Care coordination

Transitions of Care (TRC)

Transitions of Care (TRC) Measure year (MY) 25 | Weight = 1 (with four component measures)

Overview

The TRC measure assesses instances of admission and discharge information delivered to a patient's physician, as well as evaluating patient engagement provided within 30 days after an acute or nonacute discharge on or between Jan. 1 and Dec. 1 of the measurement year for patients 18 years of age and older.

The TRC measure organizes patient care and follow-up activities after a hospital admission and discharge. There are four components that contribute to the TRC score, and each requires engagement from the primary care physician (PCP) within a certain period of time, as listed below.

- Notification of Inpatient Admission (TRC–NIA)
- Receipt of Discharge Information (TRC–RDI)
- Patient Engagement After Inpatient Discharge (TRC–PED)
- Medication Reconciliation Post-Discharge (TRC–MRP)

For all the components, take note if the patient is readmitted or transferred directly to an inpatient care setting within 30 days of discharge. In this event, use the first admission's admit date and the discharge date of the last discharge.

Exclusions

- Patients in hospice, using hospice services or receiving palliative care anytime during the measurement year
- Patients who died anytime during the measurement year
- Discharges occurring after Dec. 1 of the measurement year

Measure best practices

- Have processes in place with hospitals to facilitate sharing of admission and discharge information.
- Be aware of patients' inpatient stays and obtain timely discharge summaries.
- Review discharge summaries to ensure that the minimum required information is included.
- Have processes to accommodate scheduling appointments as close to the point of discharge as possible, ideally within seven days. If a patient cannot be seen within seven days, checking in with patients by telephone is highly encouraged.
- Ensure all notifications of admits or discharges are appropriately documented in patient charts and follow-up actions are conducted.

Notification of Inpatient Admission (TRC–NIA) MY25

Measurement period
January–December

Applicable data collection method
Medical record review only

Action needed for compliance
- In the patient's outpatient medical record, the PCP practice must document receipt of notification of inpatient admission on the day of admission or within the two following days (three days total).
- Evidence must include the date the documentation was received.

Service required
Documentation in the patient's outpatient medical record of the admission communications:
- Between inpatient providers or staff and the PCP or ongoing care provider
- Between the emergency department (ED) and the PCP
- From a health information exchange or an automated admission, discharge and transfer (ADT) alert system
- Through a shared electronic health record (EHR) for first system (received date is not required but must have been accessible to the PCP on the day of admission or within the two following days)
- From the patient's health plan

There are no procedure codes that can be submitted via claims to address TRC–NIA. Information is collected via health plan medical record review only.
- If an observation stay turns into an inpatient admission, the admit notification must be documented as being received on the admit date of the observation stay or within the two following days.
- For planned admissions, documentation of a preadmission exam or advance admission notification is acceptable and:
  - Must clearly apply to the admission event and include a time frame for the planned inpatient admission
  - Is not limited to the admit date or the two following days

There may be other indications in the outpatient medical record about the admission if:
- The PCP admitted the patient or ordered tests and treatments anytime during the patient's inpatient stay.
- A specialist admitted the patient and notified the PCP.
- There is documentation that the PCP performed a preadmission exam for—or received communication about—a planned inpatient admission.

Receipt of Discharge Information (TRC–RDI) MY25

Measurement period
January–December

Applicable data collection method
Medical record review only

Action needed for compliance
- PCP practice must document discharge receipt information on the day of discharge or within the two following days (three days total).

Service required
Documentation must include:
- Name and credentials of the physician or practitioner responsible for the patient'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 to the PCP or ongoing care provider for patient care

If using a shared EHR system, evidence that the information was filed in the EHR and accessible to the patient's PCP on the day of discharge or within the two following days meets criteria—and "received date" isn't required.

Patient Engagement After Inpatient Discharge (TRC–PED) MY25

Measurement period
January–December

Applicable data collection methods
Administrative and hybrid

Eligible population
Patients 18 years of age and older who were discharged from an inpatient facility

Service required
- Engagement must take place within 30 days of discharge.
- Engagement that takes place on the day of discharge is not measure compliant.
- Follow up with patients as soon as possible following an acute stay discharge to prevent readmission and ensure understanding of post-discharge instructions.
- Medication reconciliation can be performed on the day of discharge. If that has not happened, be sure to do so at the follow-up event.
- Patient engagement may be done via office, home or telehealth visit, including real-time, interactive audio/video visits and audio only.

Note: If a patient is unable to communicate, their PCP can interact with their caregiver for any reason, including setting up an appointment.

Medication Reconciliation Post-Discharge (TRC–MRP) MY25

MRP calculates the annual percentage of adult patients whose medications were reconciled within 30 days of discharge from hospitalization. Medication reconciliation is defined as a review in which discharge medications are reconciled with the most recent medication list in the outpatient medical record.

Measurement period
January–December

Applicable data collection methods
Administrative and hybrid

Eligible population
Patients 18 years of age and older who were discharged from an inpatient facility

Service required
Medications must be reconciled by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge up to 30 days after discharge (31 days total). However, follow-up with patients as soon as possible after discharge to avoid duplication or dangerous reactions is encouraged.
- Licensed practical nurses (LPNs) and other nonlicensed staff can perform the medication reconciliation, but it must be cosigned anytime in the measurement year by an approved provider.
- Medication reconciliation may be done via office, home or telehealth visit, including real-time, interactive audio/video visits and audio only.
- Medication name is required; dose, route and frequency are not but their inclusion is highly recommended.
- When patients are directly transferred to another facility, perform reconciliation for final discharge and document all medication reconciliations with a dated notation in outpatient medical records.

Documentation in the medical record must include:
- Reference to current and discharge medications
- Evidence of medication reconciliation or that no medications were prescribed upon discharge
- National Provider Identifier (NPI) of appropriate practitioner conducting the reconciliation
- The date the service was performed

Code	Definition
Patient Engagement After Inpatient Discharge	
98966, 98967, 98968, 99441, 99442, 99443, 99483	Telehealth visit (audio only)
99495, 99496	Transitional care management service
98969, 98970, 98971, 98972	Online assessments
Medication Reconciliation Post-Discharge	
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: • Cognition-focused evaluation, including a pertinent history and examination • Medical decision-making of moderate or high complexity • Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity • Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]) • Medication reconciliation and review for high-risk medications • Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s) • Evaluation of safety (e.g., home), including motor vehicle operation • Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on care-giving tasks • Development, updating or revision, or review of an advance care plan • Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups), shared with the patient and/or caregiver with initial education and support Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
99496 (Days 1–7 post-discharge)	Transitional care management services with the following required elements: • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge • Medical decision-making of high complexity during the service period • Face-to-face visit within seven calendar days of discharge
99495 (Days 8–14 post-discharge)	Transitional care management services with the following required elements: • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge • Medical decision-making of at least moderate complexity during the service period • Face-to-face visit within 14 calendar days of discharge
1111F (Within 30 days post-discharge*)	Discharge medications reconciled with the current medication list in outpatient medical record * The 30-day limit relates to the measure specifications, not to a time limit on when the code can be used. **Note:** NPI required in addition to CPT II code to close care opportunity.

Note: If transitional care management services codes are not applicable, submit CPT II code 1111F. Different codes will be required depending on when medication reconciliation is conducted. Refer to most recent coding information.

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