NATIONAL ASSOCIATION OF Community Health Centers®

Workflows for

eClinicalWorks Transitional Care Management (TCM)

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Overview

Medicare 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.

Patients eligible for TCM services are Medicare Part B patients at a moderate or high medical decision making (MDM) level who, within the past two business days, have been discharged from an inpatient/acute care setting and transitioned to a community care setting.

Care Management Services must include these three components in 30 days:

- Initial Interactive Contact can be done via phone within 24-48 hours
- Face-to-Face Visit
- Non-Face-to-Face Services

Resources:

- NACHC Elevate Transitional Care Microlearning
- NACHC Reimbursement-Tips_TCM
- eClinicalWorks Transition Care Management User Guide

eClinicalWorks Care Team Roles

	eClinicalWorks Role	Who they Are	eClinicalWorks Functionality	CMS Service Provider Role
	**Provider**	• Physicians (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)	Provide face-to-face TCM visit within 7-14 days and general supervision of care management activity.	Authorized Billing Providers
	**Care Manager** *(Staff with Resource and Care Manager checked or Providers with Care Manager checked)*	• Licensed healthcare professional • Nurses (nurse care manager, clinical nurse specialists (CNS), RN, LPN) • Social Worker	Manage all clinical aspects of a patient's care plan under the general supervision of an authorized billing provider. Updates care plan.	Auxiliary Personnel
	**Care Coordinator** *(Staff who are not a resource and have Care Coordinator checked)*	Non-licensed or credentialed staff	Responsible for updating demographics, scheduling appointments, following up by phone, and basic care planning. **Cannot update the care plan.**	
	**Care Giver** *(Must be in Patient Contacts in Demographics)*	Family members, friends, nurses, or other individuals involved in the patient's care.		

High-Level TCM eClinicalWorks Workflow Options

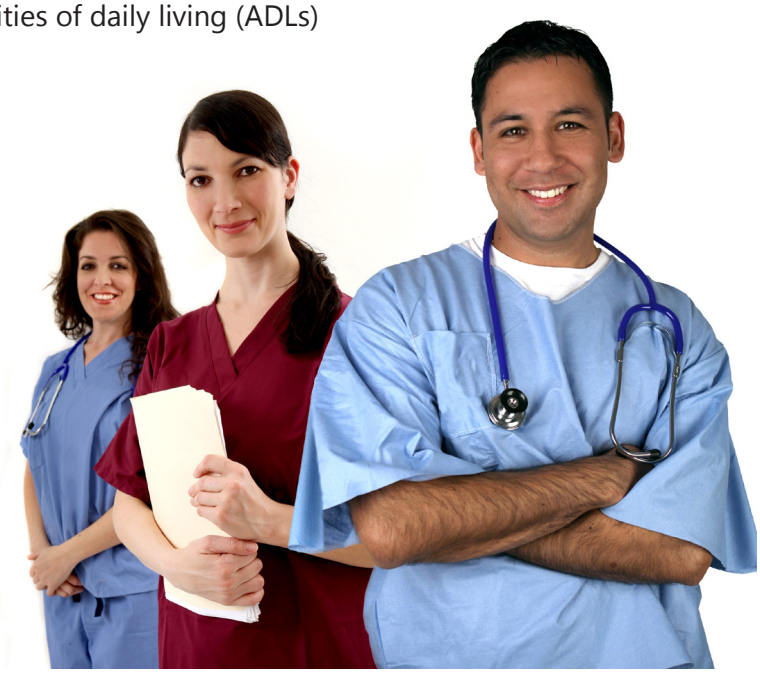
- Identify and enroll eligible patients for the TCM program in the eClinicalWorks PHM TCM Module or manually track identified patients.
- Document discharge in the TCM module TCM Note or document a Telephone encounter virtual visit using a TCM Progress Note Template.
- Document and track initial interactive contact, face to face visit and non-face to face visit using the TCM module or manually using the Registry, Telephone encounters and progress note visit.
- Address the TCM event in the TCM module to generate the claim or generate visit claims using the standard process.
- Monitor and report on TCM activity and revenue.

Best Practice Documentation Guidelines

All documentation should support medical necessity for services reported by a **CPT, HCPCS, or Diagnosis code**.

Document:

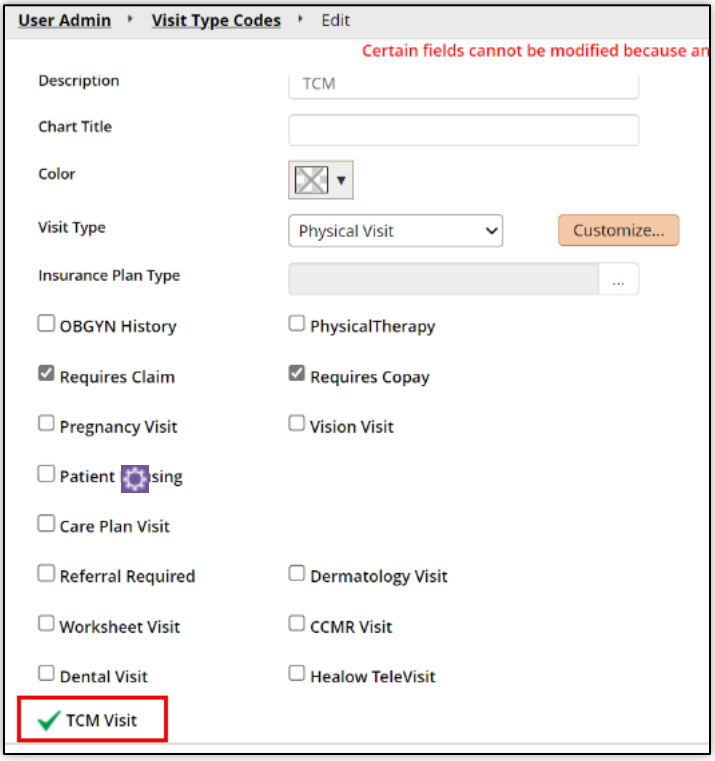
- Patient's verbal or written informed consent for the TCM program
- Patient's discharge date
- Date of interactive contact with patient/caregiver and the mode of communication
- Unsuccessful attempts to contact the patient/caregiver
- Date and details of medication reconciliation
- Date of face-to-face-visit and mode
- Moderate or high MDM
- Services performed during the face-to-face visit
- Date and who provided the non-face-to-face services
- Relevant Social Drivers of Health (SDOH) and activities of daily living (ADLs)



