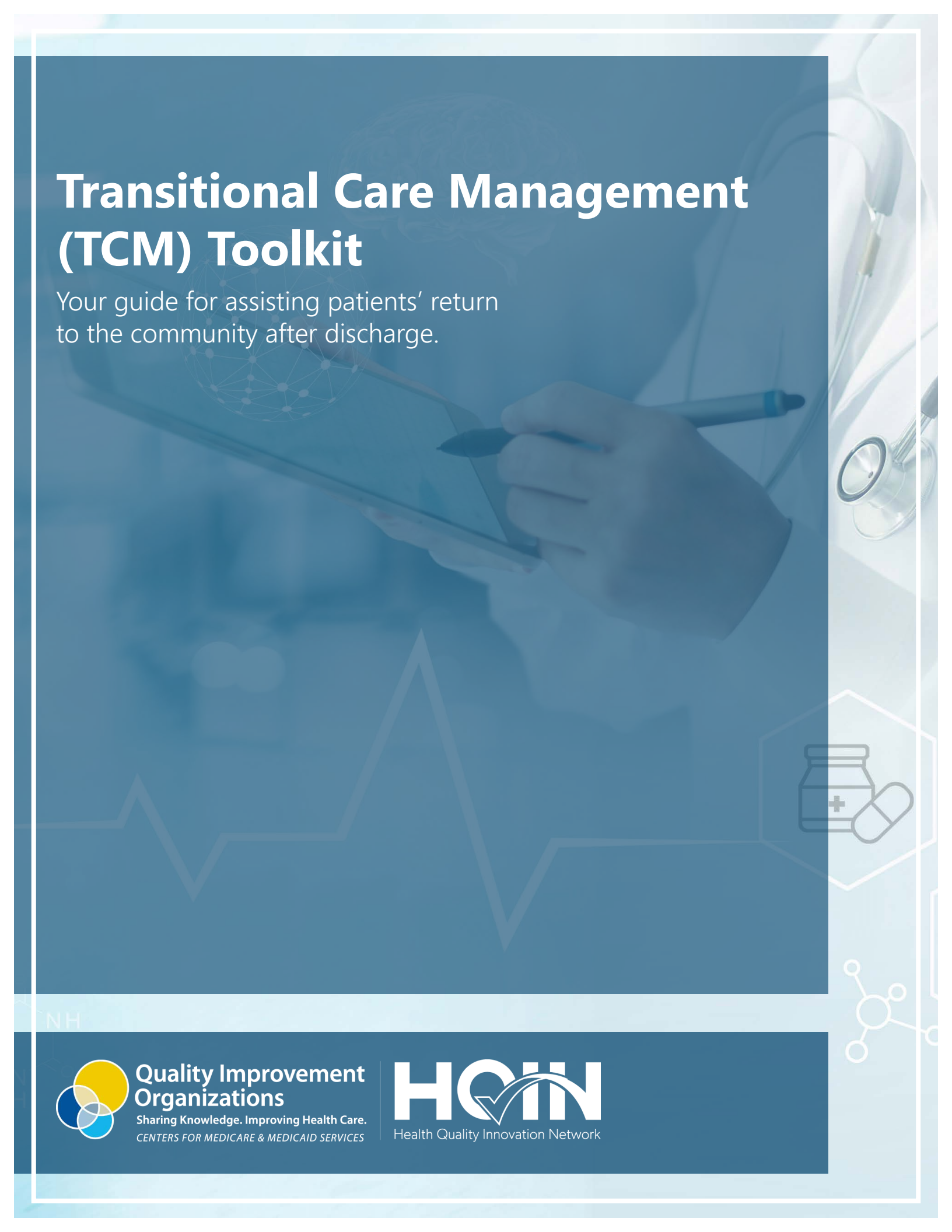
Transitional Care Management (TCM) Toolkit

Your guide for assisting patients' return to the community after discharge.



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According to the Centers for Medicare & Medicaid Services (CMS), a recent analysis found that "the beneficiaries who received TCM services demonstrated reduced readmission rates, lower mortality, and decreased health care costs. Based upon these findings, we believe that increasing utilization of medically necessary TCM services could positively affect patient outcomes."

