Transitional Care Management

All Payor Information for Transition of Care

Transitional care management (TCM) services (99495–99496)

99495 – (2.78 RVU) Moderate complexity within 14 days post-discharge
99496 – (3.79 RVU) High complexity within 7 days post-discharge
1111F – Discharge medications reconciled with the current outpatient medication list

Could incorporate these codes as well:

Basic life and/or disability evaluation services: code 99450

Care management services: codes 99439, 99487, 99489, 99490–99491

General behavioral health integration care management: codes 99484, 99492–99494 and HCPCS G2214 (Do not report 99484 in conjunction with 99492, 99493, 99494 in the same calendar month.)

Psychiatric collaborative care management services: codes 99492–99494

Work related or medical disability evaluation services: codes 99455–99456

There are differences in different types of medication reconciliation/review

Medication 'review' (which does not involve post-charge) = 1159F and 1160F

1159F – Medication list documented in medical record

1160F – Review of all medications by a prescribing practitioner or clinical pharmacist (such as, Rx, OTCs, herbal therapies, and supplements) documented in the medical record

Medication reconciliation **post discharge** is something that should be done and billed with transitional care management codes.

Some insurance payors are reimbursing physician practices for billing the 1111F code. (BCBS is paying $35)

Who can complete the medication reconciliation for transitional care management?

Medication reconciliation requires the medications on discharge be reconciled with the medications the patient was taking previously. The nurse can obtain these medications, but the physician needs to order any changes, additions, or deletions to the medication. Medication reconciliation and management must be furnished no later than the date of the face-to-face/telehealth visit.

Medication reconciliation can help:

- Address medication errors or duplications
- Educate patients on new medications and side effects
- Lower the risk for adverse interactions or readmissions

For the MRP HEDIS measure, documentation from outpatient record must include:

- Date medication reconciliation was performed
- List of current medications
- Notation stating that current medication and discharge medication lists were reviewed
- Signature of prescribing care provider, clinical pharmacist or registered nurse who performed medication reconciliation, or notation of current medications with evidence the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review.
- If medications were provided at discharge, please include your patient's next steps such as:
  - Take new medications as prescribed
  - Discontinue all discharge medications
- Notation if no medications were prescribed at discharge

Transitional care management billing requirements

- TCM services can be billed for new and established patients.
- Only one health care professional may report TCM services.
- Bill services (99495 or 99496) once during the total TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services.
- Post-op visits are excluded from TCM services.
- **Providers can bill for new problems (UTI/injury etc.) that develop during the 30-day period with the codes for office visits and virtual visits.**

Care management services include and can be billed in conjunction with (for the same calendar month) per final rule CY 2020 and 2021:

- Advance care planning: codes 99497–99498
- Care plan oversight services: codes 99374–99380
- Cognitive assessment and care plan services: code 99483
- Home health or hospice supervision: codes G0181 and G0182
- End-stage renal disease services: codes 90951–90970
- Chronic care management (CCM) services: codes 99490, 99491, 99487, 99489 (HCPCS G2058 replaced by CPT 99439 CY 2021)
- Prolonged E/M services without direct contact: codes 99358, 99359
- **If the patient is readmitted during the 30-day period, they do not receive the TCM reimbursement.**

Transitional care management documentation requirements

At a minimum, document the following information in the beneficiary's medical record:

- Beneficiary discharge date
- Beneficiary/care giver interactive contact date
- Face-to-face (or now available telehealth) visit date
- Medical complexity decision making (moderate or high)

Transitional care management components

1. The 30-day TCM period begins on the beneficiary's inpatient discharge date and continues for the next 29 days.
2. Contact the beneficiary/caregiver within two business days following a discharge. The contact may be via telephone, email, or a face-to-face visit. **Attempts to communicate should continue after the first two attempts in the required business days until successful.**
3. Conduct a follow-up visit within 7 or 14 days of discharge, depending on the complexity of medical decision-making involved.
4. **Medication reconciliation and management must be furnished no later than the date of the TCM visit (code 1111F).**
5. Obtain and review discharge information.
6. Review the need for and/or follow up on pending test/treatments.
7. Educate the beneficiary, family member, or caregiver.
8. Establish or re-establish with community providers and services.
9. Assist in scheduling follow-up visits with providers and services.