Dignity Health®

Transitional Care Management (TCM) Toolkit

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Transitional Care Management (TCM) Tip Sheets

Starting January 1, 2013, under the Physician Fee Schedule (PFS) Medicare pays for two CPT codes (99495 and 99496) that are used to report physician or qualifying nonphysician practitioner (NPP)[1] care management services for a patient following a discharge from the acute care setting to the community setting. The goal of TCM service is to improve care coordination for Medicare patients and to reduce readmission, by having the physician/NPP oversee the management and coordination of services for all medical, psychosocial, and activities of daily living support for the full 30 days post discharge. The use of TCM services is associated with a reduction in mortality and total Medicare costs[2]; however, the use of this service remain low.

What does this mean for you?

Contacting your patients shortly after hospital discharge and following up with a face-to-face office visit enhances patient satisfaction, improves care coordination, and potentially rewards you for preventing a hospital readmission within 30 days of discharge. This toolkit is designed to assist you with the understanding, documentation, and the implementation of the TCM services.

TCM Service Settings

Acute Care Setting (Discharged From)	Community Care Setting (Discharged To)
Inpatient Acute Care Hospital	Patient's Home
Inpatient Psychiatric Hospital	Domiciliary
Long Term Care Hospital	Rest Home
Skilled Nursing Home	Assisted Living
Inpatient Rehabilitation Facility	Nursing Facility (not a skilled facility)
Hospital Outpatient Observation or Partial Hospitalization	
Partial Hospitalization at a Community Mental Health Center	

[1] NPPs include certified nurse-midwives (CNMs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs)

[2] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2687989

CPT Codes for TCMs

CPT 99495 – Moderate Complexity	CPT 99496 – High Complexity
Medical Decision-Making • Documented medical and/or psychosocial problems of moderate complexity	**Medical Decision-Making** • Documented medical and/or psychosocial problems of high complexity
Face-to-Face Visit • Post-discharge, within 14 calendar days	**Face-to-Face Visit** • Post-discharge, within 7 calendar days
Medication reconciliation and management documented • No later than the date of face-to-face visit	**Medication reconciliation and management documented** • No later than the date of face-to-face visit
Thirty-day period begins on the day of discharge	Thirty-day period begins on the day of discharge
In a non-facility setting, Medicare allowance of approximately $209[3]	In a non-facility setting, Medicare allowance of approximately $282[4]

*Codes and pricing current as of March 1, 2022. For most current rates, refer to the National Physician Fee Schedule Tool (https://www.cms.gov/medicare/physician-fee-schedule/search).

Elements of Medical Decision-Making

Type of Decision-Making*	Number of Possible Diagnoses and/or Management Options	Amount and/or Complexity of Data to Be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

*To qualify for a given type of medical decision-making, two of the three elements must either be met or exceeded.

[3] Compared to CPT 99214 (Established patient office visit, Level 4) of approximately $130
[4] Compared to CPT 99215 (Established patient office visit, Level 5) of approximately $183

How to implement TCM in your office

TCM Component	Who	What
An Interactive Contact	Physician or a clinical staff with the capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care	• Within 2 business days following the discharge • May be via telephone, email, or face-to-face • Documentation of unsuccessful attempts with continuing efforts until successful
Non Face-to-Face Services	Physicians or non-physician practitioners (NPPs)	• Obtain and review discharge information • Review need for diagnostic tests and treatments • Interact with other health care professionals • Provide education to patient, family or caregiver • Establish referrals and arrange community resources • Assist in scheduling follow up with providers
	Physician or clinical staff under the direction of a physician/NPP	• Communicate with agencies and services used by the patient • Provide education to support self-management, independent living • Assess and support treatment regimen • Identify available community resources • Assist patient and family in accessing care and services
Face-to-Face Visit	Physician or NPP	• Part of TCM and not reported separately • Assume responsibility for the patient's post-discharge service • Bill using the face-to face visit (7th or 14th day) as the date of service

Billing TCM Services

Billing requirements:

- Only one professional may report
- Report once during the TCM period
- Discharging physician may bill for TCM services
- Subsequent E/M services other than required face-to-face visit
  - Bill E/M separately
- May not bill TCM service if within a global period of a procedure

If billing TCM services, do not bill:

- Care plan oversight services (99339, 99340, 99374-99380)
- Home health or hospice supervision: HCPCS codes G0181 and G0182
- 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)
- Chronic care management (CCM) services unless (a) the TCM service period ends before the end of a given calendar month, and (b) the time requirements for CCM services are subsequently met during that month (99490)

