QUALITY+ PARTNERSHIP PROGRAM

Transitions of Care

Measure Summary

of Tennessee

Transitions of Care Measure

The Medicare Advantage Quality+ Partnerships program includes the Transitions or Care (TRC) measure, a single-weighted meaure that consists of four (4) separate components.

We've included information on all four components to help you with this measure.

Definition of Transitions of Care

The TRC measure assesses the percentage of **discharges** (acute and/or non-acute) for members 18 years or older who had each of the four reported components between Jan. 1 and Dec. 1 of the measurement year:

Notification of Inpatient Admission › Receipt of Discharge Information › Patient Engagement After Inpatient Discharge › Medication Reconciliation Post-Discharge

Reminders

- Members may be in the measure more than once if there are multiple discharges during the year.
- 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. Only the last discharge counts.
- A Continuity of Care Document (CCD) is not an acceptable format of information for this measure.
- Rates for this measure are calculated using the average of the rates of each of the four (4) components.
- Members who received hospice care anytime during the measurement year are excluded from this measure.

Notification of Inpatient Admission

Source: 100% of this information is from the medical record review. (Administrative reporting/coding isn't available for this component.)

Documentation in the outpatient medical record must include evidence of receipt of a notification of inpatient admission on the day of admission or through the second day after admission (three total days). The documentation must also include evidence of the date it was received.

Note: the admission date may occur in the previous measurement year **if the discharge** is between Jan. 1 and Dec. 1 of the current measurement year.

Any of the following examples **meet criteria**:

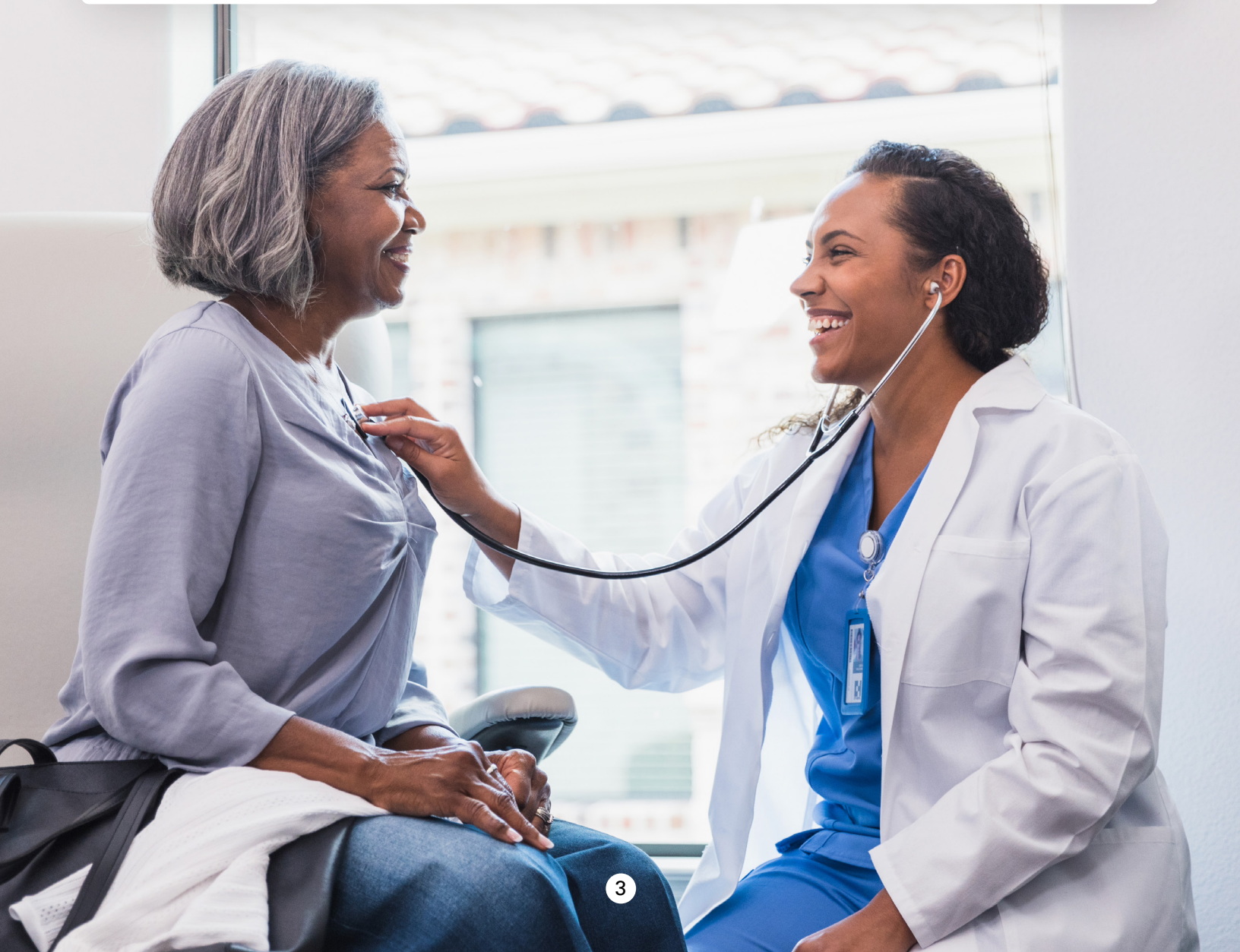
- Communication between the emergency department, inpatient providers or staff and the member's primary care provider (PCP) or ongoing care provider (e.g., phone call, email, fax)
- Communication about the admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission via discharge and transfer (ADT) alert system; or a shared electronic medical record system
- Communication about admission to the member's PCP or ongoing care provider from the member's health plan
- Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider
- Indication that the PCP or ongoing care provider placed orders for test and treatments during the member's inpatient stay
- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission

