Quality Considerations

Transitions of Care

HEDIS Measure Guide

EmblemHealth®

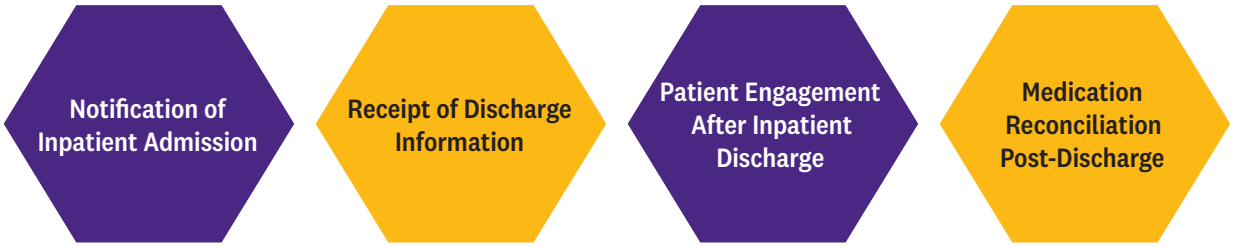
Transitions of Care Measure

Strong care coordination is vital for ensuring that patients successfully transition from an inpatient setting back to their home. Strong care coordination also helps avoid:

- Communication lapses between inpatient and outpatient providers.
- Intentional and unintentional medication changes.
- Incomplete diagnostic testing.
- Inadequate patient, caregiver, and provider understanding of diagnoses, medication, and follow-up needs.

The Healthcare Effectiveness Data and Information Set (HEDIS) Transitions of Care measure evaluates hospital admission and discharge processes to prevent rehospitalizations, emergency room visits, and other poor health outcomes.

The National Committee for Quality Assurance (NCQA) considers Transitions of Care a single weighted measure consisting of four separate components. The medical record must have acceptable evidence of all four. Each component contributes to the overall scoring of the measure which is calculated as an average of the four components.



The measure assesses the percentage of discharges (acute/non-acute) for members 18 years or older who meet each of the four reported components shown below between **Jan. 1** and **Dec. 1** of the measurement year. This measure excludes members who received hospice care anytime during the measurement year.

The **measurement year** follows the member's discharge date if the inpatient admission spans two calendar years. The discharge date used for this measure can change if the patient is readmitted to an inpatient facility within 30 days of their last discharge. The medical record review will only evaluate the last discharge.

The quality measure may include members more than once if they have distinct multiple discharges during the year. For these cases, the medical records must document the four components for each discharge.

The Importance of This Guide

This guide focuses on the required documentation to satisfy these four components during a medical record review. This guide also shows what will and will not count for each component when evaluated during a medical record review. Since certain claims and encounter data coding may serve as evidence that a component has been met, this guide includes charts below with the applicable codes.

Notification of Inpatient Admission Component

When a hospital admits a member for an inpatient stay, the hospital, emergency room staff, specialist, etc., must notify the member's primary care provider or ongoing care provider (jointly referred to as PCP) of the admission. See the **Hospital and Facility Procedures section of the EmblemHealth Provider Manual's Utilization and Care Management chapter**. For medical record reviews, documentation in the PCP's outpatient medical record must include evidence they received notice of the inpatient admission on the admission date but no later than the second day after admission (three calendar days total). The documentation must also include evidence of the date the PCP received the notice.

The following examples **MEET** the documentation criteria for notification of inpatient admission:

- Communication between the emergency department, inpatient providers, or staff and the member's PCP by:
  - Phone call.
  - Email.
  - Fax
  - Health information exchange.
  - Automated admission via discharge and transfer (ADT) alert system.
  - Shared electronic medical record system.

- Other communications in the PCP's medical record that also capture the PCP's notification and awareness of the admission include:
  - Member's health plan's communication to the member's PCP about admission.
  - Admitting specialist's notification to the member's PCP.
  - PCP records document that they placed orders for tests and treatments during the member's inpatient stay.
  - PCP records document that they performed a preadmission exam or received communication about a planned inpatient admission.

The following documentation **DOES NOT** count for the notification of inpatient admission component:

- Documentation that the member's family notified the member's PCP of the admission or discharge.
- Documentation that the provider sent the member to the emergency room.
- Documentation of notification to the PCP that does not include a time frame or date when the documentation was received.
- A Continuity of Care Document (CCD) is not an acceptable information format for this measure.

Tips: Notification of Inpatient Admission

- In general, communications must be dated. The hospital, emergency room staff, specialist, etc., must include the notification date in the inpatient admission notice. A fax's date stamp is acceptable. Other communications must be dated with a stamp, signature, or other written proof to show when the PCP received the inpatient admission notification.
- The measure does not require a date stamp if the provider shares an electronic medical record (EMR) with the discharging facility. If EmblemHealth is aware that the EMR is shared, the admission history and physical or admit note may be used.

Receipt of Discharge Information Component

Documentation in the medical record must include dated evidence of receipt of discharge information on the day of discharge, or through the second day after discharge (three total days).

Discharge information may include, but is not limited to, a discharge summary, summary of care record, or structured fields in an electronic health record (EHR).

The following items **MUST ALL** be included in the documentation to **MEET** the receipt of discharge information component:

- The name of the practitioner responsible for the member's care during the inpatient stay.
- Procedures or treatment provided.
- Diagnosis at discharge.
- Current medication list.
- Testing results, or documentation of pending tests, or notation that no tests are pending.
- Instructions for patient care post-discharge.

The following documentation **DOES NOT** count for the receipt of discharge component:

- 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 does not include a time frame or date when the documentation was received.
- A Continuity of Care Document (CCD) is not an acceptable information format for this measure.

