### Qualifying TOC settings:
- Inpatient acute care hospital
- Observation status in a hospital
- Long-term care hospital (LTAC)
- Skilled nursing facility (SNF)
- Inpatient rehabilitation facility
- Inpatient psychiatric hospital
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a community mental health center

### Current Procedural Terminology (CPT) codes:

<table>
<thead>
<tr>
<th>Current CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99495</td>
<td>2.36 wRVUs: Increase from CY19 by 0.25 - TCM (medical decision-making of at least moderate complexity) requires:</td>
</tr>
<tr>
<td>99496</td>
<td>3.10 wRVUs: Increase from CY19 by 0.05 - TCM (medical decision-making of high complexity) requires:</td>
</tr>
</tbody>
</table>

- Initial communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge (Monday-Friday, except holidays).
- If two or more separate attempts are made in a timely manner, but are unsuccessful and other TCM criteria are met, the service may be reported.

### Face-to-face or telehealth visit within 14 days of discharge
- Medication reconciliation and management
- Date of service reported on the claim is the date of the face to face visit or telehealth visit. Claims may be submitted after the visit is completed.

### Face-to-face or telehealth visit within 7 days of discharge
- Medication reconciliation and management
- Date of service reported on the claim is the date of the face to face visit or telehealth visit. Claims may be submitted after the visit is completed.

### Documentation:
- Discharge date
- Date of interactive contact and/or attempts to contact the beneficiary and/or caregiver within 2 business days
- Med reconciliation, assessment, interventions, & plan of care

### Physician/APP Encounter Documentation:
- F2F/telehealth visit date
- Consent to participate in a telemedicine visit using audio & visual technology
- Medication reconciliation
- Documentation supports the E/M service

### Insurance Payers: Medicare, Medicare Advantage / Commercial & Medicaid plans may vary by region

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Edit to Standard Evaluation &amp; Management wRVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>0.18 wRVUs</td>
</tr>
<tr>
<td>99212</td>
<td>0.48 wRVUs</td>
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<tr>
<td>99213</td>
<td>0.97 wRVUs</td>
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<tr>
<td>99214</td>
<td>1.50 wRVUs</td>
</tr>
<tr>
<td>99215</td>
<td>2.11 wRVUs</td>
</tr>
</tbody>
</table>

**Note:** Audio-video visits may be conducted. Document in the EHR as if the telehealth visits were an in-person visit. Include the time spent and any deviation in the service because the visit was not performed in-person. All care provided via telehealth should be documented in the EHR. Coding and billing for tele-video visits are to follow current processes for in-person visits per current payer guidance.
### Transitional Care Management Practice Workflow Example

#### 4/30/2020 Trinity Health © Livonia, MI

**Care Manager**

1. **Review ADT**
2. **Assess Risk Score**
   - **High and Rising Risk**
     - **Yes**
     - Initial Communication within Two Business Days:
       - May be done by direct contact face-to-face (F2F), telephone, or electronic.
       - Services may be provided by clinical staff (e.g., RN, pharmacist), under direction of physician, APP or QHP and may include:
         - Review discharge information/continuity of care documents
         - Identify need for and/or follow up on pending diagnostic tests & treatments
         - Identify patient needs, support for treatment regimen adherence, & need management
         - Identify, communicate, & facilitate access to care & services with other QHP, agencies, community services, & health resources
         - Educate patient, family, guardian &/or caregiver
   - **No**

3. **Outreach Documentation/Care Management Assessment**
   - Discharge date
   - Date of interactive contact and/or attempts to contact the beneficiary and/or caregiver within 2 business days
   - Medication assessment, interventions, & plan of care

**Practice Nurse (RN, LPN)**

- Initial Communication within Two Business Days:
  - May be done by direct contact face-to-face (F2F), telephone, or electronic.
  - Services may be provided by clinical staff (e.g., RN, pharmacist), under direction of physician, APP or QHP and may include:
    - Review discharge information/continuity of care documents
    - Identify need for and/or follow up on pending diagnostic tests & treatments
    - Identify patient needs, support for treatment regimen adherence, & need management
    - Identify, communicate, & facilitate access to care & services with other QHP, agencies, community services, & health resources
    - Educate patient, family, guardian &/or caregiver

**Medical Assistant (MA)**

- MA Intake During Face-to-Face/Telehealth Visit:
  - Intake paper select
    - TCM visit
    - Transitioning into care
    - Medication reviewed

**Physician and Advanced Practice Provider**

- Document in the TCM HIPE:
  - DX code, DX, Lab/Way results, Medication Review, Referrals needed. List the follow-up labs, tests, social determinants factors so the provider can address during the visit

- TCM Visit Encounter documentation:
  - F2F, Telehealth visit date
  - Consent to participate in a telehealth visit using audio & visual technology
  - Medication reconciliation
  - Documentation supports the EHR service
  - Select level of decision making