The following examples of documentation **do not** count for Notification of Inpatient Admission:

- Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission or discharge
- Documentation of notification that doesn't include a time frame or date when the documentation was received

Notification of Inpatient Admission Tips

- If a provider receives communication from the facility, ER staff, specialist, etc. of an inpatient admission, the communication must be dated. If the facility faxes a notification, the date stamp on the fax is acceptable. Other communications must be dated with a stamp, signature or other written proof to show when the notification of the inpatient admission was received.
- If the provider shares an electronic medical record (EMR) with the discharging facility, a date stamp isn't necessary. The admission history and physical or admit note can be used as long as BlueCross is aware that the EMR is shared.

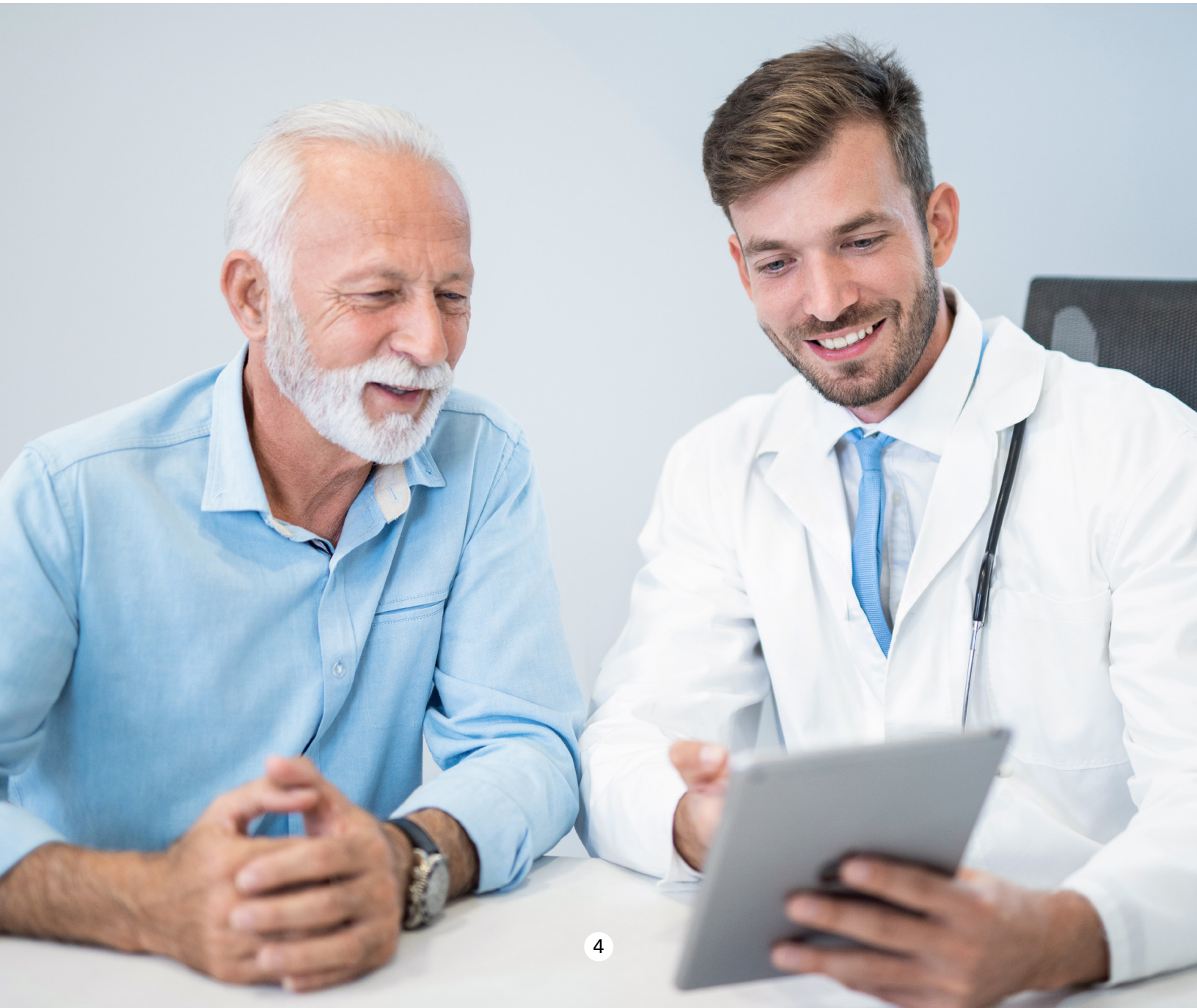


Receipt of Discharge Information

Source: 100% of this information is from the medical record review.
(Administrative reporting/coding is not available for this component.)

Documentation in the medical record must include evidence of receipt of discharge information on the day of discharge, or through the second day after discharge (three total days). The documentation must also include evidence of the date it was received.

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



At minimum, the discharge information **must** include **all** of the following:

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

The following examples of documentation **do not** count for Receipt of Discharge Information:

- Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission or discharge
- Documentation of notification that doesn't include a time frame or date when the documentation was received

Receipt of Discharge Information Tips

- The outpatient record must include dated evidence of when the discharge information or notification was received. If a provider receives communication from the facility, ER staff, specialist, etc. of a discharge, the communication must be dated. If the facility faxes a notification, the date stamp on the fax is acceptable. Other communications must be dated with a stamp, signature or other written proof to show when the notification of the discharge was received.
- If the provider shares an EMR with the discharging facility, a date stamp isn't necessary. The discharge summary can be used if dictated within the time frame as long as BlueCross is aware that there is a shared EMR.