TCM Module eCW System Configuration

Assign Visit Types to access TCM

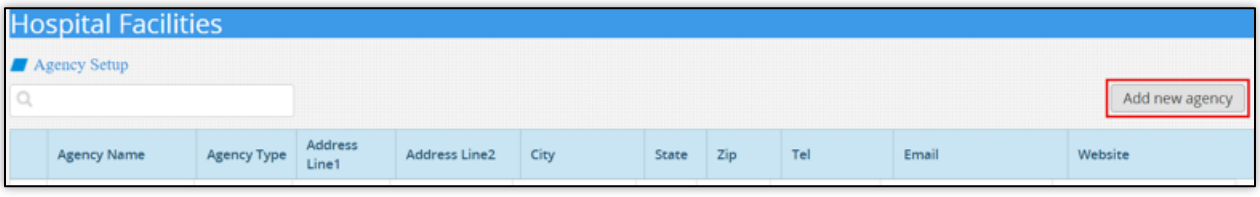
- Navigate to ***Admin > Admin > User Admin > Visit Type Codes***
- Select an "established visit type or create a new visit type"
- Check the box "TCM Visit"



Setup Hospital Facilities or Agencies

Admin Menu > PHM/CCMR Setup > Agencies/Facilities

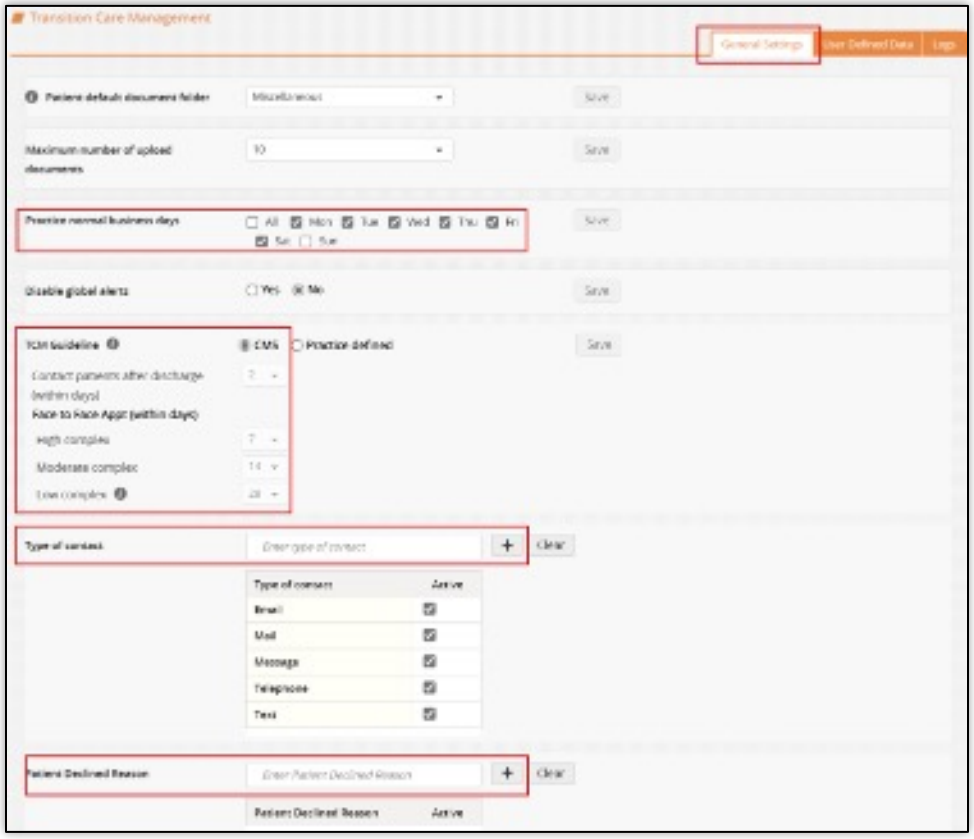
Add an "agency" for each facility the patients are transitioning care from.