What You Need

Documentation Needed in Patient's Medical Record

- Date the patient was discharged
- Date of interactive contact
- Date of face-to-face visit
- Complexity of medical decision-making (moderate or high)

Information Needed to File Claim

- Date of Service
  - Date of the 7th or 14th day visit after discharge
- Place of Service
  - Place where the face-to-face visit was done
- Patient readmitted within 30 day period
  - Bill for a second TCM service after the TCM criteria is met
  - All services described in the code are furnished
  - No other provider bills for the first 30 days
- Patient dies during the 30 day period
  - TCM should not be billed
  - Face-to-face visit may be billed using E/M code
- Practitioners under contract with physician
  - Follow "incident to" requirements
- Other medically necessary billable service
- Other than services stated earlier, allowable to bill separately

Reasons for Denials

If following all guidelines and claim denied:

- Another provider has billed for the TCM
- Not the 7th or 14th day
- Hospital has not billed yet

Frequently Asked Questions[5,6]

Q: Can practitioners under contract to the physician billing for the TCM service furnish the non-face-to-face component of the TCM?

A:
- Must follow "incident to" rules
- Appropriate supervision
- State law and scope of practice applies

Q: During the 30 day period of TCM, can other medically necessary billable services be reported, like Chronic Care Management (CCM)?

A:
- Only if the TCM service period ends before the end of a given calendar month
- 20 minutes of qualifying CCM service
- All other CCM billing requirements are met

Q: What date of service should be used on the claim?

A: The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The date of service you report should be the date of the required face-to-face visit. 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

[5] TCM Fact Sheet (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf)

[6] TCM FAQ (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf)

Transitional Care Management (TCM) Algorithm

1 Patient discharged from hospital with high or low Medical Decision Making (MDM).

YES ☐
See Step 2

NO ☐
TCM code cannot be billed
Bille E & M at normal office visit follow-up

2 Has initial patient contact been made wihin 2 business days post discharge?

YES ☐
1. Set up face-to-face follow-up visit
2. Document in pt chart

NO ☐
1. If unreachable, document in pt chart
2. Retry until patient is contacted

YES ☐
Moderate: follow-up visit scheduled no longer than 14 calendar days after discharge date
High: follow-up visit scheduled no longer than 7 calendar days after discharge date

NO ☐
If pt is not reached and follow up visit is not scheduled, TCM code cannot be billed
Bill E & M at normal office visit follow-up

3 Have you furnished certain services to the patient prior to face-to-face appointment if necessary? Example: Discharge summary or continuity of care documents, establish/re-establish referrals.

YES ☐
Enter pt date in pt chart

NO ☐
If no data necessary, document in pt chart

4 Day of face-to-face follow up visit. The following must be met.

Medication reconcilliation management performed and documented? — **YES** ☐

Obtained, reviewed and documented discharge information? — **YES** ☐

MDM of moderate or high complexity?

HIGH MDM ☐
Document in EHR and see Step 3

MODERATE MDM ☐
Document in EHR and see Step 3

5 Mark on Fee Ticket

HIGH MDM ☐
Saw patient within 7 calendar days after discharge:
Mark Trasitional Care, Date of Hospital Discharge & 99496 on fee ticket

MODERATE MDM ☐
Saw patient within 14 calendar days after discharge:
Mark Trasitional Care, Date of Hospital Discharge & 99495 on fee ticket

TCM Documentation Checklist

This checklist is use to verify documentation supports the use of these new codes.

Requirements

This table lists out the requirements to bill TCM code.

Patient Name	**Date of Discharge**
☐	Phone call or email or personal visit within 2 business days post discharge.
☐	Interactive Contact Date:
☐	Care Coordinator/Navigator Physician Handoff Date:
☐	Interactive Contact Date Documented in Medical Record
☐	Face-to-face office visit date:
☐	Within 7 calendar days, 99496 (high complexity of medical decision-making (Post TCM01 on this date)
☐	Within 14 calendar days, 99495 (moderate complexity of medical decision-making (Post TCM01 on this date)
☐	Review of discharge summary documented
☐	Reconciliation of medications documented
☐	Review need for or follow-up on pending diagnostic tests and treatments
☐	Referrals made to providers of care and community resources documented if needed
☐	Patient and/or family education to support self-management, independent living and activities of daily living documented
☐	Transitional Care Management Code 99495 or 99496 billed 30th day after discharge
Date to bill	

Medical Decision-Making (MDM)

This table includes the number of problems, the number of data reviewed, and risk level. Use this table to calculate MDM.

