

Transition of Care Management

Transition of Care Management (TCM) includes services provided to a patient whose medical and/or psychosocial problems require moderate or high-complexity medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home, or assisted living).

Upon notification of an inpatient stay or discharge for a Medicare member:

1. Obtain discharge summary and medical records from facility
 - a. Document date of discharge in record
2. Contact member/caregiver to provide assessment, teaching, referrals for patients post hospitalization and document information in record within two business days of discharge.
3. *Review discharge medication instructions give hospital or remind members to bring medications or list of discharge medications for reconciliation at appointment.*
4. Schedule follow up appointment for member.
 - a. Provide Medication Reconciliation at face to face if has not been completed.
5. Bill for TCM services based on visit date post discharge and medical complexity.

TCM Codes

CMS implemented new TCM codes in 2013 for services rendered after an inpatient transition which pay at a higher reimbursement rate than regular office visits. *Primary care providers or specialists can bill for a TCM visit.*

CPT Code 99495

- Moderate Medical Complexity
- Face to face visit within 14 days
- Contact, or attempts to contact, member or caregiver within 2 business days of discharge

CPT Code 99496

- High Medical Complexity
- Face to face visit within 7 days
- Contact, or attempts to contact, member or caregiver within 2 business days of discharge

These codes suggest additional work will occur such as reviewing discharge summary or inpatient records, making referrals as needed, teaching/education, coordinating care with other providers, completing a medication reconciliation at outreach or face to face visit post hospitalization.

Member/Caregiver Contact within 2 Business Days of Discharge

An interactive contact with the member and/or caregiver, or two attempts to contact the member/caregiver within 2 business days following the member's discharge.

- Contact may be via telephone, e-mail, text, mail or face-to-face.
- With the member or their caregiver.
- Information from the contact, or at least two attempts to contact (date, time, method, information shared) should be documented in the medical record.
- Outreach may be completed by any clinical staff member working under a provider, including a medical assistant.

Reasons to Implement TCM Services

1. Better outcomes
2. Reduces risk of readmission
3. Reduces no show rates
4. Improved provider
5. Enhanced billing opportunity

TCM Tips for Provider Offices

- Determine processes for your office to provide TCM services once notified of an admission or discharge.
- Educate phone staff / office staff on making contact within 2 business days, needed documentation, questions, and scheduling protocols for follow up appointments.
- It is helpful to label these appointments post hospital visits or TCM visits in the notes for the provider.
- Use physician TCM resource flows to help office staff with documentation needs for compliance.
- Make hospital contacts to gain access to patient portals to view your patients full inpatient medical records.
- Educate your patients to always provide your information to hospital/Urgent Care and reasons why your practice offers this care coordination service to your patients. Encourage caregivers to notify office in case of an admission.
- Always encourage members to bring medications in to office after hospitalization or once a year for medication reconciliation.

Additional Resources

American College of Physicians – Transitional Care Management (TCM) Codes

<https://www.acponline.org/practice-resources/business-resources/coding/general-medical-coding-resources/transitional-care-management-tcm-codes>

Centers for Medicare & Medicaid Services – Transitional Care Management Services

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf>