Quality Spotlight 2026

Transitions of Care (TRC)
Medication Reconciliation Post Discharge (TRC-M)

18 years or older of Medicare Advantage Population:
BCBSM MAPPO, BCNA HMO, HAP MA, Priority Health MA, Humana MA
Including Traditional Medicare Scorecard for ACO Reach

Transitions of Care (TRC)

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

- Ages: 18 years and older
- Acute or Non acute inpatient discharge
- January 1 – December 1 discharge date
- If patients have multiple discharges, they could appear in the measure more than once.

Patients 18 and up that are discharged from an inpatient setting must have 'engagement,' a medication reconciliation, and documentation of all the things!

Measure Compliance Requirements:

1. **Notification** of inpatient admission
    a) Documented in the medical record
2. **Receipt** of discharge information
    a) Documented in the medical record
3. **Patient engagement** after inpatient discharge
    a) See timing on following slides
4. **Medication reconciliation** post-discharge
    a) 1111F

Exclusions

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

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1. Notification of Inpatient Admission

Receipt of notification of the inpatient admission
ON THE DAY OF ADMISSION
through two days after the admission

Outpatient Medical Record Requirements –

MUST INCLUDE **DATE OF RECEIPT** & ANY OF THE FOLLOWING

- **Documentation** of the communication (phone call, email, fax) from hospital staff or ED regarding admission.
- **Documentation** of admission by PCP or SPC w/ PCP notification
- **ADT Notification**
- **Documentation** of PCP or managing SPC for test or treatment orders during the patient's inpatient stay
- **Documentation** of a preadmission exam or planned admission specific to the admit
- **Communication** from the member's health plan regarding admission

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2. Receipt of Discharge Information

Receipt of discharge information
ON THE DAY OF THE DISCHARGE
through two days after the discharge

Outpatient Medical Record Requirements –

MUST INCLUDE **DATE OF RECEIPT** & **ALL** OF THE FOLLOWING

- **Practitioner** responsible for the patient's care during the inpatient stay
- **Procedures** or treatment provided
- **Diagnosis** at discharge
- **Current** medication list
- **Testing** results, documentation of pending tests or documentation of no tests pending
- **Instructions** for patient care post discharge

Transitions of Care(TRC)

3. Patient Engagement After Discharge

Patient engagement provided after discharge

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

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- Acute or Non acute inpatient discharge
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TIMING for Engagement Visit-Claims close measure

- **Quality Measure**: 30 days
  - Do not include visits on the day of discharge
- **Transitional Care Management**:
  - Include the day of discharge as day 1 for the 7–14-day codes
  - Remembering you cannot close the quality measure on day 1, which is the day of discharge.
    - 7 days for high complexity – 99496
    - 14 days for moderate complexity – 99495

2026 HONEST/GLPO Joint Venture Scorecard: Patients seen within 14 days, while using either of the above codes appropriate for the patient's complexity. (See also TFU Quality Measure)

Transitions of Care(TRC)

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3. Patient Engagement After Discharge

Patient engagement provided after discharge

Outpatient Medical Record Requirements –

MUST INCLUDE **DATE OF ENGAGEMENT** & ANY OF THE FOLLOWING:

- **Outpatient Visit** including office visits and home visits
- **Virtual care visits** (audio/video)
  - Audio calls if appropriate & meets requirements
- **Documentation** indicating a **live conversation occurred** with the patient, regardless of practitioner type.
  - MA and RN may perform the patient engagement
- **Interactions** between the patient, patient's caregiver and practitioner.

Medication Reconciliation Post-Discharge (TRC-M)

Percentage of patients who had their medications reconciled following an inpatient discharge

- Ages: 18 years and older
- Acute or Non acute inpatient discharge
- January 1 – December 1 discharge date
- If patients have multiple discharges, they could appear in the measure more than once.

4. Medication Reconciliation Post-Discharge

Medication reconciliation completed on the date of discharge through 30 days after discharge (31 days total)

REQUIREMENTS FOR MEDICATION RECONCILIATION

- **Prescribing Practitioner:** clinical pharmacist, physician assistant, registered nurse
  - Other staff (MA, LPN, etc.) may conduct the medication reconciliation, but it must be signed off by the required licensed practitioner type.
- **Medical Record** documentation is required, 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**

Exclusions

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

Medication Reconciliation Post-Discharge (TRC-M)

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

- Ages: 18 years and older
- Acute or Non acute inpatient discharge
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4. Medication reconciliation post-discharge

Medication reconciliation completed on the date of discharge through 30 days after discharge (31 days total)

Outpatient Medical Record Requirements –

MUST INCLUDE **DATE PERFORMED** & ANY OF THE FOLLOWING:

- **Current medication list:**
  - With notation that the practitioner **reconciled the current against discharge medications**
  - **Reference to discharge medications** (e.g., no changes in meds post discharge, same meds at discharge, discontinue all discharge meds, discharge meds reviewed)
  - And discharge medication list with evidence both lists reviewed on the same date of service
  - **Documentation that no medications were prescribed or ordered upon discharge**.