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Overview

Thank you for using the TCM toolkit. The Health Quality Innovation Network (HQIN) offers this guide for your team to implement or expand TCM for your Medicare population that have been discharged from a facility to the community. Use this guide to assist patients and caregivers mitigate unnecessary readmissions and improve your understanding of TCM services including service requirements, patient interactions, workflows, documentation, and billing.

TCM services can be provided to Medicare beneficiaries by their primary care physician or clinical team when discharged from an appropriate facility defined by CMS. TCM services require moderate or high-complexity medical decision making by the receiving provider. Initial contact with the patient must be made within two business days of discharge.

The service period is 30 days beginning on the date a beneficiary is discharged from a hospital or other facility. The date of service is the date the provider completes the required face-to-face visit.

During this time period, the following three services must be provided.

1. An interactive communication
2. Specific non-face-to-face services
3. A face-to-face visit

Rationale for TCM

Approximately 17% of Medicare beneficiaries are readmitted to the hospital within 30 days of discharge.[1] CMS reimburses for TCM services, supporting healthy transitions after hospital stays. TCM services ensure that your highest risk patients receive the care they need immediately after discharge from a hospital or other facility.

TCM services help to mitigate readmission by closely monitoring many of the risks patients can experience after discharge from a facility. Common risk factors include but are not limited to:

- Adverse Drug Events (ADEs) can be avoided through comprehensive medication review or Blue Bag review upon discharge to ensure the patient and caregiver understand the correct medication they should be taking.
- Sepsis is one of the leading causes of readmission especially for patients who have experienced invasive medical procedures.

[1] Characteristics of 30-Day All-Cause Hospital Readmissions, 2010-2016 (ahrq.gov)

- Cardiac related complications are also a major cause of readmissions and TCM services can help identify potential complications through regular contact with the patient and potentially transition those qualifying into Chronic Care Management (CCM) services.
- Discharges for COVID-19 related admissions have become a more recent concern especially with an increased risk for pneumonia.
- Avoidable ED visits, inpatient stays and observation stays, including those of multi-visit patients.

Implementing TCM services into practices provides added value to patients and families, health systems and payers along with an added revenue opportunity.

Fiscal Performance

To understand the fiscal impact of TCM services on your bottom line, use HQIN's TCM Revenue Estimation Tool to estimate potential revenue if you maximize TCM at your practice, pharmacy or organization. Other benefits of TCM services include efficiencies in time and resources due to reduced readmissions and related work and cost-savings or improved incentive performance payments with payers or programs.

Process Performance

Measure the percent of each unique patient's eligible discharge event where TCM services were provided.

25 eligible beneficiaries discharged in past 12 months who received TCM services

100 eligible beneficiaries discharged in past 12 months

=

25% Performance

Interactive Contact

An interactive contact must be made by the practice with the beneficiary and/or caregiver, as appropriate, within two business days following discharge of the beneficiary to the community setting. Interactive communication can include direct contact, telephone, or electronic (i.e., patient portal or other secure electronic methods). Interactive communication may be made by the provider or any member of their clinical staff with capacity to address patient needs beyond scheduling follow-up care.

Considerations

Due to the reliance on hospitals and/or allowable facilities, physician practices should work to establish proactive coordination with local discharging facilities about the benefits of TCM and improve collaboration to:

- Achieve time sensitive initial contact requirements.
- Help facilities avoid potential penalties for readmissions.
- Improve medication reconciliation and follow-up treatment.
- Improve coordination of post-discharge care.

Face-to-Face Visit

One face-to-face visit must be furnished unless you determine they aren't medically indicated or needed. This visit must be completed within certain timeframes as described in Figure 1. Health care practitioners such as Physicians (any specialty) and Non-Physician Practitioners (NPPs), must provide the services associated with the TCM face-to-face visit and can supervise auxiliary personnel, which includes clinical staff. The visit can be provided via telephone or telehealth as a substitute for an in-person encounter. Telehealth services must be HIPAA secure with audio and video capabilities. The face-to-face visit is part of the TCM service, and you should not report it separately.