Problems (Diagnosis and Management)		
	Points	**Total**
Self-limited or minor – stable, improve, or prog as expected	1	
Established prob – stable, improving	1	
Established prob – worsening	2	
New prob – no further workup planned	3	
New prob – additional workup planned	4	
Diagnosis and Management Totals		
Data Reviewed		
	Points	**Total**
Review/order of clinical lab tests (80000 code series)	1	
Review/order of radiology tests (70000 code series)	1	
Review/order of medicine tests (90000 code series)	1	
Discuss test w/ performing or interpreting physician	1	
Decision to obtain old records or history from someone other than patient	1	
Review and summary of old records and/or obtaining history from someone other than pt and/or discussion w/ another provider with documentation of findings	2	
Independent visualization of actual image, tracing, or specimen (not simply review of report)	2	
Data Reviewed Total		

Table of Risk			
Risk Level	**Presenting Problems**	**Diagnostic Procedures**	**Management Options Selected**
Moderate Risk Requires any ONE of these elements in ANY of the three categories listed	One or more chronic illness, with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem, with uncertain prognosis, e.g., lump in breast Acute illness, with systemic symptoms Acute complicated injury, e.g., head injury, with brief loss of consciousness	Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test Diagnostic endoscopies, with no identified risk factors Deep needle, or incisional biopsies Cardiovascular imaging studies, with contrast, with no identified risk factors, e.g., arteriogram, cardiac catheterization Obtain fluid from body cavity, e.g., LP/thoracentesis	Minor surgery, with identified risk factors Elective major surgery (open, percutaneous, or endoscopic), with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids, with additives Closed treatment of fracture or dislocation, without manipulation
High Risk Requires any ONE of these elements in ANY of the three categories listed	One or more chronic illness, with severe exacerbation or progression Acute or chronic illness or injury, which poses a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others, peritonitis, ARF An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss	Cardiovascular imaging, with contrast, with identified risk factors Cardiac EP studies Diagnostic endoscopies, with identified risk factors Discography	Elective major surgery (open, percutaneous, endoscopic), with identified risk factors Emergency major surgery (open, percutaneous, endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate, or to de-escalate care because of poor prognosis

Medical Decision-Making Level

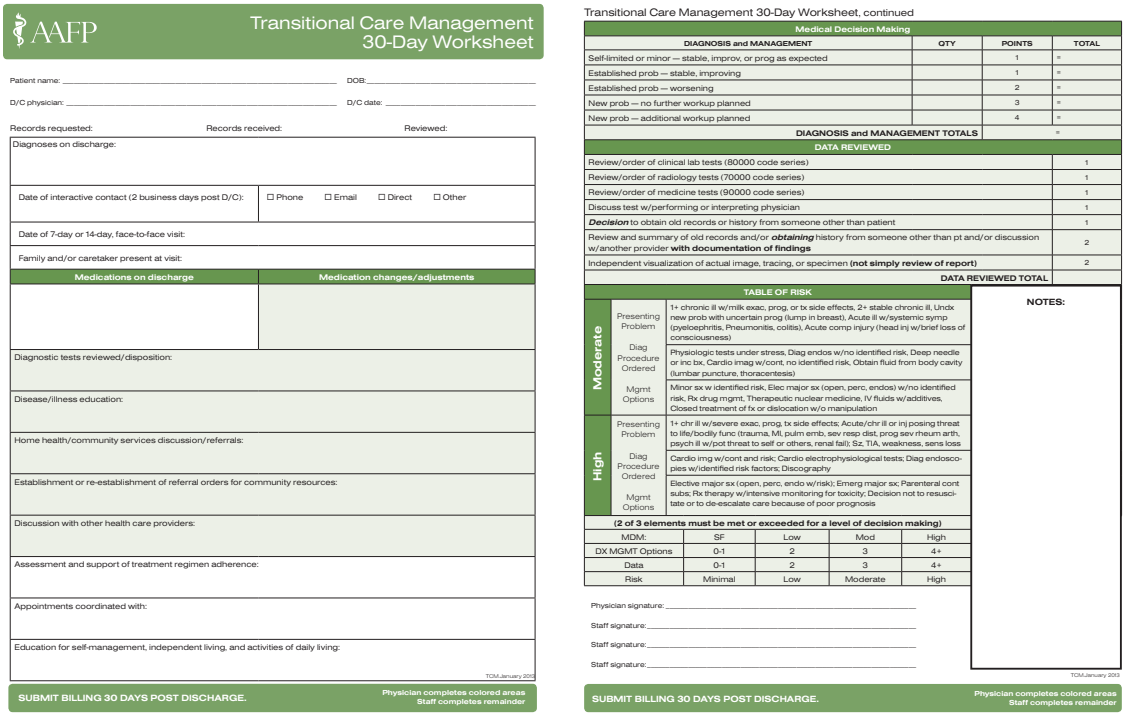
This table determines the level of complexity based on Medical Decision-Making.