TCM General Settings

Admin Menu > PHM/CCMR Setup > Programs > TCM > General Settings

- Set “practice normal business days”
- Set the “CMS TCM Guidelines” (recommended) or customize “Practice Defined guidelines” for the program
- Add “type of contacts”
- Add “patient declined reasons”



User Defined Structured Data

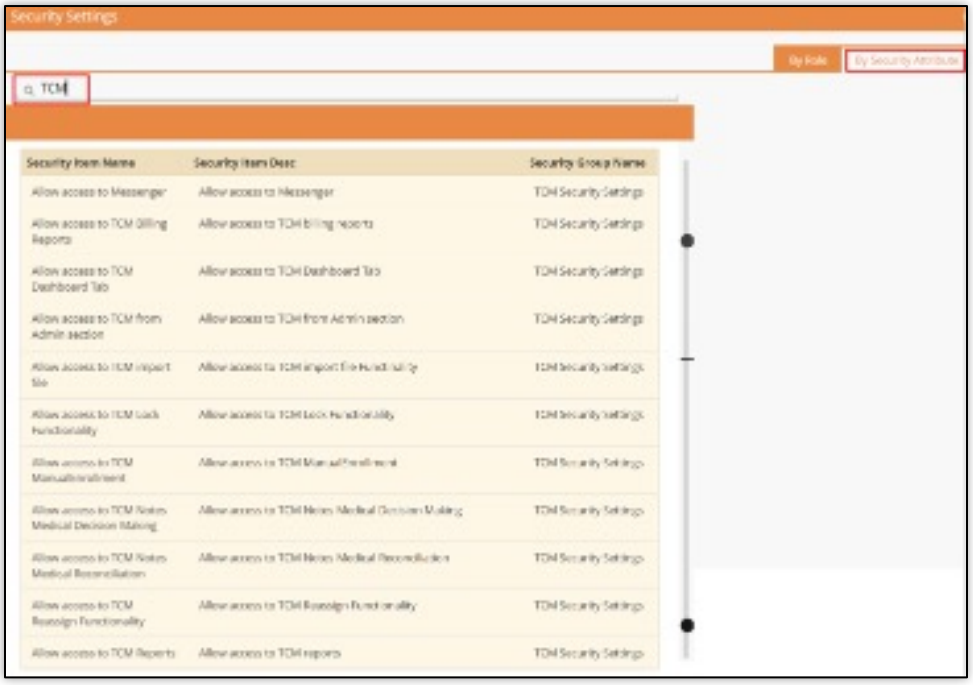
Admin Menu > PHM/CCMR Setup > Programs > TCM > General Settings

Create custom structured data to document the transition of care management notes. Create categories and structured text.

Update Security Settings

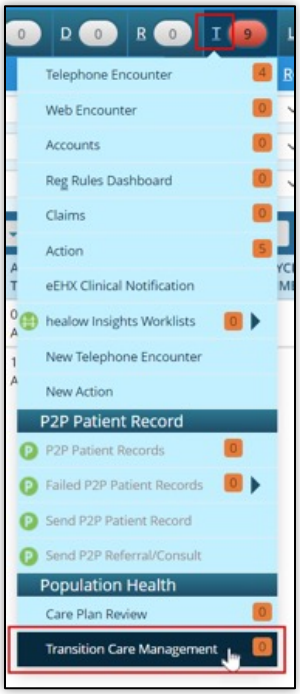
Main Menu > File > Security Settings

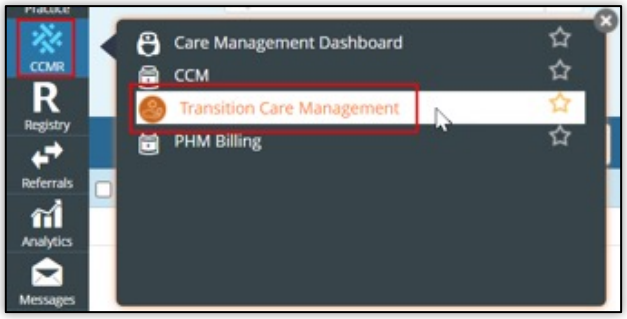
Review and update TCM Security attributes to ensure staff have the right permissions.



TCM Module Dashboard

Navigate to the ***T Jellybean > Transition Care Management or PHM/CCMR Menu > Transition Care Management***

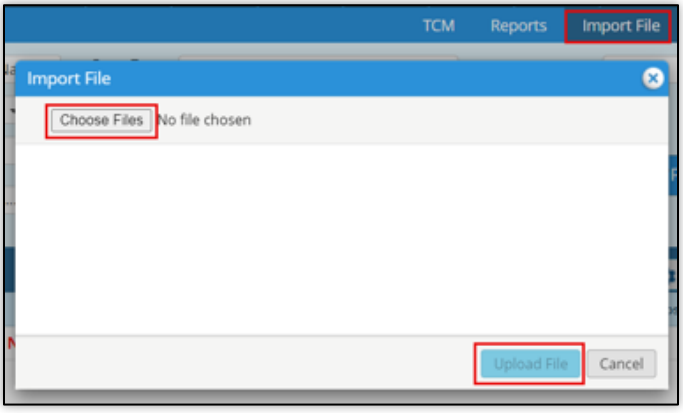




TCM Dashboard Overview

TCM tab

- Enroll a patient
- Access to healow Messenger
- Reassign a patient
- Show/Hide columns
- Filter Options
- List of patients with events/enrollments



Import File tab

Option to manually import file with a list of discharged patients

TCM Workflow

Identify Patients for Transitional Care Management

Who?
- Care Coordinators/Care Managers
- Providers
- Clinical Staff

How Often?
- Daily

Identify patients discharged from an inpatient/acute care setting and transitioned to a community care setting within the past 2 business days. The discharge notification may be provided through an Admit, Discharge, Transfer (ADT) interface, discharge summary from a Health Information Exchange (HIE)/Qualified Entity, discharge summary through P2P/Direct Messaging, fax, phone calls, or other means.