- A discharge summary dictated before the date of discharge isn't acceptable.

Patient Engagement After Inpatient Discharge

Source: This component's information comes from both medical record review and administrative reporting/coding.

Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) must be provided within 30 days after discharge. Don't include patient engagement that occurs on the date of discharge.

Any of the following **meet criteria**:

- An outpatient visit, including office visits and home visits
- An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider)
- A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication
- A audio-only telephonic visit
- Transitional care management services

Patient Engagement after Discharge Administrative Codes

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	

Receipt of Discharge Information Tips

Use weekly discharge reports available in the Quality Care Rewards (QCR) application to schedule post-hospital visits with the member.

Medication Reconciliation Post-Discharge

Source: This component's information comes form both medical record review and administrative reporting/coding.

Medication reconciliation* conducted by a prescribing practitioner, clinical pharmacist, or registered nurse must be documented through either administrative coding or medical record review on the date of discharge, or up to 30 days after discharge (31 total days).

Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following **meet criteria**:

- Documentation of the current medications with a notation that the provider reconciled the current and discharge medications
- 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, discontinue all discharge medications)
- Documentation of the member's current medications with a notation that the discharge medications were reviewed
- Notation that no medications were prescribed or ordered upon discharge
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the 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
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record

Medication Reconciliation Post-Discharge Administrative Codes

Medication Reconciliation Encounter	**CPT:** 99483 - Cognitive assessment and care plan services **CPT:** 99495, 99496 (TCM services, also closes patient engagement)
Medication Reconciliation Intervention	**CPT-CAT-II:** 1111F - Discharge medications reconciled with the current medication list in outpatient medical record

* A type of review where the discharge medications are reconciled with the most recent medication list in the outpatient medical record. The member doesn't have to be present.

