Transitional Care Management

NATIONAL ASSOCIATION OF
Community Health Centers®

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Microlearning:
Transitional Care Management

What?

Why?

How?

STEP 1 Identify/Hire Care Coordination/Care Management Staff

STEP 2 Identify Patients For Care Coordination/Care Management

Prior Steps: Empanelment, Risk Stratification, Models of Care

STEP 3 Define Care Manager-Care Team Interface

STEP 4 Define Services Provided as Part of Care Management

STEP 5 Enroll Patients in Care Management

STEP 6 Create Individualized Care Plans

STEP 7 Enhance and Expand Partnerships

STEP 8 Document and Bill for Care Management

STEP 9 Graduate (Transition) Patients from Care Management

STEP 10 Measure Outcomes

Transitional Care Management

WHAT?

WHY?

HOW?

WHAT
Is Transitional Care Management (TCM)

Examples of Care Transitions Along the Patient Continuum of Care

Primary Care
Care Transition
Specialty Care
Care Transition
Primary Care
Care Transition
Emergency Department
Care Transition
Primary Care
Care Transition
Hospital
Care Transition
Nursing Home
Care Transition
Care Transition
Primary Care
Home Health

WHAT
Is Transitional Care Management (TCM)

Transitional Care Management (TCM) supports the transition and coordination of services from an **inpatient/acute care setting** to a **community care setting** by establishing a coordinated plan with the patient's Primary Care Provider (PCP).

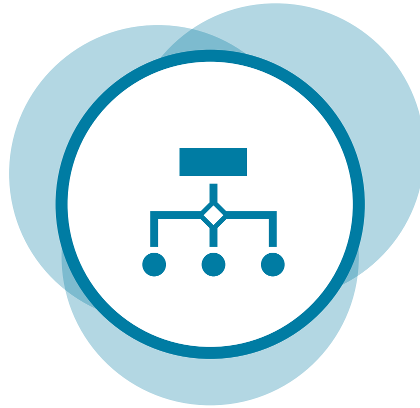
Transitional Care Management

WHAT?

WHY?

HOW?

Why Transitional Care Management?

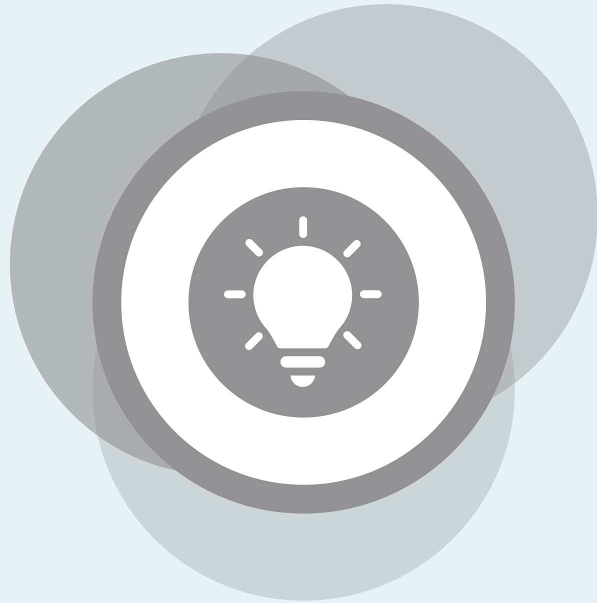


Essential population health activity

Improve health outcomes

Revenue potential

Transitional Care Management



WHAT?

WHY?

HOW?

Step 1: Identify/Hire Care Coordination/Care Management Staff

Consider the volume and care needs of the patient population

- Empanelment
- Risk Stratification

Consider the responsibilities the Care Manager may have in addition to TCM

- Chronic Care Management, nursing responsibilities, other care coordination duties

Coming Soon: Care Team Planning Worksheet – Care Coordination and Care Management

Expanded Care Roles

Job descriptions reflect staff roles and broad responsibilities that are allowable under state laws and licensure.

Job descriptions outline staff responsibilities that can be accomplished remotely.

Step 2:
Identify Patients For Care Coordination/Care Management

Patient eligible for TCM services are those who, within the past 2 business days, have been discharged from an **inpatient/acute care setting** and transitioned to a **community care setting.**

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long-term care hospital
- Skilled nursing facility
- Inpatient rehabilitation facility
- Hospital outpatient observation/partial hospitalization
- Partial hospitalization at a community mental health center

Step 3:
Define Care Manager-Care Team Interface

- Utilize state or local Health Information Exchanges (HIEs) to review Admit, Discharge, Transfer (ADT) data
- Form or strengthen relationships with local care systems (hospitals, EDs, nursing homes, etc.)
- Document a process for how care transition data will be received and reviewed, and follow up services provided as needed

Demonstrate HRSA OSV Compliance

Continuity of Care and Hospital Admitting

The health center has internal operating procedures and, if applicable, related provisions in its formal arrangements with non-health center provider(s) or entity(ies) that address the following areas for patients who are hospitalized as inpatients or who visit a hospital's emergency department (ED):

1. Receipt and recording of medical information related to the hospital or ED visit, such as discharge follow-up instructions and laboratory, radiology, or other results; and
2. Follow-up actions by health center staff, when appropriate.

