Regional HealthPlus

Transitional Care Management Coding

99495 Transitional Care Management Services requires: ✓ FTF visit within 14 calendar days post discharge ✓ Decision-Making of **Moderate** complexity	
99496 Transitional Care Management Services requires: ✓ FTF visit within 7 calendar days post discharge ✓ Decision-Making of **High** complexity	
Effective Jan 2016, the date of service for TCM should be the first day of care (face-to-face visit)	
Both codes REQUIRE communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days post discharge. This communication may be provided by ancillary staff under the supervision of the physician.	
Documentation Must Include	✓ Timing of initial post-discharge communication with patient/caregiver ✓ Date of face to face visit ✓ Complexity of Medical Decision Making (evidenced by # of diagnoses, data complexity and patient Risk).
Reporting Criteria	✓ TCM commences on date of discharge for the next 29 days ✓ TCM may be rendered by physician or NPP ✓ Includes Face to Face visit (not reported separately) within code specified time-frames ✓ Includes non-face to face services performed by staff under MD supervision ✓ Contact with patient must be made within 2 business days of discharge ✓ Medication reconciliation and management must occur no later than the date of the first face to face visit
Non-Face to Face services provided by clinical staff under the direction of physician or NPP include	□ Communication with Home Health Agencies and other community services utilized by patient □ Patient and family/caretaker education to support self-management, independent living, and ADLs □ Identification of available community and health resources □ Facilitating access to care and services needed by patient and/or family
Non-Face to Face services provided by the physician or NPP include	□ Obtaining and reviewing the discharge information or continuity of care documents □ Reviewing need for or follow up on pending diagnostic tests and treatments □ Interaction with other health care professionals who will assume or reassume care of the patient's system-specific problems □ Education of patient, family, guardian and/or caregiver □ Assistance in scheduling follow up with community providers and services
Code Frequency	**Once per patient per thirty days (*see re-admissions)**
Re-Admission during initial TCM period	There are two Options: 1 – Bill for TCM using first discharge date or 2 – Wait for next discharge date to start 30-day TCM period
Code Limitations	Surgeons in 90-day global period cannot use these codes Initial face-to-face E/M service bundled into TCM codes
Additional OV needed during TCM period	Any medically necessary encounter provided during the 30-day TCM period may be billed using the appropriate E/M code
Context **(Allowable discharge and transition sites of service)**	Transition of Care occurs when patient is discharged from these places of service: Inpatient, acute, rehab, long term acute care, partial hospitalization, observation, SNF, or NF (NOTE: EMERGENCY DEPT DISCHARGE DOES NOT QUALIFY FOR TCM) The TCM codes cover discharge from those places of service to patient's home. **DO NOT BILL TCM CODE IF THE PATIENT DOES NOT TRANSITION TO HIS HOME.**
Providing Specialty	Primarily used by PCPs, however any provider (or specialty other than hospitalist) who is managing the post-discharge care may bill these codes.