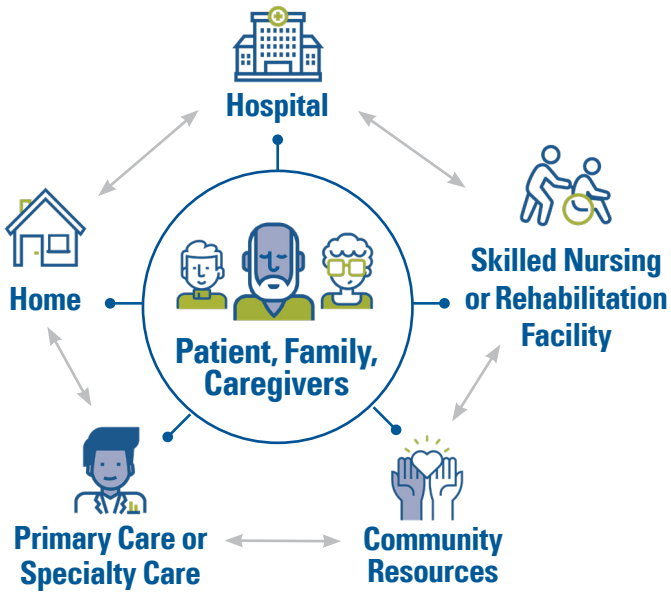
2024 Transitions of Care (TRC) Metric Description

PacificSource Medicare

A smooth transition following a hospital or skilled nursing facility (SNF) discharge improves patient outcomes and reduces adverse events and unnecessary readmissions. The Transitions of Care (TRC) metric tracks efforts by clinics to successfully transition patients from a hospital or SNF to their home, or to a different level of care.



What patients are included in the metric?

Adults with Medicare coverage age 18 and older who were hospitalized as inpatients for any reason (e.g., scheduled surgery, observation, or acute care) or who received SNF care. Patients who were in hospice care or who were deceased at any time during the measurement year are excluded.

What are the components of TRC?

These four components must be met and documented in the outpatient medical record to close the care gap:

1. **Notification of Inpatient Admission** — within 3 days including the day of admission
2. **Receipt of Discharge Information** — within 3 days including the day of discharge
3. **Patient Engagement After Inpatient Discharge** — within 30 days
4. Medication Reconciliation Post-Discharge — within 30 days

The chart on the next page outlines the components of the metric, including documentation requirements and billing opportunities (99495, 99496, 1111F, etc.).

Continued >

Transitions of Care Training from PacificSource

PacificSource has training available for your staff on the Transitions of Care metric. Ask your population health coach or strategist for more information.

Questions?

Contact the Population Health Team

PHPopulationHealth@PacificSource.com

Transitions of Care Metric Components

Component	Documentation (must be in outpatient chart notes)	Timing for Component	Who Can Perform	Coding/ Chart Audit
Notification of Inpatient Admission	Documented, date-stamped receipt of the notification of inpatient admission. Attach notification to patient's chart.	Within 3 days, including the day of admission	EMR/Health Information Exchange (HIE) notification, fax, telephone, EMR portal	Chart audit only
Receipt of Discharge Information	Documented, date-stamped receipt of notification of patient discharge and associated information in outpatient chart note. Attach notification to patient's chart.	Within 3 days, including the day of discharge	EMR/HIE notification, fax, telephone, EMR portal	Chart audit only
Patient Engagement/ Medication Reconciliation Within 7-14 days	Document contact with patient within 48 hours post-discharge. If you are unsuccessful at contacting the patient within 48 hours, document at least 2 attempts made during the first 48 hours post-discharge. Schedule patient for face-to-face visit within 14 days of discharge.	Within 48 hours after discharge — but not same day as discharge.	Clinical staff	Must contact patient within 48 hours if billing 99495 or 99496
	Provider conducts face-to-face visit, to include patient exam, medication reconciliation, and any care coordination needed. Document as follow-up to discharge.	Within 7 days	MD, DO, NP, PA	99496 (high complexity) or 99495 (moderate complexity) 1111F
	Provider conducts face-to-face visit, to include patient exam, medication reconciliation, and any care coordination needed. Document as follow-up to discharge.	Within 14 days	MD, DO, NP, PA	99495 1111F
Patient Engagement/ Medication Reconciliation 0-30 days	Schedule and conduct an e-visit, telephone, virtual or outpatient visit within 30 days. Document patient engagement and reconciliation of the discharge and outpatient medication lists. Include hospital discharge date and date medication reconciliation was performed in documentation.	Within 30 days	MD, DO, NP, PA, RN, or Clinical Pharmacist	1111F & bill (if applicable) per visit type/ provider scope and/or chart audit

Questions and answers

Can I bill for TRC?

