2022 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Transitions of Care (TRC)

Effectiveness of Care HEDIS® Measure

Measurement definition

The percentage of discharges for patients 18 years of age or older, as of December 31 of the measurement year, who had an acute or non-acute inpatient discharge on or between January 1 and December 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
- Are deceased during measurement year

continued

Information that patient medical records must include

Documentation of all 4 components must be in any outpatient record, as well as accessible by the PCP or managing specialist.

Component	Criteria	Outpatient medical record requirements
1. Notification of inpatient admission	Receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 days total). **Note:** Can only be met through medical record review.	Must include the date of receipt and any of the following criteria: • Communication from inpatient provider, hospital staff or emergency department regarding admission (phone call, email or fax). Referral to an emergency department does not meet criteria. • Documentation that the patient's PCP or managing specialist admitted the patient or a specialist admitted with PCP 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 provider placed orders for tests and treatments 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 pertain to the specific admission event.
2. Receipt of discharge information	Receipt of discharge information on the day of the discharge through 2 days after the discharge (3 days total). **Note:** Can only be met through medical record review.	Must include the date of receipt and ALL of 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

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Component	Criteria	Outpatient medical record requirements
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 visits and home visits. • Telehealth visits meet criteria with acceptable coding (audio and/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 be conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse. Other staff members (MA or LPN) may conduct the medication reconciliation, but it must be signed off by the required provider type. • Must be the outpatient medical record, but an outpatient face-to-face visit isn't required	Must include the date performed with any of the following criteria: • Current medication list with a notation that the provider 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 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. • 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

- Utilize Michigan Health Information Network's (MiHIN) admission, discharge, transfer (ADT) notifications to support TRC components.
  - Request discharge summary from facility when discharge ADT notification is received.
- You can reduce errors at time of discharge by using the computer order entry system to generate a list of medication used before and during the hospital admission.

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- 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 managing specialist of the admission or discharge.
  - Documentation of notification that doesn't include a date when the documentation was received.

Tips for coding

- This measure is based on discharges. Members may appear in the denominator more than once.
- Visits with a practitioner can be with or without a telehealth modifier (see telehealth guide).
- Bill 1111F as soon as medication reconciliation is completed. It is not necessary to wait for all components of TCM or care planning service codes to be met.
- TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period.

CPT® II code	Description
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.

CPT® codes	Description
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 (in-person or telehealth) visit within **14 days** of 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 (in-person or telehealth) visit within **7 days** of discharge.