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This material was prepared by HealthInsight, the Medicare Quality Innovation Network Quality Improvement Organization for Nevada, New Mexico, Oregon and Utah, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-C3-18-08
Why Transitional Care Management (TCM)?

Approximately one in five Medicare beneficiaries in the United States are readmitted to the hospital within 30-days of discharge; up to 76 percent of these readmissions may be preventable. A common reason for readmissions is the absence of timely follow-up appointments with primary care providers to assist patients with their new diagnoses, medications and treatments. The Centers for Medicare & Medicaid Services (CMS) recognize the importance of this transitional period and have started paying medical providers for coordinating Medicare beneficiaries’ care transitions. The new payment plan is intended to acknowledge that effective care transitions require care coordination and provide additional reimbursement to support these activities. Starting in 2013, the physician fee schedule includes payment for two new CPT codes to support TCM services.

TCM is an opportunity for providers to receive additional reimbursement for taking responsibility for the care of patients following discharge from an inpatient hospital setting and return to home or assisted living facility. The goal is to decrease the high percentage of avoidable patient readmissions after discharge through more effective care at the transition.

If implemented effectively, the anticipation is TCM will introduce the following benefits to your practice and your patients:

Benefits to your practice
- Drive improved coordination through the health information exchange (HIE) or with hospital care manager
- Greater visibility and awareness of patients discharged
- Decreased costs with avoidance of inappropriate readmissions
- Improved care decisions with discharge reports in hand in advance
- Increased positive results/quality outcomes for patients cared for by practice team
- Improved documentation of transitions and associated patient care
- Increased practice revenue

Benefits to your patients
- Decreased risk of inappropriate readmission to the hospital and attendant burdens and costs
- Enhanced satisfaction with the care at the transition from inpatient to primary care provider (PCP)
- Positive and engaging patient experience

The following workbook can assist your team in evaluating the effect of TCM discharges on readmissions. Click on the worksheet to access this file.

A HealthInsight project manager may help with setup and explanation of how to utilize this workbook.
Alignment with other Key Initiatives or Reporting Requirements

Consider Medicare Spending per Beneficiary (MSPB) and Readmissions
You should consider how this affects your outcome measures with MSPB/readmissions. Physicians who participate in the Merit-based Incentive Payment System (MIPS) program are assessed on the MSPB measure. This measure is also used to measure hospital cost. Consequently, your hospital may be interested in providing your organization all the necessary tools to ensure that the TCM visit can occur with all needed information.

Readmissions are also measured as part of MIPS and hospital value-based purchasing. If you’re in a clinic with more than 15 clinicians, you will be measured on readmissions for patients along with hospitals. Helping patients with education to work through their care plan should help patients with readmissions to the hospital.

**Readmissions**: Hospital and MIPS focus (groups greater than 15 providers).

**Cross-payer alignment (Medicaid also pays)**: In most states, Medicaid also pays for TCM visits. Consider performing for your dual-eligible patients as well as your Medicaid patients, or providing similar services that may help reduce readmissions.

The consequences of poor transitions between the hospital and community are prominent in quality and cost of care discussions. CMS has asked communities to improve patient care transitions to make them safer and more efficient. HealthInsight is working with our community partners, such as hospitals, outpatient clinics, home health agencies (HHAs) and extended care facilities, to improve communication and coordination across health care settings.
What is included in TCM?

TCM Components
During the first 30-days beginning on the date the beneficiary is discharged from an inpatient setting, the provider must furnish the following three TCM components:

1. **An interactive contact** - Contact must be made with the beneficiary and/or caregiver, as appropriate, within **two business days** following the patient’s discharge. The contact may be via telephone, email or face-to-face. It can be made by the provider or clinical staff who can prompt interactive communication addressing patient status and needs.