The following examples of documentation **do not** count for Medication Reconciliation Post-Discharge:

- 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 medications with current medications

Medication Reconciliation Post-Discharge Tips

- An outpatient visit isn't required for this component. Medication reconciliation can be done via a telehealth or telephone visit. The member doesn't need to be present to complete the medication reconciliation.
- Every discharge to a community setting requires a medication reconciliation.
- Transfers to an acute or non-acute inpatient care setting on the date of discharge through 30 days after discharge aren't included.
- Use weekly discharge reports available in the Quality Care Rewards (QCR application to plan for post-hospital visits and/or calls to the member.
- Medication reconciliation can't be performed by a Licensed Practical Nurse (LPN) or Medical Assistant (MA). A transition of care phone call made by an LPN or MA isn't acceptable. A Registered Nurse (RN) can perform the medication reconciliation.
- If using a post-discharge follow-up visit for this component, there must be evidence in the visit note documenting that the provider was aware of the recent discharge. Documentation of post-op/surgery follow up without reference to **hospitalization**, **admission** or **inpatient stay** doesn't imply a hospitalization and isn't considered evidence that the provider was aware of a hospitalization.
- A medication reconciliation on the discharge summary must be a complete reconciliation of the home medication list and the discharge medication list. A list of discharge medications alone isn't acceptable.

Quality Care Rewards (QCR) Application

Medication Reconciliation Post-Discharge (MRP) is the only component that's available for attestation in the QCR application. To assist providers with the TRC/MRP component, the QCR displays each discharge date for the member that's included in the measure. Attestation may be completed for each medication reconciliation in the list of discharge dates from the member's profile page.

Remember that each discharge listed requires a medication reconciliation.

Additionally, you can view a weekly list of your BlueCross Medicare Advantage plan patients who've been discharged and export the information from the QCR. We encourage practices to use this report to proactively address the medication reconciliation component for these discharges.

Additional MRP Component Coding Information and Tips

Patient Engagement after Discharge Administrative Codes

99495	› Initial contact with patient made within two business days of discharge › Moderate medical decision-making complexity › Can be billed with POS 02 OR the POS where the service would typically be provided with modifier 95	› Visit (generally face-to-face, but telehealth is approved by CMS during the national health emergency) within 14 days of discharge › Must be completed by a provider (MD, DO, NP or PA)
99496	› Initial contact with patient made within two business days of discharge › High medical decision-making complexity › Visit (generally face-to-face, but telehealth approved by CMS during the national health emergency) within seven days of discharge	› Can be billed with POS 02 OR the POS where the service would typically be provided with modifier 95 › Must be completed by a provider (MD, DO, NP or PA)
1111F	› Discharge medications reconciled with the current medication list in outpatient medical record within 30 days of discharge › Can be completed by RN, clinical pharmacist, NP, PA, DO or MD › If completed by an RN or clinical pharmacist, 1111F can be billed with CPT 99201 or 99211	› If completed by a practitioner, choose the E/M code that best describes the call considering problem-focused history and medical decision-making complexity › Can be billed with POS 02 OR the POS where the service would typically be provided with modifier 95

Supplemental Data Collection

Information for the **Notification of Inpatient Admission (NIA)** and **Receipt of Discharge Information (RDI)** components of the TRC measure are only collected and reported by BlueCross staff during the annual supplemental data collection project.

Practices not participating in the supplemental data collection project must submit medical record documentation for the NIA and RDI measure components to receive credit for these components. Records submitted must include practice contact information, documentation from the outpatient medical record with patient identifying information on each page and evidence of the date(s) that inpatient admission and/or discharge notifications were received. Records may be submitted by fax to **1-866-636-0162**, attention Angela Booze.

For more information about Supplemental Data Collection, please refer to page 40 of our Quality+ Partnerships 2023 Quality Program Information Guide located at:

https://www.bcbst.com/docs/providers/quality-initiatives/Quality_Partnerships_Program_Guide.pdf.

We're Right Here

For more information on the Transitions of Care (TRC) measure, please contact a member of our Provider Quality Outreach or Supplemental Data Collection Team.

Trey Brown

Supervisor, MA Provider Quality Outreach, East Region

(423) 486-8796
TreyB_Brown@bcbst.com

Natasha Brasher

Supervisor, MA Provider Quality Outreach, Middle/West Region

(423) 535-8102
Natasha_Brasher@bcbst.com

Angela Booze, RN, BSN

Supervisor, Clinical Quality Assurance

(901) 356-5967
Angela_Booze@bcbst.com

Julie Mason, MSSW, LAPSW, CCM

Manager, MA Provider Engagement and Outreach

(423) 618-2562
Julie_Mason@bcbst.com

PED-10_23PED2056902 (04/23)