Coding Reference Guide Measurement Year 2023
Transitions of Care (TRC)

Measure Description

The percentage of discharges for Members 18 years of age and older who had each of the following:

1. **Notification of Inpatient Admission:** Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days). Reporting for this indicator is by medical record review only; no administrative (claims) reporting is available.
2. **Receipt of Discharge Information:** Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days). Reporting for this indicator is by medical record review only; no administrative (claims) reporting is available.
3. **Patient Engagement After Inpatient Discharge:** Documentation of patient engagement (i.e., office visits, visits to the home, telehealth) provided within 30 days after discharge. Reporting for this indicator can be a claim or medical record review.
4. **Medication Reconciliation Post-discharge:** Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). Reporting for this indicator can be a claim or medical record review.

Definitions

Medication Reconciliation: A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.

Medication List: A list of medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications, and herbal or supplemental therapies.

Event/Diagnosis: An acute or nonacute inpatient discharge on or between January 1, 2023 and December 1, 2023. To identify acute and nonacute inpatient discharges:

- Identify all acute and nonacute inpatient stays
- Identify the discharge date for the stay

The denominator for this measure is based on discharges, not on Members. If Members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Identifying the Medical Record: Documentation in any outpatient medical record that is accessible to the PCP or ongoing care provider is eligible for use in reporting.

Notification of Inpatient Admission

Documentation of receipt of notification of inpatient admission on the day of admission or on the day of admission through two days after the admission (three total days).

Administrative (claims)

Administrative reporting is not available for this indicator.

Medical Record

Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days). Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received. Any of the following examples meet criteria:

- Communication between inpatient providers or staff and the Member's PCP or ongoing care provider (i.e., phone call, email, fax)
- Communication about admission between emergency department (ED) and the Member's PCP or ongoing care provider (i.e., phone call, email, fax)
- Communication about admission to the Member's PCP or ongoing care provider through a health information exchange or an automated admission, discharge, transfer (ADT) alert system
- Communication about admission with the Member's PCP or ongoing care provider through a shared electronic health record (EHR) system
    - When using a shared EHR system, documentation of a "received date" is not required to meet criteria
    - Evidence that the information was filed in the EHR and is accessible to the PCP or ongoing care provider on the day of admission through two days after the admission (three total days) meets criteria
- Communication about admission to the Member's PCP or ongoing care provider from the Member's health plan
- Indication that the Member's PCP or ongoing care provider admitted the Member to the hospital
- 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 tests and treatments any time 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 time frame that the planned inpatient admission must be communicated is not limited to the day of admission through two days after the admission (three total days)—documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria
    - The planned admission documentation or preadmission exam must clearly pertain to the denominator event

Notes:

- When an ED visit results in an inpatient admission, notification that a provider sent the Member to the ED does not meet criteria—evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria
- The following notations or examples of documentation do not count as numerator compliant:
  - Documentation that the Member or the Member's family/caregiver notified the Member's PCP or ongoing care provider of the admission or discharge
  - Documentation of notification that does not include admission and discharge dates or the date when the documentation was received in your office

Receipt of Discharge Information

Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days).

Administrative (claims)

Administrative reporting is not available for this indicator.

Medical Record

Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days). Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received. Any of the following examples meet criteria:

- Communication between inpatient providers or staff and the Member's PCP or ongoing care provider (i.e., phone call, email, fax)
- Communication about admission between ED and the Member's PCP or ongoing care provider (i.e., phone call, email, fax)
- Communication about admission to the Member's PCP or ongoing care provider through a health information exchange or an automated ADT alert system
- Communication about admission with the Member's PCP or ongoing care provider through a shared EHR system
  - When using a shared EHR system, documentation of a "received date" is not required to meet criteria—evidence that the information was filed in the EHR and is accessible to the PCP or ongoing care provider on the day of admission through two days after the admission (three total days) meets criteria
- Communication about admission to the Member's PCP or ongoing care provider from the Member's health plan
- Indication that the Member's PCP or ongoing care provider admitted the Member to the hospital
- 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 tests and treatments any time 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 time frame that the planned inpatient admission must be communicated is not limited to the day of admission through two days after the admission (three total days)—documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria
- The planned admission documentation or preadmission exam must clearly pertain to the denominator event

Notes:

- When an ED visit results in an inpatient admission, notification that a provider sent the Member to the ED does not meet criteria—evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria
- The following notations or examples of documentation do not count as numerator compliant:
  - Documentation that the Member or the Member's family/caregiver notified the Member's PCP or ongoing care provider of the admission or discharge
  - Documentation of notification that does not include admission and discharge dates or date when the documentation was received in your office

Patient Engagement After Inpatient Discharge

Documentation of patient engagement (i.e., office visits, visits to the home, or telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.