*Use the **TCM Module** to track patients that discharged or create a Telephone encounter to manually track the post-discharge documentation.*

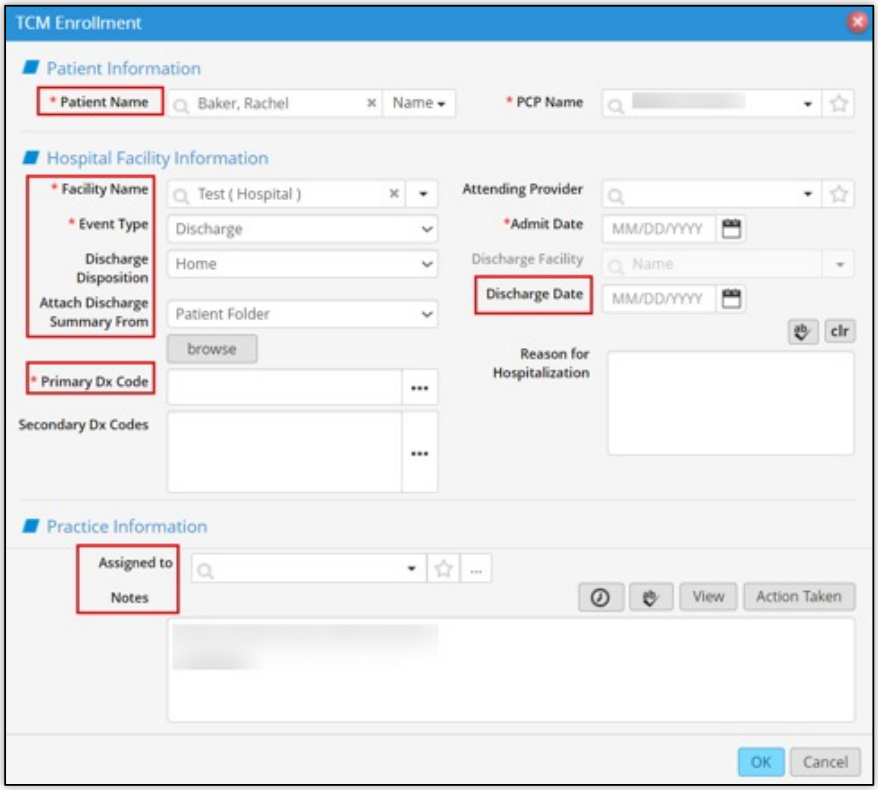
Enroll Patient to TCM

T Jellybean > Transition Care Management or PHM/CCMR Menu > Transition Care Management

Patients are automatically enrolled in the TCM program if the discharge notification is sent through an ADT interface or P2P/Direct Message. Patients can be enrolled manually when the discharge notification is received from an HIE, fax, phone calls, or other means.

Manual Enrollment to TCM Program

- Select the  icon
- Lookup and select the "Patient", the patient's PCP will automatically display
- Select the "Hospital/Discharge Facility Name"
- Select the "Discharge Event Type"
- Select the "Discharge Disposition"
- Enter the "Admit and Discharge Date"
- Select the "Primary Dx Code and any other important information"
- Assign it to the "Staff that is tracking and managing the transitional care"