Medication Reconciliation Billing

- Bill 1111F as soon as completed
  - Best not to wait until end of 30-day TCM period
  - Can be billed with $0.01 code
  - This avoids the potential to lose gap closure if patient does not come in for scheduled TCM visit or other visit
- Can be billed WITHOUT or WITH an associated visit
- Can be billed with TCM codes
  - This is the best way to ensure credit is received

Patient Engagement When Patients Can't or Will Not Come in For Scheduled Appointments

How do I know best if a patient needs TCM billing in 7-14 days, E&M billing in 15-30 days, or Phone Call billing 2-30 days follow up?

- **Who needs a 7-day TCM Appt?**
  - All high-risk patients-All Payers
- **Who needs a 14-day TCM Appt?**
  - All moderate risk patients-All Payers
- **Who can be seen with an E &M provider office visit 15-30 days?**
  - Patients that you cannot get scheduled within 7-14 days.
  - Low risk patients.
    - Other considerations:
      - Those who cancelled or did not show up for their scheduled 7–14-day appt. (Any risk)
      - Those that are not feeling strong enough after admission to come in 7-14 days.
        - However, those patients should be strongly encouraged to have telehealth visit.
      - Those who cannot make it to the practice due to ride issues or other challenges.
        - Consider performing NDOH screenings on any patient that has missed more than one provider appointment. (Not just screening at their yearly physical or AWV). These routinely missed appointments are likely to have a substantial reason.

Who Qualifies for Phone Call Follow-up After Admission?

- Patients who absolutely refuse to be seen in the office. (7,14, or 30 days)
- Patients who routinely miss/cancel appointments.
- Simple surgeries-Patients are likely to decline PCP follow up due to seeing their surgeon.
    - Keep in mind simple surgeries have big impacts for older patients, especially with other chronic conditions, on multiple medications and are high risk for readmission. These patients really need to be seen within 7-14 days by a provider.
- Which payers
    - BCBSM Commercial/MAPPO & BCN Commercial & BCNA(HMO). FFS Medicare within guidelines.

The RN, LPN, LMSW, CHW or MA, trained in care mgt, can perform follow-up and bill the phone codes

- Original 48 hr. follow-up phone call will count if it is not on the same date as the discharge.
- If you know patient is not coming into the office for a visit within 30 days.
  - Go ahead and bill appropriate phone code as well as med rec at the time of the call. As the patient is not expected to come into the practice for follow up. (MA cannot bill the med rec)
- Designate a staff person to weekly review post discharge billings to go back and bill phone codes if the patient does not come in for a scheduled follow up appointment.
- Patient may not have cost share/copay/fee if you perform phone call follow up AND they are on the PDCM list/verified for PDCM coverage. (BCBSM, BCBSM-MAPPO, BCN, BCNA-HMO.)
- Phone codes for straight FFS Medicare will incur approximately 20% copay.

Note: If you are an ACO practice: Notifications via email from Honest Medical Group staff when a BCBSM MAPPO, BCNA and Medicare patient has missed the 7-14 day follow up appt for the practice to engage again with the patient prior to the 30-day period ending.

Phone Codes That Can be Utilized

RN, LPN, LMSW, MA, CHW, Trained in Care Mgt

98966: 5-10 minutes

98967: 11-20 minutes

98968: 21-30 minutes

MD, DO, NP & PA

99441: 5-10 minutes of medical discussion

99442: 11-20 minutes of medical discussion

99443: 21-30 minutes of medical discussion

TRC & TRC-M Resource Tool

Great Lakes

Transitional Care and Medication Reconciliation

Best practice to meet criteria is to bring in all patients in for a visit after discharge **within 30 days**. **MEETS PATIENT ENGAGEMENT MEASURE**
Clinical judgement dictates whether the patient is best served with a 7, 14, or within 30-day visit.

