Trinsic
Clinically Integrated Network
An Intermountain Health and UCHealth Company

Transitional Care Management

What is Transitional Care Management (TCM)?

Transitional Care Management is a program developed by the Centers for Medicare and Medicaid (CMS) to improve care transitions for patients and ensure appropriate payment for providers.

Oftentimes providers use the E and M codes instead of the appropriate TCM CPT codes which pay at a significantly higher reimbursement rate.

Who is eligible to bill for TCM services?

Physicians	CNM	CNS	NP	PA
Any Specialty	Clinical Nurse Midwife	Clinical Nurse Specialist	Nurse Practitioner	Physician Assistant

Who are the eligible beneficiaries of TCM?

TCM is a covered benefit under Medicare fee-for-service (FFS) and some commercial plans.

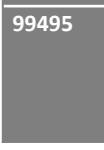
Eligible beneficiaries are those who are discharged **FROM** one of the following settings:

- Inpatient Acute Care.
- Inpatient psychiatric hospital.
- Inpatient rehabilitation facility (IRF).
- Long-term care hospital (LTAH).
- Skilled nursing facility (SNF).
- Hospital outpatient observation or partial hospitalization.
- Partial hospitalization at a community mental health center.

Additionally, to qualify, the beneficiary must be discharged from one of the settings above **TO** one of the following settings:

- Home
- Assisted living
- Nursing facility (Long term/LTC)
- Domiciliary (Group home)

What else is required?



The 30-day TCM period begins on the date of the patient's discharge and continues for the following 29 calendar days.

Patients qualify for TCM services when the following services are met:

1. Discharged from eligible setting to eligible setting (see above).
2. Appropriate form of follow up contact must be met from the list below:

Interactive contact

- Provider or clinical staff (under the provider's direction) must contact the patient or caregiver by phone, email or face-to-face within 2 business days after discharge.
- The interactive contact must be performed by clinical staff who can address patient status and needs beyond just scheduling follow-up care.
- Provider may report the service if two or more unsuccessful separate attempts to contact the patient were made as long as the effort to reach the patient continues until successful.

Non-face-to-face services

Provider or clinical staff must provide patients medically reasonable and necessary non-face-to-face service within 30-day TCM service period. There are different criteria for different provider types:

Physician or NPP requirements

- Review discharge information (i.e., discharge summary or continuity-of-care documents).
- Review the patient's need for, or follow-up on, diagnostic test and treatments.
- Interact with other health care professionals who may assume or reassume care of the patient's system-specific problems.
- Educate the patient, family, guardian or caregiver.
- Establish or re-establish referrals and arrange needed community resources.
- Help schedule required community providers and services follow-up.

Auxiliary personnel (under physician or NPP supervision) requirements

- Communicate with the patient.
- Communicate with agencies and community service providers the patient uses.
- Educate the patient, family, guardian, or caregiver 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.
- Help the patient and family access needed care and services.

Face-to-Face visit

- Provider must have 1 face-to-face or telehealth visit within the timeframes listed in the table below.
- The level of medical decision-making and the time frame for the visit determines which CPT code to use.
- Important: medication reconciliation and management must take place no later than the face-to-face visit.

TCM CPT code	Interactive contact	Face-to-face	Medical decision-making	Fee schedule	RVU
99496	x	Within seven calendar days of discharge.	High level of medical decision making during the service period.	Non-facility: $284.20 Facility: $192.40	3.79
99495	x	Within 14 calendar days of discharge.	At least moderate level of medical decision making during the service period.	Non-Facility: $209.84 Facility: $147.10	2.78

Please reach out to your network engagement team if you would like help with any of these tips.

Transforming care together.