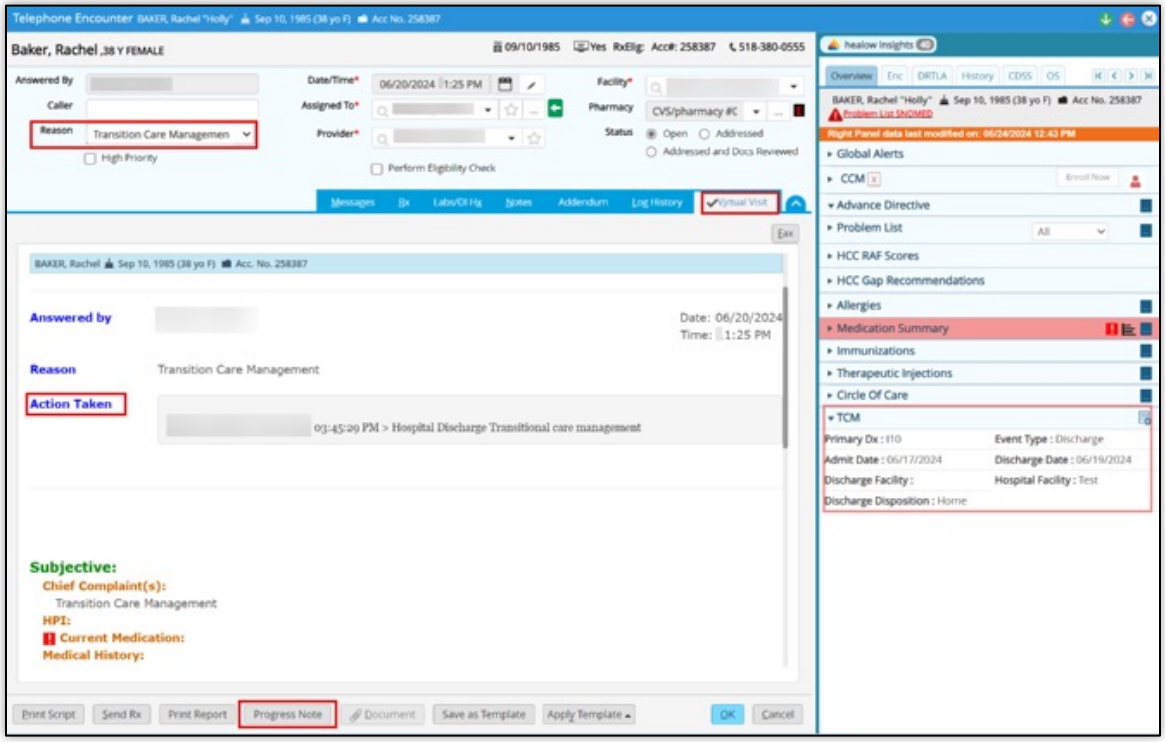
Updating TCM Enrollment Information

- Check the box on the row next to the patient listed on the event list in the **TCM Dashboard**

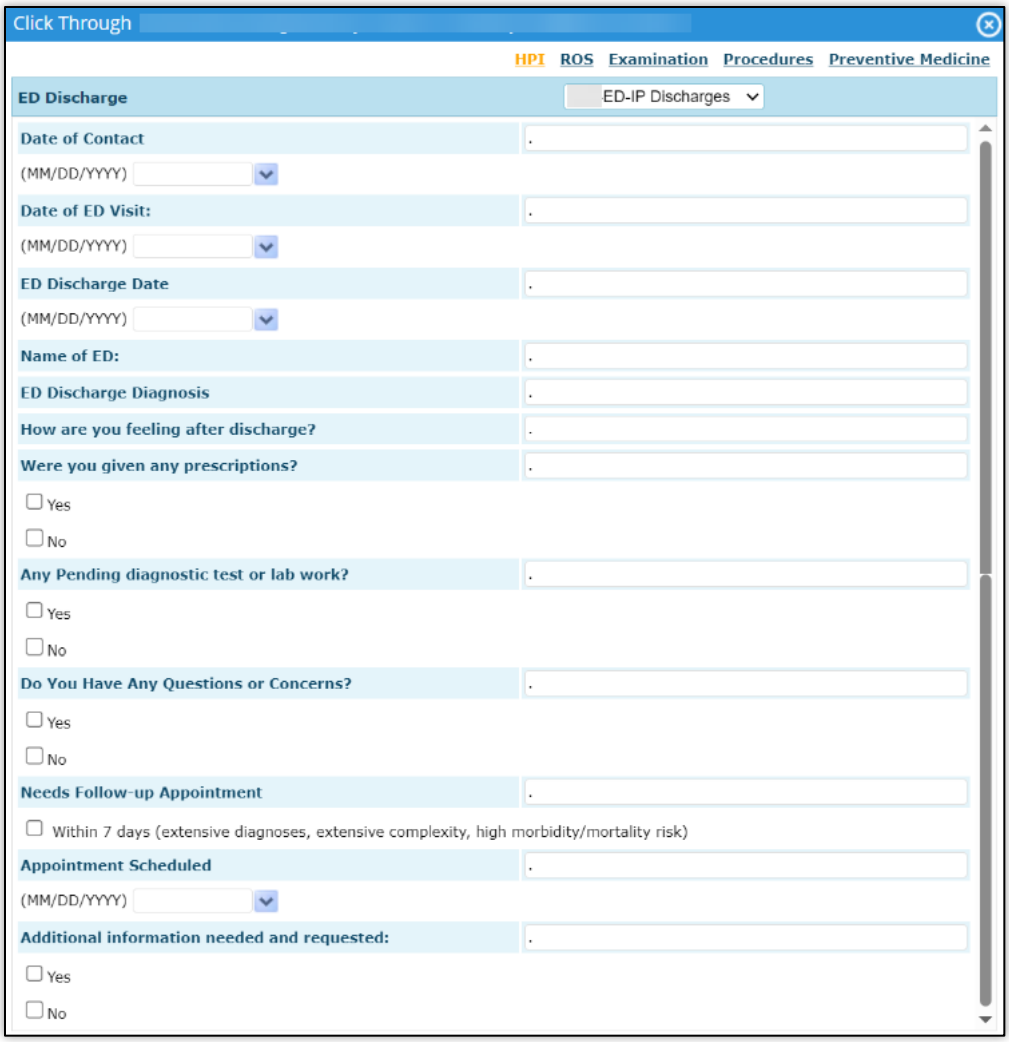
- Select the  icon
- Update any patient information on the enrollment

Manually Tracking TCM (without using the TCM Module)

