MPC, Inc.

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CELEBRATING 22 YEARS OF EXCELLENCE

MEDICAL PRACTICE CONSULTANTS, INC.

Transitional Care Management Services

Transitional Care Management (TCM)

The requirements for Transitional Care Management services include:

- The services are required during the beneficiary's transition to the community setting following particular kinds of discharges;
- The health care professional accepts care of the beneficiary post-discharge from the facility setting without a gap;
- The health care professional takes responsibility for the beneficiary's care; and
- The beneficiary has medical and/or psychosocial problems that require moderate or high complexity medical decision making.

The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days.

Health Care Professionals Who May Furnish TCM Services

The following health care professionals may furnish TCM services:

- Physicians (any specialty); and
- The following non-physician practitioners (NPP) who are legally authorized and qualified to provide the services in the State in which they are furnished:
  - ◊ Certified nurse-midwives;
  - ◊ Clinical nurse specialists;
  - ◊ Nurse practitioners; and
  - ◊ Physician assistants.

When "you" is used in this publication, we are referring to these health care professionals.

TCM Services Settings

TCM services are furnished following the beneficiary's discharge from one of the following inpatient hospital settings:

- Inpatient Acute Care Hospital;
- Inpatient Psychiatric Hospital;
- Long Term Care Hospital;
- Skilled Nursing Facility;
- Inpatient Rehabilitation Facility;
- Hospital outpatient observation or partial hospitalization; and
- Partial hospitalization at a Community Mental Health Center.

Following discharge from one of the above settings, the beneficiary must be returned to his or her community setting, such as:

- His or her home;
- His or her domiciliary;
- A rest home; or
- Assisted living.

Components Included In TCM

During the 30 days beginning on the date the beneficiary is discharged from a hospital inpatient setting, the following three TCM components must be furnished:

- An interactive contact;
- Certain non-face-to-face services; and
- A face-to-face visit.

An Interactive Contact

- You must make an interactive contact with the beneficiary and/or caregiver, as appropriate, within 2 business days following the beneficiary's discharge to the community setting. The contact may be via telephone, e-mail, or face-to-face.
- For Medicare purposes, attempts to communicate should continue after the first two attempts in the required 2 business days until they are successful. A successful attempt requires a direct exchange of information and appropriate medical direction by clinical staff with the beneficiary and/or caregiver and not merely receipt of a voicemail or e-mail without response from the beneficiary and/or caregiver. You may not bill the TCM if there was no successful communication within the 30-day period between the facility discharge and the date of service for the post-discharge TCM code.

Certain Non-Face-To-Face Services

You must furnish non-face-to-face services to the beneficiary, unless you determine that they are not medically indicated or needed. Certain non-face-to-face services may be furnished by licensed clinical staff under your direction.

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Services Furnished by Physicians or NPPs

You may furnish the following non-face-to-face services:

- Obtain and review discharge information (for example, discharge summary or continuity of care documents);
- Review need for or follow-up on pending diagnostic tests and treatments;
- Interact with other health care professionals who will assume or reassume care of the beneficiary's system-specific problems;
- Provide education to the beneficiary, family, guardian, and/or caregiver;
- Establish or re-establish referrals and arrange for needed community resources; and
- Assist in scheduling required follow-up with community providers and services.

Services Furnished by Licensed Clinical Staff Under the Direction of a Physician or NPP

Licensed clinical staff under your direction may furnish the following face-to-face services:

- Communicate with agencies and community services used by the beneficiary;
- Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living;
- Assess and support treatment regimen adherence and medication management;
- Identify available community and health resources; and
- Assist the beneficiary and/or family in accessing needed care and services.

A Face-To-Face Visit

One face-to-face visit must be furnished within certain timeframes as described by the following two new Current Procedural Terminology (CPT) codes (effective for services furnished on or after January 1, 2013):

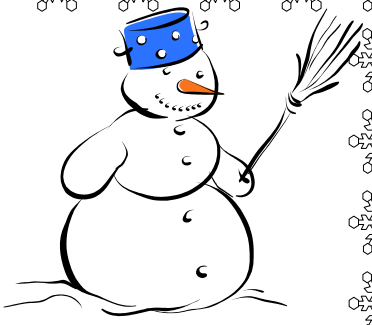
- CPT Code 99495 – Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge); or
- CPT Code 99496 – Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge).

The face-to-face visit is part of the TCM service and is not reported separately.

Medical Decision Making

Medical decision making is determined by considering the following factors:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), selecting the diagnostic procedure(s), and/or selecting the possible management options.



Medication Reconciliation and Management

Medication reconciliation and management must be furnished no later than the date you furnish the face-to-face visit.

Billing TCM Services

Information about billing TCM services is provided below:

- Only one health care professional may report TCM services;
- Report services once per beneficiary during the TCM period;
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day discharge day management services are reported;
- Reasonable and necessary evaluation and management (E/M) services (other than the required face-to-face visit) to manage the beneficiary's clinical issues should be reported separately;
- You may not bill TCM services and services that are within a post-operative global period (TCM services cannot be paid if any of the 30-day TCM period falls within a global period for a procedure code billed by the same practitioner);
- When you report CPT codes 99495 and 99496 for Medicare payment, you may not also report the following codes during the TCM period:
  - ◊ Care plan oversight services: Healthcare Common Procedure Coding System (HCPCS) codes G0181 and G0182; and
  - ◊ End-Stage Renal Disease services: CPT codes 90951 – 90970; and
- You must document the following information, at a minimum, in the beneficiary's medical record:
  - ◊ Date the beneficiary was discharged;
  - ◊ Date you made an interactive contact with the beneficiary and/or caregiver;
  - ◊ Date you furnished the face-to-face visit; and
  - ◊ The complexity of medical decision making (moderate or high).

"And now we welcome the new year, full of things that have never been"

– Rainer Maria Rilke