transitions of Care (TRC)

Effectiveness of Care HEDIS® Measure

HEDIS MEASURE DEFINITION

The percentage of discharges for patients 18 years of age or older, as of Dec. 31 of the measurement year, who had an acute or non-acute inpatient discharge on or between Jan. 1 and Dec. 1 of the measurement year, who had each of the following:

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

EXCLUSIONS

Patients are excluded if they:

- Received hospice care during the measurement year
- Deceased during the measurement year

PATIENT MEDICAL RECORDS SHOULD INCLUDE

Documentation of all four components must be in any outpatient record, as well as accessible by the PCP or ongoing care provider.

Documentation		
Component	Criteria	Outpatient medical record requirements
1. Notification of inpatient admission	Receipt of notification of inpatient admission on the day of admission through two days after the admission (three days total).	Must include the date of receipt and any of the following criteria: • Communication between inpatient providers (hospital staff or emergency department) and the patient's primary provider or ongoing care provider (phone call, email or fax). Referral to an emergency department does not meet criteria. • Documentation that the patient's primary provider or ongoing care provider admitted the patient, or a specialist admitted with primary provider notification. • Communication through a health information exchange; an admission, discharge and transfer alert system (ADT); or a shared electronic medical record.

		• Documentation indicating the patient's primary provider or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay. • Documentation that the primary provider or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date. The exam must pertain to the specific admission event.
2. Receipt of discharge information	Receipt of discharge information on the day of the discharge through two days after the discharge (three days total).	Must include the date of receipt and **all** the following criteria: • The practitioner responsible for the patient's care during the inpatient stay. • Procedures or treatment provided. • Diagnoses at discharge. • Current medication list. • Testing results, documentation of pending tests or documentation of no tests pending. • Instructions for patient care post-discharge.
3. Patient engagement after inpatient discharge	Patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.	Must include the date of engagement with any of the following criteria: • An outpatient visit, including office visit or home visit. o Telehealth visits meet criteria with acceptable coding (telephone, audio or video, e-visits, virtual check-ins). Documentation indicating a live conversation occurred with the patient will meet criteria, regardless of provider type. For example, medical assistants and registered nurses may perform the patient engagement. If the patient is unable to communicate with the practitioner, interaction between the patient's caregiver and the provider meets criteria.
4. Medication reconciliation post-discharge	Medication reconciliation completed on the date of discharge through 30 days after discharge (31 total days).	Must include the date performed with any of the following criteria: • Current medication list and notation that provider reconciled the current and discharge medications.

	Must be conducted by a prescribing practitioner, clinical pharmacist or registered nurse. Other staff members (MA or LPN) may conduct the medication reconciliation, but it must be signed off by the prescribing practitioner. Must be in the outpatient medical record. An outpatient face-to-face visit isn't required.	• Current medication list with reference to discharge medications (e.g., no changes in meds post-discharge, same meds at discharge, discontinue all discharge meds, discharge meds reviewed) • Current medication list and discharge medication list with evidence both lists reviewed on same date of service. • Current medication list with evidence that the patient was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge. • Discharge summary medication list indicates reconciled with current meds. Must be filed in the outpatient record within 30 days after discharge. • No medications were prescribed or ordered upon discharge.

TIPS FOR SUCCESS

- You can reduce errors at time of discharge by using your order entry system to generate a list of medication used before and during the hospital admission.
- Safe and effective transfer of responsibility for a patient's medical care relies on effective provider communication with **patient comprehension of his or her discharge instructions.**
- Documentation of notification must include a date when the document was received.
- **Examples of documentation that are not acceptable:**
    - Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission of discharge.
    - Documentation of notification that doesn't include a date when the documentation was received.

TIPS FOR CODING

Visits with a practitioner can be with or without a telehealth modifier (see telehealth guide).

CPT II code	ICD-10-CM code
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including

	medication reconciliation and review for high-risk medications, if applicable.
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least moderate complexity and a face-to-face visit within 14 days or discharge.
99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least high complexity and a face-to-face visit within seven days of discharge.