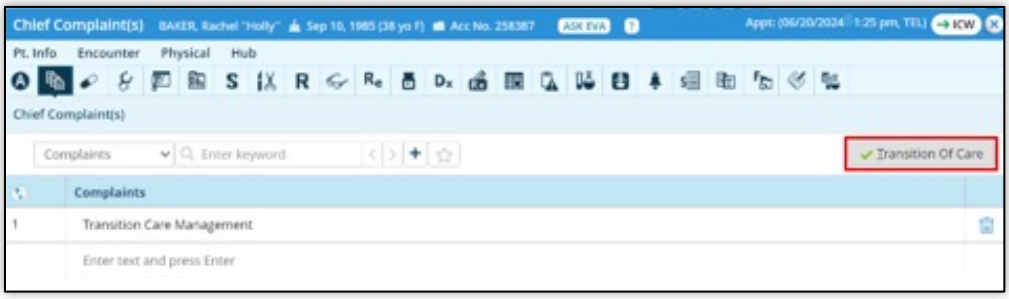
- Navigate to the **Patient HUB**
- Create a Telephone Encounter
  - Enter Reason "Transition Care Management"
  - Enter "Action Taken" notes
  - Select the "Virtual Visit" tab
  - Select the "Progress Note" button

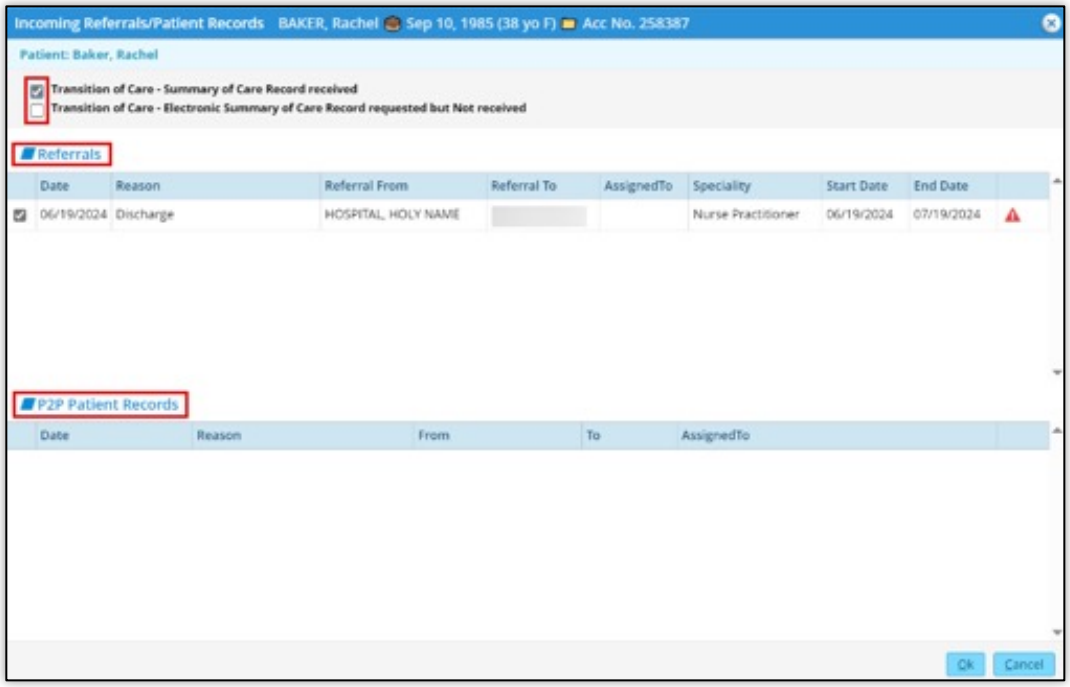


- Merge custom **TCM Template** in the **Progress Note** to document appropriately with structured data



- Optional: In the **Chief Complaint(s)** section, select "Transition of Care" button to attach the Summary of Care Record





- Use the Registry or a custom report to track TCM services with the structured data documentation

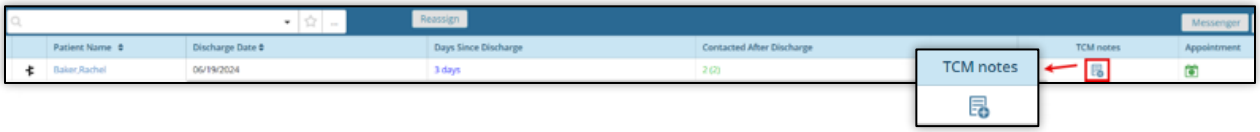
Document the Initial Interactive Contact Post-Discharge