Figure 1 - TCM Services Summary

Moderate Complexity CPT 99495	**High Complexity** CPT 99496
Communication w/Patient/caregiver within 2 business days of discharge	Communication w/ patient/caregiver within 2 business days of discharge
A face-to-face visit within 14 calendar days of discharge	A face-to-face visit within 7 calendar days of discharge
Medical decision making of at least moderate complexity during service period	Medical decision making of at least high complexity during service period
2021 National non-facility price $207.96*	2021 National non-facility price $281.59*

***Codes and pricing current as of May 19, 2021. For most current rates, refer to the National Physician Fee Schedule Tool.**

NOTE for FQHC: Within the COVID-19 PHE period, TCM provided by distant site Telehealth services, Physician's code 99495/99496 accordingly but FQHC bills G2025 to CMS, CMS pays $99.45.

Both codes require medication reconciliation and management, which must be documented no later than the date of the face-to-face visit.

Billing for TCM Services

- Only one provider can bill per patient
  - Establish the primary provider in charge of care coordination prior to discharge. The discharging physician should communicate to the patient who will be providing the TCM services and any available appointment and contact information.
- Coding frequency is once per patient per admission
  - Applies to both new and established patients.
- The required face-to-face visit is part of the TCM service and is not reported separately.
- The required face-to-face visit may not take place the same day as discharge day management services.
- Additional E/M services provided **AFTER** the face-to-face visit can be billed separately.
- Additional visits during the service period of 30 days can be billed using a standard E/M office visit code. (99213/99214)
- Ancillary services to include labs, radiology, EKG, etc. can be billed on the same day.
- Services such as care plan oversite, end-stage renal disease, and chronic care management can now be billed concurrently during the service period.
- Billing should be complete at the end of the 30-day post-discharge period.
- You may not bill the TCM if there was no successful communication within the 30-day period between the facility discharge and the date of service for the post-discharge TCM code.

As of January 1, 2020, the following services and codes may now complement TCM and be used concurrently as deemed medically necessary. Refer to the federal register links below. *Exception: FQHC/RHC limitations for TCM and other services may still apply: See FQHC/RHC FAQ link below.*

Services	Codes
Prolonged Services without Direct Patient Contact	99358, 99359
Home and Outpatient International Normalized Ratio (INR) Monitoring Services	93792, 93793
End-Stage Renal Disease Services (patients who are 20+ years)	9060, 90961, 90962, 90966, 90970
Analysis of Data	99091
Complex Chronic Care Management Services	99487, 99489
Non-Complex Chronic Care Management Services*	99490, 99491, 99439
Care Plan Oversight Services	G0181, G0182

Important Notes: This table represents Medicare only and is new as of the Medicare program CY 2020 Revisions to Payment Policies Under the Physicians Fee Schedule. Medicare Advantage plans and commercial payers may have different rules. Please verify with those payers, as needed. The changes made by CMS, documented in the federal register, do not appear to be reflected in the AMA CPT coding rules at the time of this toolkit development. Please refer to the most recent changes to TCM services in the CMS MLN TCM Booklet.

Reference most current updates here: https://www.federalregister.gov/d/2019-24086/p-1167
*Non-Complex CCM Services Changes: https://www.federalregister.gov/d/2019-24086/p-1177
FQHC/RHC FAQ: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Non-Face-to-Face Services

Non-face-to-face services such as arranging of follow-up appointments, obtaining and reviewing records, providing education to the patient caregiver, and interaction with healthcare professionals for coordinating care which must be provided to the beneficiary, unless the physician determines that they are not medically indicated or needed.

The TCM codes are care management codes. As care management codes, auxiliary personnel may provide the non-face-to-face services of TCM under the general supervision of the physician or NPP subject to applicable state law, scope of practice, and the Medicare Physician Fee Schedule (PFS) "incident to" rules and regulations.

Under the direction of the physician, clinical staff (i.e., pharmacist) or Non-Physician Practitioners (NPP) may furnish TCM services.

