Transitions of Care (TRC)

2025

Members ages 18 and older **MEDICARE**

Measure definition

Members who had a discharge and **each** of the following:

- **Notification of inpatient admission**
- **Receipt of discharge information**
- **Patient engagement after inpatient discharge**
- **Medication reconciliation post discharge**

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

Members who have more than one discharge include **all** discharges on or between January 1 and December 1 of the measurement year.

Medical record requirements

- Member legal name and date of birth
- Provider/practice identifier
- Provider Business Group (PBG) name and number
- Date of service (DOS)
- Applicable lab/test results and date collected

Commonly used claim codes*

(Not all-inclusive)

- Outpatient and telehealth: **98970, 99202, 99401, 99442**
- Transitional care: **99496**
- Medication reconciliation encounter or intervention: **99483**, **1111F**
- Medication reconciliation by pharmacist (procedure): **428701000124107**
- Medication reconciliation (procedure): **430193006**

Medical record submission methods may not be applicable to all plan types. For more details, you can reach out to your HEDIS plan representative.

Required exclusions (Other exclusions may also apply)

- **Members** anytime during the measurement year:
  - Who use hospice services or elect to use a hospice benefit
  - Who have died

Insights and recommendations

Notification of inpatient admission (NIA): Documentation in the outpatient medical record **must** include evidence of receipt of NIA **or** evidence that the information was integrated in the appropriate medical record **and** is accessible to the PCP or ongoing care provider **on the day of admission through 2 days after admission (3 total days)**

All medical record documentation **must** be accessible to PCP or ongoing provider; **examples include:**

- **Communication:**
  - Between inpatient provider/staff and PCP or ongoing provider
  - With PCP or ongoing provider about member being admitted through emergency department
  - About admission with PCP or ongoing provider through health insurance exchange **or** automated alert system
  - About admission with PCP or ongoing care provider through shared electronic medical record (EMR) including evidence that the information was integrated in the EMR
  - About admission with PCP or ongoing provider from Aetna®
- **Documentation:**
  - PCP or ongoing provider admitted member to hospital
  - Specialist admitted member to hospital **and** notified PCP or ongoing provider
  - PCP or ongoing care provider placed orders for tests and/or treatment during inpatient stay
  - PCP or ongoing care provider performed a preadmission exam or received information regarding a planned inpatient admission **is not** limited to the day of admission through 2 days after the admission. To meet criteria for a planned admission there **must** be documentation in the outpatient record showing:
    - PCP or ongoing care provider performed a preadmission exam **or**
    - PCP or ongoing care provider received notification of a planned admission **prior** to admit date

Planned admission documentation or preadmission exam **must** clearly pertain to the denominator event

Reminder: The patient's family notifying PCP or ongoing care provider of admission **does not** meet criteria.

Receipt of discharge information (RDI): Documentation in the outpatient medical record must include evidence of RDI **or** evidence that the information was integrated in the appropriate medical record **and** accessible to the PCP or ongoing care provider **on the day of discharge through 2 days after discharge (3 total days)**

- **Discharge information:**
  - May be included in, but not limited to, a discharge summary or summary of care record **or** located within structured fields of an electronic health record (EHR)

- **At a minimum, the discharge information must include all the following:**
  1. Member's practitioner responsible for inpatient stay
  2. Procedures and treatments provided
  3. Diagnoses at discharge
  4. Current medication list
  5. Testing results listed, pending tests or documented no test
  6. Instructions for patient care post discharge

Patient engagement (PE): PE post discharge by the PCP or ongoing care provider **must be performed within 30 days post discharge (30 days total)**

- **Documentation in the outpatient medical record can include:**
  - An outpatient visit, including office visits and home visits
  - Telephone visit
  - A synchronous telehealth visit using both audio and video
  - An e-visit or virtual check-in

  Do not include PE that occurs on date of discharge

Medication reconciliation (MRP): MRP **must** be performed **and** documented **on date of discharge through 30 days after discharge (31 total days)**

- Can be performed by the prescribing provider, clinical pharmacist, physician assistant, or RN
- Member **does not** need to be present
- **Must** be notated in the member's outpatient medical record **and must** include documentation of discharge MRP **with** current medication list as evidenced by:
  - **A list of current medications**:
    - With documentation that provider reconciled current and discharge medications
    - That references discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications)
    - With documentation that discharge medications were reviewed
    - With discharge medication list and documentation that **both** lists were reviewed on same date of service
    - With documentation in discharge summary that discharge medications were reconciled (must have evidence that discharge summary was filed in member's outpatient chart on date of discharge through 30 days after discharge)
    - With evidence a member was seen for a follow-up hospital visit and evidence of medication reconciliation and review
  - **A notation**: That no medications were prescribed **or** ordered upon discharge
- **The following examples** (without a reference to "hospitalization," "admission" or "inpatient stay") **are not** considered evidence that the provider was aware of the member's hospitalization or discharge:
  - Documentation of "post-op/surgery follow-up"
  - Documentation only of a procedure that is typically inpatient (e.g. open-heart surgery)
  - Documentation indicating that the visit was with the same provider who admitted the member or who performed the surgery

*FOR COMMONLY USED CODES: Not a comprehensive list of codes.
For measures that require claims data only, we cannot accept supplemental data sources such as data feeds and medical record collection methods.

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The above information is not a complete list of services for this measure. For a complete list, please refer to the NCQA website at **NCQA.org**. HEDIS 2025 Volume 2: Technical Specifications for Health Plans by the National Committee for Quality Assurance (NCQA). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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