Transition of Care (TRC) 2025

HEDIS® is a widely used set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). These are used to drive improvement efforts surrounding best practices.

HEDIS Measure

This measure assesses the percentage of acute or non-acute discharges that include all four of the following: Notification of Inpatient Admission, Receipt of Discharge Information, Medication Reconciliation, and Patient Engagement within 30 days after discharge.

Numerator
Number of eligible patient discharges received all components of patient engagement within 30 days after discharge from January 1 to December 1 of the measurement year

Denominator (eligible patients)
Number of in-patient hospitalization discharges within the calendar year

Note: Patients may be in the measure more than once if multiple admissions exist.

Exclusions:

- Patients who use hospice services or elect to use a hospice benefit at any time during the measurement year
- Patients who die at any time during the measurement year

Best Practices:

- Implement automated alerts when a patient is admitted or discharged from an inpatient facility.
- Schedule a post-discharge follow-up appointment and make reminder calls.

Note: HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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Notification of Inpatient Admission

Admission refers to the date of inpatient admission or the date of admission for an observation stay that turns into an inpatient admission.

Documentation in the outpatient medical record must include evidence of receipt of inpatient admission notification on the day of admission through two days after admission with a date and timestamp. Examples include:

- Communication between the inpatient providers or staff and the patient's primary care provider (for example, phone call, email, or fax)
- Communication about the admission to the patient's primary care provider through a health information exchange, an automated admission via discharge and transfer (ADT) alert system, or a shared electronic medical record system
- Communication about admission to the patient's primary care provider from the patient's health plan
- Indication that a specialist admitted the patient to the hospital and notified the patient's primary care provider
- Indication that the primary care provider placed orders for tests and treatments during the patient's inpatient stay
- An indication that the admission was elective and the patient's primary care provider was notified or had performed a preadmission exam

Note: The following notations or examples of documentation do not count as numerator-compliant:

- Documentation that the patient or the patient's family notified the patient's primary care provider of the admission
- Documentation of notification without a time frame or date and timestamp

Receipt of Discharge Information

- The outpatient medical record must include evidence of receipt of discharge information from the day of discharge through two days after discharge, with a date and timestamp.
- Discharge information may be included in a discharge summary or summary of care record or in structured fields in an electronic health record.
- At a minimum, the discharge information must include each of the following:
  - Name of practitioner responsible for the patient's care during the inpatient stay
  - Procedures or treatment provided
  - Diagnoses at discharge
  - Current medication list (including medication allergies)
  - Test results, or documentation of pending test, or no test pending
  - Instructions to the primary care provider for patient care

Medication Reconciliation Post-discharge

- Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse within 30 days of discharge, as documented through administrative data or medical record review.
- The outpatient medical record documentation must include evidence of medication reconciliation and the date it was performed.
- Any of the following will meet the documentation criteria:
  - There is documentation of the current medications, with a notation indicating that the provider reconciled the current and discharge medications.
  - The documentation includes the current medications and a notation referencing the discharge medications, such as whether there have been no changes *since discharge, whether the medications are the same as at discharge, or whether all discharge medications have been discontinued.*
  - The patient's current medications are documented, with a notation confirming that the discharge medications were reviewed.
  - The documentation includes a current medication list, a discharge medication list, and a notation indicating that both lists were received on the same date of service.

— The current medications are documented, with evidence showing that the patient was seen for a post-discharge hospital follow-up, which includes evidence of medication reconciliation or review.

— The discharge summary documents that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. It also provides evidence that the summary was filed in the outpatient chart on or up to 30 days after discharge.

— There is a notation in the medical record stating that no medications were prescribed or ordered upon discharge.

Notes:

- Documentation in any outpatient medical record that is accessible to the PCP or ongoing care provider is eligible for use in reporting.
- Only documentation in the outpatient medical record meets the intent of the measure. However, the patient does not need to be present.

Patient Engagement After Inpatient Discharge

- Documentation of patient engagement (for example, office visit, home visit, telehealth, or virtual/e-visit) must be provided within 30 days of discharge.
- An outpatient medical record documentation needs to meet the intent; an outpatient visit is not required.

Note: Do not include patient engagement that occurs on the same date of discharge.

Closing the Gap

Codes

Medication reconciliation encounter:

- **CPT®:** 99483, 99495, 99496

Medication reconciliation intervention:

- **CPTII:** 1111F
- 99496 Transition of care management services (TCM) within seven days
- 99495 TCM within 14 days

Outpatient and telehealth:

- **CPT:** 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99244, 99245, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99455, 99456, 99457, 99458, 99483
- **HCPCS:** G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, T1015

Let's Work Together

The measure is closed by way of the following:

- Claims
- CCDA
- SFTP/Flat files
- Cotiviti

Please visit **My Diverse Patients** for more information about eLearning experiences on provider cultural competency and health equity.

https://bluecrossnc.com/providers/networks-programs/blue-medicare/healthy-blue-medicare

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