NPPs include the following:

- Certified Nurse Midwife (CNM)
- Clinical Nurse Specialist (CNS)
- Nurse Practitioner (NP)
- Physician Assistant (PA)

Services Provided by Physicians or NPPs
• Obtain and review discharge information (for example, discharge summary or continuity of care documents) • Review the need for or follow-up on pending diagnostic tests and treatments • Interact with other health care professionals who will assume or reassume care of the beneficiary's system-specific problems • Provide education to the beneficiary, family, guardian, and/or caregiver • Establish or re-establish referrals and arrange for needed community resources • Assist in scheduling required follow-up with community providers and services

TCM Services Provided by Auxiliary Personnel Under Physician or NPP General Supervision
• Communicate with the patient • Communicate with agencies and community service providers the beneficiary uses • Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living • Assess and support treatment adherence including medication management • Identify available community and health resources • Assist the beneficiary and/or family in accessing needed care and services

Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering these factors:

- The number of possible diagnoses and/or the number of management options that must be considered.
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

Refer to CMS MLN E/M Service Guide for further details: Evaluation and Management Services Guide Booklet (cms.gov)

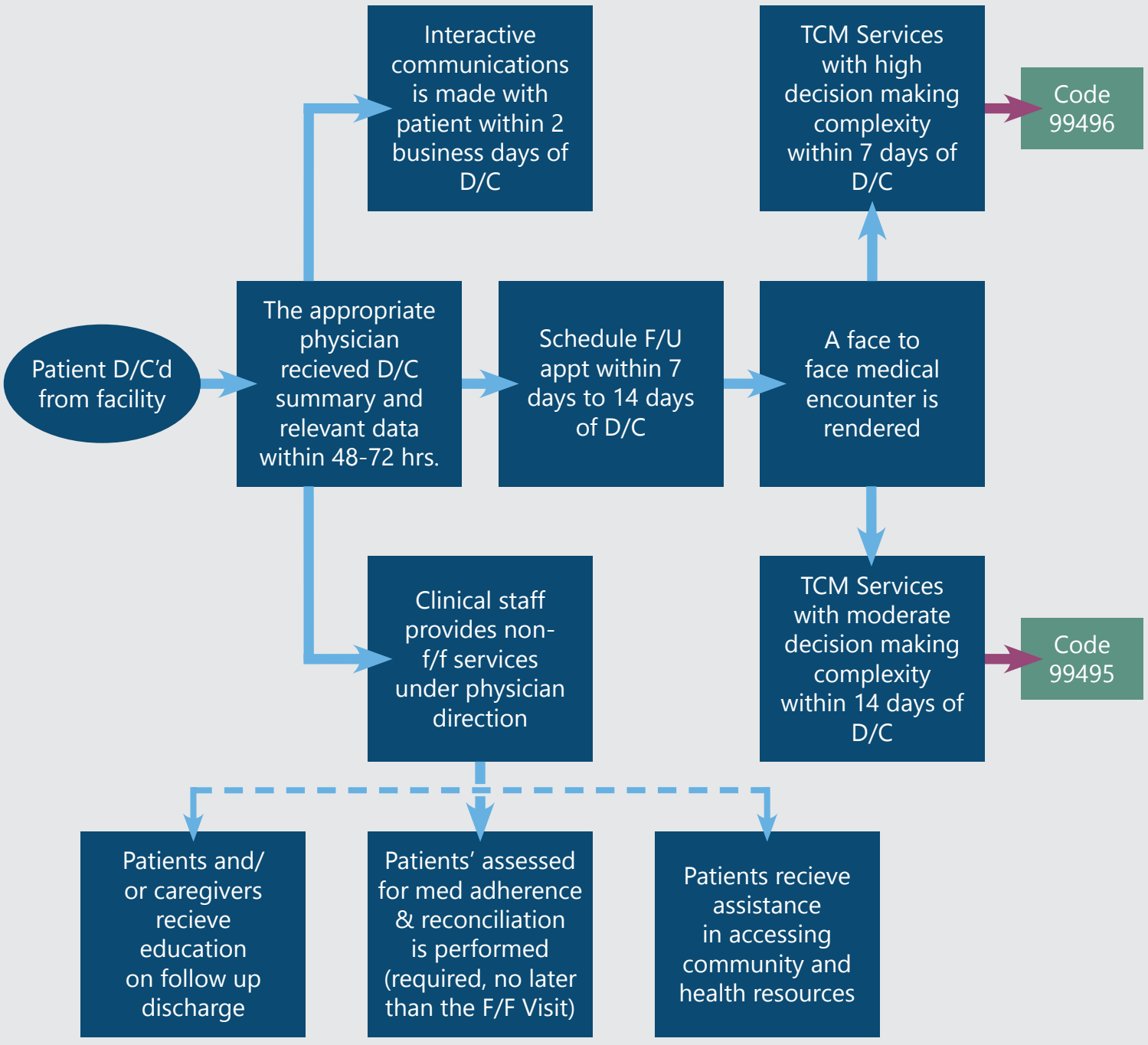
Documenting TCM Services

The following information and details at minimum, should be documented in the patient's medical record:

- Relevant details regarding the discharge of the beneficiary and the date.
- The date of the interactive contact/communication that was made or attempted within the required two days of discharge.
- The date of the required face-to-face visit: to include details of the medication management and reconciliation.
- The non-face-to-face services provided and dates.
- The level of complexity of medical decision making (moderate or high.)

Defining Discharge for TCM Services
Discharge must be from one of the following facility settings: • Inpatient Acute Care Hospital • Inpatient Psychiatric Hospital • Inpatient Rehabilitation Hospital • Long-term Care Hospital • Skilled Nursing Facility • Partial hospitalization • Hospital outpatient observation The patient must be returned to their community setting: • Patient home • Veteran's domiciliary • Rest home (e.g., boarding home, adult care home) • Assisted living