Tips: Receipt of Discharge Information

- The outpatient records must include dated evidence of when the discharge information or notification was received. The facility, emergency room staff, specialist, etc., must date the discharge notification. A fax's date stamp is acceptable. Other communications must be dated with a stamp, signature, or other written proof to show when the PCP received the discharge notification.
- A date stamp is not required if the provider shares an EMR with the discharging facility. If EmblemHealth is aware that there is a shared EMR, the discharge summary can be used if dictated within the three-day time frame.
- A discharge summary dictated before the date of discharge is not acceptable.

Patient Engagement After Inpatient Discharge Component

Medical record reviews will look for documentation showing that patient engagement was provided within 30 days after discharge (starting the day after discharge).

The following examples **MEET** the criteria for the patient engagement after inpatient discharge component:

- An outpatient visit, including office visits and home visits.
- A telephone visits.
- A synchronous telehealth visits 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).

The following documentation **DOES NOT** count for patient engagement after inpatient discharge component:

- Do not include patient engagement that occurs on the discharge date.
- A Continuity of Care Document (CCD) is not an acceptable information format for this measure.

Tips: Receipt of Patient Engagement After Inpatient Discharge

- If the member is unable to communicate with the provider, interaction between the member's caregiver and provider is an acceptable alternative.
- There is no provider type requirement. The member may see their PCP or other health care provider for post-discharge care.

Patient Engagement After Discharge Administrative Codes

Another way to meet the criteria for this component is to use the following codes on your claims or encounter data.

Outpatient visits	**CPT:** 99341-99345, 99347-99350 (home visits) **CPT:** 99201-99205, 99211-99215, 99241-99245, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483 **HCPCS:** G0402, G0438, G0439, G0463, T1015 **UBREV:** 0510-0517, 0519-0523, 0526-0529, 0982, 0983
Audio-only telephonic visits	**CPT:** 98966, 98967, 98968, 99441, 99442, 99443
Transitional care management services	**CPT:** 99495, 99496 (also closes medication reconciliation)
E-visits or virtual check-ins (online assessments)	**CPT:** 98969, 98970, 97971, 98972, 99421, 99422, 99423, 99444, 99457 **HCPCS:** G0071, G2010, G2012, G2061, G2062, G2063

Medication Reconciliation Post-Discharge

A prescribing practitioner, clinical pharmacist, or registered nurse must reconcile the outpatient record's most recent medication list with the medications prescribed with the discharge plan.

The medication reconciliation must be documented either through administrative coding or a medical record review on the date of discharge, or up to 30 days after discharge (31 days total). A medication list must be present in the medical record.

The following examples **MEET** the criteria for the medication reconciliation post-discharge component:

- Notation that no medication was prescribed or ordered upon discharge.
- Documentation of the current medications with a notation that the provider reviewed or reconciled the current and discharge medications.
- Documentation of a current medication list, a discharged medication list, and notation that both lists were reviewed on the same date.
- 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, or discontinue all discharge medications).
- Documentation of a post-discharge hospital follow-up visit with evidence of medication reconciliation or review, including a current medication list.
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent outpatient medical record's medication list.

Medication Reconciliation Post-Discharge Administrative Codes

Another way to meet the criteria for this component is to use the following codes on your claims or encounter data.

Medication reconciliation encounter	**CPT:** 99483 - Cognitive assessment and care plan services **CPT:** 99495, 99496 (Traditional care management services, also closes patient engagement.)
Medication reconciliation intervention	**CPT-CAT-II:** 1111F - Discharge medications reconciled with the current medication list in outpatient medical record

The following documentation **DOES NOT** count for the medication reconciliation post-discharge component:

- Documentation of a medication list without evidence that the practitioner was aware of the hospitalization/discharge.
- No documentation of a current medication list or evidence of reconciling discharge mediations with current medications.
- A Continuity of Care Document (CCD) is not an acceptable information format for this measure.

Tips: Medication Reconciliation Post-Discharge

- Every discharge to a community setting requires a medication reconciliation.
- An outpatient visit is not required for this component. Medication reconciliation can be done via a telehealth or telephone visit. The member does not need to be present to complete the medication reconciliation.

- Transfers to an acute or non-acute inpatient care setting on the date of discharge through 30 days after discharge are not included.
- A registered nurse (RN) may perform the medication reconciliation; a licensed practical nurse (LPN) or medical assistant (MA) may not. A transition of care phone call made by an LPN or MA is not acceptable evidence of post-discharge medication reconciliation.
- Documentation of "post-op/surgery follow-up" without reference to "hospitalization," "admission," or "inpatient stay" is not considered evidence that the provider was aware of the member's hospitalization or discharge, even if the procedure is typically performed in an inpatient setting (e.g., open-heart surgery).
- A medication reconciliation on the discharge summary must be a complete reconciliation of the home medication list and the discharge medical list. A list of discharge medications alone is not acceptable.

Reminders for the Transitions of Care Measure

- Inpatient facilities must notify the member's PCP or other treating provider when there is an inpatient admission and provide specific information for the PCP's medical record (notification of inpatient admission and receipt of discharge information).
- PCPs should make sure their patients understand what they need to do post-discharge (patient engagement), including the appropriate medications they need to take (medication reconciliation).
- It is critical for each of the four components to be properly documented in the medical record for each unrelated discharge during the measurement year. Even the best of care will be considered no care at all if not properly documented.
- It is best practice to document the transition of care in the medical record even if claims and encounter data may also be used to meet part of the measure.

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