2. **Certain non-face-to-face services**
   Physicians or non-physician providers (NPPs) must furnish the following services:
   - Obtain and review discharge information (for example, discharge summary or continuity of care documents)
   - Review 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

   Clinical staff under the direction of a physician or non-physician providers (NPP) may provide:
   - Communication with agencies and community services the beneficiary uses
   - Education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living and activities of daily living
   - Assessment and support treatment regimen adherence and medication list entry and records management
   - Identify available community and health resources
   - Assisting the beneficiary and/or family in accessing needed care and services

3. **Face-to-face visit (or telehealth services)** – You must furnish one face-to-face (or telehealth) visit within certain timeframes as described below for each CPT code:
   - **CPT Code 99495** – TCM services with moderate medical decision complexity (face-to-face visit **within 14 days of discharge**); approximately $163.00
   - **CPT Code 99496** – TCM services with high medical decision complexity (face-to-face visit within **seven days of discharge**); approximately $231.00
Who is included in the TCM?

TCM services provided after the Medicare Part B beneficiary’s discharge from one of these inpatient hospital settings:

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long-term care Hospital
- Skilled nursing facility (SNF)
- Inpatient rehabilitation facility
- Hospital outpatient observation or partial hospitalization

Following the discharge from one of the above instances, the beneficiary will need to go to his or her community setting, such as:

- His or her home
- Veteran’s domiciliary
- A rest home or adult care home
- Assisted living
How do I Implement TCM in my Practice? 4-Step Approach

This guide will help you develop your plan for successful TCM implementation by walking you through the following steps:

- **Step 1 - Prepare for TCM**
- **Step 2 - Perform Outreach and Engagement**
- **Step 3 - Perform TCM visit**
- **Step 4 - Complete Appropriate and Effective Coding and Billing**

**Step 1 - Prepare for TCM**

**DISCHARGE | HOW WILL YOU:**
- Know if your patients have been discharged
- Obtain the discharge summary
- Gather data from your hospitals, are data sent electronically, by fax, or paper

Notification of Discharge - The key to successful TCM implementation lies in the notification of the discharge to the PCP within the two contact day window. Providers are often unaware of the hospitalization and subsequent discharge. Possible solutions may include:

- Notification via HIE – admission, discharge and transfer (ADT) alerts
- Hospital case managers call PCP upon discharge
- Provider to provider notification
- Vertically integrated – accountable care organizations (ACOs) for example
- Patient direct to practice (as in the case of patients under care management)

State-specific resources or tools:
- Utah – [UHIN’s Clinical HIE](#)
- Oregon - [PreManage kit for discharges](#)
- Nevada - [HealthHIE Nevada, Nevada 211](#)
- New Mexico – [New Mexico Health Information Collaborative (NMHIC)](#)
TCM Discharge Tool Evaluation Worksheet / TCM Data Utilization Worksheet

Use this worksheet to establish which facilities your patients are discharged from. Record your facilities and methods.

### Practice Patient Discharges

<table>
<thead>
<tr>
<th>Number of Discharges/Week:</th>
<th>Number of Discharges/Month:</th>
<th>Number of Discharges/Year:</th>
</tr>
</thead>
</table>

### Discharges Per Facility (Hospital, SNF)

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Number / Month</th>
<th>Notification System (Fax, EHR, DI, HIE, DSM, Other)</th>
<th>Note</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility A:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility B:</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Facility C:</td>
<td></td>
<td></td>
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<tr>
<td>Facility D:</td>
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<tr>
<td>Facility E:</td>
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<tr>
<td>Facility F:</td>
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<td></td>
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<tr>
<td>TOTAL:</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Discharge Aggregate Method

<table>
<thead>
<tr>
<th>Method</th>
<th>Number / Month</th>
<th>Notes</th>
<th>Delay of Notification from Discharge</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR Portal</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Direct Secured Messaging</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIE</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Fax</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>TOTAL:</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Pilot Hospital (Name:  )

