2026 Star Measure Tips

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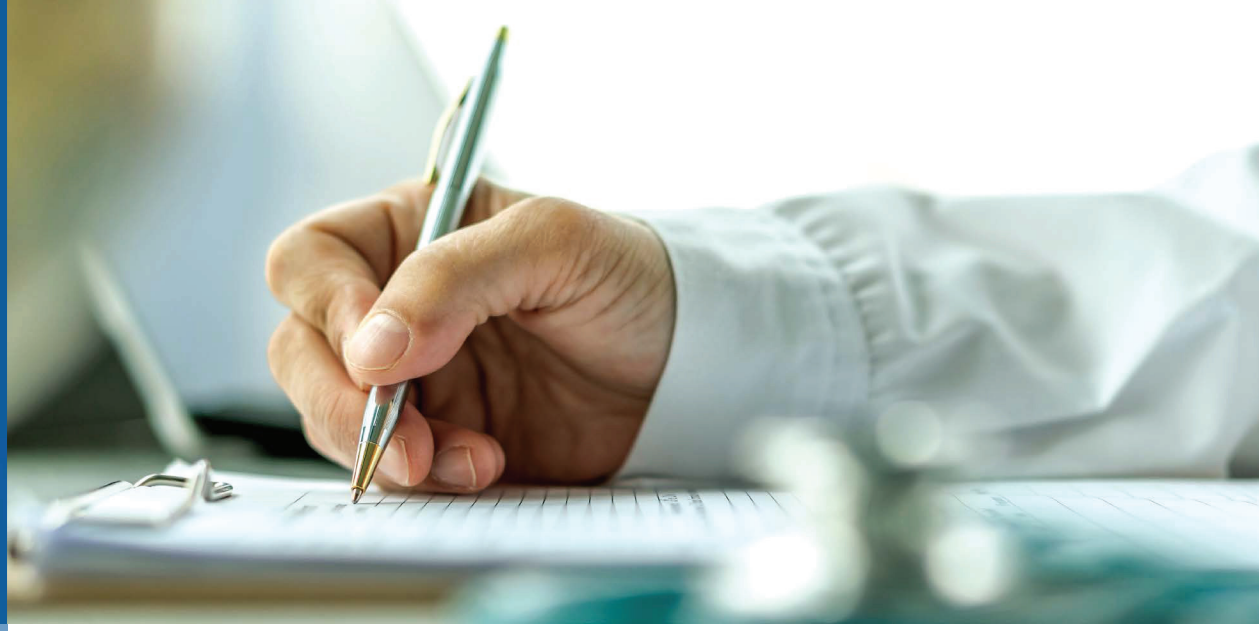

One in a series of tip sheets that look at key HEDIS® measures.

Transitions of Care (TRC)

Effectiveness of Care HEDIS® Measure

Measure description

Percentage of patients that received continuity of health care following an inpatient discharge.

Measure population (denominator)

Patients 18 years and older with an acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year.

Note: If patients have multiple discaharges, they could appear in the measure more than once.

Measure compliance (numerator)

Patients that had all four of the following components completed and documented in the outpatient medical record (see medical record requirements in table below).

1. Notification of inpatient admission (NOIA)
2. Receipt of discharge information (ROD)
3. Patient engagement after inpatient discharge (PE)
4. Medication reconciliation post-discharge (MRP)

Exclusions

- Received hospice services anytime during the measurement year
- Deceased during the measurement year

DID YOU KNOW?

- Inadequate care coordination and poor care transitions result in billions of unnecessary medical expenses.
- Transitions of care has emerged as an important point of vulnerability in the health care system where medical errors and clinical deterioration can occur.
- The period between discharge and first outpatient appointment is recognized as a vulnerable time for patients when adverse events can occur.
- Patients are unaware of how to seek help if a question arises or a new event occurs, leading to overuse of the emergency department.

continued

Helpful HEDIS hints

Documentation of all four components must be in the outpatient record and accessible to the PCP or managing specialist within the required timeframe:

