Hospital measures key highlights

Follow-up after emergency room visits for high-risk multiple chronic conditions (FMC)

Administrative measure

- Schedule patients within 7 days post-discharge for face-to-face, virtual, phone or online visit
- Members with 2+ chronic conditions who have an emergency department discharge are included in the measure. Conditions are identified by 2 outpatient or 1 inpatient discharge in the past year. Conditions included in the measure are COPD/asthma, Alzheimer's disease and related disorders, chronic kidney disease, depression, heart failure, acute myocardial infarction, atrial fibrillation, stroke and transient ischemic attack.

Transitions of Care – Notification of Admission and Receipt of Discharge (TRCRA/TRCRD)

Chart chase measure

- Include **Notification of Admission** and **Receipt of Discharge** information in the outpatient medical record. Show proof of notification of admission and discharge information from the day of admission until 2 days after (a total of 3 days).
- Include date you received the documentation by phone, fax or email
- At a minimum, the discharge information must include the following:
  - The practitioner responsible for the member's care during the inpatient stay
  - Procedures or treatment provided
  - Diagnoses at discharge
  - Current medication list
  - Testing results, documentation of pending tests or no tests pending
  - Instructions for patient care post-discharge

Transitions of Care – Patient Engagement and Medication Reconciliation Post-Discharge (TRCPE/TRCMRP)

Hybrid measure

- Patient Engagement and Medication Reconciliation have a 30-day compliance window
- Patient engagement can include any of the following visits:
  - Outpatient (office or home)
  - Phone
  - E-visit or virtual check-in
  - Telehealth
- Use transitional care management CPT® codes (e.g., 99495 and 99496)
- Use the Transitions of Care Management **Worksheet**
- A prescribing practitioner, clinical pharmacist, physician assistant or registered nurse must conduct medication reconciliation

Plan All-Cause Readmissions (PCR) measure

- Administrative only/risk adjusted utilization measure
- Formula-based observed rate (admits/readmits) and expected rate (clinical comorbidities)
- Requires 2 claims for observed rate (admit/readmit)
- Requires ongoing documentation of hierarchical category conditions (HCC)

Please help members avoid readmission by:

- Following up with them within 1 week of their discharge
- Making sure they filled their new prescription post discharge
- Implementing a robust, safe discharge plan that includes a post-discharge phone call to discuss questions
- Ensure all conditions are appropriately identified in the patient's medical record and claims

Tips and best practices

Add CPT/CPTII codes (e.g., 1111F, 99483, 99495, 99496) to the claim when you submit patient engagement post-hospitalization documentation.

Document and load **Notification of Admit and Receipt of Discharge** into the EMR or in the patient's chart.

Patients with multiple comorbidities are expected to return post-inpatient or observation discharge at a higher rate. Identify all conditions in the patient's medical record and claim.

Use UnitedHealthcare Practice Assist, Point of Care Assist (reports **daily** to identify members who have been admitted or discharged).

Schedule hospital and emergency room follow-up office visit or telehealth within **7 days** of discharge. Help ensure patients are filling their new prescriptions post-discharge.

Schedule office visits for high-risk chronic condition patients **quarterly.**

Example of common issues with 3 hospital measures

Mrs. Martinez* is elderly and has multiple chronic conditions. She still believes she can live by herself at home. During the pandemic, her health has dramatically declined.

* Not an actual patient. For illustrative purposes only. Stock photo used.

- Mrs. Martinez was recently discharged from the hospital. In the past year, she has also had 30 emergency department discharges and 2 inpatient admissions with 1 of the admissions resulting in a readmission within 30 days.
- As a result of Mrs. Martinez's hospitalizations, she is identified in the denominator for all 3 hospital measures. She schedules an appointment with her primary care provider (PCP) only after inpatient visits and rarely receives a call after her emergency discharges.
- In addition to her hospitalization concerns, Mrs. Martinez is on 25 medications. She lives alone and has a high risk for falls. She has some food insecurity and relies on public transportation to help her get to medical appointments.
- Mrs. Martinez's documentation shows most of her conditions. However, there are some previously coded conditions (COPD, protein malnutrition) which are currently not assessed. This lack of assessment can cause challenges when Mrs. Martinez shares her illnesses with pharmacists, RNs or other medical professionals. She may not receive all the care she needs.
- Mrs. Martinez has completed a HouseCalls visit, but she doesn't have an after-care plan. She is not aware of urgent care and is not sure who will answer after hours at her PCP's office. Therefore, her solution is to call 9-1-1.
- There is evidence in the PCP record they are aware of Mrs. Martinez's discharge and have received both the Notification of Inpatient Admission and received her discharge summary. There is no stamp when the discharge summary was placed in her chart. Her insurance received a claim for her post-hospital patient engagement, but there was no coding to show a medication reconciliation was completed.

Learn more about clinical use cases for telehealth, training resources for health care professionals and staff, coding, billing and reimbursement information, general tips and best practices at **UHCprovider.com/training**. Find quality measurement programs and tools used to address care opportunities, as well as how to report data and related billing codes at **UHCprovider.com/training.**

PCA-1-24-00743-Clinical-QRG_04172024

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