Administrative	
Outpatient Visit	**CPT:** 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 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, 99429, 99455, 99456, 99483
	HCPCS: G0402, G0438, G0439, G0463, T1015
	SNOMED: 30346009, 37894004, 77406008, 84251009, 185463005, 185464004, 185465003, 281036007, 439740005, 3391000175108, 444971000124105
	UBREV: 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0982, 0983

Telephone Visit	**CPT:** 98966, 98967, 98968, 99441, 99442, 99443
	SNOMED: 185317003, 314849005, 386472008, 386473003, 401267002
Transitional Care Management Services	**CPT:** 99495, 99496
E-visit or Virtual Check-in	**CPT:** 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99457, 99458
	HCPCS: G0071, G2010, G2012, G2061, G2062, G2063, G2250, G2251, G2252

Medical Record

Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any of the following meet criteria:

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

Note:

If the Member is unable to communicate with the provider, interaction between the Member's caregiver and the provider meets criteria.

Medication Reconciliation Post-discharge

Administrative	
Medication Reconciliation Encounter	**CPT:** 99483, 99495, 99496
Medication Reconciliation Intervention	**CPT-CAT-II:** 1111F (Discharge medications reconciled with the current medication list in outpatient medical record)
	SNOMED: 430193006, 428701000124107

Medical Record

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 (i.e., 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
- 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
    - Evidence that the Member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the Member's hospitalization or discharge
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record
    - There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days)
- Notation that no medications were prescribed or ordered upon discharge

Notes:

- A medication reconciliation performed without the Member present meets criteria
- Documentation of "post-op/surgery follow-up" without a reference to "hospitalization," "admission", or "inpatient stay" does not imply a hospitalization and is not considered evidence that the provider was aware of a hospitalization

The following will exclude Members from this measure:	
Hospice Encounter During 2023	**HCPCS:** G9473, G9474, G9475, G9476, G9477, G9478, G9479, Q5003, Q5004, Q5005, Q5006, Q5007, Q5008, Q5010, S9126, T2042, T2043, T2044, T2045, T2046
	SNOMED: 183919006, 183920000, 183921001, 305336008, 305911006, 385765002
	UBREV: 0115, 0125, 0135, 0145, 0155, 0235, 0650, 0651, 0652, 0655, 0656, 0657, 0658, 0659
Hospice Intervention During 2023	**CPT:** 99377, 99378
	HCPCS: G0182
	SNOMED: 170935008, 170936009, 385763009
Patients who died any time during 2023	

Tips and Best Practices to Help Improve Performance

- Utilize the monthly Gaps in Care (GIC) report for a list of MVP Members who need services
- Encourage billing staff to use CPT Category II codes which are intended to facilitate the collection of information about the quality of care delivered by coding specific services or test results that support performance measures
    - CPT-CAT-II codes will lessen the need for record abstraction and chart review and minimize the administrative burden
- Consider utilizing alerts or flags within the EHR
- Document medical/surgical history and preventive care in the medical record, include dates and results
- Submit all results to your local Regional Health Information Organization (RHIO)
- Use correct diagnosis and procedure codes and submit claims and encounter data in a timely manner
- Establish the following office practices to inform Members that it is important for your office to be aware of their hospital admissions and discharges to improve care coordination and maintain patient safety:
    - Ensure that your patient records are updated with current medications, treatments, test results, referrals, and discharge plans
    - Establish an office culture that prioritizes daily review of local RHIOs for patient information related to hospital admission and discharge
    - Establish relationships with hospitals in your region that will review admissions and discharges with office staff

Tips and Best Practices to Help Improve Performance (cont.)

- Have a clear understanding of medical record requirements:

  Inpatient Admissions
  - Show evidence of receipt of information through dated emails, faxes, phone encounters, ADI alerts, etc.
  - Include the date of admission, facility name, reason for admission, and providers of hospital care

  Discharge Information
  - Clear evidence in the medical record that the discharge occurred as well as details of the hospital stay, available and pending test results, treatments, new and discontinued medications, referrals, discharge orders, and instructions to the patient about follow-up care and appointments
  - Include names of hospital care providers and discharge diagnosis vs. the admission diagnosis

  Patient Engagement
  - Member engagement following hospitalization has shown to reduce readmissions
  - Documentation should include a reference to post-hospital discharge follow-up and include admission, discharge, and follow-up details.
  - The day of discharge cannot be counted for the Patient Engagement indicator

  Medication Reconciliation
  - Documentation in the medical record must indicate that a prescribing provider, clinical pharmacist, physician assistant, or registered nurse reconciled the most current medication list with the discharge medication list