# Transitional Care Management (TCM)

There are two new codes that allow for reimbursement of the non-face-to-face care provided when patients transition from an acute care setting back into the community. These codes are used to pay for all services that up until now were done but not reimbursed.

The requirements for TCM services include:

- The services are required during the patient's transition to the community setting following particular kinds of discharges;
- The provider accepts care of the patient post-discharge from the facility setting without a gap;
- The provider takes responsibility for the patients care; and
- The patient has medical and/or psycho social problems that require moderate or high complexity decision making.

These codes should be billed at the conclusion of the 30-day post discharge period. The 30-day post discharge period begins on the date the patient is discharged from the inpatient hospital setting and continues for the next 29 days. TCM codes are payable once per patient in the 30 days following discharge, thus if the patient is readmitted, TCM codes cannot be billed again.

One face-to-face visit must be furnished within certain time frames as described by the following TCM codes:

- **99495** covers communication with the patient or caregiver within **2 business days** of discharge. This can be done by phone, by e-mail, or in person. It involves medical decision making of at least **moderate complexity** and face-to-face visit within **14 days** of discharge.

- **99496** covers communication with the patient or caregiver within **2 business days** of discharge. This can be done by phone, by e-mail, or in person. It involves medical decision making of **high complexity** and a face-to-face visit within **7 days** of discharge.

According to the Centers for Medicare and Medicaid Services (CMS), attempts to communicate should continue after the first two attempts in the required business days until they are successful. A successful attempt requires a direct exchange of information and appropriate medical direction by the clinical staff with the patient and/or caregiver and not merely receipt of a voicemail or e-mail without response from the patient and/or caregiver. You may not bill the TCM codes 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.

You must furnish non-face-to-face services to the patient, unless it is determined that they are not medically indicated or needed. The following is a breakdown of the types of non-face-to-face services that licensed clinical staff under the providers direction can provide as well as the type of non-face-to-face services the provider can provide:

Licensed clinical staff under the direction of the provider:

- Communicate with the patient or caregiver by phone, e-mail, or in person

- Communicate with a home health agency or other community service that the patient needs
- Educate the patient or caregiver to support self-management and activities of daily living
- Provide assessment and support for treatment adherence and medication management
- Identify available community and health resources
- Facilitate access to services needed by the patient or caregiver

Physician or other qualified clinician:

- Obtain and review discharge information
- Review need of or follow-up on pending testing or treatment
- Interact with other clinicians who will assume or resume care of the patient's system-specific conditions
- Educate the patient or caregiver
- Establish or re-establish referrals for specialized care
- Assist in scheduling follow-up with other health services

The following documentation requirements, at minimum, should be in the patients' record:

- Date the patient was discharged
- Date interactive contact was made with the patient or caregiver
- Date the face-to-face visit was furnished
- The complexity of medical decision making (moderate or high)

CMS provides further billing information, frequently asked questions and resources to assist in understanding these new codes. **To download the Transitional Care Management Fact Sheet, please click here.**

This Week's Tip Provided By:

**Kristi Menyfield, CPC**
Kristi serves as a Medical Auditing Specialist for DoctorsManagement LLC and NAMAS