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Weekly Number of Discharges</th>
<th>Weekly Number Notified</th>
<th>Weekly Missed Notifications</th>
<th>Monthly Number of Discharges</th>
<th>Monthly Number Notified</th>
<th>Monthly Missed Notifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pilot Quarter 1:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pilot Quarter 2:</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Here are a few additional, yet simple steps to consider that may increase timely follow-up:

- **Educate patients** before they go into the hospital to do follow up afterwards
- **Adjust schedules** to allow for more timely follow-up appointments
- **Open a telephone line** for hospital discharge planners and providers to use for scheduling hospital discharge related appointments
- Front desk or scheduling staff **ask patients** if they were discharged recently
- **Modify your automated phone system** to include a message about having patients notify the receptionist if they were discharged recently from the hospital

**TCM Notification Process**

It’s critical to make sure you have a method for understanding where your visits are coming from. Consider the following workflow options.
TCM Pre-Encounter Process
After your notification, consider preparation before the visit. What’s needed, and who should do it? Consider the following, since you have only two days to contact the patient post-discharge. Medication reconciliation must be completed before or at the time of the face-to-face encounter - will you do this over the phone or with staff prior to or during the clinician visit?

**Considerations:**
- All activities are “Pre-Encounter”
- Two business days to contact patient
- Medication reconciliation must be completed before or during the face-to-face encounter
- Documentation of pre-encounter activities in your EHR/other
- Use of disease-specific template
- Who conducts process
- Identify patient caregiver if one is available
- Collect method of transportation for appointment purposes

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**Step 2 – Perform Outreach and Engagement**

**INITIAL CONTACT | HOW WILL YOU:**
- Contact your patient within two business days
- Contact the patient - what is your documentation process?
- Ensure that scheduling an appointment can be completed while being mindful of the seven or 14 day limits

Reach out to the patient within two business days from discharge
- Who will track the discharge notices and make the outreach calls to the patients?
- The encounter may NOT occur on the same day as discharge

Document the outreach attempts
- How will the calls be documented?

Schedule encounter appointment
- How will the scheduler be mindful of the seven or 14-day time limits?
Step 3 – Perform TCM Visit (Medical Encounter)

TCM Encounter Process
Next, make sure you have a method for notifying the doctor about the recently discharged patient, so she/he can perform a TCM visit or let the staff know to accommodate the patient appropriately.

Considerations:
• How will the medical provider know if it is a transitional care encounter?
• Proper selection of the TCM code

ENCOUNTER | HOW WILL YOU:
- Complete the encounter
  * Provider needs to know this is a transition encounter
- Document the place of the encounter
- Complete the medication reconciliation
  * Pre-encounter vs. Encounter
- Documenting complexity of the patient (moderate vs. high)

What is required for post encounter follow-up?
No additional follow-up specified for TCM.

Step 4 – Complete Appropriate and Effective Coding and Billing

Select the appropriate code for TCM billing:
• CPT Code 99495 – TCM services with moderate medical decision complexity (face-to-face visit completed within 14 days of discharge); approximately $163.00
• CPT Code 99496 – TCM services with high medical decision complexity (face-to-face visit completed within seven days of discharge); approximately $231.00
Question: Do I need to wait for the bill until after the full 30 days post-discharge have passed?

Answer: You may submit the claim once the face-to-face visit is furnished and need not hold the claim until the end of the service period.

Many other questions about billing can be answered in CMS’s “Frequently Asked Questions about Billing the Medicare Physician Fee Schedule for Transitional Care Management Services” at: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf)

**Develop a workflow that supports TCM Implementation**

Consider your workflow and who will carry out each task to support the successful implementation of TCM in your practice.

You can use the form below to set up who’s responsible for the overall plan to implement TCM visits in your clinic.

