Transitional Care Management – October 2018

Transitional Care Management (TCM)

TCM codes are intended to report the transitional care and medical management given to established or new patients whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transition in care from a facility setting (hospital, skilled nursing facility/nursing facility), to their community setting (home, domiciliary, rest home or nursing home).

TCM covers 30 days of management services with one evaluation service bundled into the code, starting on the date of discharge. These codes may not be reported more than once by the same individual or group for any subsequent discharge within 30 days. The TCM code should not be submitted for billing until 30 days post the discharge date.

CPT **99495** -Transitional Care Management requires the following elements:

- Communication (direct contact, telephone, electronic) from Physician or other qualified healthcare professional with the patient and/or caregiver within **2** business days of discharge.
- Medical decision making of at least moderate complexity during the service period
- A face-to-face visit within **14** calendar days of discharge.

CPT **99496** -Transitional Care Management requires the following elements:

- Communication (direct contact, telephone, electronic) from Physician or other qualified health care professional with the patient and/or caregiver within **2** business days of discharge.
- Medical decision making of high complexity during the service period
- A face-to-face visit within **7** calendar days of discharge.

TCM Documentation should include:

- Date of discharge
- Date of interactive contact & type within 2 business days post D/C
- Date of 7-day or 14-day, face to face visit.
- Medications on discharge and changes/adjustments to medications after D/C (must be done on or by face to face visit)
- Documentation of services, referrals, patient education and diagnostic test reviewed, ordered and or re-established.

TCM Smart Phrase .UHATCM

Transitional Care Management Visit

History of Present Illness:

@NAME@ is a @AGE@ @SEX@ who presents for their follow-up 7-14 day follow-up visit after discharge from *** for ***.

Discharge diagnoses were:
***
***

Date of interactive contact post discharge: *** (by email, visit, phone)
Family and/or caregiver(s) present today: ***

Update since post-discharge contact: ***

Pertinent Review of Systems

Other than noted in HPI above,
ROS positive for: ***
ROS negative for: ***

Medications at Discharge

@MED@
@ALLERGY@

Updated Problem List and Functional Assessment:

@PROBL@
@SOCDOC@

Pertinent Physical Exam:

@VS@
@BMI@
Previous weights: @LASTWT(3)@
General:

Assessment and Plan

In summary, @NAME@ is a @AGE@ @SEX@ who presents for their follow-up 7-14 day follow-up visit after discharge from *** for ***.

Diagnoses addressed today, and interventions including:
-- medication changes made
-- tests reviewed
-- new tests ordered
-- specialty/community referrals made
-- additional interventions including communication with other providers

@DIAG@

Patient Instructions

@PATINSTR@

These instructions were discussed with the patient and/or caregiver(s) and a printed copy given in the After Visit Summary.

TCM Documentation should include:

- Date of discharge.
- Date of interactive contact (2 business days post D/C) and type
- Date of 7-day or 14-day, face to face visit
- Medications on discharge and changes/adjustments to medications after D/C (must be done on or by face to face visit)
- Documentation of services, referrals, patient education and diagnostic test reviewed, ordered or re-established

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TCM FAQ

Q: What happens if the patient is re-admitted before the 30 days are up?
A: The face-to-face visit would become the appropriate evaluation and management level code for the service that was rendered. You would start your 30 days of service for TCM over once the patient was discharged.

Q: What diagnosis code(s) do I use when reporting TCM?
A: Report the diagnoses for the conditions that require TCM services. Typically, these will be the conditions that the patient had at the time of discharge, which represents the start of TCM.

Q: When do I bill for Transitional Care Management?
A: You should submit your bill on the 30th day after discharge. TCM covers 30 days of management services with one evaluation service bundled into the code. The date of service on the claim would be the 30th day post the discharge.

Q: Must the required face-to-face visit be in the office?
A: No. Typically the visit will be in the office but may also be in the patient's home or other location where the patient resides.

Q: Do you have to be a primary care physician to bill TCM services?
A: No. Neither CPT nor Medicare restricts use of the TCM codes to specific specialties. Qualified NPPs may also bill these services.

Q: What are the coding limitations associated with TCM?
A: A physician or other qualified health care professional who reports codes 99495, 99496 may not report care plan oversight services (99339, 99340, 99374-99380), prolonged services without direct patient contact (99358, 99359), anticoagulant management (99363, 99364), medical team conferences (99366-99368), education and training (98960-98962, 99071, 99078) telephone services (98966-98968, 99441-99443), end stage renal disease services (90951-90970), online medical evaluation services (98969, 99444), preparation of special reports (99080), analysis of data (99090, 99091), complex chronic care coordination services (99487-99489), medication therapy management services (99605-99607) during the time period covered by the transitional care management services codes.

Q: TCM also includes a lot of non-face-to-face care provided by the physician and clinical staff. What are some examples?
A1: Non-Face-to-Face Services Example by **Provider**
- Obtaining and reviewing the discharge information (discharge summary, as available, or continuity of care documents).
- Reviewing need for or follow-up on pending diagnostic tests and treatments.
- Interaction with other qualified health care professionals who assume/ reassume care of the patient's specific problems.
- Education of patient, family, guardian, and/or caregiver.
- Establishment or reestablishment of referrals and arranging for needed community resources.
- Assistance in scheduling any required follow-up with community providers and services.

A2: Non-Face-to-Face Services by **Clinical Staff** (Under direction of a physician or other qualified health care professional)
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
- Communication with home health agencies and other community services utilized by the patient.
- Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living.
- Assessment and support for treatment regimen adherence and medication management.
- Identification of available community and health resources.
- Facilitating access to care and services needed by the patient and/or family.

Q: What if the patient passes away and care has been less than 30 days?
A: If care is less than 30 days you cannot bill TCM. The face-to-face visits under appropriate the E/M level should be reported.