Best Practices and Coding to Accurately Capture Follow-up Visits for Transitions of Care (TRC) and Follow-Up After Emergency Department Visit for People with Multiple High Risk Chronic Conditions (FMC) HEDIS Measures

For Medicare Advantage patients, following up with a provider after a hospitalization or emergency department (ED) visit, especially when they have chronic medical conditions, is important. When a patient transitions from a healthcare setting (hospital, rehabilitation, skilled nursing facility or emergency room) to home, proper care coordination is vital to improve safety and reduce the chance of readmission.

The National Committee for Quality Assurance (NCQA) has developed two coordination of care measures in the Healthcare Effectiveness Data and Information Set (HEDIS®), Transitions of Care (TRC) and Follow-Up After Emergency Department Visit for People with Multiple High Risk Chronic Conditions (FMC).

Transitions of Care (TRC)

This measure assesses four key points for Medicare Advantage members ages 18 and older after discharge from an inpatient facility.

Notification of Inpatient Admission and Receipt of Discharge Information can ONLY complete care gap closure via medical record review. <u>The documentation in the medical record must contain the following information.</u>

1. Notification of Inpatient Admission – Documentation of receipt of notification on the day of admission through 2 days after the admission (3 total days).
    - *<u>OR</u>* documentation of a preadmission exam for a planned inpatient admission is acceptable.
2. Receipt of Discharge Information – Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
    - The discharge information must include ***<u>ALL</u>*** of the following topics
        - Practitioner responsible for patient's care during the stay
        - Procedures or treatment provided during the stay
        - Diagnosis at discharge
        - Current medication list
        - Documentation of test results, pending tests, or no tests completed
        - Patient instructions post discharge
3. Patient Engagement After Inpatient Discharge – Documentation of patient engagement provided within 30 days after discharge.
4. Medication Reconciliation Post-Discharge (MRP) – Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).
    - When documenting a medication reconciliation in the medical record please observe the following guideline: **<u>Documentation of "post op" and "routine follow up" *does not* qualify for compliant documentation.</u>**

Follow-Up After Emergency Department Visit for People with Multiple High Risk Chronic Conditions (FMC)

This measure assesses Emergency Department (ED) visits for Medicare Advantage members ages 18 and older who have two or more high-risk chronic conditions and who had a follow-up service within 7 days of an ED visit. Chronic conditions included in this measure are:

- Alzheimer's disease and related disorders
- Depression
- Atrial Fibrillation
- Heart failure
- Chronic kidney disease
- Myocardial infarction (acute)
- COPD and Asthma
- Stroke and Transient ischemic attack

Best Practices for These HEDIS Measures

- Educate members on ED avoidance and other care options like telehealth, telephone, or urgent care.
- Develop a daily notification or EMR work que process for members discharged from the ED or hospital.
- Embed support services into ED and schedule follow up appointments prior to discharge.
- Patient Engagement After Inpatient Discharge (TRC), Medication Reconciliation Post-Discharge (TRC) and Follow-Up After Emergency Department Visit (FMC) can be completed via an office, home, telehealth, or telephone visit.
- If a member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets the criteria for both Patient Engagement After Inpatient Discharge and Medication Reconciliation Post-Discharge for TRC.
- Medication Reconciliation Post-Discharge can be added to your claim submission or accepted as supplemental data for TRC. Contact your Medical Mutual provider representative to discuss data exchange opportunities.

Use the below HEDIS CPT codes to document follow-up visits for TRC Patient Engagement, TRC Medication Reconciliation Post-Discharge, and Follow Up After an Emergency Department Visit.

Measure	Opportunity	Code System	Code Set**
TRC FMC	Transitional Care Management ▪ Patient Engagement After Inpatient Discharge ▪ Medication Reconciliation Post-Discharge ▪ 7-day Follow-up	CPT	99495, 99496
TRC	Medication Reconciliation Post-Discharge	CPT	99483, 1111F
TRC FMC	Outpatient and telephone visits ▪ Patient Engagement After Inpatient Discharge ▪ 7-day Follow-up ▪ Behavioral Health outpatient and telehealth visits	CPT	99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99401, 99402, 99403, 99404, 99441, 99442, 99443

For the TRC and FMC measures, any members in hospice are excluded from reporting.

**This is not an all-inclusive list of the value sets codes for TRC and FMC measures.

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Medical Mutual Programs and Resources

We offer programs and resources that can help support you and Medical Mutual Medicare Advantage members that have chronic health conditions.

- **Case Management -** Offers help and support with complex medical needs. Is available for both medical and behavioral health conditions. Provider referral: Medicare Advantage Case Management referral: 1-855-887-2273 or CaseMgmt-MedAdv@medmutual.com.
- **Transitional Care -** Options for certain members to receive health coaching and support for follow-up care after a hospital stay. Members are identified through internal process.
  - Return to Home Telephonic Program
  - In-Home/Telephonic Program administered by Area Agency on Aging
- **In-Home Palliative Care -** You can refer a member to the palliative care program by emailing PopHealthSupport@medmutual.com with the member's name, date of birth and program you are recommending or members can self-refer, by calling toll free 1-844-232-0500.
- **24-hour/7 day-a-week Nurse Line -** available to answer members' questions and help to guide care, 1-888-912-0636.
- **Discharge Checklist -**A resource tool for members to ensure a smooth transition to home Discharge Checklist.docx

These recommendations are informational only. They are not intended to require a specific course of treatment or take the place of professional medical advice, diagnosis or treatment. Members should make decisions about care with their healthcare providers. Recommended treatment or services may not be covered. Eligibility and coverage depend on the member's specific benefit plan.

None of the information included in this article is intended to be legal advice. It remains the provider's responsibility to ensure that all coding and documentation are done in accordance with applicable state and federal laws and regulations.