1111F Medication Reconciliation: Must be **within 30 days** of d/c. **MEETS MED REC POST DISCHARGE MEASURE**
*Must be documented that the discharge medications and the current medications were review and/or reconciled. *

99495: Transitional Care Management **• Moderate Complexity •** **• Visit within 14 Calendar Days •**	**99496: Transitional Care Management** **• High Complexity •** **• Visit within 7 Calendar Days •**	**E/M Visit: i.e., *99212-99215* with 1111F** **• Any Complexity •** **• within 30 days of discharge •** *If complexity or timeframe of TCM not met,* **STILL MEETS THE PATIENT ENGAGEMENT AND MED REC POST DISCHARGE MEASURES**

• Document
  ○ Date of notification of admit
  ○ Date of admit
  ○ Date of notification of discharge
  ○ Date of discharge
  ○ Discharge Information
  ▪ Inpatient practitioner responsible for the patient's care
  ▪ Procedures or treatment provided
  ▪ Diagnosis at discharge
  ▪ Current medication list
  ▪ Testing results, documentation of pending tests, or documentation of no test pending
  ▪ Instructions for patient care post discharge
• Contact the patient within **2 business days**
  ○ Document the contact (i.e., the phone call)
  ○ Med Rec can be done on the phone call by licensed clinical staff
• Provide an office visit or telehealth visit within 14 calendar days
  ○ Document visit
  ○ Med Rec can be done at this point if not completed during phone call or again
1111F can be used with TCM Codes
	• Document
	  ○ Date of notification of admit
	  ○ Date of admit
	  ○ Date of notification of discharge
	  ○ Date of discharge
	  ○ Discharge Information
	  ▪ Inpatient practitioner responsible for the patient's care
	  ▪ Procedures or treatment provided
	  ▪ Diagnosis at discharge
	  ▪ Current medication list
	  ▪ Testing results, documentation of pending tests, or documentation of no test pending
	  ▪ Instructions for patient care post discharge
	• Contact the patient within **2 business days**
	  ○ Document the contact (i.e., the phone call)
	  ○ Med Rec can be done on the phone call by licensed clinical staff
	• Provide an office visit or telehealth visit within 7 calendar days
	  ○ Document visit
	  ○ Med Rec can be done at this point if not completed during phone call or again
	1111F can be used with TCM Codes
		• Document
		  ○ Date of notification of admit
		  ○ Date of admit
		  ○ Date of notification of discharge
		  ○ Date of discharge
		  ○ Discharge Information
		  ▪ Inpatient practitioner responsible for the patient's care
		  ▪ Procedures or treatment provided
		  ▪ Diagnosis at discharge
		  ▪ Current medication list
		  ▪ Testing results, documentation of pending tests, or documentation of no test pending
		  ▪ Instructions for patient care post discharge
		• Contact the patient within 30 days
		(2 business days is still best practice)
		  ○ Document the contact (i.e., the phone call)
		  ○ Med Rec can be done on the phone call by licensed clinical staff
		• Provide an office visit or telehealth visit within 30 days of discharge
		  ○ Document visit
		  ○ Med Rec can be done at this point if not completed during phone call or again
		1111F must be used with E/M code to close gaps

BCBSM Commercial: $241.26 (before withhold & uplift) MAPPO and CMS rate: $192.73	BCBSM Commercial: $326.34 (before withhold & uplift) MAPPO and CMS rate: $261.36	BCBSM Commercial: $124.45 (before withhold & uplift) MAPPO and CMS rate: $120.84

Using any of these will meet the patient engagement portion of the Transitional Care Measure
BCBSM will accept claims for post hospital follow-up from a PCP even during a global surgery period.
Many patients need their medications reviewed and chronic conditions address more closely during this time.

Quality Spotlight 2026

Plan All Cause Readmission (PCR)

18 years or older of Medicare Advantage & Traditional Medicare Population:

BCBSM MAPPO, BCNA HMO, HAP MA, Priority Health MA, Humana MA, FFS Medicare

Plan All-Cause Readmissions (PCR)

Percentage of patients that were readmitted to the hospital within 30 days of discharge

- Ages: 18 years and older
- Acute inpatient or observation discharge
- January 1 – December 1 discharge date
- If patients have multiple discharges; they could appear in the measure more than once.
- Includes acute discharges from any type of facility

Number of patients who had an unplanned acute readmission for ANY diagnosis within 30 days following an acute discharge

- Keep open appointments on your schedules
- Reach out to schedule follow up appointments as needed
- Request patient brings all medication and supplements to the post-discharge visit
- Consider implementing weekly follow up phone calls for 30 days during TCM process
- Refer to in office Care Management or Honest's Enhanced Care Management (ECM) program during TCM process

Similar Quality Measures

To be reviewed at upcoming meetings

ACO REACH

- All cause readmission (ACR)
- Unplanned admissions for multiple chronic conditions (UAMCC)
- Timely follow up after acute exacerbation of multiple chronic conditions (TFU)

MSSP

- Hospital Wide, 30 day, All cause unplanned readmission


Questions