Overall MDM	Problem Points	Data Reviewed Points	Risk
99495 – Moderate Complexity	3	3	Moderate
99496 – High Complexity	4+	4+	High

Additional References

For the JAMA Article regarding TCM services and the reduction in mortality and cost: (https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2687989)

For the link to the TCM 30-Day Worksheet from AAFP (screenshot below): (https://familymedicine.med.uky.edu/sites/default/files/TCM30day.pdf)



AAFP

Transitional Care Management
30-Day Worksheet

Patient name: _____ DOB: _____

D/C physician: _____ D/C date: _____

Records requested: Records received: Reviewed:

Diagnoses on discharge:
Date of interactive contact (2 business days post D/C): ☐ Phone ☐ Email ☐ Direct ☐ Other
Date of 7-day or 14-day, face-to-face visit:
Family and/or caretaker present at visit:

Medications on discharge	Medication changes/adjustments

Diagnostic tests reviewed/disposition:
Disease/illness education:
Home health/community services discussion/referrals:
Establishment or re-establishment of referral orders for community resources:
Discussion with other health care providers:
Assessment and support of treatment regimen adherence:
Appointments coordinated with:
Education for self-management, independent living, and activities of daily living:

TCM January 2013

SUBMIT BILLING 30 DAYS POST DISCHARGE.

Physician completes colored areas
Staff completes remainder

Transitional Care Management 30-Day Worksheet, continued

Medical Decision Making			
DIAGNOSIS and MANAGEMENT	QTY	POINTS	TOTAL
Self-limited or minor — stable, improv, or prog as expected		1	=
Established prob — stable, improving		1	=
Established prob — worsening		2	=
New prob — no further workup planned		3	=
New prob — additional workup planned		4	=
DIAGNOSIS and MANAGEMENT TOTALS			=

DATA REVIEWED	
Review/order of clinical lab tests (80000 code series)	1
Review/order of radiology tests (70000 code series)	1
Review/order of medicine tests (90000 code series)	1
Discuss test w/performing or interpreting physician	1
Decision to obtain old records or history from someone other than patient	1
Review and summary of old records and/or ***obtaining*** history from someone other than pt and/or discussion w/another provider **with documentation of findings**	2
Independent visualization of actual image, tracing, or specimen **(not simply review of report)**	2
DATA REVIEWED TOTAL	

TABLE OF RISK		
Moderate	Presenting Problem	1+ chronic ill w/milk exac, prog, or tx side effects, 2+ stable chronic ill, Undx new prob with uncertain prog (lump in breast), Acute ill w/systemic symp (pyeloephritis, Pneumonitis, colitis), Acute comp injury (head inj w/brief loss of consciousness)
	Diag Procedure Ordered	Physiologic tests under stress, Diag endos w/no identified risk, Deep needle or inc bx, Cardio imag w/cont, no identified risk, Obtain fluid from body cavity (lumbar puncture, thoracentesis)
	Mgmt Options	Minor sx w identified risk, Elec major sx (open, perc, endos) w/no identified risk, Rx drug mgmt, Therapeutic nuclear medicine, IV fluids w/additives, Closed treatment of fx or dislocation w/o manipulation
High	Presenting Problem	1+ chr ill w/severe exac, prog, tx side effects; Acute/chr ill or inj posing threat to life/bodily func (trauma, MI, pulm emb, sev resp dist, prog sev rheum arth, psych ill w/pot threat to self or others, renal fail); Sz, TIA, weakness, sens loss
	Diag Procedure Ordered	Cardio img w/cont and risk; Cardio electrophysiological tests; Diag endoscopies w/identified risk factors; Discography
	Mgmt Options	Elective major sx (open, perc, endo w/risk); Emerg major sx; Parenteral cont subs; Rx therapy w/intensive monitoring for toxicity; Decision not to resuscitate or to de-escalate care because of poor prognosis

(2 of 3 elements must be met or exceeded for a level of decision making)

MDM:	SF	Low	Mod	High
DX MGMT Options	0-1	2	3	4+
Data	0-1	2	3	4+
Risk	Minimal	Low	Moderate	High

NOTES:

Physician signature: _____

Staff signature: _____

Staff signature: _____

Staff signature: _____

TCM January 2013

SUBMIT BILLING 30 DAYS POST DISCHARGE.

Physician completes colored areas
Staff completes remainder

For TCM Fact Sheet from CMS: (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf)

For TCM Frequently Asked Questions from CMS: (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf)

185 Berry Street #300, San Francisco, CA 94107