<table>
<thead>
<tr>
<th>Responsible for Performing</th>
<th>Who is Responsible for the Implementation</th>
<th>Implementation Date and who is Responsible for Performing the Actual Tasks for the Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>Point Person</td>
<td></td>
</tr>
<tr>
<td>Discharges</td>
<td>Medical Records</td>
<td></td>
</tr>
<tr>
<td>Set Appointment</td>
<td>Front Desk</td>
<td></td>
</tr>
<tr>
<td>Visit Performance Elements, Determination for Documentation</td>
<td>Internal services - Annual Wellness Visit (AWV)/Chronic Care management (CCM)/Advanced Care Planning (ACP)/External Services Specialists/External Community – Self Management Services (SM)</td>
<td></td>
</tr>
<tr>
<td>Referral to Additional Services</td>
<td>Clinician and or Medical Assisting Staff</td>
<td></td>
</tr>
<tr>
<td>Bill</td>
<td>Administrator/Biller</td>
<td></td>
</tr>
</tbody>
</table>
Where can I get Additional Information about TCM?

Resources from Medicare

- CMS Fact Sheet on TCM – Education document from CMS on TCM visits
- CMS Discharge Planning Checklist – This tool can help patients with their discharge process from a hospital setting.

Forms and Tools

- Initial Transitional Care Contact Tracking Form – AAFP document that can support documentation and tracking of initial TCM contact
- A Method for Tracking to Readmissions: HealthInsight Quality Project Workbook - TCM
- HealthInsight TCM Implementation Checklist – Detail oriented TCM checklist for implementing into your clinic
  http://healthinsight.org/files/Care%20Coordination%20Hospital%20Readmissions/Educational%20Resources/TCM%20Implementation%20Checklist.pdf

Additional Education

- TCM Code Action Plan Presentation – Presentation document on TCM coding
- Noridian Medicare Administrative Contractor (MAC) – MAC presentation from Noridian on TCM visits
  https://med.noridianmedicare.com/documents/10542/2840524/Transitional+Care+Management+Presentation

Return on Investment (ROI) Tools

Basic ROI calculator
Current TCM visits being performed: ____________
Estimate per visit: $156.00
Potential discharges per month: ____________
Total estimate per month: _______________

Calculated ROI
HealthInsight can create an ROI dashboard for you that will share your potential revenue based on patients who have not received a TCM visit. Please contact us to get this information via the formal report.
Promoting Effective Communication and Coordination of Care

IMPROVING TRANSITIONS OF CARE USING TRANSITIONAL CARE MANAGEMENT

THE FACTS

20% of Medicare patients are readmitted within 30 days

76% of those readmissions are due to poor transitions of care

$12 BILLION PER YEAR is what unnecessary readmissions cost Medicare

THE RULES

Medical encounter may NOT occur on the same day as discharge

Documentation guidelines may not apply (e.g., pre-encounter communication)

Communication with the patient/family/caregiver may be completed by clinical staff under “provider direction” (e.g., RN, LPN, MA, other)

Medical encounter must be face-to-face or telehealth

THE CODES

99495 Office: $163.00 Transitional Care: Moderate

99496 Office: $231.00 Transitional Care: Complex

99214 Office: $84.00 General office visit

THE ACTION PLAN

DISCHARGE | HOW WILL YOU:
- Know if your patients have been discharged
- Obtain the discharge summary
- Gather data from your hospitals, are data sent electronically, by fax, or paper

INITIAL CONTACT | HOW WILL YOU:
- Contact your patient within two business days
- Contact the patient - what is your documentation process?
- Ensure that scheduling an appointment can be completed while being mindful of the seven or 14 day limits

ENCOUNTER | HOW WILL YOU:
- Complete the encounter
  * Provider needs to know this is a transition encounter
- Document the place of the encounter
- Complete the medication reconciliation
  * Pre-encounter vs. Encounter
- Documenting complexity of the patient (moderate vs. high)

BILLING | HOW WILL YOU:
- Bill as soon as possible after encounter has occurred.
- How will you remember this? Electronic, Spreadsheet, Ticker File

WHERE DID THEY GO?

Where did those who were readmitted go when they left the hospital that first time?

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