Who?
- Care Coordinators/Care Managers
- Providers
- Clinical Staff

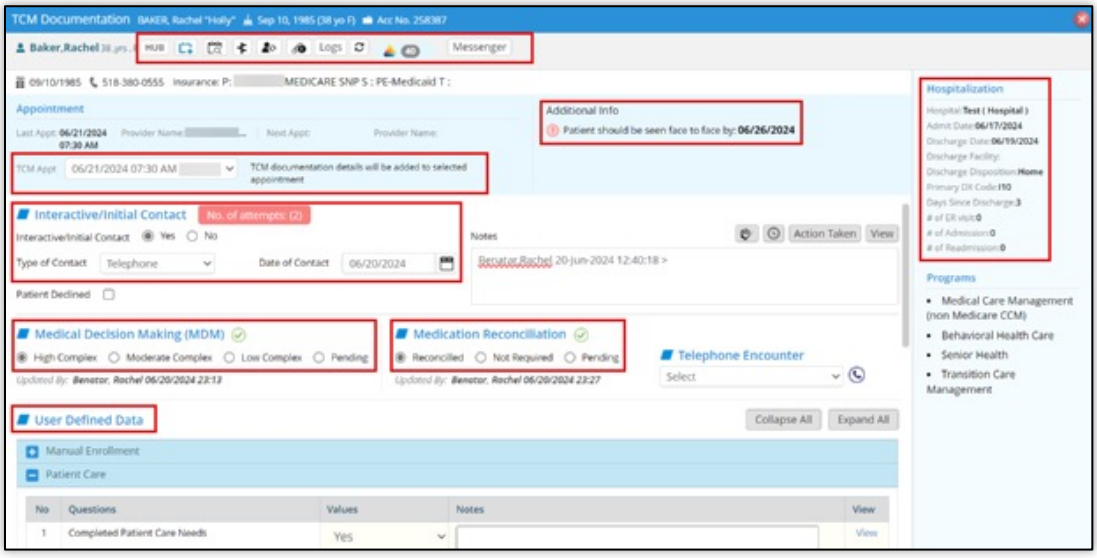
How Often?
- Daily

TCM Module

Update the **TCM note** to document attempts made to reach the patient, interactive contact within two business days after discharge, necessary assessments, and other non face-to-face services.



- The TCM notes provide access to document the patient information related to the transition of care.
  - o Document the **Interactive/Initial Contact, Type of Contact, Date of Contact**, and any action taken/ notes as needed (the system will calculate the number of attempts)
  - o Select "values and answer questions to document custom structured data" in the **User Defined Data** section
  - o Utilize the Action icons in the **Patient Information** section



Telephone Encounter (without using the TCM Module)

Update the Telephone encounter using the **Virtual Visit Progress Note** template.

Schedule the Patient for a Face-to-Face TCM Appointment with Provider

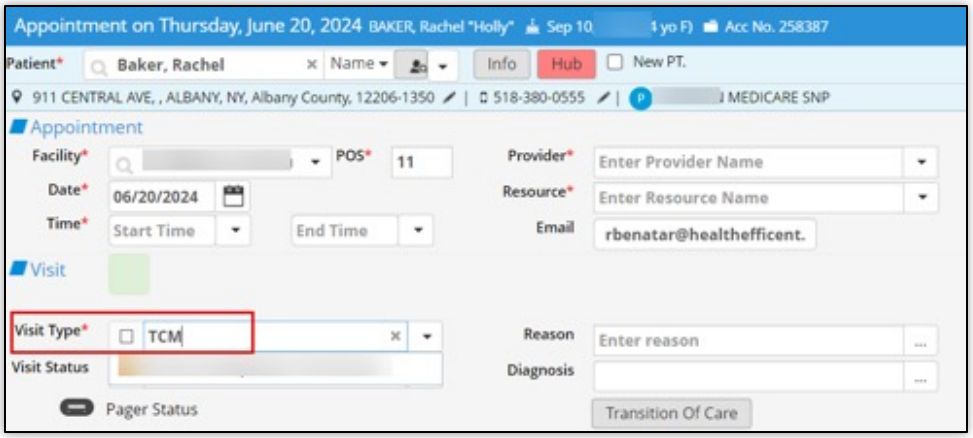
Who?
- Care Coordinators/Care Managers
- Scheduling Staff

How Often?
- Once within 7 or 14 days of discharge

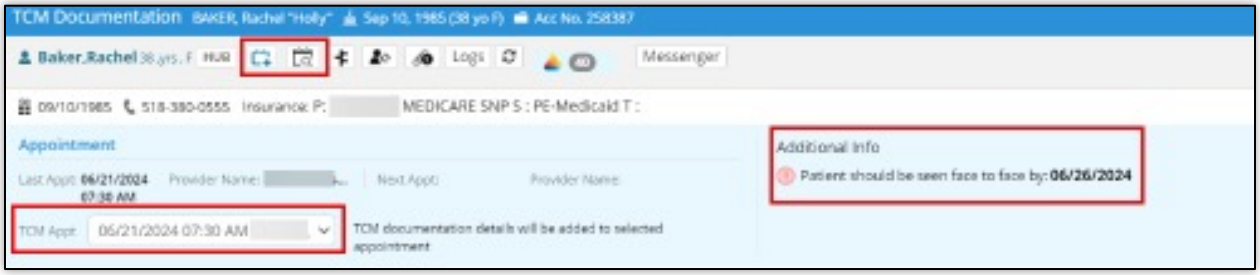
Schedule an appointment for the patient with the primary care provider based on MDM complexity:

- **High complexity** within 7 days of discharge
- **Moderate complexity** within 14 days of discharge

Select "TCM" Visit Type when scheduling the appointment.



Note: The TCM program will automatically calculate when the patient needs to be seen based on the entered discharge date and level of MDM complexity in the TCM Note. The TCM Note provides easy access to schedule the Face-to-Face appointment and link the upcoming TCM Appt.