TCM Workflow Example



Sample TCM Discharge and Communications Template

Patient Name:	**Date of Contact:**
Sources of Information: ☐ Patient, family member or caregiver ☐ Hospital discharge summary	Family/Caregiver Name: ☐ Other: ☐ List of recent hospitalization or ED visits:
Discharge Location:	**Discharge Date:**
☐ Home ☐ Family Member Home ☐ Non-Family Home ☐ Assisted Living ☐ Other:	
Diagnosis/problem:	
Medication Changes: ☐ **Yes** ☐ **No**	**Notes:**
Medication list updated: ☐ **Yes** ☐ **No**	**Notes:**
Referral/Lab Needed: ☐ **Yes** ☐ **No**	**Notes:**

Initial Communication Post-Discharge:
First 2 attempts must be withing 2 business days of discharge date listed above.
Continue to contact patient even if attempts past the 2 days are not successful.

Attempts	Date	Time	Method	Initials
1st			☐ call ☐ fax ☐ email ☐ secure message ☐ other	
2nd			☐ call ☐ fax ☐ email ☐ secure message ☐ other	
Additional			☐ call ☐ fax ☐ email ☐ secure message ☐ other	
Additional			☐ call ☐ fax ☐ email ☐ secure message ☐ other	
Additional			☐ call ☐ fax ☐ email ☐ secure message ☐ other	
Additional			☐ call ☐ fax ☐ email ☐ secure message ☐ other	

Follow-up Appointment:

☐ Within 7 days of discharge
☐ Within 14 days of discharge

Date:

Provide

Additional Information:

Form Completed By: (Clinic Staff Member) Date:

Signed Off By: (Provider Date:

TCM Face-to-Face Visit Template

To be used by provider to document the requirements of the face-face visit.

Patient Name:		**Appointment Date:**
Initial Communication Date:		**Made By:**
Medications: ☐ Medication list reconciled and updated ☐ Updated medication list given to patient/caregiver (print or send to portal)		
Patient Education: ☐ Education Provided ☐ Education Discussed		Notes/Details:
Durable Medical Equipment: ☐ DME ordered ☐ No DME needed		Notes/Details:
Community Resources:	Notes/Details	
☐ Assisted Living:		
☐ Home Health		
☐ Hospice		
☐ Program		
☐ Support Group		
☐ Other		
Referrals:		
Referrals Needed: ☐ Yes ☐ No	Reason(s):	
Referrals Made: ☐ Yes ☐ No	Where:	
	Where:	
	Where:	
Follow-up Appointment:	Date:	
	Provider:	
Additional Information:		
Form Completed By: (Clinic Staff Member)		Date:

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