Yes. Transitional Care Management (TCM) codes (99495, 99496) can be billed for Transitions of Care. These codes close the gap for the Patient Engagement and Medication Reconciliation components of the metric. The 1111F CPT II should be coded between days 15-30 to avoid chart review, but it can be coded with TCM codes to collect the $10 reimbursement.

Am I required to contact every patient post-discharge within 48 hours to meet the metric?

No. However, TCM billing requires that the patient be contacted within 48 hours.

What role can a Clinical Pharmacist or Nurse play in transitions of care?

A Clinical Pharmacist or Nurse can provide follow-up to an inpatient or SNF discharge, and perform medication reconciliation. Best practice for these visits includes coding 1111F. For TCM billing, a provider must conduct the visit.

Why shouldn't I bill an office visit, rather than TCM?

TCM codes capture and reimburse for extended work providers do for their patients as they transition from a hospital or SNF. For patients who need a lesser level of service (e.g., postsurgical admission), providers may choose to bill an office visit or conduct the post-discharge visit via telephone, patient portal, virtual, or e-visit. Clinical Pharmacists and Nurses may also conduct follow-up in these situations.

What are some TRC workflow best practices?

- Timing is key with this metric. Use the PointClickCare (formerly Collective Medical) platform to identify when patients are admitted to and discharged from the hospital. If your clinic is not currently using the PointClickCare platform, contact your strategist or coach. Hospital portals may also be used to identify when patients are admitted and discharged.
- The PointClickCare platform can identify when a patient is discharged to a SNF. Contact the SNF and establish communication so you are notified when they discharge the patient.
- Streamline your workflows by designating staff to monitor the transitions of care process, including daily PointClickCare review and patient scheduling.
- Ensure the correct documentation in the outpatient chart is in place:
  - Document admissions and discharges with receipt date-stamped. Acknowledge receipt from PointClickCare or other patient event notifications.
  - Be sure discharge information is in the chart, including inpatient or SNF responsible provider; procedures, treatments, and tests received (results and/or pending); diagnosis at discharge; and current medications. Attach discharge summaries to the outpatient chart.
  - Document contact with patient within 48 hours of discharge.
  - Document follow-up, including patient engagement and medication reconciliation.

Pathways to Success: The Transitions of Care Metric – Medicare Stars

PacificSource Medicare

Patient admitted to a hospital or skilled nursing facility (SNF) for any reason

→ Primary Care Provider (PCP) notified of hospital or SNF admission within 3 days, including day of admission → Electronic Medical Record (EMR), telephone, fax, or other notification with date stamp in record → **Metric Component 1 (Chart Audit)**

Patient discharged from hospital or SNF

→ PCP notified of hospital or SNF discharge within 3 days, including day of discharge → EMR, telephone, fax, or other notification with date stamp in record → **Metric Component 2 (Chart Audit)**

Patient engagement

Three pathways to meet the metric

1. **Is it within 7 days of discharge?**
   - YES → **Clinical Staff:** Contact patient within 48 hours to coordinate care and schedule face-to-face visit within 7 days of discharge[1] → **MD, DO, NP, PA:** Provider conducts visit to include patient exam, medication reconciliation,* and any care coordination needed. Document as follow-up. → **Moderate or high complexity visit?**
     - High → Consider billing TCM 99496[2]
     - Moderate → Consider billing TCM 99495[2]
   - NO ↓

2. **Is it within 14 days of discharge?**
   - YES → **Clinical Staff:** Contact patient within 48 hours to coordinate care and schedule face-to-face visit within 14 days of discharge[1] → **MD, DO, NP, PA:** Provider conducts visit to include patient exam, medication reconciliation,* and any care coordination needed. Document as follow-up.
     - After 7 days, can only code for moderate complexity
   - NO ↓

3. **Schedule and conduct an e-visit, telephone, virtual, or outpatient visit within 30 days**[3,4] → **MD, DO, NP, PA; RN or PharmD:** Provider, RN, or PharmD conducts visit to include any care coordination needed and medication reconciliation.* Document as follow-up. → **Code 1111F and bill (if applicable) per visit type/provider scope**

Metric Components 3 & 4 (Billing and/or Chart Audit)

STOP

*Medication reconciliation can be completed by an RN or PharmD ahead of the provider visit. Use the 1111F code to ensure compliance outside of a TCM visit.

[1] Moderate- or high-complexity (respectively) decision-making required if billing 99495 or 99496. Document at least two outreach attempts.

[2] Providers should use their best judgment and knowledge when billing Transition Care Management (TCM) Codes. Medication reconciliation is included in TCM codes.

[3] Metric can be met by chart audit only, but compliance is more difficult to achieve.

[4] Providers may consider this pathway for low-acuity and/or post-surgical patients, or if opportunity for TCM is lost.

Further reading: See AAFP's "Building a Financially Sustainable Transitional Care Management Workflow" at https://PacSrc.co/aafp-tcm