Alameda Alliance Wellness

Measure Tip Sheet

Transitions of Care (TRC)

This tip sheet is part of the *Alliance Medicare Stars Guide: A Resource for Providers and Clinic Staff.* This tip sheet provides measure-specific guidance, coding tips, and documentation strategies to help clinical teams close care gaps and improve performance on HEDIS® measures tied to Medicare Star Ratings.

For questions or more information, please email the Alliance Stars Team at **DeptStarsTeam@alamedaalliance.org**.

Data Collection Methodology: Administrative and hybrid

Measure Description: The percentage of members who received continuity of health care following an inpatient discharge.

Measure Population (denominator): Members 18 years and older with an acute or non-acute inpatient discharge on or between January 1st and December 1st of the measurement year.

Please Note: If members have multiple discharges, they could appear in the measure more than once.

Measure Compliance (numerator): Members who had all four (4) of the following numerators completed and documented in the outpatient medical record:

1. Notification of Inpatient Admission
2. Receipt of Discharge Information
3. Patient Engagement after Inpatient Discharge
4. Medication Reconciliation Post-Discharge

Outpatient Medical Record Requirements:

Numerator	Measurement	Medical Record Criteria
1. Notification of Inpatient Admission	Receipt of notification of inpatient admission and evidence that the information was integrated in the appropriate medical record on the day of admission through two (2) days after admission (three (3) days total). **Please Note:** Can only be met through a medical record review (MRR).	Must include the date of receipt and any of the following criteria: • Communication from inpatient practitioner, hospital staff, or ED regarding admission (phone call, email, or fax). Referral to an ED does not meet the criteria. • Documentation that the PCP or managing specialist admitted the member, or a specialist admitted with PCP or managing specialist notification. • Communication about admission through a health information exchange: an admission, discharge, and transfer alert system (ADT) or a shared electronic medical record (EMR). • Documentation indicating the PCP or managing specialist placed orders for tests and treatments at any time during the member's inpatient stay. • Documentation of a preadmission exam or a planned admission prior to the admit date. The exam must refer to the planned admission (not just pre-op or pre-surgical). • Communication from the member's health plan regarding admission. **Please Note:** Documentation that the member/caregiver notified the PCP or managing specialist of the admission does not count.
2. Receipt of Discharge Information	Receipt of discharge information and evidence that the information was integrated in the appropriate medical record on the day of discharge through two (2) days after discharge (three (3) days total). **Please Note:** Can only be met through an MRR.	Must include the date of receipt and all the following criteria: • The practitioner responsible for the member'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 **Please Note:** Documenting that the member/caregiver notified the PCP or managing specialist of the discharge does not count.
3. Patient Engagement After Inpatient Discharge	Patient engagement is 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 visits and home visits. • Virtual care visits (asynchronous or synchronous). • Documentation indicating a conversation occurred with the member, regardless of practitioner type. For example, medical assistants (MA), and registered nurses may perform the patient engagement. • Interactions between the member's caregiver and practitioner.

Numerator	Measurement	Medical Record Criteria
4. Medication Reconciliation Post-Discharge	Medication reconciliation completed on the date of discharge through 30 days after discharge (31 days total). • Must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse. Other staff members (e.g., MA or Licensed practical nurse (LPN)) may conduct the medication reconciliation, but it must be signed off by the required practitioner type. • Must be in the outpatient medical record, but an outpatient face-to-face visit is not required.	Must include the date performed AND specific documentation of inpatient hospitalization with any of the following criteria: • Current medication list with a notation that the practitioner reconciled the current and discharge medications. • 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 the same date of service. • Documentation of the current medications with evidence that the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. • Discharge summary medication list indicates reconciled with current meds. Must be filed in the outpatient record within 30 days after discharge. • Documentation that no medications were prescribed or ordered upon discharge.

Coding Tips:

Value Set Name	CPT Code	Description
Medication Reconciliation Encounter	99483	Assessment and care plan patient cognitively impaired
	99495	Transitional care management moderate, face-to-face 14 days
	99496	Transitional care management high, face-to-face 7 days
Medication Reconciliation Intervention	1111F CPT II	Discharge medications reconciled with the current medication list in outpatient medical record
Outpatient and Telehealth	98016	Brief communication technology-based service
	99202	Office or other outpatient visit new straightforward 15 minutes
	99203	Office or other outpatient visit new low 30 minutes
	99204	Office or other outpatient visit new moderate 45 minutes
	99205	Office or other outpatient visit new high 60 minutes
	99211	Office or other outpatient established may not require physician or other qualified healthcare professional
	99212	Office or other outpatient established straightforward 10 minutes
	99213	Office or other outpatient established low 20 minutes
	99214	Office or other outpatient established moderate 30 minutes

Value Set Name	CPT Code	Description
Outpatient and Telehealth (cont.)	99215	Office or other outpatient established high 40 minutes
	99242	Office or other outpatient consultation new/established straightforward 20 minutes
	99243	Office or other outpatient consultation new/established low 30 minutes
	99244	Office or other outpatient consultation new/established moderate 40 minutes
	99245	Office or other outpatient consultation new/ established high 55 minutes
Transitional Care Management Services	99495	Transitional care management moderate face-to-face 14 days
	99496	Transitional care management high face-to-face 7 days

Please Note: The table shows a partial list of value set codes. Additional codes are available upon request.

Exclusions

- Members who died at any time during the measurement year.
- Members who received hospice services at any time during the measurement year.

How to Improve Your Stars Performance

- ADT alerts of inpatient admission should land in the EHR with an auto date/time stamp.
- If the discharge summary is faxed or scanned, document 'date received' and upload into the chart.
- Ensure documentation is clear, concise, consistent, complete, and comprehensive.
- Documentation of the current medications with evidence that the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review.
- Medication reconciliation can be completed without the member present.
- Schedule appointments with members within the first seven (7) days of discharge.
- Remind members of their appointment by making calls or sending texts.
- Make outreach calls and/or send letters to advise members of the need for a visit.