Face-to-Face Visit

Who?
- Clinical Staff/Care Team
- Providers

How Often?
- Once within 7 or 14 days of discharge

Patient Intake

- Clinical staff completing intake for TCM appointments should complete the following:
  - Review the patient's Medications, Allergies, Social History, and any Documents that have not been discussed with the patient previously.
  - Verify the patient's Care Team is accurate and up-to-date
  - If a Telephone Encounter was used for the initial contact, merge the template notes to the face-to-face encounter.
- When using the TCM module the TCM event, information displays in the TCM visit
  - Select the "Transition Care Management" section to update the TCM Note as needed

Plan:

Treatment:
Recommended Wellness and Prevention Guidelines:
Procedures:
Immunizations:
Therapeutic Injections:
Diagnostic Imaging:
Lab Reports:
Procedure Orders:
Preventive Medicine:
Health Risk Assessment:
Care Plan:
Transition Care Management:

Hospitalization Info	
Event Type	Discharge
Admit Date	06/17/2024
Primary Dx	I10
Secondary Dx	
Discharge Date	06/19/2024
Hospital Facility	Test
Discharge Disposition	Home
Reason	
Practice follow up	
Initial Contact	Yes 06/19/2024
No of Attempts	2
Medical Decision Making	High Complex
Medication Reconciliation	Reconciled
Practice defined data	
Manual Enrollment	
Patient Education	
Patient Care	
Completed Patient Care Needs	Yes
Stepdown	

Next Appointment:

Provider Workflow

Providers will document the encounter like a standard office visit.

Review the information documented during intake and enter the following information recommended to meet CMS Guidelines:

- Medication – be sure to mark these as *reviewed to document medication reconciliation performed*
- Allergies – mark these as *verified*
- Social History – mark these as *verified*
- Document Review
- Care Team
- Assessment and Problem List
- Add appropriate TCM CPT code **99495** or **99496**

In addition to minimum documentation requirements, the Clinical Notes may include:

- Community resources available to the patient
- Any contacts made with other providers to coordinate care
- Continuing care instructions for family members present during the visit
- Labs and/or diagnostic tests performed
- DME ordered or discontinued

***Note:** It is recommended to create a **TCM Face-to-Face visit Template** to guide the provider and clinical team with documentation and coding.*

Non-Face-to-Face Visit

Who?
- Care Coordinators/Care Managers
- Providers

How Often?
- As needed in 30 days post discharge

Document TCM non-face-to-face services provided after the face-to-face visit during the 30 days following the patient's discharge by amending the TCM note or Telephone encounter.

Care Coordination Services

Provider

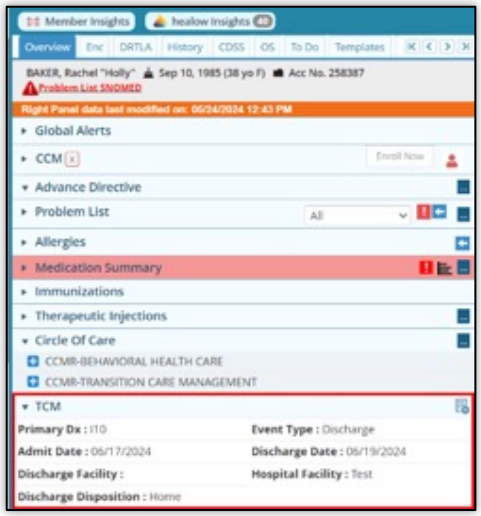
- Obtains and reviews discharge information.
- Reviews the need for or follow-up on pending diagnostic tests and treatments.
- Interacts with other healthcare professionals who will assume or resume care of the beneficiary's system-specific problems.
- Provides education to the beneficiary/family/guardian/caregiver.
- Establishes or reestablishes referrals for needed community resources.

Care Manager/ Care Team

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

TCM Module

Update the TCM Note as needed. The TCM program event information is displayed in the **Right Chart Panel**. Click on the "TCM Note icon" to update documentation.



Telephone Encounter (without using the TCM Module)

Create a Telephone Encounter to document the post face-to-face visit follow-up. Assess if the patient should be transitioned to Chronic Care Management or Remote Patient Monitoring programs.

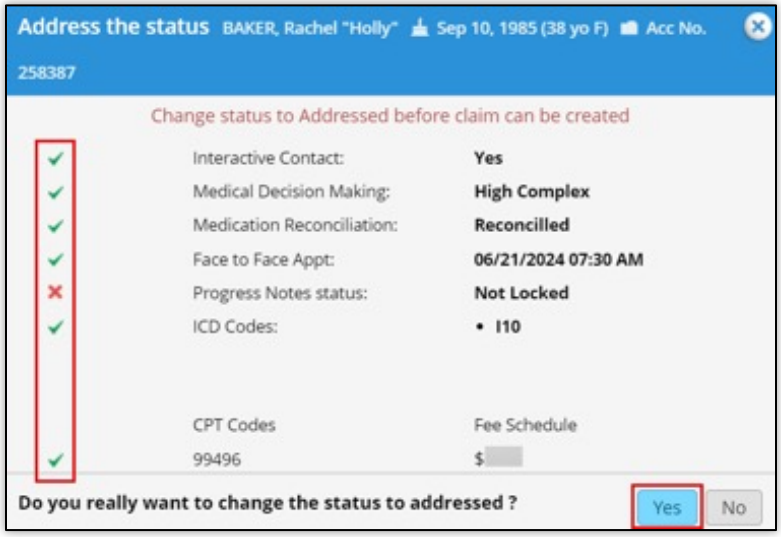
Close/Address the Transition of Care

Who?
- Providers

How Often?
- Once, at the end of 30 days post discharge

Navigate to the TCM Dashboard to lock and address the Transition of care event.

- Click on the "Lock icon"
- Review the information and verify all elements are addressed; an ***x*** displays next to an item that was not addressed
- Click "Yes" to change the status to "Addressed"



Billing Workflow

Who?
- Billers

How Often?
- As needed

Create TCM claims following the same process as other claims. Verify the documentation meets the Medicare guidelines.