Component	Criteria	Outpatient medical record requirements
1. Notifcation of inpatient admission	Receipt of notifcation of inpatient admission on the day of admission through two days after the admission (three days total). ***Note:*** *Can only be met through medical record review.*	Must include the date of receipt and any of the following criteria: • Communication from inpatient practitioner, hospital staff or emergency department regarding admission (phone call, email or fax). Referral to an emergency department does not meet criteria. • Documentation that the PCP or managing specialist admitted the patient, or a specialist admitted with PCP or managing specialist notification. • Communication about admission through a health information exchange: an admission, discharge and transfer alert system (ADT) or a shared electronic medical record (EMR) • Documentation indicating the PCP or managing specialist placed orders for tests and treatments any time during the patient's inpatient stay • Documentation of a preadmission exam or a planned admission prior to the admit date. The exam must reference the planned admission (not just pre-op or pre-surgical). • Communication from the member's health plan regarding admission ***Note:*** *Documentation the patient/caregiver notified the PCP or managing specialist of the admission does not count.*
2. Receipt of discharge information	Receipt of discharge information on the day of the discharge through two days after the discharge (three days total). ***Note:*** *Can only be met through medical record review.* • Can only be met through medical record review • Pay attention to discharge disposition and request the SNF/SAR discharge summary if indicated	Must include the date of receipt and all the following criteria: 1. The practitioner responsible for the patient's care during the inpatient stay 2. Procedures or treatment provided 3. Diagnoses at discharge 4. Current medication list 5. Testing results, documentation of pending tests or documentation of no tests pending 6. Instructions for patient care post discharge ***Note:*** *Documentation the patient/caregiver notified the PCP or managing specialist of the discharge does not count.*

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Component	Criteria	Outpatient medical record requirements
3. Patient engagement after inpatient discharge	Patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.	Must include the date of engagement with any of the following criteria: • An outpatient visit including office visits and home visits • Virtual care visits (asynchronous or synchronous) • Documentation indicating a conversation occurred with the patient, regardless of practitioner type. For example, medical assistants and registered nurses may perform the patient engagement. • Interactions between the patient's caregiver and practitioner
4. Medication reconciliation post-discharge	Medication reconciliation completed on the date of discharge through 30 days after discharge (31 days total). • Must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse. Other staff members (e.g., MA or LPN) may conduct the medication reconciliation, but it must be signed off by the required practitioner type. • Must be in the outpatient medical record, but an outpatient face-to face visit is not required • Documentation of "post-op/ surgery follow-up" without a reference to "hospitalization," "admission," or "inpatient stay" does not count.	Must include the date performed AND specific documentation of inpatient hospitalization with any of the following criteria: • Current medication list with a notation that the practitioner reconciled the current and discharge medications • Current medication list with reference to discharge medications (e.g., no changes in meds post discharge, same meds at discharge, discontinue all discharge meds, discharge meds reviewed) • Current medication list and discharge medication list with evidence both lists reviewed on same date of service • Documentation of the current medications with evidence that the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review • Discharge summary medication list indicates reconciled with current meds. Must be filed in the outpatient record within 30 days after discharge. • Documentation that no medications were prescribed or ordered upon discharge

- Utilize Michigan Health Information Network's (MiHIN) admission, discharge, transfer (ADT) notifications to support TRC components. mihin.org/
- Request discharge summary from the inpatient facility when discharge ADT notification is received.
- Request discharge summary from SNF, SAR, etc. if indicated.
- You can reduce errors at the time of discharge by using the computer order entry system to generate a list of medication used before and during the hospital admission.
- Assess patient or caregiver comprehension of discharge instructions.
- Contact patients immediately following discharge to conduct medication reconciliation (e.g., over the phone if possible) and to schedule an appointment.

continued

Tips for coding

- TCM codes will satisfy both the Patient Engagement and Medication Reconciliation Post-Discharge components.
- Bill 1111F as soon as medication reconciliation is completed.
  - 1111F can be billed alone or with an associated visit.
  - Bill 1111F for $35 reimbursement for Medicare Plus Blue℠ and BCN Advantage.

    Note: *There is no member cost share associated with 1111F for Medicare Plus Blue or BCN Advantage.*
- TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period.

CPT® II code	Description
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.
CPT® codes	**Description**
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least moderate complexity and a face-to-face (in-person or audio/video telehealth) visit within 14 days of discharge.
99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least high complexity and a face-to-face (in-person or audio/video telehealth) visit within seven days of discharge.

Note: *In addition to the Care Planning Service and TCM codes above, there are several additional codes that will satisfy the patient engagement component of TRC.*

Resources

1. National Committee for Quality Assurance (NCQA). 2023. "Transitions of Care (TRC)." ncqa.org/hedis/measures/transitions-of-care/
2. National Institutes of Health (NIH). 2016. "Focusing on Transitions of Care: A change is here." ncbi.nlm.nih.gov/pmc/articles/PMC5720617/

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