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# Transitional Care Management

Stabilizing and Supporting Patients During Vulnerable Transitions Home

Returning home after an acute or skilled stay can be overwhelming, and it's not unusual for patients to quickly decompensate, requiring a trip to the ED or re-hospitalization. Transitional Care Management (TCM) bridges the gap between an inpatient stay and care in the patient's home. This extra support can help patients adjust to their new medication and care routines, learn to cope with changes in their functional status, and manage barriers to successful self-management. Both hospitals and primary care providers can manage patients in transitional care, but the goal remains the same: support the patient's needs and prevent deterioration or readmission.

## Eligibility Requirements

To be eligible for TCM, patients must be discharged from an acute setting to their home setting. The qualifying settings are:

**Discharge Setting:**

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long-term care hospital
- Skilled nursing facility
- Inpatient rehabilitation
- Hospital outpatient observation
- Partial hospitalization

**Home Setting:**

- Home
- Domiciliary
- Rest home
- Assisted living facility

## Levels of Service for TCM

TCM has two levels of service, determined by the complexity of medical decision making required during the 30-day service period. Regardless of level of service, communication with the patient and/or caregiver must occur within 2 business days of discharge. Care management services are required to continue for 30 days after discharge.

**99495** Transitional Care Management Services with the following required elements:

- Medical decision making of at least ***moderate*** complexity during the service period
- Face-to-face visit within ***14 calendar days*** of discharge

**99496** Transitional Care Management Services with the following required elements:

- Medical decision making of ***high*** complexity during the service period
- Face-to-face visit within ***7 calendar days*** of discharge

For the 2 day required communication, counting begins on the day *after* discharge

For the 7 or 14 day required visit, counting begins on the day *of* discharge.

**99495 –** TCM, ***moderate*** medical complexity, requiring a face-to-face visit within 14 days of discharge

**99496 –** TCM, ***high*** medical complexity, requiring a face-to-face visit within seven days of discharge

**Who Can Bill for TCM Services?**

- Physician (any specialty)
- Clinical nurse specialist (CNS)
- Nurse practitioner (NP)
- Physician assistant (PA)
- Certified nurse midwife

**TCM face-to-face visits may be provided**

- In the patient's home
- Another setting where the patient resides
- Via telehealth

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## Providing TCM Services

TCM provides patients with 30 days of care management services after discharge. Additionally, TCM provides at least two different care touchpoints:

- Contact with the patient within 2 business days following discharge
- Face-to-face visit with the patient within 7 or 14 days of discharge, depending on level of TCM service

The first contact the patient or their caregiver must occur within 2 business days following discharge; the first business day after discharge is day 1. This contact may be conducted by clinical staff

- Contact may be via telephone, email, face-to-face visit or telehealth
- Attempts to communicate should continue until successful, even if more than 2 business days have elapsed. Each attempt at communication should be documented
- Communication must address certain issues, see box ▶

A follow-up face-to-face visit must be conducted within 7 or 14 days of discharge, depending on the level of TCM service. The visit can be conducted by the physician, non-physician provider, or licensed clinical staff under general supervision of the billing provider. Certain elements of care management must occur **before or during this visit**, including:

- Medicine reconciliation and management
- Review of discharge information
- Review need for and/or follow up on pending tests or treatments
- Assessing and supporting compliance with the treatment regimen
- Education to the patient and family/caregivers to support the patient's self-management and return to activities of daily living
- Identifying available community resources and supports and assist the patient/family to access needed care and services
- Assist in establishing or re-establishing and scheduling with primary care provider, and, if necessary, community providers and services
- Communicating and coordinating with other providers, agencies, and services involved in the patient's post-discharge care

**During the initial contact with the patient, care management services must address, at minimum, these areas:**

- Obtaining and reviewing any discharge information given to patient
- Review the need for any follow-up diagnostic tests or treatment
- Interact with other healthcare professionals involved in patient's after care
- Provide education to patient, family members or caregivers
- Establish referrals and arrange community resources that patient can be involved in to regain activities of daily living; and
- Assist in scheduling the follow-up visit to physician

## Billing Tips

- TCM codes can be utilized on new or established patients
- If two or more separate attempts are made to contact the patient in a timely manner but are unsuccessful, and other TCM criteria are met, the service may be reported.
- TCM services may be billed by only one billing practitioner during the post-discharge period
- TCM may not be billed by physicians billing 10 or 90 day global surgical services
- **99495** or **99496** may not report the following codes during the 30-day service period covered by TCM:
    - Care plan oversight: **99339**, **99340**, **99374-99380**
    - Home health or hospice supervision: **G0181** and **G0182**
    - End Stage Renal Disease (ESRD) services: **90951-90970**
    - Prolonged E/M services without direct patient contact: **99358** and **99359**
- TCM may be reported in the same month as CCM, Complex CCM, and Provider-Only CCM in FFS settings
- Should the patient require an E/M visit during the 30 day service period, it is separately billable but may not replace the 7 or 14 day follow-up visit
- If the patient is re-admitted within the 30 day service period, but the 7 or 14 day follow up visit and other service requirements have been met, the service may be billed
- Additional details and guidance is available from the **American Academy of Family Physicians**
- During the National Public Health Emergency, providers **may waive cost sharing** for this service

**Documentation Requirements:**

- Date of discharge
- Date of initial communication with the patient and/or caregiver
- Date of face-to-face visit
- Complexity of medical decision making

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