Step 4:
Define Services Provided as Part of Care Management

Three components in 30 days:

1. Initial Interactive Contact
2. Face-to-Face Visit
3. Non-Face-to-Face Services

All three components are required to bill Medicare for TCM services.

This process is best practice and can be applied for all patients moving through transitions of care, though reimbursement may vary by state or payer.

Step 5:

Enroll Patients in Care Management

Initial Interactive Contact

Within 2 business days of discharge date, the Care Manager (under the supervision of the billing provider) initiates direct and interactive communication with the patient (phone, in-person, electronic)

- Contact should address:
  - Type of services the patient had during admission
  - The discharge diagnosis
  - Follow up services that may be needed
  - Scheduling a face-to-face follow up appointment with the provider (PCP)

- It may also be beneficial (though not required) to address:
  - Medication reconciliation (required on or before the date of the face-to-face visit)
  - Social Drivers of Health (SDOH)
  - ADLs (Activities of Daily Living)

Step 5:

Enroll Patients in Care Management

Face-to-Face Visit

Following discharge, a face-to-face visit with a provider (PCP) is required.

- A patient whose condition warrants medical decision making of **high complexity** must be seen within **7** days of discharge.
- A patient whose condition warrants medical decision making of **moderate complexity** must be seen within **14** days of discharge.

Telehealth Visits

During the COVID-19 Public Health Emergency (PHE), CMS allows TCM to be provided as an audio-visual telehealth service. As it is on the CMS list of telehealth services, the current guidance is that it would be billed for using G2025 for the duration of the PHE when provided as an audiovisual telehealth service.

Step 6:

Create Individualized Care Plans

Face-to-Face Visit

The face-to-face visit does not have to meet typical Evaluation and Management documentation requirements. In addition to minimum documentation requirements, clinical notes may include:

- Medication reconciliation (required on or before the date of the face-to-face visit)
- Referrals made to other providers
- Identification of community resources available to the patient
- Any contacts made with other providers to coordinate care
- Continuing care instructions for family members who may be present
- Patient education materials given to the patient
- Labs and/or diagnostic tests performed
- DME ordered or discontinued

Step 6:

Create Individualized Care Plans

Non-Face-to-Face Services

Throughout the 30-day post-discharge time period, additional care coordination services may be needed by the patient. These “Non-Face-to-Face Services” by the **Provider** may include:

- Reviewing the discharge information
- Reviewing the need for, or following up on, pending diagnostic tests and treatments
- Interacting with other qualified health care professionals who will assume or reassume care of the patient’s system-specific problems
- Educating patient, family, guardian, and/or caregiver(s)
- Establishing or reestablishing referrals and arranging for needed community resources

Step 6:

Create Individualized Care Plans

Non-Face-to-Face Services

Throughout the 30-day post-discharge time period, additional care coordination services may be needed by the patient. These “Non-Face-to-Face Services” by the **Care Manager** or other care team members may include:

- Identify and facilitate access to, and communication with, community and health resources, including home health agencies, available to support patient and/or family service needs
- Provide assessment to support adherence and management of medication treatment regimen
- Educate patient and/or family/caretaker to support self-management, independent living, and ADLs
- Communicate aspects of care with the patient and any individuals involved in the care or decision-making process.

Step 7:
Enhance and Expand Partnerships

- Create or enhance partnerships with community agencies to connect patients moving through care transitions with needed social services and community support.

- Work with applicable Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), payors, or local health care systems to improve TCM processes and optimize communication.

Step 8:
Document and Bill for TCM

TCM Documentation Requirements

- ✓ Date the beneficiary was discharged
- ✓ Date of interactive contact with the beneficiary and/or caregiver
- ✓ Date of the face-to-face visit
- ✓ Complexity of medical decision making (moderate to high)
- ✓ Services provided during Face-to-Face Visit and Non-Face-to-Face components

FQHC Provider CPT Codes	What FQHC bills to CMS	What CMS Pays
99495 (Moderate Complexity) Communication with patient and/or caregiver within 2 days of discharge; **Moderate MDM** ; Face-to-face visit, **within 14 calendar days of discharge** **99496 (High Complexity)**Communication with patient and/or caregiver within 2 days of discharge; **High MDM**; Face-to-face visit, **within 7 calendar days of discharge**	**G0467**; established FQHC patient visit *TCM services are qualified visit codes under G0467*	**$180.16 (PPS)**
If services are provided via Telehealth During PHE, G2025 rate trumps non-PHE telehealth rate.	**G2025**	**$97.24**

Step 9:

Graduate (Transition) Patients from Care Management

- Provide care management services to high-risk patients on a routine basis to prevent readmissions and support management of chronic conditions.
- The face-to-face visit included in Transitional Care Management (TCM) services qualifies as a “comprehensive” visit for care management service initiation.
- Use TCM visit as an opportunity to enroll qualifying patients in Chronic Care Management programs.

Step 10: Measure Outcomes

Track TCM process and outcome measures

- Completed TCM encounters
- Hospital/ED discharges
- Hospital admissions/readmissions
- ED visits
- Cost of care

Work with applicable Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), payors, or local health care systems to improve processes and track outcomes together!